Examining infectious disease surveillance in Lebanon after 2011: “Border as method” as a discourse-historical approach

Majd Saleh, MPH, DrPH(c)

Department of Global Health and Development, LSHTM

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Supervisory team:

Natasha Howard, Department of Global Health and Development, LSHTM

Diane Duclos, Department of Global Health and Development, LSHTM

London School of Hygiene and Tropical Medicine, Keppel Street, London, WC1E 7HT, United Kingdom

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Declaration by candidate

I have read and understood the LSHTM definition of plagiarism and cheating. This thesis presents my own original work, and I have acknowledged all results and quotations from published or unpublished work of others.

Signature: Majd Saleh

Date: August 2024

Acknowledgment and dedication

This work would not have been possible had I not had the emotional and technical support of so many people.

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I dedicate this thesis to my mother, husband, and children.

ABSTRACT

Background

Lebanon is a neoliberal society with a sectarian façade that experienced civil wars, foreign interventions and hosted displaced populations during the last century. These conditions have eroded Lebanese governmental institutions, including those working on infectious disease surveillance among refugees. I aimed to examine the interplay between Lebanon's historical-political background (e.g. sectarianism, internal conflict, internal and external border creation) and infectious disease surveillance activities and discourses and how these affect public health policy and practice, after the 2011 start of the Syrian conflict, using Border as Method theory.

Methodology

I conducted a discourse-historical analysis (DHA) between 2022 to 2023 using Ministry of Public Health (MOPH) infectious disease surveillance internal documents, news from four media outlets (broadcast and print) associated with different political poles, and semi-structured interviews with surveillance professionals within public and private sectors. I linked findings to Border as Method theories, literature, and Lebanon's historical-political context.

Findings

Border creation, both internal and external to modern-day Lebanon, appears to have affected perceptions of epidemiological surveillance activities for Syrian refugees. Media and MOPH documents described refugees as infectious disease threats to which health surveillance authorities and international partner organizations are justified in responding. Interviewees additionally emphasized how sectarian fragmentation led to clientelist employment in refugee health programmes and how power dynamics in setting health agendas with international organizations often diverged from national needs.

Conclusion

Findings show that Lebanon's historic socio-political context affects infectious disease surveillance discourses, policies, and activities, especially related to refugees. This original effort to address infectious disease surveillance using socio-political theories, historical contexts, and a discourse-historical analysis, contributes to the limited literature in this domain. Despite complexities, critical disease surveillance analysis that incorporates the history, socio-politics, and economics of the creation of modern West Asia has benefits for swapping fear/threat-approaches to promote more inclusive policies and practices, e.g. using inter-regional grass-root conviviality.

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List of Abbreviations

AMR	Anti-Microbial Resistance
AUB	American University of Beirut
CDA	Critical Discourse Analysis
CDC	Centres for Disease Control and Prevention
COVID	Corona-Virus Disease
DHA	Discourse-historical Approach
DrPH	Doctor of Public Health
ESU	Epidemiological Surveillance Unit/program
EU	European Union
GOARN	Global Outbreak Alert and Response Network
GPHIN	Global Public Health Intelligence Network
IHR	International Health regulations
IMC	International Medical Corps
ITS	Informal Tented Settlements
LBCI	Lebanese Broadcasting Corporation International
LSHTM	London School of Hygiene and Tropical Medicine
MOPH	Ministry of Public Health
NAP	National Aids Programmes
NGO	Non-Governmental Organizations
NTP	National Tuberculosis Program
OPA	Organizational and Policy Analysis
SARS	Severe Acute Respiratory Syndrome
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFIL	United Nations Interim Force in Lebanon
UNRWA	United Nations Relief and Works Agency for Palestine Refugees
USA	United States of America
USD	United States Dollars
VPD	Vaccine Preventable Diseases
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Chapter overview

This chapter introduces this thesis entitled *Examining infectious disease surveillance in Lebanon after 2011: "Border as method" as a discourse-historical approach*. I start by providing the reader with a short summary of my Organization and Policy Analysis (OPA) research on infectious disease surveillance addressing refugees in Lebanon, a prerequisite to this thesis. I also explain how this led to the current thesis topic at hand. Pertinent to any study, I discuss my choice of population of interest for this study along with the aims and objectives. This is followed by a short discussion of the terminology I use, or don't use, within this thesis for clarity of concepts. I address the philosophical foundations for this study, and how this thesis can contribute to the literature. Finally, I provide a summary of each chapter in this thesis.

Thesis context

This thesis contributes to completion of the Doctor of Public Health (DrPH) programme at the London School of Hygiene and Tropical Medicine (LSHTM). Part of the program requires that I conduct an Organization and Policy Analysis (OPA) before completion of the thesis, my analysis was on infectious disease surveillance activities targeting refugee populations at the epidemiological surveillance program, commonly referred to as ESU, at the Lebanese Ministry of Public Health (MOPH). The OPA report aimed to examine how the organizational structure of the Lebanese Epidemiological Surveillance Program (ESU), Ministry of Public Health (MOPH), and Lebanese socio-politics affected infectious disease surveillance for refugees in Lebanon. The refugee population of interest were the Palestinian and Syrian refugees. Taking the ESU as a case study, I used observations at central and peripheral infectious disease surveillance offices, semi-structured interviews with surveillance professionals, and internal document revision. I analysed the data thematically to find recurring themes and used organizational analysis tools such as stakeholder mapping and socio-political enablers and challenges to fit within the OPA structure (Saleh & Howard, 2023).

Three major themes appeared in the OPA project. First, Lebanon is not a 1951 Refugee Convention signatory, and this affected the government's response or involvement in the refugee displacement in 1948 and 2011 (Janmyr, 2017). It has been articulated that Lebanese representatives at the 1951 convention were uncertain about the Convention's obligations, preferring third parties take care of refugees rather than being directly involved (Janmyr, 2017). Hence the creation of UNRWA as the main contributor to Palestinian healthcare programmes, including infectious disease surveillance which works

in parallel with the national Lebanese infectious disease surveillance (Knudsen, 2009; Saleh & Howard, 2023; UNRWA, 2018). This however played differently in 2011, with the Syrian displacement into Lebanon, internal disagreement on policies related to Syrian presence was prominent among Lebanese parliamentary and political groups. At the start of the displacement, authorities considered anti-Syrian regime, welcomed Syrian refugees and suggested official refugee camps. On the other hand, authorities supporting the Syrian regime rejected the suggestion (Frangieh, 2014; Frangieh & Barjas, 2016). This had a toll on the Syrians who resorted to renting apartments, living in abandoned structures, or setting up informal tented settlements (ITS) while receiving assistance from a multitude of United Nations and International NGOs (Frangieh, 2014; Frangieh & Barjas, 2016). After dramatic increases in refugee numbers in 2013, and the increase in international funds provided to Lebanon, the government, including ESU, became involved in the response to the Syrian displacement (Saleh & Howard, 2023). The second theme that emerged from the OPA was that of the suboptimal epidemiological surveillance program organizational context, in terms of its hierarchy and reporting system before and post-2011 (Saleh & Howard, 2023). The ESU lacked a clear reporting hierarchy, and some offices and personnel had no job descriptions leading to a missing team environment. This was an issue when addressing refugee populations where some personnel had to take part in the Syrian displacement in an ad hoc manner rather than through formal mechanisms. The third related theme is that the ESU coordination with partners, internal to MOPH and external, appeared limited to personal efforts rather than organisational intent. As a result, many partners did not know of the presence of a national surveillance programme, and other systems of infectious disease surveillance such as that of UNRWA, was working in parallel with no connection to that of national surveillance (Saleh & Howard, 2023).

Through the OPA I identified a gap in understanding how the Lebanese socio-political context affected infectious disease surveillance more deeply. I realised it was necessary to analyse infectious disease surveillance from a different perspective and methodology to understand how the Lebanese context and the prevailing discourses arising from this context can affect or be affected by infectious disease surveillance in Lebanon. Helping me understand further were the readings on borders - both physical and cognitive - that shape people's day-to-day lives, particularly Mezzadra and Neilson's (2013) border as method framing that I use for my thesis. Borders, they suggest, are not just lines drawn on maps, but also cognitive ones that shape social identities and ideologies, creating a form of hierarchy between who is accepted to cross the border and who is excluded based on their usefulness (labour) or infectivity, which in itself, authors suggest, is a form of violence (Mezzadra & Neilson, 2013). Helping me further was the statement by White (2023) who suggested that it is pertinent to not just study the structure and practices

of health programmes in general, and in my case infectious disease surveillance in particular, but also to try to understand the discourses around such practices and activities, especially when looking at how this might affect displaced populations (White, 2023). Hence, from readings of these authors and others - Edward Said, Arturo Escobar, and Achille Mbembe, to name a few, the idea of this thesis emerged.

Aim and objectives

My aim was to analyse discourses related to, and arising from, infectious disease surveillance within Lebanon's historical-political background (e.g. history of sectarianism, Lebanese identity, border creation).

Objectives were to:

1. identify how infectious disease surveillance of, and related discourses about, Syrian refugees in Lebanon, shape, replicate, or challenge Lebanon's historical-political context, particularly in external and internal frontier (re)creation.
2. investigate how different data types (media reports, official documentation, and interviews) reveal similar or different discourse schemes.
3. analyse whether different political camps or sectarian groups in Lebanon, within their media outlets, differ in their discourses concerning infectious disease surveillance for Syrian refugees.
4. consider how the findings of these discourses on infectious disease surveillance for Syrian refugees in Lebanon might shape or inform public health policy and practice responses in Lebanon.

Population of interest

I would like to provide a note on why I chose to focus on Syrian refugees in this thesis. My OPA showcased that the national surveillance program is not involved in the surveillance of Palestinian refugees given the presence of UNRWA's health and surveillance programs (Saleh & Howard, 2023). Hence, due to time and word count constrains, I narrowed my focus to Syrian refugees. This is important given there is a multiplicity of agencies working with this population providing a privileged space for studying how surveillance, discourses around it, and policies and practices, affects the Syrian refugees. However, this does not mean that the significance of the history of Palestinian displacement into Lebanon is not discussed; its importance is mentioned throughout the historical context and discussion of this thesis. Nonetheless, it is important to reflect on this specific population of interest. This population, in principle, are the Syrian refugees that have been registered with the UNHCR and receiving assistance from UN agencies for whom coordination activities between MOPH and its surveillance programme take place. This does not exclude unregistered Syrians from surveillance activities, since surveillance officers receive

reports from all health institutions in Lebanon and investigations are conducted with all populations. As my OPA research showed "Standard ESU reporting forms began including 'Nationality' to stratify Syrian refugees during analysis […] this proxy did not indicate whether they were actually refugees or pre-conflict residents" (Saleh & Howard, 2023, p. 8). Given this finding, both registered and unregistered Syrians, pre and post conflict, from differing socio-economic statuses, would have been included in surveillance activities. In terms of how this is reflected in my findings, most media reports, documents, and interviews do not stratify by refugee status. The complexity of refugee status in Lebanon thus affects interpretation and reporting in many different ways.

Defining relevant terminology

In this section, I describe and discuss the major terms I use, and avoid, throughout the thesis. Many are explained further throughout this study's chapters. The conceptual framing guiding my thesis is **border as method**. Though Mezzadra and Neilson (2013) do not provide a clearcut definition of what border as method is, yet they do explain this concept throughout their theoretical and historical discussions. They suggest that borders are in a constant state of change and proliferation and depend on the process of valorisation of capital, in turn, creating hierarchies between who is allowed across borders for their labour usefulness, and whose movement is restricted, making borders a method and not just lines drawn on maps (Mezzadra & Neilson, 2013). This act of hierarchy creation is a form of violence particularly affecting migrant populations seeking better living conditions. Pertinent to my study is what the authors suggest of borders being cognitive barriers, that shape our social identities, and that these identify cannot be detached from material contexts such as violence and domination (Mezzadra & Neilson, 2013).

A pertinent note, in relation to **borders** and **boundaries** is that the use of both terms to mean the same thing can be contested. The term boundaries, as written by Sahlins (1989) for example, distinguishes a territory and identity and its role in the creation of "Us" versus "Them" ideology, as in the history of the demarcation of the Pyrenees. Borders, meanwhile, are more often used to mean physical demarcation lines (Sahlins, 1989). However, this distinction remains unclear and Border as Method uses border in the sense of both territory and identity. Therefore, I also use "borders" to indicate these physical and cognitive boundaries as suggested by Border as Method (Mezzadra & Neilson, 2013).

Related to the creation of cognitive borders and hierarchies, Said (1978) investigated how discourses used in Orientalists' writings, both literature and political speeches, created Oriental knowledge and reality

(Said, 1978). These discourses emphasized Western dominance, both military and economic, when writing about the division and discrimination between Western "us" and Eastern "them." Hence, the dichotomization of "the Self" versus "the Other," which I also write as "**othering**," are terms recurring in this thesis. As elaborated below, and suggested by authors - that states, and their borders, capitalise differences emphasising the concept of "us" versus "them" (Goldberg, 2002; Sahlins, 1989). My use of "The Self" in my results chapters reflects the state that encompasses: the Lebanese population, the Lebanese authorities (health and others), and international organization counterparts as they are oftentimes described as amalgamated with national authorities. My use of "The Other" is to describe Syrian refugees in Lebanon, and potentially other displaced populations i.e. non-Lebanese.

Further, **colonialism**, **postcolonialism**, and **postcolonial theory** are important terms that need to be explored. My use of the term Colonialism or colonial era expresses an era spanning the late fifteenth century and the twentieth century, where European and Western forces occupied, settled, ruled, and produced knowledge about, foreign spaces (Mezzadra & Neilson, 2013; Said, 1978; White, 2023). It was and still is a mode of rule and a mode of creating social identities, especially those dichotomizing the "west versus the rest" (Said, 1978; White, 2023). I use Postcolonialism to describe the era after colonial settlements were physically removed, though their effects are still visible now, especially by Western capitalist societies, what Said (1978) refers to as neocolonialism. Postcolonial theory, on the other hand, I use to signify the critique of colonial and postcolonial discourses or scholarship in general (Burney, 2012). Related to this is the term decolonization or decolonial epistemology, though barely used within this thesis, it will be discussed further in the philosophical foundations section below.

A key term is health surveillance. The definition I use, which is the most salient one, is that of the World Health Organization (WHO) that states surveillance is "the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in planning, implementing, and evaluating public health policies and practices" (WHO, 2006, p. 1). My use of this term does not, however, suggest that I am not aware of the contestations with regards to the activities of infectious disease surveillance themselves. As will be further discussed in Chapter 4, it has been argued that WHO built on past European and Western international convention experiences of the 17th century on regulations for notification of specific infectious diseases and hence these surveillance activities still hold on to colonial time motives (Cameron-Smith, 2019; Genest, 2015; King, 2002; Pereira, 2008; Sastry & Dutta, 2012; White, 2023).

The term's **migrant**, **displaced populations** and **refugees** are sometimes used interchangeably and have been contested. For this thesis, I recognise the definitions by IOM and UNCHR (IOM, 2019; UNHCR, 2010).

Migrants, according to the International Organization for Migration (IOM), is a general term that includes any person leaving their usual residence for whatever reason (IOM, 2019). Refugees on the other hand, according to the UNHCR 1951 Convention protocol, are those that flee their usual place of nationality in fear of persecution and unable to return or be protected in their usual place (UNHCR, 2010). The definition of displacement is an individual leaving their usual residence due to armed conflict or violence (IOM, 2019). Despite these definitions, my stance within this thesis is that these terms can be socially constructed, as scholars have suggested the political status of, attitudes towards, and socio-linguistics around a migrant or refugee can differ from one community to another (Rheindorf & Wodak, 2020). Importantly, migrant/refugee status can be either accepted or refuted depending on their usefulness within the economy of the host community (Mezzadra & Neilson, 2013).

The subaltern is a term coined by Antonio Gramsci and later used extensively by post-colonial authors, most notable Gayatri Chakravorty Spivak (Spivak, 1999). The subaltern, sometimes referred to by Gramsci as subordinate, are individuals who are subject to the ruling classes or other hegemonic entities (Gramsci et al., 1971). Despite this general definition, the term is heterogeneous and encompasses several subaltern groups (Spivak, 1999). Some once established can exercise a form of internal hegemony, there are other subaltern groups that never can (Gramsci et al., 1971). According to Spivak, there lies within this heterogeneity a group that are denied speaking, in her examples, the female subaltern (Spivak, 1999). For this thesis, I will be using the term subaltern to express all those who have been colonized, their knowledge produced for them in European-USA centred education systems, and who wish to create change. I will be addressing the topic of how I fit within the subaltern discussion in my reflection section in Chapter 3.

In terms of specifying the location of study, Lebanon will be addressed as part of **West Asia** rather than the Middle East. Scholars addressing the construct of the term Middle East suggest that it is a western-imperial term, particularly European in accordance to their perspective of space, yet also suggest that it is a replacement of the term Oriental coined by orientalists at the beginning of the 17th century (Culcasi, 2010; Khalidi, 1998). As the orient was described as inferior in most oriental discourses, so too is the Middle East, legitimizing expansion of Euro-USA presence in the area (Culcasi, 2010). Another reason for not using the term is that the geographical boundary of the Middle east is ambiguous and hard to pinpoint even on world atlases in the West (Culcasi, 2010; Khalidi, 1998). The term Middle East is contested by Arabs themselves, and by some academics, whilst barely used in the maps created by individuals in that region themselves (Culcasi, 2010, 2012). It is worth noting that I am aware that the use of “Arab homeland”, as some Arabs in the region prefer to name it, excludes the non-Arabs in the region (Culcasi,

2012; Khalidi, 1998). Despite that I coincide with border as method that regions are in a constant state of proliferation and/or erasure and their mapping has cognitive consequences (for example attributing inferiority of locations) and hence deciding on a naming of the area can be controversial, I will still use the term West Asia to provide the reader with a sense of the geographical location (Khalidi, 1998), and to render the area more inclusive.

Since I am conducting a discourse analysis, I must state what I mean by **discourse**. I will be using the agreed Critical Discourse Analysis (CDA) description of discourse, as the "use of language seen as a form of social practice" (Fairclough, 1995, p. 7; Wodak & Meyer, 2001). Fairclough (1995) further states that discourse is not only the agreed upon written or spoken text, but even pictures or musical pieces can be discourses. These different multi semiotic sources of data have been used in the analysis of discourses since they are part of this social practice (Fairclough, 1995). Discourse, according to Wodak and Meyer (Wodak & Meyer, 2001) "can be seen as constituting non-discursive and discursive social practices and, at the same time, as being constituted by them" (2001, p. 66).

Another concept I use often is that of **racialization of diseases**, a term coined by some social scientists when addressing the link created between specific infectious diseases and a specific race identity (Briggs, 2011; King, 2003; White, 2023). This term is important since the stigmatization of certain groups, through the racialization of diseases, is suggested to contribute to the strict control measures that can eventually lead to these populations' exclusion from healthcare access and prevention efforts (Briggs, 2011; King, 2003; White, 2023). Therefore, I will use this term when addressing how authorities, and the media they represent, use discourses on racial identity and its connection to diseases as a means of justifying subjugation of these 'othered' populations, especially in the context of national health security (White, 2023). While I recognise that Lebanese and Syrians cannot be differentiated in terms of race, Goldberg (2002) suggests that the state capitalizes on racial differences to control "the other." In this thesis, the state is Lebanon and the "other" is the Syrian population, which is a cross-border ethnic rather than racial difference (Goldberg, 2002). However, in the way it is framed in Lebanon, I would argue that this conceptualisation is appropriate. I thus apply this term for differences imaged between cross-border populations, using the discourse of difference for creating hierarchies and control systems that appears very relevant to my findings.

Finally, concerning my use of the word **subjectivities**, the concept of the production of subjectivity is a contested one and does mean several things depending on the scientific domain being studied. Since I will be conducting discourse analysis, I will be using what Fairclough describes as **social identities** being

"constituted, reproduced, and transformed in and through social practice" (Fairclough, 1992, p. 44). Fairclough (1992; 1995) suggests we understand how discourses or discursive practices affect social identities or subjectivities. Hence, my referring to subjectivities essentially posits how social structures and practices affect social identities in Lebanon, and how this can be changed or challenged. Further, Mezzadra and Neilson (2013) often refer to this as the production of political subjectivities when analysing border struggles (Mezzadra & Neilson, 2013). Salloukh et al (2015), also declare that sectarianism in Lebanon affects subjectification, which is another form of political subjectivity (Salloukh et al., 2015).

Philosophical foundations

My ontological and epistemological stance are closely related to critical theory, particularly to epistemic de-coloniality, sometimes referred to as epistemological de-coloniality. This views the world as a state of conflict shaped by the hegemonic socio-political influences yet encourages room for socio-political transformation (Brown & Dueñas, 2020). Though this perspective is argued by Mignolo (2011) as distinct from postcolonial epistemologies, I find that my study started out with the understanding that knowledge can and needs to be decolonized, an aspect many postcolonial theorists encourage such as Frantz Fanon and Achille Mbembe. Mignolo (2011) and Ndlovu-Gatsheni (2013) suggest that epistemic de-coloniality is a form of "Epistemic disobedience" or provides a "Counter-hegemonic" perspective where we delink ourselves from colonial thinking and understand the struggles that arise from it while encouraging transforming of economic and knowledge hegemonies (Mignolo, 2011; Ndlovu-Gatsheni, 2013). Despite its relevance to today's political and economic context, it also suggests we acknowledge the genealogy of decolonial thinking, i.e. understand that decolonial thinking dates back to South America in the 16th century decades before the modern decolonial thinking post British and French mandates emerged (Guilherme, 2019; Mignolo, 2011). This brings me to finally address the axiology of this study, or why am I conducting this study (Brown & Dueñas, 2020). My stance is to encourage public health researchers and practitioners to help transform and change the current hegemonic practices of colonial medicine that, based on the literature (Chapter 2), and findings of this study, suggest that history of hegemony still has a place in our practices making health equity harder to achieve. The theoretical framework and methodology are detailed in Chapter 3.

Contribution to the literature

To my knowledge, there is limited literature on how borders, physical and cognitive, condition public health surveillance activities (Mezzadra & Neilson, 2013). The existing literature suggests that infectious disease surveillance has contributed to the creation of several socio-political and discursive conditions. The first

condition was of the historical justification of colonial presence in the name of humanitarian and modernizing activities and the continuation of this logic through international surveillance programmes (Abeysinghe, 2016; Au, 2006; Barker, 2012; Caduff, 2014; Cameron-Smith, 2019; Cole & Dodds, 2020; Crane, 2010; Davis & Sharp, 2020; Faleye, 2017; Figuié, 2014; Figuié et al., 2015; French, 2009; Genest, 2015; Hinchliffe, 2021; Hinchliffe et al., 2012; Hsien-Yu, 1998; Ingram, 2007, 2009; King, 2002; Manderson, 2009; Papamichail, 2021; Peckham, 2018; Pereira, 2008; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007, 2010). Second, and contemporarily, the national security discourses and the resulting border closures resulting in the exclusion of populations. Additionally, public health surveillance was presumed to have assisted in the ever-changing form of borders, in terms of their proliferation, blurring, erasure, security control rhetoric, and in the creation of hierarchies, i.e. the healthy who are allowed entrance versus nonhealthy who are excluded (Barker, 2012; Caduff, 2014; Cheng, 2015; Chuengsatiansup & Limsawart, 2019; Cole & Dodds, 2020; Crane, 2010; Davis & Sharp, 2020; Figuié et al., 2015; French, 2009; Genest, 2015; Hinchliffe et al., 2012; Ingram, 2009, 2009; King, 2002; Peckham, 2018; Peckham & Sinha, 2019; Pereira, 2008; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007, 2010). The third condition was that of safeguarding trade and capitalist interests in the form of ensuring healthy labour. This also encompasses the unethical focusing on infection threats to European and Western industrial countries while ignoring the outbreaks that happened as a result of colonial presence such as Smallpox in indigenous populations in the 1560s (Caduff, 2014; Cameron-Smith, 2019; Figuié et al., 2015; Genest, 2015; Hinchliffe, 2021; Hinchliffe et al., 2012; Hsien-Yu, 1998; Ingram, 2007; King, 2002; Manderson, 2009; Peckham, 2018; Pereira, 2008; Sastry & Dutta, 2012; White, 2023). The fourth condition is that of media discourses and their assistance in the racialization of diseases and eventually with the production of physical and cognitive borders (Abeysinghe, 2016; Barker, 2012; Caduff, 2014; Genest, 2015; Ingram, 2009; King, 2002, 2002; Peckham, 2018). Finally, and notwithstanding, forms of resistance have been documented, yet also fall short of providing operational recommendations for challenging these conditions (Au, 2006; Faleye, 2017; Figuié et al., 2015; Hsien-Yu, 1998; Ingram, 2007; Manderson, 2009; Peckham, 2018).

The literature showcases that in depth analysis is needed with examples of how these physical and cognitive borders affect or are affected by infection disease surveillance, both from the past and present, by subalterns themselves, to better articulate this linkage. Further, to my knowledge, there has not been a holistic study linking both structural aspects of infectious disease surveillance activities and their discourses using historical and socio-political theories in West Asia and Lebanon particularly. This study provides such an example and positions itself within the literature and contemporary debates on infectious disease surveillance and the socio-political conditions and discourses that shape it, especially when

addressing refugee and migrant populations. As far as I am aware, this is a novel study addressing infectious disease surveillance using socio-political theories, historical contexts, and a discourse-historical analysis method, and its findings contribute to the limited literature in this domain and this geographical area. Hopefully, it allows other public health professionals to critique their activities by examining the historical and socio-political complexities of health programmes addressing refuge populations to inform more inclusive practices and policies.

Thesis overview

This thesis is divided into eight chapters. In Chapter 1, I introduce the thesis, provide a summary of my previous work on infectious diseases surveillance in Lebanon, outline rational and aims and objectives of the research, and position my study within the broader literature.

In Chapter 2, I provide a summary of the historical and infectious disease surveillance context, as a foundation for thesis findings and discussion. The historical context of Lebanon is turbid: people in Lebanon have experienced civil wars, foreign interventions, forced displacement, and this within a neoliberal system with a sectarian façade. These factors lead to reduced governmental authority affecting Lebanese institutions especially those working with refugees such as the health sector.

In Chapter 3, I detail the methodology of the thesis. The theoretical framing of my thesis is "Border as method." The data genres, or types, I used are broadcast and print media reports, from different political poles, internal MOPH surveillance documents, and key informant interviews with surveillance professionals, present and former, in infectious disease surveillance in Lebanon. For the analysis I applied a discourse-historical approach as detailed by Wodak (2015). I also reflect on my positionality as a Lebanese public health practitioner and researcher conducting this study.

In Chapter 4, I present the results of a scoping literature review informed by critical interpretive literature synthesis. I detail the history of surveillance and its significance today. Surveillance activities targeting colonized populations were believed to have assisted colonial motives to justify colonial presence, a motive said to be present today in the rhetoric of national security. Further, the ever-changing form of borders, in terms of their proliferation, blurring, erasure, control, creating hierarchies, and cognitive creation was a presumed result of public health surveillance. Trade, economic interests, and healthy labour were presumed to be the motive behind the working of infectious disease surveillance activities, an example of which is the International Health Regulations (IHR). The chapter ends with a description of forms of resistance to these conditions and resultant recommendations.

In Chapters 5-7, I take the reader through the outcomes of the discourse historical analysis. The analysis of media (Chapter 5) showed that discourses evident in newspapers and television broadcast outlets, regardless of political background, emphasized the threat of infectious disease importation from refugee populations into Lebanon, and in turn stressed the role of authority, in our case health, surveillance, and international organizations, in combating this threat. The same discourses were evident in the documents reviewed (Chapter 6), which were overwhelmingly circulars and memos inviting institutions to attend training on surveillance after the displacement of Syrian refugees into Lebanon. Finally, the interviews (Chapter 7) emphasized the role of the sectarian system and its fragmentation on the activities and policies around infectious disease surveillance and how it affects their work with the refugee populations. Examples of its effects are clientelism in employment due to sectarianism backed by neoliberalism, and the taking up of projects due to international funds despite the evidence that they are not needed. In these chapters, findings are accompanied by concise discussion sections, while the main discussion is in Chapter 8.

In Chapter 8, I discuss all findings, exploring convergences, divergences, and their significance regarding health surveillance policy and practice. The discussion also bridges theory, historical background, and literature with the findings, an essential step for discourse-historical analysis. Internal fragmentation, or sectarianism, is a typical phenomenon in Lebanese history, and this has affected the work of health surveillance especially in terms of clientelism and employment. Notwithstanding, the “othering” of Syrian refugees and alarmist discourse of threats of disease importation appeared across Lebanese political poles. Border as method helped me understand and discuss this form of cognitive border creation in which epidemiological data released by authorities, and the discourses revealed in the different data sources, helped create hierarchies to divide and classify people, i.e. who is a threat of disease importation (the Other) versus who is not (the Self). My recommendations provide suggestions for future infectious disease surveillance, where practitioners are encouraged to take a more critical and self-reflective stance in their work. This can be accompanied by changes in systems of formal education, while recognizing the complexity and fluidity of cultural identities and historical processes. Finally, another form of resistance to the status-quo would be starting from a clean slate to involve inter-regionalism and grassroots conviviality to try to eradicate the othering of migrant populations

CHAPTER 2: CONTEXTUALISING DISEASE SURVEILLANCE IN LEBANON

Chapter overview

The history of Lebanon is complex, yet its complexity might explain many of the discourses and actions of modern-day Lebanese, including its healthcare system. This chapter does not provide a thorough historical recount as this has been covered extensively by other authors (Salibi, 1988; Salloukh et al., 2015; Traboulsi, 2012). Here, however, I contextualise the health system, particularly the surveillance system, within the complex history and socio-political conditions of Lebanon before the declaration of Greater Lebanon until today. Particularly, I will be providing the readers with a history of Lebanese sectarian system, its modern geography and the resulting identity, and finally the Lebanese public health sector and its surveillance system.

Lebanese historical context

History of sectarianism, geography, and identity in Lebanon

The history of Lebanon has been traced back to Fatimid and Byzantine eras when it was a small mountainous area called Mount Lebanon (Salibi, 1988; Traboulsi, 2012). The first inhabitants were Druze, located mostly in its south, and Christian Maronites located in its north (Salibi, 1988; Traboulsi, 2012). In 1523, during Ottoman rule (1516-1918), the Druze were given feudal privilege and autonomy over the area. The Druze were landowners (Muqataaji), and oversaw silk production, while the Maronites were farmers producing the silk. With time, and because of their work as silk producers, the Maronites were able to build wealth, buy land, and become influential, especially in their relations with Europe. Despite its cultural, educational, and economic advancement, Mount Lebanon experienced several civil conflicts between different sects and social classes. This led to the end of the feudal system after 1840 and the division by the Ottomans into two districts headed by a Druze and a Maronite respectively, the first sectarian representation in the history of Lebanon (Salibi, 1988; Salloukh et al., 2015; Traboulsi, 2012, p. 26).

Lebanon's historical connection with Europe, particularly France and Britain, influenced the development of Greater Lebanon (Kaufman, 2015; Salibi, 1971, 1988; Traboulsi, 2012). Mount Lebanon experienced a devastating civil war in 1860, in which thousands of Maronites were massacred. This concerned France - considering itself the protector of the Christians of Lebanon - which deployed several thousand French troops to assist the Maronites (Salibi, 1988; Traboulsi, 2012). Britain also had an interest in the economic situation in Syria and silk production in Mount Lebanon, so it assisted the Druze by sending them weapons

(Salibi, 1988; Traboulsi, 2012). France initiated the end of the conflict, agreeing with other European powers that Lebanon be ruled by a Christian known as the Mutasarif. This was the case until the fall of the Ottoman empire (Salibi, 1971, 1988; Traboulsi, 2012).

After World War I, when the French and British divided and colonized areas previously under Ottoman rule, Mount Lebanon came under French mandate from 1920-1943 (Salibi, 1971, 1988; Traboulsi, 2012). The Maronites took advantage of their closeness to France and requested assistance in expanding their territories (Kaufman, 2015; Salibi, 1971, 1988; Traboulsi, 2012). Thus, in 1920, coastal cities such as Beirut and Tyr, predominantly Muslim, became part of the new Greater Lebanon (Salibi, 1971, 1988). However, this was a challenging decision since these areas were inhabited by different religious groups with different identities, complicating the sectarian governance structure further. Moreover, settlers in these annexed districts resisted, particularly in the North, and opposed being detached from Syria, however both France and the local bourgeoisie were interested in their ports (Salibi, 1971, 1988; Traboulsi, 2012). Despite opposition, all sects eventually accepting their assigned borders and the Republic of Lebanon was established after the end of the French mandate in 1943 (Salibi, 1988; Traboulsi, 2012).

The creation of Greater Lebanon led to identity formations within Lebanon. Salibi discussed the notion of Lebanese identity as having a complex composition and history (Salibi, 1971, 1988). Some Lebanese, particularly Christian Maronites, despite historical recounts emphasizing their Arab descent and their usage of Arabic language, began advocating for a Lebanese nationality and identity, or Lebanonism, traced back to the Phoenicians where the official language would be “Lebanese” (Salibi, 1988; Traboulsi, 2012). This was said to have been supported by the French (Salibi, 1988; Traboulsi, 2012). Other Muslim sects, despite internal divisions, saw themselves belonging to the larger Arab region, particularly Greater Syria, after the decline of the Ottoman empire, leading to the identity of Arabism (Salibi, 1971, 1988). Salibi expresses this complex and fragmented national identity in Lebanon after its division by Britain and France: **“**Of the five [Iraq, Syria, Palestine, Transjordan, Lebanon], however, common Arabic opinion singled out Lebanon as being an artificial creation of foreign imperialism in a special way” (Salibi, 1988, p. 31).

