The over-securitization of global health: Changing the Terms of Debate

Introduction

Linking health and security has become a dominant narrative within health policy over the past two decades[1]. Whilst the debates surrounding the security-health nexus differ in levels of analysis from the global to the national to the individual, as well as what can be considered a security threat and differences in the process of something becoming securitized[2], I argue that the consideration of the global health security narrative and associated governance regime[3], and the ensuing path dependencies has shifted in the last decade in three ways. Firstly, the concept has been broadened to the extent that a multitude of health issues (and beyond) are constructed as threats to health security. Second securitizing health has moved beyond a rhetorical device to include direct involvement of the security sector, and third, that the performance of health security has become a security threat in itself. I argue these factors alter the remit of the global health security narrative and the global health community needs to recognise this contemporary shift and adapt its use of security focused policies accordingly. This poses particularly important in the consideration of future developments of health security, particularly in the longevity of the concept and the need for greater sustainability in global health security interventions.

To make this claim, this paper traces the development of health security conceptually. Whereas others have sought to chart the development of health security through institutional

[1] Colin McInnes and Anne Roemer-Mahler, From security to risk: reframing global health threats, *International Affairs*, 93: 6, November 2017, pp 1313–1337

[2] Colin McInnes and Kelley Lee, *Global Health and International Relations* (Polity, 2012).; Christian Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia*. (Abingdon: Routledge 2007)

[3] Sara E Davies, Adam Kamradt-Scott and Simon Rushton, *Disease Diplomacy: International Norms and Global Health Security*, (Baltimore: Johns Hopkins University Press, 2015); Simon Rushton, *Security and Public Health* (Cambridge UK, Medford MA: Polity Press, 2019)

expansion, policy change, or its historical development from the International Sanitary Conferences to present day infectious disease management[4], this paper seeks to highlight the different uses of the global health security narrative. In doing so, I demonstrate that despite an assumption of a narrow mutually recognised understanding of what constitutes a global health security concern, the project of global health security has never referred to one unitary whole, but is a dynamic concept which has altered depending on context, pathogen and who/what is at risk. In doing so, I recognise that we have reached a critical juncture in global health security and now is the time to reflect on what the term can offer and what are the limitations of the policy response on meaningful control of infectious disease and sustainability of global health. To do so, I propose a new typology for global health security to delineate between global health emergencies, global health security threats, global health security risks and global health security concerns to the extent that the categorisation offers nuance that to date does not exist within the global health security narrative. Yet, beyond rhetoric, fundamental shifts are occurring within global health security including military creep into this area of health and the very real risks posed to health workers by undertaking health security activity. This raises 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 piece considers whether distinguishing terminology within the global health security narrative to reflect the context, risk or activity may appease some of the risks associated with the contemporary practices in global health security that I outline below, including the expansion of what is considered a security threat, the consequences of involving the military and the risks posed to health workers in performing health security activities.

[4] Steven Hoffman, 'The Evolution, Etiology and Eventualities of the Global Health Security Regime', *Health Policy and Planning* 25:6, 2010; David Fidler, From International Sanitary Conventions to Global Health Security: The New International Health Regulations, *Chinese Journal of International Law* 4:2, 2005.

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 policymaking over time[6]. This follows the securitizing logic of the Copenhagen School[7], that 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 characterised by fast-moving transmission, little scientific knowledge of the disease, no known treatment or cure, high mortality or morbidity, or associated with a particular visceral fear of pain or suffering[10]. When a pathogen like this emerges, the legal and normative

[5] Sara E Davies, Adam Kamradt-Scott and Simon Rushton, *Disease Diplomacy*
[6] Institute of Medicine (IOM) *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, Colo. ; London: Lynne Rienner, 1998).
[8] Ibid.
[9] Ibid.
[10] Christian Enemark, *Disease and Securitya*.; Andrew Price-Smith, *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development*. (Cambridge, Massachusetts: The MIT Press, 2002)

workings of the global health security regime (re) produce a particular policy response which is focused on preparedness, detection and response of acute infectious diseases[11].

Yet, the meaning of both "health" and "security" in the global health security narrative has 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% in some African states[12]) which may affect the standing ability of the army and therefore directly impact on state stability and security[13]. This perpetuated a further concern that HIV/AIDS might lead to societal instability as societal structures crumble due to lack of capacity, overwhelmed social provision sectors 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 needed to be some real risk within this construction to posit the broader health security narrative, and to get an audience to accept the security process[16].

For influenza like illnesses, including major global outbreaks of SARS, H1N1 or H5N1, this conceptualisation of security moved beyond military concerns, recognising the (potential) impact of a pathogen on the global population, and importantly the risk to western

[11] Simon Rushton, *Security and Public Health*; United States Centers for Disease Control and Prevention, The Global Health Security Agenda, https://www.cdc.gov/globalhealth/security/ghsagenda.htm
[12] Colin McInnes and Kelley Lee, 'Health, Security and Foreign Policy', *Review of International Studies* 32:1, 2006.
[13] Colin McInnes and Simon Rushton, 'HIV/AIDS and Securitization Theory', *European Journal of International Relations* 19:1, 2013. Stefan Elbe, 'Risking Lives: Aids, Security and Three Concepts of Risk', *Security Dialogue* 39:2-3, 2008.; David, M. 'Rubber Helmets: The Certain Pitfalls of Marshalling Security Council Resources to Combat AIDS in Africa'. *Human Rights Quarterly* 23: 3,2001, pp 560-582.
[14] McInnes and Rushton, HIV/AIDS and Securitization Theory'.
[15] Pieter Fourie, 'The Relationship between the Aids Pandemic and State Fragility', *Global Change, Peace & Security* 19:3, 2007.
[16] McInnes and Rushton, HIV/AIDS and Securitization Theory'.

