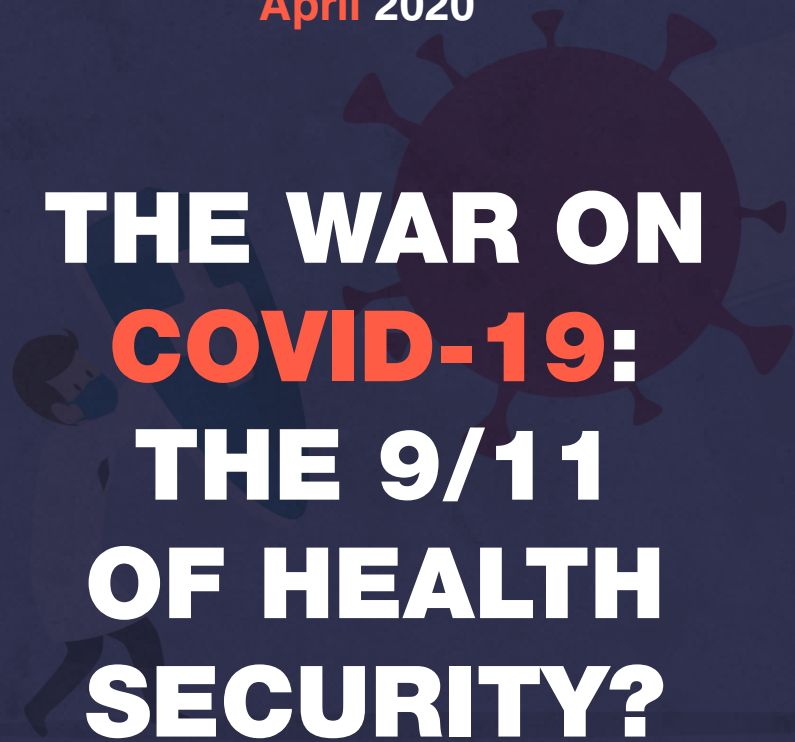




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**THE WAR ON
COVID-19:
THE 9/11
OF HEALTH
SECURITY?**

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The War on COVID-19: The 9/11 of Health Security?

Summary

The coronavirus pandemic represents a turning point in security studies, shedding light on the importance of the health of populations for sustaining the political, economic, and social health of the nation-state. Playing a role akin to the 9/11 events in propelling terrorism at the forefront of the global security agenda, COVID-19 reshuffles national security priorities. As such, the securitization of health has allowed the implementation of drastic exceptional measures aimed at containing the pandemic. However, as states increasingly turn inwards, the international community is losing momentum to multilaterally respond to the crisis and build sustainable health systems that can absorb the shocks of future disease outbreaks. For this purpose, this paper explores the politicization and securitization of COVID-19, and how it can set the basis for the renegotiation of the importance of health as a core component of security, not only in times of crises, but also in the ‘new normal’.

In many ways, COVID-19 has uncovered the failings and fragilities of current political and economic systems. While the sustainability of our current growth models and socio-political organizations has long been debated, questioned, defended, and negated, the surprising resilience of liberal internationalism in the face of various challenges has solidified its ideological foothold. Nonetheless, it has taken less than a few weeks for COVID-19 to erode the social fabric of our societies and dismantle their orderly structure, causing more than 1.3 million infections and over 73,000 deaths, at time of writing. It might as well be the 9/11 of health security; an event that will constitute a turning point in security studies and redefine global health governance post-COVID. Years-long neglect of healthcare systems and health inequalities have surfaced as deeply rooted problems that have been left unresolved, acting as a reminder of the prime importance of the health of populations for sustaining the political, economic, and social health of the nation-state. This is not a novel insight. Pandemics have always been part of human history, acting as disturbing forces remapping and reshaping political and geopolitical anxieties. Critical episodes such as the Black Plague and the Spanish Flu have caused millions of deaths. The World Health Organization's (WHO) raison d'être is to precisely foster global cooperation in the face of similar threats jeopardizing the health and well-being of communities worldwide, with the aim of upholding a global responsibility to protect the right to health for all. However, despite some great common successes in eradicating diseases, such as smallpox, or mobilizing resources to advance scientific knowledge, health remains marked by severe inequalities and significant vulnerabilities, accentuated by the emergence or re-emergence of infectious diseases. Although pathogens in themselves do not discriminate, collective resilience and individual immunity are

influenced by a whole set of biosocial factors, including the quality and accessibility of healthcare systems. The COVID-19 pandemic illustrates this in many ways. While it has spread to more than 180 countries, preexisting health weaknesses and policies have influenced the resilience of health systems to the outbreak. The lack of a centralized and common response to the pandemic, as states turned inwards to manage their internal health and governance crises, declaring war on COVID-19, has been marked by the depth of economic and geopolitical disparities underpinning the global order.