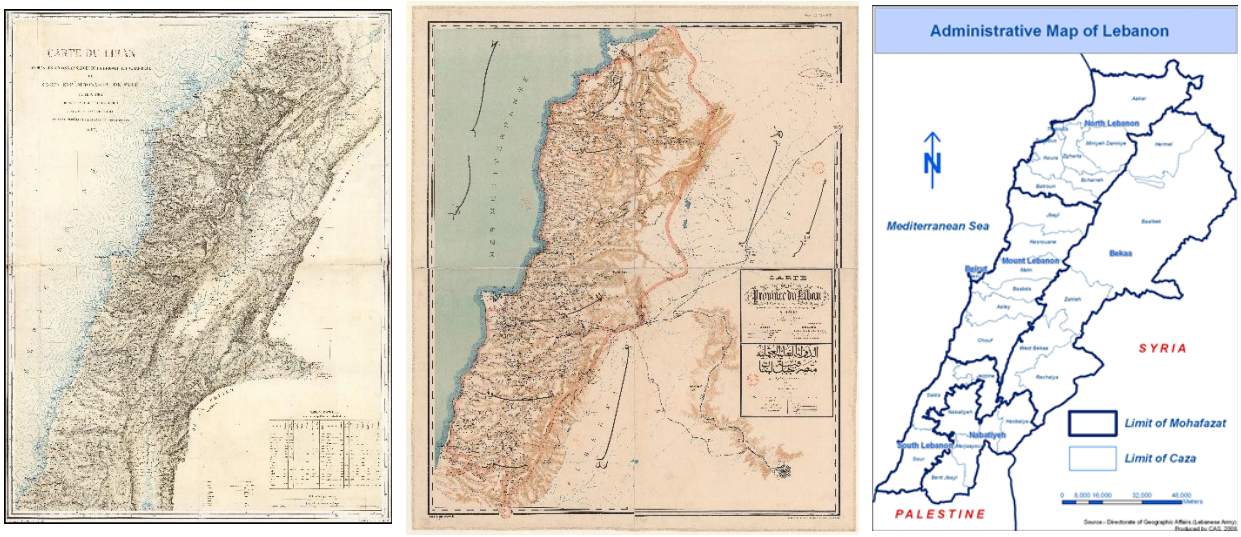
Contesting this notion of artificial creation, it has been documented that the geography of Lebanon was portrayed by France before the establishment of Greater Lebanon (Kaufman, 2015; Traboulsi, 2012). Emperor Napolean III ordered the first map of Mount Lebanon, Carte de Liban, 1862 (Figure 1), to assist his military aims when the French entered Lebanon during the 1860 Mountain civil war (Kaufman, 2015; Traboulsi, 2012). Kaufman indicates that maps of Greater Syria and Lebanon were present before colonials actually settled there, so they did not start from nothing to establish national territories after World War

I (Kaufman, 2015). For instance, the 1862 map established that Lebanon was a distinct area from the rest of the Arab region and Lebanese Christian Maronites used this to support their calls for expanding and establishing what they perceived as the "natural" boundaries of Mount Lebanon as aforementioned (Kaufman, 2015; Salibi, 1988). It appears that this establishment of natural boundaries has been the work of greater power, as documented in Chapter 4 and suggested by Sahlins' (1989) study on demarcation of the Pyrenees (1659-1868), now Catalonia, which Napoleon established as a distinct area from Spain (Sahlins, 1989).

The complexity of Lebanese history continued to affect its internal politics. Its sectarian socio-political structure, though not explicitly written in its constitution, became an institutionalized custom in that all major religions and their sects were represented proportionally in government employment and elections, in turn staying true to the 1943 National pact (Crow, 1962; Salloukh et al., 2015; Traboulsi, 2012). Not long after independence, and partly due to its sectarian structure, Lebanon experienced a devastating 15-year civil war (1975-1990). The civil war was followed by the Ta'if accord, which also emphasized the sectarian system, where the Troika or the three main sectarian representatives, the Maronite president, Sunni Prime minster, and the Shia speaker of parliament, were the decision-makers and sole representatives of their respective sects (Salloukh et al., 2015; Traboulsi, 2012). This accord, however, reduced the authority of the president, to the dismay of Lebanese Maronite Christians (Salloukh et al., 2015; Traboulsi, 2012).

Figure 1: Evolution of political Lebanese geographical boundaries

Carte de Liban (1862) | Mount Lebanon Mutasarifia (1914) | Political Lebanon (2009)*



* As of February 2022, Lebanon is divided into eight provinces and 25 districts and estimated by the United Nations to have a population of six million (UN, 2021)

Moreover, the war drew newly perceived internal geographical boundaries, established by different sects. These boundaries were in the form of cantons that divided Beirut into west and east – and determined an individual's right to passage from one Lebanese area to another (Traboulsi, 2012). These passageways were in the form of checkpoints set up by the different sects from north to south, where an individual's identification would be checked and a fee of passage (similar to customs) would be imposed (e.g. fee per head, depending on type of car and goods present). This created mini-borders within the grander borders of Lebanon and through this process, those who came to be known as the warlords i.e. the sectarian leaders, accumulated their wealth during the civil war leading to other implications mentioned below (Salloukh et al., 2015; Traboulsi, 2012).

Hence, during the civil war the warlords accumulated capital within their respective areas, and created what is referred to as an economic *laissez faire* (Salloukh et al., 2015; Traboulsi, 2012). For instance, in addition to the passageway customs, the different ports in Lebanon, from North to South, were headed by each sectarian warlord who collected all revenues (Traboulsi, 2012). Even when there were no clashes, the warlords accumulated capital and by the end of the civil war, each warlord owned most of the capital within the country (Salloukh et al., 2015; Traboulsi, 2012, 2016). Therefore, it has been speculated that Lebanon is sectarian in practice, yet capitalist in essence, i.e. Lebanese sectarianism only exists as a means of masking what truly rules the country: the Lebanese Oligarchy (prominent families that enjoy both political and economic dominance of the country), or in other terms capitalists (Salloukh et al., 2015; Traboulsi, 2012, 2016). As a result, the sectarian and political elites, along with the nouveau riche, became the economic elites of Lebanon (Salloukh et al., 2015; Traboulsi, 2012, 2016)

> "Lebanon was under the domination of armed mafias who had renounced fighting each other and indeed collaborated in order to better exploit the country's resources for their own ends… The same militia representatives who would sit on joint 'security' committees as representatives of belligerents at war would, perhaps in the same day, reconvene as members of the board of directors of companies that they now collectively controlled …" (Traboulsi, 2012, p. 243)

Though it has been argued that the economic *laissez-faire* was present before the civil war, post-war implications were increased political fragmentation and reduced governmental authority, given the highly privatized institutions in Lebanon and the rise of clientelism (i.e. sectarian competition for the market and state benefits). One of the most prominent sectors affected by this reduced authority is the health system, encouraging the establishment of nonstate health provisions, on which I elaborate further below (Ammar,

2009; Blanchet et al., 2016; Frangieh, 2014; Knudsen, 2009; Salloukh et al., 2015; Traboulsi, 2012, 2016). However, pertinent to this study is another sector in which civil war repercussions were obvious: Lebanese media. Within the audio-visual media, most television stations were acquired by warlords or political elites during and after the civil war, who invested in the media to control public opinion, creating a marriage between politics and capitalism (Traboulsi, 2012, 2016). Until today, all print and broadcasting media in Lebanon "harden the sectarian loyalties and reproduce sectarian modes of subjectification" (Salloukh et al., 2015, p. 4).

Related to this study, there are important historical events that need to be mentioned here due to their addition to the internal Lebanese problems: 1) the Israeli invasion into Lebanon reaching Beirut in 1982, its collaborators in Lebanon, its continuous assaults on the Lebanese established borders, and the creation of strong nonstate actors such as Hezbollah (Norton, 2007; Traboulsi, 2012); and 2) the presence of the Syrian army in Lebanon who entered in agreement with the warlords and Arab leaders, "unopposed" in 1976 and their meddling with internal security and political affairs until the death of Rafik Hariri and their withdrawal in 2005 (Salloukh et al., 2015; Traboulsi, 2012). Both these events were apparently planned, and imaginary demarcation lines were drawn (referred to as the red line), with the aid of the West and Arab regions, presumably to end the Lebanese civil war (Traboulsi, 2012).

The significance of the former occupation, was US interference - especially at the time of Kamil Sham'un's presidency (1952-1958), creating a form of resistance to the occupation within Lebanon (Traboulsi, 2012). Eventually, this led to the rise of Hezbollah in 1984 as an armed resistance that turned into a strong political force in Lebanon, a provider of social provisions including health, enjoying close relations with the Syrian regime and funding and support by Iran (Norton, 2007; Salloukh et al., 2015). The later occupation strengthened Syrian allies in Lebanon, such as Hezbollah, while stirring resentment especially among the Christian communities (Salloukh et al., 2015). Withdrawal from Lebanon was supposed to be in 1992, according to the Ta'if accord, yet that was not actualized until after the assassination of Rafik Hariri in 2005 (Norton, 2007; Salloukh et al., 2015). Post Hariri, withdrawal of the Syrian army led to revival of sectarian militias and blocks such as 14 March backed by the USA and KSA, and 8 March backed by Syria and Iran, who competed for control (Norton, 2007; Salloukh et al., 2015). Adding another layer of complexity, Hezbollah support for the Syrian region post-2011 created another divide among Muslim followers in Lebanon (Salloukh et al., 2015).

History of hosting displaced populations in Lebanon

Since its establishment in 1943, Lebanon has hosted displaced populations, both internal and cross-border. After the 1948 Nakba (Arabic for catastrophe), also referred to as ethnic cleansing, and establishment of the state of Israel helped by the British Government in the Balfour declaration (Said, 1978), Lebanon received the first recorded displacement of Palestinians (Knudsen, 2009). More than 60 years later, with the onset of the Syrian conflict in 2011, both the Palestinians and Syrians became the largest cross-border displaced people in Lebanon with population estimates of 174,422 and 844,052 respectively (CAS, 2017; Janmyr, 2017; UNHCR, 2022). Though numbers of Syrian UNHCR registered refugees have decreased since the beginning of the Syrian conflict, Lebanon hosted the largest population of refugees per capita globally after 2011 (Janmyr, 2017).

Despite large numbers of displaced cross-border populations, Lebanon has not signed the 1951 United Nations Convention Relating to the Status of Refugees under the United Nations High Commission for Refugees (UNHCR) or the 1967 Protocol and hence has no laws concerning refugees (Human Rights Watch, 2007; Janmyr, 2017). Janmyr (2017) reports that the reasons for Lebanon not being a signatory were primarily because Lebanese representatives at the Convention were uncertain about the Convention's obligations, preferring third parties take care of refugees rather than being directly involved. Lebanese representatives also preferred terming neighbouring nationals as "guests" or "displaced people" rather than "refugees" (Frangieh, 2014; Janmyr, 2017). This has affected institutions working with refugees in Lebanon, including the national infectious disease surveillance programme whose response to the 2011 refugee surge was slow and still appears to lack dedicated refugee infectious disease surveillance (Saleh & Howard, 2023).

Lebanese public health surveillance

Despite most of the literature (including my pervious study on health surveillance in Lebanon) is focused on post-civil war of 1975, the health structure, including surveillance activities, of what is now known as Lebanon dates to the Ottoman reign in the region, particularly the 19th century. The first recorded health intervention was the creation of a Beirut quarantine centre for port inspection in 1834 referred to as Lazaretto and known today as the Karantina (Abou-Hodeib, 2007). While the creation of the quarantine centre focused solely on avoiding contamination on site of the Beirut port, the Beirut municipality, Ottoman officials, and some foreign medical personnel initiated preventive measures in the wake of the Cholera outbreak of 1882 (Tanielian, 2012). Despite these documented efforts of the Beirut municipality, a full public health administration, which included surveillance, in the Beirut and later in Mount Lebanon

areas, did not come to light until the year 1914 (Tanielian, 2012). In 1915, an official regulation was released stating that physicians (both military and civilian) declare any health issue to the municipality and Ottoman officials, investigate the health issue, and isolate if necessary. This marks the first recorded surveillance activities and decrees on reporting in what is now known as Lebanon. These activities were after the decline of the Ottoman empire and the start of the French Mandate in Lebanon. During the mandate, the French appointed a director general for health and built additional hospitals, all of which remained until Lebanese independence and the start of the 1975 civil war (Ammar, 2003). Below I present information on health care and surveillance activities in Lebanon post-1975 civil war an important turning point in the public health history of Lebanon.

Lebanese public health sector post 1975 civil war

As mentioned, the Lebanese civil war (1975-1990) reduced governmental authority in the country (Ammar, 2009), yet it has also been argued that the economic laissez-faire was present before the civil war. For instance, pre-war, health care was said to be "determined by monopoly control and by the extroverted orientation of medical services, to satisfy the needs of the rich in the Gulf" (Traboulsi, 2012, p. 161). Post war, weak governance along with unclear policies and unregulated private economic activities created a fragmented and competitive market-driven, clientelist, health system, with 90% of all hospital beds in the private sector (Ammar, 2009; Blanchet et al., 2016; Salloukh et al., 2015). Despite this, in 2016, MOPH updated its health strategic plan (2016-2020), documenting its commitment to implementing universal health coverage, and signed international declarations to this effect (MOPH, 2016).

Even with these commitments, Lebanon's 2019 economic crisis led to further health system deterioration (Bou Sanayeh & El Chamieh, 2023; Nemr et al., 2023). The crisis began with the devaluation of the Lebanese Lira (pound) and the inability of residents to access their bank accounts, especially those with foreign currency such as US dollars (USD). Due to this, and up to this date, health facilities are experiencing shortages in budgets and in purchasing medical supplies (Bou Sanayeh & El Chamieh, 2023). An integral part of its difficulties was retaining human resources, who left Lebanon to find better paid jobs abroad (Bou Sanayeh & El Chamieh, 2023; Nemr et al., 2023).

Ultimately, capacity and resources to cover all residents was and remains limited, where uninsured households (53% of Lebanese citizens as of 2016) face considerable financial risks due to high out-of-pocket payments (37% of private sector Health Expenditure as of 2016) and low public-sector expenditure on primary healthcare (Blanchet et al., 2016; Khalife et al., 2017; MOPH, 2016). Consequently, healthcare access for refugees in Lebanon is challenging and Palestinians do not receive government healthcare and

usually cannot afford private healthcare, receiving services solely from UNRWA and non-governmental organisation (NGO) facilities (Chaaban et al., 2015). For Syrian refugees, UNHCR provides healthcare costs. However, coverage has decreased since 2011 and as of 2015 refugees' OOP expenditure was at 25% (Blanchet et al., 2016).

Noticeably, these healthcare access challenges can be disproportionate for displaced populations, leading to increased concerns about identifying disease outbreaks (Saleh et al., 2022). A few outbreaks were identified since 2011, e.g. a 2013 outbreak of Leishmaniasis, an uncommon infection in Lebanon before 2011, resulted in an incidence of 205 per 100,000, where Syrian constituted 97% of cases (Alawieh et al., 2014; Farah et al., 2023; Ozaras et al., 2016). Also in 2013, 2018, and 2019, measles outbreaks affected Syrians in Lebanon, after which vaccine campaigns were initiated (Farah et al., 2023; Ozaras et al., 2016). In 2014, a Hepatitis A outbreak was identified through Lebanon's routine passive surveillance among displaced Syrians in North and Bekaa regions, with an incidence of 72 per 100,000 (Bizri et al., 2018; Farah et al., 2023; Ozaras et al., 2016). Ozaras *et al* reported a 27% increase in tuberculosis cases after 2011, though Lebanon was traditionally considered a low-incidence country, again mostly in migrant populations (Araj et al., 2016; Ozaras et al., 2016). Finally, the 2013 polio outbreak in Syria raised concerns about spillover into Lebanon, leading to mass vaccination and increased surveillance activities still applied till today (Alawieh et al., 2017; Farah et al., 2023; Saleh & Howard, 2023).

Public health surveillance

The World Health Organization (WHO) defines health surveillance as "the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in planning, implementing and evaluating public health policies and practices" (WHO, 2006, p. 1). Disease surveillance is continuous information generation on morbidity, mortality, trends, and particular risk factors, to prevent outbreaks (Levy & Sidel, 2016). It is argued that infectious disease surveillance provides ongoing information on the health status of a population, contributing to morbidity and mortality prevention, improving health service provision, identifying needs and resource allocation, and guiding population health programmes (Elias et al., 1990; Knudsen, 2009; Levy & Sidel, 2016; Thomas & Thomas, 2004; WHO, 2006). Hence, surveillance activities within health have been used within humanitarian contexts to identify clusters and outbreaks as formal and informal settlements of displaced people can be "overcrowded" and often lack basic needs, e.g. water, sanitary supplies, nutrition, and environmental protection (Elias et al., 1990; Levy & Sidel, 2016; WHO, 2006).

Health surveillance was initially established for infectious diseases. However, it expanded to include other events such as noncommunicable diseases, mental health, and neonatal birth defects (Declich & Carter, 1994). The perceived importance of infectious diseases surveillance, other than the fact that infections cause high morbidity and mortality, is that infections can spread, re-emerge, be transported from one person or area to another, and potentially become an epidemic or pandemic such as SARS-CoV-2 today (Morens & Fauci, 2020). Knowing this, WHO built on previously established regulations for notification of specific infectious diseases of potential risk of crossing borders to what became known today as the International Health Regulations (IHR) (White, 2023; WHO, 2016). These were last updated in 2005 after the World Health Assembly urged they be taken seriously due to modern increases in international travel and trade (WHO, 2016). Surveillance, the core component of these regulations, entails detection and immediate WHO notification of any event of public health concern, in particular infectious diseases. Hence, IHR requires member states to have an adequate surveillance system in place to detect such events (WHO, 2016). An elaborated history on the development of surveillance and its historical and socio-political implications can be found in Chapters 3 (theorisation) and 4 (literature review).

Health surveillance in Lebanon

Infectious disease surveillance and mandatory reporting in Lebanon was revisited with the implementation of the 1957 law on infectious diseases (Governmental Law on reportable disease, 31 December, 1957), mandating that all health institutions report to the Ministry of Public Health (MOPH) any infectious diseases from a predefined list (Annex 1), last updated May 2014 in an MOPH decision #1/899 (MOPH, 2019). The Epidemiological Surveillance Unit (ESU) was officially established in 1995 not long after the end of the civil war and works within MOPH, as the national disease surveillance entity, responsible for monitoring 40 highest-burden infectious diseases, syndromes, and cancers (Ammar, 2003). The ESU's additional core functions are to screen for epidemiological alerts, detect and investigate outbreaks, train and sensitize reporting facilities on surveillance methods, and disseminate health information for internal and general public uses (MOPH, 2018). Despite ESU taking the load of infectious disease surveillance work, other surveillance entities work in parallel such as the national tuberculosis program, the national aids program, as well as other sentinel surveillance systems established within private academic hospitals (Saleh & Howard, 2023).

The importance of the political context in the work of surveillance has been documented, especially with regards to response to displacement contexts. The national surveillance ESU was not involved in Syrian displacement response in 2011 (Saleh & Howard, 2023). This aligned with the government's decision not

to sign the 1951 Refugee Convention and refer to refugees as guests (Human Rights Watch, 2007; Janmyr, 2017). It was not until the peak of the refugee influx in 2013 that the government, and eventually the ESU, assisted in crisis response (Saleh & Howard, 2023). However, it is worth analysing how this involvement took place within the complex nature of the Lebanese socio-political context and how this was manifested in discourses around refugees, which is what will be presented in the upcoming chapters.

CHAPTER 3: METHODOLOGY

Chapter overview

In this chapter, I present the methodology and theorisation that guided the data collection and analysis methods for this research. The diverse data genres (types), collection tools, and the analysis approach, i.e. discourse-historical approach are also summarised. I outline the data management and quality checks I adhered to while conducting research, reflect on my positionality and how this affected my research, and finally discuss ethical considerations.

Study design

Drawing on border as method, detailed below, I conducted a discourse-historical analysis (DHA), a structured method of Critical Discourse Analysis (CDA), adapting KhasraviNik's guidance (KhosraviNik, 2010; Wodak & Krzyżanowski, 2008; Wodak & Meyer, 2016). Below I contextualise thesis theorisation and summarise the rationale for choosing CDA as suggested by Fairclough (1992, 1995) and the DHA method specifically. Table 1 provides summary clarification of the theories and methods and how they are applied within this thesis.

Theorisation: Border as Method

Modern cartographic activities have been criticized as being a creation of Western European colonization. Colonial powers drew new geographic representations legitimizing their territorial, economic, and political expansion in almost every continent (Kaufman, 2015; Mezzadra & Neilson, 2013; Said, 1978, 1994). Lamberg et al. (2011) state that in the sixteenth century, maps began to be used for political and economic expansion, and during this expansion or colonialism "new worlds were conquered, divided, disputed and also mapped" (Lamberg et al., 2011, p. 71). In the below passages, I will introduce the theoretical framework that guided my methodology. I aim to take Mezzadra and Neilson's (2013) stance that borders are not just separation lines physically drawn on maps, but also cognitive borders that have shaped social identities within Lebanon. I will also review Orientalism (Said, 1978), and most recently Epidemic Orientalism (White, 2023), since they share a specific understanding of borders, and feed into overall postcolonial readings of how borders and the powers they represent affect population movement, especially migrants trying to find better living conditions.

To start with a postcolonial critique on the European creation of borders, Said (1978; 1994) investigated the cultural domination of Western European societies through the establishment and development of a

discourse about the East, or the Orient, and highlighted the racist ideology underlying these discourses (Said, 1978, 1994). According to Said, the Orient indicates the East or Asia, and Orientalists were mostly Western European individuals who studied and represented the Orient, geographically but also culturally and politically. In *Orientalism* (1978), Said investigated how discourses used in Orientalists' writings, both literature and political speeches, created Oriental knowledge and reality (Said, 1978). These discourses emphasized Western dominance both military and economic when writing about the division and discrimination between West and East, or Western "us" and Eastern "them," with the East regarded as inferior and therefore justifying the colonial project. This knowledge creation was usually one-sided with little or no insights from Asian residents (Said, 1978). Said (1994) described political-geographic boundaries as also cultural boundaries, highlighting how social life is intertwined with geography and territory (Said, 1994). He argued that colonizers shaped the areas they entered by political, military, economic, and cultural domination, taking lands that were already inhabited for territorial expansion and economic gains (Mezzadra & Neilson, 2013; Said, 1978, 1994). He noted that being confined within borders is a struggle for all people, because "it is not only about soldiers and cannons but also about ideas, about forms, about images and imaginings" (Said, 1994, p. 7).

Following up on this, are the concepts from Mezzadra and Neilson (2013) who further examined the concept of borders in *Border as Method: Or, the Multiplication of Labor* (2013). In what they call "Border as Method", they propose that we look at borders, their multiplication, and diversification under capitalist conditions, as privileged spaces to understand the intimate relationship between capital, human movement, and collective action. They elaborate further that borders, beyond the traditional political, administrative, and geographical understanding, also encompass racial and socioeconomic divisions within societies that create specific subjectivities, affecting peoples' day-to-day activities (Mezzadra & Neilson, 2013). They agree with Said that geographical representation helped colonialists retain power by changing spatial-temporal perspectives, as newly imposed boundaries overlooked local and indigenous representations of territories (Mezzadra & Neilson, 2013). They discuss how the creation of borders between what is now India and Bangladesh and how the establishment of these modern nations resulted in people feeling trapped or alienated from lands that once were easily accessible. The proliferation of physical borders created physical and mental violence, which they refer to as "cartographic anxiety or crisis", especially among people living between these created borders (Mezzadra & Neilson, 2013). Authors indicate this violence is evident not just *at* borders but also *within* each bordered area and even more evident in cross-border agreements controlling movements of migrants and displaced populations seeking a better life (Mezzadra & Neilson, 2013). With that in mind, Border as Method can be applied to help us

understand the effects of borders on public health and epidemiological surveillance activities, particularly for migrants and cross-border displaced populations.

Bridging the concept of Border as Method to health activities, and building on Said's (1978) Orientalism, a study of how public health has encouraged the othering of populations, racialization of diseases, and the fictional border creation has been discussed further in the work of White's (2023) Epidemic Orientalism. It investigates the history of the International Health Regulations (IHR) in their new and historical forms and how these conventions were contingent on the creation of fictional geographies of modernity by "raising up Western and European spaces and peoples as hygienically and civilizationally superior in contrast to those at the sites of epidemic outbreak" (White, 2023, p. 36). This in turn justified epidemic controls by Europe or the West from the "epidemic oriental" populations, a concept of Said's Orientalism, and divisions between "Us" versus "Them" par excellence (White, 2023, p. 36). White (2023) documents that disease control was a precursor to the establishment of colonial settlements - most often white Europeans, in turn agreeing with Said and Mezzadra and Neilson that with the help of disease control, geographical representation helped colonialists retain power (White, 2023). Further, diseases emanating from Europe were not the centre of focus in these conventions, though they caused considerable destruction to indigenous populations. For instance, smallpox which originated in Europe in the 1560s and led to the deadly outbreak among Brazil's indigenous populations, did not receive the same response during the early starts of the international sanitary conventions and quarantine measures, the diseases they focused on were those that threatened to enter their ports or lands from Egypt and Türkiye (White, 2023).

Moreover, Said (1994) wrote about the importance of images and imaginings in creating social identities, he argued that different forms of cultural production, which include media discourses, shape colonial power dynamics and reinforce imperialist ideologies (Abimbola, 2023; Aviles, 2001; Escobar, 2011; Fanon, 2008; Hirsch & Martin, 2022; Said, 1994), encouraging the subjugation of some populations given their race, and in turn, racializing diseases (Mbembe, 2001, 2019; White, 2023). Despite being an important contributor to the dissemination of information on infectious diseases and being part of the data collection process, the media usually comes hand-in-hand with promoting fear of foreign infectious diseases and helps shape the discourse about national security (Abeysinghe, 2016; Barker, 2012; Caduff, 2014; Ingram, 2009; King, 2002; Peckham, 2018). These discourses encompass racial and socioeconomic divisions within societies that create specific social identities, what authors suggest as political subjectivities, affecting peoples' day-to-day activities (Mezzadra & Neilson, 2013). This creates a form of hierarchy between who

can cross the border and who is excluded based on their usefulness in labour or infectivity respectively, this in itself, authors suggest, is a form of violence (Bell et al., 2006; Cheng, 2015; Hinchliffe et al., 2012; King, 2002; Mezzadra & Neilson, 2013; Papamichail, 2021). Therefore, given media appears to help with the creation of subjective and physical borders, it can be useful to analyse its discourses.

For discourses, it is focal to analyse those on public health activities in addition to those on structures and practices of health programmes (White, 2023). Briggs (2005) suggests that "The authority of accounts of epidemics springs from how epidemiologists hybridize multiple discourses, including popular stereotypes that also circulate in rumors, jokes, legends, and other genres" (Briggs, 2005, p. 273). Communication, or discourses, not only establish old structures or hierarchies, but can create new ones. The author suggests the usefulness of applying CDA as it helps understand "historical residues of racism" (Briggs, 2005, p. 272), especially those discourses that help in surveillance activities such as media accounts. Here is the importance of studying discourses, and from a critical standpoint using historical contexts, around health programmes and how they are reflected in, and might shape the context in which they are situated.

Critical Discourse Analysis (CDA) can help in doing so and is relevant to border as method, since it analyses how social and political conditions are manifested in language and how language use creates social structures and identities (Fairclough, 1995; van Dijk, 2006). Importantly, CDA is used to investigate how power struggles are articulated within the rhetoric used in the texts being studied, i.e., how discrimination is evident in language (Fairclough, 1995; van Dijk, 2006). Fairclough (1992; 1995) argues that discourse practice, what he refers to as a form of social practice, is essentially the continuation of discourse used throughout history: how it is shaped historically and how it changes and evolves (Fairclough, 1992, 1995). Bridging discourse to the historical context of the texts from which they arise, is a faction of CDA called the Discourse-Historical Approach (DHA), which I will be applying in this thesis. DHA is interested in how discourses reproduce ideologies and are manifested by, and maintains, those who are in power, taking historical contextualization for discussing findings (Wodak & Meyer, 2001). This approach views social practices and discourses as dialectic (change in social practice and discourse practice affect each other) and encourage transdisciplinarity when conducting discourse analyses (Fairclough et al., 2011).

Border as method dwells on these articulations, or discourses, taking borders as a crucial site of investigation. For instance, according to border as method, the discourse on international human rights and migration management, though masked as a humanitarian practice, has indeed "structurally erased" the struggles of population movement across borders (Mezzadra & Neilson, 2013, p. 202). They argue further that discourse brings about actions and vice versa, such as the rhetoric on national securitization

of borders post-September 11 that went hand in hand with securitization control practices and actions (Mezzadra & Neilson, 2013). Relevant to public health, the use of the term national security was seen as a prominent metaphor, or discourse practice, in the work of public health control programmes and activities at borders including infectious disease surveillance (French, 2009; Genest, 2015; King, 2002; Pereira, 2008). These practices have been argued to be historically linked to justifications for colonial presence and subjugation of nations as will be presented in Chapter 4.

Connected and pertinent to this thesis is the importance of resistance that resulted from these discursive practices. Scholars have emphasized the importance of resistance activities and discourse practices to overcome hegemonic conditions or transform discursive structures (De Genova et al., 2015; Fairclough, 1992; Mezzadra & Neilson, 2013). Border as method notes that the struggles resulting from the proliferation of physical and cognitive borders can lead to the emergence of forms of resistance that most importantly create new subjectivities, i.e. subjectivities that produce and encourage more resistance activities (De Genova et al., 2015; Mezzadra & Neilson, 2013). In this regard, it is relevant to note the work of Chatty (2017; 2021) who studied how alternatives to rights-based approaches for refugees in West Asia have alleviated the harsh conditions of displacement of refugees (Chatty, 2017). People in this area, for example, Syria, Lebanon, and Türkiye, never relied on international organization mandates for refugees yet welcomed displaced neighbouring populations out of generosity, hospitality, or duty (‘karam’ in Arabic), phenomena significantly diminished in Western nations (Chatty, 2017). She proceeds to highlight how Iraqi and Syrian refugees preferred to integrate into neighbouring countries and were welcomed by host governments as guests. This surprised some international humanitarian organizations and challenged the “camp-based” provisions when dealing with refugees. However, she noted that hospitality is beginning to dwindle due to the lengthy period of displacement (Chatty, 2017, 2020). The concept of acceptance of Syrian refugees appeared within the findings of this thesis as something that was not homogenous, yet it was a concept that I also tried to answer within the findings and chapters below.

In the context of Lebanon, Border as Method can be relevant to health surveillance programmes after the forced cross-border displacement of Syrian refugees in 2011 to explore how it intensified border and ideological divisions. Further, given the conflicted history of the establishment and modern day Lebanon, the use of Discourse-Historical Analysis (DHA), a structured CDA method, can help us further understand these distinctions within discourses, as it bridges historical and socio-political contexts to give us context of whether or not social practice and discourse practice indeed affect each other. Lebanon, whose borders were created during the French mandate, with the assistance of Great Britain and Lebanese political elites,

which led to the division of what was at one point called Bilad Al Sham (بلاد الشام) or Greater Damascus (Salibi, 1988). As covered in Chapter 2 on the historical background of Lebanon, this creation not only led to the division of the countries we know today as Lebanon, Syria, Palestine, and Jordan, yet within Lebanon, also led to a form of identity confusion between the Lebanese themselves, that of Lebanonism versus Arabism (Salibi, 1971, 1988; Traboulsi, 2012). This intensified the already present sectarian system in Lebanon leading to a civil war in 1975, continual disagreement between sects, the weakening of the public sector, and the rise of privatization (Salibi, 1988; Salloukh et al., 2015; Traboulsi, 2012). These internal conditions affected the healthcare system in Lebanon, which is characterized as fragmented, market-driven, and clientelist, with refugee populations being the most disadvantaged (Ammar, 2009; Blanchet et al., 2016; Frangieh, 2014; Knudsen, 2009; Salloukh et al., 2015; Traboulsi, 2012, 2016).

I would like to end this section by justifying my choosing not to reference Foucault in this thesis. Foucault is commonly referenced by postcolonial scholars, and scholarship on health programmes often mobilises Foucauldian concepts of biopower and governmentality. However, his theories have also been critiqued and I think it is important to address this. Firstly, Mezzadra and Neilson (2013) and White (2023) have argued that using Foucauldian concepts outside of the context of Europe is problematic given most of his work was exclusively in the Western context, bringing us back to the perception that the world functions according to European standards. White (2023), as Mbembe, declares that there is no reference to how Foucault's concepts functioned within colonial spaces which more often than not "worked outside the parameters of Europe" (White, 2023, p. 28).

The second argument is in relation to Foucault's lack of commitment to the concept of exploitation when addressing the productive and positive nature of power, where power is not looked at as a form of subjugation per se but rather as a process that needs to be perfected (Kerr, 1999; Mezzadra & Neilson, 2013). Perfecting power comes in the shape of removing the state (Foucault addresses it as a monarchy) and diffusing this power to technical entities, what Kerr (1999) suggests is nothing more than to replace state power with the market. In this sense, the concept of power brought forth by Foucault and contemporary Foucauldian scholars, has been effectively "a theory of social reproduction rather than of transcendence" (Kerr, 1999, p. 177), while "masking the inherent antagonistic dialectic of capitalist reproduction"(Kerr, 1999, p. 183). In addition, within Foucault's concept of governmentality, these technical entities that shape neoliberal standards, are the new form of indirect governing, and this according to Kerr (1999) is the perfection of power Foucault suggests (Kerr, 1999). Investigated this within border as method showed that the blurring of roles between government and international institutions

working on cross-border arrangements as a form of governmentality, led to the violent exclusion of migrants trying to seek a better life (Mezzadra & Neilson, 2013). Kerr (1999) suggests that "The 'zone of research' labelled as Foucauldian governmentality is therefore not a zone of critical-revolutionary study, but one that conceptually reproduces capitalist rule" (Kerr, 1999, p. 197).

The third and critical aspect the authors point to is that of the limited interest in resistance, class struggles, and social change in Foucault's writings. These concepts are very vague within the works of Foucault and "disappear behind the systematic process of the continuous perfecting and augmentation of techniques of power" (Kerr, 1999, p. 183). Adding to this critique from a discourse analysis perspective, Fairclough (1992), although theoretically and methodologically inspired to some degree by Foucault's study of discourse, argues that social agency and transformations in discourse structures are very weakly communicated within Foucault's writing (Fairclough, 1992). Furthermore, he writes that it is this lack of study of practice and struggles/resistance within the work of Foucault that is problematic when conducting discourse analysis since discourse structures are not only "reproduced but also transformed in practice" (Fairclough, 1992, p. 58).

