

## Securitisation of Zika

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JOSIE HORNUNG, AUG 17 2016

While securitisation has proven an effective tool in recent infectious disease outbreaks, this essay will argue that the current Zika outbreak does not yet meet the threshold to make securitisation appropriate, because it is not yet a quantifiable and serious security risk. It will argue that the current Zika threat is best conceptualised and responded to in the way that the WHO and the Brazilian government already are. The soundness of this position will be demonstrated by way of four parallel arguments. First, by establishing who securitisation is designed to protect and who bears the burden of it, it will be shown that securitising Zika would not be equitable. Second, by illustrating the applicability of the security framework to the current Zika outbreak, and comparing this to current national and international responses, it will be shown that enough is being done. Third, by showing that Zika is a largely unknown risk, due to the lack of information available on the virus, it will be argued that securitising the outbreak would be premature. Finally, by conceding that Zika does have the potential to become an international threat, the 'health emergency' stance that the WHO and the Brazilian government have taken will be shown to be the most sensible one.

Considering infectious diseases as threats to national and international security (in terms other than in the context of armed conflict) represents, perhaps surprisingly, a new development in health policy. By the year 2000, concerns over health were no longer limited to the direct impact of armed conflict on militaries, as was previously the case, but to the wider effects health can have on economic and political stability (Brundtland 2003, 421). The first years of the new millennium saw a new narrative appear which placed select health issues higher on the security agenda than ever before (McInnes and Lee 2012, 131). A key moment was the WHO's 2007 World Health Report, which focussed, for the first time, solely on global public health security in the 21st century (WHO 2007). Similarly, the United Nations Security Council's (UNSC) resolution 1308 reconceptualised the HIV/AIDS pandemic not only as a humanitarian catastrophe, but a risk to national security and international stability (S/RES/1308 2000). UNSC resolution 2177 during the recent Ebola crisis, for the first time explicitly clarified an infectious disease as a 'threat to peace and security according to article 39 of the UN charter' (S/RES/2177, 2007). Thus, through the process of securitisation, health has been elevated from being solely a domestic policy or humanitarian issue, to one that can be conceptualised as a threat to international peace and security.

To securitise health is to take it out of the realm of technocratic policy, into the privileged realm of security policy. The securitisation of public health, as described above, draws its theoretical foundations from the Copenhagen school of securitisation theory (see Buzan 1998). Securitisation, as such, is a norm-establishing process whereby a non-security issue comes to be considered a security issue by international actors (Hornung 2015). The theory proposes that for a threat to be identified as a security issue, the threat must first meet strictly defined criteria that distinguish it from a merely a technical or political one (Buzan 1998, 21). A security issue, then, "has to be staged as an existential threat to a referent object by a securitising actor, [to generate] endorsement of emergency measures beyond the rules that would otherwise bind" (Buzan 1998, 21). Having met these criteria, the threat must then be accepted as a security threat by the securitising actor's target audience, in this case, states in the international community (Buzan 1998, 21). In the final step of securitisation, the threat must generate extra-budgetary reallocation of resources to combat it (Buzan 1998, 21). Enemark contends that the value of securitising health issues is that it "promises to attract greater political resources and attention for protecting human health and human lives in the face of specific infectious disease threats" (Enemark 2007, 20). The logic behind the securitisation of global health, particularly regarding infectious disease outbreak events (whether it arises out of political pressure to conform with

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new norms, states' self or common interests, or public image concerns [remembering WHO has no enforcement mechanism]), is that states are more likely to take health threats seriously and allocate additional resources accordingly (Hornung 2015). Considering health as a security issue could be seen as a pragmatic or strategic act to gain increased policy and media attention (McInnes and Lee 2012, 131).

Although securitisation is a useful tool in the policy maker's toolkit, it is not without controversy. Security, as famously described by Buzan, is 'essentially contested' and 'creates unresolvable debates about its meaning and application' (Buzan 1991, 7). Each meaning of security, so conceptualised, is constructed for a particular purpose, usually to promote a certain agenda or privilege certain interests over others (McInnes and Lee 2012, 133).

International Relations practitioners such as Davies and Rushton have questioned the motivations of the WHO to securitise health, and what political forces drove the reconceptualization. They contend that there are signs of discontent from the developing world over the concept of 'health security' and its political implications (Rushton 2011, 780). The limited range of recognised 'health security threats' (i.e. infectious disease and bioterrorism) reveal a great deal about the agendas that underpin the concept. What Rushton and Davies argue is that the West is the primary beneficiary of the securitisation of infectious disease. Views from developing nations about the most pressing health threats within their borders typically have a strikingly different focus, and many of the diseases widely framed by the WHO and the West as major health security threats are endemic in the global south (Rushton 2011, 780). Not only that, the revised IHRs' emphasis on surveillance places a huge economic and technical burden on developing nations, whose efficacy at bearing the burden rests largely on their often already overburdened state health infrastructures. The burden placed on developing nations by the IHRs does not correspond with any greater protection (as was stated many of the diseases under surveillance are already endemic in these countries). It seems the developing world is being asked to bear the cost of ensuring that the West stays protected. The discourse on health security, thus conceptualised, appears very narrow; focussed on protecting the West from threats emanating from the global south (Rushton 2011, 780). The overwhelming focus of global health security on surveillance and containment, rather than prevention, heightens unease about 'whose security really matters' (Aldis 2008). It does not seem contentious, given this evidence, to assert that the health security agenda is significantly skewed, reflecting the concerns of the most powerful actors in the international system (Abram 2011). Thus, any move to securitise the current outbreak of the Zika virus could fairly be characterised as an inequitable one.

