D6 | FRAMING OF HEALTH AS A SECURITY ISSUE

Introduction

In the last couple of decades, political actors' perceptions of what constitutes a threat to international security has broadened. Health issues, particularly those related to infectious diseases, have increasingly been presented as security threats. The framing of health as a security issue, or 'health securitization', is often a successful strategy for generating interest in, and resources for, a specific health issue. Nevertheless, it is also problematic in several respects. This chapter describes the evolution of health securitization and critically analyses the impact that it has on global health. We first introduce the concept of securitization and follow it up with an exploration of how health issues have been securitized over the last two decades, with particular attention to the manner in which the outbreak of Ebola in West Africa in 2014 was presented primarily as a security threat. Finally we examine the problems associated with the increased tendency to securitize health issues.

What is securitization?

The notion of securitization has been conceptualized by the Copenhagen School of Security Studies (Buzan, Wæver and De Wilde, 1998). The argument is that a security threat is not an objective condition that exists independently of the person or organization that is representing it as such. Securitization refers to the discursive process by which an issue is socially constructed as a security threat through the speech and representations of relevant political actors. The central issue for securitization studies is not how much of a security threat a particular issue poses. Rather, it aims to understand who defines the threat to security and whose interests are being served by securitization.

Securitization occurs when an actor claims that the referent object faces an existential threat, demands that urgent and extraordinary countermeasures be taken to deal with the threat and persuades an audience that such action is necessary. Buzan, Wæver and De Wilde (1998) point out that there is no universal definition of an existential threat. Existential threats are problems that, if not tackled, will render "everything else…irrelevant (because we will not be here or will not be free to deal with it in our own way)" (ibid., p. 24). What constitutes a threat can only be understood with reference to the particular character of the referent object, but the nature of the referent object varies between sectors.

The Copenhagen School argues that security is invoked in a variety of different arenas: that is, it does not just refer to military threats to the state. It identifies four other sectors: political, societal, economic and environmental. In the military sector, the referent object will usually be the state and it can be subject to threats to its sovereignty from either external aggressors or internal dissidents. But in the environmental sector, for example, the referent objects can be anything from individual species (including humans) to planet Earth, and these are subject to threats to their survival from human activity of various sorts.

The Copenhagen School argues that framing an issue in terms of security is the most effective strategy for bringing about a large-scale response (Buzan, Wæver and De Wilde, 1998). It is, nevertheless, troubled by securitization as a mode of dealing with problems. One reason is that securitization legitimates the bypassing of normal political rules of the game: for example, public debate, democracy, legal-rational decision-making procedures and respect for another countries' sovereignty. Thus, securitization allows the state to take extraordinary measures in order to deal with perceived existential threats. In the most extreme cases, security might be invoked to legitimize the use of force, as in a declaration of a state of emergency or an attack on another country. Another reason that the Copenhagen School is concerned with securitization is that it can result in a misallocation of resources. An issue that has been successfully securitized will garner disproportionate attention and resources as compared to one that has not, even when the latter actually poses a greater threat.

Securitizing health

The end of the Cold War, the War on Terror and the increasing focus on domestic security in developed countries have led to a broadening of the perception of what constitutes a threat to security (ibid.). Since the 1990s, health issues have increasingly been framed as security threats, and health has become one of the most important non-traditional security issues (Heymann et al., 2015). The securitization of health has occurred in two distinct ways, which are often conflated and confused with each other.

In one, the referent object is individual human beings and the health issue is a presented as a threat to their well-being and lives. This is apparent in a report published by the United Nations Development Programme (UNDP) in 1994 entitled *New Dimensions of Human Security*, which identifies seven categories of threat to human security, including health. It distinguishes between the idea of human security, an individual, people-centred concept and the more traditional state-centred concept of security. The report argues that, irrespective of the threat, people rather than borders, international relations or economics should be the primary concern of politicians and policymakers. In the field of health policy, this has been referred to as "individual health security", which is defined as "security that comes from access to safe and effective health services, products, and technologies" (ibid., p. 1884).

In the second, the referent object is the state and the health issue is presented as a threat to international peace. Heymannet et al. (2015) refer to this as collective health security. This is the dominant way in which health security is conceptualized, for example in the International Health Regulations. It has its roots in the efforts to stop the spread of bubonic plague in the fourteenth century. The increased securitization of health in the past couple of decades has been driven by the concern that infectious diseases have the potential to cause problems far beyond public health. In large part, this has been the result of fears about the HIV/AIDS epidemic, as well as the outbreak of SARS in 2003 and fears about avian flu. In 2000, HIV/AIDS was the first health issue to be recognized by the UN Security Council as a threat to international security, when it passed Resolution 1308, pertaining to the impact of HIV/AIDS on peacekeeping operations in Africa. The securitization of health has also been a result of the perceived threat of 'bioterrorism' in the wake of the sarin gas attack in the Tokyo subway system in 1995 and the mailing of anthrax spores to US senators and the media in 2001 (Calain and Sa'Da, 2015, p. 29).