populations of pandemic flu. Moreover the construction of the security narrative recognised the risk to a state's or region's economy with alterations to travel and/or trade patterns[17]. This is a different understanding of security to that of HIV/AIDS, for which the referent object of the threat remains the state, but 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. Due to rigorous infection control protocols, Ebola would not cause the same threat to states pushing the dominant global health security narrative[18], and therefore its construction as a security threat reflects something different to HIV/AIDS and pandemic flu. Enemark suggests that the security focus within the Ebola outbreak focused on securing circulation within a public health sphere to protect the population, an important tenet which may not have been so evident in previous outbreaks. Conversely, Obama suggested that the outbreak threatened state stability in post-conflict West-Africa[19]. In the Ebola outbreak in Democratic Republic of Congo (DRC) the outbreak threatens regional stability due to cross border risk. but not in the same way as in West-Africa, due to already weak infrastructure, without the same level of reconstruction and this, in part, may explain the delay in the construction of this 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 recognised path dependency for the West-African outbreak and couldn't not have been a security threat.

[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 141-166

[18] Simon Rushton, 'Global health security: security for whom? Security from what?'. *Political Studies, 59*: 4, 2011, pp 779-796.

[19] Barack Obama, Remarks by President Obama and U.N. Meeting on Ebola, 25th September 2014, https://obamawhitehouse.archives.gov/the-press-office/2014/09/25/remarks-president-obama-un-meeting-ebola

For Zika, a similar path dependency was a driving force for the global health security construction. It emerged straight after Ebola and thus amid a heightened global normative assumption of securitized pathogens[20], yet the use of global health security was different once again. Instead of concern for the military, trade or travel restrictions, or circulation of pathogens, the security process, as epitomised in the declaration of the Public Health Emergency of International Concern (PHEIC), was not related to the virus, but owing to the uncertainty surrounding the causal link between the virus and microcephaly, the visceral innocence of newborns as the affected population, combined with ensuring the continuity of the upcoming Olympic Games in Brazil. .

What is important to recognise from these empirical examples is the dynamism and variance internal to the use of the term global health security. This suggests that that there is at least one grammar of security in the global health security narrative, and that there is a poor vocabulary within the international community of what global health security entails. I suggest that we should call a spade a spade and this should be reflected in the language used to differentiate between different health issues which may be used within the global health security narrative y to more clearly delineate what response is required. This is even more important in contemporary discourse, owing to the number of recent developments in both the narrative and practice of global health security.

Whilst this has started to emerge through the differing of language of risk[21] I argue that the range of words for outbreak events, including global health emergencies, global health crises, global health security threats and global health security concerns need clearer definitions and these should be embedded into a collective, institutionalised understanding to demonstrate the range of meanings implicit within the expressions chosen, the differing

[20] Clare Wenham and Deborah Barros Leal Farias, Securitizing Zika: The Case of Brazil, Security Dialogue, 2019 https://doi.org/10.1177/09670106198 56458

[21] McInnes and Roemer-Mahler, 'From security to risk: reframing global health threats'

severity, role of the global health security regime and in doing so, ensure that an appropriate response is mounted relative to risk posed to global health security. In turn this may limit some of the unintended consequences of the global health security narrative that I relate below.

Developments in Health Security

I perceive that this nuancing of the global health security is required due to three important changes to global health security in the last decade. Firstly, that the expansion of what is constructed a security threat goes beyond what has been previously recognised by the global health security regime, and the new breadth requires delineation of terminology for the rhetorical tool to ensure efficacy of delivery of an effective, rapid response for the next 'big one'; second that 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 "boots on the ground" traditional security response to an external threat, which has tangible repercussions for our understanding of global health security operations, and risks jeopardising future acceptance of global health security interventions by global audiences if they perceive this might be a military intervention and thus the ability to enact extraordinary measures which may be required; and third that global health security is facing an ontological threat as those undertaking global health security activity are now security targets themselves

Everything is a security issue

A key development in understanding the security-health nexus is that too many health issues are now framed within the global health security narrative. Given the entrenchment of the global health security narrative (based on the centrality of the speech act[22]), this has been

[22] Jutta Weldes, *Cultures of Insecurity: States, Communities, and the Production of Danger* (Minneapolis: University of Minnesota Press, 1999). Didier Bigo and Anastassia Tsoukala,

used by a range of policymakers and practitioners, recognising the political and financial benefits to be derived from elevating an issue to the security arena[23]. Accordingly, it is important to understand the implications of this expansive move, whether it challenges the legitimacy of the original global health security narrative to limit the cross border spread of infectious disease and what risks it poses in normalising security interventions. Consequently, I argue that it is important to offer a rhetorical distinction between different types of global health security activity to recognise the "big one" when it occurs.

