The Securitisation Epidemic

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The World Health Organisation estimates that there are 34 million people suffering from the Human Immunodeficiency Virus (HIV) across the globe, with 1.7 million people dying as a result of Acquired Immune Deficiency Syndrome (AIDS) in 2011 (2012). The humanitarian cost of HIV/AIDS and other infectious diseases has created debate within the discipline of security studies, as some critical scholars argue that disease creates instability within societies that poses a threat to national and international security. More traditional scholars dismiss these claims, only going as far as admitting that disease from the impacts of biological weapons represents a security threat, as they are an attack against a state. However, given that the intentions of biological weapons are to cause damage to the social and economic order of society, and that infectious disease also causes damage to social and economic order, infectious disease constitutes a traditional, as well as a new security threat. It is crucial to define disease, examine securitisation theory, explore the securitisation of disease, analyse the ramifications of biological weapons in security studies, and evaluate the impacts of disease and biological weapons on security in order to understand why disease is a security threat.

Defining disease as a general concept is problematic, given the vast array of disease types. This argument will focus on infectious disease, which the World Health Organisation (WHO) defines as "caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another" (2013b). Examples of infectious disease include HIV/AIDS, tuberculosis, malaria, and various strains of influenza.

It is also important to define both the political and apolitical dimensions of disease. The political aspect of infectious disease is when it is used as a weapon; that is, when the impacts of a disease on individuals and society are deliberately used to cause damage and harm to gain concessions. The apolitical aspect of infectious disease is when diseases function under normal pathogenesis and spread through a population (Davies 2008: 300).

Another concept that needs to be discussed in order to understand the security dimension of disease is the Copenhagen School's securitisation theory. The Copenhagen School first conceptualised securitisation in the 1990s and attempted to understand how previously benign issues become security threats. There are three steps involved in securitising an issue. The first is an actor declaring an existential threat against their survival or existence, through a 'speech act.' Second, the audience of the speech act, generally civil society, accepts that there is a threat working against their survival or existence. Finally, extraordinary action, effort, and allocation of resources are dedicated to combating the new security threat (Lo Yuk-ping, Thomas 2010: 448). Securitisation theory seems to be closely aligned with constructivist views on security, as both stress that security issues are perceived and created through actions, rather than being inevitable parts of the international system (Hampson 2013: 292; McInnes, Rushton 2013: 119).

Securitisation theory has been criticised on several levels; however, concerns about the theory broadening the security agenda are particularly relevant. A common theme amongst sceptics and critics of a broader security agenda is that a broad and all-encompassing definition of security removes the validity and seriousness of security threats. As Deudney notes, "If everything that causes a decline in human well-being is labelled a 'security' threat, the term loses any analytical usefulness and becomes a loose synonym for 'bad'" (Enemark, Selgelid 2008: 459). The theoretical backgrounds of infectious disease and securitisation theory can now be used to analyse the securitisation

of disease in constituting a security threat.

The United Nations Development Programme (UNDP) created the term human security in the *1994 Human Development Report* where it began to shift the focus of security away from the state, and onto the experiences of individuals and how they feel insecure in their everyday lives (Altman 2003: 419). Coincidently, the UNDP's human security agenda, which included health security, arose at the same point as the idea that infectious disease, most notably HIV/AIDS, could be a threat to national security, particularly in the United States of America. As early as 1990, the National Intelligence Council described HIV/AIDS as a 'time bomb' that would have unmeasurable economic and political consequences (McInnes, Rushton 2013: 124). By the mid to late 1990s, US Secretary of State Colin Powell raised serious concern over the prevalence of HIV/AIDS in the Global South for national security in his country, but also for regional security in Africa, Asia, and Latin America (Lee, McInnes 2010: 6). It is clear that the USA identified HIV/AIDS, amongst other infectious diseases, as a threat to its survival and integrity. The USA needed to make a speech act in order to begin securitising infectious disease.

The first meeting of the United Nations Security Council (UNSC) at the beginning of the millennium in 2000 was dedicated to the issue of HIV/AIDS in Africa. The UNSC was under the Council presidency of the USA at this point, who saw HIV/AIDS as a pressing threat to their security (McInnes, Rushton 2013: 122). In July of 2000, Security Council Resolution 1308 was unanimously passed which noted that HIV/AIDS would be a threat to stability and security if action was not taken to combat the disease (Lee, McInnes 2010: 8). While the unanimous passing of Resolution 1308 shows that the threat of infectious disease was a priority for many countries' security agendas, there has been debate as to whether the UNSC really considered infectious disease as a genuine threat. Rushton agrees with this idea based on evidence that China, Russia, and France, who are permanent members of the Security Council, were originally hesitant to consider HIV/AIDS as a security threat. However, the other 14 members of the Security Council could not be seen to be complacent about a humanitarian disaster like the HIV/AIDS pandemic, and had to follow the securitisation claims by the USA (2010: 498). Resolution 1308 primarily faced the issue of HIV/AIDS prevalence in military and peacekeeping forces in order to create tentative links between national and international security in relation to the disease (McInnes 2006: 323; Bigirumwami et al 2010: 517). The securitisation move made in the UNSC was then followed by other United Nations agencies in combating the threat of HIV/AIDS.

