D2.3   **Security and health**

A recent development in global health has been the way in which health issues are being framed in terms of security. This section describes the origins of this development and raises questions that civil society should be grappling with.[1]

One of the drivers for this development is the awareness of the potential for fast-moving epidemics to deliver shocks to the global economy. The threat of a lethal influenza pandemic has further accentuated the process of framing disease as a security issue. In 2005 the World Health Assembly (WHA) adopted a revised version of the International Health Regulations, which establishes a set of obligations and standards for countries to respond to 'public health emergencies of international concern'. In 2007 the World Health Organization (WHO) devoted its annual *World Health Report* to 'Global Public Health Security in the 21st Century'.

Bioterrorism has been another focus of attention, especially following anthrax attacks in the US, which led to increased international collaboration via the Global Health Security Initiative (GHSI).[2] However, while there are some synergies between preparedness for bioterrorist events and other health risks, the overall nature of the bioterrorism preparedness agenda and the disproportionate allocation of scarce resources, particularly within the US, have been questioned (Tucker 2004).

Since the Cold War, and especially after the 9/11 terrorist attacks on the United States, issues such as poverty, climate change and HIV/AIDS have also become framed as security threats by virtue of their negative impact on economic and political stability, both within countries and across borders. A range of US government agencies, including the Departments of State and Defense and the Central Intelligence Agency (CIA), began working

on HIV–security links during the mid-1990s. A resulting US Strategy on HIV/AIDS argued that the pandemic needed to be seen not only in terms of human health or international development, but also as a threat to 'international security' and to the security of the US (USDS 1995).

It noted that 'as the HIV/AIDS pandemic erodes economic and security bases of affected countries, it may be a 'war-starter' or 'war-outcome-determinant'. It also described how 'HIV directly impacts military readiness and manpower, causing loss of trained soldiers and military leaders', and how 'worldwide peacekeeping operations will become increasingly controversial as militaries with high infection rates find it difficult to supply healthy contingents.'

This view subsequently gained ground within Washington. In 2000, the US National Intelligence Council (NIC) issued a report on the threat of global infections to the US (NIC 2000). In the same year, the Clinton administration declared that HIV/AIDS represented a threat to US national security interests. This led to a US-backed UN Security Council resolution identifying HIV/AIDS as a threat to international peace and security (UNSC 2000).

The National Intelligence Council returned to the subject in 2002, issuing a report on five countries (Nigeria, Ethiopia, Russia, China and India) strategically important to the United States that identified links between disease, political instability and the threat to socioeconomic development and military effectiveness (NIC 2002). By 2005 the Global Business Coalition on HIV/AIDS was making links between AIDS, economic decline and potential terrorist threats, including speculating on how a steady stream of orphans might be exploited and used for terrorist activities (Neilson 2005).

At one level, the linkage of health to security can be viewed positively in the sense that it can highlight the concept of *human security*, which can help move the focus in security thinking away from state security and more towards people and their basic rights and needs.

At another level, there are risks associated with extending the scope of security into the health and development spheres. Importantly, the framing of health in terms of security has emerged from global power centres. As the foreign policy and intelligence agencies of the most powerful states are drawn into the domain of health within low- and middle-income countries, health policies and programmes may be co-opted into serving economic and political projects, especially in the post 9/11 landscape in which counter-terrorism has emerged as an overriding policy priority, and which has made the space for health and human rights harder to maintain.

While the interest of security actors in selected aspects of public health has increased markedly, parts of the public health and medical communities have also adopted the language of security, seeing opportunities to advance broader public health goals. By accentuating the destabilising effects of HIV/AIDS and poverty, civil society groups have helped gain much-needed attention and resources for the long neglected health concerns of poorer countries.

Yet the linking of health with security is not necessarily a win–win situation. Crucially, those seeking to use security arguments to boost health up the political agenda may not be able to control where the logic of security takes them. While the linking of health and security may generate more attention and resources for health, the use of health as an instrument of foreign policy, or as a bridge for securing better control over strategic resources in other countries, is also evident. For example, the 2002 NIC report on HIV/AIDS stated in relation to Nigeria that HIV/AIDS could contribute to the deterioration of state capacity in a country important to US energy security and US counterterrorism strategies (CSIS 2005).