Considering the aforementioned critiques, I am choosing not to use Foucault's writings within this thesis due to the importance of inclusion of matters of power struggles and change and encouraging research arising from these struggles. Firstly, power struggles are valuable when researching the socio-political conditions and discourses affecting or affected by health programmes and infectious disease surveillance especially when looking at how neoliberalism has contributed immensely to violence at borders (Mezzadra & Neilson, 2013). My stance, addressed further in the following section and chapters, is to not only research the dialectic nature of power and discourse around it as such, but to address the dialectic nature of struggles and resistance and how these are essential to bring about change. Moreover, research on public health programmes, as I will argue in Chapter 8, structured and organizational changes need to be from the periphery to the centre rather than from centre to periphery as colonial legacy had it (Abimbola, 2019, 2023; Smith, 2021). Due to these reasons, I will be referencing concepts of power and governmentality from a critical standpoint, which address resistance struggles, especially conveyed by authors such as Edward Said, Linda Tuhiwai Smith, Arturo Escobar, and Achille Mbembe, to name a few.

Table 1: Theories and methods described

Concept	Description/Key Ideas	Source(s)
Border as Method	A theory to study the relationship between borders, capital, human movement, and collective action, focusing on racial and	Mezzadra & Neilson (2013)

	socioeconomic divisions within societies. Political and cultural borders imposed by colonizers influence social identities and shape geography. Concepts within Border as Method: • Cartographic anxiety: The mental and physical violence caused by the proliferation of physical borders, leading to feelings of entrapment or alienation. • National security discourse: national security rhetoric to justify border control practices (surveillance) Application for thesis: discusses how historical and modern day national security rhetoric have shaped perceptions, actions, and discourses within Lebanese infectious diseases surveillance.	
Critical Discourse Analysis (CDA) and Discourse-Historical Approach (DHA)	How discourse (in media, literature, etc.) constructs social identities leading to discrimination, social hierarchies, and exclusions. A method for analyzing how language in texts reflects and perpetuates power, ideologies, and social inequalities. DHA uses a structured method of analysis that focuses on how historical context shapes discourse and reinforces power structures. Application for thesis: allows multidisciplinary analysis of discourses, pertinent to understanding the shaping of perceptions and ideologies within Lebanese infectious diseases surveillance especially when looking at Lebanese historical events.	Fairclough (1992, 1995), van Dijk (2006), Wodak & Meyer (2001)
Epidemic Orientalism	A critique of how public health has historically framed diseases as threats from "other" populations, often aligning with colonial or racial boundaries. Concept within Epidemic Orientalism: • Racialization of Diseases: The tendency in public health to categorize diseases as affecting certain populations, based on racial or national lines. Application for thesis: critiques how historical and modern day public health control measures have shaped perceptions, actions, and discourses within Lebanese infectious diseases surveillance.	White (2023)
Orientalism	Investigates the cultural domination through colonial discourses constructing the "Orient" (East or Asia). These discourses emphasize cultural, political, and racial dominance and the inferior status of the East. Application for thesis: links findings within Lebanese infectious diseases surveillance to how ideologies and discourses have been shaped by historical cultural domination.	Said (1978, 1994)
Resistance	The concept that struggles from border and identity-related violence can create new forms of resistance and alternative subjectivities.	Mezzadra & Neilson (2013), De Genova et al.

	Concept within resistance: • Displaced populations have been received through local generosity or hospitality rather than through formal international humanitarian structures. Application for thesis: looks into how, and whether or not, resistance of status-quo takes place, most importantly in the Lebanese situation where resistance activities within public health activities, particularly surveillance activities, appears to have been minimal.	(2015), Chatty (2017, 2020)

Research questions

Building on the aim and objectives presented in Chapter 1, the questions I addressed are:

1. how does infectious disease surveillance of, and related discourses about, Syrian refugees in Lebanon, shape, replicate, or challenge Lebanon's historical-political context, particularly in external and internal frontier (re)creation.
2. how do different data types (media reports, official documentation, and interviews) diverge or converge within their discourse schemes.
3. how do different political camps or sectarian groups, in Lebanon, within their media outlets, convey their perceptions concerning infectious disease surveillance for Syrian refugees.
4. how do the findings of these discourses on infectious disease surveillance for Syrian refugees in Lebanon shape or inform public health policy and practice responses in Lebanon.

Data collection

Discourse-historical analysis (DHA) is a structured method of Critical Discourse Analysis (CDA) (KhosraviNik, 2010; Wodak & Krzyżanowski, 2008; Wodak & Meyer, 2016). My main data sources were media reports, documents, and interviews used for triangulation (Wodak & Meyer, 2001). To inform this analysis, provide contextualisation, and understand how my thesis provides a novel contribution to the literature, I conducted a scoping review in parallel with the DHA.

Scoping literature review (Chapter 4)

This scoping literature review used Arksey and O'Malley's six-stage scoping review method with Levac et al's revisions, as detailed in Woodward et al (Woodward et al., 2014). This structured method of information gathering was informed by critical interpretive literature synthesis as described by Dixon-Woods et al (Dixon-Woods et al., 2006). The stages were: (i) defining the research question; (ii) identifying

relevant sources; (iii) selecting sources meeting inclusion criteria; (iv) charting/extracting relevant data; (v) synthesising and analysing data; and (iv) consulting topic experts to identify additional sources and sense-check initial findings as appropriate.

Defining research questions

To guide the scoping review, I asked three questions:

(1) What are the extent and findings of the existing literature recounting and analysing infectious disease surveillance activities in (post)colonial eras or using (post)colonial theories?
(2) What are the extent and findings of the existing literature focusing on infectious disease surveillance related to border studies and geopolitics?
(3) What recommendations can be retrieved or generated from these findings?

I examined terms for both "borders" and "colonial" because they often work together. Postcolonial approaches require scrutiny of how borders function regarding including or excluding different populations, referred to as the "Other" (Mezzadra & Neilson, 2013). As there are no clear-cut definitions for the theories I used, to guide the search I used the definitions provided in Table 1 and in some cases included more than one relevant definition.

Table 2: Literature revision guiding definitions

Terms	**Definition**
Border studies	"… the implicit recognition that agency and structure are mutually influential and interrelated in the shaping of emerging and integrated borderlands." (Brunet-jailly, 2005, p. 644)
Geopolitics	"a special 'discipline' … the understanding of borders according to the crisis of a specific 'pattern of the world'" (Mezzadra & Neilson, 2013).
Biosecurity	Biosecurity can be related to both Foucault's concept of biopolitics and geopolitics since it governs all forms of life "across spaces of homeland security and foreign policy intervention" (Ingram, 2009)
Colonialism	"a period of European expansion from the late fifteenth to the twentieth century when European nation states established colonies on other continents" (Burney, 2012)

Postcolonialism/ Postcolonial theory	"Postcolonial analysis is critical of the discourse of cultural imperialism, which is manifested in several different spheres of thinking, from literary writing and criticism to historical and cultural analysis of artifacts and ideas" (Burney, 2012)
Neocolonialism	"sees the role of modern superpowers and forces of capitalism, globalism, and Western cultural imperialism as a new form of colonialism" (Burney, 2012)
Discourse/rhetoric	1. Discourse under postcolonial theory: "It is a system of statements and structures by which we know and see the world around us" (Burney, 2012) 2. "Postcolonial discourse is the critical underside of imperialism" (Mishra, 2020)
Surveillance (health)	"Ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in planning, implementing and evaluating public health policies and practices" (WHO, 2006, p. 1)

Identifying sources

I used general and specific keywords in four social science databases (i.e. SCOPUS, Jstor, ProQuest, Web of science) and four medical databases (i.e. OVID Medline and PubMed, EMBASE, Global Health) shown in Table 2. I also purposively hand-searched for eligible grey and missed literature: (i) the first 100 hits in Google and Google Scholar; (ii) reference lists of eligible sources; and (iii) expert suggestions.

Table 3: Examples of search syntax in Medline, SCOPUS, and ProQuest

Medline	**Search syntax**
General: Surveillance	*1.* data collection/ or disease notification/ or epidemiological monitoring/ or sentinel surveillance/ *2.* (Surveillance or notification).mp. *3.* ((data or information) adj3 (collect* or gather*)).mp. *4.* 1 or 2 or 3
General: Public health terms	*5.* public health/ or epidemiology/ *6.* Communicable Diseases/ *7.* public health.mp. *8.* (communicable disease* or infectious disease* or emerging disease*).mp. *9.* epidemiolog*.mp. *10.* 5 or 6 or 7 or 8 or 9 *11.* 4 and 10
Specific: surveillance terms	*12.* epidemiological monitoring/ *13.* public health surveillance/ or sentinel surveillance/ *14.* 11 or 12 or 13

Postcolonial, borders, discourse	*15.* (Post-colonial* or postcolonial* or Border* or Discourse or Rhetoric* or Cartograph* or Geopolitic*).mp.
	16. 14 and 15
SCOPUS	
Keywords	(("Health notification" OR "public health surveillance" OR "health surveillance") AND (infectious AND diseases OR communicable AND diseases) AND (discourse OR rhet oric) AND (postcolonial OR post-colonial OR colonial OR spatial OR borders OR "border as method"))
ProQuest	
Keywords	((postcolonial theory) OR (post-colonial theory)) AND ((Public health) OR (Global health) OR (Global health security)) AND ((Public Health surveillance) OR (global health surveillance) OR (infectious disease surveillance) OR (surveillance)) AND ((border studies) OR (geopolitics) OR (cartography) OR (frontier))

Selecting sources

I exported retrieved results into Endnote 20 referencing software for deduplication. I then screened titles and abstracts, removing additional duplicates and irrelevant references. I then retrieved full texts and screened them based on eligibility criteria (Table 3).

Table 4: Scoping literature review eligibility criteria

Criteria	**Include**	**Exclude**
Area	Any country	None
Health topic	Documents that address public health surveillance and Infectious-communicable disease surveillance, or ongoing infectious disease screening programmes/activities.	Documents on other topics, e.g. general medical practices, public health programmes, health education programmes, health care systems without reference to surveillance or screening activities.
Theories	Postcolonial theory, postcolonialism, colonialism, colonial era, border studies, geopolitics, border as method, biosecurity, discourses.	Documents only addressing globalization, global health, national security agendas with no reference to colonial/postcolonial studies/era and borders/ border studies.
Population	Any population	None
Time period	Any	NA
Document type	Original research articles Commentaries/editorials Book chapters	Conference abstracts Tertiary sources

Language	English abstracts available	English abstract unavailable

Extracting/charting data

I extracted data from eligible documents in a Microsoft Excel sheet. Headings were: (i) characteristics (i.e. author, year, population, country/area; (ii) surveillance/screening component; (iii) post-colonial component/discourse; (iv) borders/geography/geopolitics/border discourse); and (v) evolving themes (i.e. trade/economy; media expressions; modes of resistance).

Analysis

I conducted a descriptive synthesis in Microsoft Excel of document scope, including numbers of documents retrieved, excluded, included, publication year, and source type. I managed documents in NVivo 12 and conducted reflexive thematic analysis (Braun et al., 2019), using abductive coding informed by critical interpretive literature synthesis as described by Dixon-Woods et al (Dixon-Woods et al., 2006).

Consulting experts

I consulted two internationally recognised professors of 10 contacted through unsolicited email and incorporated their suggestions on interpreting initial findings and potentially eligible sources. One was a sociology professor in a UK university and the other a public health professor in a Chilean university.

Media review (Chapter 5)

Media analysis included written and audio-visual material related to news on health surveillance from national newspaper and television coverage. The 5-year data retrieval time period (2011-2015) included the start to the peak of Syrian conflict-related refugee influxes (Kelley, 2017). I selected sources from opposing Lebanese political identities/viewpoints to identify any divergence or convergence in the rhetoric of infectious diseases surveillance with regards to Syrian refugees. The significance of choosing media, especially print media, was that it is easily accessible and not influenced by observers - as interviews can be - and is thus indicative of the mainstream discourses even if heterogenous. Media is very powerful in reaching a wide population range and in turn allows for agenda pushing and shaping people's shared construction of reality (Wodak & Krzyżanowski, 2008). Below I present the details of the genres used for analysis.

Newspapers

For print, I chose the two newspapers Annahar and Alakhbar. Literature on Annahar newspaper indicates it was established in 1933 and is considered liberal, serving in the past as a "mouthpiece for the bourgeoisie" (Traboulsi, 2016, p. 42). Its writing is anti-Nasserism, anti-communism, and more recently anti-Syrian regime (El-Richani, 2020; Traboulsi, 2012). Alakhbar, on the other hand, was established in 2006 by editors of the now defunct leftist newspaper Assafir, and is described as being leftist, communist, and pro-Hezbollah and the Syrian regime, though it does cover broad topics that do not align with the principles of the latter (El-Richani, 2020; Hanssen & Safieddine, 2016). Initially, its editors were clear they wanted to "break what they perceived as the hegemonic pro-Western, anti-Syrian media bias propagated by al-Nahar…" (Hanssen & Safieddine, 2016, p. 206). Given their differing histories and ideologies, these two newspapers appeared to be excellent sources for comparing discourses on the topic of this study.

For access, Annahar newspaper requires a subscription fee for online/print access or via microfilm at the American University of Beirut (AUB). For the years 2011 to mid-2013 I went through microfilms at AUB's Jafet Library, manually screening each page of each day of the year and saving potentially relevant documents as PDF files onto a pen drive. For the years mid-2013 to 2015 I subscribed to the newspaper and conducted a keyword search for all the days of the year as specified in Table 4. Alakhbar newspaper is freely available online, so I saved all years (2001-2015) in PDF format and searched for keywords (Table 4) using the find option on Adobe reader.

Table 5: Media search keywords

Arabic keyword	**English Translation**
الترصد الوبائي	Epidemiological surveillance
الامراض الانتقالية؛ الامراض؛ مرض انتقالي؛ الامراض المنقولة؛ مرض معدي؛ مرض؛ عدوى؛ وباء؛ اوبئة	Communicable disease(s); Disease(s); Epidemic(s)
صحة	Health
لاجئ؛ نازح	Refugee; Displaced

Television

Regarding broadcasting, I selected the television channels LBCI and Almanar. LBCI was launched in 1985 by the Lebanese forces, a right-wing faction now aligned with Christian liberals (Khazaal, 2020). It is currently closer to the March 14 movement, which is anti-Syrian regime, though not explicitly part of the movement (Dabbous, 2010). Traboulsi (2016) argued that Lebanese visual media owned by holders of wealth, was in effect a form of investment to control public opinion (Traboulsi, 2016), highlighting the

importance of discursive practice and the production of social subjectivities (Fairclough, 1992; Mezzadra & Neilson, 2013). Traboulsi further suggests this is exemplified by the practices of LBCI, because its stocks are controlled by a range of prominent Lebanese families and its CEO (Traboulsi, 2016). The other broadcaster, Almanar television was established in 1991 as a Shia Muslim Hezbollah-led, Iranian-funded, pro-Syrian regime channel (Khazaal, 2020). Though there does not appear to be much research on Almanar, this station is primarily a political platform for showcasing military resistance activities during wars with Israel and military involvement in the Syrian crisis (Dabbous, 2010; Khazaal, 2020).

For LBCI, I was referred by staff to the archive with suggested dates I might find news related to infectious diseases among displaced populations. I had to pay a subscription fee to access news articles, though I later found they were all freely available on YouTube, and easier to access there. For Almanar, its search engine only displayed written articles. Upon calling Almanar, staff referred me to the archive. However, archive personnel suggested it was almost impossible to find videos on my topic as Almanar is more interested in Syrian war progress than health programmes. I was eventually referred to Almanar's Dar Almanar station office, which provides records of videos for a cost. I provided them with keywords (Table 4) and they conducted the search and provided me with videos on a pen drive, which consisted of two news reports and one interview with a public health figure.

Selecting and charting media articles

I extracted newspaper and television news reports into an excel table, which included the following headings: title, date of report, news type (political context or health related), media outlet, URL, mention of surveillance, mention of investigations, analysed, included in synthesis.

Eligibility criteria

For media, given it was not easy to find reports mentioning infectious disease and refugees, I screened for inclusion and exclusion after extraction of reports with health-related contexts to ensure I do not miss any report. Inclusion criteria were: (1) describing or referring to surveillance programmes in Lebanon specifically (i.e. epidemiological surveillance programme, national tuberculosis programme, national AIDS programme, other programmes related to in Lebanon) in relation to refugees in Lebanon; (2) mentioning infectious disease surveillance information or activities in relation to refugees in Lebanon, without the mention of surveillance in particular; OR (3) mentioning numbers of investigations of infectious diseases in Lebanon and in relation to refugees, without mentioning surveillance in particular. Exclusion criteria were: (1) not mentioning refugee populations; and 2) mentioning infectious diseases generally without

mentioning surveillance, investigations, or cases of diseases among refugee populations. The reports selected were marked as included for synthesis and were exported as an excel file for descriptive quantitative analysis.

Document review (Chapter 6)

Search strategy

To identify and analyse discourses used in Lebanese infectious disease surveillance for displaced populations, documents (e.g. legal or policy papers, internal circulars and memos, official letters, guidelines, constitutions) are important sources. For a previous study (i.e. my organizational and policy analysis), I was granted permission to access MOPH surveillance programme documents by the head of the ESU and director general, in June - November 2018. I obtained permission to reanalyse them, as they are now available to the public. The retrieval period was 2011-2015, to cover the start to the peak of the Syrian refugee influx (Kelley, 2017).

Beyond MOPH and ESU, I searched publicly available Lebanese legal documents through the Lebanese University Electronic Legal Library (مركز الابحاث والدراسات في المعلوماتية القانونية) and Lebanese Parliament Online (رئاسة مجلس الوزراء) using specific keywords (Table 5) and the same retrieval period (i.e. 2011-2015, to cover the start to the peak of the Syrian refugee influx (Kelley, 2017). However, manual searching of these databases, with title and full text screening identified no documents relevant to the topic of my thesis.

Given my thesis objectives and theoretical stance on the discourses dichotomizing “the self” versus “the other”, I used documents issued by Lebanese institutions rather than international/humanitarian organizations as these organizations’ dichotomization differs (more on this in Chapter 8, limitation section below).

Table 6: Document revision search key terms

Arabic keyword	**English Translation**
الترصد الوبائي	Epidemiological surveillance
الامراض الانتقالية	Communicable diseases
الامراض	A communicable disease
مرض انتقالي	Diseases

الامراض المنقولة الامراض المعدية مرض عدوى وباء اوبئة	Epidemic(s)
صحة	Health
لاجئ نازح	Refugee Displaced

Eligibility criteria

My inclusion criteria for document analysis were: (1) addresses surveillance activities concerning refugees in Lebanon (e.g. data collection guidance, training invitations, decisions, memos, or circulars). Excluded documents: (1) did not mention refugee populations; or (2) described/addressed general infectious diseases without mentioning surveillance, investigations, or disease cases among refugee populations.

Semi-structured key informant interviews (Chapter 7)

I conducted interviews with infectious disease surveillance programme employees and stakeholders. Interviews were intended to produce new data on perspectives related to my research questions (Green & Thorogood, 2004, p. 80). I analysed using DHA so intertextual relations could be built into understanding of the grander socio-political and historical context from which the interviews were produced (Fairclough, 1992; Wodak & Krzyżanowski, 2008).

I selected interviewees purposively, based on their knowledge of public health surveillance in Lebanon. Potential interviewees were contacted by email and telephone and asked to participate after providing an information sheet explaining the study (Annex 1). Those who refused, or did not respond to three invitations, were treated as non-respondents. I tried not to use snowballing, to maintain anonymity. However, a few respondents suggested names of people who might know more on the subject. I planned to conduct 20 interviews from a seed list and expand as needed depending on the degree of information saturation. However, given that interviews are intended to be complimentary to the other data types (i.e. media and documents in my case) for DHA (Wodak, 2015), I identified a saturation of information at 20

interviews and thus deemed them enough. All potential interviewees had an opportunity to discuss and ask questions after reading the information sheet before signing the consent form (Annex 2). The interviews were guided by a semi-structured interview guide (Annex 3) I had prepared ahead of the interview, however this guide often changed depending on the interviewee or was not used due to the course of the interview. Interviews were mostly conducted via online platforms (e.g. Zoom) and in person at times and locations of the interviewees' choosing. They were conducted in Arabic or English depending on interviewee preference. However, the majority mixed the two languages. Interviews averaged 40 minutes, ranging from 18 to 84 minutes, and were audio recorded via Zoom or audio recorder.

Transcription and translation

With regards to media reports and documents, I analysed the selected reports in their original language as encouraged by Fairclough (1995). I translated the quotations for this thesis into English keeping the main phrases or words in Arabic to stay as close as possible to the original meaning. I chose to keep the Arabic word as is rather than transliterate it as that is my guiding aim and recommendation for this thesis, i.e. write and protect the originating language (refer to Chapter 8).

For the interviews, I chose to transcribe based on the language of the interview to preserve the meanings of the words, yet I did translate some interviews: 1) interviews predominantly English were transcribed to English keeping only key Arabic words, and 2) interviews predominantly Arabic were kept in Arabic, however, a select of paragraphs were translated into English for use in quotations. I did the transcriptions and translations and consulted on specific Arabic terms and phrases from an Arabic-English sworn translator in Lebanon, without their knowledge of the context or identity of the interview. Examples of complex Lebanese Arabic terms included:

النقمة – Indignation

كب المصاري - Money throwing

شو متشرب – what they've drank or what they have absorbed throughout their lives

ناقوس الخطر – sounded the alarm

Analysis

Though there is no one method of conducting DHA, Fairclough (1992, 1995) suggests a general three-dimensional CDA framework (Fairclough, 1992, 1995). The first dimension relates to linguistic textual

analysis, which investigates the meanings of words in terms of vocabulary, how clauses are structured and linked together in terms of grammar and cohesion, and text structure. The second dimension relates to discursive or discourse practices, which he describes as the production, distribution, and consumption of texts and the socio-cognitive aspects of text production and interpretation. Discourse practice can also be described as the different genres used in discourse dissemination, for instance, newspapers have a different mode of production, distribution, and consumption than poems do. The third dimension of discourse relates to discourse as a social practice, or the sociocultural/political context, which shapes, and is a form of, discourse practices (Fairclough, 1992, 1995).

As a branch of CDA, DHA differs slightly in "its endeavour to work with different approaches, multi-methodologically and on the basis of a variety of empirical data as well as background information" (Wodak & Meyer, 2001, p. 65). Hence, it stresses the value of interdisciplinarity in the sense of inclusion of anthropological, historical, and theoretical sources to enable background context for evolving rhetoric and prefers the triangulation among different data sources/genre (Wodak, 2015; Wodak & Meyer, 2001). DHA also investigates how discourse and social practices interchangeably affect each other, i.e., it involves investigating "intertextual and interdiscursive relationships" (Wodak & Meyer, 2001, p. 70). This approach provides a structured method of applying discourse analysis. Analysis using DHA thus considers data from a macro-level, in which the investigator identifies overall discourse topics within the discourse genre being studied. To do so, a micro-level, inter-textual analysis is preceded. These are referred to as discursive strategies, defined as practices conducted to achieve a specific goal and including what Fairclough (1992) defines as discursive practices (Fairclough, 1992; Wodak & Meyer, 2016). These strategies extrapolate the actors, actions, and arguments described within the discourse genre (KhosraviNik, 2010; Wodak & Meyer, 2001). I analysed data using DHA's two level analysis at the macro-level and micro-level as detailed below.

With regards to interviews, textual analysis for interviews is a common practice in CDA (Fairclough, 1992; Wodak & Krzyżanowski, 2008). I chose to use DHA textual analysis for interviews to be able to find intertextual relationships within interviews and common discourses with other data genres. However, I would like to note that many of the discourses or narratives within interviews are prompted by the interviewer, in this case my interview questions, especially those related to the socio-political context of Lebanon and how it affects the work of infectious disease surveillance. This might explain differences in findings from those of the media and document analyses.

Microlevel - Intertextual analysis

At the microlevel, I conducted inter-textual analysis to show how local identities of Self and Other are represented in discursive materials and how historical, contextual, ideological, and political realities were constructed and established through this discourse (KhosraviNik, 2010; Wodak, 2015; Wodak & Meyer, 2016). Analysis thus included a three-level analytical framing of actors (or referential), actions (or predicational) and argumentation strategies (or topoi) for what was constructed as positive Self and negative Other presentation in relation to surveillance and populations, detailed in Table 6 (KhosraviNik, 2010).

Table 7: Levels of intertextual analysis

Discursive strategies	**Description**
Actors or referential strategies	Identifies the main actors mentioned, or not, within the outlet categorized as part of "the Self" or "the Other", i.e. which actors are described as "in-group" or "out-group". Looks at how these actors are referred to within the texts (KhosraviNik, 2015; Wodak, 2015; Wodak & Meyer, 2001)
Actions or predicational strategies	Finds what main actions are attributed to the identified main actors (KhosraviNik, 2015; Wodak, 2015; Wodak & Meyer, 2001)
Argumentation/topoi strategies	Describes the argumentation strategy(ies) being used, or not, within the texts, explaining or justifying how the actors and actions are constructed (Wodak & Meyer, 2001). Here topos (or topoi) will be used to organize these arguments and elaborate how the arguments within the text lead to conclusions (be they reasonable or fallacious) and how they are used to justify claims (Boukala, 2016; KhosraviNik, 2015; Wodak, 2015; Wodak & Meyer, 2016)

I conducted this analysis iteratively in two phases. In the first phase, I familiarized myself with the data then tabulated texts into the three intertextual discursive strategy levels for each data type. I then identified the recurring patterns within each strategy level for each data type. In the second phase, I translated the selected text in the tables from Arabic to English. An example of this analysis is provided in Table 7, from one media outlet, Annahar, 3 May 2013, looking at how the "Self" and the "Other" appear to be constructed within the report.

Table 8: Example intertextual analysis - Annahar May 3, 2013

Level	English translation	Original language
Referential "Other"	Displaced Syrians Cases	النازحين السوريين حالات
Referential "Self"	Ministry of Health Parliamentary health committee	وزارة الصحة لجنة الصحة النيابية
Predication "Other"	"TB, Leishmania, scabies, and viral hepatitis, are cases reported by the MOPH till now **as a result of the large arrival of displaced Syrians**" "… these diseases are **a result of the haphazard spread of displaced** in more than one city and village"	"السل، حبة حلب، الجرب واللتهاب الكبد الوبائي، حالات مرضية سجلتها وزارة الصحة حتى الان نتيجة التوافد الكبير للنازحين السوريين" "هذه الامراض جاءت نتيجة الانتشار العشوائي للنازحين في اكثر من مدينة وبلد"
Prediction "Self"	"The Parliamentary committee **sounded the alarm**" "**Gave fundamental information**" "[the Ministry of health] **formed a board** that follows up"	"دقت لجنة الصحة النيابية ناقوس الخطر في ما يتعلق بانتشار الاوبئة بين النازحين" "معطيات أساسية تدل على وجود حالات من الامراض المعدية" "شكلت (وزارة الصحة) هيئة لمتابعة الاوضاع الصحية وخصوصا الامراض المعدية"

Macrolevel - recurring discourse topics

After the microanalysis, I analysed overarching discourse topics that arose from each data type to identify the main recurring discourse topics.

Quality criteria

During research, I used the critical appraisal of qualitative research method suggested by Hannes (2011) to help ensure transparency, dependability, credibility, and confirmability (the following are in no particular order):

1) Transparency: I ensured study background and population were well described.
2) Dependability: I documented methods in detail and these methods have been revised by supervisors and advisory team, especially Majid KhosraviNik, an expert in CDA.

3) Credibility: I tried to ensure the validation of results by continuous correspondence with supervisors, advisory committee, and study participants. I was in contact with my supervisors and advisory team, at each stage of my data analysis and writing of my findings for their feedback. I was also in contact with several key-informant interviewees to ask for clarification on some statements and whether they considered them worth including in the thesis (though I made the final decision).
4) Confirmability: through my reflexivity section I clarified my personal standpoint about the research background, process, and results

Reflexivity

I ensured reflexivity in my position as researcher during the entire research process. I was born with a Lebanese nationality in Beirut but was displaced to North America until the end of the civil war in 1995. After returning to Beirut, I experienced the political turmoil of Lebanon, studied secondary, undergraduate, and postgraduate studies at universities in Lebanon, and worked at the MOPH and surveillance programme as an epidemiologist for more than 13 years. My work as an epidemiologist has been both a strength and weakness while conducting this doctoral research.

The advantage of having worked as an epidemiologist within Lebanese institutions is that it helped me in my data collection process. I could use my Alma Mater libraries for access to media reports that are no longer publicly available. Further, having access and permission to use internal documents for surveillance activities for this research was a result of personal connections that evolved during the years of work there. Therefore, my being part of the cultural background of Lebanon, understanding the history of modern-day Lebanon (Chapter 2 on Lebanese history), and knowledge of the work of epidemiology and health programmes in Lebanese institutions allowed me to navigate difficulties and use these difficulties as opportunities for understanding the complexities of my research (Wodak & Krzyżanowski, 2008). As an example, the interviews were often structured like a conversation between two friends as I knew many of the interviewees personally, and they knew my own socio-political background just as I knew theirs. Also, many were no longer working in Lebanon and saw me as an outsider and the chances of this affecting their jobs was minimal. Respondents still working in governmental institutions expressed their anger with the situation in Lebanon and how it affected their work, maybe seeing me as an outsider that might listen to or help them. Hence, both these situations created spaces where participants were open about the factors affecting surveillance and provided a rich set of discourses for analysis.

Adding to the strengths of my background as an epidemiologist, it provided me with the essential tools to understand the difference between what is hypothesized about health programmes in the literature versus what really takes place, i.e. the demonization of health and surveillance activities versus their actual usefulness. My positionality in this research takes the stance of a subaltern epidemiologist and health researcher who wants to understand the history and the appropriation of infectious disease surveillance to be able to provide populations with alternatives, and even changes, to health policies, programmes, and literature from within without the hegemony and imposition of Eurocentric and western experts (Abimbola, 2023; Escobar, 2011).

The weakness, however, of being an epidemiologist is that my educational and career history preconditioned me to see the world from a positivist perspective or epistemology. My work has been predominantly quantifying infectious diseases without understanding the historical and social aspects of these quantifications nor how they might shape or change the future. This has influenced my writings in general and specifically of this thesis, which was very challenging. I am aware of my lack of experience in writing as a social scientist, historian, or linguist, which is something that I have not perfected while conducting this research. However, I aspire to improve during my future research and writings on the socio-political and historical aspects of health programmes.

Finally, there are two aspects related to my privilege as a student at a UK university with colonial legacies and as a Lebanese person generally. First, I am aware that my studying within a university in London with a colonial history is a matter for reflection since it does provide me with academic privilege. Colonial schools of medicine have been studied by historians as major contributors to racialization of diseases and justifying colonial presence (Hirsch & Martin, 2022; White, 2023). Despite this, my knowledge in this area and language has helped me provide alternative knowledge from the periphery, in this case Lebanon, to the centre, in this case LSHTM, without it needing to be the other way around (Abimbola, 2019, 2023; Smith, 2021). Second, I sometimes use the term subaltern to reflect my work as a Lebanese researcher studying infectious disease surveillance in Lebanon, but particularly addressing refugees. I am aware that this study lacks the perspective of refugees (Chapter 8 discusses this further) and hence lacks the voices of another subaltern group, the Syrian refugees, a limitation I address in Chapter 8. As provided in my introduction, the term subaltern is heterogeneous especially among those who have been colonized, for instance, there are the elite subaltern who have been the voice piece of the colonizers, whereas unorganized and underprivileged subalterns such as females are usually the least heard from (Gramsci et al., 1971; Spivak, 1999). Nonetheless, I as a Lebanese have also been dominated by western disciplines

and knowledge, making us “Native informants” where many insights within this country have been produced by Euro-USA scientific experts (Escobar, 2011; Spivak, 1999). As a Lebanese subaltern, I can study the socio-political context and discourse within Lebanese institutions I have worked in in a more cultural/linguistic sensitive manner and provide the world with this knowledge.

Ethics

I obtained ethics approval from the LSHTM observational ethics review committee in the United Kingdom (LSHTM Ethics Ref: 27321) and from Rafik Hariri University Hospital local ethics board (Ref: 2022-0501).

To ensure confidentiality, interviews were conducted at times and locations of the interviewee’s choosing after completion of written informed consent procedures. To ensure anonymity, numerical identification codes were used on recordings, transcripts, and all outputs. Recordings and transcriptions of interviews and all data types (media reports, documents, and interviews) were stored in LSHTM virtual storage through my personal password-protected laptop and only shared with my two DrPH supervisors if necessary. Hard copies of study documents were not used. However, notes taken during interviews were anonymised and stored in a notebook locked in a cabinet to which only I have access. Media reports and most documents were available for public access online. Some documents internal to the surveillance program in Lebanon were available for the public after receiving permission from the head of the programme. Data will be destroyed or archived in the LSHTM repository once all study outputs are completed, depending on permissions granted by individual participants.

CHAPTER 4: ENTANGLED HISTORIES OF HEALTH SURVEILLANCE AND BORDER CREATION

Chapter overview

In this chapter I present findings of the scoping literature review, informed by critical interpretive literature synthesis, to understand infectious disease surveillance activities and/or discourses around these activities, under theories related to, and that can contribute to postcolonial discussions. As a foundation for this thesis, this review is relevant in providing literature gaps, contextual information for this study, and extracting recommendations this information.

I used Arksey and O'Malley's six-stage scoping review method and screened eight scientific databases systematically and grey literature, reference lists of eligible sources, and expert suggestions. Title/abstracts and full texts were screened against eligibility criteria and extracted data were synthesised thematically. The resulting 30 eligible documents of 8,340 screened were synthesized.

