Rethinking the Securitization of Public Health in Africa: A Frame of Reference

Abdou Rahim Lema and Lukmon Akintola

Abstract

Drawing from the growing literature on the securitisation of public health in general and, in particular, that of infectious diseases in Africa, this paper explores the process through which certain health issues are perceived as security and existential threats. It uses securitisation theory as its theoretical and conceptual foundation to offer a critical analysis of the securitisation of public health in the African continent and its implications before presenting a frame of reference, a better and more constructive way of strengthening health systems in the continent.

Keywords

COVID-19, securitization, public health, healthcare, Africa

Introduction

The end of the Cold War and its power politics has significantly opened up the space on security agendas to allow the inclusion of issues such as infectious diseases[1]. According to Rushton (2014), such opening up has led to recent changes in how policymakers perceive and deal with public health crises. The result has been a growing convergence of public health policymakers and those in foreign policy and security sectors towards perceiving and reacting to public health crises as security threats (Fidler, 2007; Eroukhmanoff, 2018). Hence, notwithstanding calls for caution, the health-security nexus has grown to become a dominant paradigm in recent years (Burci, 2014).

Drawing from the growing literature on the securitisation of public health in general and, in particular, that of infectious diseases in Africa, this paper explores the process through which

1 However, it is worth noting that some researchers trace this process of 'opening up' the security space back to the adoption of the Biological Weapons Convention in the 1970s, as it framed infectious diseases as a security issue and began to blur the lines between infectious diseases as public health threats and security threats. See, for instance, Kelle (2007).

certain health issues—particularly infectious diseases—are perceived[2] as security and existential threats that call for actions outside the normal and regular bounds of political processes and procedures (Buzan, Wæver, & de Wilde 1998). It uses securitisation theory as its theoretical and conceptual foundation to offer a critical analysis of the securitisation of public health in the African continent and its implications. It also presents a frame of reference, a better and more constructive way of *strengthening* public health systems in the continent.

As Elbe & Voelkner (2014) observe, securitisation theory is primarily concerned with understanding how specific issues draw different responses in national and international policy circles once they become widely perceived or presented as pressing existential threats. Drawing from several empirical examples in African countries, we examine the implications of securitisation for the continent. Following Elbe & Voelkner (2014), the empirical materials for the study are drawn from a variety of sources. And though particular attention is given to those dealing with the securitisation of public health in Africa, materials covering other regions have also been useful in allowing comparisons.

The remainder of the paper is structured as follows. We first cover the conceptual and theoretical discussions on the securitisation of public health. We then move on to briefly survey some of the existing literature[3] to analyse the general implications of securitising public health before zooming in on the specific and contextualised impact for Africa. The analysis in this part looks at the effects of securitising public health in the African context and draws empirical evidence from several examples in African countries. Before concluding, we present a detailed discussion on our suggested frame of reference that offers a more constructive way of *strengthening* public health systems throughout the continent. The paper mainly calls for, and this is our central argument, the urgent adoption of people-centred approaches to better address health and other crises across the continent more inclusively and sustainably. It concludes by making the case that effective public health could help African countries deal with the multiple layers of fragility facing them.

Theoretical and conceptual discussions

The theory of securitisation emerged as a reaction to the mainstream International Relations (IR) theories that have dominated the field until the end of the Cold War. While major IR theories such as realism take 'security' for granted, securitisation theorists posit that security threat is not an objective condition independent of the person who perceives and represents it. That is, following Alexander Wendt (1995) 's logic, security is what we make of it: Securitisation is the

2 The conceptualization is in line with the original presentation of 'securitisation' processes provided by Buzan and colleagues, and we adopt it for this work in the specific context of the nexus between health and security. But it is important to note and recognize that, while such definition is popular in international relations scholarship, it is generally considered 'overbearing' or 'overstretched' in the global health space. For example, in an article tracing the process of linking health and security, Wenham (2019) argues that "the discourse of global health security has become close to synonymous with global health, their meanings being considered almost interchangeable", leading to path dependencies and altering the global health security narrative.

3 It should be noted that, due to the limited time and space at our disposal, it is impossible to provide an exhaustive review of this rich and wide-ranging literature. We sincerely thank the anonymous reviewer for bringing this to our attention.

discursive process through which an issue is socially constructed as a security threat through "speech act"[4] by relevant political actors (Buzan, Wæver, and de Wilde 1998; Eroukhmanoff, 2018). By successfully labelling an event as a 'security' threat, the relevant political actors convey a sense of threat that calls for measures outside the regular bounds of political procedures. In that sense, Giorgio Agamben's description of "the state of exception"[5]effectively applies to the securitisation process whereby an event gains saliency and prioritisation on political agendas.