Laying bare our rawest vulnerabilities, the pandemic, therefore, represents a stress test as much for individual nations as for the global order as a whole. With the biological survival instinct overshadowing the political and economic ties sustaining the international order, states have increasingly turned inwards, treating COVID-19 as a matter pertaining to the national security realm and exclusive to national sovereignty. This paper explores the politicization and securitization of COVID-19, and how it can set the basis for the renegotiation of the importance of health as a core component of security, not only in times of crises, but also in the 'new normal'.

1. The Evolution of Security as a Discursive Practice

The relentless pursuit of national security driving state politics has often focused solely on protecting borders from adversarial attacks and foreign intrusion. Mainstream accounts of security give nation states a pivotal role in simultaneously constituting a threat and a defense against anarchy. Hobbes' (1651) reading of security derives from a similar logic, wherein the state acts as a leviathan to protect citizens from the state of nature—in which fear and conflict predominate—by enforcing the social contract. The presumed anarchy of the international system immutably posits states as the sole referent objects of security, and interstate conflicts as the sole manifestations of insecurity. Hence, the centrality of 'the phenomenon of war' in delineating the concept of security is asserted, with scholars such as Walt (1991) arguing that security studies are essentially a study of military force and interstate confrontation.

The adoption of realist lenses to understand international relations weakened at the dawn of the twenty-first century, as the dissipation of the bipolarity of the international system and the limited number of interstate wars brought to light new challenges that realism was ill-suited to decipher. Traditional security studies assumed interstate relations to be confrontational, thus defining a state's security in relation to other states, rather than to transnational or internal forces. Yet, exploring how diseases represent a security threat requires moving beyond a state-centric conceptualization of security towards a more human-centered approach. Buzan (1983) mainly critiques traditional militarized perspectives on security, which, he argues fail to dissociate security from peace when neither guarantees the other. This assertion was significant in acknowledging that threats to the state and its populations are not only military in nature, but rather that the intersubjective nature of security means its construction can encompass political, social, environmental, and biological hazards. The intersubjectivity of security has been a prime concern for the Copenhagen School of thought, which introduced securitization as a discursive practice by which issues are socially and politically construed as threats through a securitizing move negotiating with an audience the adoption of exceptional measures (Buzan et al, 1998). While old-fashioned territorial threats remain a menace to individuals' livelihoods, the main threat jeopardizing the survival of populations today

stems also from phenomena such as terrorism, illness, poverty, and the politicization of ethnic cleavages. The immediate and protracted impacts of poverty, for instance, erode human resilience and dignity over time, while the lethality of certain diseases represents an instant threat to life. Securitizing these threats does not dismiss military threats. Rather, it is a discursive practice reflecting a normative position concerned with individual survival and dignity, while acknowledging that non-military insecurities also carry potential political, economic, and social costs.

Pandemics accurately reify these threats, especially when surrounded by uncertainty. For many reasons, while it is hard to accurately assess the dangerousness of a virus, it is equally tricky to predict its impact on socio-political stability. The level of scientific uncertainty during these early phases is only matched by the unpredictability of human nature and its response to the outbreak. These uncertainties fueling fear from the disruptive potential of diseases, explain why outbreaks have often been elevated to high-politics issues, triggering aggressive responses by states.

2. COVID-19: The Threat Behind the Disease

In less than three months, COVID-19 has turned from a local outbreak in mainland China to a global pandemic. While the Chinese government reported the outbreak to the WHO in mid-January, government reports suggest that the first cases of the disease can be traced back to the Chinese city of Wuhan as early as November 2019 (South China Morning Post, 2020). Yet, it wasn't until late December that doctors in the city started raising their concerns about a new SARS-like disease, only for those concerns to be actively suppressed. To maintain panic levels to a minimum and avoid the political, economic, and social consequences of the outbreak, local authorities attempted to quell the voices of whistleblowers reporting on the epidemic via social media. When China ultimately reported the situation to the WHO, little was known about the lethality or virulence of what closely resembled seasonal flu, but investigations rapidly showed that a novel strain of coronavirus was causing the disease, likely to have emerged in Wuhan's wholesale seafood market. However, by the time more information was disclosed about the disease, the spread of undiagnosed cases was already uncontrollable, with several Chinese provinces simultaneously reporting their first cases.

Even then, the SARS-CoV-2 virus did not immediately gain traction. Its perceived similarity to the flu and supposed contained presence in China did not ring any alarm bells at the international level. The naïve assumption that China could be quarantined despite its centrality to the globalized economic order was a rather incomplete understanding of the lessons that could have been learned from the many pandemic waves that preceded COVID-19. The novel coronavirus has emerged against the backdrop of an unprecedented level of interconnectedness and interdependency through the facilitated flow of goods, people, and capital. Therefore, given the context, it only took a few weeks before COVID-19 crossed borders and turned into a pandemic with multiple active epidemiological foyers in China, the United States, Europe, and Iran. The extended geographical reach of the disease outbreak has served to propel the crisis to the forefront of the international agenda, although failing to mobilize a coordinated global response. One of the main reasons for the uncontained initial spread of COVID-19 has been unwarranted comparisons between the disease and the flu, brushing aside some of the factors that render COVID-19 a greater menace than seasonal flu. One of these factors

