The oversecuritization of global health: changing the terms of debate

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The health–security nexus has become a dominant narrative within health policy over the past two decades.[1] While debates on this topic vary in levels of analysis from the global to the national to the individual, as well as in the definition of what can be considered a security threat and in the treatment of the process of becoming securitized,[2] I argue that more recently the global health security narrative, associated governance regime,[3] and the ensuing path dependencies have shifted in three ways. First, the concept has been broadened to the extent that a multitude of health issues (and others) are constructed as threats to health security. Second, securitizing health has moved beyond a rhetorical device to include the direct involvement of the security sector. Third, the performance of health security has become a security threat in itself. These considerations, I argue, alter the remit of the global health security narrative. The global health community needs to recognize this shift and adapt its use of security-focused policies accordingly. This poses important considerations for future developments in health security policy, particularly relating to the longevity of the concept and the need for greater sustainability in global health security interventions.

To support this claim, this article traces the development of health security conceptually. Whereas others have sought to chart development through institutional expansion, policy change or its historical development from the International Sanitary Conferences,[4] here I seek to highlight the different uses of the global health security narrative. In doing so, I demonstrate that, despite an assumption of a narrow, commonly recognized understanding of what constitutes a global

health security concern, the project of global health security has never referred to a unitary whole, but is a dynamic concept that has altered depending on context, pathogen and who/what is at risk. In doing so, I recognize that we have reached a critical juncture in global health security and that now is the time to reflect on what the term can offer and what are the limitations of the policy response in relation to the meaningful control of infectious disease and sustainability of global health. I propose a new typology for global health security to distinguish between global health emergencies, global health security threats, global health security risks and global health security concerns—a categorization that offers a degree of nuance hitherto absent from the global health security narrative.

Beyond rhetoric, fundamental shifts are occurring within global health security, including an encroachment of military activity into this area of health and an increase in the very real risks posed to those undertaking health security work. These shifts raise concerns in relation to entrenched policy path dependencies in global health security and questions whether securitized policy is always the most useful response. As a thought experiment, this article considers whether the use of differentiated terminology within the global health security narrative to reflect the context, risk or activity associated with particular situations may reduce some of the negative externalities associated with the contemporary practices in global health security that I outline below.

Unbundling health security

Health and security have been increasingly connected through the evolution of a particular predominant approach to a global health security narrative,[5] which has become entrenched in the global health landscape and policy-making discourse.[6] This process follows the securitizing logic of the Copenhagen School,[7] according to which any issue can be perceived as a security threat 'not necessarily because a real existential threat exists but because the issue is presented as a threat' to a receptive audience.[8] Thus, the key to this understanding of health securitization is not the actual 'threat' of a pathogen but a successful speech act or narrative 'through which an intersubjective understanding is constructed within a political community to treat something as an *existential threat* to a *referent object* by a *securitising actor*, [generating] endorsement of *emergency measures* beyond the rules that would otherwise bind',[9] or a suspension of so-called 'normal politics'. A narrow understanding of the global health security narrative suggests that pathogens can be considered threats when characterized by fast-moving transmission, little scientific knowledge of the disease, no known treatment or cure, or high mortality or morbidity, or when they are associated with a particular visceral fear of pain

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[5] Davies et al., *Disease diplomacy*.
[6] Institute of Medicine, *Emerging infections: microbial threats to health in the United States* (Washington DC: National Academies Press, 1992).
[7] Barry Buzan, Ole Wæver and Jaap de Wilde, *Security: a new framework for analysis* (Boulder, CO, and London: Lynne Rienner, 1998).
[8] Buzan et al., *Security*, p. 24.
[9] Buzan et al., *Security*, p. 5 (emphasis added).

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or suffering.[10] When a pathogen of this kind emerges, the legal and normative workings of the global health security regime (re)produce a particular policy response which is focused on preparedness for, detection of and response to acute infectious diseases.[11]

Yet the meanings of both 'health' and 'security' in the global health security narrative have varied depending on the immediate pathogen posing a threat, reflecting the dynamism of this concept. For HIV/AIDS, the security–health nexus constructed a narrative based on the more traditional security threat posed to militaries with high prevalence of the virus (with infection rates as high as 50 per cent in some African forces[12]) which may affect the ability of the army to perform its function and could therefore have a direct impact on state security.[13] This perpetuated a further concern that HIV/AIDS might lead to state instability as societal structures crumbled owing to lack of capacity, overwhelming demand on social provision and fearmongering, leading to a potential breakdown of social norms.[14] Although Fourie has argued that these societal impacts have yet to be witnessed,[15] McInnes and Rushton show that there had to be some real risk underlying this construction of the broader health security narrative, to get an audience to accept the security process.[16]

For pandemic influenza and related illnesses, including major global outbreaks of SARS, H1N1 and H5N1 influenzas, this conceptualization of security moved beyond military concerns, recognizing the (potential) impact of a pathogen on the global population, and importantly the risk to western populations. Moreover, the construction of the security narrative recognized the risk to a state's or region's economy arising from alterations to patterns of travel and/or trade.[17] This is a different understanding of security from that associated with HIV/AIDS, for which the referent object of the threat remains the state; yet importantly the manifestation of the threat changes to reflect differing objectives of the global health security narrative.

For Ebola, the logic of security is quite different. Owing to rigorous infection control protocols, Ebola would not pose the same threat to states in the global

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[10] Enemark, *Disease and security*; Andrew Price-Smith, *The health of nations: infectious disease, environmental change, and their effects on national security and development* (Cambridge, MA: MIT Press, 2002).

[11] Rushton, *Security and public health*; United States Centers for Disease Control and Prevention, *The global health security agenda* (Atlanta, GA, 27 Jan. 2016), https://www.cdc.gov/globalhealth/security/ghsagenda.htm. (Unless otherwise noted at point of citation, all URLs cited in this article were accessible on 19 July 2019.)

[12] Colin McInnes and Kelley Lee, 'Health, security and foreign policy', *Review of International Studies* 32: 1, 2006, pp. 5–23.