In the context of public health, securitisation refers to the discursive process by which public health issues are perceived and framed as security threats, elevating them from technical public health issues which could be dealt with through routine procedures of public health institutions and scientific expertise to something perceived as posing a much more existential threat and, therefore, requiring immediate and more forceful measures (see Burci, 2014; Elbe & Voelkner, 2014). In that sense, securitising public health involves identifying and declaring a particular health issue as an existential security threat. There are plenty of historical examples illustrating such securitisation moves.

On September 18, 2014, the United Nations Security Council (UNSC) declared that the Ebola outbreak in three West African countries—Guinea, Liberia, and Sierra Leone—constituted "a threat to international peace and security" (UNSC 2014). As Enemark (2017) pinpoints, the declaration was the first time a disease outbreak of natural origin was explicitly described using a language usually applied to political violence. Nonetheless, it is worth noting that already in 2000, HIV/AIDS was also recognised by the UNSC's "Resolution 1308" as a threat to international security (Jin & Karackattu, 2011). Quite remarkably, however, not only was the language used then significantly less dramatic, but the focus was also primarily on the impact of HIV/AIDS on peacekeeping operations in Africa. In that regard and irrespective of its original intent, the UNSC's resolution on Ebola was unprecedented in describing a naturally occurring disease outbreak using a language ordinarily applied to politically motivated violent conflicts (Enemark, 2017). More recently, the African Union's Peace and Security Council warned on February 13, 2020, that the COVID-19 outbreak "could constitute a threat to peace and security in the [African] continent."[6]

According to Burci (2014), it should not be surprising that public health challenges "would appear on the agenda of the [UNSC] given the increasing perception that the spread of infectious diseases […] could threaten regional and global security." More specifically, these concerns mainly

4 According to Buzan and colleagues, "speech act" involves threats and vulnerabilities which are mainly "staged as existential threats to a referent object by a securitizing actor who thereby generates endorsement of emergency measures beyond rules that would otherwise bind" (Buzan, Wæver, and de Wilde 1998, p.5; emphasis added).

5 According to Giorgio Agamben, "the state of exception" refers to the ways an issue is dealt with through measures that circumvent normal legal procedures, for instance, by declaring a state of emergency to help justify the suspension of laws, only for them to become "a prolonged state of being." Also, see Raulff (2004).

6 See https://reliefweb.int/report/world/910th-meeting-au-peace-and-security-council-psc-ebola-and-coronavirus-outbreak-africa

focus on the potential effects of infectious diseases on the stability of the affected countries[7], their potential regional spillover, and the potential risk of international spread.

Securitisation of public health: A critical analysis

A careful analysis of the extensive literature on securitisation reveals a wide range of arguments put forward to either defend or critique the growing efforts to securitise public health issues. This section first examines the leading ideas to support securitising public health before turning to the major criticisms of such securitisation efforts. We close the section with a summary table to synthesize the analysis.

Arguments for securitising public health

The securitisation of public health appears appealing for some reasons, including the fact that security actors have a crucial role to play in protecting their populations from disease; that disease events can have widespread and devastating political, social, and economic effects[8]; that there are areas in which the security and public health communities can work together constructively; and that securitisation offers those in public health an opportunity to gain increased attention and much-needed resources for otherwise neglected health issues (Rushton, 2014). Moreover, Enermark (2010) emphasizes the significant role of policy measures under the Biological Weapons Convention (BWC), often used to address naturally occurring infectious diseases and the traditional concerns about possible weaponisation of pathogenic microorganisms.

As such, successfully securitising a particular health issue may help raise its status on political agendas by persuading governments to devote considerable attention and resources to tackle it. Accordingly, the issue may transcend "normal politics" to become "so important that it should not be exposed to the normal haggling of politics" (Buzan *et al.*, 1998). This is especially true where such crises lead to a state of emergencies and constant executive orders, whereby "the worlds of health and security collide inescapably" (Elbe, 2011; see also Fidler, 2007).

In addition to helping mobilise the needed resources, other benefits of securitisation include instituting and enforcing hygienic practices and behaviours, actively promoting more public awareness, and preventing panic and social instability (Wishnick, 2010). In that regard, securitisation of health istherefore perceived as hedging against the potentially dramatic consequences of highly pathogenic infectious diseases (Burci, 2014).