is the basic reproduction number (R_0) of SARS-CoV-2, which recent studies estimate to be between 2.28 and 3.58 (Zhang et al, 2020), meaning one person contaminates on average about 3 other people. Based on this range of estimates, COVID-19 is significantly more contagious than the flu, the R_0 of which averages 1.3. Moreover, individuals can be infectious before displaying any symptoms, posing a great risk for undiagnosed cases to sustain the spread of the virus uncontrollably. This is further compounded by the significant number of asymptomatic patients and healthy carriers, who never develop symptoms, representing an untraceable source of infections. This explains the rapid multiplication of infectious clusters within China at the onset of the disease, and its spread beyond the country. The contagious nature of COVID-19 is particularly worrying since the disease has proven to be lethal. Given current confirmed numbers of cases and deaths, the global case fatality rate averages 5.54%, although it is likely to be lower given the significant number of estimated non-diagnosed or unreported cases.

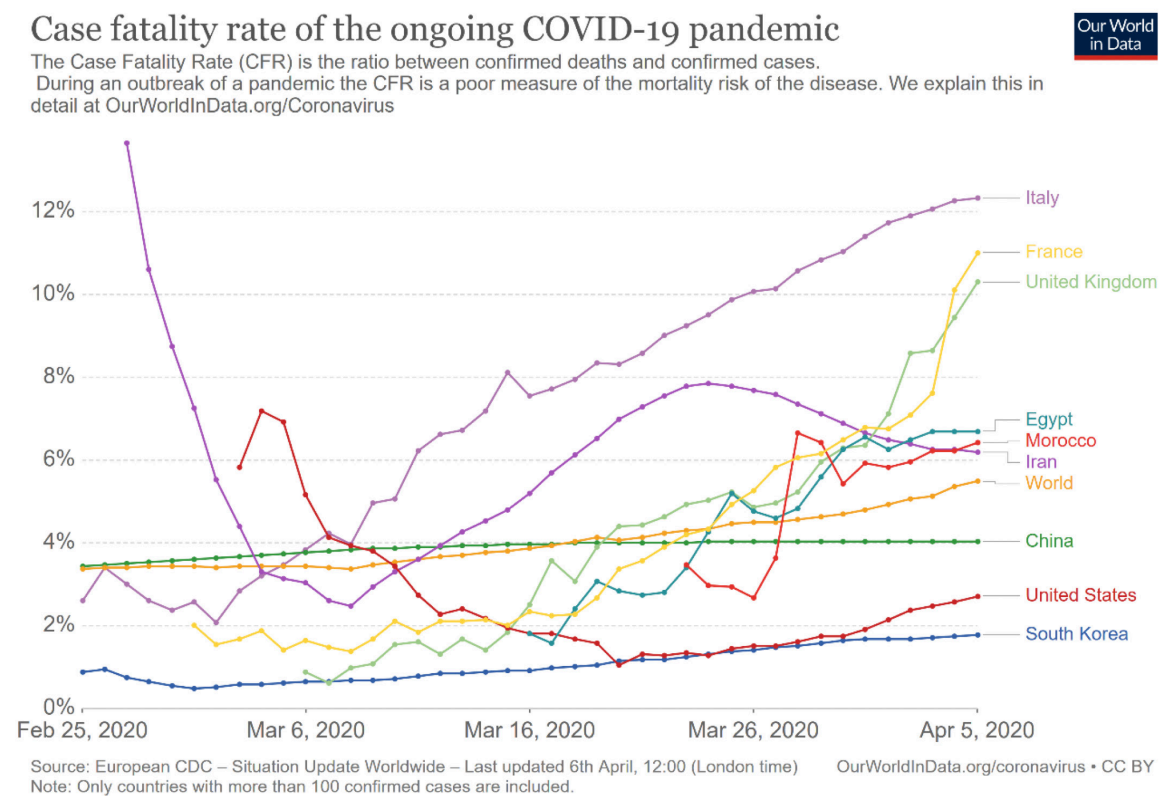
The fatality rate is, however, limited as a metric, although often used to approximate the gravity of a disease, and needs to be contextualized. While the general case fatality rate indicates the likelihood of dying from complications caused by COVID-19 upon infection, it glosses over other forms of health insecurity deriving from the disease. Beyond mortality, the morbidity associated with COVID-19 also presents a risk to the well-being of infected populations, as the disease causes varying degrees of illness. The severity of the symptoms at the onset of the disease differs greatly from one age group to another and from one comorbidity to another. Most symptomatic cases express relatively mild symptoms and do not require hospitalization. However, these symptoms can worsen during the second week of illness as the infection progresses, leading to pneumonia, respiratory failure, septic shock, or organ dysfunction, the treatment of which requires intensive health care. While no exhaustive listing of risk factors currently exists, some studies have suggested that older patients, those with underlying health conditions such as diabetes, and those with compromised immune systems, might be at greater risk of contracting critical forms of the disease. This increased likelihood of suffering from severe symptoms translates into a higher case fatality rate for the above-mentioned groups. A study evaluating the case fatality rate per risk group among 44,000 cases in China has indicated that while the case fatality rate for patients with no comorbidities averaged 0.9%, it was as high as 10.5% among patients with cardiovascular disease history, 7% among those suffering from diabetes, and 6% among patients with chronic respiratory disease, hypertension, and cancer. The same study has estimated the case fatality rate to be highest for people aged over 80 years, averaging 14.8%, but an alarming number of young people are increasingly succumbing to COVID-19.