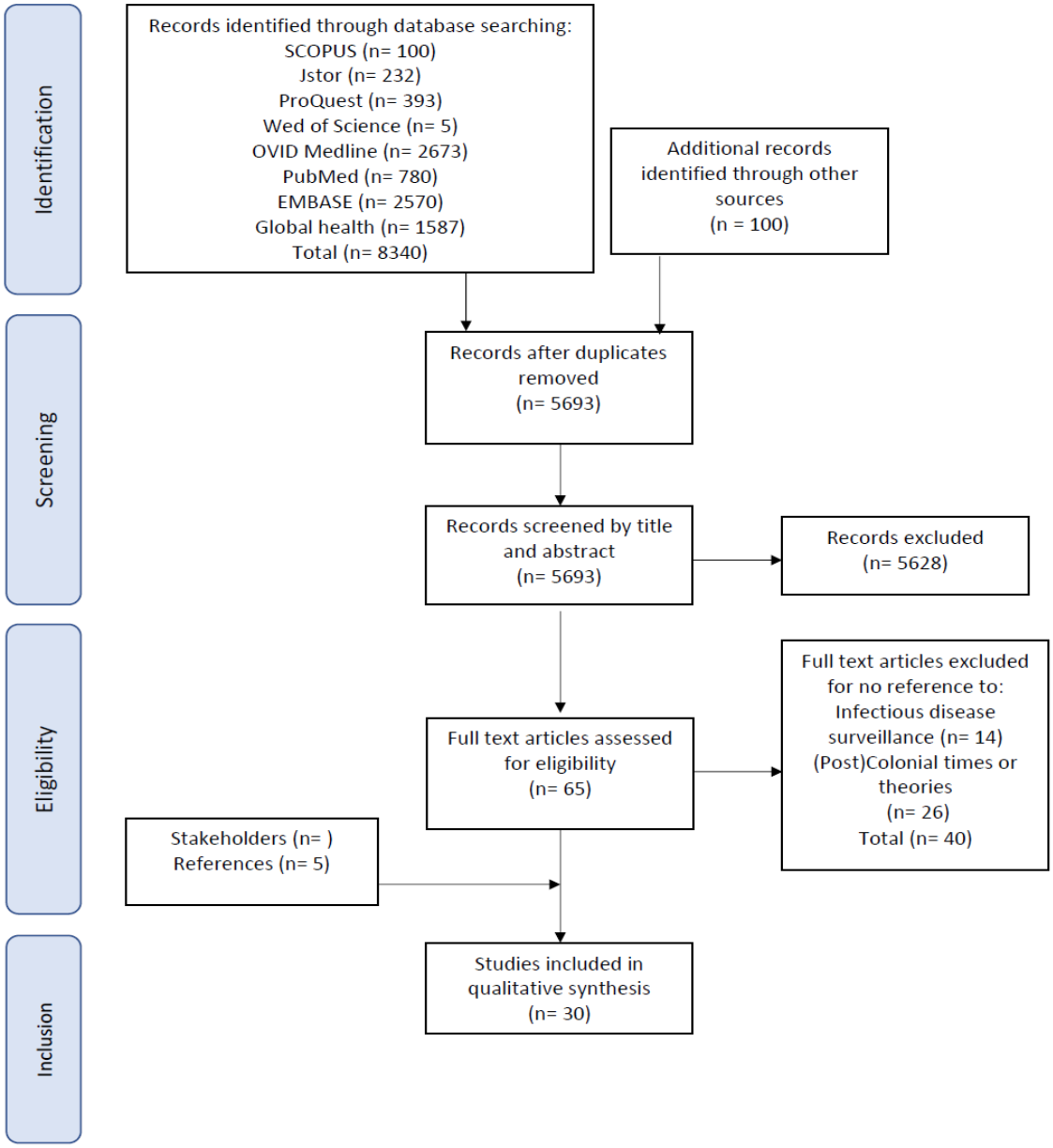
The Synthesis revealed that much of the literature on infectious disease surveillance originates in the West, lacking relevance for the subaltern health professionals. Moreover, surveillance historically served colonial agendas by justifying presence and controlling populations. Today, it continues to influence national security rhetoric and trade dynamics. Media plays a crucial role in both disseminating disease information and contributing to surveillance data. Despite these motives, resistance movements have emerged historically and persist today.

Finally, research should explore these dynamics through subaltern perspectives, utilizing case studies to deepen our understanding of surveillance's impact on marginalized populations, especially migrant populations, across different historical contexts.

Literature scope

Figure 2 shows the PRISMA flowchart, with 30 eligible documents (Table 8) included of 8340 records identified in eight databases, the first 100 hits on Google Scholar, and reference lists. I removed 8275 through deduplication (2747) and title and abstract screening (5628), another 30 through full text screening, and added 5 through backward searching references.

Figure 2: PRISMA flow diagram for scoping literature review



Included documents were published between 1998 and 2021, 26 as journal articles and four as book chapters (Cameron-Smith, 2019; Manderson, 2009; Weir & Mykhalovskiy, 2007, 2010). Eleven mentioned specific countries, four addressing countries in the Africa region (Davis & Sharp, 2020; Faleye, 2017; Figuié et al., 2015; Ingram, 2007), four in the Western Pacific (Au, 2006; Cameron-Smith, 2019; Hsien-Yu, 1998; Manderson, 2009), one in Southeast Asia (Chuengsatiansup & Limsawart, 2019), one in the Americas (King, 2002), and one in the Europe region (Bell et al., 2006). Disciplines included nine in sociology and anthropology, five in geography, five in history, and three in international relations, political sciences, and

communication, and two in public health. Authors were mostly affiliated with institutions in high-income nations, namely 13 from the UK and eight from North America. Similarly, predominant publishers included five from Taylor & Francis, four from SAGE, and three from Routledge.

Table 9: Literature revision summary of included papers

Author(s)	Year	Surveillance/ screening	(Post)colonial	Borders	Trade	Forms of resistance	Media
Hsien-Yu	1998	✓	✓		✓		✓
King	2002	✓	✓	✓	✓	✓	✓
Bell, Brown & Fair	2006	✓	✓	✓			✓
Au	2006	✓	✓			✓	
Ingram	2007	✓	✓	✓	✓	✓	
Weir & Mykhalovskiy	2007	✓	✓	✓			✓
Pereira	2008	✓	✓	✓			
French	2009	✓	✓	✓	✓		✓
Ingram	2009	✓	✓	✓	✓	✓	✓
Manderson	2009	✓	✓	✓	✓		
Crane	2010	✓	✓	✓			
Weir & Mykhalovskiy	2010	✓	✓	✓		✓	✓
Hinchliffe et al	2012	✓	✓	✓	✓		
Barker	2012	✓	✓	✓	✓		✓
Sastry & Dutta	2012	✓	✓		✓		
Caduff	2014	✓	✓	✓			✓
Figuié	2014	✓	✓	✓	✓	✓	
Cheng	2015	✓	✓		✓		
Figuie et al	2015	✓	✓	✓	✓	✓	
Genest	2015	✓	✓	✓	✓		✓
Abeysinghe	2016	✓		✓	✓		✓
Faleye	2017	✓	✓	✓	✓	✓	
Peckham	2018	✓	✓	✓		✓	✓
Cameron-Smith	2019	✓	✓	✓	✓		

Chuengsatiansup & Limsawart	2019	✓	✓	✓	✓		
Peckham & Sinha	2019	✓	✓	✓	✓	✓	✓
Davis & Sharp	2020	✓	✓	✓			
Cole & Dodds	2020	✓	✓	✓	✓	✓	
Papamichail	2021	✓	✓	✓	✓		
Hinchliffe	2021	✓	✓	✓	✓		

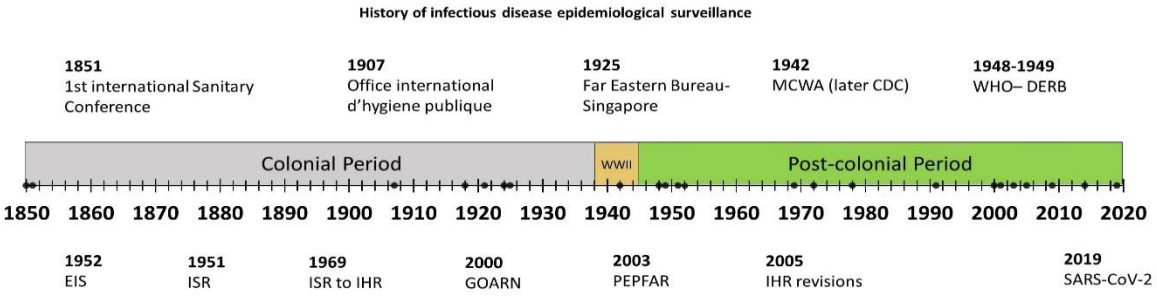
Thematic findings

I included two deductive themes addressing research questions: (i) colonial and post-colonial infectious disease surveillance motives and activities; and (ii) surveillance and borders/geography. I also generated four relevant inductive themes: (iii) surveillance as national security rhetoric; (iv) surveillance and trade; (v) surveillance and the role of media, and (vi) surveillance and forms of resistance.

Colonial and post-colonial infectious disease surveillance motives and activities

Figure 3 summarises the historical timeline of epidemiological surveillance or intelligence based on eligible documents. During the 19th century colonial times, the first international sanitary conference in 1851 – convened, and according to authors was essentially European centred (with 12 European countries) despite including other nations. This convention was a result of the main European ports' worry about infections spreading across their borders. (Genest, 2015; King, 2002; Manderson, 2009; Weir & Mykhalovskiy, 2007, 2010). As a result of the information of outbreaks in Turkey and Egypt, the convention identified plague and cholera as quarantinable diseases to be monitored (King, 2002). The work of the convention and health data of colonized populations were believed to have assisted the empire's ideology of territorial expansion and humanitarian action, with the help of tropical medicine schools (Cameron-Smith, 2019; Genest, 2015; King, 2002; Pereira, 2008; Sastry & Dutta, 2012). As a result of these meetings, the Office International d'Hygiene Publique in Paris began collecting health-related information in 1907 (Cameron-Smith, 2019; King, 2002).

Figure 3: Historical timeline of public health surveillance based on selected literature



Source: historical timeline of surveillance or epidemiological intelligence adapted from this review's eligible documents found in Table 8

The oldest national surveillance systems documented in the English language included Taiwan, Cambodia, Nigeria, and Zimbabwe (Au, 2006; Faleye, 2017; Figuié et al., 2015; Hsien-Yu, 1998). Surveillance activities, referred to as "policing", in Japanese-colonised Taiwan between 1895-1950, involved monitoring health-related issues by police officers or "Hoko officers", while during the Kuo-Min Tang (KMT) rule in the 1950s, surveillance was conducted by public health nurses (Hsien-Yu, 1998). In French colonized Cambodia, health surveillance activities used the term "dépistage" during a bubonic plague outbreak in 1907, which involved disease registration through mandatory declaration of specific diseases by an attending French physician (Au, 2006). In British colonised Lagos, between 1924-31, port surveillance for transborder diseases were reported, with a greater emphasis on quarantine measures than other aspects of surveillance (Faleye, 2017). In British colonised 19th century Zimbabwe, animal surveillance disregarded indigenous populations' wildlife concerns and confined them by physical fences to prevent infection (Figuié et al., 2015).

The League of Nations Health Office was established in 1921, and in 1925 assisted the formation of systematic surveillance of ports - called the Far Eastern Bureau in Singapore (Cameron-Smith, 2019; Manderson, 2009; Pereira, 2008; Weir & Mykhalovskiy, 2007). Three sources describe activities of the Colonial Epidemiological Intelligence Bureau, which collected information from the West Pacific and West Asia, reaching the Panama Canal (Cameron-Smith, 2019; Manderson, 2009; Weir & Mykhalovskiy, 2010). The establishment of the bureau was said to be colonial in essence. It was headed by selected colonial health officials and funded by the Rockefeller Foundation (Manderson, 2009). The Bureau began

surveillance tasks in March 1925, gathering information from 156 ports, although it was reported to have done so without subaltern knowledge, eventually leading to resistance (Cameron-Smith, 2019; Manderson, 2009; Weir & Mykhalovskiy, 2010). Australia attempted to form its unique health surveillance initiatives instead of welcoming the Bureau. Despite this, the last head of the Bureau until the fall of Singapore in 1942 was an Australian public health official (Cameron-Smith, 2019; Manderson, 2009).

Several sources suggest the continuation of colonial logic within surveillance activities Post-World War II. In 1948, WHO was conceived (Figuié, 2014; Weir & Mykhalovskiy, 2010) and produced a Daily Epidemiological Radio Bulletin (DERB) in 1949 (Weir & Mykhalovskiy, 2010). In 1951, WHO published the International Sanitary Regulations, which were revised and renamed to International Health Regulations (IHR) in 1969 (Genest, 2015; Weir & Mykhalovskiy, 2007, 2010). In 1952, the US Centres for Disease Control and Prevention (CDC), formerly the Malaria Control in War Areas (MCWA), established the Epidemic Intelligence System (EIS) (French, 2009; King, 2002). Further, as a result of worries over national health security in the early 2000s, the Global Outbreak Alert & Response Network (GOARN) was established in 2000, PEPFAR in 2003, IHR revision in 2005, Ebola outbreak [international] response in 2014, and SARS-CoV-2 pandemic restrictions at the end of 2019, among others (Abeysinghe, 2016; Barker, 2012; Caduff, 2014; Cole & Dodds, 2020; Crane, 2010; Davis & Sharp, 2020; Figuié, 2014; Figuié et al., 2015; French, 2009; Genest, 2015; Hinchliffe, 2021; Hinchliffe et al., 2012; Ingram, 2007, 2009; King, 2002; Papamichail, 2021; Peckham, 2018; Pereira, 2008; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007, 2010).

Surveillance and borders

The ever-changing forms of borders, in terms of their proliferation, blurring, erasure, control, creating hierarchies, and cognitive creation was a presumed result of public health surveillance among sources. Authors stated that with the help of health programmes, including systematic collection of data on diseases of people, livestock, and localities, hierarchies classifying and separating individuals and locations between who is a threat of infection (the Other) and who is not (the Self), led to the creation of cognitive borders especially evident in the mid-19th century (Genest, 2015; Hinchliffe et al., 2012; Ingram, 2009, p. 2085; King, 2002).

Concerning the blurring of borders, international collaborations and interventions in national data collection, policies, and activities were reported to have led to unclear borders in the name of global health (Chuengsatiansup & Limsawart, 2019; King, 2002; Peckham, 2018; Weir & Mykhalovskiy, 2007, 2010). This has intensified fears among some populations, e.g. the undefined Afghanistan/Pakistan border, where

both governments and the USA capitalised on this lack of clarity with military and health surveillance interventions (Peckham, 2018). Early warning or vigilance drones and platforms such as the Global Public Health Intelligence Network (GPHIN) and Program for Monitoring Emerging Diseases (ProMED-mail), have encouraged WHO to add unofficial sources to its list of information, in turn bypassing authorities and weakening national borders (Peckham & Sinha, 2019; Weir & Mykhalovskiy, 2007, 2010).

Despite this blurring of borders, epidemics and pandemics showed that strict border control in the form of health checks and surveillance activities remains heavily present and have underlying motives (Cheng, 2015; Cole & Dodds, 2021; Figuié et al., 2015; Pereira, 2008). For example, Hinchliffe (2012) references Foucault's concepts of governmentality within animal health, arguing that surveillance activities and the data they produce, are a means to justify "closure", lockdown, or the mere idea of division between diseases and disease-free areas, eventually ensuring healthy circulation of goods (Hinchliffe et al., 2012). For instance, coercive health surveillance was reportedly to civilize populations, protect colonial soldiers and settlers, and ultimately improve labour efficiency (Au, 2006; Caduff, 2014; Hsien-Yu, 1998; King, 2002; Peckham, 2018). Additionally, sources critiqued the One Health perspective as the apparent entangling of human, animal, and environment, are based on a deep conceptual separation, rather than inclusion, that was evident in the politics of colonial and postcolonial management of livestock health in East Africa (Davis & Sharp, 2020).

Surveillance as national security rhetoric

National security and military linkages to infectious disease surveillance were predominantly discussed and traced back to the colonial era (Genest, 2015; Pereira, 2008). According to Manderson (2009), the rhetoric used at the time of epidemiological intelligence at the Far Eastern bureau in Singapore borrowed many military metaphors (Manderson, 2009). These military metaphors can be seen across centuries where the use of infectious disease threats to justify the funding and expansion of public health surveillance globally, is what an author described as a "war-time mentality" (French, 2009). This war-time rhetoric was re-branded as the concept of health security and biosecurity (Hinchliffe et al., 2012, p. 532). Most sources emphasized that infectious diseases were represented as a threat to industrialized nations' national security (Barker, 2012; Caduff, 2014; Crane, 2010; French, 2009; Ingram, 2007; King, 2002; Pereira, 2008; Sastry & Dutta, 2012) and others blamed WHO as a contributor to this health security discourse (Barker, 2012; French, 2009; Pereira, 2008), with programmes such as IHR and GOARN established to protect industrialized countries (French, 2009; Pereira, 2008).

Exemplifying the above, sources regularly highlighted the US as an example of a neo-colonial or imperial power, contributing to surveillance activities abroad (Ingram, 2009; Pereira, 2008; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007). Sources described the increased epidemiological surveillance activities, in collaboration with the US Department of Defence (DoD), to detect and stop infectious diseases from crossing US borders (French, 2009; Ingram, 2007, 2009; King, 2002; Sastry & Dutta, 2012). Ingram (2007; 2009), taking Nigeria as a case study, suggested that geopolitical discourse representing biological threats as security threats paved the way for DOD military and intelligence involvement in the country (Ingram, 2007, 2009). Peckham (2018) emphasized that surveillance activities conducted outside industrial nations' borders "amounted to an outward extension and inscription of the nation's borders on the 'front lines' of the 'war' against infectious disease in the developing world." (Peckham, 2018, p. 192). This highlights the authors' argument about colonial logic, where military and surveillance activities are integrated, and where data use and interpretation is significantly connected with outside economic, political, and social issues (Ingram, 2009; Papamichail, 2021; Weir & Mykhalovskiy, 2007).

Furthermore, some sources suggest that, especially during the SARS-CoV-2 pandemic, surveillance at borders emphasised national security discourses. They note the extension of activities and funds in the direction of the "service of discerning approved and nonapproved cross-border mobility" (Cole & Dodds, 2021, p. 172). Surveillance activities extended to self-surveillance, with people expected to monitor their own movements to help prevent the virus from entering their space (Cole & Dodds, 2021). This emphasizes Papamichail's (2021) argument on how surveillance activities and resulting numbers have shaped the "public imagination", or subjectivities, in relation to COVID-19, linking surveillance to national security activities (Papamichail, 2021).

This public imagination on disease threat has had a toll on cross-border populations, as mentioned by several sources. The notion of the Self versus Other, and related hierarchy creation, is evident in discourses around "who" brings to the "inside" infectious diseases from the "outside" (Bell et al., 2006; Cheng, 2015; Hinchliffe et al., 2012; King, 2002). While potentially serving in preventing the spread of diseases, isolation and quarantine activities have led to divisions between people and isolation of social groups such as migrants (Ingram, 2009; King, 2002). Contemporarily, US national security rhetoric argued that these mobile individuals are a reason, or reservoir, behind the entry of diseases into its borderlands, threatening internal "immunities", and affecting their migration policies (Caduff, 2014; King, 2002; Papamichail, 2021; Peckham, 2018; Pereira, 2008; Sastry & Dutta, 2012). Moreover, sources pinpoint that international infectious disease surveillance in non-industrialized nations has been labelled "humanitarian work" or

“scientific expertise” during colonial and postcolonial times (Bell et al., 2006; King, 2002; Sastry & Dutta, 2012). For instance, many parts of Africa are viewed as sources of data for industrial nations’ knowledge production, manifesting a postcolonial power dynamic (Crane, 2010). Despite this, humanitarian work is often contradicted when investment is only made in combating diseases that have potential to spread into high-income countries, while diseases posing less risk, such as tuberculosis in South Africa, are largely ignored (Genest, 2015; Pereira, 2008).

Surveillance and trade

Health activities, including surveillance during colonial times, were reportedly used coercively to civilize populations, protect colonial soldiers and settlers, improve labour efficiency, and eventually protect capitalist economic interests (Caduff, 2014; Figuié et al., 2015; Genest, 2015; Hsien-Yu, 1998; Ingram, 2007; King, 2002; Peckham, 2018; Pereira, 2008; Sastry & Dutta, 2012). For instance, in colonial times, epidemiological intelligence was aimed at protecting trade, preventing native populations from declining, ensuring healthy labour, and eventually aiding in economic inequality (Cameron-Smith, 2019; Figuié et al., 2015; Hinchliffe, 2021; Hinchliffe et al., 2012; Hsien-Yu, 1998; Manderson, 2009). Another example, animal infectious disease surveillance in Zimbabwe, both under colonialism and after independence, affected indigenous populations, with their wildlife isolated and excluded from national and international markets (Figuié et al., 2015).

More recently, documents suggest, the justification of international surveillance activities has aimed at preserving capitalist interests in preserving trade. Precisely, WHO's IHR was claimed to be for safeguarding trade during outbreaks (Figuié, 2014), and US involvement in international activities aimed at preserving the US economy and security (Figuié, 2014; King, 2002). Further, it was assumed that the neoliberal agenda was supported by the insistence that IHR take the lead to prevent any interference with trade, which might have been the reason behind WHO's declaration of the H1N1 pandemic (Cole & Dodds, 2021; Figuié, 2014; Genest, 2015). These declarations have been documented as having widened economic gaps, for instance, Anti-Microbial Resistance (AMR) surveillance in low and middle-income countries has disadvantaged farms by requiring adherence to international mandates that many lack the capacity for, leading to expansion of industrialized farms (Hinchliffe, 2021). Finally, funding from "philanthrocapitalist organizations" (Papamichail, 2021), such as the Rockefeller Foundation, played a significant role in supporting international surveillance programmes including the Far Eastern Bureau in Singapore and US CDC (Cameron-Smith, 2019; King, 2002; Manderson, 2009; Pereira, 2008).

Surveillance and the role of media

The media was portrayed as important in both disseminating information about infectious diseases and being part of the data collection process. Promoting fear of foreign infectious diseases helped justify international health surveillance activities and quarantine measures (Abeysinghe, 2016; King, 2002; Peckham, 2018). For example, sources claim that WHO's list of IHR notifiable infectious diseases echoes the fears presented in Western media (Genest, 2015), and helps shape the discourse about national security (Barker, 2012; Caduff, 2014; Ingram, 2009; King, 2002). Additionally, the media's role has been capitalized by institutions out of fear of spread of infectious diseases (Weir & Mykhalovskiy, 2007). Health officials in Canada developed GPHIN, a vigilance platform with news outlets as its main source of information (Weir & Mykhalovskiy, 2007). GPHIN, along with ProMED-mail, emphasized the importance of non-systematic sources of information, including unofficial sources, which WHO later included in IHR 2005 (Weir & Mykhalovskiy, 2010).

Surveillance and forms of resistance

Forms of resistance to colonial or geopolitical interference have been documented. During colonial times, people in Taiwan and Cambodia resisted foreign medical services and activities that did not match their social norms (Au, 2006; Hsien-Yu, 1998). There was opposition to the establishment of the Far Eastern Bureau from India and later resistance from Hong Kong (Manderson, 2009). In Lagos, people resisted plague control measures as they were seen as racial segregation (Faleye, 2017). In Zimbabwe, indigenous farmers resisted livestock restrictions imposed by colonizers (Figuié et al., 2015).

Contemporarily, resistance activities have also been reported. Sources relay how “panic” is a form of recollection of past events, identifying it as a probable reason behind some resistances in the health field (Peckham, 2018). Refusals of recent polio vaccination can be framed as refusal of Western involvement, a form of anti-imperialistic sentiment or an anti-colonial act (Ingram, 2007; Peckham, 2018). Sovereignty has also been a motive behind resistance as shown in Indonesia not sharing its influenza samples and reporting to WHO (Figuié, 2014). Finally, opposing medical drones, authors suggest, which might also benefit health surveillance, are counter-cartography activities conducted by indigenous populations (Peckham & Sinha, 2019).

Discussion

This review is an initial effort to synthesises the literature on the history of infectious disease surveillance, its hierarchies and subjectivities, and ways of resistance. My research questions included the extent and findings of existing literature recounting and analysing infectious disease surveillance activities in (post)colonial eras or using (post)colonial theories, focusing on infectious disease surveillance related to border studies and geopolitics, and what recommendations could be retrieved or generated from these findings. Here I will be discussing the findings along the lines of these questions.

(Post)Colonial motives, or the appropriation of infectious disease surveillance

Several themes emerged when addressing the first question on the existing literature recounting and analysing infectious disease surveillance activities in (post)colonial eras or using (post)colonial theories.

The first theme identified suggests that surveillance activities during and after colonization were often accompanied by colonial ideologies, where health information was a means to justify the empire's humanitarian action (Genest, 2015; King, 2002; Pereira, 2008; Sastry & Dutta, 2012). This has implications on the work of infectious disease surveillance up until today. Writing on colonial appropriation of health information, Smith (2021), characterizes colonial endeavours as an era for “collecting” from indigenous populations, including the collection of knowledge that was “rearranged” to fit colonial interests (Smith, 2021). Collecting information on health, or health surveillance activities in our case, fits this description, where data are collected and repurposed for racialization of diseases, and this is still prevalent (Smith, 2021; White, 2023). Further, Mbembe (2001, 2009) argues that to civilize populations, and in turn mask the violence of colonial endeavours, surveillance has been used in different aspects of subaltern lives (Mbembe, 2001, 2019). This progressed into passive or structural violence, resulting in individual suffering due to social, economic, and political factors (Farmer et al., 2013), as evident in passive approaches such as self-surveillance, international humanitarian intervention, data exchange networks, and One Health salient in our public health systems today (Cole & Dodds, 2021; Davis & Sharp, 2020; King, 2002; Pereira, 2008; Sastry & Dutta, 2012). Similar arguments have been made within the domain of global health and international development projects, suggesting that its current state has evolved from colonial medicine, primarily as a method to benefit colonial forces sometimes even ‘disguised’ alternatives to colonial rule (Abimbola & Pai, 2020; Escobar, 2011; Farmer et al., 2013; Hirsch & Martin, 2022; Khan et al., 2022; Richardson, 2020; White, 2023).

The second theme is that of humanitarian work or international surveillance activities and their colonial origins. My findings highlighted how international infectious disease surveillance outside of Europe or the West was often labelled modernization activities, humanitarian work, or technical assistance during colonial and neocolonial times (Bell et al., 2006; Chuengsatiansup & Limsawart, 2019; Crane, 2010; Genest, 2015; King, 2002; Peckham, 2018; Pereira, 2008; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007, 2010). Elaborating on this, Escobar (2011) recounts how the "developing world" has been inundated with "experts" in development and health to study their populations, using racist discourses about 'beneficiary' populations to justify sending experts to oversee, impose power, collect data, and develop an idea of the supposed problems populations are facing (Aviles, 2001; Escobar, 2011; Hirsch & Martin, 2022). These motives and their health surveillance activities have led to the stigmatization of these populations being studies rather than their use for health access, and this is an aspect health surveillance professionals need to take note of to counteract these conditions.

The third theme is that of racialization of diseases. Discussing the topic of identity, Said (1994) suggested that identity has been embedded in the ideology of both imperial and subaltern, leading to "us" and "them" rhetoric (Said, 1994). This was later emphasized by other authors positing colonial discourse encouraged subjugation of populations recounted to be unfit because of their race, in other words, lead to the racialization of diseases (Bhabha, 1990; Mbembe, 2001, 2019; White, 2023). For example, authors argued that the racialization of infectious diseases, especially tuberculosis, contributed to the stigmatization of certain groups leading to their exclusion from healthcare access and prevention (Briggs, 2011; King, 2003). This returns us to the necessity of understanding social and cultural contexts that shape the production and circulation of infectious diseases, and not just look at numbers from a pure objective lens. Developing more critical and reflexive approaches to surveillance activities and the rhetoric and subjectivities they produce is pertinent for proper health access (Aviles, 2001; Farmer et al., 2013; Richardson, 2020; White, 2023).

The fourth theme is that of health surveillance being used historically to ensure well-functioning labour in colonial territories and to protect capitalist economic interests in modern societies (Figuié et al., 2015; Genest, 2015; Ingram, 2007; King, 2002; Pereira, 2008; Sastry & Dutta, 2012). Well-functioning labour has been said to be the objective of most public health and funding programmes (White, 2023), where colonial medicine in Africa and Asia, was essentially economic stemming from the ideological belief that to protect colonial projects and trade, labour needed to be protected (Cameron-Smith, 2013; Hirsch, 2021; Marks, 1997; Mbembe, 2001, 2019; White, 2023). Literature addressing the current importance of protecting

labour, as well as production, has become normalized as part of our social life or political economy (Escobar, 2011). Related to this is the importance of prominent funding agencies supporting surveillance activities such as the Rockefeller Foundation (Cameron-Smith, 2019; King, 2002; Manderson, 2009; Papamichail, 2021; Pereira, 2008). Scholars have suggested that dominant philanthropists such as the Ford Foundation; have their own economic interests and hence could skew information according to these interests (Mezzadra & Neilson, 2013). For instance, it is argued that the Rockefeller Foundation's funding of public health programmes in Latin America in the 1910s, and later in nutrition and health development, has been essentially to impose USA's economic and ideological hegemony (Escobar, 2011). Contemporarily, it has been assumed that the Bill & Melinda Gates Foundation, which because of money status, was able to have an important impact on global health and funded many health projects targeting infectious diseases for economic and political interests (Levich, 2015).

Border as Method, or the rhetoric of national security

The second question posited regards how infectious disease surveillance fits within border studies. Here the primary theme was that of international collaborations and interventions in national data collection, policies, and activities leading to blurring of borders and a decline in sovereignty in the name of global health (Chuengsatiansup & Limsawart, 2019; King, 2002; Peckham, 2018; Weir & Mykhalovskiy, 2007, 2010). Postcolonial studies encompass the understanding of border creation, both physically and conceptually. While maps, and the borders they depict, are increasingly seen merely as lines marking territories, they are in a constant state of change (Mezzadra & Neilson, 2013). This represents a form of "cartographic anxiety or crisis", where maps are means for creating subjectivities and "trapping people," yet also, and contradictorily, contributing to the proliferation of borders that restrict movement and impact people's quality of life (Mezzadra & Neilson, 2013, p. 28). Amplifying this is the military rhetoric of colonial times that has contemporarily been replaced by concepts of national or global health security (Barker, 2012; Caduff, 2014; Crane, 2010; French, 2009; Hinchliffe et al., 2012; Ingram, 2007; King, 2002; Pereira, 2008; Sastry & Dutta, 2012). This was seen during colonial medicine's surveillance activities linked to schools of tropical medicine in Great Britain were led by the military (Hirsch & Martin, 2022). Fast forward to the present, investments in the securitization of borders and security measures at borders were enforced by the USA post-September 11 and this came hand-in-hand with increased epidemiological surveillance activities, both in the US and abroad, supported by the US Department of Defence (French, 2009; Ingram, 2007, 2009; King, 2002; Mezzadra & Neilson, 2013; Peckham, 2018; Sastry & Dutta, 2012). Hence, the selectiveness of borders that open and close for people depending on their use, or infectivity,

represent a form of structural violence affecting the work of surveillance (Mezzadra & Neilson, 2013). Particularly, the notion of "Us" versus "Them", evident in discourses around "who" brings to the "inside" infectious diseases from the "outside", affects surveillance activities for cross-border populations "who are carrying them [borders]" (Bell et al., 2006; Cheng, 2015; Hinchliffe et al., 2012; King, 2002; Papamichail, 2021).

Can the subaltern public health professional speak?

My third question, on whether recommendations can be brought forth from these documents, includes the themes on forms of resistance and knowledge production. The review showcased forms of resistance such as by people in Taiwan, Cambodia, Nigeria, India, and Hong Kong (Au, 2006; Faleye, 2017; Figuié et al., 2015; Hsien-Yu, 1998; Manderson, 2009). Many postcolonial scholars advocate showcasing resistance acts against colonial or hegemonic rule (Bhabha, 1990; Escobar, 2011). The most radical form of resistance is presented by Fanon (1963), who suggests that no decolonization can be completed without violence since colonization was conceived through violence (Fanon, 1963). Alternatively, Mezzadra and Neilson (2013) suggest that resistance struggles are most importantly about changing subjectivities, i.e., subjectivities that produce more resistance activities (Mezzadra & Neilson, 2013). Border as method is not limited to how people, especially migrants, defy borders, but also how they organize into transnational social spaces to understand the effects of, and appealing against, these borders (Mezzadra & Neilson, 2013).

Hence, the *first recommendation* I would put forth is that health surveillance professionals take a more critical and self-reflective stance, while recognizing the complexity and fluidity of cultural identities and historical processes, ultimately and ideally, eliminating colonial ideologies (Abimbola, 2019; Aviles, 2001; Farmer et al., 2013; Richardson, 2020; Said, 1978). In turn, these professionals can work together to create national and transnational surveillance policies and activities from within, i.e. from the subaltern to the subaltern themselves, contributing to the production of social identities not linked to historical colonial and modern hegemonies.

Moreover, most authors in this revision writing on the history and socio-political conditions of infectious diseases surveillance are from the fields of geography, geopolitics, history, and anthropology while predominantly affiliated to high-income European and Western institutions (Caduff, 2014). Pertinent is what Escobar (2011) suggests that divisions between objective researchers or "knowledge producers" and the communities they study cannot provide any true knowledge or policies (Escobar, 2011), especially

since coloniality might affect people's subjectivities, or how they perceive themselves (Fanon, 1963; Mbembe, 2019; Said, 1978). This reflects a "centre-to-periphery" flow highlighted in global health programmes and publishing, with the centre mostly within institutions in Europe and USA (Abimbola & Pai, 2020). Publishing within, or, bringing the periphery to the centre, has been encouraged, but remains under cited due to unindexed journals or, though very limited, articles written in languages other than English (Abimbola, 2019, 2023). For instance, most literature on the plague has been documented by Europe or the West. Ibin Hajjar Al-Asqalani of the 15th century touches on the topic of governmental surveillance in the Arab region but his work has only recently been translated from Arabic to English (al-Asqalani et al., 2023).

Therefore, a *second recommendation* would be that historical manuscripts on health programs and surveillance in languages other than English be translated and available to the public. However, producing knowledge 'locally', using indigenous languages, is also an important step within resistance or creation of subjectivities, where writing and publishing in local languages become inherent within research (Abimbola, 2019, 2023). Smith (2021), gives an example of how Māori language in New Zealand is beginning to be structured and organized into knowledge platforms in education and health as a form of resistance (Smith, 2021).

Consequently, the *third recommendation* for this review would be that radical changes to education systems and knowledge dissemination within medicine and health sciences be planned an implemented with emphasis on indigenous languages, translations to other languages for exposure, and interregional standardization of health activities that are from within rather than from abroad. In this way, the subaltern health surveillance professionals can ensure they have a voice and their voice be heard.