7 These concerns are even greater when the outbreak hits conflict-ridden regions where state authorities are mistrusted and militias commit violent acts. This already difficult security situation would likely magnify the challenges of dealing with the health crisis, further disrupting public order, challenging the delivery of health care, and affecting disease control measures (Burci, 2014).

8 It is not hard to imagine how severe outbreaks of infectious disease could significantly threaten both the ability and viability of the state to operate effectively (Rushton, 2014). See Gulati & Voss (2019, p.3) for analyses on the consequences of HIV/AIDS in the seriously affected regions of Africa. For further analyses on the potential widespread political, social, and economic effects of infectious diseases more broadly in Africa, see Chan (2014), Enemark (2017), BBC (2014), Nossiter (2014), Garrett (2005), etc.

Finally, the "synergy thesis", discussed by David Fidler (2007), maintains that the first line of defence is usually the public health system when an outbreak of infectious disease occurs. At its core, securitisation thus helps strengthen the public health system, allowing for achieving the dual purpose of defending against biological weapons and naturally occurring diseases[9]. Also, since the security and defence sectors usually attract a larger share of national budgets, securitisation of health allows decision-makers to redirect these resources toward reinforcing public health capabilities in times of crisis (Burci, 2014; Davies, 2010). As such, it is contended, "[bio]security has elevated public health from the margins of 'low politics' to a seat at the table of the 'high politics' of national security…" (Fidler, 2007). These advantages notwithstanding, there are significant concerns with the surging moves towards securitising public health crises.

Arguments against securitising public health

To begin with, securitising health challenges may, in some cases, lead to subordinating public health to scrupulous security agendas by dramatising the threats they pose. Moreover, the (over)reactive mobilisation involved in securitising a health crisis and the implied right to use extraordinary means to fence off the existential threat run counter to the preventive risk management strategies required to effectively address infectious diseases (Wishnick, 2010; Jin & Karackattu, 2011; Nunes, 2017).

Furthermore, Jin & Karackattu (2011) and Honigsbaum (2017) make the case that the dramatic moves to securitise health issues are often not motivated by the concerns or sympathy for the affected and most vulnerable populations. Instead, securitisation is primarily meant to protect more powerful countries. Ultimately, this gives credence to the widespread suspicion that global health security prioritises measures designed to *contain* diseases within the developing world rather than actions that address their root causes, including dysfunctional national health systems, institutional neglect, and delays as well as fragmentations of global responses to disease outbreaks. As such, securitisation is a short-termist strategy. It focuses on developing surveillance systems to contain outbreaks when and where they occur, instead of tackling the underlying structural causes of epidemics rooted in the lack of access to healthcare and the underlying social, economic, and political determinants of health (Hofman & Au, (eds.)., 2017; Honigsbaum, 2017).

Other major arguments against securitising health issues include the fact that securitisation can distort the global health agenda and lead to a narrow and disproportionate focus on certain types of health problems while ignoring others with equal or greater morbidity and mortality; undermine the traditional humanitarian orientation of public health; impact negatively on individual rights, particularly the rights of those infected with illnesses that make "security threats"; potentially undermine the global cooperation necessary to deal with infectious disease threats in a globalised world; facilitate corruption by skewing public spending toward inflated defence and security

9 Indeed, according to Standley et al. (2015), the cooperative efforts on bio-engagement among many countries exist at the nexus between public health and security, whereby the efforts explicitly prioritize projects that aim to reduce "the potential for accidental or intentional misuse and/or release of dangerous biological agents" as well as to improve basic public health capacities/systems. This usually helps meet the priority areas of both donor and partner countries, in that case making it a win-win engagement.

budgets; etc. (see Aldis, 2008; Ingram, 2008; McInnes and Lee, 2006; Feldbaum *et al*., 2006; Elbe 2006, 2009; Enemark, 2009; Burci, 2014; and Rushton, 2014).

Equally concerning is the fact that securitising health issues turns them into threats to existence and survival. Therefore, tackling health concerns requires exceptional and urgent measures "that would otherwise bind" (Buzan, Wæver, and de Wilde, 1998). The danger, however, is that they quite often escape democratic scrutiny due to their urgency. For that reason, it is fair to argue that securitisation threatens democracy and human rights, especially in countries where institutions are weak or almost nonexistent. Characterising health issues as security threats pushes civilian healthcare responses towards the military, law enforcement agencies, and intelligence organisations. The logical result of embracing the appeal of muscular responses is the adoption of authoritarian approaches and coercive measures that override freedoms and civil liberties, which can directly and easily turn securitisation into a pretext to trample on human rights violations and further stigmatise the most vulnerable (Burci, 2014; Huang, 2014). Similarly, the language of security used to characterise health crises can also be invoked to justify repugnant deeds and egregious abuses.