These human losses translate into productivity losses for the state, adding to the long list of economic costs associated with disease outbreaks. All strategies to contain, mitigate, or ignore pandemics require the state to incur economic costs, either over the short or the long-term. Global shocks such as COVID-19 significantly impact growth perspectives, as funds are diverted from other sectors to the health sector while governments impose stringent measures halting trade and production. According to the OECD (2020), widespread travel restrictions, financial market turmoil, and heightened uncertainty could cost major economies up to 2 percentage points in annual GDP growth per month. This unprecedented scale of economic disruption could jeopardize the stability of countries, triggering an economic fallout threatening the foundations of the modern state.

3. Legitimizing the Security Response to COVID-19

Drawing greater attention to the political nature of this health crisis is how the factors determining the virulence and lethality of COVID-19 depend on the ways in which the disease interacts with social and political institutions. Figure 1 depicts the variation of the fatality rate in select countries. The fatality rate depends on two factors: the number of cases reported, and the number of deaths recorded. Both of these are heavily influenced by the political strategy and systemic health capacity of the state, whereby testing policies determine the likelihood of diagnosing real cases, while the structure and capacity of national health systems influence the quality of the care provided to the infected. As such, South Korea and Germany owe their significantly lower fatality rates to mass testing policies that bring them closer to diagnosing the real number of cases. Mass testing also helps isolating asymptomatic patients before they infect someone more vulnerable, which significantly alleviates the pressure on health systems.

Figure 1: Our World in Data (2020). Case fatality rate of the ongoing COVID-19 pandemic. Accessed April 7, 2020.



The resilience of health systems is the result of the public health policies pursued by states and the allocated budget, determining the accessibility and performance of the healthcare infrastructure. Several indicators can be used to approximate health capacities, including the number of laboratories capable of diagnosing cases, and the number of hospital beds, physicians, and health workers available. The International Health Framework (IHR) regulating global health governance, requires State Parties to self-evaluate their core capacities for emergency preparedness and response. These encompass legislation and financing, IHR coordination and national focal point functions, zoonotic events and the human-animal interface, food safety, laboratory, surveillance,

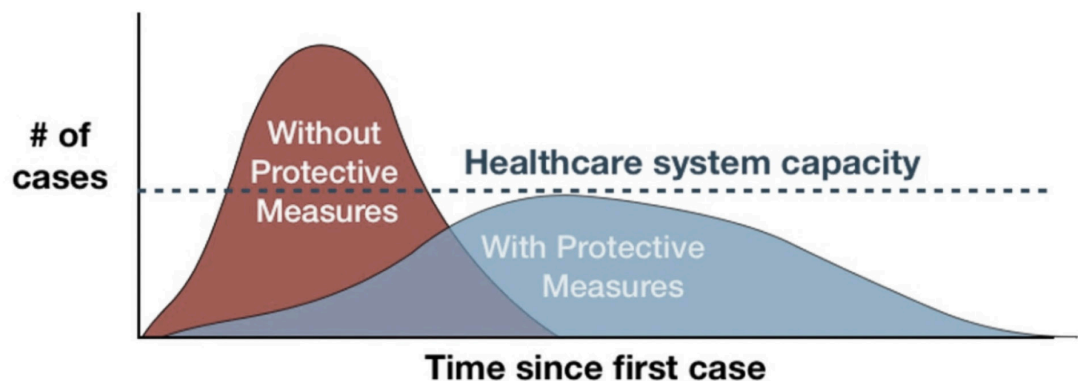
human resources, national health emergency framework, health service provision, risk communication, points of entry, chemical events, and radiation emergencies. Figure 2 summarizes the average of the 13 above-mentioned core capacities per WHO region, to provide an overview of the capacity of each region to deal with COVID-19.

Figure 2: World Health Organization (2019) Accessed March 31, 2020.