Whilst the global health security narrative has, to date, had a narrow understanding of what constitutes a health security concern, including fast spreading, unfamiliarity and lacking treatment[24], contemporary discourse in health policy and beyond has framed a number of broader issues as health security threats. This has included maternal health[25], mental health[26], non-communicable disease[27], contraceptive access[28], reproductive health[29], migration[30], food

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Terror, Insecurity and Liberty: Illiberal Practices of Liberal Regimes after 9/11 (Abigndon: Routledge, 2008).

[23] Simon Rushton, 'Global health security: security for whom? Security from what?'

[24] Christian Enemark, *Disease and Security*.; Andrew Price-Smith, *The Health of Nations*.)

[25] Maisha Reza, 'Is Maternal Health an Issue Of security?', 2017 https://maishareza.com/is-maternal-health-an-issue-of-security/ .

[26] Stewart M. Patrick (and Ryan Fedasiuk), 'Silent Suffering: Mental Health as a Global Health Priority', Council for Foreign Relations, 2017 https://www.cfr.org/blog/silent-suffering-mental-health-global-health-priority .

[27] 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', 9th April 2018, *The Telegraph;* . Stockholm International Peace Research Institute, 'On Non-Communicable Diseases and Security', *WritePeace blog*,2011, https://www.sipri.org/commentary/blog/2011/non-communicable-diseases-and-security.

[28] Meba Kagone, Eric Takang, Antoine Ndiaye, Olga Sankara, and Ernest Ouédraogo, ' West Africa Reproductive Health Commodity Security. "Country Assessment Report: Burkina Faso.', in Inc./DELIVER John Snow, for the U.S. Agency for International Development, ed. (Arlington, VA, 205).

[29] UNFPA, 'Investing in Sexual and Reproductive Health Key to Global Health Security, Unfpa Head Tells World Health Assembly', (2007).

security[31], counterfeit medicines[32], universal health coverage[33], climate change[34], water and sanitation[35], salty foods [36] and even Brexit[37]. Whilst those who perceive security at the human level may suggest that each of these issues may produce individual insecurity, it seems a stretch to be able to put these all onto a global security agenda.

In one interpretation, this expansion of threats to health security is personified by 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"[38]. With such ambiguity, this could raise concern of opening the door to a broader range of diseases being able to muscle in on the health security narrative if the facilitating political conditions allow, and further weakening the narrative's meaning.

This amplification of issues which have been framed as health security issues raises new questions for studying health security. For example, echoing the critiques of human security in the 1990s[39], trying to fit too much under the umbrella of global health security may have

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[30] David L. Heymann et al., 'Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic', *The Lancet* 385:9980, 2015.
[31] Scientific Advisory Board of the United Nations Secretary-General, 'Food Security and Health: Policy Brief by the Scientific Advisory Board of the Un Secretary-General', in UNESCO, ed. (2016).
[32] Heymann et al., 'Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic'.
[33] Vageesh Jain and Azeem Alam, 'Redefining Universal Health Coverage in the Age of Global Health Security', *BMJ global health* 2:2, 2017.
[34] Regional Office for the Eastern Mediterranean World Health Organization, 'Technical Discussion on Climate Change and Health Security ', EM/RC55/Tech.Disc.1, 2008.
[35] Kathleen O'Reilly, 'From Toilet Insecurity to Toilet Security: Creating Safe Sanitation for Women and Girls', *Wiley Interdisciplinary Reviews: Water* 3:1, 2016.
[36] Chicago Tribune, 'Salty School Lunches: Our Real National Security Threat', 2019.
[37] Solomon, 'Brexit and Health Security: Why We Need to Protect Our Global Networks'.
[38] World Health Organization, 'List of Blueprint Priority Diseaes ', (2016).
[39] Ken Booth, *Critical Security Studies and World Politics* (Lynne Rienner Publishers Boulder, 2005). S Neil MacFarlane and Yuen Foong Khong, *Human Security and the Un: A Critical History* (Indiana University Press, 2006), Roland Paris, 'Human Security: Paradigm Shift or Hot Air?', *International security* 26:2, 2001.

the result of the concept being watered down or lacking the political saliency which it has enjoyed to date to encourage activity, resource generation and decisive action for prevention, detection and response of highly pathogenic infectious disease. As Gavin Yamey epitomised, with the trajectory that health security is on, it's only a matter of time before we see "toe nail fungus: a threat to global health security"[40]. Despite these efforts to construct these new health issues within the global health security narrative, this doesn't mean that they were successful. We know that securitization requires the acceptance of the threat by an audience and whilst policy makers may try to securitize any one of these concerns, through the use of narrative, this doesn't mean it will be successfully securitized, and I would argue that none of this list has achieved security status as yet.

The irony of this is, however, that different lobby groups and policy advocates have used the global health security terminology precisely as a mechanism to raise their concerns up the political agenda, recognising that security gets to the top levels of decision makers at national, regional and global levels. Yet the outcome of hijacking this discourse for issues which do not fit the fast moving, unknown criteria is the erosion of the power that the global health security narrative may have going forward. The risk for infectious disease control is that "crying wolf" from other health policy areas may have a meaningful impact on the response to a potentially catastrophic outbreak. Global health security fatigue may become a real concern, limiting the acceptance of the global health security rhetoric by global audiences which in turn means that emergency measures are not endorsed. Thus, this broadening of the health security discourse can actually prove cannibalistic to the concept itself, if either the global audience tires of the global health security narrative, or if they start to accept increasing securitization of pathogens.