Lastly, but still with regards to knowledge production, is the finding on the media's contribution to discourses of surveillance activities, especially that of fear of foreign infections (Abeysinghe, 2016; King, 2002; Peckham, 2018; Weir & Mykhalovskiy, 2010). Media has been said to be effective in portraying cognitive border divisions, since it provides visual scenes to link descriptions of infections and racialization of diseases, as a result a virus 100 miles away is not just perceived, but also physically mapped within the borders of the country (Briggs, 2005; Koch, 2017). Media discourses, including literature and other forms of cultural production, can reinforce imperialist ideologies and be shaped by power dynamics of colonialism (Abimbola, 2023; Fanon, 2008; Said, 1994). This brings me to the *fourth recommendation* for this review, that health professionals plan and implement communication strategies with media

representatives to be informed of the nature of any epidemic and to ensure discourses that are inclusive and devoid of blame and racialization.

Limitations

This review depended on literature indexed in accessible databases, and hence some documents published in non-indexed journals or without English abstracts may be missed. I did not assess the quality of the documents as this is not required or directly relevant for scoping reviews, and instead relied on the opinions of experts in the field to determine whether the scope of included documents was sufficient.

Conclusion

This synthesis of the literature suggests that the original motive behind infectious disease surveillance was to protect colonial armies and Western borders from threats perceived as originating from indigenous colonised populations. Despite the importance of infectious disease surveillance in assisting public health activities and policies, its historical effects in contemporary public health activities require critique, particularly by subalterns themselves. How surveillance has affected and affects our social identities, is a matter of future study. Therefore, case studies on disease surveillance and linkages to sociological and geopolitical discourses and ideologies, especially by subaltern public health professionals and published in peripheries, can better articulate this linkage. This thesis is an effort to bring forth such a case study on infectious disease surveillance and its historical and socio-political contexts in Lebanon.

CHAPTER 5: INFECTIOUS DISEASE SURVEILLANCE AND OTHERING DISCOURSE IN LEBANESE MEDIA DISCOURSE

Chapter overview

In this chapter, I will be analysing the media discourses addressing infectious disease surveillance or epidemiological investigation activities targeting displaced populations in Lebanon, specifically Syrian refugees post 2011. These findings address the first and third objective of this thesis: to identify how infectious disease surveillance of, and related discourses about, Syrian refugees in Lebanon post-2011, shape, replicate, or challenge Lebanon's historical-political context, particularly in external and internal frontier (re)creation; and to analyse whether different political camps or sectarian groups in Lebanon, within their media outlets, differ in their discourses concerning infectious disease surveillance for Syrian refugees.

I extracted 28 media reports from two print and two broadcast media outlets using. I conducted a discourse analysis following DHA's steps. For the microlevel intertextual analysis I identified the actors, actions, and arguments within the text and found macrolevel overarching discourse topics. Findings are backed up by quotations from the media outlets.

The overarching discourse topics within the selected media reports were very similar across the different media outlets despite their political differences with regards to their stance on displaced populations in Lebanon. These topics were essentially on the Syrian refugees (the Other) being the source of infections into Lebanon, Lebanese national's (the Self) fear of this disease importation, and the presence of a ready, prepared health surveillance authority (supported by international organizations) that is capable to respond to these infectious disease threats.

This chapter showcases how media outlets and their discursive practices can contribute to discourses of surveillance activities that are intertwined with engendering fear of infection and blame toward others. This has repercussions on health policies addressing refugees and eventually their health access. Health surveillance professionals need to be attentive to such discourse to mitigate them through constant communication with media representatives.

Media characteristics

I included 28 sources (26 newspaper and 3 TV) of 64 potential sources identified. I found only eight newspaper reports addressing infectious disease surveillance activities among refugees, while 17 discussed numbers and investigations related to infectious diseases among refugee populations. Television sources did not mention surveillance per se, but 3 reported numbers of cases of specific diseases among refugees, two from LBCI and one from Almanar Television. Of these reports, most (16) were published in 2013 and most (17) were from Annahar newspaper. The Detailed list of included reports is found in Table 9 below.

Table 10: Analysed media reports sorted by ascending report date

#	Media outlet	Media type	Report Date	Report Title
1	Annahar	Print	24 December 2012	الواقع الصحي للنازحين السوريين في عكار: وضع معيشي صعب يعرضهم للأوبئة والامراض
2	Annahar	Print	4 April 2013	وفاة امرأة مصابة بمرض السل يثير مخاوف من تفشيه في عكار
3	Annahar	Print	10 April 2013	الامراض الوبائية في عكار
4	Alakhbar	Print	11 April 2013	وزارة الصحة: أدوية الجرب متوافرة مجاناً
5	Annahar	Print	20 April 2013	حالات جرب بين النازحين في اردە
6	Annahar	Print	3 May 2013	حالات معدية وانتشار أوبئة بين النازحين لجنة الصحة: لبنان امام مشكلة
7	Alakhbar	Print	3 May 2013	لجنة الصحة النيابية تحذر من انتشار الأوبئة
8	Annahar	Print	5 June 2013	اصابات بالليشمانيا بين الاجئين
9	Annahar	Print	11 July 2013	لجنة الصحة تحذّر من قضية اللاجئين
10	Annahar	Print	12 July 2013	وزارة الصحة أصدرت تقريرًا عن مرض الليشمانيا
11	Alakhbar	Print	25 July 2013	انتشار وباء الجرب بين عدد من اللاجئين السوريين
12	Alakhbar	Print	5 August 2013	عوارض السل تصيب طفلاً نازحاً
13	Annahar	Print	30 August 2013	تفشّي الأمراض المعدية بين اللاجئين السوريين في الجنوب
14	LBCI	Broadcast	16 October 2013	شلل الاطفال في لبنان
15	Annahar	Print	28 October 2013	حالة شلل لدى طفلة لاجئة
16	Alakhbar	Print	28 October 2013	شلل الطفلة السورية في عكار غير معد
17	Almanar TV	Broadcast	30 November 2013	حملة تلقيح لمرض شلل الأطفال

18	Annahar	Print	21 February 2014	توافد اللاجئين السوريين يعزّز انتشارها
19	Annahar	Print	27 February 2014	جرب وسلّ محدودان بين سوريين ولبنانيين
20	Alakhbar	Print	18 March 2014	تسع حالات صفيرة في الهبارية
21	Annahar	Print	11 April 2014	أبو فاعور أطلق حملة للقاح ضد شلل الأولاد
22	Annahar	Print	29 May 2014	سِلّ وجَرب وليشمانيا وحصبة وريقان وسحايا وشلل
23	Annahar	Print	22 July 2014	ندوة عن مرض اللشمانيا
24	Alakhbar	Print	22 July 2014	خطر انتقال اللشمانيا محدود
25	Alakhbar	Print	23 August 2014	حملة طبية للاجئين في كفرشلان
26	LBCI	Broadcast	25 August 2014	تفشي الليشمانيا
27	Annahar	Print	15 October 2014	إطلاق الحملة الوطنية للتحصين ضد مرض شلل الأولاد
28	Annahar	Print	30 October 2015	لبنان غير مهدّد بالكوليرا مثل سوريا

Discourse topics

Despite the apparent differences in political stances and discourse practices between the media outlets chosen, my analysis showed that the recurring discourse topics were very similar as shown in Table 10. These discourse topics revolved around refugees being a threat to infectious disease importation into Lebanon, the fear of Lebanese nationals from these infectious diseases, and the preparedness of health authorities (and their international support) in dealing with infectious disease surveillance.

Table 11: Media revision discourse topics

	Discourse topic of health authorities	**Discourse topic of fear**	**Discourse topic of displaced populations**
Topic 1	Authorities plan and prepare to respond	Nationals fear the threat disease spillover from refugees	Refugees are the reason/source for infections
Topic 2	Statistical reports reveal everything is under control		Refugees bring diseases not/no longer present in Lebanon
Topic 3	Assisted by international organizations		

Three-level textual analysis

I divided textual discourse analysis into the three discursive strategies elaborated in Chapter 3: referential strategies or how actors are framed, predicational strategies or the actions attributed to the actors, and argumentative strategies that explain or justify actions. I included media quotes that exemplified each strategy. It is important to note that some quotes could fit into several discursive strategies.

Referential

Here the self, unlike in chapter 6 and 7, has two sides given the nature of media reports addressing different populations; the self as Lebanese population and the self as Lebanese authorities and their counterparts.

The self as Lebanese population: Among reports mentioning surveillance, seven addressed the self as "Lebanon", five as "nationals", five as "Lebanese families" or "Lebanese community" or "welcoming families", and five as "Lebanese lands" as compared to neighbouring lands. Reference to the Self appeared to be framed in a positive and welcoming way.

> "In the context of the harsh conditions the displaced Syrian families are living in, and especially the **welcoming Lebanese families [**العائلات اللبنانية المضيفة**]**, on all levels… then health authorities might not be able to control the exacerbation of the health situation and the appearance of new epidemics and diseases." Annahar 24 December 2012.

> "Nine new cases of jaundice among residents of Hebbariye [village in Nabatieh Governorate] and among displaced Syrians [الهبارية سكان], led to fear among **nationals** of the spread of this infectious disease [خوفا في صفوف **المواطنين** من تفشي المرض المعدي]" Alakhbar 18 March 2014.

The references to the Self that stood out were those mentioning Lebanese as vulnerable victims, or citizens in danger, from infections entering. For example, "Lebanese woman" infected with leishmania, a disease endemic in Syria only, that there were only a few Lebanese cases (as compared to Syrian), and that Lebanon needs to respond rapidly to ensure Lebanon remains Polio-free.

> "… the infection [leishmania] of a **woman from Akkar** [**امراة عكارية**], and she is still under treatment till today… [television reporter asking] Does the appearance of this disease, **foreign to the**

Lebanese community [المرض الغريب عن المجتمع اللبناني**]**, create a threat for the **Lebanese [** خطورة على اللبنانيين**]?**" LBCI 25 August 2014.

"[Minister of health speaking] we want to be proactive to prevent this threat [استباقية لمواجهة هذا الخطر] – which we assure that **Lebanon is free of [polio]** [لايوجد فية اى اصابة بمرض] until this moment" Almanar 8 November 2013

The self as the authority: Be it national or international, most emphasis within reports was on experts or technical entities, the significance of which is discussed in the argumentation strategies below. Most technical entities mentioned are the Ministry of Public Health (MOPH) and its teams, discussed in 18 reports. Surveillance, as in national surveillance teams or the Epidemiological Surveillance Unit/Program (ESU), was mentioned in five reports, the peripheral MOPH offices conducting surveillance activities were mentioned in two reports, and general surveillance activities in three reports. Ten reports addressed international organizations such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations High Commissioner for Refugees (UNHCR), and International Medical Corps (IMC) among others. What was noticeable was the limited mention of the ESU in general, and lack of mention of other surveillance teams outside of the ESU, such as the national tuberculosis centre.

"and the **World Health Organization** had contributed [**منظمة الصحة العالمية ساهمت**] to the strengthening of **epidemiological surveillance** [**الترصد الوبائي** تقوية] for the disease [Leishmania]" Annahar 22 July 2014.

"The **minister of public health** headed [**ترأس وزير الصحة العامة**] a working meeting to follow-up on the steps and procedures … to combat infectious diseases" 5 Annahar June 2013.

The Others: In terms of how others are mentioned, there seemed to be equal and interchangeable use of the term "refugees" as apparent in 12 reports, and "displaced populations" in another 12 reports, while two reports use both terms, one addressed them as Syrians, and one as victims. Other expressions included the ill, the affected, the cases, the neighbours, Syrian child(ren), they/them, the displaced/refugee clusters, and haphazard camps.

"a report informed of the spread of the scabies epidemic among **Syrian refugees** [اللاجئين السوريين] … **they** [هؤلاء] shelter **their families and children** in nylon tents" Alakhbar 25 July 2013.

"Tuberculosis, Aleppo sore, scabies, and hepatitis, are disease cases reported by the Ministry of Health up till today as a result of the huge arrival of **displaced Syrians** [نتيجة التوافد الكبير للنازحين السوريين]" Annahar 3 May 2013.

"[television reporter asking] Does the appearance of this disease, **foreign to the Lebanese community [**المرض الغريب عن المجتمع اللبناني**]**, **create a threat for the Lebanese [**خطورة على اللبنانيين**]?**" LBCI 25 August 2014

Predicational

The Self: afraid of being infected, afraid of the burden and threat of importation of infectious disease

One of the actions attributed to the Self was that of feeling afraid of the spread of disease foreign to the Lebanese community. Reports wrote that Lebanese nationals were afraid of being infected by foreigners, in this case, Syrian refugees. Other reports did not implicitly use the term afraid, though their discourse did. For instance, health officials warned that lack of planning to combat diseases foreign to Lebanon could lead to the importation of new viruses and ultimately lead to a national catastrophe.

"[Headline] death of a woman infected by tuberculosis [يثير مخاوف] **triggers fear** [among residents] from its spread in Akkar [North Lebanon]" Annahar 4 April 2013.

"This is a big problem, and if we do not know how to deal with it and **contain its spread**, then it will possibly turn into a **national catastrophe** [تتحول الى كارثة وطنية]" 3 Alakhbar May 2013.

"… with the escalation of **events in Syrian, the same fear [of disease importation] is back to the forefront**" LBCI 16 October 2013

"Lebanon is **not far from receiving its share of this deadly virus** [تلقي نصيبه من هذا الفيروس القاتل], given the vicinity and shared borders [بحكم الجيرة والحدود المشتركة] between the countries [Lebanon and Syria]" Annahar 30 October 2015.

Interestingly, there appeared to be contradictions in the language used to describe fear or fear of threat from 2012 until 2015, with some reports using threatening statements such as the Lebanese community needs to be alert since Polio is at the borders. However, other reports mentioned that the health situation in Lebanon was under control and the health sector was well prepared to combat any threat, hence there

is no need to be scared. These reassuring statements are showcased in the next predication of the Self below.

The Self: Ready and prepared

Contrary to the threatening statements reported above, some reports declared that authorities were following up on the health situation, responding rapidly, notifying MOPH or ESU, having a plan/strategy, and assuring that there is no threat of the spread of diseases since it is under control. Displaying readiness intertwined with the rhetoric of national security, two outlets reported how a whole displaced Syrian family was deported from Lebanon given one of their children was suspected to be infected with tuberculosis.

> "The family, consists of 13 members… **was transferred** to the Masnaa [border check point between Syria and Lebanon] in **coordination with the general security** in Lebanon [نقلت بالتنسيق مع الامن العام الى نقطة المصنع] and left to Syria" Alakhbar 5 August 2013.

Some statements noted how governmental statistical reports reveal "satisfying" information on how the health status in Lebanon is doing well, despite the presence of infections among refugees, and that preventive measures are being taken.

> "**Reports revealed** [اظهرت التقارير] relieving and satisfying information… Lebanon is free from these cases [Polio] [لبنان خال من تلك الحالات] ...only one case was reported of a child infected with Leishmania and that it was not confirmed that it was transmitted from the Syrian refugees … and they took the **preventive measures to stop the spread of disease**." Annahar 5 June 2013

> "[Minister of health speaking] **we want to be proactive** to **prevent this threat** [استباقية لمواجهة هذا الخطر] – which we assure that **Lebanon is free** of [polio] [لايوجد فية اى اصابة بمرض] until this moment and there are no suspected cases" Almanar 8 November 2013

> "The MOPH's current concern is to confirm the presence of the sandfly and put a **response plan to protect its nationals** [وضع آلية تحرك من شأنها حماية المواطنين]**"** LBCI 25 August 2014

> "[the district physician] reported to the epidemiological surveillance unit at the ministry of public health, which is **dealing with [interested in] this topic** [المهتمة بهذا الموضوع] and he noted that this type of paralysis is not contagious, so **no need to panic**" Annahar 28 Oct 2013.

The Self: Assisted and supported by international organizations

An important contributor to the notion of the Self within the selected media reports appears to be the presence and assistance of technical entities, especially those coming from international organizations. Hence, their presence is a form of authority in addition to that of the local state health authorities. For example, reports stated that WHO and UNICEF provide support/assistance to surveillance activities and strategic planning as quoted below. Among the reports mentioning surveillance, the majority is about what technical entities (or authorities) have to say about the status of surveillance in the context of refugee displacement.

> "The World Health Organization had **contributed** [منظمة الصحة العالمية ساهمت] **to the strengthening** of epidemiological surveillance [تقوية الترصد الوبائي] for the disease [Leishmania]" Alakhbar 22 July 2014.

> "[She] explained the **strategy for patient treatment [for leishmania]** [استراتيجية علاج المرض] set forth **in collaboration with the World Health Organization [**التعاون مع منظمة الصحة**]**" Annahar 22 July 2014.

> "[she added that] the Organization [WHO] is **assisting in the advancement of the epidemiological surveillance structure [**دعمت تطوير نظام الترصد الوبائي**]** by … training the human capacity at the epidemiological surveillance unit, central and peripheral." Annahar 30 October 2015

> "UNICEF **provided** [منظمة اليونسف قدمت] maps of unvaccinated children, especially among Syrian refugees children" Annahar 10 April 2013

The Other: are the source of contamination/ infection

The othered or "them", in this case, Syrian refugees, were portrayed as being the ones spreading diseases due to their "haphazard" presence, increased numbers, mass-gathering, and "unsanitary" living conditions. Additionally, the reports highlighted that some diseases endemic in Syria, for instance, leishmania, and diseases that recently reappeared in Syria, such as polio, had the potential to come to Lebanon which had been free of these diseases for years. Importantly, the different media outlets chosen for this revision which correspond to different political poles, reported the news of the spread of diseases

due to the displaced Syrians in the same manner, i.e. blaming the displaced population for being the source of infections foreign to Lebanon.

> "The parliamentary health committee sounded the alarm [ناقوس الخطر] with regards to the spread of epidemics among the displaced [يتعلق بانتشار الاوبئة بين النازحين] … 'these **diseases are a result of the haphazard spread of displaced** in more than one city and village' [جاءت نتيجة الانتشار العشوائي للنازحين]" Annahar 3 May 2013

> "The cabinet committee recommended that … 'the MOPH be assigned to **conduct a survey or take samples from displaced Syrians to pinpoint the infectious diseases present among them [** من النازحين السوريين لتحديد الامراض المعدية الموجودة بينهم**]** to present the **dangerous situation present in Lebanon … which resulted from the number of displaced [Syrian] [**العرض الاوضاع الخطيرة الحاصلة**]'**" Alakhbar 3 May 2013

> "**Increase in number of cases** of scabies and lice which is **related to over crowdedness and lack of cleanliness [**المرتبطة بالاكتظاظ السكاني وسوء ظروف النظافة**], especially in areas where displaced [Syrians] are present [**وخاص في اماكن وجود النازحين**]**" Alakhbar 11 April 2013

> "Recording of the **spread of several diseases and epidemics in the haphazard refugee camps that lacks health and safety conditions [**الامراض والاوبئة في المخيمات العشوائية**]** … and it is **beginning to affect the local host community."** Annahar 29 May 2014

> "[Minister of health speaking] there is **information [**في معلومات**] that this disease [Polio] may be transmitted from Syria to here [**ينقل من سورية لهون**]** and **come back to us** [ويرجع لعنا]" LBCI 16 October 2013.

Argumentation

Most discourse topics in the reports revolved around the claim that the Lebanese authorities were prepared, were doing their job, international organizations were supporting them, that the displaced populations posed a threat with regards to infectious disease, and that the Lebanese community feared that. The argumentation strategies used in the reports are discussed below in terms of how they used these arguments to justify their claims.

Topos of fear, burden, and threat

Argumentation schemes of fear, burden, and threat appeared to be the inherent framing of the media reports. Rephrasing the argumentation strategies in the form of topoi, the first topos is that of burden, and fear *(Boukala, 2016; Wodak, 2015; Wodak & Meyer, 2001)*, which work together in one topos and can be addressed as follows:

If Lebanon (the Self) is fearing the burden of infections imported by the displaced Syrian refugees (the Other), then Lebanon should act to remove this burden.

Similarly, the second topos is that of threat, which can also be associated with the argument of blaming the Syrian refugees for this threat *(Boukala, 2016; KhosraviNik, 2015; Wodak, 2015; Wodak & Meyer, 2001)*. The topos would then be described as the following:

If the fear of threat of infectious diseases contamination from displaced Syrians is there, then Lebanon is rightful to do something about it.

Topos of authority, readiness, assistance, and numbers

Following the topos of threats and burden, other common claims within the media reports were that of readiness of authorities, their assistance by international organizations, and that their numbers, or statistical reports, gave them legitimacy to take specific action *(Boukala, 2016; Wodak, 2015)*. These arguments appeared to be interconnected. In this context, topos of authority appeared to be as follows:

The actions, plans, and statements by Lebanese Ministry of Health, surveillance programmes, and their international organization counterparts, are ready, legitimate, and trustworthy given if it is the only health authority.

The other topos is that of numbers, which in our context is related to statistical reports. The argument was as follows:

The statistical reports released by the Ministry of Health, surveillance programmes, and its international organization counterparts, give these authorities the right to be ready to conduct, plan, and implement specific health actions

Moreover, topos of assistance is inherent in the reports as well and can be read as follows:

Given their assistance by international counterparts, the Ministry of Health and surveillance programmes are prepared to conduct, plan, and implement specific health actions.

Discussion

Quotations extracted from the media reports appear to construct the notion that Lebanon was at risk of receiving infectious diseases given its shared close borders with Syria, necessitating that authorities take control measures. This was conveyed in the reports of a child transferred back to Syria with his family due to the possibility of having tuberculosis. Discursive strategies like these, demonstrate that media outlets and their discursive practices can contribute to discourses of surveillance activities that are intertwined with engendering fear of infection and blame toward others. Also, more often than not, reports highlighted that it was those in power, i.e. authorities, who possessed the means to state who decides what constitutes a threat and who is to be blamed and in turn decides on control actions to be taken (Briggs, 2005; Koch, 2017). It has been suggested that promotion of fear as evidenced here of infectious diseases originating from foreign lands, led to the "Us" versus "Them" rhetoric (Said, 1978), and helped justify health surveillance activities, internationally and locally, and ultimately quarantine measures or deportation (Abeysinghe, 2016; King, 2002; Peckham, 2018; White, 2023).

The indirect reporting of the Self versus Other, or the formation of identity, has been discussed by different authors suggesting that the discourses around "who" (i.e. refugees) bring to the "inside" (i.e. Lebanon) infectious diseases from the "outside" (i.e. Syria), affects or burdens surveillance activities for cross-border populations, a population carrying imaginary borders as they move (Bell et al., 2006; Cheng, 2015; Hinchliffe et al., 2012; King, 2002; Papamichail, 2021). In this sense, it can be corroborated, based on border as method, that the selectiveness of borders that open and close on people depending on their use, infectivity, or burden, represents a form of structural violence that might affect or be an outcome of the work of surveillance (Mezzadra & Neilson, 2013).

With regards to numbers, or in our case epidemiological data released by authorities, the literature suggests that systematic collection of data on diseases of people, livestock, and localities, created hierarchies to divide and classify people, and this was traced back to actions in the mid-19th century during colonial times (Genest, 2015; Hinchliffe et al., 2012; Ingram, 2009, p. 2085; King, 2002). An example has been drawn from SARS-CoV-2 experiences and how surveillance numbers shaped the "public imagination" ensuring threat of disease importation and ultimately, leading to national security activities and border division intensification (Papamichail, 2021).

This epidemiological surveillance activities in the media reports reflected the assistance of international organizations in Lebanon and this has socio-political roots. The literature suggests that international

intervention, or collaboration between local and international organizations, is an important aspect of indirect subjugation, where international experts are assigned to help others in perceived need when this collaboration only intensifies the racialization of diseases (Chuengsatiansup & Limsawart, 2019; Escobar, 2011; King, 2002; Peckham, 2018; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007, 2010).

Integrating the above topos inherent within the Lebanese media reports, it appears that despite its historical identity fragmentation (Salibi, 1988; Traboulsi, 2012), media outlets and the differing political poles they represent converged rather than diverged in their statements on infectious diseases among refugees and surveillance activities. Explaining this convergence is what Said (1994) argues of identity as being the product of Orientalist ideology later embedded within the subconscious of the subaltern, leading nations to dichotomize Themselves versus Others (Said, 1994). Contemporarily, the rhetoric of national security has been mobilized extensively to allow the work of international surveillance activities within Lebanon, as it has been demonstrated elsewhere (Barker, 2012; French, 2009; Genest, 2015; Hinchliffe et al., 2012; King, 2002; Pereira, 2008). This rhetoric encouraged the stigmatization and subjugation of some populations given their race and leading to their exclusion from healthcare access and prevention efforts (Briggs, 2011; King, 2003; Mbembe, 2001, 2019; White, 2023). In due course, discourses on the threat of importation of disease from foreign lands, among different political poles in Lebanon prevail, and this has repercussions on refugee populations in terms of health policies addressing this populations and health access.

Conclusion

In this chapter I sought to analyse how the Lebanese media discourse portrays the activities of surveillance targeting refugees in Lebanon. As aforementioned, racialization of infectious diseases appeared to contribute to the stigmatization of certain groups, leading to their exclusion from healthcare access and prevention efforts going further to excluding them from Lebanon as media reports suggested (Briggs, 2011; King, 2003; White, 2023). Perhaps surprisingly, given Lebanon's history, we see a unified version of racialization of diseases. The notion of Arabism present in the discourses during the inception of Greater Lebanon, appeared to have faded with this new ideology of national security. Despite this, health surveillance professionals need to be aware of the Lebanese history and modern rhetoric, such as national security, constructing such ideologies and need to be attentive to media discourses on fear of disease importation to mitigate. This can be achieved through constant communication with media

representatives to find a common ground for infectious disease representation especially those that are attributed to displaced populations in Lebanon.

CHAPTER 6: LEGITIMISING AUTHORITY WITHIN SURVEILLANCE DOCUMENTATION DISCOURSE ON DISEASE THREATS

Chapter overview

In this chapter I analyse the discourses apparent within internal documents of the Ministry of Public Health (MOPH) surveillance programme. This analysis relates to objective one and four of this thesis, which is to identify how infectious disease surveillance of, and related discourses about, Syrian refugees in Lebanon, shape, replicate, or challenge Lebanon's historical-political context, particularly in external and internal frontier (re)creation. Also to consider how the findings of these discourses on infectious disease surveillance for Syrian refugees in Lebanon might shape or inform public health policy and practice responses in Lebanon to generate recommendations to inform them.

The official documents found were limited, and only 5 were eligible for the analysis. I conducted DHA's microlevel intertextual analysis to identify actors, actions, and arguments within the official documents and I extracted the macrolevel recurring discourse topics. I described the findings using quotations from the documents.

The recurring discourse topics within the selected were as those in the media revision in Chapter 5: that Syrian refugees (the Other) are responsible, or to blame, for the spread of infectious disease; and that health surveillance authority (the Self), and its international counterparts, is the lead in responding, conducting training activities, and receiving epidemiological information to mitigate the threat.

As in Chapter 5, this chapter highlights how official health documents can contribute to the promotion of fear of infection and blame toward others, emphasising the notion of national security. It is recommended that health professionals pay attention to the historical and socio-political conditions that shape their surveillance activities and use inclusive discourses when planning health policies and programs.

Document characteristics

Five documents fit the inclusion criteria for analysis. One was a general law from December 1957 that is still used to guide surveillance today. Though not addressing refugees directly, this document was included because it mentioned inclusion of people of different nationalities, including refugees, and is the main guiding document for surveillance and thus pertinent to our understanding of how surveillance discourses are articulated. Two documents were circulars. Two were memos, one on invitation letters for training sessions on infectious diseases addressed to hospitals, surveillance staff, and municipalities and the other

about management of Leishmania within referral hospitals in Lebanon and reporting to the surveillance programme.

Table 12: Selected documents for analysis

#	Document number and title	Document type
1	Law on infectious diseases in Lebanon of 31 December 1957	Governmental law
2	Memo #28 of 22 March 2013 Leishmania management	Ministry of Public Health Memo
3	Circular #52 of 28 May 2013 Training sessions for hospitals in the Bekaa region	Epidemiological Surveillance Program circular
4	Circular #20 of 21 March 2014 Training sessions on Polio surveillance & investigation	Epidemiological Surveillance Program circular
5	Memo #69 of 4 August 2014 Training sessions for municipalities	Epidemiological Surveillance Program memo

Discourse topics

Table 12 shows the main discourse topics in these documents, and they revolved around: (1) health surveillance authority procedures and their international collaboration; and 2) Syrian refugees being responsible for infectious disease spread.

Table 13: Document revision discourse topics

	Discourse topic of health authority	Discourse topic of Syrian refugees
Topic 1	MOPH and surveillance are the sole authority to receive information on infectious diseases	Syrian refugees are a threat with regards to spreading infectious diseases
Topic 2	MOPH conducts trainings on reporting to different entities within Lebanon	
Topic 3	MOPH collaborates with WHO	

Three-level textual analysis

My textual discourse analysis is again divided into the three discursive strategies of referential, predicational, and argumentative, with exemplar quotes from the documents (though again these could potentially fit into several discourses).

Referential

The Self

Given all eligible documents were issued by MOPH, except one general governmental law, the Self is primarily portrayed by, and addresses, technical entities such as health authorities (السلطات الصحية) in the form of: (1) MOPH (وزارة الصحة العامة) and central surveillance unit/team or ESU (الوحدة المركزية للترصد) or programme (برنامج الترصد الوبائي); (2) WHO (منظمة الصحة العالمية) as MOPH partner/supporter; and (3) other technical entities such as public or private hospitals (المستشفيات الحكومية والخاصة) and municipalities (البلديات) as the audience for training activities on reporting and supporting surveillance. What is lacking in representation here are the other international organizations mentioned in other data types such as UNICEF and UNHCR.

The Others

In the context of official documentations, the Others were referred to as patients (مريض), cases (حالات), and infection hosts (حامل الجراثيم), and, when addressing Syrians, as Syrian refugees to Lebanon.

Predicational

When addressing the Self, there were two purposes apparent in the chosen documents. First, those that certify that the health authorities, such as surveillance entities, are the sole authority or lead for receiving information and reports on infectious diseases. Second, that the surveillance team - in collaboration with WHO, is responsible for training on reporting methods and surveillance activities to other sectors or facilities.

The Self: Lead information receptor

Surveillance programmes, especially the epidemiological surveillance programme, function based on the law of December 1957 which still applies. The only updates to this law relate to the list of infectious diseases in 2014 where leishmania was added as a reportable infectious disease (Saleh & Howard, 2023).

This law and another memo on the management of leishmania provide a rhetoric of authority, in that the team and leadership of infectious disease surveillance is the main authority to receive information on infectious diseases. This was emphasized in the circulars distributed to health institutions and other technical entities after 2011 for training sessions on reporting to the surveillance programme. Epidemiological reporting was emphasized as an important step to avoid the spread of diseases, given the presence of the Syrian refugees and the presence of polio and cholera in Syria at that time.

> "If an epidemic threatens the areas of the republic … then the **ministry of health releases a decree that specifies the procedures** [فعلى **وزارة الصحة أن تستصدر** مرسوما **تعين فيه التدابير**] to prohibit the spread of the epidemic."

> "…the diseases that are **mandated to be reported** to the **health authorities [يتوجب الاخبار عنها إجباريا الى السلطات الصحية]**" Law of 31 December 1957, on infectious diseases in Lebanon

> "The hospitals (treatment centres in governmental hospitals) **report to the epidemiological surveillance program [يبلغ المستشفى برنامج الترصد الوبائي في وزارة الصحة العامة]** at the ministry of public health any patient immediately upon arrival [to the centre]" Memo #28 of 22 March 2013 Leishmania management

> "The importance of **reporting any case** [اهمية الابلاغ عن اي حالة] suspected of polio or cholera or any disease that might spread given the current circumstances [في ظل الوضع الحالي]." Memo #69 Memo #69 of 4 August 2014, Training sessions for municipalities

<u>The Self: Conduct, and collaborate in, training on epidemiological reporting</u>

The action attributed to surveillance programs within the documents revised is that surveillance teams and the WHO personnel conduct training to a diverse audience of public and private hospitals and municipalities. The diverse range of partners working in the management and reporting of infectious diseases was addressed and in turn, portrayed the surveillance team communication and collaboration capability with other partners. Moreover, collaboration between and assistance by WHO partners and the surveillance team in conducting these trainings was emphasised, though there was no mention of their specific roles in these documents.

"The central epidemiological surveillance unit is **conducting a training** [تقوم الوحدة المركزية للترصد **الوبائي باعداد ندوة**] directed to the public and private hospitals" Circular #52 of 28 May 2013 Training session on surveillance for hospitals in Bekaa

"A mission from the World Health Organization is **conducting trainings** [**منظمة الصحة العالمية باعداد ندوات**] for the Ministry of Public Health teams, and that is **in collaboration with** the epidemiological surveillance program [**بالتعاون مع برنامج الترصد الوبائي**]" Circular #20 of 21 March 2014 Training sessions on polio

"The Ministry of Public Health **in collaboration** with the World Health Organization **are conducting trainings** [**تقوم وزارة الصحة بالتعاون مع منظمة الصحة العالمية باعداد ندوات**] directed to the municipalities" Memo #69 of 4 August 2014 Training sessions for municipalities

<u>The Other: threat of spreading infection</u>

Opening statements for all circulars calling for training sessions include an alarming statement, i.e. how the presence of Syrian refugees risks the spread of disease. In turn, these 'alarm statements' promoted the rhetoric of blame and threat, justifying the training on the reporting of any suspected infection to avoid the spread of these diseases. This was primarily evident in the circulars on Poliovirus training, as polio is a devastating but vaccine-preventable disease that had largely been eliminated in Lebanon.

"Given the spread of measles cases in Lebanon [**تفشي حالات الحصبة في لبنان**], and the **arrival of Syrian refugees** to Lebanon [**وفود الاجئين السوريين**]…" Circular #52 of 28 May 2013 Training session on surveillance for hospitals in Bekaa

"Given the **spread of Polio cases in Syria** [**تفشي حالات شلل الاطفال في سوريا**]…" Circular #20 of 21 March 2014 Training sessions on polio

"… the areas that are **witnessing Syrian displacement** …The importance of **reporting any case** [اهمية الابلاغ عن اي حالة] suspected of Polio or cholera or any disease that might **spread given the current circumstances** [في ظل الوضع الحالي]". Memo #69 of 4 August 2014 Training sessions for municipalities

Argumentation

Similar to the outcomes found in the media analysis (Chapter 5), the predominant argument schemes inherent in these documents were that of authority, collaboration, and threat.