Summary Table of the advantages and disadvantages of the securitisation of public health

Advantages	Disadvantages
Preventing or limiting potentially devastating consequences (economic, social, political, etc.) of disease outbreaks; Providing the opportunity to raise the status of some health issues on political agendas and mobilise much-needed resources; Instituting and enforcing hygienic practices and behaviours; Actively promoting public awareness, etc.	Subordinating public health to scrupulous security agendas; Dramatising the threat and spreading fear and anxiety; Lacking required preventive management strategies for quality public health; Promoting containment rather than addressing root causes of disease outbreaks; Possibly distorting global health agenda and leading to a narrowed and disproportionate focus on specific health problems while ignoring others with equal or greater morbidity and mortality; Possibly undermining democratic procedures, overriding freedoms and civil liberties, and violating fundamental human rights, etc.

Analysing the Implications of Securitisation of Health Crisis in Africa

In this section, we explore the implications of securitising government responses to health crises in Africa. We conclude that the securitisation of public health in the continent has mainly been counter-productive.

As it did to other parts of the world, the outbreak of the COVID-19 pandemic threw African countries off-balance. The pandemic has disrupted Africa's overall political-economic configuration, with countries turning to hard-line policies and incurring significant economic losses (OECD, 2020). As they struggled to curb the spread of the virus, many African governments imposed nationwide lockdowns and night curfews. Moreover, some governments opted for militarised responses to COVID-19, treating the virus as a threat to national stability that, in many instances, legitimised the use of force and brutality against civilians to enforce containment and preventive measures (HRW, 2021; Africa News, 2020). These drastic measures have far-reaching consequences for the continent and its people, as the following discussion illustrates.

Securitisation of Public Health in Africa and Human Rights Abuses

As mentioned earlier, health securitisation stresses the deliberate framing of a public health crisis as a threat to national and international peace and stability. Roberts (2019) rightly posits that labelling a public health crisis as a security threat creates a sense of urgency. Hodgson (2017) also notes that "health securitisation is often a successful strategy for generating interest in, and resources for, a specific health issue". With effective framing of health securitisation, policymakers find reasons to boycott existing democratic and institutional procedures, opening doors for blatant abuses of human rights.

The responses to the COVID-19 pandemic in some African countries have often involved the use of lethal force on civilians by law enforcement agencies to implement lockdown orders. Citizens' rights to freedom of movement and expression are thus brutally quelled, leaving some civilians dead and many more injured. In Rwanda, for instance, about 60,000 people were severely punished for either not wearing face masks outdoors or breaching curfews or for not observing the social distancing order (BBC, 2020). This illustrates the danger of securitising health during a crisis, especially in the context where governments lack the trust of their citizens, as is the case in virtually all African countries.

Police brutality may pose more threat to peoples' lives than the virus itself. In Nigeria, the police force has a notorious record of human rights abuses, brutality, and extra-judicial killing (Council of Foreign Relations, 2020). Unsurprisingly, it only got worse during this COVID-19 pandemic. Nigeria's National Human Rights Commission released a report on April 1, 2020, noting that 18 people were killed by the Nigerian police in the course of enforcing the lockdown rules, even though only 12 people had died of COVID-19 in Nigeria at the time (BBC, 2020; Foreign Policy, 2020; The Guardian, 2020).

Kenya is another African country that recorded incidents of extra-judicial killing by the police while implementing the lockdown measures. A recent report from the Independent Policing Oversight Authority (IPOA) revealed that 15 deaths and 31 incidents were directly linked to actions of police officers during curfew enforcement in Kenya (Anadolu Agency, 2020). The report's central claim is that extra-judicial killing has eaten deep into the fabric of these countries, feeding into the concerns that, in their bid to appear resolute in dealing with the crisis, policymakers are not particularly investing their efforts in preserving human lives.

Things are not any better in South Africa either, where the government deployed over 3,000 soldiers to enforce lockdown rules. If anything, the surged cases of brutality by law enforcement agents in South Africa during the COVID-19 lockdown orders is just as worrisome as in other African countries. Data from the Independent Police Investigative Directorate (IPID) show that 376 cases of police brutality and ten deaths are directly linked to the lockdown enforcement (ISS, 2020; Knoetze, 2020; Ncube, 2020).