[13] Colin McInnes and Simon Rushton, 'HIV/AIDS and securitization theory', *European Journal of International Relations* 19: 1, 2013, pp. 115–38; Stefan Elbe, 'Risking lives: AIDS, security and three concepts of risk', *Security Dialogue* 39: 2–3, 2008, pp. 177–98; M. David, 'Rubber helmets: the certain pitfalls of marshalling Security Council resources to combat AIDS in Africa', *Human Rights Quarterly* 23: 3, 2001, pp. 560–82.

[14] McInnes and Rushton, 'HIV/AIDS and securitization theory'.

[15] Pieter Fourie, 'The relationship between the AIDS pandemic and state fragility', *Global Change, Peace and Security* 19: 3, 2007, pp. 281–300.

[16] McInnes and Rushton, 'HIV/AIDS and securitization theory'.

[17] Thomas Abraham, 'The chronicle of a disease foretold: pandemic H1N1 and the construction of a global health security threat', *Political Studies* 59: 4, 2011, pp. 797–812; Melissa Curley and Jonathan Herington, 'The securitization of avian influenza: international discourse and domestic politics in Asia', *Review of International Studies* 37: 1, 2014, pp. 141–66.

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North that promote the dominant global health security narrative,[18] and therefore its construction as a security threat reflects yet again something different from HIV/AIDS and pandemic flu. Enemark[19] suggests that the security focus within the west Africa Ebola outbreak of 2014–16 was on securing circulation of the pathogen within a public health sphere to protect the population, an important tenet which may not have been so evident in previous outbreaks. Conversely, President Obama suggested that the outbreak threatened state stability in post-conflict west Africa.[20] The Ebola outbreak which started in 2018 in the Democratic Republic of Congo (DRC) threatens regional stability owing to cross-border risk of the disease's spread but this is not constructed as a risk with the same immediacy. The DRC has exceptionally weak state and health infrastructure, without the same levels of investment in post-conflict reconstruction as witnessed in Sierra Leone and Liberia; this may, in part, explain the delay in the construction of this latter outbreak as an emergency. An alternative explanation might be that by 2014 the global health security narrative had become so entrenched in global policy that it produced a recognized path dependency for the west African outbreak, which was therefore inevitably perceived as a security threat.

A similar path dependency was a driving force for the global health security construction of the Zika outbreak of 2015–16. This emerged straight after the west African Ebola crisis, and thus amid a heightened global normative assumption of securitized pathogens;[21] yet here the use of the global health security concept was different again. Instead of concern for the military, trade or travel restrictions, or the circulation of pathogens, the security process, as epitomized in the declaration of the Public Health Emergency of International Concern (PHEIC), was related not to the virus, but to the uncertainty surrounding the causal link between the virus and microcephaly, the innocence of newborns as the affected population, and concern for the forthcoming Olympic Games in Brazil.

The important point to draw from these empirical examples is the dynamism and variance inherent in the use of the term 'global health security'. This suggests that there are multiple grammars of security in the global health security narrative, and that there is a poor vocabulary within the international community to describe what global health security entails. I suggest that this variance should be reflected in the language used to distinguish different health issues within the global health security narrative and to delineate more clearly what response is required. This is especially important in contemporary discourse, owing to the number of recent developments in both the narrative and practice of global health security.

[18] Simon Rushton, 'Global health security: security for whom? Security from what?', *Political Studies* 59: 4, 2011, pp. 779–96.

[19] Christian Enemark, 'Ebola, disease control and the Security Council: from securitization to securing circulation', *Journal of Global Security Studies* 2: 2, 2017, pp. 137–49.

[20] White House, Office of the Press Secretary, 'Remarks by President Obama at UN meeting on Ebola', 25 Sept. 2014, https://obamawhitehouse.archives.gov/the-press-office/2014/09/25/remarks-president-obama-un-meeting-ebola.

[21] Clare Wenham and Deborah Barros Leal Farias, 'Securitizing Zika: the case of Brazil', *Security Dialogue*, 2019, https://doi.org/10.1177/0967010619856458.

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While such a differentiation has started to emerge through the language of risk,[22] I argue that the various terms used to describe outbreak events, including global health emergencies, global health security crises, global health security threats and global health security concerns, need to be defined more clearly. These definitions should be embedded in a collective, institutionalized understanding to demonstrate the range of meanings implicit within the expressions chosen, including the differing severity of the event and the role of the global health security regime, to ensure that an appropriate response is mounted relative to the risk posed to global health security in each case. This in turn may limit some of the unintended consequences of the global health security narrative that I outline below.

Developments in health security

This nuancing of 'global health security' is required owing to three important changes in the last decade. First, what is constructed as a security threat has expanded beyond what has been previously recognized by the global health security regime, and the new breadth requires a new delineation of terminology to allow the rhetorical tool an efficacious response for the next 'big one'. Second, military involvement in health security activities constitutes a move away from a global health security narrative based on the logic of the Copenhagen School to a more traditional, 'boots on the ground' security response to an external threat. This has tangible repercussions for global health security operations, and risks jeopardizing future acceptance by global audiences of global health security interventions if they perceive them as military interventions, and thus also jeopardizing the ability to enact extraordinary measures which may be required. Third, global health security is now facing an ontological threat as those undertaking this activity have themselves become security targets.

Everything is a security issue

A key element in understanding the new security–health nexus is the recognition that too many health issues are now framed within the global health security narrative. This entrenched narrative, based on the centrality of the speech act,[23] has been used by a range of policy-makers and practitioners who are aware of the political and financial benefits to be derived from elevating an issue to the security arena.[24] It is important to understand the implications of this expansive move, and to ask whether it risks the legitimacy of the concept for limiting the cross-border spread of infectious disease and what risks it poses in normalizing security interventions. Consequently, I argue that it is important to offer a series of rhetorical

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[22] McInnes and Roemer-Mahler, 'From security to risk'.
[23] Jutta Weldes, *Cultures of insecurity: states, communities, and the production of danger* (Minneapolis: University of Minnesota Press, 1999); Didier Bigo and Anastassia Tsoukala, *Terror, insecurity and liberty: illiberal practices of liberal regimes after 9/11* (Abingdon: Routledge, 2008).
[24] Rushton, 'Global health security: security for whom?'.