	Average of 13 International Health Regulations core capacity scores, SPAR versionⁱ	
WHO region	2018	
Global		60
Africa		42
Americas		65
South-East Asia		56
Europe		72
Eastern Mediterranean		65
Western Pacific		64

Based on the above, it appears that significant health disparities persist among regions, with Africa and South-East Asia being the least equipped to cope with a large-scale outbreak. This means that the influx of newly infected patients is likely to heavily stress these systems and stretch health resources, threatening the quality of care received by both COVID and non-COVID patients. Concomitant mortality and indirect deaths should equally be taken into account when evaluating the impact of pandemics. The greatest risk stemming from pandemics is in the aggregation of cases burdening health systems and stretching them well beyond their capacities. With an estimated 20% of cases requiring hospitalization, COVID-19 diverts medical, financial, and human resources, and constrains access to health services, jeopardizing the health of the many other patients suffering from non-coronavirus related diseases. This is particularly burdensome for countries suffering from a double burden of disease, both communicable and non-communicable, for which COVID-19 represents an additional threat, both in the way it increases their vulnerability and disrupts their access to adequate services. Moreover, this amplified pressure on health systems replicates an ethical dilemma usually faced during wartime. In highly affected areas, as hospitals run out of beds and ventilators for critically ill patients, healthcare workers are forced to decide whom to prioritize and admit. Despite having one of the best performing health systems, the overwhelming number of cases in Italy has surpassed available healthcare capacities, contributing to the increasingly high number of deaths. A similar pressure on weaker health systems simultaneously fighting other infectious diseases, such as malaria and tuberculosis, would admittedly be disastrous. Therefore, in order to alleviate pressure on health systems, one of the main strategies endorsed by the majority of states has been attempting to curb the progression of cases, and ‘flatten the curve’ of infections through containment and mitigation measures.

Figure 3: The New York Times (2020). Epidemic curve. Accessed March 31, 2020.



The number of real cases is largely the result of the degree of exposure to infections and risk factors associated with illness, itself contingent on political, geographical, socio-economic, and demographic considerations. The reproduction rate estimated above is that of the virus if left to roam free amongst people, without the adoption of social distancing measures or the imposition of mandatory quarantine. The effective rate, however, can be conditioned by behavioral dynamics, which impact transmission patterns. It firstly reflects the extent to which the society is able to reorganize itself and self-enforce measures that go against basic needs for socialization, that challenge current social structures, and that jeopardize economic activity. It then also reflects the extent to which the state can enforce these measures and discipline the population, while protecting itself from the damage arising from the measures. Thus, the state faces a unique conundrum: implementing drastic measures at the risk of alienating the population and suspending economic life, or prioritizing short-term economic and political well-being at the risk of the health crisis touching the nerves of the state body and undermining socio-political stability in the long run.

a) Internal Confinement Measures

Most states at the epicenter have sought to strike an equilibrium in their response, to protect both their populations and economies, but none has truly succeeded given the magnitude of the pandemic. The urgency of implementing drastic measures, such as complete or partial lockdowns, halting non-vital economic activities, forbidding large gatherings, and closing down public spaces, has imposed itself to contain the pandemic. These are surveillance measures that in ordinary times would meet resistance, except when the threat is securitized, such as has been terrorism post-9/11. Consequentially, to effectively combat the propagation of the virus and justify the unusually severe measures, several states have adopted a security discourse framing COVID-19 as a high national security threat. Drifting away from an initial discourse minimizing the menace posed by the disease, states have increasingly adopted a martial rhetoric, renegotiating the importance of population health for national stability and positing COVID-19 as an existential threat. The use of such rhetoric has been crucial in legitimizing the exceptional measures taken by states to forcefully respond to the health crisis, especially in democracies where populations have traditionally been wary of any infringement of individual liberties. Convincing populations to relinquish individual freedoms at the expense of collective

well-being is arduous. It requires full trust in state capacities and a will to contribute to a greater purpose, akin to warfare. In France, the shadow of horror cast by the pressures on the health system in neighboring Italy was already ingrained in the national collective imaginary. President Macron's national address on March 16, 2020, further contributed to securitizing the disease. He declared the country at war against the virus as he commanded the population to subject itself to measures severely restricting freedom of movement (Elysée, 2020). His repeated use of the word "war", seven times in his speech, emphasized the nature of the threat, while the framing of the virus as an "invisible enemy" highlighted its pernicious nature. Comparing hospitals to frontlines in this decisive battle, Macron further translated the abstract idea of health warfare into a tangible threat to the health system's resilience and population survival. The launch of the special military operation Resilience to help fight the pandemic illustrates how the rhetoric has paved the way for the military to be drafted to provide logistical and medical support in a matter ordinarily considered as purely civil.