Topos of leadership, authority, and collaboration

The underlying assumption within these documents was that the Ministry of Public Health, its surveillance programme, and the international organizations it collaborated with, were legitimate authorities for reporting infectious diseases and conducting trainings on this matter *(Boukala, 2016; KhosraviNik, 2010; Wodak, 2015)*. Documents assumed that:

> *Trainings on reporting by the Lebanese Ministry of Health, surveillance programmes, and their international organization counterparts, is legitimate and necessary given they are the health authority and given there is a threat of disease importation.*

Topos of threat

The second underlying assumption was that refugees brought these infections and, hence, training sessions were necessary to address this *(Boukala, 2016; KhosraviNik, 2015; Wodak, 2015; Wodak & Meyer, 2001)*. In this context, it would read as follows:

> *Given the threat of infectious diseases from displaced Syrians exists, Lebanon is right to mobilise against it.*

Discussion

The training invitations analysed in this chapter highlighted important discursive strategies when justifying infectious disease surveillance activities to protect national security and combat infectious diseases arising from outside the national 'Self.' The rhetoric of the infectivity of some populations, especially displaced populations, has been documented in the literature as a means to justify authorities' power in imposing data collection, monitoring, and developing health strategies, where data are repurposed for the control of diseases in less privileged areas (Aviles, 2001; Escobar, 2011; Hirsch & Martin, 2022; Smith, 2021; White, 2023). Moreover, the national security rhetoric against importation of diseases has been documented across centuries, with data from infectious disease surveillance and the assumption of threat used to justify the expansion of public health surveillance and prevention measures nationally and globally (Barker, 2012; Caduff, 2014; Crane, 2010; French, 2009; Ingram, 2007; King, 2002; Manderson, 2009; Pereira, 2008; Sastry & Dutta, 2012; White, 2023).

These arguments were extracted from the opening statements of invitation letters, which emphasised the threat of disease importation and thus served to justify health authorities taking the lead. Hence, we see a cognitive differentiation between internal and external, emphasizing hierarchies and divisions between who is a threat (the Other, i.e. refugees) versus who is not (the Self) (Bell et al., 2006; Cheng, 2015; Hinchliffe et al., 2012; King, 2002; Papamichail, 2021). In essence, this form of differentiation takes us back to the conceptualisation of racialization of diseases, in which certain diseases are linked to certain races, or in this case an identity of national displacement as Syrian refugees, to allow the control of their access to health and a better life (White, 2023).

Tracing this back to the history of Lebanon, despite its internal ideological differences, its perception of itself compared to its neighbouring countries, as evidenced in the official documents, appears to be a result of the Lebanese establishment, with the aid of the French mandate (Kaufman, 2015; Salibi, 1988; Traboulsi, 2012). The idea of "natural" geographical boundaries of Lebanon since 1862, provided Lebanese with an imagination of an established Lebanon was a distinct area from the rest of the Arab region (Kaufman, 2015; Salibi, 1988). This might relate to Said's (1994) suggestion that identity differentiation emphasized by imperial forces has been embedded in the ideology of the subaltern, leading to the dichotomization of "us the clean" and "them the threat" (Said, 1994).

Documented collaboration with international organizations within the official documents can also be traced back to Lebanese history where external collaboration after the civil war affected most of Lebanon's health sector activities (Salloukh et al., 2015; Traboulsi, 2012). The presence of international organizations supporting the health sector has always been portrayed as advantageous and a privilege, given financial and human resources have been provided as a result (Saleh & Howard, 2023). However, this support may have underlying agendas, political and economic, as argued by Escobar (2011), where external 'experts' study these populations for these agendas without considering socio-political contexts and histories that shape health conditions (Chuengsatiansup & Limsawart, 2019; Escobar, 2011; King, 2002; Peckham, 2018; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007, 2010). Agreeing with this, Border as method examines the contributions of international organizations in the exercise of power, not just as external contributions but also internally to the state (Mezzadra & Neilson, 2013). These organizations, they suggest, have been used by governments that do not wish to be burdened by international laws (e.g. Lebanon) "to diffuse criticism or avoid political debate" (Mezzadra & Neilson, 2013, p. 182). Therefore, it is pertinent to understand these international contributions to health programs by local health professionals to better plan policies and activities that are inclusive of all its residents.

Conclusion

In this chapter I analysed the discourses used in internal official documents in Lebanon's MOPH to understand its discourse practice, connections to Lebanese history and socio-political context, and how this contributes to racializing diseases. These discourses were similar to those in media reports, emphasising the importance of understanding how these discourses affect public health policy and practice, and most importantly, how they can be used to strategically plan for inclusive health policies, as I will discuss in Chapter 8. To that end, it is recommended that health professionals pay attention to the historical conditions of their surveillance activities and use inclusive discourses without blame of vulnerable populations.

CHAPTER 7: LEBANESE FRAGMENTATION NARRATIVES AMONG HEALTH SURVEILLANCE PROFESSIONALS

Chapter overview

In this chapter, I analyse the discourses emanating from interviews conducted with personnel working in infectious disease surveillance in Lebanon's public and private sectors. This chapter addresses the first and fourth objective of this thesis: to identify how infectious disease surveillance of, and related discourses about, Syrian refugees in Lebanon, shape, replicate, or challenge Lebanon's historical-political context, particularly in external and internal frontier (re)creation; and to consider how the findings of these discourses on infectious disease surveillance for Syrian refugees in Lebanon might shape or inform public health policy and practice responses in Lebanon to generate recommendations to inform them.

I conducted interviews with 20 health professionals mostly working within the domain of infectious disease surveillance. Using the transcripts of the interviews, I followed the DHA steps of analysis: microlevel intertextual analysis to identify interviewees' articulation of actors, actions, and arguments and I extracted the macrolevel recurring discourse topics.

There were similarities in discourse topics with those in previous chapters such as refugees being a threat for disease importation into Lebanon, and discourses on health surveillance authorities and their competence in their response. The discourse topics did differ with regards to the sociopolitical context of Lebanon, such as the sectarian system and the leading fragmentation, and how this affects their work in infectious disease surveillance. Interviews also addressed health authorities' money-driven actions and international organizations' hidden agenda in Lebanon.

This chapters adds to the Chapters 5 and 6 and suggests that the rhetoric of infectious disease surveillance in Lebanon still holds on to the historical socio-political conditions with emphasis on cognitive borders between the Self and the Other. It is recommended that these health professionals stay attentive to their history and discourses and encourage inter-regional agreements to form inclusive policies regarding surveillance activities.

Interviewee characteristics

I conducted 20 interviews for this analysis. Table 13 shows anonymised interviewee characteristics, as professional numbers are few and they are known to one another and their employers. Eight of 20 interviewees were epidemiologists working in both governmental and non-governmental institutions with Master of Epidemiology or Master of Public Health degrees. Five were field epidemiologists with a non-epidemiology background who were certified through field epidemiology training in Lebanon. Four were directors of departments or programmes of governmental or non-governmental organizations. Two were researchers in academic institutions. One was a former member of parliament with an academic public health background. Five of the interviewees are former employees in Lebanese infectious disease surveillance. For the sake of anonymity, I will be referring to all interviewees as she/her.

Table 14: Interviewee characteristics

Interview code	**Position**	**Employment status**
12082022	Epidemiologist	Former
16082022	Field epidemiologist	Current
25082022	Academic	Current
26082022	Epidemiologist	Former
09092022	Epidemiologist	Former
10092022	Epidemiologist	Former
14092022	Director	Current
16092022	Director	Current
28092022	Epidemiologist	Current
05102022	Field epidemiologist	Current
12102022	Epidemiologist	Current
18112022	Academic	Former
02122022	Field epidemiologist	Current
09122022	Epidemiologist	Current
18122022	Academic turned Politician	Current
10012022	Director	Current
25012023	Epidemiologist	Current
31012023	Director	Current

26042023	Field epidemiologist	Current
27042023	Field epidemiologist	Current

Discourse topics

Table 14 shows the main discourse topics generated in the interviews. Like previous results, discourse topics revolved around refugees: their threat of disease importation into Lebanon, and their uncooperative attitudes. Additionally, discourses on health surveillance authorities and their competence in their response were articulated. The discourse topic did differ, however, when interviewees discussed the sociopolitical context of Lebanon, such as the sectarian system and the leading fragmentation, and how this affects their work in infectious disease surveillance. Interviewees also addressed health authorities' money-driven actions and international organizations' hidden agenda in Lebanon. These are detailed in the intertextual analysis section below.

Table 15: Interview analysis discourse topics

	Discourse topic of health & surveillance authorities	**Discourse topic of Lebanese fragmentation**	**Discourse topic of international organizations**	**Discourse topic of displaced populations**
Topic 1	Authorities need to be representative	Lebanon is sectarian in its activities and employment	Provide assistance	Refugees are a threat to infection importation
Topic 2	Authorities are transparent and competent	Lebanon is divided in its perceptions towards refugees	Have monetary power and hidden agendas	Uncooperative and require assistance
Topic 3	Authorities are money-driven	Lebanese are superior to others		
Topic 4		Indignation among Lebanese		
Topic 5		Changing the structure is very difficult		

Three-level textual analysis

Referential

The main actors referenced within the Self were surveillance programme workers in MOPH and its departments, academic researchers, and NGOs and International organisations, hence the Self mainly consists of authorities and authority collaborators. Actors referenced as the Other by interviewees were Syrian refugees in Lebanon. Unfortunately, I was not able to interview Syrian refugees due to funding and ethics constraints. Referential strategies in interviews were fragmentation, representation, money-motivation, and indignation.

<u>The Self: Fragmentation</u>

When asked about the socio-political conditions in Lebanon shaping their work, most interview discourses revolved around the fragmentation of the Lebanese community. These divisions were described in several forms: (1) sectarian fragmentation affecting employment; (2) structure/organisation fragmentation within governmental organizations and surveillance activities; and (3) fragmentation of perspectives on Syrian refugees in Lebanon (interviewees 09092022, 10092022, 28092022, 31102023, 12082022, 14092022, 16092022).

Sectarian fragmentation and employment

Within the discourse of sectarian fragmentation, the main issue articulated was that of employment of temporary (extra) staff, after international organisations provided funds to respond to the Syrian crisis. Components of funding provided were for strengthening and enhancement of the infectious disease surveillance system and hiring teams to conduct these surveillance activities (Saleh & Howard, 2023). In 2013, Lebanon's surveillance leadership and international organization teams reviewed CVs of potential surveillance candidates, conducted interviews, and hired a team of professionals to assist in surveillance activities. However, most MOPH ministers post-2011 would fire existing staff and replace them with people from their own sect or political party. Interviewees indicated this led to intensifying sectarian fragmentation, affected team morale, and left people frustrated.

> "**It affects the work**; it affects the quality of work… Like if I'm a person that doesn't think in a sectarian way, when someone comes and does that [referring to the Minister replacing staff] I'll start thinking like that" interviewee 10092022

> "He got us a driver to go from [district x] to [district y]! **It's not my problem** if you were employed from [district x] to come here, you need to be on time!" interviewee 28092022

Outside the public sector, interviewees expressed how day-to-day surveillance activities seemed to reflect the Lebanese sectarian and political system even in private institutions. Sectarianism is automatically reflected in every entity within Lebanon, since people who work there represent Lebanese society and, in turn, are not neutral (interviewee 16092022, 09092022). For instance, in private institutions employing Lebanese, sectarian division is not obvious, but people can still be stereotyped due to their last names or political statements they make (interviewee 18112022, 10092022): "*… if you spend enough time at any place, you know that it's there, and then **you get stereotyped very quickly**, and that affects a lot of things that you could do*" (interviewee 18112022). The sectarian roots of individuals, or "what they have absorbed" throughout their lives ("شو متشرب"), affect personalities and in turn actions, and this was said to be evident not just in ministers' actions but also among technical people (interviewee 10092022, 09092022).

Organizational fragmentation

Related to sectarian fragmentation, interviewees suggested organizational fragmentation in that MOPH teams work within blocks of, for example, religion, sectarian, and education level. The additional lack of policy updates and team structure or management, in turn hindered effective MOPH surveillance work, including for refugees. One interviewee suggested that this is all related to the history of Lebanon, how it was established, and how it dealt with the Palestinian displacement into Lebanon post Al-Nakba.

> "… The **mismanagement** of the Syrian presence in Lebanon, by not allowing camps and doing informal tented settlements, was the result of the history back in Lebanon where in 1944-45 the first batch of Palestinian … they put them in camps hoping them to go back and then actually they didn't go back. So, it reacted as sectarian, but it is not only that, it is actually the several elements that go back in the history of Lebanon" interviewee 14092022

> "…if I were from **a different sect or different religion**, things would have been much better in my work [in surveillance] today" interviewee 31102023

> "We never had a solid teamwork, or team spirit [at MOPH]. It was as though we were **working in blocks [silos]**…this is a religious one or this is, I don't know another block!**"** interviewee 12082022

Some stated that the whole Lebanese structure, policies, and laws, even within the surveillance programme, had not been updated since the presence of the French mandate in Lebanon. Accordingly, it was difficult for Lebanon to (re)establish programmes after independence, leading to weakened surveillance functions (interviewee 16082022, 25082022, 12082022). One indicated that investigations for foodborne issues within butcheries still used the old Lira rate for penalties since the mandate [which is worthless at this time]: "*if you want to work in surveillance of food poisoning, this person [owner of butchery]* ***needs to pay, for example, 200 liras*** *[less than US$0.02 in 2024 constants]****. Of course they will do the mistake again****, so, of course it affects your work!*" (interviewee 16082022).

In contrast to this sectarian fragmentation discourse, two interviewees suggested that Lebanon was divided into many pieces but not into sects. Rather, Lebanon was divided into governmental packages, and how much of these each sect got (interviewee 05102022, 14092022). The establishment of Lebanon, and its laws and policies, has ignored social justice (interviewee 18122022) as "*the elite have built the system in a way* ***to preserve their interest****… and it impacted everything including the health*… " (interviewee 14092022). These interviewees thus suggested that sectarianism has been used as an excuse to cover the accumulation of capital by elites of each sectarian sect, so the Lebanese government was unable to cope with any domestic crisis, whether pandemic or economic, let alone with non-Lebanese populations (interviewee 14092022).

> "… **we would not say only sectarian because it is the easy thing to blame**, you know … but actually, the long strategic planning of the public or the strategic direction for the country… is a presence of the body who needs to do the **"chef d'orchestre" which theoretically should be the ministry of health but practically it is not like that**" interviewee 14092022

Fragmentation in perspectives towards refugees

Another way fragmentation was implied within interviews was in the different perspectives on refugees. Syrian refugees in Lebanon were treated differently by different groups in Lebanon depending on ideology, sect, or closeness to Syrian borders (interviewee 16092022, 25012023, 10092022). For instance, Tripoli in northern Lebanon historically refused to be part of Greater Lebanon when it was established in 1943, declaring itself part of Greater Syria, which positively affected the way people there reacted to events in Syria post 2011 (interviewee 25082022) in terms of felt kinship towards and welcoming of refugees (interviewee 16092022). This was reflected historically in the health sector, as an interviewee noted "*under*

the French mandate when the order of physicians was created the colleagues in Tripoli refused to participate because ***they said we're not Lebanese***" and belonged to Greater Syria (interviewee 25082022). This history improved the initial reception of Syrian refugees in 2011 and helped surveillance activities take place.

> "I think because we have so much **diversity in the way we perceive refugees**, so we have a lot of humanitarian approaches, we have a lot of political [people] who are from the same political views of these refugees, and this **alleviated the situation**… more or less as overall general balance, I think that **refugees access areas where they feel they are accepted and welcomed and then the surveillance systems in these places, they were functioning**" interviewee 16092022

An interviewee mentioned how being Lebanese enabled understanding of Syrian culture in terms of the importance of relationships as compared to European culture. Refugees were allowed to have tents that had a common area for socializing and receiving visitors, something the interviewee had not seen in EU responses (interviewee 16092022).

Two interviewees provided another perspective on why Lebanese welcomed Syrians in 2011, that the Lebanese population benefitted from the Syrian refugees who buy or rent accommodation and food from Lebanese markets and provided a cheap source of human resources (interviewee 05102022, 16092022). They suggested that most receiving countries did not accept refugees unless they could benefit from their presence, which in turn served capitalism (interviewee 05102022, 16092022). Thus, allowing refugees into Lebanese borders was less for humanitarian than economic interests.

> "They wanted low-cost human resources and then **they facilitated their [refugee] stay** and they succeeded there because they wanted low-cost area **because, you know, manpower**" interviewee 16092022

Conversely, a few interviewees expressed discontent with the presence of Syrian refugees, along racially charged lines. Two stated that Lebanese composition is changing due to the presence of Syrians, who are from a different environment and coming to replace the Lebanese who are leaving the country (interviewee 26042023, 02122022). One complained about how the number of Syrian children increased as compared to Lebanese children, which risked changing Lebanon's demography and epidemiological indicators (interviewee 26042023). Another stated that "thank God" they did not have Syrian refugees in

the periphery where she worked, and hence was relieved (Interview 27042023). Further negative perspectives on refugees are detailed in The Other sections below.

The Self: Representation

Though many interviewees critiqued sectarian employment, rhetoric on the importance of having people who represent the area in which they work was obvious in 4 interviews (interviewee 12082022, 28092022, 10092022, 18112022). Hiring people according to their sect or geographic representation was acceptable, given they would know the context of that location and have relevant capacities and competencies (interviewee 10092022, 28092022, 12082022). One stated that to ease the setup of surveillance, you just needed a representative of the area to facilitate data collection (interviewee 18112022). Representativeness included the Lebanese accent (or colloquial Arabic) of the individual, for example conducting investigations over the phone, having a specific accent from a specific location, and in turn being identified from a different sect, affected surveillance work. Additionally, an interviewee complained about the sectarian system yet recounted how she was easily employed in the surveillance programme as she was the only representative of her sect (interviewee 12082022).

> "**Someone who knows the specificity of that location**, she won't get anyone from another location and some sensitive issues arise between them. And I understand, someone in the office there, should know the location and the mentality of the people there" interviewee 12082022

> "We were doing data collection, there was one [in surveillance] who told me that they were having **low a response rate**…then it turns out that those two ladies, they are from [district x] and they talk in [a recognisable accent from their home district and sect]. They were talking and making calls to [district y with a different accent] … I ended up giving them fewer investigations, I gave the ones [with a neutral accent] who had more response rates" interviewee 28092022

The Self: Money-driven

Five interviews mentioned how MOPH was driven to respond to the Syrian displacement because of the money coming in for the response (interviewee 09092022, 12082022, 12102022, 10092022, 25012023). Agencies were careful to write who exactly would receive funds. For example, though Lebanon officially considers Syrian immigrants as displaced populations, agencies used the term 'refugees' in their reports to obtain funding. Despite this, in accepting these funds, MOPH assured donors that it would provide to the Lebanese equally.

> "So when they started **throwing money into Lebanon** (كب المصاري على لبنان) … they were all tailored for the Syrians and the government was the first on board, that we are supporting the Syrians, but whatever you give to the Syrians you need to give to the Lebanese" interviewee 09092022

> "… the presence of Syrian refugees to Lebanon, **it let us get that grant** [from an international organization]" interviewee 25012023

Interviewees indicated this drive for money was also evident in the MOPH blaming health outcomes on Syrian refugees to obtain funding for conducting prevention activities. Blaming Syrian refugees for infectious diseases and outbreaks to get funds was particularly evident in vaccine-preventable disease (VPD) outbreaks and vaccine campaigns, with surveillance teams pressured to declare that the source of the infection was Syrian refugees even if this was not the case (interviewee 09092022, 12082022, 12102022). As one interviewee suggested, authorities would use the refugees as "scapegoats" to cause fear and in turn receive money (interviewee 25082022)

> "Some people wanted us to show the data to **show that it [VPD] is because of the Syrians**, you know some people **want funding** for their programmes" interviewee 12102022

> "… they wanted to link [VPD] directly to Syrians **to get more donations** … we said we can't correlate it, but this was not put anywhere documented … **you need to say that they [Syrians] are under-vaccinated**" interviewee 09092022

One interviewee suggested that MOPH, despite the scientific evidence provided, would accept any projects funded by an international organization without considering its usefulness while useful public health projects with less funding would be rejected, and that this may have increased infectious disease risks in the country.

> "… so you have a struggle between the scientific part, and the ethical part, and the nomination of the government, what it wants, and the power, the power of the person with the money… **who does the government decide to go with? [Project x] because of the money**…" interviewee 09092022

<u>The Self: indignation (نقمة)</u>

Interviewees indicated that the historical context of Lebanon and Syrian army presence in Lebanon or what some interviewees suggested as an "occupation" between 1976 till 2005, intensified feelings of racism and indignation (نقمة) among Lebanese. This discourse was obvious across all sectors, public and private as well as international organizations.

> "… **history [of Syrian occupation] affects how we think** … I still have the humanitarian side, with the people, some of them are oppressed, they didn't come willingly to Lebanon. **But you feel that you're overcome with this feeling of indignation**" interviewee 16082022

> "It [infectious disease outbreak] was because of the Syrians, but if you open the report, we didn't put nationality, because we don't want to show that it came from Syria, so we don't **cause indignation among the people**" interviewee 12102022

This indignation was not just due to historic relations between Lebanon and Syria, but also the current economic crisis in Lebanon. Though beyond the scope of this study, the economic crisis of 2018 onwards, was mentioned by several interviewees as another complex layer concerning surveillance and refugees. For instance, while conducting this research several interviewees who had worked in surveillance left Lebanon due to the economic crisis and low wages. The economic crisis appeared to intensify resentment towards refugees because their support system through international organisations appeared better (interviewee 12102022). One interviewee stated that their work with refugees has not ended because they were still in Lebanon, but as the economic crisis began, they preferred to delegate refugee matters to international organizations since they were in Lebanon for the refugees while the Lebanese had no one to support them (interviewee 28092022).

> "The surveillance is now in **bad shape**, because the ministry is in bad shape, because the country is in bad shape, because the economy is in bad shape" interviewee 25082022

> "There is a lot of talk that they [Syrian refugees] have people [international organizations] to support them, but **we don't**" interviewee 28092022

<u>The Other: threat [of infection to the Self]</u>

Six interviewees used terms reflecting Syrian refugees as a threat of infection to the Lebanese nationals, by being a high-risk population and unsanitary in terms of their livelihoods as refugees. These discourses were accompanied by claims that their experience within epidemiological surveillance proved this claim

(interviewee 12082022, 26082022, 10092022, 05102022, 31102022, 26042023). Moreover, interviewees mentioned that they felt Syrians were different from them, with a different environment and even different diseases.

> "You can fear from refugees, not that they are the source, but the fear is that if anything happens, or consequences, **if anything happens there [refugee sites] then this has a potential of a high magnitude** because you have the crowding index, **they live on top of each other, the transmission will be faster, the event will be high, or the threat will be high**… Also, polio, they were afraid that the Syrian is the high-risk population, as they are the ones bringing the disease" interviewee 10092022

> "… we studied and know that health is for all residents in Lebanon … but **numbers tell us that the nature of communicable diseases has a specific harbour, like crowdedness and hygiene [in refugee settings]**" interviewee 05102022

> "… the children of Syrians are several times more than our kids… **you know us in epidemiology, we have indicators, and this is a threat to Lebanon**… a lot of diseases that are typical there [in Syria] we never used to see. Like Aleppo sore, they called it Leishmania… you have scabies and lice, they returned to our schools!" interviewee 26042023

> "These people [refugees] have a different environment and different diseases, we felt that we got something we did not have before, **like diseases that were not present and now came back with these people who have a different environment**" interviewee 01122022

Predicational

<u>The Self: we are competent, transparent, and superior in surveillance</u>

In contrast to the discourses above on sectarianism, lack of motivation to challenge the system, and the threat from refugees, 8 interviewees (interviewee 14092022, 05102022, 12102022, 01122022, 02122022, 31012023, 26042023, 27042023) insisted that they treated all residents of Lebanon the same and did not differentiate in their surveillance work. Most of these interviewees attributed this non-sectarian approach in their work to surveillance leadership who never showed signs of sectarianism (interviewee 31012023, 05102022, 12102022).

> "I can't differentiate because **this goes against the work of epidemic surveillance … you can't divide health according to nationalities**" interviewee 31012023

> "…by definition, a national authority would have to do surveillance regardless of any area within the one country… **I didn't see any type of activity by the epidemiological surveillance what was driven by sectarianism**" interviewee 14092022

> "**We did not differentiate** [between nationalities]. A patient is a patient, even those with leishmania [Syrian]!" interviewee 01122022

Further, other interviewees (interviewee 26082022, 14092022, 260042023, 28092022, 12102022) declared that they still have a well-functioning, competent, experienced, transparent, and prepared surveillance system. Some stated that despite everything happening in Lebanon and their limited resources, surveillance must be done and that they have been doing it professionally. Moreover, they suggested that the surveillance data are shown as they are and that they "tell the truth" (interviewee 12102022, 28092022, 05102022). The status-quo within surveillance, i.e. carrying on in their usual work, is a form of challenging the system.

> "We are still working. We are still here. We are steadfast (صامدون) [we are able]!" interviewee 31012023

> "We have a good surveillance system, if you want, with the refugees… **a small country like this dealing with our problems, we work good**" interviewee 26082022

> "I think surveillance, poor things [حرام], **they have done a great job in the limited resources** that they had" interviewee 14092022

> "As surveillance, no one replaces us [as compared to other workers], don't forget **25 years of experience**" interviewee 260042023

Despite this positive discourse, another discourse of superiority (الفوقية) emerged in five interviews (interviewee 16082022, 10092022, 28092022, 12102022, 26082022). The feeling of superiority was mentioned as present among the Lebanese community and workers within the MOPH.

"… how they [at other MOPH departments] **think of Syrians, it was always superior (فوقية)** the way was not pleasant" interviewee 10092022

The Self: international organizations support us

Six interviews (interviewee 16082022, 14092022, 09092022, 10092022, 09122022, 31012023), both from public sector and international organizations, agreed that international organizations supported surveillance as per their mandate, especially in terms of handling the displacement of Syrians and providing financial, technical, and training support. Most reference to the support was that of the World Health Organization (WHO).

"Lebanese settings you have, whether refugees, migrant worker, Palestinian, this was I think very challenging for the ministry, and **they had to have some kind of support from a sister organization.**" interviewee 14092022

"**International organizations they did a really great role in, to give us some kind of awareness** that "where are you?" … we're handling the surveillance and indicators. The question is always 'Are you detecting cases among Syrians?'" interviewee 10092022

Additionally, interviewees reported a positive aspect of the WHO's International Health Regulations (IHR) and how it positively affected the work of surveillance in Lebanon. The IHR helped surveillance professionals build capacities for responding to outbreaks or emergencies (interviewee 31012023). One way it helped was in sharing information or removing barriers (interviewee 16082022), for the benefit of response (interviewee 09122022). Another was its capacity-building mandate, which helped Lebanon "to build their capacities on the same areas, prevent, detect, respond, and recover" (interviewee 09122022). Interviewees agreed that a global entity, in the form of the IHR, was needed to help manage disease transmission (interviewee 09092022, 10092022, 09122022).

The Self: International organizations possess monetary power and hidden agendas

In spite of the assistance of international organizations mentioned above, four interviewees (interviewee 09092022, 16082022, 31012023, 10092022) stated there were obvious hidden agendas within this support and that many times the monetary support came at a price. Like the discourse above on the money-driven public sector, international organizations often had the financial power to make decisions when epidemiological studies needed to be conducted. One interviewee gave an example of how scientific

knowledge and expertise are disregarded when money is present. The surveillance team would provide evidence on why a project (for example vaccination campaign in a specific area) is needed, however the higher management would prefer another project that has international funding when it is not needed (interviewee 09092022). Moreover, international organizations, including NGOs and research groups coming from outside Lebanon, were said to have more liberty and access.

> "the types of priorities you have [surveillance] are not from you (مش طالعة من عندكم) they come from [international organizations], if you get money from this donor you prioritize something but if you get the money from a different donor, you will prioritize something else**…[international organization] is not independent, it is ruled by people sitting on their chairs like the government**" interviewee 09092022

> "Because we are getting the financial support to go on. **It's not in her, the higher management's, best interest [to her advantage] to upset them [international organization]** (مش من مصلحتها الهاير مانجمنت تزعل المنظمة العالمية ابدا)" interviewee 10092022

> "Sometimes research groups coming from outside the country have more access… **the more money you have, the more access you get**, because it's you know, it's obviously **a country where money speaks"** interviewee 18112022

> "… big countries such as EU, USA, that perceived that having these borders [for information] are a danger for themselves, and then **they provide funds to virtually remove these borders, to have information related to surveillance on epidemiological surveillance**" interviewee 16082022

<u>The Self: powerlessness to effect change</u>

Due to the divisions and challenges mentioned above, interviewees expressed scepticism about Lebanon's future, inability to challenge the system, and lack of motivation to conduct any research. Some stated that Lebanon's problems are not from colonial times and Lebanon could have handled another 20 years of colonization (interviewee 25082022): "*They say that if we stayed under the French mandate, it would have been better."* (interviewee 12082022). Two stated that they gave up their research due to demotivation within the Lebanese system (interviewee 18112022, 12082022).

> "You can recommend it [change] but I do not think it will change. This is in my opinion, unfortunately. **That is Lebanon and will stay like this**" interviewee 26082022

> "We go with the flow. **We can't challenge anything, because you're part of a bigger system**. You challenge it, you start bringing more troubles to the department" interviewee 12082022

> "it's just like really kind of a black box [due to gatekeeping] … how can we get into this population [refugees] and in other words, data… which led me to **give up in trying to do research in that area**" interviewee 18112022

The Other: uncooperative and requiring awareness

Four interviewees complained about Syrian refugees not being cooperative during epidemiological investigations. They suggested that the refugees would deny infections because they are ignorant about how to manage infections and hence were dependent and required health promotion (interviewee 09092022, 31012023, 27042023, 26042023). Here we identify a form of racially motivated discourse with regards to their perspectives on refugees.

> "**[Syrians] are dependent** on [international organizations] to go to them to vaccinate, to the extent that they don't seek medical attention anymore." interviewee 09092022

> "These are people [refugees] that **health promotion has not reached them**. Here is our task to provide more health activities to explain to them what health means." interviewee 31012023

> "When we went to [vaccinate], we used to knock on doors, they refused to open … they are **protected with the international organizations**. Every time you talk to them, they say check with the organization." interviewee 27042023

Argumentation

The argumentation strategies inherent within the interviews are somehow contradictory. This could be due to the interview process itself, which was led by interviewer questions, despite also revealing the underlying perspectives of these interviews (Wodak & Krzyżanowski, 2008). However, three main claims were prominent: (i) Lebanese historical complexities and resulting fragmentation affected surveillance work; (ii) authorities were capable and supported internationally in surveillance activities; and (iii) refugees were uncooperative sources of infection threat that required surveillance response.

Topos of history and fragmentation

The argument that Lebanese history dictates a specific perspective or action towards one another and towards displaced populations was the essence of most interviews (Boukala, 2016; KhosraviNik, 2015; Wodak, 2015; Wodak & Meyer, 2001). This shows an intertwined argument of history and its emphasis on fragmentation. These fragmentations took two routes. One was essentially internal, in terms of MOPH's socio-political and organizational structure. The other was external, in terms of ways interviewees perceived refugees. Thus, the arguments are as follows:

> *Given the history of sectarianism in Lebanon led to proper representation of employees, despite its disadvantages, Lebanon should keep this system functioning.*

> *Given the history of receiving displaced populations in Lebanon is complex, Lebanon and its government should not be responsible to welcome and respond to more displaced populations.*

Topos of legitimate authority, competent, transparency, and assistance

Related to the topos of history, the topos of authority was apparent, in terms of readily available and transparent data, assistance by international organizations, and competency enabling the surveillance programme to take action *(Boukala, 2016; Wodak, 2015)*. These arguments appeared to be interconnected. In our context, the topos of authority was argued as follows:

> *The actions, plans, and statements by the Lebanese Ministry of Health, surveillance programmes, and their international organization counterparts, are trustworthy and competent, given this is the only legitimate health authority.*

The topo of data transparency, which related to what interviews suggested as transparent statistics, could be argued as:

> *The statistical reports released by the Ministry of Health, surveillance programmes, and their international organization counterparts, give these authorities the right to be ready to conduct, plan, and implement specific health actions.*

The topo of assistance related to financial and technical assistance to the Ministry of Health surveillance programmes by international organization counterparts, argued as:

Given their assistance by international counterparts, the Ministry of Health, and surveillance programme specifically, are prepared and ready to conduct, plan, and implement appropriate health actions.

Topos of threat and burden of Syrian refugees

The common argumentation scheme inherent across data types was the threat of infectious diseases from Syrian refugees *(Boukala, 2016; KhosraviNik, 2015; Wodak, 2015; Wodak & Meyer, 2001)*. Topos of threat and burden were intertwined in interviews and can be addressed as follows:

If Lebanon and its government fears the burden of infections imported by displaced Syrian refugees, then Lebanon and its government should act to remove this burden.

Discussion

These argumentation schemes are relevant to the Lebanese context in terms of its complex history and its fragmented policies and organization. Arguments on fragmentation within the interviews can be traced to the establishment of greater Lebanon after its independence from the French Mandate in 1943, when differences in identities within Lebanon emerged, that of Lebanonism versus Arabism as elaborated in Chapter 2 (Salibi, 1988; Traboulsi, 2012). These divisions were intensified post 15-year civil war where the public sector weakened, the private sector emerged, and clientelism (for state benefits) became salient (Salloukh et al., 2015; Traboulsi, 2012, 2016). Additionally, internal disagreement on the presence of Syrian refugees among Lebanese parliamentary and political groups was another factor within the Lebanese fragmentation. Anti-Syrian regime politicians, welcomed Syrian refugees whereas Syrian regime supported rejected the suggestion of presence of refugees given Syrians are neighbours (Frangieh, 2014; Frangieh & Barjas, 2016). These fragmentations were articulated within interviewee narratives taking the shape of internal sectarian divisions, as addressed by interviewees on employment (in the form of clientelism) and lack of organization (due to weak government and lack of coordination between partners). Another fragmentation was external as in divisions on how to deal with displaced populations from neighbouring countries.

Coinciding with results of Chapters 5 and 6, narratives on authority were apparent. The literature suggests that authorities have been aided by the rhetoric of threat or infectivity of some populations, or races, to justify power or control activities that were often disproportionate (Briggs, 2011; King, 2003; White, 2023). This act of racializing diseases for control measures, as was used during colonial health conventions,

included the collecting of health data and developing strategies repurposed for the control of diseases feared to enter the nation's borderlands (Aviles, 2001; Escobar, 2011; Hirsch & Martin, 2022; Smith, 2021; White, 2023).