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distinctions to differentiate the various types of global health security event in order to enable us to recognize the 'big one' when it occurs.

While the global health security narrative has, to date, had a narrow understanding of what constitutes a health security concern, based on rapid spread, unfamiliarity and an absence of effective treatment,[25] contemporary discourse in and beyond health policy has framed a number of broader issues as health security threats. These have included maternal health,[26] mental health,[27] non-communicable disease,[28] access to contraception,[29] reproductive health,[30] migration,[31] food security,[32] counterfeit medicines,[33] universal health coverage,[34] climate change,[35] water and sanitation,[36] salty foods[37] and even Brexit.[38] While those who perceive security at the human level may suggest that each of these issues may produce individual insecurity, it seems overstretch to attempt to put these all onto a global security agenda.

In one interpretation, this expansion of threats to health security is embodied in the WHO's naming of 'Disease X' as a priority research need. As stated, 'Disease X represents the knowledge that a serious international epidemic could be caused by a pathogen currently unknown to cause human disease'.[39] So ambiguous a formulation raises concern that the door might be opened to a range of diseases

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[25] Enemark, *Disease and security*; Price-Smith, *The health of nations*.

[26] Maisha Reza, 'Is maternal health an issue of security?', 2017, https://maishareza.com/is-maternal-health-an-issue-of-security/.

[27] Stewart M. Patrick (and Ryan Fedasiuk), *Silent suffering: mental health as a global health priority* (New York: Council on Foreign Relations, 7 April 2017), https://www.cfr.org/blog/silent-suffering-mental-health-global-health-priority.

[28] Amrita Saha and George Alleyne, 'Recognizing noncommunicable diseases as a global health security threat', *Bulletin of the World Health Organization* 96: 11, 2018; Kostova Deliana et al., 'Synergies between communicable and noncommunicable disease programs to enhance global health security', *Emerging Infectious Disease Journal* 23: 13, 2017; David L. Heymann, 'The sugar tax—a "nanny state" levy that could save lives', *Daily Telegraph*, 9 April 2018; Stockholm International Peace Research Institute, 'On non-communicable diseases and security', *WritePeace blog*, 8 Nov. 2011, https://www.sipri.org/commentary/blog/2011/non-communicable-diseases-and-security.

[29] Meba Kagone, Eric Takang, Antoine Ndiaye, Olga Sankara and Ernest Ouédraogo, 'West Africa reproductive health commodity security; country assessment report: Burkina Faso', ed. John Snow (Arlington, VA: US Agency for International Development, 2005), https://www.rhsupplies.org/uploads/tx_rhscpublications/DOC21.pdf.

[30] UN Population Fund, 'Investing in sexual and reproductive health key to global health security, UNFPA head tells World Health Assembly', 15 May 2007, https://www.unfpa.org/press/investing-sexual-and-reproductive-health-key-global-health-security-unfpa-head-tells-world.

[31] David L. Heymann et al., 'Global health security: the wider lessons from the west African Ebola virus disease epidemic', *The Lancet* vol. 385: 9980, 2015, pp. 1884–901.

[32] Scientific Advisory Board of the UN Secretary-General, *Food security and health*, policy brief (Paris: UNESCO, 2016).

[33] Heymann et al., 'Global health security'.

[34] Vageesh Jain and Azeem Alam, 'Redefining universal health coverage in the age of global health security', *British Medical Journal: Global Health* 2: 2, 2017, e000255.

[35] WHO, Regional Office for the Eastern Mediterranean, *Technical discussion on climate change and health security*, EM/RC55/Tech.Disc.1 (Cairo, 2008), http://applications.emro.who.int/docs/EM_RC55_tech_disc_1_en.pdf.

[36] Kathleen O'Reilly, 'From toilet insecurity to toilet security: creating safe sanitation for women and girls', *Wiley Interdisciplinary Reviews: Water* 3: 1, 2016, pp. 19–24.

[37] Dan Glickman and Ann Veneman, 'Salty school lunches: our real national security threat', *Chicago Tribune*, 28 February 2019.

[38] Danielle Solomon, 'Brexit and health security: why we need to protect our global networks', *Journal of Public Health Policy* 40: 1, 2019, pp. 1–4.

[39] WHO, *List of blueprint priority diseases* (Geneva, 2016).

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to muscle in on the health security narrative if political conditions allow, further weakening the narrative's meaning.

This expansion of the range of issues which have been framed in health security terms raises new questions for studying health security. For example, just as critics of human security have suggested,[40] trying to fit too much under the umbrella of global health security may result in the concept becoming diluted or losing the political saliency which has encouraged activity, resource generation and decisive action in the prevention and detection of, and response to, highly pathogenic infectious disease. As Gavin Yamey pointed out, if health security continues on its current trajectory, it is only a matter of time before we see 'toe nail fungus: a threat to global health security'.[41]

Even so, not all efforts to incorporate new health issues into the global health security narrative have been successful. Securitization requires the acceptance of the threat by an audience; and while policy-makers may try to securitize any one of the concerns listed, through the use of the established narrative, that is not to say they will succeed; and indeed, I would argue that none on this list has achieved security status as yet.

The irony of this is, however, that various lobby groups and policy advocates have used the global health security terminology precisely as a mechanism to push their concerns up the political agenda, recognizing that security gets to the top levels of decision-making in national, regional and global forums. Yet the outcome of hijacking this discourse to serve issues which do not fit the criteria of the fast-moving and unknown pathogen is the erosion of the power that the global health security narrative may have in the future. The risk for infectious disease control is that 'crying wolf' from other health policy areas may have a substantially detrimental impact on the response to a potentially catastrophic outbreak. Global health security fatigue becomes a real concern, limiting the acceptance of the global health security rhetoric by audiences across the world and in turn leading to a failure to endorse emergency measures. Thus, this broadening of the health security discourse can actually prove cannibalistic to the concept itself, if the global audience either tires of the global health security narrative, or starts to accept the expanding securitization formula.