[40] Gavin Yamey, 2018, Twitter communication

A counter argument is that there is a mismatch between academic and policymakers understanding of what health security is, and how it was initially conceived. For example, in the path founding World Health Report (2007), the risks posed to health security are defined as ranging from emerging pathogens to economic stability, international crises and humanitarian emergencies, chemical, radioactive and biological terror threats, environmental change, and weak health systems[41]. Thus, an alternative explanation is not that there has been an expansion of issues considered to be health threats, but that the concept had not been used to the extent that it had been intended by the concept's norm entrepreneurs at the WHO (amongst others) which championed its use[42].

What's more, by over-using the global health security narrative this perpetuates the global health security policy path dependency and in doing so may legitimise a securitized response as the first course of action, encouraging further security risks. By changing the terms of debate within this global health security narrative, such as by more clearly delineating between global health emergencies, global health security crises, global health security risks and global health security concerns, this may reduce the need for military involvement for some more routine activity such as preparedness and thus reduce the risks posed to health security workers.

Securitizing Health or Healthyfying Security?

The traditional approach to understanding health as a security threat is hypothetical. The flexibility within the Copenhagen School approach to security means that a pathogen doesn't actually have to pose a risk, as long as it is constructed as such. Yet, beyond a rhetorical device which produces a policy pathway based on prevention, detection and

[41] World Health Organization, 'World Health Report 2007: A Safer Future: Global Public Health Security in the 21st Century.(Geneva: WHO, 2007).
[42] Adam Kamradt-Scott, 'The Who Secretariat, Norm Entrepreneurship, and Global Disease Outbreak Control', *Journal of International Organizations Studies* 1:1, 2010.

response, a more recent trend in global health security has been the involvement of the military in global health security operations. This recent activity within the global health security regime pushes health security beyond a rhetorical tool and demonstrates a new departure for our analysis.

Whilst militaries have been at the forefront of advances in public health since 18th century[43], this had predominantly been in medical research (such as Walter Reed Army Institute of Research, USA), surveillance[44]or in disaster response, such as in the wake of flooding in Pakistan or the Haiti earthquake[45]. Yet as Michaud et al. highlight "the trend of the past two decades has been towards greater military engagement in global health (security)"[46]. This has included China's domestic military participation in influenza preparation and response[47], Peruvian military led surveillance network, Thailand's military

[43] G Quail, 'The Debt Tropical Medicine Owes to the Military', *J Mil Veterans Health* 23, 2015.
[44] Institute of Medicine (US) Committee to Review the Department of Defense Global Emerging Infections Surveillance and Response System; Brachman PS, O'Maonaigh HC, Miller RN, editors. Perspectives on the Department of Defense Global Emerging Infections Surveillance and Response System: A Program Review. Washington (DC): National Academies Press (US); 2001. 4, GEIS at the Armed Forces Research Institute of Medical Sciences, Thailand. Available from: https://www.ncbi.nlm.nih.gov/books/NBK223717/
[45] Derek Licina, 'The Military Sector's Role in Global Health: Historical Context and Future Direction', *Global Health Governance* 6:1, 2012.
[46] Joshua Michaud et al., 'Militaries and Global Health: Peace, Conflict, and Disaster Response', *The Lancet* 393:10168, 2019.
[47] Hui Ma et al., 'Military-Civilian Cooperative Emergency Response to Infectious Disease Prevention and Control in China', *Military Medical Research* 3:1, 2016.

HIV screening activities[48], Brazil's militarised vector control[49] and armed forces management of cholera in Zambia[50].

However, these have involved domestic military activity within a state's own borders. Placing the military in the role of providing health security remains within the state infrastructure and at the discretion of the sovereign government. This is conceptually different to 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 (2013-5) witnessed the deployment of international militaries from USA, UK, China, Canada, France and Germany among others for global health security response. This represented a gear change for health security and a different modus operandi. The deployment of an international military force for a health emergency represents a physical securitized practice, beyond rhetoric, with boots on the ground to combat a disease threat[51]. Each military's remit and activity varied, including the building of Ebola treatment facilities, treatment of compatriot staff, training of health workers, and treatment of locals affected and command / control structures for maintaining contact tracing and quarantines[52].

[48] David L Blazesb Jean-Paul Chretiena, Rodney L Coldrenc, Michael D Lewisd, Jariyanart Gayweec, Khunakorn Kanac, Narongrid Sirisopanac, Victor Vallejosb, Carmen C Mundacab, Silvia Montanob, Gregory J Martinb, Joel C Gaydosa, 'The Importance of Militaries from Developing Countries in Global Infectious Disease Surveillance', *Bulletin of the World Health Organization* 85:3, 2007.
[49] Sean Michael Griffing et al., 'A Historical Perspective on Malaria Control in Brazil', *Memorias do Instituto Oswaldo Cruz* 110:6, 2015.
[50] Reuters, 'Zambia President Orders Military to Help Fight Cholera Spread', *Reuters* (Lusaka, 2017).
[51] Michaud et al., 'Militaries and Global Health'.
[52] A Kamradt-Scott, Harman, S, Wenham, C and Smith III, F, 'Saving Lives: The Civil-Military Response to the 2014 Ebola Outbreak in West Africa. ', (University of Sydney 2015).