President Trump has adopted a similar martial rhetoric, despite an initial reluctance to acknowledge the gravity of the situation. Fearing panic and social turmoil over the potential economic disruptions deriving from both the spread of the pandemic and the measures taken to counter it, the U.S. administration's initial posture was to minimize the threat. Since few cases were reported nationally, it seemed unnecessary to take costly preventive measures, especially since global markets were already displaying erratic behavior. Yet, as the number of cases increased and as the threat loomed closer over Europe, the administration could no longer look away. Assuming his metaphorical role as a wartime president fighting an "invisible enemy," Trump encouraged Americans to limit social gatherings and avoid unnecessary travel, before invoking the Defense Production Act (DPA) to ensure enough resources are mobilized to scale-up testing and healthcare capacities. The DPA is a residual legal framework from the Cold War era, endowing the President with the power to control the allocation of resources essential to national defense, which in these tense times would be the supply of medical equipment, including testing kits, masks, and ventilators. The ascendance of this equipment to such a status has been accompanied by a growing awareness of how interdependent global supply chains shape individual nation-state vulnerabilities, raising a whole new concern for health sovereignty.

One of the many other aims of the adoption of the security narrative has been to mobilize the general public's patriotism, as would be done in wartime, especially where the legitimacy of the regime is highly valued and the protection of the population linked to the *raison d'être* of the state. In China, the social contract rests on the ability of the state to contribute to the economic and physical well-being of the population. Yet, initial missteps in the handling of the crisis have deepened a serious crisis of faith in the systemic ability of the Chinese leadership to provide for the social and health needs of its citizens. The political instinct for self-preservation overshadowed for a few weeks the biological instinct for survival, leaving room for the emergence of parallel networks of information competing with the official state narrative. However, the uniqueness of the Chinese regime has also allowed its response to be more forceful and drastic, building on pre-existing social structures and surveillance technologies to enact a holistic contingency plan. These technologies have helped with contact tracing, phone tracking, and temperature monitoring, for the purpose of preventing those already infected from spreading the virus. Paradoxically, epidemics both weaken and strengthen the surveillance state: they weaken it by uncovering its potential to silence dissidents and

cover up the extent of internal threats, and strengthen it by legitimizing the efficiency of its surveillance apparatus. China's centralized bureaucracy also helped implement drastic lockdown measures in certain provinces, scale-up the resources needed to combat the epidemic, and mobilize the workforce to build or reinforce the health infrastructure. The Chinese Communist Party has tried to popularize the fight against COVID-19 by depicting it as a common battle and stressing the responsibility of every individual to take part in the fight. As the number of cases started decreasing a few weeks after the lockdown, the Chinese government has posited its more vigorous handling of the crisis as leading a "people's war" it was "resolutely winning" (Reuters, 2020). Xi Jinping's visit to Wuhan on March 10, 2020, served to reinforce this narrative, by showing leadership as he toured the city thanking the people for their commitment to stay home and contribute to this battle.

B) International Containment Measures

While infectious diseases have always been able to transcend national borders, successive waves of globalization have increased states' interdependence and exacerbated the risk that local outbreaks would morph into global pandemics. The facilitated flow of goods and people across borders contributes to the rapid spread of bacteria and viruses globally, as demonstrated by the far-reaching H1N1 and SARS outbreaks. The re-emergence of various diseases, such as tuberculosis, and the spreading of viruses well beyond the areas where they have traditionally been endemic, has further contributed to remapping the geopolitical nature of health. The growing awareness of the transnational nature of health issues has been accompanied by an evolving understanding of the need to cooperate to strengthen disease monitoring, surveillance, and control, thereby leading to the emergence of global health as an interdisciplinary and multinational governance space, in which several critical notions in world politics are renegotiated and redefined. Embodied by the establishment of the WHO, the globalization of health concerns has been an important step in health securitization, by exposing international and national security's vulnerabilities to the spreading of diseases, given the threat public health crises in one country represent to the military, economic, and social organization of other countries.

It is therefore unsurprising that one of the most popular measures adopted by states has been to reduce exposure to the virus through tightened border controls. These range from mandatory quarantines for incoming visitors to the full suspension of international travel and closure of borders. Such measures have been adopted by countries at different phases of their epidemic progression curves. At the onset of the disease, when the outbreak was still confined mainly to China, most countries implemented health screening measures at borders checkpoints to monitor the fever of passengers, especially those coming from severely affected countries. These measures then gradually evolved as the expanded reach and scope of the disease called for more stringent actions to be enacted. By early March, several European Union (EU) member states, including Slovakia and the Czech Republic, had imposed further border checks or completely closed their borders to neighboring states reporting higher numbers of cases. States outside the newly emerging European epicenter also strongly felt the impact of the outbreak, imposing travel bans to minimize contagion risks. For instance, the United States announced on March 13 that it was barring entry to all foreign nationals who had been to the Schengen Area, China, or Iran in the previous 14 days. By then however, the U.S. was estimated to host a few thousand cases, with several community clusters reported, meaning not only

was the virus already within the country, but it was also spreading locally.