The current Zika virus has thus far been shown to have limited international security implications, and the approach taken by the WHO and the Brazilian government thus far has been measured and appropriate. Premature securitisation of a disease outbreak can have devastating effects on countries and regions dealing with a disease. Speaking on the recent Ebola outbreak in West Africa, Harmon notes that misinformation and the resulting anxiety of a perceived health crisis can be far more dangerous than the pathogens themselves (Harmon 2016, 2). Public and private sector responses to Zika have been more productive and better at mitigating concerns than the responses to other recent health crises (Harmon 2016, 4). This is measurable by the fact that Brazil, the epicentre of the disease, has experienced a very limited economic impact to date, despite widespread travel advisories (Harmon 2016, 4). The WHO followed the proper steps, as outlined in the IHRs, and declared a 'Public Health Emergency of International Concern' (PHEIC), at the appropriate time (2 February 2016) in relation to the possible new link to microcephaly in infected pregnant women. The Brazilian government had earlier declared the situation a national public health emergency (November 11, 2015) (Samarasekera 2016, 523). The PHEIC released funding for research into the disease and its possible new neurological complications, for developing rapid diagnostic testing, for research into vaccine production, and for on-the-ground measures, such as mosquito control efforts. The response of the WHO to Zika thus far is proportionate to the threat Zika currently poses to the international community.

At this time, the current Zika outbreak is best conceptualised as an unknown risk to the international community, due to the lack of reliable information on its effects. Symptoms of the disease are reportedly mild (a fever, rash and conjunctivitis), with only twenty percent of those affected showing symptoms, and with their symptoms only lasting for up to one week (Sikka et al. 2016, 6). With mortality low and hospitalisation infrequent, the health burden of the disease is not comparable to other infectious disease outbreaks such as the Ebola virus or pandemic influenza. What the concern is, and what the PHEIC relates to, is the suspected link between Zika and microcephaly in babies born to mothers infected while pregnant. As yet, the causal relation between the two has not been established, and reporting

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problems have skewed any data on a possible link. According to an epidemiological report by Brazilian health authorities, 4180 cases of microcephaly have been reported between November 2015, and the end January 2016 (Samarasekera 2016, 523). Despite this seemingly high number, the increase in the percentage of the population affected may not be as pronounced as it appears, since mandatory reporting for microcephaly in Brazil were only put in place a few months prior to the outbreak (Samarasekera 2016, 523). Mauro de Freitas Rebelo, a professor at the Federal University of Rio de Janeiro highlights this salient fact, and contends that it 'adds a bias that overestimates the increased rate of microcephaly in Brazil in the past year' (Samarasekera 2016, 523). The definition of head circumference to diagnose microcephaly is also not standardised in Brazilian health policy, which may have allowed a confirmation bias effect to boost the number of reported cases. Additionally, Zika infection can only be confirmed by specialised blood testing called 'PCR' 1, and the current capacity for doing PCR tests for Zika in Brazil is extremely limited (there are only five laboratories nationally that are equipped to do the test, who together can run a maximum of 100 tests per week) (Samarasekera 2016, 523).

Even when such specialised testing is available, the window of opportunity to do the test is very small, as the blood of infected patients needs to be tested in the first few days after symptoms appear, for accurate diagnoses to be given (Samarasekera 2016, 523). Such issues with the lack of technical capacity to diagnose Zika, added to the lack of a quantifiable medical definition of microcephaly in Brazilian health policy, have made accurate data on the impact of Zika difficult to obtain. Without accurate data, the potential new impacts of the Zika virus cannot be known. The term PCR refers to the laboratory technique performed on blood tests called 'polymerase chain reaction'.

Until the link between this relatively benign disease and the more insidious microcephaly have been established, Zika does not rise to the threshold of risk required to be considered a threat to international security, and thus to be securitised. The current Zika outbreak is best conceptualised as an unknown risk to the international community, due to the lack of reliable data on its impact. The WHO and the Brazilian government's response, including the PHIEC and the declaration of a national health emergency, have thus far been measured and appropriate given this lack of data, and their desire to avoid unnecessary panic (which could cause economic or political instability). Securitising Zika at this stage would therefore be a mistake, as not only could it reinforce the inequity embedded in the IHRs, it may be unnecessary. To make such a mistake would risk further damage to the fragile reputation of the WHO; a reputation it needs to maintain in order to effectively coordinate international responses to real health-security threats in the future.

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