In West Africa the military were broadly perceived to have been pivotal in bringing about the end of the outbreak. Whilst the exceptionalism discourse 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 occurred when other government and international mechanisms failed to manage the response[53]. Regardless of the role or justification, these deployments are important in broader analysis of global health security as they moved the rhetorical threat of disease of health security to a real security presence operationally beyond sovereign borders.

During Zika, the second global health emergency that occurred subsequent to the West-African Ebola outbreak, the (albeit national) military was used as the first option to combat the disease threat, with the Rousseff government galvanising support for this activity through bellicose language such as a *war on the mosquito* to further convince the population of the military's vital role. 60% of the national armed forces were deployed to combat the Zika virus through extensive vector control, fumigation programmes and health education activities[54]. This discourse not only cemented the use of military at the centre of managing health security in Brazil, it signals a broader systematic change for health security; the normalisation of security forces in emergency response in infectious disease control.

This normalisation can be seen in other contexts: In Pakistan, the military have been deployed to accompany polio workers in delivering immunisations in an effort to ensure greater vaccine immunity, and to limit any travel restrictions placed on Pakistan by other states fearing international spread[55]. In DRC, the Congolese military and police have

[53] Sophie Harman and Clare Wenham, 'Governing Ebola: Between Global Health and Medical Humanitarianism', *Globalizations* 15:3, 2018.
[54] Government of Brazil, 'Pronunciamento Da Presidenta Da República, Dilma Rousseff, Em Cadeia Nacional De Rádio E Televisão, Sobre O Vírus Zika.', 2016.
[55] Ryan Hyland, 'Polio's Last Stand: Frantic Effort to Eradicate Pakistan's 'Badge of Shame'', *The Guardian* (2017).

provided escorts to health workers in Ebola response efforts[56]. Moreover, the military's role has gone beyond operationalised response to specific outbreaks to a seat at the table within the global health security regime; militaries have been considered pivotal to the Global Health Security Agenda, through standing committees and action plans – including those of Bangladesh, Guinea, Sierra Leone and Vietnam[57]. 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 is undeniably and increasingly recognised as a stakeholder in global health security operations.

A further question to be raised by this involvement of the military in health security activity is whether they are securitizing health, or simply healthy-fying security. There could be several reasons for this increased preference for military involvement in global health security activity, including human resource availability, biosecurity training and equipment, the self-fulfilling prophecy of securitizing health, or a lack of provision to respond in the health sector of a country. It is important to remember that the increasing role of the military in global health security activity has occurred during relative peacetime, and particularly for Western narratives it could be that the role of the military in health security represents mission creep and the need to find 'jobs for the boys' to legitimise military spending. For example, anecdotal discussions during the West-African Ebola outbreak questioned the link between deployment of the UK military and the planned military spending review in 2020[58]. This raises a host of concerns of the role of the military, and the risks posed to health security

[56] Anne & Dewast Gulland, Louise 'Congo at a Knife Edge as Number of Cases of Ebola Continues to Rise', *The Telegraph* (2018). Anne Gulland, 'Msf Condemns 'Militarised' Response to Ebola Outbreak', *The Telegraph* (2019). David Milliband, 'The response to DRC's Ebola crisis isn't working. Here's what we need to do, The Guardian (2019) https://www.theguardian.com/commentisfree/2019/jul/15/democratic-republic-of-the-congo-drc-ebola-crisis-outbreak

[57] Michaud et al., 'Militaries and Global Health '.

[58] Personal Communication with military sources

by their involvement. Firstly, does their involvement defy the Oslo Guidelines which state militaries should only be used as a last resort when "there is no comparable civilian alternative… to meet a critical humanitarian need"[59]? Secondly, what would happen if an outbreak occurs when the military is engaged in more traditional war-activities and/or in a location where international or national militaries had been recent combatants, such as in DRC, this could create a further risk to the maintenance of health security if they were no longer able to perform the role that was expected of them if their involvement produces further security risks to personnel.

There should be further consideration of when militaries should be engaged in global health security, and under what conditions. Should this be for just the 'big ones' or for routine activities such as preparedness also. Through greater delineation of language within the global health security narrative this could provide clear parameters from when military can be used for global health security, for example for emergencies, but not for more routine preparedness.