Well-aware of their geographical proximity to Europe and economic proximity to China, African countries have been on the frontlines of the fight against COVID-19, rapidly taking similar internal and international measures, despite significantly lower numbers of cases. Morocco cancelled events, shut down schools and public spaces, and suspended its maritime and air connections with most affected countries, even though fewer than 10 cases had been reported nationally. Other African countries, including Senegal and Côte d'Ivoire, declared states of emergency before reaching their hundredth COVID-19 case, while Zimbabwe declared a national emergency, banning large gatherings and imposing travel restrictions, even before declaring any case on its territory. Similarly, despite zero reported cases, Botswana and Comoros have taken the preventive step of closing their borders in order to minimize contagion risks. This relatively rapid response on the African continent reflects in part the fragility of some health systems in the region due to protracted conflicts or endemic diseases, and the limited systemic capacity of others. For instance, South Africa's drastic response to COVID-19 can be partially justified by the country's years-long battle with HIV/AIDS, which affects an estimated 7.7 million South Africans (UNAIDS, 2018). Given the impending heightened risk COVID-19 poses to individuals suffering from immunosuppression, a major outbreak of the disease could reverse hard-won gains and jeopardize the livelihoods of millions of South Africans. Additionally, for several African countries, including Côte d'Ivoire and Malawi, 2020 is an election year. The way the current governments respond to the health crisis carries, therefore, great weight over their potential reelection or demise. These added political considerations dictate the greatest care to parties in power, for whom the pandemic could rapidly turn into an indelible mark staining their electoral campaigns. However, the relatively rapid African response also reflects the experiences most countries have shaped during the Ebola outbreak, during which an early response system was developed, supported by the Africa Centers for Disease Control and Prevention (Africa CDC) and the WHO. The fever-monitoring and surveillance systems implemented at airports at the onset of the disease are one of the remaining legacies of the Ebola outbreak, similarly to the communication outreach programs set in place to help populations avoid contagion.

The success in containing the pandemic and minimizing its threat will unfailingly require similar multilateral solidarity and cooperation. Yet, we are witnessing an unprecedented hardening of borders, both triggered and justified by the toughened discourse depicting COVID-19 as a security threat. The implementation of travel bans epitomizes the radical shift in states' security narratives and represents perhaps one of the major setbacks to liberal internationalism in the century. The peculiar nature of this shift stands out more within the EU: the resurgence of hard borders in the closest form of a supranational ideal promoting the free movement of goods and people highlights the profound transformations the world has undergone. While necessary to prevent the further propagation of the disease, the closing of borders could be a harbinger of an increasing lack of solidarity, as each state turns inward to face the crisis, forgetting that winning over the pandemic will require an unprecedented level of cooperation, for every remaining case represents a permanent threat to all.

4. Solidarity Beyond Security

While securitizing non-traditional issues has the benefit of mobilizing resources within a short time span and legitimizing the adoption of necessary severe measures, it fails to translate into a sustained policy shift in the long run. The need to occasionally securitize health during large-scale disease outbreaks such as HIV/AIDS, Ebola, and COVID-19, testifies to the relatively minor importance health is ordinarily given in national and global security agendas. Hence, the securitization of specific health issues establishes a hierarchy of diseases based not on associated mortality and morbidity, but rather on the level of fear harnessed, thereby causing a certain discrepancy between enacted policies and real threat. For instance, far more lethal and contagious, measles has caused 140,000 deaths in 2018 alone (WHO, 2018), but failed to mobilize similar levels of political and financial attention despite being a vaccine-preventable disease. Furthermore, health securitization can be politicized by regimes seeking to centralize decision-making, paving the way for the adoption of measures outlasting emergencies, or suspending human rights and freedoms in the name of security. From South Korea to Western Europe, democracies are turning to digital tracing, while Hungary's Prime Minister Viktor Orban has just seized power to rule by decree indefinitely. Elsewhere, electoral considerations guide government responses, which explains the initial hesitancy to acknowledge the severity of the disease outbreak and national under-preparedness.

The politicization of health ultimately harms the most vulnerable by prioritizing political considerations over medical realities. For securitization to work, it has to be accompanied by a set of social policies that ensure no one is left behind. Confinement is only effective insofar as the entire society can afford to withdraw from or suspend its economic activity. Pandemics exacerbate sharp health inequalities arising from socio-economic disparities, such as income levels and access to clean water and sanitation. The inequalities that in the past only seemed outrageous, become lethal today. In that sense, initiatives such as Mohammed VI's Special Fund for the Management and Response to COVID-19 in Morocco help shield the most vulnerable. With more than 32 billion dirhams (\$3.2 billion), the fund will strengthen the health capacity of the country by increasing ICU beds and testing capacities, and will compensate households who do not have to bear the burden of the crisis, and reduce their exposure to health and socio-economic losses.

Similar efforts of national solidarity contrast to an extent with what has unfolded at the international level. In the context of COVID-19, securitization has often translated into blame-shifting and been accompanied by an increase in xenophobia against Asians or foreigners in general, which complicates global cooperation. Terming COVID-19 a national security crisis carries a confrontational connotation. As each government scrambles to respond to the issue with its own specific policies, the international community loses the window of opportunity for a coordinated response under the WHO's leadership. Rather, great powers such as China and the United States have engaged in a blaming contest, each assigning the responsibility of causing the outbreak to the other amidst a global governance vacuum. The quest for vaccine has turned into a quest for leadership, and individual contributions to alleviate the crisis turned into pawns in a hegemonic battle for soft power. As the United States enters its most critical epidemiological phase, becoming the epicenter of the epidemic, it will gradually retreat from the international scene, while China's national victory over COVID-19 will allow it to gain increasing prominence as a benevolent savior willing to lend a helping hand.