The General Assembly's Millennium Summit in September 2000 also brought further attention to the HIV/AIDS pandemic by devoting Goal 6 of the Millennium Development Goals (MDGs) to combat the disease, as well as other prevalent infectious diseases such as malaria and tuberculosis (Ruston 2010: 499; United Nations 2013). The United Nations General Assembly Special Session in June 2001, a rare occasion reserved to discuss matters of high political importance, was devoted to HIV/AIDS. It was clear that the security dimensions of HIV/AIDS were only a part of political rhetoric by this stage, rather than addressing fundamental and systemic problems of the HIV/AIDS-security nexus, as the academic literature and policy advice was lacking (Altman 2003: 420). Rushton argues that security was not even a priority of the Special Session, but was intended to focus on the human rights and international development aspects of HIV/AIDS (2010: 500). Nonetheless, Resolution 1308 codified HIV/AIDS as a genuine international security concern, which still has resonance in the humanitarian and development concerns of the MDGs and Special Session. However, the securitisation move by the UNSC did prompt the WHO to take on a more authoritative role in managing infectious diseases and the security concerns that they presented.

The WHO was established in 1948 in order to medically and scientifically assist states dealing with health issues, and has acted as a humanitarian entity representing the health concerns of international civil society (Jin, Karackattu 2011: 181). However, the securitisation of infectious disease, particularly HIV/AIDS, has encouraged the WHO to take on a different role in recent years. It now states that, "[i]n the 21st century, health is a shared responsibility, involving equitable access to essential care and collective defence against transnational threats," (2013a). Referencing defence and threats fits in with a security discourse, as well as a public health discourse, yet it still highlights the changing role of the WHO in a securitised world, rather than taking a more humanitarian focus. Davies takes a critical position against the WHO and its role in global health advocacy, stating that due to the USA spearheading the initiative to securitise disease as an existential threat for Western states, the WHO has turned its main responsibility into being a surveillance agent for Western security interests while consolidating its role as the ultimate authority on global health (2008: 296). When the World Health Assembly allowed the WHO to reform the

International Health Regulations (IHR), the WHO created the Global Public Health Information Network to scan the World Wide Web and identify disease outbreaks in order to reduce economic and political damage, as well as humanitarian costs (2008: 304).

Jin and Karackattu concur with Davies' statements that the WHO seeks to continue using a security discourse in relation to health and disease, particularly since 2001, and is also an important securitising agent alongside the UNSC (2011: 182). The WHO has worked outside its own jurisdiction in the past in order to prevent the spread of disease; for example, it issued global alerts on travel to China and Canada during the Severe Acute Respiratory Syndrome (SARS) pandemic in 2003 for not being transparent in their cooperation with the WHO to manage the situation (2011: 183). It is estimated that the world lost US$100 billion during the SARS pandemic due to insecurity surrounding social, economic, and political activity (Lee, McInnes 2006: 10), showing links between economic security and infectious disease. Given this vulnerability to economic insecurity, let alone social and political insecurity in times of uncertainty from disease, states began to fully acknowledge the link between disease and security and allowed the WHO to increase surveillance of disease around the world (2008: 306). The number of people who succumbed to SARS during the 2003 pandemic was quite low (McInnes 2013: 329), however, the level of fear against the disease seems irrational even if it has been securitised. Enemark and Selgelid note that traditional measurements of morbidity and mortality with infectious disease are almost ignored; they suggest that dread of a disease compounds the social, political, and economic disruptions in society (2008: 460). States and individuals are left feeling insecure because they dread the impacts of infectious disease to such an extent that they view it as an existential threat. This feeling of insecurity also highlights that human security also needs to be addressed alongside the institutional analysis of disease securitisation.