A counter-argument is that there is a mismatch between academics' and policy-makers' understandings of what health security is, and how the concept was initially conceived. In the foundational *World Health Report* of 2007, the risks posed to health security are defined as ranging from emerging pathogens to economic instability, international crises and humanitarian emergencies, chemical, radioactive and biological terror threats, environmental change and weak health systems.[42] Thus, an alternative explanation is not that there has been an expansion of issues considered to be health threats, but that the concept has

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[40] Ken Booth, *Critical security studies and world politics* (Boulder, CO: Lynne Rienner, 2005); S. Neil MacFarlane and Yuen Foong Khong, *Human security and the UN: a critical history* (Indianapolis: Indiana University Press, 2006); Roland Paris, 'Human security: paradigm shift or hot air?', *International Security* 26: 2, 2001, pp. 87–102.
[41] Gavin Yamey, Twitter communication @GYamey, 5 November 2018.
[42] WHO, *World Health Report 2007: A safer future: global public health security in the 21st century* (Geneva, 2007).

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not been used to the extent intended by the norm entrepreneurs that championed its use.[43]

What's more, overusing the global health security narrative perpetuates the global health security policy path dependency and increases the likelihood of a securitized response as the first course of action, and the likelihood of further security risks. Changing the terms of debate within this global health security narrative, such as by more clearly distinguishing between global health emergencies, global health security crises, global health security risks and global health security concerns, may reduce the need for military involvement in some areas of more routine activity, such as preparedness, and thus reduce the ongoing risks posed to health security workers.

Securitizing health or healthifying security?

The traditional approach to understanding health as a security threat is hypothetical. The flexibility within the Copenhagen School means that a pathogen doesn't actually have to pose an objective risk, as long as it is constructed as such. Yet, beyond the rhetorical device that produces a policy pathway based on prevention, detection and response, a more recent trend in global health security has been the involvement of the military in global health security operations. This takes health security beyond a rhetorical tool and represents a new point of departure for analysis.

While militaries have been at the forefront of advances in public health since the eighteenth century,[44] this involvement largely took the form of medical research (as in the US Walter Reed Army Institute of Research), surveillance,[45] or disaster response (following flooding in Pakistan or the Haiti earthquake).[46] However, as Michaud and colleagues point out, 'the trend of the past two decades has been towards greater military engagement in global health [security]'.[47] This trend has included China's domestic military participation in preparation for and response to influenza outbreaks,[48] Peru's military-led surveillance network, Thailand's military HIV screening activities,[49] Brazil's militarized

[43] Adam Kamradt-Scott, 'The WHO secretariat, norm entrepreneurship, and global disease outbreak control', *Journal of International Organizations Studies* 1: 1, 2010, pp. 72–89.

[44] Geoffrey Quail, 'The debt tropical medicine owes to the military', *Journal of Military and Veterans' Health* 23: 3, 2015, pp. 18–21.

[45] Philip Brachman, Heather O'Maonaigh and Richard Miller, eds, *Perspectives on the Department of Defense global emerging infections surveillance and response system: a program review* (Washington DC: National Academies Press, 2001), ch. 4, 'GEIS at the Armed Forces Research Institute of Medical Sciences, Thailand'.

[46] Derek Licina, 'The military sector's role in global health: historical context and future direction', *Global Health Governance* 6: 1, 2012, pp. 1–30.

[47] Joshua Michaud et al., 'Militaries and global health: peace, conflict, and disaster response', *The Lancet* 393: 10168, 2019, pp. 276–86.

[48] Hui Ma Ji-Ping Dong, Na Zhou and Wei Pu, 'Military–civilian cooperative emergency response to infectious disease prevention and control in China', *Military Medical Research* 3: 1, 2016, https://doi.org/10.1186/s40779-016-0109-y.

[49] Jean-Paul Chretien, David Blazes, Rodney Coldren, Michael Lewis, Jariyanart Gaywee, Khunakorn Kana, Narongrid Sirisopana, Victor Vallejos, Carmen C. Mundaca, Silvia Montano, Gregory Martin and Joel Gaydos, 'The importance of militaries from developing countries in global infectious disease surveillance', *Bulletin of the World Health Organization* 85: 3, 2007, pp. 174–80.

vector control,[50] and armed forces management of cholera in Zambia.[51] Even so, all these instances have involved domestic military activity within a state's own borders and at the discretion of the sovereign government. This is conceptually different from the parallel shift in global health security with the involvement of international militaries to respond to external infectious disease concerns.

The west African Ebola outbreak of 2013–15 witnessed the deployment of international militaries from China, Canada, France, Germany, the United Kingdom and the United States, among others, in the global health security response. This represented a gear change for health security and a different *modus operandi*. The deployment of an international military force in a health emergency represents a physically securitized practice, beyond rhetoric, with boots on the ground to combat a disease threat.[52] The remit and activity of the different militaries varied, ranging from the building of Ebola treatment facilities, treatment of compatriot staff, training of health workers, treatment of locals affected and establishment of command-and-control structures for maintaining contact tracing and quarantine areas.[53]

In west Africa, the military were broadly perceived to have been pivotal in bringing the outbreak to an end. The discourse of exceptionalism and widespread failures around Ebola in west Africa may suggest that drastic times called for drastic measures; and the call for the military as an actor of last resort was made after other government and international mechanisms had failed to manage the response.[54] Regardless of the role performed or the justification advanced, these deployments are important in a broader analysis of global health security as they moved health security beyond the rhetorical threat of disease to a real security presence operationally deployed beyond sovereign borders.

During the Zika outbreak, emerging not long after the west African Ebola episode, the (national) military was used as the first option to combat the disease threat. The Rousseff government in Brazil galvanized support for this activity through bellicose language—for example, referring to a 'war on the mosquito'— and in doing so justifying the military's vital role. Sixty per cent of the national armed forces were deployed to combat the Zika virus through extensive vector control, fumigation programmes and health education activities.[55] This not only established the military in a central role in managing health security in Brazil; it

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[50] Sean Michael Griffing, Pedro Luis Tauil, Venkatachalam Udhayakumar and Luciana Silva-Flannery, 'A historical perspective on malaria control in Brazil', *Memorias do Instituto Oswaldo Cruz* 110: 6, 2015, pp. 701–18.