Securitizing Ebola The securitization of infectious diseases reached its apogee in the (delayed) reaction to the 2014 Ebola outbreak in West Africa (Burci, 2014, pp. 27–39). Concern for the people of West Africa was not what motivated the concerted international reaction to Ebola in West Africa. Rather, it was fear that the epidemic could spread out of Africa and cause harm to Western societies (Calain and Sa'Da, 2015, p. 29). Three political decisions taken in September 2014 followed this reasoning. First, the UN Security Council adopted Resolution 2177, which stated that the Ebola outbreak constituted a threat to international peace and security. Second, the USA deployed 3,000

Image D6.1 President Barack Obama convenes a meeting on the Ebola virus at the Center for Disease Control (Official White House Photo by Pete Souza)

military personnel to work on outbreak-control measures in Liberia. While this is generally seen to have had a positive effect on controlling the outbreak, it has also been viewed as an example of the militarization of humanitarian aid (De Waal, 2014). Third, the secretary-general of the United Nations created the first-ever emergency health mission, the United Nations Mission for Ebola Emergency Response (UNMEER).

Depicting Ebola as a threat to international security helped to increase the amount and speed of aid to affected countries. But this was also problematic in several respects. It reinforced the suspicion that global health security priorities are determined by Western conceptions of risk. As Rushton (2011, p. 781) points out, "the result has been the prioritization of measures designed to contain disease within the developing world rather than measures designed to address the root causes of disease". The 'root causes' of the outbreak are not hard to identify. It is widely acknowledged that the extent of the Ebola outbreak was a consequence of dysfunctional national health systems combined with a delayed and fragmented response from global health actors (Moon et al., 2015, pp. 2204–21; Panel of Independent Experts, 2015). Nevertheless, the human insecurity dimension of this failure of health systems (failures both at the national and international levels and played out in multiple countries, and therefore global) has been all but ignored in the literature.

The challenges facing the three Western African countries most affected by Ebola – Liberia, Sierra Leone and Guinea – in rebuilding their health systems are substantial. Internationally, the World Health Organization has convened two high-level meetings on Ebola: the first held in Cape Town in July 2015, followed a year later by a meeting in Bali. Box D6.1 lists the urgent requirements agreed upon amongst participants at the latter meeting (WHO, 2016, p. 12):

Reviewing these requirements, it is easy to see how they might present an additional burden on health systems barely recovering from the Ebola pandemic. The promise of financial assistance has been forthcoming, with two funding mechanisms available for member states: the WHO's first-line Contingency Fund for Emergencies and a longer-term option available through the World Bank's Pandemic Emergency Facility. The latter has approved US$ 110 million in International Development Association financing to help build a disease surveillance system in West Africa. In 2015, Ban Ki-Moon held an International Ebola Recovery Conference, raising US$ 3.4 billion to support West African countries' recovery plans. While the support is welcome, the question remains: How will these countries process such large amounts of money? In an overview of post-Ebola recovery plans in *The Lancet*, Andrew Green recalls an interview with Sjoerd Postma, the chief of party in Liberia for Management Sciences for Health (MSH): "However, that influx of cash created new problems, Postma said, because the countries were not necessarily equipped to absorb it" (Green 2016, p. 2465).

Box D6.1: Recommendations for implementing national preparedness plans to advance global health security

- Country preparedness plans must be urgently developed or updated, taking into consideration 'One Health', 'whole of society' and 'whole of government' approaches.
- Legislative frameworks are required for working together across ministries/sectors.
- Technical guides and controls should be used or designed where necessary, to help ministries work together on zoonoses and shore up the legislative framework. These should be underpinned with training.
- Coordination mechanisms should be established between sectors and guided by a multisectoral steerage committee chaired by a political authority of the highest level.
- Clear definitions should be used for common goals and areas of interest – for example, 'One Health' approach to address, among other problems, antimicrobial resistance (AMR) – underpinned by common frameworks or approaches to anchor collaboration.
- Exercises and simulations should be conducted to strengthen collaboration.

For those with experience of the problems that recipient countries' health systems faced during the early 2000s from large sums of money raised through global health partnerships, these concerns will sound very familiar. So too will Green's further observation, "Now that systems are starting to develop, international interest has been diverted to other hotspots, including the Zika virus response and the ongoing refugee crisis" (ibid.). In the 'rush to implement' post-Ebola security plans, there is the very real risk that: i) recipients of aid will not be able to absorb the levels of external financial assistance either at all or quickly enough; ii) funds will not be spent on reforms to ensure long-term health system strengthening, such as health worker retention and public works such as road building; and iii) donors will not continue to give these funds for long.