This is showcased in the Lebanese authorities linking the threat of infectious diseases to Syrian refugees, as in the example of blaming the Syrian refugees for being under vaccinated and the reason for VPD outbreaks funding purposes, despite the surveillance data showing otherwise. This can be said to be a form of racialization of diseases (White, 2023). This has negative health outcomes for the Syrian population where health programs or projects are no longer administered because of data findings yet for money-driven purposes as suggested by interviewees. Aligning with the above, the rhetoric of health security, or discourses on threat, have justified the use of public health surveillance and coercive authority, not just nationally but also globally with the aid of international organizations (Barker, 2012; Caduff, 2014; Crane, 2010; French, 2009; Ingram, 2007; King, 2002; Manderson, 2009; Pereira, 2008; Sastry & Dutta, 2012)

Finally, I would like to note some of the inherent contradictions existing within interviewees' approaches to the discourse on infectiousness of Syrian refugees. For instance, the same interviewees would complain about authorities pushing them to state that infectious disease outbreaks were caused by Syrians however would also claim that refugees' lack of hygiene threatened to spread infection and required surveillance response (Interviewee 10092022, 05102022, 12102022, 02122022). Here we can see traces of Lebanese identity, or the sense of superiority suggested by interviewees, as evidenced in the previous chapters (5 and 6), creating cognitive borders and hierarchies between who is a threat (the Other, i.e. refugees) versus who is not (the Self) (Bell et al., 2006; Cheng, 2015; Hinchliffe et al., 2012; King, 2002; Papamichail, 2021). Further, it is important to note that given the small number of respondents, they could easily be recognised amongst themselves and by their employers. Hence, to protect their anonymity I did not including details on sectarian background, which can be an explanation to many of these discourse contradictions found mentioned above.

Conclusion

In this chapter I presented the findings of the analysed surveillance professionals' interview discourses. The discourse topics and discursive strategies appeared to align with those in media and documents, especially the articulation of fear and threat of disease importation by Syrian refugees, and how these threats justify authority action and control. This analysis allowed the integration of the broader historical context into discussions, particularly the Lebanese history of sectarian fragmentation and how it affected

employment, internal organizations, and personnel motivation. Though recommendations will be detailed in Chapter 8, I would like to recommend here that health surveillance professionals in Lebanon, be aware of the Lebanese history and contemporary national security rhetoric and try to start from a clean slate to overcome ideologies of divisions to use inclusive discourses without blame of vulnerable populations. For higher surveillance management, it is important to work on inter-regional grassroots conviviality (elaborated further below) to create inclusive policies and programs.

CHAPTER 8: DISCUSSION

Chapter overview

In this thesis, I identified discourses related to, and arising from, infectious disease surveillance, and how they fit, or did not fit, within Lebanon's historical-political background. In analysing literature, media, documents, and interview transcripts I attempted to connect findings to the historical context of Lebanon and Border as Method theorisation. In this chapter, I will discuss these key findings and how they address the research objectives, how they link them to the broader literature, their implications for policy, practice and future research, to eventually provide recommendations and conclude by summarising key messages. To my knowledge, there has not been a holistic study linking both structural aspects of infectious disease surveillance activities and their discourses using historical and socio-political theories in West Asia and particularly in Lebanon. Therefore, as far as I am aware, this is a novel study addressing infectious disease surveillance in Lebanon using a discourse-historical analysis approach, and its findings contribute to the limited literature in this domain and this geographical area.

Key findings

The main findings across the data types, interviews, media, and documents, align in specific discourses such as authority preparedness, their assistance by and collaboration with international organizations, and the threat of disease importation from the displaced Syrian population. The findings diverge in interview analysis, however, with discourse topics emphasizing Lebanese history, sectarianism, and divisions or fragmentation in Lebanon. The overall discourse topics are visualized in Figure 4.

Firstly, the media reports from different print and broadcast outlets appeared to share perspectives concerning how the work of surveillance targets refugee populations, i.e. refugees are sources of infection, and the authorities and their international organization counterparts are ready to prevent this source of infection. The story of the little boy being deported back to Syria with his family for being suspected of having tuberculosis is the most alarming story recounted by several media sources and which I refer to often in this discussion.

Second finding within the surveillance official documents, given they belong to the internal circle of the ministry and health institutions, was the portrayal of surveillance or MOPH authorities as the sole leadership when it comes to reporting infectious disease cases. While this is very important with regards to information management for avoiding duplication of work, the discursive strategies underlying these

practicalities was obvious in their opening statements that are intended to fight infections coming from the Syrian borders.

The third analysis of interviews coincided with the above findings, portraying Syrian refugees as the hub for infections given their lifestyle. Yet, the analysis diverged when the emphasis is made on Lebanese history, sectarianism, and divisions or fragmentation in Lebanon and its governmental institutions and how this affects infectious disease surveillance activities, targeting displaced populations in Lebanon. This diversion might have been due to the guided questions led by the interviewer questions, but despite this the answers can reveal the underlying perspectives of these interviews (Wodak & Krzyżanowski, 2008). For instance, in Lebanon, employment in general and especially within projects related to refugees was an aspect many interviewees complained about; ministers would fire and hire employers depending on their sect or political affiliation, in other words, ministers were very openly practicing clientelism. Moreover, some interviewees recounted how the Lebese public sector is money-driven whereby they take any project that provides them with monetary privileges regardless of the scientific evidence provided by surveillance, and hence, the decision-making follows the financial powers i.e. international organizations and their donors. These discourses in interviews were starkly absent from the other data sources.

Figure 4: Discourse topics across all data types

Discussion of findings

In the following passages, I discuss how the findings of this thesis fit within the research objectives of the study and how they how they relate to the Lebanese history and socio-politics, and to the literature. I would like to note that some findings appear to address more than one objective.

Objective 1: to identify how infectious disease surveillance of, and related discourses about, Syrian refugees in Lebanon, shape, replicate, or challenge Lebanon's historical-political context, particularly in external and internal frontier (re)creation

The findings of this thesis help situation the Lebanese context within the work of infectious disease surveillance activities. There appeared to be a striking divide between the portrayal of the Self (Lebanon) versus the Other (Syrian refugees), in turn proliferating the imaginary borders Lebanon has witnessed since its inception (Mezzadra & Neilson, 2013).

Historical and modern Lebanon within health surveillance, or the discourse of fragmentation

The first finding pertinent to our understanding of the historical context of Lebanon, was that of a fragmented Lebanese society. The argument that Lebanese history dictates a specific perspective or action toward one another and towards displaced populations, was the essence of most interviews but not reflected in media or documents reviewed. Within interviews, we see an intertwined argument of history and its emphasis on fragmentation that aligns with the historical readings of Lebanon except for one distinction, a common narrative on national security among the contemporary Lebanese interviewed in this thesis. Looking into the discourses on fragmentation these appeared to take two routes, one which was essentially internal, as in its socio-political structure, and one which was external as in the way the respondents perceive themselves and the displaced populations (the second route will be discussed in objective 2 and 3 below).

Narratives on internal fragmentation were evident within interviews, especially those suggesting that the ministry of health workers worked in blocks (or silos) partly due to religious and sectarian affiliations (interviewee 12082022). This form of internal fragmentation presumably predates the establishment of greater Lebanon, which began as Mount Lebanon and was home to Druze and Maronite Christians. After Lebanon's independence from the French Mandate, the annexation of what is now the North and Southern areas of Lebanon and the creation of Greater Lebanon, lead to the emergence of differences in identities within Lebanon, that of Lebanonism versus Arabism (Chapter 2) (Salibi, 1988; Traboulsi, 2012). These national identities in Lebanon can be said to have been artificially constructed to allow for the ongoing fragmentation of its society. This led to several internal conflicts, but the most devastating of them all was the 15-year civil war (1975-1990) (Salibi, 1988; Traboulsi, 2012).

Despite the end of the civil war, Lebanon's socio-political structure remains heavily sectarian. An example of this is the interviewees' perspective on the sectarian employments that take place in Lebanon and

particularly post-2011 in projects geared to refugees after the money spillages into Lebanon (Interviewee 09092022). Though not written in the constitution, the institutionalized norm in Lebanon now requires all major religions and their sects to be represented proportionally in government employment and elections (Crow, 1962; Salloukh et al., 2015; Traboulsi, 2012). Though the civil service council, established during the Shihab presidency between 1958 and 1970, was created to reduce the sectarian and political interference in employment, this did not abolish sectarianism (Traboulsi, 2012). Traboulsi (2012) writes "Kinship relations and regionalism played an important role in employment and in maintaining a balance of power inside firms that was favourable to employers" (Traboulsi, 2012, p. 163). Salloukh et al (2015) corroborate these claims stating that "politicizing everything … to public sector appointments" turned workers into their sectarian or region client, whose loyalty is not necessarily to the country (Salloukh et al., 2015, p. 4). This form of clientelism, referred to as "Wasta" (واسطة) in Arabic, can mean mediation or "practice of patronage" (Doughan, 2024; Makhoul & Harrison, 2024). In Lebanon, this mediation is primarily sectarian, however, it also provides a façade for the historical warlords' accumulation of capital in Lebanon before, during, and after the civil war, in turn the masking of capitalist or neoliberal conditions (Salloukh et al., 2015; Traboulsi, 2012, 2016). As elaborated in Chapter 2, during the civil war, sectarian warlords accumulated capital via different modes. By the end of the civil war, each warlord owned most of the capital within the country, and healthcare was no exception (Salloukh et al., 2015; Traboulsi, 2012, 2016). The healthcare system, was one of the most affected sectors in the neoliberal era of Lebanon, and as implied by interviewees, the infectious disease surveillance program as well (Ammar, 2009; Blanchet et al., 2016; Frangieh, 2014; Knudsen, 2009; Salloukh et al., 2015; Traboulsi, 2012, 2016).

Linking to the next section on authority, it is important to note the continuation of sectarian fragmentation and authoritarian domination during the COVID-19 pandemic in Lebanon and beyond. Despite the pandemic being proceeded by protests in the streets of Lebanon in 2019 demanding change in the Lebanese system (Di Peri, 2020; Harb et al., 2021), the start of COVID-19 further highlighted the sectarian divide. For instance, news outlets contributed to this divide in their analysis of which Lebanese sect brought the first case of COVID-19 into Lebanon: the Shia from Iran or the Christian from Italy (Melki et al., 2020). Further, the pandemic intensified the status quo in which sectarian politicians profited from lockdown and vaccination campaigns by re-establishing themselves in different territories, further elaborating internal border and cognitive divides in the name of public health (Di Peri, 2020; Harb et al., 2021). Worth noting as well was the lack of mention of the refugee population during the pandemic, since Lebanese turned their attention to internal rather than the cross-border divides that were apparent at the start of the Syrian displacement in 2011 (Di Peri, 2020).

Authority and governance within a fragmented society, or the assemblages of power

The underlying assumption articulated in most media, document, and interview findings was that MOPH, its surveillance program team, and the international organizations they collaborate with, provide legitimacy to take specific action and are trustworthy given they are the only health authority available (Boukala, 2016; KhosraviNik, 2010; Wodak, 2015). In this section I will discuss aspects of authority in the shape of the presence or lack of sovereignty and governance within the Lebanese health surveillance structure, which links to the next section on international organizations' assistance and its drawbacks.

In more ways than not, it is argued, justifying authority subjugation lies in the rhetoric of the threat of infectivity of some populations, with emphasis on their race (i.e. racialization of diseases). This is especially pronounced with displaced populations where imposing data collection is repurposed for their subjugation (Aviles, 2001; Escobar, 2011; Hirsch & Martin, 2022; Smith, 2021; White, 2023). This was noticeable in the wording of media reports in Chapter 5 and training invitations analysed in Chapter 6, where combating infectious diseases arising from the outside justified infectious disease surveillance and control activities on the inside to protect the Lebanese national security. Some authors have traced this logic back to colonial times, where discourses within surveillance of diseases and military narratives could not be differentiated, and, contemporarily, the rhetoric of national health security against importation of diseases is emphasized to justify the expansion of public health surveillance (Barker, 2012; Caduff, 2014; Crane, 2010; French, 2009; Ingram, 2007; King, 2002; Manderson, 2009; Pereira, 2008; Sastry & Dutta, 2012).

This rhetoric was apparent in my findings on infectious diseases from Syrian borders, where statements of alarming numbers and a possible "national catastrophe" in Lebanon, stressed the importance of national authorities' action. Numbers, or in our case epidemiological data released by authorities, contributed to the creation of cognitive borders, or hierarchies, to divide and classify people, the inside (the Self) versus the outside (the Other) (Genest, 2015; Hinchliffe et al., 2012; Ingram, 2009, p. 2085; King, 2002). Here, and agreeing with border as method, Mbembe suggests that borders in effects are not mere passageways to cross rather are forms of dividing and warding off anyone who does not belong to the Self, an aspect disease surveillance activities seem to be taking part in based on the findings of this thesis (Mbembe, 2019). Consequently, it important that these forms of cognitive divisions that justify physical divisions, such as closures and lockdowns, via data of disease surveillance, be addressed by health professionals themselves (Hinchliffe et al., 2012; Ingram, 2009; Papamichail, 2021; Weir & Mykhalovskiy, 2007).

Alternatively, within interviewees, Lebanese authority was also portrayed as being money-driven rather than science-driven, in that authorities would declare an outbreak, apply for support, and hire professionals, depending on receipt of funds rather than need. This was more pronounced after 2011, when donors provided Lebanon with significant funding to respond to the displacement of Syrian refugees, what an interviewee described as donors throwing money into Lebanon (Interviewee 09092022). This was common to other countries bordering Syria and receiving refugees. For instance, in Jordan it was documented that funds were important for both Jordanians and refugees and boosted its economy with every wave of refugees (Doughan, 2022). This was noted in Lebanon by interviewees, in terms of projects and employment within the surveillance programme. Here we see a contradiction between on the one hand authorities using surveillance data as a justification for control measures especially within the media and document analysis, while on the other hand not relying on scientific data when funds are available as suggested by interviewees.

Nevertheless, this pride of authority in Lebanon came at a price, that of being a capitalist society masked by its sectarian system and backed by international funding. My findings showed Lebanese authorities, and the discourse around them as an authority actively working in the field of refugee health, would not have been possible without reliance on international funding. This blurred sovereignty requires the revisiting of the concept of governance. As argued by Mezzadra and Neilson (2013), governance and sovereignty are challenged at borders, since they change depending on the situation, the actors, and – as in the example of Lebanon - the funds and/or capitalist functions. According to the authors "a multiplicity of stakeholders play crucial and not always predictable roles" (p. 179) and this in turn weakens sovereignty or the monopoly of power of the state and gives rise to the "assemblage" of power (Mezzadra & Neilson, 2013). These assemblages of power in Lebanon were pronounced before and after 2011, as its sociopolitical structure was an assemblage of power par excellence due to different actors (Chapter 2) – subnational, national, and international, working with refugee populations, and more often than not, working in parallel (Saleh & Howard, 2023). Further, Border as Method emphasizes that sovereignty can exist without an actual state while a state can exist without being sovereign, and this is exemplified in the work of Lebanese health authorities (Mezzadra & Neilson, 2013). This brings us to the next discussion point, on international support of national surveillance activities.

Assistance by international/external organizations, or the discourse of hidden agendas

All data sources in this thesis reported the assistance and support of international organizations with regards to the work of surveillance activities and teams. This was prominent in the media reports, official

documents, and interviews, when the plans, trainings, and statements made by authorities always stressed the assistance provided by international organizations. As aforementioned, reading Lebanese history suggests that, internally, the assemblages of power in Lebanon (prominent part of which is Lebanon's warlords), have reportedly survived by "enlisting outside help in their struggle for power" and this was even more evident post-war especially within healthcare (Traboulsi, 2012, p. viii). The Lebanese health sector has seen extreme privatization, clientelism, and external collaboration after the civil war (Salloukh et al., 2015; Traboulsi, 2012). In this regard it is argued that international organizations are sometimes used by governments that do not wish to be burdened by international laws and more importantly some governments declare and cite their involvement especially with migrants "to diffuse criticism or avoid political debate" (Mezzadra & Neilson, 2013, p. 182). This is exhibited in the case of Lebanon not signing the 1951 refugee convention, its complete reliance on UNRWA to take care of Palestinian refugees, and its slow response to the Syrian refugee presence (Saleh & Howard, 2023).
International intervention, often portrayed as collaboration between local and international organizations to address a perceived need, is highlighted in the literature as an important aspect of indirect subjugation (Chuengsatiansup & Limsawart, 2019; King, 2002; Peckham, 2018; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007, 2010). Mezzadra and Neilson (2013) suggest that international organizations, while proclaimed to be "external to the exercise of power" within a specific location or country (p. 176), are essentially internal where they exercise power as much as governments do, hence, these organizations are not impartial (Mezzadra & Neilson, 2013). For instance, with regards to refugees, these organizations, as the governments they collaborate with, hinder movement across borders though it is perceived that their role is to facilitate passageway (Mezzadra & Neilson, 2013).

Furthermore, international organizations often employ personnel not from the area. Addressing this is Escobar (2011) who pinpoints the problems with international "experts" being sent to countries in perceived need of development, health development programs being an example of this, while in turn ignoring the socio-political contexts and histories that shape the health conditions they are studying, an aspect that is evident in the work of global public health surveillance (Aviles, 2001; Chuengsatiansup & Limsawart, 2019; Escobar, 2011, 2011; Hirsch & Martin, 2022; King, 2002, 2002; Peckham, 2018; Sastry & Dutta, 2012; Weir & Mykhalovskiy, 2007, 2010).

Supporting the above, interviewees suggested that these international organizations in Lebanon have hidden agendas, and this aligns with some of the literature on the matter. Traboulsi (2007) argued that while the United Nations in Lebanon sent its Interim Forces in Lebanon (UNIFIL) during Israel's 1977

offensive in the southern border of Lebanon to contain the problem, it actually acted in Israeli's favour to help maintain Israeli presence (Traboulsi, 2012). Moreover, in Sweis's (2021) Paradoxes of Care, an anthropological study on international humanitarian medical aid for children in Egypt, revealed undeclared harms imposed by such actions (Sweis, 2021). For instance, aid workers were trained to shape children behaviour according to "international standards" of a child while disregarding the structural disadvantages these children faced every day and disregarding the child's agency. Portraying the child as a vulnerable victim, aid is provided yet mainly to alleviate symptoms rather than work on the root causes of pain, and though presented as a benevolent act this inflicts damage (Sweis, 2021). This was obvious in international monetary assistance for surveillance programmes and personnel in Lebanon, as interviewees suggested, that did not consider need, sustainability, or the structural changes required.

Hands tied, or the inability to resist

What was lacking in many discourses was the concept of challenging or resisting the status quo. Though I did prompt interviewees about whether they could challenge the situation, many said they could not, that they had given up, or that the mere fact they were still doing their job and releasing transparent data was a form of resistance and challenging the system. Despite these answers, it is important to note that it might be difficult to identify the real perceptions on resisting or challenging the system through interviews.

The notion of changing a system that has not altered since its establishment might be difficult indeed. Doughan (2024) touched on the idea of fighting corruption in anthropological studies in Jordan, and showcased how people complained about the concept of "wasta", but also sought to use it since it was an ingrained system that was very difficult to change despite policies present against it (Doughan, 2024). This is also evident in the work of personnel in infectious disease surveillance, who complained about the sectarian division of labour, or clientelism in Lebanon, but also stated that employers needed to be representative of their own area, sect, and even have the same colloquial Arabic when working with communities.

Additionally, some suggested that they could not change since that would lead to more trouble and staying away from trouble was better so that they could keep doing their job. Other interviewees suggested that in their continued work in surveillance they were challenging the system as such. However, this primarily served to enable continuation of the status-quo of a country that is suffering ongoing economic and political crisis. Many skilled workers, including from the health system have already left the country as a result (Bou Sanayeh & El Chamieh, 2023; Nemr et al., 2023).

Objective 2 and 3: to inve*stigate how different data types (media reports, official documentation, and interviews) reveal similar or different discourse schemes and to analyse whether different political camps or sectarian groups in Lebanon, within their media outlets, differ in their discourses concerning infectious disease surveillance for Syrian refugees*

With my second and third objectives I wanted to understand whether or how different data sets and political/sectarian groups in Lebanon differ in their discourses concerning infectious disease surveillance for Syrian refugees. The brief answer to this is that they did not significantly differ. The feeling of nationality and the othering of cross-border peoples appeared consistent across different media outlets, documents, and interviews. This might be explained by Said's (Said, 1994) argument that identity has been the product of Orientalist ideology later embedded within the subconscious of the subaltern, in our case the Lebanese, leading nations to dichotomize Themselves versus Others, e.g. Lebanese versus Syrians (Said, 1994). Hence, we see a unified version of Lebanese racialization of diseases. The notion of Arabism present in discourses during the inception of Greater Lebanon, appears to have faded with this new ideology.

Contradicting narratives, or the common discourse of threat

Despite the common narratives on national security, interviewees did show contradicting perceptions with regards to their perceptions on Syrian refugees. The first narrative was evident in one interviewees declaration that Syrian children were too many compared to Lebanese, and this could change Lebanese demography (Interviewee 26042023), while the second narrative is crystallized in interviewees suggesting that Syrians and Lebanese at the borders do not view themselves as different (Interviewee 25082022, 16092022).

Discussing the first narrative, I found that historical discourses regarding Palestinian refugee presence in Lebanon post 1948, prominently mimic those addressing Syrian refugees now. In the past, supporters of the French Mandate (e.g. Edde, Corm, among others), wanted a Lebanese (particularly Christian) homeland and saw it as different from the Arabs (or Muslims), whom they regarded as a threat in terms of their increasing numbers (Traboulsi, 2012). Similarly, advocates of the Palestinians leaving Lebanon post-Nakba, such as president Gemayel "conceived [Palestinians] as a 'people too many'" (Traboulsi, 2012, p. 224). This had consequences such as Gemayel's faction's collaboration with the Israeli army in the Sabra and Shatila Massacre, which was in essence to help heal the demographical changes in Lebanon (Traboulsi, 2012).

Amplifying these examples of discourses on disease threats from these "outsiders", Traboulsi (2007) documents how some Lebanese used refugees as scapegoats for all the ailments of Lebanon. For example, a pastor:

> "*… called for a census of those 'miserable' individuals who constituted a 'source of corruption petrification and illness that sap the moral, human and spiritual values of Lebanon' … who 'spread among us, Lebanese, epidemics from those hotbeds of contagion and slums deposited, in all their noisiness, on the heart of our capital*" (p. 148).

A similar interview discourse was: "*These people [refugees] have a different environment and different diseases, we felt that we got something we did not have before, like diseases that were not present and now came back with these people who have a different environment*" (Interviewee 01122022). Over-crowdedness and lack of hygiene were also noted in interviews.

Regarding the second narrative, and despite that some interviewees suggested that some Lebanese consider themselves part of Greater Syria or advocated for Arabism, especially among the Muslim communities bordering modern Syria, this discourse appears to be changing. During the first phase of Syrian displacement into Lebanon hospitality was at its highest. Addressing this is Chatty (2017; 2021) who studied how alternatives to rights-based approaches for refugees in West Asia surprised international organizations (Chatty, 2017). People in Syria, Lebanon, and Türkiye never relied on organization mandates for refugees yet welcomed displaced neighbouring populations out of generosity, hospitality, or duty ('karam' in Arabic), a phenomena significantly diminished in western nations (Chatty, 2017). Nevertheless, as Chatty further suggests, this hospitality dwindled with time given the long period of displacement (Chatty, 2017, 2020). This was noted in my research – particularly interviews, in which discourses of threat predominated in reference to refugees. This common discourse among different Lebanese groups can be explained by the contemporary rhetoric of national and health security, as shown in my literature review in Chapter 4. The literature emphasised how surveillance activities and the resulting numbers from reporting, shaped the "public imagination" regarding infectious diseases, leading to national security concerns and ultimately intensifying border divisions, justifying "closure", lockdown, and creating hierarchies between diseased and disease-free areas (Hinchliffe et al., 2012; Ingram, 2009; Papamichail, 2021; Weir & Mykhalovskiy, 2007). I discuss this concept of security and how it emphasizes the role of authorities further in the next section.

Rationalization of disease within health surveillance, or the act of blame

Related to the above discussion, findings within this thesis highlight the collaborative act of blaming infectious diseases on specific populations for hegemonic and economic interests. For example, interviewees stated that Lebanese authorities were keen on declaring that infectious disease outbreaks resulted from Syrian displacement into Lebanon, despite this not being proven. Further, media reports and interviews blamed Syrian refugees for potential epidemics due to their living conditions, including hygiene and crowding constraints, without looking at the structural reasons behind these conditions, and disregarding the possible threat of infections to Syrian refugees from the Lebanese communities they integrated into. Statements by the Lebanese authorities and international counterparts, in the analysed documents and media reports, link the threat of diseases and their importation from Syria or the Syrian population, and in turn justifying securitised responses.

Tracing this back to the history of Lebanon, despite internal ideological differences, perception of Self compared to its neighbouring countries resulted from the idea of "natural" boundaries on maps (Carte de Liban, 1862), establishing Lebanon as distinct from the rest of the Arab region (Kaufman, 2015; Salibi, 1988). Though this differentiation was emphasized by a specific social group of Lebanese, the idea of privilege over neighbours, or superiority as in interviews, seems to have spread to other sectarian groups of Lebanon, as evidenced in my findings. Obvious fragmentation notwithstanding, the Lebanese found commonality when addressing the threat of disease importation from displaced populations, indirectly agreeing on racializing diseases. These similarities in discourse are no longer related to Lebanonism versus Arabism and are seen across religious and sectarian divides.

The act of blaming the Other for epidemics is not limited to the Lebanese context. The literature suggests that this has been employed within Western or European spaces perceiving themselves as being the only civilized and hygienic spaces compared to populations from other regions (Briggs, 2011; Hirsch & Martin, 2022; King, 2003; Said, 1978; White, 2023). Despite the European introduction of smallpox to indigenous populations of the Americas, e.g. causing an epidemic in 16th century Brazil, international sanitary conventions mainly blamed other populations - in presumably less hygienic areas - for diseases entering their continent and justified their control activities in those areas (White, 2023). This colonial cognitive differentiation, according to Said (1994) has been embedded in the ideology or subconscious of the subaltern; hence, the dichotomization of "us the clean" versus "them the threat" prevails (Said, 1994). This rhetoric of dichotomization encouraged the subjugation of some populations due to race (Mbembe, 2001, 2019).

Further, how borders open or close on people, in both their physical and cognitive sense, is emphasized though not explicit within the discourses analysed on surveillance for displaced populations. Examples can be drawn from the statements within Lebanese media, that Lebanon is at risk of receiving infectious diseases given its shared borders with Syria, and the child reportedly returned to Syria with his family due to the possibility of having tuberculosis. Lebanon since its inception and especially during its civil war, saw the proliferation of imaginary borders allowing or blocking passageway of different Lebanese sects, but was more pronounced for migrant populations (Traboulsi, 2012). Lebanese borders, however, also opened for Syrians given their value as low-cost workers, before the Syrian crises and after, according to interviewees. This inconsistency is a form of structural violence, as border as method suggests, where border crossing become selective depending on the migrants' usefulness, infectivity, or burden (Mezzadra & Neilson, 2013). The outcome is most often than not detrimental to the livelihood and health of Syrian refugees crossing borders seeking better conditions.

Objective 4: to consider how the findings of these discourses on infectious disease surveillance for Syrian refugees in Lebanon might shape or inform public health policy and practice responses in Lebanon

The findings of this thesis and the discussion above showcases the effects of discourses regarding refugee populations within the context of infectious disease surveillance on public health policy and practice. Therefore it can be said that without understanding the complexity of history and socio-political conditions that shaped and continues to shape health programs, in particular health surveillance, it can be difficult to form structural and operational changes that can provide better access to marginalized populations (Farmer et al., 2013). This understanding, however, needs to be followed by action, and this can be challenging in a context where lingering colonial ideologies (in Lebanon's context sociopolitical conditions) are engrained within the current global health system (Abimbola & Pai, 2020). Border as method, aligns with the concept of promoting a form of resistance (or change) to what is present, or what it suggests as resistance struggles to change subjectivities that create more resistance activities (Mezzadra & Neilson, 2013).

In Lebanon, it has been said that governance structures "reproduce the sectarian modes of subjectification and mobilization," (Salloukh et al., 2015, p. 175). Despite this, Lebanese authors have recommended change in Lebanon that could ultimately change discourses, through practically nothing much is changing. Salloukh et al (2015) provided a list of important institutional and structural reforms and describe "Grass-root conviviality" in which inter-sectarianism is promoted (Salloukh et al., 2015, p. 180). Moreover, Salibi

(1988) encouraged a rethinking of Lebanese history by looking at the positive aspects of each sect and starting from a clean slate (Salibi, 1988). This clean slate could involve inter-regionalism, grassroots conviviality, and eradicating the othering of migrant populations. This leads me to list the suggested recommendations for change that can help inform public health practice, especially infectious disease surveillance.

Recommendations

My recommendations for public health policy and practice, informed by my findings, are primarily for epidemiologists (field and academic) and surveillance professionals working with refugees, though may also have relevance for public health decision-makers and those working with other marginalised groups. While these recommendations are somewhat aspirational, working consistently from a grassroots resistance level can eventually ensure change.

1. I invite public health professionals, particularly subaltern practitioners and academics, to critically analyse health surveillance within its historical and socio-political context. Public health practitioners can take a more critical and self-reflective stance, while recognizing the complexity and fluidity of cultural identities and historical processes, to ultimately and ideally eliminate the dichotomization of populations and intensifying cognitive and physical borders (Abimbola, 2019; Aviles, 2001; Farmer et al., 2013; Mezzadra & Neilson, 2013; Richardson, 2020; Said, 1978).
2. I encourage subaltern practitioners and academics to explore inter-regionalism and grassroots conviviality to create indigenous methods for infectious disease surveillance, hence redressing the globally dominant notion of objective scientists with no understanding of the conditions of the location they are working in. In the context of Lebanon, this can be a West Asian regional agreement on surveillance methods and collaboration.
3. I suggest, in contrast with colonial approaches to public health, that research is centred around subaltern narratives of surveillance and resistance. This can start locally, with subalterns studying their own public health programmes rather than relying on European and Western centric approaches, thus bringing the periphery to the centre (Abimbola & Pai, 2020).
4. I propose that using indigenous languages for writing and publishing is an important step within resistance or creation of subjectivities in global health research (Abimbola, 2019, 2023; Smith, 2021). This allows more inclusive public health policies and practices based on socio-political contexts. While I also recommend that historical writings related to health surveillance be translated to English for more exposure of what has been there historically.

5. I advise state public health practitioners and health authorities, international partners, and media representatives, given the haphazard governance of actors working in the field of refugee health, to agree on continuous communication, identifying the practices, policies, and discourses that might result in the racialization of diseases and agreeing on how to avoid them.
6. I recommend that public health researchers step out of their comfort zone and try to conduct discourse analyses within health practices and programmes. These studies could further expand to understand how these discourses affect refugees by interviewing refugees directly. Furthermore, refugees are encouraged to perform their own studies in this regard, and in turn having their voices heard.

Strengths and limitations

A key strength of this study is its embeddedness in Lebanon's socio-political and disease surveillance context, possible due to my background as someone born Lebanese and an epidemiologist who worked in Lebanon's surveillance unit for many years. I was able to conduct this study in Arabic rather than losing nuance through analysing translated texts. The second strength relates to the use of DHA for healthcare research. Firstly, my findings show the importance of using several data types and disciplinary sources, such as sociological, historical, and theoretical, to identify meaning behind discourses, an aspect encouraged by DHA founders (Wodak, 2015; Wodak & Meyer, 2016). Hence, this study provides an early attempt to encourage more public health researchers to integrate their medical or allied health background more explicitly with social science methodologies to analyse discourses used within health activities. More importantly, how these discourses, especially those arising from those in power, discriminate, subjugate and eventually isolate certain populations (Wodak, 2015; Wodak & Meyer, 2016).

Nevertheless, several limitations should be considered. First was the lack of inclusion of refugee perspectives. This would have required resources and time beyond the capacities of this thesis. However, I intend to conduct future research to address this gap. Second, the lack of inclusion of international and humanitarian organization documents within this analysis due to the difference in discourse dichotomization of "the self" versus "the other". This, however, is an important complimentary study that I can further develop after this thesis. Third, though I tried to show Lebanon's historical and sociopolitical context, many aspects were not included given the scope and word count of this research. Fourth, I am not a linguist and conducting a discourse analysis was challenging and might have flaws. However, I was guided by a professor in linguistics specialized in critical discourse analysis and this helped me navigate the

analysis. Fifth, with regards to interviews, these were semi-structured in that I prompted conversations that might have affected some discourses. However, this proved to be of benefit since it provided the complexity of the interaction required (Wodak & Krzyżanowski, 2008). For example, some interviewees stated they were not racist but shared obviously racist discourses: "*I still have the humanitarian side … But you feel that you're overcome with this feeling of indignation*" (Interviewee 16082022). Trying not to appear racist appeared to be normal for interviewees who then expressed themselves otherwise (Wodak & Krzyżanowski, 2008). Hence, analysing discourses in interviews can be achieved provided the interviewer has a background like those of the interviewees established or at least a good repertoire. Further on interviews, given their small number and the workers being known among themselves and to their employers, I decided to protect their anonymity by not including details on their sectarian background, which can be an explanation to many discourses found in this thesis. This is a limitation that unfortunately could not be avoided to protect respondents. Finally, and though not a limitation per se, I did not delve into the detailed external aspects shaping the media outlets in Lebanon as suggested by Harris (2018), which could explain further the outputs of the media analysis and is something I will try to address in further studies (Harris, 2018).

Conclusion

In this thesis I presented findings on Lebanon's historical and socio-political conditions affecting infectious disease surveillance discourses, policies, and activities related to refugees in Lebanon. This is an original effort to address infectious disease surveillance using socio-political theories, historical contexts, and a discourse-historical approach, and its findings contribute to the limited literature in this domain.