[51] 'Zambia president orders military to help fight cholera spread', Reuters, 30 Dec. 2017, https://uk.reuters.com/article/uk-zambia-cholera/zambia-president-orders-military-to-help-fight-cholera-spread-idUKKBN1E-O03X.

[52] Michaud et al., 'Militaries and global health'.

[53] Adam Kamradt-Scott, Sophie Harman, Clare Wenham and Frank Smith III, *Saving lives: the civil–military response to the 2014 Ebola outbreak in west Africa* (Sydney: University of Sydney, 2015).

[54] Sophie Harman and Clare Wenham, 'Governing Ebola: between global health and medical humanitarianism', *Globalizations* 15: 3, 2018, pp. 362–76.

[55] Government of Brazil, 'Pronunciamento da Presidenta da República, Dilma Rousseff, em cadeia nacional de rádio e televisão, sobre o vírus Zika', 3 Feb. 2016, http://www.biblioteca.presidencia.gov.br/presidencia/ex-presidentes/dilma-rousseff/discursos/discursos-da-presidenta/pronunciamento-da-presidenta-da-republica-dilma-rousseff-em-cadeia-nacional-de-radio-e-televisao-sobre-o-virus-zika.

signalled a broader systematic change for health security in normalizing the use of security forces in emergency response to infectious disease.

This normalization can be seen in other contexts. In Pakistan, the military have been deployed to accompany workers delivering polio vaccines in an effort to ensure greater distribution and uptake of immunization.[56] Similarly in the DRC, the military and police have provided escorts to health workers in Ebola response efforts.[57] Beyond operationalized response to specific outbreaks, the role of the military has been elevated to having a seat at the table within the global health security regime: militaries have been considered pivotal to the Global Health Security Agenda, incorporated in standing committees and action plans including those of Bangladesh, Guinea, Sierra Leone and Vietnam.[58] Similarly, the inaugural Military Health Summit occurred in connection with the first major global health security conference in 2019. The result is that the military are undeniably and increasingly recognized as a key stakeholder in global health security operations.

One question raised by this involvement of the military in health security activity is whether they are securitizing health, or simply healthifying security. There are several possible reasons for this increased military involvement in global health security activity, including the availability of personnel and of biosecurity training and equipment, a lack of response capability in the health sector and simply the self-fulfilment of securitizing health. It is also important to remember that the increasing role of the military in global health security has occurred during a period of (relative) peace, and—particularly for western states—it could be that the role of the military in health security represents both 'mission creep' and the need to find 'jobs for the boys' to legitimize military spending. For example, anecdotal discussions during the west African Ebola outbreak queried the possibility of a link between deployment of the UK military and the planned military spending review in 2020.[59] This raises a host of concerns about the role of the military, and the risks posed to health security by their involvement. First, does such involvement defy the Oslo Guidelines, according to which state militaries should be used only as a last resort when 'there is no comparable civilian alternative … to meet a critical humanitarian need'?[60] Second, what would happen if an outbreak were to occur when the military are engaged in more traditional war-related activities and/or in a location where international or national militaries had been recent combatants, as in the DRC? This could create a further risk to the

[56] Ryan Hyland, 'Polio's last stand: frantic effort to eradicate Pakistan's "badge of shame"', *Guardian*, 15 March 2017.

[57] Anne Gulland and Louise Dewast, 'Congo at a knife edge as number of cases of Ebola continues to rise', *Daily Telegraph*, 23 May 2018; Anne Gulland, 'MSF condemns "militarised" response to Ebola outbreak', *Daily Telegraph,* 7 March 2019; David Miliband, 'The response to DRC's Ebola crisis isn't working: here's what we need to do', *Guardian*, 15 July 2019, https://www.theguardian.com/commentisfree/2019/jul/15/democratic-republic-of-the-congo-drc-ebola-crisis-outbreak.

[58] Michaud et al., 'Militaries and global health'.

[59] Personal communication with military sources.

[60] United Nations Office for the Coordination of Humanitarian Affairs (OCHA), *Oslo Guidelines: guidelines on the use of foreign military and civil defence assets in disaster relief* (2007), https://www.unocha.org/sites/unocha/files/OSLO%20Guidelines%20Rev%201.1%20-%20Nov%2007_0.pdf.

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maintenance of health security if they were no longer able to perform the role that the globe expects of them because their involvement in recent incursions poses further security risks.

There needs to be further consideration of when, and under what conditions, militaries should be engaged in global health security. Should such involvement be kept for just the 'big ones', or should it be used for routine activities such as preparedness as well? Greater specification of language within the global health security narrative could provide clear guidance on the circumstances in which military forces can and cannot be used in global health security contexts: for example, perhaps for global health emergencies, but not for global health security concerns or preparedness activity.

Risks to health workers in securitizing health

There is clearly an occupational hazard to anyone who responds to an outbreak of infectious disease. The number of health care workers who die as a result of the care they provide in global health security events is well known, and the high-profile deaths of leading global infectious disease specialists such as Carlo Urbani and Richard Mousoko during major outbreaks have made this risk ever more visible.[61] During the west Africa Ebola outbreak, several NGOs found it hard to recruit volunteers to join the response effort for fear of contracting the virus;[62] this is one reason why the military were required. More recently, the risk to individual safety has become manifest beyond infection and through more traditional security concerns. Perhaps as a consequence of the increased securitization and militarization of global health, the blurring of health and security activities now poses an ontological paradox as global health security now represents a security risk in itself.

The broader trend of health workers coming under attack is unfortunately an increasingly common feature of global health reality. Attacks on health care workers have occurred in many areas, including Afghanistan, the Central African Republic, Pakistan, South Sudan, Syria and Yemen,[63] with combatants unable to distinguish between warring factions, military forces and aid workers.[64] This raises a number of challenges for post-conflict reconstruction, development and civilian health, and also for the cost–benefit analysis of military involvement in health activity more broadly.