Risking Security Activity

There is clearly an occupational hazard to anyone who responds to an outbreak of infectious disease. The number of healthcare workers who die as a result of the care they provide in global health security events is well known, and high profile deaths of leading global infectious disease specialists such as Carlo Urbani and Richard Mousoko make this risk ever more visible[60]. This individual risk was evident during the West Africa Ebola

[60] Brigg Reilley, Michael Van Herp, Dan Semand and Nicoletta Dentico, SARS and Carlo Urbani, *NEJM*, 2003; 348:1951-1952 15th May 2003 ; Fiston Mahamba, Militamen kill senior WHO official in attack on Congo Ebola centre, Reuters, April 19 2019, https://uk.reuters.com/article/uk-health-ebola-congo/militiamen-kill-senior-who-official-in-attack-on-congo-ebola-centre-idUKKCN1RV119

outbreak as several NGOs found it hard to get volunteers to go to join the response effort for fear of contracting the virus[61] (and hence why the military were easier to deploy). Yet this individual risk has manifested beyond disease risk and through more traditional security concerns more recently. Perhaps as a consequence of the increased securitization and militarization of global health, the blurring of the health and security activities poses an ontological paradox of global health security practice posing a security risk in itself

The broader trend of health workers being under attack is unfortunately an increasingly common feature of global health reality. Attacks of health care workers have occurred across Pakistan, South Sudan, Syria, Yemen, Afghanistan, Central African Republic and beyond [62] with combatants unable to distinguish between warring factions / military and aid workers[63]. This raises a number of challenges in post-conflict reconstruction, development and civilian health and questions the cost benefit analysis of military involvement in health activity more broadly.

Yet this trend has also started to occur in global health security activities. A securitized response to health issues tend to focus on the short term responses such as surveillance, disease detection, and vaccine / treatment development and deployment. It is these very activities which have started to come under attack.

Military actors have had to accompany health workers vaccinating children against polio in Pakistan, in order to ensure the safety of these workers who had been targeted by

[61] Kamradt-Scott et al, 'Saving Lives".
[62] World Health Organization, Surveillance System for Attacks on Healthcare (SSA) as accessed https://publicspace.who.int/sites/ssa/SitePages/PublicDashboard.aspx; Preeti Patel et al., 'Documenting Attacks on Health Workers and Facilities in Armed Conflicts', *Bulletin of the World Health Organization* 95:1, 2017.
[63] Rachel Irwin, 'Violence against Health Workers in Complex Security Environments', *SIPRI Background Paper* (2014).

Taliban fighters (following the US-led capture of Bin Laden using polio workers[64]). These forces support healthcare workers in the facilitation and delivery of the vaccines amongst the population to reduce incidence of this vaccine preventable infectious disease and major global health security threat (which continues to be a Public Health Emergency of International Concern[65]). Even once security forces had been engaged to support health workers in this effort, these security forces became a secondary target alongside continued attacked on health workers[66]. Accordingly, being part of the global health security machinery through the delivery of this oral vaccine poses a dual threat – not only the risk of contracting polio, but from 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 left some WHO workers dead[67]. There are multiple and complex reasons for this including, but not limited to a lack of meaningful community engagement with locals at the start of the outbreak, a deep mistrust of government, and local wariness of external interference, reticent of land appropriation to international multinationals for resource extraction[68]. This turned violent with attacks on WHO teams in Guinea, and others hiding in the bush, facing vandalism and arson on their equipment[69].

[64] Saeed Shad, 'Cia Organised Fake Vaccination Drive to Get Osama Bin Laden's Family DNA', *The Guardian* (2011).
[65] WHO, Statement of the nineteenth IHR Emergency Committee Regarding the International Spread of Poliovirus https://www.who.int/news-room/detail/30-11-2018-statement-of-the-nineteenth-ihr-emergency-committee-regarding-the-international-spread-of-poliovirus
[66] BBC, 'Pakistan Polio: Seven Killed in Anti-Vaccination Attack'
[67] 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. Ouendeno Marie, 'Rapport Détaillé De La Mission Dans La Sous-Préfecture De Womey, Préfecture De. N'zérékoré ', (2014).
[68] Fairhead, 'Understanding Social Resistance to the Ebola Response in the Forest Region of the Republic of Guinea'.
[69] WHO, Ground Zero in Guinea: The Ebola Outbreak smoulders, undetected, for more than 3 months https://www.who.int/csr/disease/ebola/ebola-6-months/guinea/en/

This traditional security risk within global health security is also evident in the Ebola outbreak in DRC (2018-). The outbreak is taking place in a complex political situation, in disputed territory with a number of non-state armed groups attacking health workers and health facilities meaning thwarted efforts to bring about the end of the epidemic[70]. There have been arson attacks on Ebola treatment units, attacks on healthcare workers and broader instability and insecurity affecting response efforts. Such attacks have a direct effect on disease transmission: disease control actors including have had to halt disease response which means the virus is able to spread unabated [71].

The traditional security risks embedded within global health security activity pose a number of concerns. Firstly this ontological risk creates a circular analysis of security when those working in the extraordinary response become the referent object of a security threat and in providing this global health security activity, they are putting themselves in the firing line. This may impact future recruitment into global health security related activity Secondly, if healthcare workers are unable to carry out their jobs, emergency response efforts will be limited, posing a greater risk to global health security. Such security concerns have directly impacted Ebola in DRC, with WHO and MONUSCO forces agreeing that the security situation will directly lead to an increase in cases of the virus[72], for example with those undertaking contract tracing being disrupted in their efforts and losing track of this activity, which is so vital to the success of any disease control strategy[73]. Thirdly, this has broader impact on preparedness within global health security. For example, if children are unvaccinated against polio – this increases the risk of disease transmission.