The discourse analysis resulted in the identification of topics across the different data sources. The discourse topics revolved around, first, discourse on displaced populations and their presence as a threat to disease importation into Lebanon, and second, discourse on health authorities, and their international organization counterparts, and their readiness to control these perceived infections threats. A diverging discourse topic was evident in interviewees, where most discourses were on Lebanese fragmentation, emphasizing Lebanon's history of sectarianism and neoliberalism leading to clientelist employment within surveillance projects addressing refugees. Also, power dynamics between international organizations with monetary power versus local surveillance data was highlighted, where setting health agendas often diverged from national needs. Surprisingly, and despite Lebanese historical fragmentation addressed in the interviews, discourses on threat of diseases importation were common among different media reports

with diverging political stances in Lebanon, official documents, and interviews. Hence, it can be concluded that the contemporary rhetoric of national security has taken over in Lebanon despite the presence of a Lebanese population that attributes itself to Syria or the Arab world. However, when asked about a chance of resisting the status quo, i.e. socio-political context, most interviewees expressed their pessimism about any change given the current Lebanese structure.

Despite these complexities within the Lebanese context, critical disease surveillance analysis that incorporates the history, socio-politics, and economics of the creation of modern West Asia, and Lebanon, has benefits for swapping fear/threat-approaches to promote more inclusive policies and practices. This can begin with a clean slate and using inter-regional grass-root conviviality to create indigenous or subaltern methods for infectious disease surveillance. This can be done in coordination and communication with authorities and media representatives to pinpoint narratives that can subjugate populations leading to their exclusion from the healthcare system. Finally, I would encourage that more health professionals conduct critical discourse analyses and integrate social sciences within their work to hopefully provide the literature with a wholesome picture of health policies and practices.

References

Abeysinghe, S. (2016). Ebola at the borders: Newspaper representations and the politics of border control. *Third World Quarterly*, *37*(3), 452–467. https://doi.org/10.1080/01436597.2015.1111753

Abimbola, S. (2019). The foreign gaze: Authorship in academic global health. *BMJ Global Health*, *4*(5), e002068. https://doi.org/10.1136/bmjgh-2019-002068

Abimbola, S. (2023). Knowledge from the global South is in the global South. *Journal of Medical Ethics*, *49*(5), 337–338. https://doi.org/10.1136/jme-2023-109089

Abimbola, S., & Pai, M. (2020). Will global health survive its decolonisation? *The Lancet*, *396*(10263), 1627–1628. https://doi.org/10.1016/S0140-6736(20)32417-X

Abou-Hodeib, T. (2007). Quarantine and Trade: The Case of Beirut, 1831–1840. *International Journal of Maritime History*, *19*(2), 223–244. https://doi.org/10.1177/084387140701900210

al-Asqalani, I. H., Blecher, J., & Syed, M. (2023). *Merits of the Plague*. Penguin Publishing Group. https://books.google.cl/books?id=_JFUEAAAQBAJ

Alawieh, A., Musharrafieh, U., Jaber, A., Berry, A., Ghosn, N., & Bizri, A. R. (2014). Revisiting leishmaniasis in the time of war: The Syrian conflict and the Lebanese outbreak. *International Journal of Infectious Diseases*, *29*, 115–119. https://doi.org/10.1016/j.ijid.2014.04.023

Alawieh, A., Sabra, Z., Langley, E. F., Bizri, A. R., Hamadeh, R., & Zaraket, F. A. (2017). Assessing the impact of the Lebanese National Polio Immunization Campaign using a population-based computational model. *BMC Public Health*, *17*(1), 1–11. https://doi.org/10.1186/s12889-017-4909-0

Ammar, W. (2003). *Health System and Reform in Lebanon*. Entreprice Universitaire d'Etudes et de Publications.

Ammar, W. (2009). *Health beyond politics*. http://www.moph.gov.lb/en/view/3908/health-beyond-politics

Araj, G. F., Saade, A., Itani, L. Y., & Avedissian, A. Z. (2016). Tuberculosis burden in Lebanon: Evolution and current status. *Journal Medical Libanais*, *64*(1), 1–7. https://doi.org/10.12816/0023824

Au, S. (2006). Indigenous politics, public health and the Cambodian colonial state. *South East Asia Research*, *14*(1), 33–86.

Aviles, L. A. (2001). Epidemiology as discourse: The politics of development institutions in the Epidemiological Profile of El Salvador. *Journal of Epidemiology & Community Health*, *55*(3), 164–171. https://doi.org/10.1136/jech.55.3.164

Barker, K. (2012). Infectious Insecurities: H1N1 and the politics of emerging infectious disease. In *Health and Place* (Vol. 18, pp. 695–700). https://doi.org/10.1016/j.healthplace.2012.01.004

Bell, M., Brown, T., & Faire, L. (2006). Germs, genes and postcolonial geographies: Reading the return of tuberculosis to Leicester, UK, 2001. *Cultural Geographies*, *13*(4), 577–599.

Bhabha, H. (1990). *Nation and Narration*. Routledge.

Bizri, A., Fares, J., & Musharrafieh, U. (2018). Infectious diseases in the era of refugees: Hepatitis a outbreak in Lebanon. *Avicenna Journal of Medicine*, *8*(4), 147. https://doi.org/10.4103/ajm.ajm_130_18

Blanchet, K., Fouad, F. M., & Pherali, T. (2016). Syrian refugees in Lebanon: The search for universal health coverage. *Conflict and Health*, *10*(1), 1–5. https://doi.org/10.1186/s13031-016-0079-4

Bou Sanayeh, E., & El Chamieh, C. (2023). The fragile healthcare system in Lebanon: Sounding the alarm about its possible collapse. *Health Economics Review*, *13*(1), 21. https://doi.org/10.1186/s13561-023-00435-w

Boukala, S. (2016). Rethinking *topos* in the discourse historical approach: Endoxon seeking and argumentation in Greek media discourses on 'Islamist terrorism.' *Discourse Studies*, *18*(3), 249–268. https://doi.org/10.1177/1461445616634550

Braun, V., Clarke, V., Hayfield, N., Moller, N., & Tischner, I. (2019). *Handbook of Research Methods in Health Social Sciences* (P. Liamputtong, Ed.). Springer Singapore.

Briggs, C. L. (2005). Communicability, Racial Discourse, and Disease. *Annual Review of Anthropology*, *34*, 269–291.

Briggs, C. L. (2011). Communicating biosecurity. *Medical Anthropology: Cross Cultural Studies in Health and Illness*, *30*(1), 6–29. https://doi.org/10.1080/01459740.2010.531066

Brown, M. E. L., & Dueñas, A. N. (2020). A Medical Science Educator's Guide to Selecting a Research Paradigm: Building a Basis for Better Research. *Medical Science Educator*, *30*(1), 545–553. https://doi.org/10.1007/s40670-019-00898-9

Brunet-jailly, E. (2005). Theorizing Borders: An Interdisciplinary Perspective. *Geopolitics*, *10*(4), 633–649. https://doi.org/10.1080/14650040500318449

Burney, S. (2012). Conceptual Frameworks in Postcolonial Theory: Application for Educational Critique. In *PEDAGOGY of the Other: Edward Said, Postcolonial Theory, and Strategies for Critique* (Vol. 417, pp. 173–193).

Caduff, C. (2014). On the Verge of Death: Visions of Biological Vulnerability. *Annual Review of Anthropology*, *43*, 105–121.

Cameron-Smith, A. (2013). Race, Medicine, and Colonial Rule in the Mandated Territory of New Guinea. *Canadian Bulletin of Medical History = Bulletin Canadien d'histoire de La Medecine*, *30*(2), 47–67. https://dx.doi.org/10.3138/cbmh.30.2.47

Cameron-Smith, A. (2019). Coordinating empires Nationhood, Australian imperialism and international health in the Pacific Islands, 1925–1929. In *A Doctor Across Borders* (pp. 93–132). ANU Press. http://www.jstor.org/stable/j.ctvdjrrfp.9

CAS. (2017). *التعداد العام للسكان والمساكن في مخيمات والتجمعات الفلسطينية في لبنان—2017*. https://www.pcbs.gov.ps/Downloads/book2356.pdf

Chaaban, J., Salti, N., Ghattas, H., Irani, A., Ismail, T., & Batlouni, L. (2015). *Survey on the Socioeconomic Status of Palestine Refugees in Lebanon 2015*.

Chatty, D. (2017). The duty to be generous (karam): Alternatives to rights-based asylum in the Middle East. *Journal of the British Academy*, *5*(October), 177–199. https://doi.org/10.5871/jba/005.177

Chatty, D. (2020). Commentary: When Hospitality turns into Hostility in Prolonged Forced Migration. *International Migration*, *58*(3), 258–260. https://doi.org/10.1111/imig.12736

Cheng, J.-F. (2015). "El tabaco se ha mulato": Globalizing Race, Viruses, and Scientific Observation in the Late Nineteenth Century. *Catalyst : Feminism, Theory, Technoscience*, *1*(1). https://doi.org/10.28968/cftt.v1i1.28810

Chuengsatiansup, K., & Limsawart, W. (2019). Tuberculosis in the borderlands: Migrants, microbes and more-than-human borders. *Palgrave Communications*, *5*(1). https://doi.org/10.1057/s41599-019-0239-4

Cole, J., & Dodds, K. (2020). Unhealthy geopolitics? Bordering disease in the time of coronavirus. *Geographical Research*. https://doi.org/10.1111/1745-5871.12457

Cole, J., & Dodds, K. (2021). Unhealthy geopolitics? Bordering disease in the time of coronavirus. *GEOGRAPHICAL RESEARCH*, *59*(2), 169–181. https://doi.org/10.1111/1745-5871.12457

Crane, J. T. (2010). Unequal 'partners'. AIDS, academia, and the rise of global health. *Behemoth-A Journal on Civilisation*, *3*(3), 78–97.

Crow, R. E. (1962). Religious Sectarianism Political System. *University of Chicago Press*, *43*(3).

Culcasi, K. (2010). CONSTRUCTING AND NATURALIZING THE MIDDLE EAST. *Geographical Review*, *100*(4), 583–597.

Culcasi, K. (2012). Mapping the Middle East from Within: (Counter-)Cartographies of an Imperialist Construction. *Antipode*, *44*(4), 1099–1118. https://doi.org/10.1111/j.1467-8330.2011.00941.x

Dabbous, Y. T. (2010). Media With a Mission: Why Fairness and Balance Are Not Priorities in Lebanon's Journalistic Codes. *International Journal of Communication*, *4*, 719–737.

Davis, A., & Sharp, J. (2020). Rethinking one health: Emergent human, animal and environmental assemblages. *Social Science & Medicine*, *258*, 113093.

De Genova, N., Mezzadra, S., & Pickles, J. (2015). New Keywords: Migration and Borders. *Cultural Studies*, *29*(1), 55–87. https://doi.org/10.1080/09502386.2014.891630

Declich, S., & Carter, A. O. (1994). Public health surveillance: Historical origins, methods and evaluation. *Bulletin of the World Health Organization*, *72*(5479), 285–304.

Di Peri, R. (2020). A Sectarianised Pandemic: COVID-19 in Lebanon. *The International Spectator*, *20/71*. https://www.iai.it/en/pubblicazioni/c05/sectarianised-pandemic-covid-19-lebanon

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R., & Sutton, A. J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology*, *6*(1), 35. https://doi.org/10.1186/1471-2288-6-35

Doughan, Y. (2022). *Life and Precarity in the Border Zone of War: Insights from Ramtha, Jordan*. *1*.

Doughan, Y. (2024). The Rule-of-Law as a Problem Space: *Wāsṭa* and the Paradox of Justice in Jordan. *Comparative Studies in Society and History*, *66*(1), 131–154. https://doi.org/10.1017/S0010417523000312

Elias, C. J., Alexander, B. H., & Sokly, T. A. N. (1990). *Infectious Disease Control in a Long-term Refugee Camp: The Role of Epidemiologic Surveillance and Investigation*. *80*(7), 824–828.

El-Richani, S. (2020). Whither the Lebanese press? The trials and tribulations facing the Lebanese print media. In N. Miladi & N. Mellor (Eds.), *Routledge Handbook on Arab Media* (1st ed., pp. 167–178). Routledge. https://doi.org/10.4324/9780429427084-21

Escobar, A. (2011). *Encountering Development: The Making and Unmaking of the Third World*. Princeton University Press.

Fairclough, N. (1992). *Discourse and Social Change*. Polity Press.

Fairclough, N. (1995). *Critical discourse analysis: The critical study of language*. Longman.

Fairclough, N., Mulderrig, J., & Wodak, R. (2011). Critical discourse analysis. In *Critical discourse analysis* (2nd ed.). SAGE Publications Ltd. https://doi.org/10.4135/9781446289068

Faleye, O. A. (2017). Environmental Change, Sanitation and Bubonic Plague in Lagos, 1924–31. *International Review of Environmental History*, *3*(2), 89–103.

Fanon, F. (1963). *The Wretched of the Earth*. Grove Press.

Fanon, F. (2008). *Black skin, white masks*. Pluto Press.

Farah, Z., Saleh, M., Abou El Naja, H., Chaito, L., & Ghosn, N. (2023). Communicable Disease Surveillance in Lebanon during the Syrian Humanitarian Crisis, 2013–2019. *Epidemiologia*, *4*(3), 255–266. https://doi.org/10.3390/epidemiologia4030026

Farmer, P., Kim, J., Basilico, M., & Kleinman, Arthur. (2013). *Reimagining Global Health: An Introduction*. University of California Press.

Figuié, M. (2014). Towards a global governance of risks: International health organisations and the surveillance of emerging infectious diseases. *Journal of Risk Research*, *17*(4), 469–483.

Figuié, M., Binot, A., & Caron, A. (2015). Wild and Domestic, Human and Animal: Colonial and post-colonial surveillance policies in Zimbabwe. *Revue d'Anthropologie Des Connaissances*, *9*, 163–188.

Frangieh, G. (2014). *Syrian Refugees in Limbo: Is Lebanon's Establishment of Camps the Answer?* Legal Agenda.

Frangieh, G., & Barjas, E. (2016). *Interior Ministry Advisor: Lebanon Refugee Policy Based on Set of "Nos."* Legal Agenda.

French, M. A. (2009). Woven of War-Time Fabrics: The globalization of public health surveillance. *Surveillance & Society*, *6*(2), 101–115.

Genest, G. B. (2015). World Health Organization and disease surveillance: Jeopardizing global public health? *Health*, *19*(6), 595–614.

Goldberg, D. T. (2002). *The Racial State*. Wiley. https://books.google.cl/books?id=8dGRnEXY6pkC

Gramsci, A., Hoare, Q., & Nowell-Smith, G. (1971). *Selections from the Prison Notebooks of Antonio Gramsci*. International Publishers. https://books.google.cl/books?id=z4vFJ-3jh6sC

Green, J., & Thorogood, N. (2004). *Qualitative Methods for Health Research*. SAGE Publications Ltd.

Guilherme, M. (2019). The critical and decolonial quest for intercultural epistemologies and discourses. *Journal of Multicultural Discourses*, *14*(1), 1–13. https://doi.org/10.1080/17447143.2019.1617294

Hanssen, J., & Safieddine, H. (2016). LEBANON'S "AL-AKHBAR" AND RADICAL PRESS CULTURE: TOWARD AN INTELLECTUAL HISTORY OF THE CONTEMPORARY ARAB LEFT. *The Arab Studies Journal*, *24*(1), 192–227.

Harb, M., Gharbieh, A., Fawaz, M., & Dayekh, L. (2021). Mapping Covid-19 Governance in Lebanon: Territories of Sectarianism and Solidarity. *Middle East Law and Governance*, *14*(1), 81–100. https://doi.org/10.1163/18763375-14011293

Harris, S. T. G. (2018). Questioning the Role of Foreign Aid in Media System Research. In B. Mutsvairo (Ed.), *The Palgrave Handbook of Media and Communication Research in Africa* (pp. 401–412). Springer International Publishing. https://doi.org/10.1007/978-3-319-70443-2_22

Hinchliffe, S. (2021). Postcolonial Global Health, Post-Colony Microbes and Antimicrobial Resistance. *Theory, Culture and Society*. https://doi.org/10.1177/0263276420981606

Hinchliffe, S., Allen, J., Lavau, S., Bingham, N., & Carter, S. (2012). Biosecurity and the topologies of infected life: From borderlines to borderlands. *Transactions of the Institute of British Geographers*, *38*(4), 531–543. https://doi.org/10.1111/j.1475-5661.2012.00538.x

Hirsch, L. (2021). Is it possible to decolonise global health institutions? *The Lancet*, *397*(10270).

Hirsch, L., & Martin, R. (2022). *LSHTM and Colonialism: A report on the Colonial History of the London School of Hygiene & Tropical Medicine (1899–c. 1960)*. London School of Hygiene & Tropical Medicine.

Hsien-Yu, C. (1998). Colonial Medical Police and Postcolonial Medical Surveillance Systems in Taiwan, 1895-1950s. *Osiris*, *13*, 326–338.

Human Rights Watch. (2007). Rot Here or Die There Bleak Choices for Iraqi Refugees in Lebanon. *Human Rights Watch*, *19*(8).

Ingram, A. (2007). HIV/AIDS, Security and the Geopolitics of US: Nigerian Relations. *Review of International Political Economy*, *14*(3), 510–534.

Ingram, A. (2009). The geopolitics of disease. *Geography Compass*, *3*(6), 2084–2097. https://doi.org/10.1111/j.1749-8198.2009.00284.x

IOM. (2019). *Key Migration Terms*. https://www.iom.int/key-migration-terms

Janmyr, M. (2017). No Country of Asylum: 'Legitimizing' Lebanon's Rejection of the 1951 Refugee Convention. *International Journal of Refugee Law*, *29*(3), 438–465. https://doi.org/10.1093/ijrl/eex026

Kaufman, A. (2015). Colonial Cartography and the Making of Palestine, Lebanon, and Syria. In *The Routledge Handbook of the History of the Middle East* (p. 19). https://doi.org/10.4324/9781315713120.ch14

Kelley, N. (2017). Responding to a Refugee Influx: Lessons from Lebanon. *Journal on Migration and Human Security*, *5*(1), 82–104. https://doi.org/10.1177/233150241700500105

Kerr, D. (1999). Beheading the King and Enthroning the Market: A Critique of Foucauldian Governmentality. *Science & Society*, *63*(2), 173–202.

Khalidi, R. (1998). The "Middle East" As a Framework of Analysis: Re-Mapping a Region in the Era of Globalization. *Comparative Studies of South Asia, Africa and the Middle East*, *18*(1), 74–81. https://doi.org/10.1215/1089201X-18-1-74

Khalife, J., Rafeh, N., Makouk, J., El-Jardali, F., Ekman, B., Kronfol, N., Hamadeh, G., & Ammar, W. (2017). Hospital Contracting Reforms: The Lebanese Ministry of Public Health Experience. *Health Systems & Reform*, *3*(1), 34–41. https://doi.org/10.1080/23288604.2016.1272979

Khan, T., Abimbola, S., Kyobutungi, C., & Pai, M. (2022). How we classify countries and people—And why it matters. *BMJ Global Health*, *7*(6), e009704. https://doi.org/10.1136/bmjgh-2022-009704

Khazaal, N. (2020). Lebanese broadcasting: Small country, influential media. In *Routledge Handbook on Arab Media* (1st ed.). Routledge.

KhosraviNik, M. (2010). Actor descriptions, action attributions, and argumentation: Towards a systematization of CDA analytical categories in the representation of social groups 1. *Critical Discourse Studies*, *7*(1), 55–72. https://doi.org/10.1080/17405900903453948

KhosraviNik, M. (2015). *Discourse, Identity and Legitimacy: Self and Other in representations of Iran's nuclear programme* (Vol. 62). John Benjamins Publishing Company. https://doi.org/10.1075/dapsac.62

King, N. B. (2002). Security, Disease, Commerce: Ideologies of Postcolonial Global Health. *Social Studies of Science*, *32*(5/6), 763–789.

King, N. B. (2003). Immigration, Race and Geographies of Difference in the Tuberculosis Pandemic. In *The Return of the Plague: Global Poverty and the New Tuberculosis* (First, p. 336). Verso.

Knudsen, A. (2009). Widening the protection gap: The "politics of citizenship" for Palestinian refugees in Lebanon, 1948-2008. *Journal of Refugee Studies*, *22*(1), 51–73. https://doi.org/10.1093/jrs/fen047

Koch, T. (2017). *Cartographies of disease: Maps, mapping, and medicine* (New expanded edition). Esri Press.

Lamberg, M., Hakanen, M., & Haikari, J. (2011). *Physical and Cultural Space in Pre-Industrial Europe: Methodological Approaches to Spatiality*. Nordic Academic Press.

Levich, J. (2015). The Gates Foundation, Ebola, and Global Health Imperialism. *The American Journal of Economics and Sociology*, *74*(4), 704–742.

Levy, B. S., & Sidel, V. W. (2016). Documenting the Effects of Armed Conflict on Population Health. *Annual Review of Public Health*, *37*(1), 205–218. https://doi.org/10.1146/annurev-publhealth-032315-021913

Makhoul, J., & Harrison, L. (2024). *INTERCESSORY WASTA AND VILLAGE DEVELOPMENT IN LEBANON*.

Manderson, L. (2009). Wireless wars in the eastern arena: Epidemiological surveillance, disease prevention and the work of the Eastern Bureau of the League of Nations Health Organisation, 1925–1942. In P. Weindling (Ed.), *International Health Organisations and Movements, 1918–1939* (pp. 109–133). Cambridge University Press. https://doi.org/10.1017/CBO9780511599606.008

Marks, S. (1997). What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health? *Social History of Medicine*, *10*(2), 205–219. https://doi.org/10.1093/shm/10.2.205

Mbembe, A. (2001). *On the Postcolony* (1st ed.). University of California Press; JSTOR. http://www.jstor.org/stable/10.1525/j.ctt1ppkxs

Mbembe, A. (2019). *Necropolitics*. Duke University Press; JSTOR. https://doi.org/10.2307/j.ctv1131298

Melki, J., Abou Zeid, M., & El Takach, A. (2020). *Lebanon: Coronavirus and the media* [Media]. European Journalism Observatory. https://en.ejo.ch/ethics-quality/lebanon-coronavirus-and-the-media

Mezzadra, S., & Neilson, B. (2013). *Border as Method, Or, the Multiplication of Labor*. Duke University Press. https://doi.org/10.1215/9780822377542

Mignolo, W. (2011). Epistemic Disobedience and the Decolonial Option: A Manifesto. *TRANSMODERNITY: Journal of Peripheral Cultural Production of the Luso-Hispanic World*, *1*. https://doi.org/10.5070/T412011807

Mishra, V. (2020). *Postcolonial Theory*. Oxford University Press. https://doi.org/10.1093/acrefore/9780190201098.013.1001

MOPH. (2016). *Health Strategic Plan: Strategic Plan for the medium term (2016 to 2020)*. https://www.moph.gov.lb/en/Pages/9/1269/strategic-plans#/en/view/11666/strategic-plan-2016-2020-

MOPH. (2018). *Epidemiological Surveillance*. https://www.moph.gov.lb/en/Pages/2/193/esu

MOPH. (2019). *Classical reporting system*. https://www.moph.gov.lb/en/Pages/0/11352/classical-reporting-system

Morens, D. M., & Fauci, A. S. (2020). Emerging Pandemic Diseases: How We Got to COVID-19. *Cell*, *182*(5), 1077–1092.

Ndlovu-Gatsheni, S. J. (2013). Decolonial Epistemic Perspective and Pan-African Unity in the 21st Century. In *The African Union Ten Years After: Solving African Problems with Pan-Africanism and the African Renaissance*. Africa Institute of South Africa. https://books.google.cl/books?id=uNwWAgAAQBAJ

Nemr, E., Moussallem, M., Nemr, R., & Kosremelli Asmar, M. (2023). Exodus of Lebanese doctors in times of crisis: A qualitative study. *Frontiers in Health Services*, *3*, 1240052. https://doi.org/10.3389/frhs.2023.1240052

Norton, A. R. (2007). *Hezbollah*. Princeton University.

Ozaras, R., Leblebicioglu, H., Sunbul, M., Tabak, F., Balkan, I. I., Yemisen, M., Sencan, I., & Ozturk, R. (2016). The Syrian conflict and infectious diseases. *Expert Review of Anti-Infective Therapy*, *14*(6), 547–555. http://dx.doi.org/10.1080/14787210.2016.1177457

Papamichail, A. (2021). The Global Politics of Health Security before, during, and after COVID-19. *Ethics & International Affairs*, *35*(3), 467–481.

Peckham, R. (2018). Polio, terror and the immunological worldview. *Global Public Health*, *13*(2), 189–210.

Peckham, R., & Sinha, R. (2019). Anarchitectures of health: Futures for the biomedical drone. *Global Public Health*, *14*(8), 1204–1219.

Pereira, R. (2008). Processes of securitization of infectious diseases and Western hegemonic power: A historical-political analysis. In *Global Health Governance* (Vol. 2, pp. 1–15).

Rheindorf, M., & Wodak, R. (Eds.). (2020). *Language Policy, Identity and Belonging*. Multilingual Matters. https://doi.org/doi:10.21832/9781788924689

Richardson, E. T. (2020). *Epidemic illusions: On the coloniality of global public health*. MIT Press.

Sahlins, P. (1989). *Boundaries: The Making of France and Spain in the Pyrenees*. University of California Press.

Said, E. (1978). Orientalism. In *Vintage Books*. Vintage Books. https://doi.org/10.2307/2536347

Said, E. (1994). *Culture and Imperialism*. Vintage Books.

Saleh, M., Farah, Z., & Howard, N. (2022). Infectious disease surveillance for refugees at borders and in destination countries: A scoping review. *BMC Public Health*, 1–14. https://doi.org/10.1186/s12889-022-12646-7

Saleh, M., & Howard, N. (2023). Socio-political and organizational influences on national infectious disease surveillance for refugees: A qualitative case study in Lebanon. *PLOS Global Public Health*, *3*(6), e0001753. https://doi.org/10.1371/journal.pgph.0001753

Salibi, K. (1971). The Lebanese Identity. *Journal of Contemporary History*, *6*(1), 76–81.

Salibi, K. (1988). *A House of Many Mansions: The History of Lebanon Reconsidered*. I.B. Tauris.

Salloukh, B. F., Barakat, R., Al-Habbal, J. S., Khattab, L. W., & Mikaelian, S. (2015). *The Politics of Sectarianism in Postwar Lebanon*. Pluto Press. https://doi.org/10.2307/j.ctt183p3d5

Sastry, S., & Dutta, M. J. (2012). Public health, global surveillance, and the "emerging disease" worldview: A postcolonial appraisal of PEPFAR. *Health Communication*, *27*(6), 519–532. https://dx.doi.org/10.1080/10410236.2011.616626

Smith, L. T. (2021). *Decolonizing Methodologies: Research and Indigenous Peoples* (Third). Bloomsbury Publishing.

Spivak, G. C. (1999). *A Critique of Postcolonial Reason*. Harvard University Press; JSTOR. https://doi.org/10.2307/j.ctvjsf541

Sweis, R. K. (2021). *Paradoxes of Care: Children and Global Medical Aid in Egypt*. Stanford University Press. http://www.sup.org/books/title/?id=27766

Tanielian, M. (2012). *The War of Famine: Everyday Life in Wartime Beirut and Mount Lebanon (1914-1918)* [UC Berkeley]. https://escholarship.org/uc/item/4bs8383d

Thomas, S. L., & Thomas, S. D. M. (2004). Displacement and health. *British Medical Bulletin*, *69*(February), 115–127. https://doi.org/10.1093/bmb/ldh009

Traboulsi, F. (2012). *A History of Modern Lebanon*. Pluto Press.

Traboulsi, F. (2016). *Social Classes and Political Power in Lebanon*. Heinrich Böll Stiftung - Middle East Office.

UN. (2021). *Country Profile: Lebanon*. https://data.un.org/CountryProfile.aspx/_Images/CountryProfile.aspx?crName=Lebanon

UNHCR. (2010). Convention and Protocol Relating to the Status of Refugees. In *International and Comparative Law Quarterly* (Vol. 10, pp. 255–264).

UNHCR. (2022). *Operational data portal: Refugee situations*. https://data2.unhcr.org/en/situations/syria/location/71

UNRWA. (2018). *Who we are*.

van Dijk, T. (2006). Ideology and discourse: A multidisciplinary introduction. *Journal of Political Ideologies*, *11*(2), 115–140. https://doi.org/10.1080/13569310600687908

Weir, L., & Mykhalovskiy, E. (2007). The geopolitics of global public health surveillance in the twenty-first century. In A. Bashford (Ed.), *Medicine at the Border* (pp. 240–263).

Weir, L., & Mykhalovskiy, E. (2010). Early Warning Outbreak Detection and Alert: A Technique Postcolonial Knowledge of Outbreak. In *Global Public Health Vigilance: Creating a World on Alert* (p. 230).

White, A. I. R. (2023). *Epidemic Orientalism: Race, Capital, and the Governance of Infectious Disease*. Stanford University Press.

WHO. (2006). *Communicable disease surveillance and response systems—Guide to monitoring and evaluating* (p. 90).

WHO. (2016). The International Health Regulations (2005). In *World Health Organization*.

Wodak, R. (2015). Critical Discourse Analysis , Discourse-Historical Approach. In K. Tracy (Ed.), *The International Encyclopedia of Language and Social Interaction*. John Wiley & Sons, Inc. https://doi.org/10.1002/9781118611463

Wodak, R., & Krzyżanowski, M. (2008). *Qualitative discourse analysis in the social sciences* (1–1 online resource (xi, 216 pages) : illustrations). Palgrave Macmillan Houndmills, Basingstoke, Hampshire

[England]; WorldCat. https://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=1523136

Wodak, R., & Meyer, M. (2001). *Methods of Critical Discourse Analysis*. SAGE Publications Ltd.

Wodak, R., & Meyer, M. (2016). *Methods of critical discourse studies* (Third edition). SAGE.

Woodward, A., Howard, N., & Wolffers, I. (2014). Health and access to care for undocumented migrants living in the European Union: A scoping review. *Health Policy and Planning*, *29*(7), 818–830. https://doi.org/10.1093/heapol/czt061

Annexes

Annex 1: Study information sheet for interviews

Examining infectious disease surveillance in Lebanon after 2011: "Border as method" as a discourse-historical approach

1. **Introduction**

As part of my Doctorate of Public Health (DrPH) studies at The London School of Hygiene and Tropical Medicine (LSHTM) in the United Kingdom, I am conducting a research project on infectious disease surveillance for refugees in Lebanon using Border as Method approach. The aim is to examine the interplay, if present, between Lebanon's historical-political background (e.g. sectarianism, internal conflict, pre-colonial, colonial, postcolonial foreign interventions, border creation) and infectious disease surveillance discourse, policy, and practice for cross-border displaced populations.

2. Participation

We request your kind participation in an interview for this research since your knowledge in this matter can contribute to our analysis. Participating in this interview is voluntary and you can withdraw at any time without needing to give any reasons. If you agree to participate in this research, a consent form is attached for your kind review and signature. The duration of the interview will be around 45 minutes. With your permission, I would like to audio record the interview to improve transcription quality.

3. Risks and benefits

The research will only require some time from your part while we conduct the interview and will not cause any other inconvenience. In case you find a question uncomfortable, you can inform us to skip it. The information that will result from this research will be used to inform the Lebanese government and their infectious surveillance activities of the factors influencing infectious disease surveillance and suggest recommendations for further improvements. No compensation will be offered for taking part in the interview.

4. Anonymity and confidentiality

This study has been approved by the London School of Hygiene & Tropical Medicine's Research Ethics Committee and Rafik Hariri University Hospital IRB. Audio recording of the interview will be numerically coded and saved to my personal storage space on LSHTM servers and secured with a password only accessible to me. Hard copy notes will be anonymised and stored securely in a locked cabinet. Your name or any other personal information will not be mentioned in quotations or research outputs.

Thank you very much for considering taking part in this interview and if you have any questions regarding this research study, please contact:

Majd Saleh, DrPHc Majd.Saleh1@lshtm.ac.uk Mobile: +96170812022
Dr Natasha Howard natasha.howard@lshtm.ac.uk

If you have any further comments regarding the conduct of this research study, please contact Patricia Henley at RGIO@lshtm.ac.uk.

Annex 2: Consent form for interviews

Examining infectious disease surveillance in Lebanon after 2011: "Border as method" as a discourse-historical approach

Please tick the appropriate boxes

1. I confirm that I have read, and I understood the information sheet dated DD/MM/YYYY ☐
2. I have had the opportunity to have my questions fully answered about the research project ☐
3. I know that my participation is voluntary and that I am free to withdraw at any time from the interview, without providing reasons for my withdrawal ☐
4. I agree to take part in this research project. ☐
5. I agree to being audio-recorded for this interview. ☐
6. I understand that my identifying information and personal details will not be revealed to people outside the research team. ☐
7. I agree to be anonymously quoted in research outputs and publications ☐
8. I agree to my transcript being anonymously archived in the LSHTM data repository in accordance with LSHTM data management policies and the UK Data Protection Act. ☐

Participant's Name	**Date**	**Signature**

Researcher's Name	**Date**	**Signature**

If you have any questions regarding this research project, please contact:

Majd Saleh, DrPHc Majd.Saleh1@lshtm.ac.uk Mobile: +96170812022
Dr Natasha Howard natasha.howard@lshtm.ac.uk

If you have any complaints regarding the conduct of this research project, please contact:

Patricia Henley RGIO@lshtm.ac.uk

This research project has been approved by the London School of Hygiene & Tropical Medicine's Research Ethics Committee and the Rafik Hariri University Hospital IRB in Lebanon.

Annex 3: Semi-structured interview guide

Examining infectious disease surveillance in Lebanon after 2011: "Border as method" as a discourse-historical approach

Introductory question

1. Please describe your involvement in health surveillance activities and whether you work(ed) with displaced people, directly or indirectly?

General questions

2. How do you think Lebanon's history affects the popular perception of borders?
3. How do you think Lebanon's history affects the popular perception of people from other countries, particularly displaced people, and other migrants?
4. How do you think Lebanon's constitution and political system affects work with displaced people, particularly public health surveillance and disease control for displaced people?
5. In what way do you think Lebanon's history and constitution affects the work of surveillance programmes?

Specific to Surveillance

6. What are good examples of public health surveillance activities targeting displaced people in Lebanon and why do they work or not work?
7. How are displaced people or other migrants treated by governmental (MOPH) or international (WHO, UNHCR, UNICEF…) surveillance activities?
8. How are surveillance activities for refugees or other migrants different from surveillance for Lebanese nationals?
9. How do you think borders affect the work of MOPH, especially when addressing displaced people?
10. How does political sectarianism affect the work of MOPH, particularly for disease surveillance?