While opinion is still divided on an exact definition and remit for the concept of human security, it is generally believed to encompass humanitarian issues, freedom from want, and freedom from fear (Hampson 2013: 280, 281). It is also acknowledged that people from the Global South are the main referents in advancing a human security discourse, as the evidence shows that people from the Global South are more likely to experience insecurities in their day to day lives than people in the Global North (2013: 286). Bigirumwami et al take a human security point of view in applying a gender analysis to the affects of HIV/AIDS on the conflict in Burundi in order to readdress some of the problems with the current HIV/AIDS security nexus. They agree with other scholars that Resolution 1308 only focuses on military personnel and peacekeeping forces in regards to HIV/AIDS and conflict, as well as criticise the dominant structuralist and institutionalist view on HIV/AIDS and security (2010: 517; Davies 2008: 296; McInnes 2006: 323). Bigirumwami et al largely agree with McInnes in claiming that simply viewing HIV/AIDS as being passed on between soldiers and other forces involved in conflict, internal displacement migration, and gendered sexual violence is highly problematic as it does not address the socio-cultural aspects spreading infectious disease (Bigirumwami et al 2010: 519; McInnes 2006: 318, 320, 321, 324). They stress that the experience of the individual and how conflict and HIV/AIDS makes them feel insecure is how the HIV/AIDS nexus, as well as the general infectious disease-security nexus, should be viewed as the cause for economic, social, and political disruption of society due to disease (2010: 525). The structural, institutional, and human security aspects of infectious disease securitisation is important in assessing disease as a security threat; however, it is equally important to re-examine the traditional security argument of disease as a threat in relation to biological weapons.

Biological weapons have held an incredibly powerful position within international security, due to the ease of access in acquiring the agents needed to make the 'poor man's atomic bomb' (Finel et al 2003: 54; Kupperman, Smith 1993: 38). One of the USA's biggest fears currently is terrorists acquiring a weapon of mass destruction, particularly a biological weapon (Finel et al 2003: 41). During the Persian Gulf War, the biggest threat facing the West was the use of biological weapons (Kupperman, Smith 1993: 37). The unpredictability and irrationality of Saddam Hussein being in control of such weapons, as well as demonstrating his willingness to use them against Iran, created immense insecurity (Finel et al 2003: 52). The USA was stockpiling vaccines for diseases such as smallpox even before the October 2001 anthrax attacks, displaying an immense fear of biological attacks (Lee, McInnes 2006: 14). The United Nations Office at Geneva's Disarmament committee states that biological weapons "disseminate disease-causing organisms or toxins to harm or kill humans, animals or plants," (2013), thus clearly showing that infectious disease has always been part of the security agenda. The threat of biological attack is so great that even the WHO, a group that is meant to advocate for health, has been enlisted in counter-bioterrorism operations (Jin, Karackattu

2011: 183, 184). Enemark and Selgelid again reiterate the concept of dread, especially with the use of anthrax as a biological weapon, as people dread the suffering that such a disease can cause (2008: 460). Examining disease as a security threat in both a traditional and new security framework now makes it possible to compare and contrast these two security agendas.

It is clear that the new security agenda sees disease as both an apolitical and political threat, acknowledging the disruptions to the functioning of society and human suffering, from both biological weapons and infectious diseases occurring. Meanwhile, the traditional security agenda only sees disease as a political threat arising from the use of biological weapons as an attack on the state. There are two commonalities within the new and traditional security agendas, the first being an institutional response to infectious disease. The WHO plays an integral part within each framework; traditionalists see the WHO as important for enforcing the Biological Weapons Convention, despite their remit traditionally being advocacy (Jin, Karackattu 2011: 183). The new security agenda sees the WHO as essential in monitoring infectious disease epidemiology in order to assess the international security situation (Davies 2008: 304). The second commonality is the concept of dread, with traditionalists dreading the use of biological weapons to disrupt the functioning of society during conflict. The new security agenda dreads infectious disease, whether political or apolitical, disrupting the functioning of society and causing human suffering. As such, it is appropriate to consider apolitical infectious disease as a genuine security threat. Infectious disease arising apolitically has the same implications for society and international security as infectious disease arising from political factors; it also enriches security discourse with the addition of human security and suffering.

The new security agenda and increasing incidences of infectious disease coincidently arose during the post-Cold War period when states were readdressing their values in a relatively peaceful world. Infectious disease became part of this new security discourse, and whether or not it has a place within security studies and international relations has been debated. Infectious disease has the power to disrupt the functioning of society, which is linked to international security and causes human suffering, thus making it an appropriate topic for security studies. Examining the theoretical backgrounds of disease and securitisation theory, exploring the securitisation of disease, the human security aspect, the traditional security argument, and evaluating the political and apolitical threats of disease make clear that this is a genuine security issue. The challenge now for the international community is to engage with infectious disease dynamics within a human security framework in order to secure the international realm against both political and apolitical disease threats.

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