[70] Vinh-Kim Nguyen, 'An Epidemic of Suspicion — Ebola and Violence in the Drc', *New England Journal of Medicine* 0:0.
[71] A Blomfield, 'Ebola Outbreak Spreads as War and Disease Threaten Perfect Storm ', *The Telegraph* (2018).
[72] UN News, 'Dr Congo: Insecurity and Attacks Mean Ebola Will Keep Spreading, Warns World Health Agency', (Geneva, Switzerland, 2019).
[73] Blomfield, 'Ebola Outbreak Spreads as War and Disease Threaten Perfect Storm '.

Accordingly, we are witnessing an unusual turn in the security-health nexus whereby the practice of health security now poses its own security threat, something that will need to be considered in depth to develop a complex management plan and a clear way forward to ensure the safety of those working on the front line of health security, ensuring that they are able to carry out their activities safely and ensure global health security more broadly. This will require self-reflection within the global health security regime to recognise the shortfalls and risks created by military involvement and whether the continued focus on prevent, detect, response remains the most suitable policy pathway within more systemic development needs which perpetuate security and inequalities and can manifest in direct insecurity.

Emergencisation and normalisation

Initially, the global health security narrative was utilised as a rhetorical tool by health policymakers as a justification for extraordinary measures in order to combat disease outbreaks, leveraging more attention and financing to emerging infectious disease. However, the increased normalisation of the discursive tool, which has moved beyond words to operationalised 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 does an extraordinary response look like for the next 'big one' when extraordinary becomes the norm? Conversely, what does this mean for governing outbreaks and conversely for the more endemic, everyday health issues which may get further relegated down the prioritised 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 have routinized health security to the extent that the global health community seems barely shocked when

another health emergency emerges[74]. Compare, for example, the response seen to the 2018-Ebola outbreak in DRC to that of the West-African outbreak 2014-6. It took 4 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 long since met. Moreover, there has been considerably less mainstream media coverage of this outbreak globally. Although these outbreaks are markedly different; including the current scale of the crisis, it may also suggest a fatigue of the global health security narrative[75].

I propose one solution would be to create a typology within the global health security narrative to distinguish these different types of concerns. For example, reserving global health emergency for the 'big ones', and then a tiered scale including global health security crises, global health security threat or global health security concern for smaller issues, as well as encouraging the greater use of regional, national and local language for health security threats. Whilst the challenges of this would be the risks to these lower down the typology and not getting the desired attention, and to the potential for further discrepancies between financing mechanisms and actors involved within the tiered structure. This would allow global health security to maintain its legitimacy and use relevant language and activity only for major concerns. In effect, this is embodied within the PHEIC process and Pandemic Emergency Financing Facility (PEF) already, with each of these only being deployed for exceptional events. However, there is a mismatch currently between these 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

[74] Tine Hanrieder and Christian Kreuder-Sonnen, 'Who Decides on the Exception? Securitization and Emergency Governance in Global Health', *Security Dialogue* 45:4, 2014.
[75] Janet G. Baseman et al., 'Public Health Communications and Alert Fatigue', *BMC Health Services Research* 13:1, 2013.

maintain the intended power of global health security when needed. This typology mirrors previous calls to include a gradient system of the PHEIC process, to denote exigent outbreaks which need international support and increased financing but to allow the PHEIC to maintain its power for major events[76].

By changing the terminology also in this way may allow for a greater evaluation of the use of the military in global health security and whether they should perform more routine health security provision, such as preparedness and capacity building. The reduction of which, may reduce the risks posed to healthcare workers within health security, although this is speculative.

Sustainability

A further self-reflection that global health security needs to confront is the trait of securitised responses to favour short term, reactive, firefighting policy and 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[77], but they do little to systematically address the root causes of disease which makes some populations and individuals susceptible or vulnerable to disease. This question of sustainability is rarely considered within 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 2016-7, but will fail to control future outbreaks. Temporarily destroying vectors does not address the socio-economic conditions which allow mosquitoes to thrive – such as a lack of WASH facilities, poor quality housing, the need to store which become breeding grounds for

[76] Lawrence O Gostin and Rebecca Katz, The International Health Regulations: The Governing Framework for Global Health Security, *Millbank Quarterly*, 94, 2016, pp264-313
[77] Nathan L Yozwiak et al., 'Roots, Not Parachutes: Research Collaborations Combat Outbreaks', *Cell* 166:1, 2016.

mosquitoes, and the gender sensitivities which are mostly ignored in outbreaks. Taking a more sustainable approach to responding to the outbreak, through addressing these broader global health security risk factors may prove a longer lasting success. As such, global health security needs to consider the balance between short term focus and making lasting changes to improve outbreak preparedness.

Similarly, the fire-fighting response to manage the West-African Ebola outbreak was achieved through the channelling of all national and local health resources and activity to Ebola prevention, detection and response. The cost of this was a significant reduction in essential primary health services in the affected states[78], including in childhood immunisation programmes[79] and in maternal and child health services[80] which raises a number of challenges for understanding equity across the health system and the impact that a health security event can have at the health and societal system level.