This forms part of the context for the massive increases in US aid for Nigeria. Indeed, through 2007 PEPFAR allocated some US$578 million for Nigeria, far outstripping other donors. As part of this, PEPFAR is creating a total HIV surveillance system for the Nigerian military; conducting prevention initiatives; creating more reliable supply chains; and organising treatment for military personnel and dependants who are living with HIV.[3]

To an extent this might be welcomed. HIV/AIDS is a multidimensional problem affecting all sectors of society, including the military. The HIV/AIDS–security link has also drawn attention to the spread of HIV via military and security forces in conflict or peacekeeping situations. But questions might be asked as to whether targeting such sectors in HIV/AIDS relief risks privileging certain parts of society because of their relevance to US strategic goals (Elbe 2005).

There is now concern that political and economic elites will be able to insulate themselves from the worst effects of HIV/AIDS while exploiting scaled-up AIDS relief to entrench their positions (de Waal 2006). While saving lives in the short term, HIV/AIDS relief could perpetuate a closed political loop that is detrimental to wider human security and fails to address the deeper-rooted social determinants of health. It is also noteworthy that the hypothesis that high-prevalence HIV/AIDS epidemics would destabilise national and regional security has not been substantiated, raising the question of whether HIV/AIDS has been used opportunistically by the security apparatus (Whiteside et al. 2006; Barnett and Prins 2006).

The trade-offs associated with the linking of security to health is illustrated also with the prevention and control of acute infectious disease outbreaks. Some authors argue that global health security has helped to normalise the intrusive and extensive use of external surveillance and the suspension of sovereignty across a range of policy areas (Hooker 2006). Whilst protecting the health security of populations is a good thing, it is necessary to ask who is being secured, from what, how, and at whose cost?

The surveillance of public health threats requires a major upgrading of data capture and information systems. While efforts have been made by the WHO and other agencies to ensure that data are managed and used for politically neutral and scientific purposes, some researchers have identified links between public health surveillance networks and intelligence communities, calling its supposed neutrality into question (Weir and Mykhalovskiy 2006). It also places demands on poorer countries to develop surveillance and response strategies that can help protect the global community. However, it is unclear whether such demands are affordable or appropriate to their health priorities (Lee and Fidler 2007). The focus on cross-border infectious disease control may mask structural problems in global public health, leading to solutions which benefit the rich more than the poor.

The linking of health and security therefore creates a complex political space that requires discussion and research, particularly in relation to three issues (Lee and McInnes 2004).

First is the process of determining what is and isn't a security issue. The same powerful actors who determine what constitutes a security issue also tend to be responsible for shaping international responses to those threats. Placing health issues in national security strategies or on the agenda of bodies like the UN Security Council, or defining the WHO's role in terms of global security, creates a space where particular ideas of security and associated interests that are promoted must be questioned and reframed if necessary.

Second is the danger that efforts to address health problems deemed important through a security lens, rather than more objective measures of need, will distort health priorities. How is the conceptualisation of health as a poverty, justice or human rights issue to be reconciled, for example, with strategic objectives linked to 'fragile states', 'failed states' or 'rogue states'? What are the consequences of health being used as an instrument of foreign policy?

Third, a concern with security may reinforce problematic aspects of health policy. For example, the desire to enhance security may lead donors

to prioritise bilateral funding mechanisms at the expense of multilateral channels. A 'control and containment' focus on infectious disease outbreaks may detract from more effective and sustainable approaches to health promotion. Vertical, disease-control policies and programmes, with their emphasis on disease prevention, may flourish at the expense of comprehensive primary health-care programmes and emphasise an authoritarianism within the health sector that runs against principles of decentralisation and community empowerment, or could lead to certain communities being demonised as 'security threats' (Elbe 2006).

Final comments

The recently created links between health and security will help raise the profile of certain health issues, but they may also reframe them to the advantage of the more powerful. The key question is whether this shift represents a welcome advance in ideas of security, or the co-option of health by vested interests, raising the risk that security will simply lead to new forms of selectivity and inequality in the landscape of global health and the global political economy. Public health advocates need to examine and debate the issue in four ways:

- Monitor the links being made between health and security in a wide range of settings.
- Contribute to the evidence base on how health–security links are affecting global health initiatives in practice. More detailed case studies from a wider range of places are required.
- Encourage critical debate and discussion about different conceptions of security, whilst constantly advancing perspectives grounded in human rights and ethics.
- Support networks of enquiry and discussion for groups from different disciplines and regions to develop more comprehensive understandings of links between health and security, whilst building the capacity to react to unwanted developments in the field.

Notes

1. A longer version of this chapter is available at www.ghwatch.org.
2. The members of the GHSI are Canada, France, Germany, Italy, Japan, Mexico, the UK, the US and the EU. See www.ghsi.ca/english/index.asp.
3. Information on PEPFAR in Nigeria via www.pepfar.gov/.

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