Yet, if cooperation is harder during crises, it is also ever-more needed to scale up global resilience. The most urgent step countries worldwide need to take is the strengthening of testing capacities. This is particularly the case in Africa, where the younger demographic structure of the continent might cause a large share of the population to be asymptomatic and therefore undetectable without mass testing. For the purpose of increasing testing and treatment capacities, public and private sectors must share knowledge, increase the availability of testing kits and medical supplies, and cooperate on the development of a vaccine. The United Nations has launched a \$2 billion coordinated global humanitarian response plan, calling for contributions to ensure that the world's most vulnerable enjoy the protection they need against COVID-19. It is crucial to ensure that the funds that go towards supporting this global response are not diverted from other global health programs. Diseases such as HIV/AIDS, tuberculosis, or malaria continue to be real threats that could be amplified by disproportionate fund allocations and misalignment of priorities.

If the first waves of the pandemic have hit relatively advanced economies, subsequent ones will overwhelm primarily the most fragile, endangering in particular conflict-torn countries and refugee camps, where social distancing is not a viable option, and washing hands a luxury not all can afford. Subsequent global responses have to be engineered under the overarching human security paradigm to bridge the gap between security and development, health and stability, and individual and national security. The concept self-evidently adopts individuals as referent objects of security instead of states, and sheds light on different threats to the realization of individual well-being, including conflict, poverty, terrorism, hunger, and disease (UNDP, 1994). Its health security subset translates the right to health into not only a human right to be upheld, but also a safeguard to preserve individual and communal livelihoods. Human security, therefore, repositions security as an everyday struggle enacted through different aspects of life, ranging from the political to the biological. It is an attempt to capture the importance of human life and dignity at the heart, instead of the margins, of the security agenda.

Conclusion

Declaring war on COVID-19 might be misleading. Wars require more sacrifice than could be acceptable by public health standards, and more fragile alliances than needed to face a pandemic. The evolving transnational nature of health threats brings into tension rigid and iconoclastic conceptions of sovereignty, with potentially long-lasting impacts on how the 'new normal' post-COVID-19 order will be shaped. Securitizing health restricts health governance to states, narrowing the range of actors able to partake in advancing the global health agenda, and losing touch with normative predicaments, whereas achieving global health equity and preserving the health of populations throughout the world requires the participation of both state and non-state actors. It also requires the mobilization of a unique spirit of solidarity in the face of adversity. Rather than each state declaring war on COVID-19 on its own, the world needs to engage in a common battle, the end goal of which is not only to eradicate this specific disease, but also to build sustainable health systems that can absorb the shocks of future disease outbreaks. As much as 'flattening the curve' of case progression represents the main goal during pandemics, it is equally important to work on 'raising the bar' of health capacities. Otherwise, containment strategies and the mobilization of resources will only constitute band-aid solutions to deeper wounds scarring the health system, that will radiate at the dawn of every pandemic.

References

- Buzan, B. (1983). *People, states and fear: The national security problem in international relations*. Brighton, UK: Wheatsheaf books.
- Buzan, B., Waeber, O., & de Wilde, J. (1998). *Security: A new framework for analysis*. Boulder, CO: Lynne Rienner.
- Center for Disease Control and Prevention. (2020). *Coronavirus Disease 2019 (COVID-19)*.
- Hobbes, T. (1651). *Leviathan* (Reprint) (R. Tuck, Ed.). Cambridge: Cambridge University Press, 1996.
- OECD. (2020). *Evaluating the initial impact of COVID-19 containment measures on economic activity*.
- Reuters. (2020). In 'People's War' on coronavirus, Chinese propaganda faces pushback.
- South China Morning Post. (2020). *Coronavirus: China's first confirmed Covid-19 case traced back to November 17*.
- The Joint United Nations Programme on HIV/AIDS. (2018). *Country: South Africa*.
- UNDP. (1994). *Human Development Report*. New York: Oxford University Press.
- Walt, S. (1991). The Renaissance of security studies. *International Studies Quarterly*, 35(2), 211-239. doi:10.2307/2600471
- World Health Organization. (2019). *More than 140,000 die from measles as cases surge worldwide*.
- Zhang, S., Diao, M., Yu, W., Pei, L., Lin, Z., & Chen, D. (2020). Estimation of the reproductive number of novel coronavirus (COVID-19) and the probable outbreak size on the Diamond Princess cruise ship: A data-driven analysis. *International Journal of Infectious Diseases*, 93, 201–204. doi: 10.1016/j.ijid.2020.02.033

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