The recent move to connect global health security to that of universal health coverage (UHC), as championed by WHO Director General Dr Tedros, may offer a greater opportunity for sustainability, as the globe moves towards more comprehensive, accessible, affordable healthcare 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 healthcare, such as frequency of healthcare visits[81]. It also allows for broader sustainability in the health sector for systematic engagement for responses to infectious diseases. Yet, whilst

[78] B. H. Wagenaar et al., 'The 2014-2015 Ebola Virus Disease Outbreak and Primary Healthcare Delivery in Liberia: Time-Series Analyses for 2010-2016', *PLoS Med* 15:2, 2018.
[79] C. S. Wesseh et al., 'Did the Ebola Outbreak Disrupt Immunisation Services? A Case Study from Liberia', *Public health action* 7:Suppl 1, 2017.
[80] A. Delamou et al., 'Effect of Ebola Virus Disease on Maternal and Child Health Services in Guinea: A Retrospective Observational Cohort Study', *Lancet Glob Health* 5:4, 2017. 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.
[81] Jain and Alam, 'Redefining Universal Health Coverage in the Age of Global Health Security'.

offering hope for sustainability, the instrumentalist nature of this connection for UHC to draw on the political saliency and financing of global health security[82], also risks conceptually broadening health security, mimicking the earlier criticisms of the expansive global health security agenda. Instead of connecting UHC to global health security, UHC could instead be interlinked with another concept elsewhere in the health security matrix, such as a global health security threat and thus garner some of the support, and yet not impact on the utility of the big emergency declaration. This is important to develop a meaningful future for global health security and its diverse meanings.

Value of Health Security

Whilst this paper critiques global health security, I do not suggest that we should move away from global health security as a concept. As Rushton highlights, that horse has bolted[83] and indeed the concept has significant benefits - in the USA alone emergency government disbursement to respond to outbreaks has included $1.1Bn for Zika and $5.4Bn for Ebola in West-Africa[84]. More recently, DFID has committed considerable financing to DRC Ebola outbreak, and called on other G7 states to do the same. As such, instead of suggesting the end of global health security, this paper seeks to nuance the terms of debate and recognise the benefits which could be reaped of doing so. Beyond financing, raising an issue up a political agenda through securitization facilitates concentrated activity respond to emerging outbreak. The urgency that several Latin American governments moved to respond to the Zika outbreak, once securitized, resulted in a significant reduction to the mosquito

[82] Gorik Ooms et al., '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.
[83] Simon Rushton, *Security and Public Health*
[84] J; Michaud Kates, J; Wexler, A; Valentine, A, 'The U.S. Response to Ebola: Status of the Fy2015 Emergency Ebola Appropriation ', (The Henry J Kaiser Family Foundation 2015). S Epstein, Lister, A, 'Supplemental Appropriations for Zika Response: The Fy2016 Conference Agreement in Brief', in Congressional Research Service, ed. (Washington D.C. , 2016).

462 population and Zika incidence[85]. This had the added impact of also reducing cases of Dengue
463 Fever, Chikungunya and Yellow Fever which share the same vector, and arguably cause
464 greater morbidity and mortality yet never feature in the global health security landscape and
465 therefore were not previously able to benefit from the increased attention.

466 Moreover, the global health security narrative has led to significant changes to the
467 global health landscape through the global health security regime. The creation of the Global
468 Health Security Agenda, for example, and WHO's Global Outbreak Alert and Response
469 Network (GOARN) and WHO's Health Emergencies Programme (HEP) established to
470 globally ensure health security have significantly changed how we view global health
471 governance. Not only did GOARN facilitate easier engagement between non-state and state
472 actors, championing the move from international to global disease governance, but the
473 creation of the HEP has fundamentally shifted WHO from a normative technical advisor, to
474 have an operational role in global health security. This is supplemented by a range of NGOS
475 and non-state actors which comprise the global health security regime, including United
476 States Centers for Disease control, African Centres for Disease Control etc., albeit without
477 criticism of siloes of practice and the challenges this brings for coordination and efficiency.
478 Governed by novel forms of legislation such as the IHR (2005), the global health security
479 regime represents one of the best examples of international cooperation for any governance
480 issue, and arguably this would not have occurred had health not been securitized and political
481 exigence given to cross border infectious disease control. Perhaps more pertinently, despite
482 its numerous critics[86], global health security has proved it can fulfil its raison d'etre; to reduce
483 the spread of pathogens with pandemic potential. As a global community, we still need to

[85] Jon Cohen, 'Where Has All the Zika Gone? ', *Science* (2017).
[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. Colin McInnes, 'Crisis! What Crisis? Global Health and the 2014–15 West African Ebola Outbreak', *Third World Quarterly* 37:3, 2016.

have this discursive and operational tool to maintain momentum for limiting potential outbreaks. This would be embodied in the global health emergency, but allows this to maintain its legitimacy through greater nuance with 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.

Conclusion

This paper has shown the development of the health security framework highlighting that health security does not mean one thing. By tracing the security-health nexus from its history as a discursive tool, based on the Copenhagen School's speech act to contemporary health security 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 activities being a security threat in and of itself. 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 in health security to see what implications these have on the aim 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 solution to overcome some the new challenges in global health security is to change the terms of debate, allowing for greater consensus on what is a global health emergency compared to a global health security crisis, global health security threat or global health security concern. Beyond semantics, this nuanced approach could create differing path dependencies ensuring the legitimacy of global efforts for the 'big one' and limiting the ultra-securitization involving the military with the risks this poses to healthcare workers in health security delivery.