Problems with the securitization of health

The notion that collective health security is dominant in global health is underpinned by the assumption that states, specifically Western states, are the referent object under threat. As Rushton (2011, p. 781) summarizes, "[T]he focus tends to be overwhelmingly (albeit implicitly) on securing states against the ingress of disease." As such, collective health security is concerned with preventing potential threats to developed countries – to health, to the economy, or as a matter of non-proliferation of biological weapons and counter-terrorism. This is problematic for several reasons.

One problem is that there is no real empirical basis for the argument that infectious diseases have the potential to cause political instability, especially in the developed world (Burci 2014, pp. 27–39). There are some historical examples of infectious diseases having grave effects on international peace and security. The Plague of Justinian is said to have contributed to the decline of the Eastern Roman Empire in the sixth century CE (Rosen, 2007). The intentional and unintentional introduction of smallpox and other infectious diseases to the Americas had a devastating effect on the local population and facilitated the European colonial conquests (Diamond, 1988). The Black Death, which killed about one-third of the population of Europe, radically changed the relationship between feudal lords and their chattels, resulting in a series of peasant rebellions in Europe and ultimately being a contingent factor in the transition to capitalism (Brenner 1977, p. 25). Nevertheless, there are no recent examples and even the biggest infectious disease outbreaks of modern history – for example, Spanish influenza and HIV/AIDS – have not had a significant negative effect on international peace and security (De Waal, 2010).

Another problem with the dominant form of health securitization is the presumption that disease is the primary source of risk. This constructs a dynamic in which global health actors are focused on the biological determinants of disease. They become focused on developing surveillance systems and 'fighting wars' against outbreaks when and where they occur. This means that the underlying structural causes of epidemics, which are rooted in the lack of access to healthcare and the underlying social, economic and political determinants of health, are overlooked. But unlike states, humans are not immune to the health insecurity that comes with poverty, discrimination or migration. It is apparent, therefore, that collective health security overlooks humans and the idea of human or individual security.

One possible alternative to the dominant view would be to advocate a more people-centred approach to health security. Such an approach would be positive because it would prioritize human life over the interests of the state and society. Nevertheless, it could be argued that individual health security is problematic because it invokes fear in order to legitimize a reaction to health issues. Andrew Lakoff (2010) suggests 'humanitarian biomedicine' as an alternative to the security vision of global health. The former is motivated by a concern for the suffering of others, whereas the latter is implicitly motivated by fear and selfishness (Hofman and Au, 2017). Thus, humanitarian biomedicine aims to alleviate the suffering of individuals in developing countries for its own sake by, for example, taking a long-term approach and building up health systems.

What is more, securitization creates problems that go beyond securitization itself. As public health is increasingly seen as a tool of domestic politics and foreign policy, global health actors become entangled in a wider set of political disputes than would be the case if focus had been solely on public health issues (Elbe, 2006, pp. 119–144). In Syria, for example, the Assad regime has severely

restricted access to organizations providing medical aid to rebel-controlled areas (Kennedy and Michailidou, 2017, pp. 690–98). This has exacerbated the health crisis in these areas. In the most extreme examples, global health programmes are used as a cover for political interventions in foreign states.

Perhaps the most notorious case is that of the Central Intelligence Agency (CIA) of the USA using a fake Hepatitis B campaign in Abbottabad, Pakistan, in a failed attempt to obtain DNA from Osama bin Laden's children prior to his assassination (Kennedy, forthcoming). This led to a boycott of vaccination campaigns in militant-controlled areas of northwestern Pakistan, which was a setback for the global efforts to eradicate polio. After a public outcry, the Obama administration pledged that vaccination schemes would never again be used to collect intelligence (Gambino, 2014). Nevertheless, it is clear that this was not an isolated incident. For example, in 2014 it was revealed that the United States Agency for International Development (USAID) had used HIV prevention workshops in Cuba as a cover for attempts to encourage political opposition (Associated Press, 2014). Such activities undermine trust between health workers and local populations, which is especially problematic in postcolonial countries where a great deal of work has been done to counter mistrust that resulted from the colonial encounter.

Conclusions

Although the securitization of health can be a useful tactic for generating interest and resources, there are a variety of problems associated with it. There is no real empirical basis for securitization. It operates by encouraging feelings of selfishness and fear rather than compassion. It can result in the misallocation of scarce resources in a manner that undermines efforts to extend universal health coverage and improve the social determinants of health. And it can, more generally, lead to the dangerous entanglement of politics and health. As such, the securitization of health should be treated with scepticism by global health activists and academics.

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