This trend has also started to become apparent in global health security activities. A securitized response to health issues tends to focus on the short-term such

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[61] Brigg Reilley, Michael Van Herp, Dan Semand and Nicoletta Dentico, 'SARS and Carlo Urbani', *New England Journal of Medicine*, vol. 348, 15 May 2003 ,pp. 1951–2; Fiston Mahamba, 'Militiamen kill senior WHO official in attack on Congo Ebola centre', Reuters, 19 April 2019, https://uk.reuters.com/article/uk-health-ebola-congo/militiamen-kill-senior-who-official-in-attack-on-congo-ebola-centre-idUKKCN1RV119.

[62] Kamradt-Scott et al., *Saving lives*, p. 8.

[63] WHO, *Surveillance System for Attacks on Healthcare (SSA)*, 2017, https://publicspace.who.int/sites/ssa/SitePages/PublicDashboard.aspx; Preeti Patel, Fawzia Gibson-Fall, Richard Sullivan and Rachel Irwin, 'Documenting attacks on health workers and facilities in armed conflicts', *Bulletin of the World Health Organization* 95: 1, 2017, pp. 79–81.

[64] Rachel Irwin, *Violence against health workers in complex security environments*, background paper (Stockholm: Stockholm International Peace Research Institute, 2014).

as surveillance, disease detection, and the development and deployment of vaccines and treatment; and it is these very activities which are now coming under attack.

Military actors have had to accompany health workers vaccinating children against polio in Pakistan, in order to protect them from Taliban fighters following the US-led capture of Osama bin Laden using polio workers.[65] These troops support health care workers in the facilitation and delivery of vaccines among the population to reduce the incidence of this major global health security threat (which continues to be a PHEIC).[66] However, these security forces themselves then become a secondary target alongside the health workers they were sent to protect, who continue to suffer attacks.[67] Accordingly, being part of the global health security machinery through the delivery of the polio vaccine poses a dual threat—not only that of potentially contracting the disease, but that of physical attack owing to your occupation.

More recently, this ontological crisis was mirrored in the Ebola outbreak in west Africa, when community resistance to WHO teams turned violent and some WHO workers were killed.[68] There are multiple and complex reasons for this, among them a lack of meaningful community engagement with locals at the start of the outbreak, a deep mistrust of government and wariness of external interference among local people suspicious of land appropriation by multinational enterprises for resource extraction.[69] This violence included attacks on WHO teams in Guinea and others driven into hiding in the bush, their equipment subject to vandalism and arson.[70]

A similar security risk is also evident in the current Ebola outbreak in the DRC. The outbreak is taking place in a complex political situation on disputed territory, with attacks by a number of non-state armed groups on health workers and health facilities thwarting efforts to put an end to the epidemic.[71] There have been arson attacks on Ebola treatment units, attacks on health care workers, and broader instability and insecurity affecting response efforts. Such attacks have a direct effect on disease transmission: if those trying to control the spread of the disease have to halt their response activity, the virus is able to spread unchallenged.[72]

These traditional security risks embedded within global health security activity pose a number of concerns. First there is the circular phenomenon whereby those

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[65] Saeed Shad, 'CIA organised fake vaccination drive to get Osama bin Laden's family DNA', *Guardian*, 11 July 2011.

[66] WHO, *Statement of the nineteenth IHR Emergency Committee regarding the international spread of poliovirus*, 30 Nov. 2018, https://www.who.int/news-room/detail/30-11-2018-statement-of-the-nineteenth-ihr-emergency-committee-regarding-the-international-spread-of-poliovirus.

[67] 'Pakistan polio: seven killed in anti-vaccination attack', BBC News, 20 April 2016, https://www.bbc.co.uk/news/world-asia-36090891.

[68] James Fairhead, 'Understanding social resistance to the Ebola response in the forest region of the Republic of Guinea: an anthropological perspective', *African Studies Review* 59: 3, 2016, pp. 7–31.

[69] Fairhead, 'Understanding social resistance'.

[70] WHO, *Ground zero in Guinea: the Ebola outbreak smoulders, undetected, for more than 3 months* (2014), https://www.who.int/csr/disease/ebola/ebola-6-months/guinea/en/.

[71] Vinh-Kim Nguyen, 'An epidemic of suspicion: Ebola and violence in the DRC', *New England Journal of Medicine*, vol. 380, 2019, pp. 1298–9.

[72] Adrian Blomfield, 'Ebola outbreak spreads as war and disease threaten perfect storm', *Daily Telegraph*, 26 Oct. 2018.

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working in global health emergency response themselves become the object of a different security threat and find themselves in the firing line. This may have a damaging impact on future recruitment into global health security-related activity. Second, if health care workers are unable to carry out their jobs, emergency response efforts will be limited, increasing the risk to global health security of the spread of the pathogen. Such security concerns have had direct impacts on the response to Ebola in the DRC, with WHO and MONUSCO forces agreeing that the security situation will directly lead to an increase in cases of infection,[73] for example when those undertaking contact-tracing are disrupted in their efforts and lose track of their work, which is so vital to the success of any disease control strategy.[74] Third, there is a broader impact on preparedness within global health security. For example, if children are not vaccinated against polio, the risk of disease transmission rises.

Accordingly, we are witnessing an unusual turn in the security–health nexus whereby the practice of health security now poses its own security threat. This will need to be considered in depth, and a sophisticated management plan developed that offers a clear way forward to ensure the safety of those working on the front line of health security and their ability to carry out their activities without coming to harm, as well as to ensure global health security more broadly. This will require self-reflection within the global health security regime to identify the shortcomings and risks associated with military involvement and to assess whether the continued focus on prevention, detection and response remains the most suitable policy pathway in the face of more systemic development needs, or whether current approaches may in fact perpetuate insecurity and inequalities.

Emergencization and normalization

Initially, the global health security narrative was used as a rhetorical tool by health policy-makers to justify extraordinary measures to combat the rare crisis events, leveraging more attention to and financing for responses to emerging infectious diseases. However, the increased normalization of the discursive tool, which has moved beyond words to operationalized action, suggests that perhaps health security is no longer the exception but the norm in global health policy, raising questions of its utility as a concept. What will an extraordinary response to the next 'big one' look like if extraordinary has become the norm? What does this mean for dealing with large-scale outbreaks—and, conversely, for the more endemic, everyday health issues which may find themselves further relegated down the list of prioritized activities in global health?

One concern is that, with the frequent use of the global health security narrative, the global health community has created a perpetual state of emergency and routinized health security to the extent that it barely seems shocked when

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[73] 'DR Congo: insecurity and attacks mean Ebola will keep spreading, warns World Health Agency', UN News, Geneva, 1 March 2019, https://news.un.org/en/story/2019/03/1033842.
[74] Blomfield, 'Ebola outbreak spreads'.

another health emergency arises.[75] Compare, for example, the response to the ongoing Ebola outbreak in the DRC and that to the west African outbreak of 2014–16. It took four meetings of the Emergency Committee of the International Health Regulations (IHR) for the DRC Ebola outbreak to be declared a PHEIC, despite the legal criteria having been met long before. Moreover, there has been considerably less mainstream media coverage of this outbreak globally. Although these outbreaks are markedly different in scale and context, the contrast may also suggest a fatigue in the global health security narrative.[76]

I propose that one solution would be to create a typology within the global health security narrative to distinguish the different types of concerns. This might entail reserving the term 'global health emergency' for the really big events, with a tiered scale below this level for global health security crises, global health security threats and, for smaller issues, global health security concerns, as well as encouraging the greater use of regional, national and local language to describe health security threats. While this would raise the challenging possibility of those pathogens and events lower down the typology not getting the desired attention, and the potential for further discrepancies between financing mechanisms and actors involved within the tiered structure, the use of relevant language would enable global health security to maintain its legitimacy. In effect, this principle is already embodied within the PHEIC process and the Pandemic Emergency Financing Facility (PEF), each of which is deployed only for an exceptional event. However, there is currently a mismatch between these labels and the broader global health security narrative—and, importantly, global health security activity. Securitized responses are evident prior to PHEIC declarations and beyond PEF-eligible pathogens. There should be greater consistency within the global health security regime and narrative to reserve the intended power of global health security for those situations in which it is most urgently needed. This typology mirrors previous calls to include a gradient system in the PHEIC process, to denote exigent outbreaks which need international support and increased financing while allowing the PHEIC to maintain its power for major events.[77]

Changing the terminology in this way may also facilitate better evaluation of the use of the military in global health security, particularly in more routine health security provision, such as preparedness and capacity-building. The reduction of such activity may possibly—though this is speculative—reduce the risks posed to health care workers within health security operations.

Sustainability

A further point on which global health security needs to reflect is the tendency of securitized responses to favour short-term, reactive, fire-fighting policy and

[75] Tine Hanrieder and Christian Kreuder-Sonnen, 'Who decides on the exception? Securitization and emergency governance in global health', *Security Dialogue* 45: 4, 2014, pp. 331–48.
[76] Janet Baseman, Debra Revere, Ian Painter, Mariko Toyoji, Hanne Thiede and Jeffrey Duchin, 'Public health communications and alert fatigue', *BMC Health Services Research* 13: 1, 2013, pp. 1–8.
[77] Lawrence O. Gostin and Rebecca Katz, 'The International Health Regulations: the governing framework for global health security', *Millbank Quarterly* 94: 2, 2016, pp. 264–313.

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response mechanisms. 'Parachute' activities, where financial, human and medical resources are pumped into an outbreak location to quell a particular pathogen may stop the spread of a disease at that time,[78] but do little to systematically address the socio-economic factors that make some populations and individuals particularly susceptible or vulnerable to disease. This question of sustainability is rarely considered within the global health security narrative and raises a number of inconvenient truths. For example, during the Zika outbreak, the fumigation of vectors and destruction of their breeding grounds may have reduced the incidence of the virus in 2016–17, but will not prevent future outbreaks. Temporarily destroying vectors does not address the socio-economic conditions that allow mosquitoes to thrive—such as a lack of water and sanitation, poor-quality housing and inadequate civic waste management that all could create breeding grounds for mosquitoes, nor does it challenge the gender inequalities which are mostly ignored in outbreaks. Taking a more sustainable approach in responding to an outbreak, through addressing these broader global health security risk factors, might yield longer-lasting success. Global health security needs to consider the balance between a short-term focus and making lasting changes to improve outbreak preparedness.

Similarly, the fire-fighting response to managing the west African Ebola outbreak was achieved by channelling all national and local health resources and activity into Ebola prevention, detection and response. The cost of this was a significant reduction in essential primary health services in the affected states,[79] including in childhood immunization programmes and in maternal and child health services,[80] which raises a number of questions about equity across the health system and the impact that a health security event can have across health and societal systems.

The recent move to connect global health security to universal health coverage (UHC), as championed by WHO Director-General Tedros Adhanom, may offer a greater opportunity for sustainability, as the globe moves towards more comprehensive, accessible, affordable health care for all. UHC expansion would lead to system strengthening in the health sector and would allow for earlier detection of infectious disease through routine provision of health care, for example through more frequent visits to health services.[81] It would also facilitate broader sustainability in the health sector through systematic engagement in response to infectious diseases. Yet, while offering hope for sustainability, the instrumentalist nature of

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[78] Nathan Yozwiak, Christian Happi, Donald Grant, John Schieffelin, Robert Garry, Pardis Sabeti and Kristian Andersen, 'Roots, not parachutes: research collaborations combat outbreaks', *Cell* 166: 1, 2016, pp. 5–8.

[79] Bradley Wagenaar, Orvalho Augusto, Jason Beste, Stephen Toomay, Eugene Wickett, Nelson Dunbar, Luke Bawo and Chea Sanford Wesseh, 'The 2014–2015 Ebola virus disease outbreak and primary healthcare delivery in Liberia: time-series analyses for 2010–2016', *PLOS Medicine* 15: 2, 2018, pp. 1–26.

[80] C. S. Wesseh, R. Najjemba, J. Edwards, P. Owiti, H. Tweya and P. Bhat, 'Did the Ebola outbreak disrupt immunisation services? A case study from Liberia', *Public Health Action* 7: suppl 1, 2017, pp. S82–S87; Alexandre Delamou et al., 'Effect of Ebola virus disease on maternal and child health services in Guinea: a retrospective observational cohort study', *Lancet Global Health* 5: 4, 2017, pp. e448–e457; Laura Sochas, Andrew Amos Channon and Sara Nam, 'Counting indirect crisis-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone', *Health Policy and Planning* 32: suppl. 3, 2017, pp. 32–9.

[81] Jain and Alam, 'Redefining universal health coverage'.

this connection between UHC and global health security, enabling the former to draw on the political saliency and financing of the latter,[82] also risks conceptually broadening health security yet further, opening it up to more criticism on the same basis as that directed earlier at the expansive global health security narrative. In place of this connection to global health security, UHC could instead be linked with another concept elsewhere in the health security matrix, such as a global health security threat, and thus garner some of the associated support without detracting from the force and utility of the highest 'emergency' designation. This distinction, and others like it, are important if we are to develop a meaningful future for global health security and its diverse meanings.

The value of health security

While this article presents a critique of global health security as currently perceived and operationalized, I do not suggest that we should move away from global health security as a concept. As Rushton points out, that horse has bolted;[83] and indeed the concept has significant resource benefits—in the United States alone, emergency government disbursements in response to outbreaks have included US$1.1 billion for Zika and US$5.4 billion for Ebola in west Africa.[84] More recently, the UK Department for International Development has committed considerable financing to the DRC Ebola outbreak, and called on other G7 states to do the same. Accordingly, rather than suggesting we abandon the concept of global health security, this article seeks to nuance the terms of the debate and recognize the benefits which could be reaped from doing so. Beyond financing, moving an issue up a political agenda through securitization facilitates concentrated activity in response to an emerging outbreak. The urgency with which several Latin American governments moved to respond to the Zika outbreak, once it was securitized, resulted in a significant reduction in the mosquito population and thereby in the incidence of infection.[85] This had the added impact of also reducing cases of dengue fever, chikungunya and yellow fever, which share the same vector, and arguably cause greater morbidity and mortality, yet never feature in the global health security landscape and therefore were not previously able to benefit from attention on the same scale as Zika.

Moreover, the global health security narrative has led to significant changes in the global health landscape through the global health security regime. The creation of the Global Health Security Agenda, for example, and of the WHO's Global

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[82] Gorik Ooms, Claudia Beiersmann, Walter Flores, Johanna Hanefeld, Olaf Muller, Moses Mulumba, Trygve Ottersen, Malabika Sarker and Albrecht Jahn, 'Synergies and tensions between universal health coverage and global health security: why we need a second "maximizing positive synergies" initiative', *BMJ Global Health* 2: 1, 2017, e000217.

[83] Rushton, *Security and public health*.

[84] J. Michaud, J. Kates, A. Wexler and A. Valentine, *The US response to Ebola: status of the FY2015 emergency Ebola appropriation* (Washington DC: Henry J. Kaiser Family Foundation, 2015); S. Epstein and A. Lister, *Supplemental appropriations for Zika response: the FY2016 conference agreement in brief* (Washington DC: Congressional Research Service, 2016).

[85] Jon Cohen, 'Where has all the Zika gone?', *Science* 357: 6352, 2017, pp. 631–2.

Outbreak Alert and Response Network (GOARN) and its Health Emergencies Programme (HEP), established to ensure health security across the world, have significantly changed how we view global health governance. Not only did GOARN facilitate easier engagement between non-state and state actors, championing the move from international to global disease governance, the creation of the HEP has fundamentally shifted the WHO from the role of a normative technical adviser to that of an operational actor in global health security. This institutional structure is supplemented by a range of NGOs and non-state actors that comprise the global health security regime. Although there are challenges relating to coordination and efficiency among these disparate bodies, the global health security regime, governed by novel forms of legislation such as the IHR (2005), represents one of the best examples of international cooperation for any governance issue, and arguably this would not have occurred had health not been securitized and political priority given to cross-border infectious disease control. Perhaps more pertinently, despite its numerous critics,[86] global health security has proved it can fulfil its *raison d'être*: to reduce the spread of pathogens with pandemic potential. As a global community, we still need this discursive and operational tool to maintain the necessary momentum in limiting potential outbreaks. The highest level of urgency would be embodied in the global health emergency; and at the same time the legitimacy of action at this level would be sustained through the use of more nuanced terminology to identify global health security crises, threats, risks and concerns. We, as a global health community, need to reconsider what is meant by health security and think about the risks posed to the longevity of the concept by its indiscriminate use.

Conclusion

This article has described the development of the health security framework, emphasizing the point that 'health security' does not have a unitary meaning and tracing the security–health nexus from its history as a discursive tool, based on the Copenhagen School's speech act, to contemporary health security practice, involving a broad range of securitized health concerns, the military's boots on the ground in health emergencies, and the ontological concern of global health security activity itself coming under threat. These developments not only represent a departure for health security conceptually and operationally, but pose concerns for the longevity of global health security. We need to question these recent trends to analyse what implications they have for the goal of infectious disease control, particularly around issues of sustainability and how to mitigate future security risks posed by global health security activity.

I propose that one way to overcome some of the new challenges in global health security is to change the terms of debate, allowing for greater consensus on what is

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[86] Adam Kamradt-Scott, 'Who's to blame? The World Health Organization and the 2014 Ebola outbreak in west Africa', *Third World Quarterly* 37: 3, 2016, pp. 410–18; Colin McInnes, 'Crisis! What crisis? Global health and the 2014–15 west African Ebola outbreak', *Third World Quarterly* 37: 3, 2016, pp. 380–400.

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a global health emergency compared to a global health security crisis, global health security threat or global health security concern. This more nuanced approach could create differing path dependencies, ensuring the legitimacy of global efforts for the 'big one' and limiting ultra-securitization involving the military, with the risks this poses to health care workers in health security delivery.

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