In a similar trend, at least 12 people were killed by the police in the bid to enforce the lockdown rules in Uganda. Nyeko (2020) confirmed that "security forces have been using COVID-19 and the measures put in place to prevent its spread as an excuse to violate human rights." More worrisome still, public health securitisation can be used to legitimise racial exclusion (Roberts, 2019). As Ncube (2020) pithily puts it during a virtual forum on the South Africa police's long history of abuse and impunity, "it is evident that police brutality is real, but it disproportionately affects the poor and the people of colour, specifically, the blacks."

As these empirical examples show, there is danger to securitising public health, as it places priority on militarised responses rather than effectively tackling the disease and improving people's well-being. Calain and Sa'da (2015) point out that securitisation of health by policymakers is mostly not out of concern for the people; rather, it is a concern for themselves and their interests. While this position might be debatable, killing and maiming civilians in the name of preventing the spread of a virus does not add up. However, these tragic abuses go beyond the COVID-19 pandemic as similar developments were also rampant during the Ebola outbreak of 2014-2016 (see Benton, 2017).

Failed efforts to build resilient public health systems

It is beyond any doubt that the health systems in many African countries are very weak, clearly manifested by chronically understaffed health facilities, unmotivated and ill-equipped health workers, insufficient medical supplies, and delayed staff payment (McPake *et al.*, 2016). This situation is largely caused by political instability, corruption, limited budgeting, among others (Rowden, 2014; Kentikelenis *et al.*, 2015). African countries are ranked very low in the area of quality healthcare, and citizens' life expectancies across the continent are among the lowest in the world. For instance, the WHO's best healthcare system ranking for 2019 puts Nigeria at 73rd, while Algeria and Kenya ranked 68th and 70th, respectively (WHO, 2019). In 2015, Sierra Leone ranked 1st, Central African Republic 2nd, Chad 3rd, and Nigeria 4th highest in

maternal mortality among 184 countries around the world (CIA, 2015). These facts underscore the fragility of the health systems in many African countries.

The state of the health systems becomes worse in the face of health emergencies such as the Ebola outbreak or the COVID-19 pandemic as it is quickly over-stretched. With the outbreak of Ebola in Sierra Leone, for instance, Philips (2017) notes that material goods, finances, and human resources were drawn from already fragile and undersupplied health services to cater for the Ebola response. Clinical staff moved to Ebola treatment centres where financial remuneration and infection protection materials were available. In Monrovia, an assessment done in 2015 revealed that the Ebola outbreak caused critical deficiencies in the implementation of infection prevention and control (IPC) in several health facilities (IPC Partners Mapping, 2014; Cooper, 2015)

Amidst the COVID-19 pandemic, local clinics in some countries were quick to reject patients in need of primary care, leading to an increase in casualties from other diseases (World Economic Forum, 2021). As mentioned earlier, securitising health raises the profile of a particular disease and downplays that of others which could be equally or even more deadly (Philips, 2017). As such, Roberts (2019) asserts that "securitising health crisis is usually at the detriment of primary healthcare that could prevent the outbreak of an epidemic in the first place." This is evident in the early days of HIV/AIDS, as funding significantly increased from 6% of all global health aid in 1998 to roughly half the total health funding in 2007. An estimated 5.2 million people received antiviral treatment by 2008, but funding for health systems declined from 62% to 26% of total health aid as a result (Roberts, 2019).

It is worth noting, moreover, that securitising public health further creates "knock-on effects" on the health systems, with a given health crisis causing significant impacts on other health issues and disrupting peoples' social lives (Helleringer and Noymer, 2015). With the Ebola outbreak, for instance, on average, hospital visits dropped by 54%, antenatal care by 59%, and vaccination rates by 30% in the affected countries (Leuenberger *et al.*, 2015; Van de Pas and Van Belle, 2015). Moreover, it was estimated that across the three most-affected countries in West Africa—Sierra Leone, Liberia and Guinea—several additional malaria fatalities (10,900) were recorded, almost equal to the number of Ebola fatalities (11,308) (Walker et al., 2015). In Guinea alone, a study shows that the number of malaria deaths was almost certainly "likely to greatly exceed the number of deaths from Ebola virus disease" (Plucinski et al., 2015).

Securitisation of health crisis, politics, corruption, and national interests

Finally, it is imperative to note that securitisation might increase the complex entanglement between politics and health, with policymakers prioritising political gains over the welfare of the people. Fundamentally, in many African countries, like elsewhere around the world, securitising health is often used as a strategic tool to prioritise a health issue as a political agenda (Roberts, 2019). This is evident in recent outbreaks in Africa, as national governments hurriedly doll out state funds to address the COVID-19 pandemic and further request additional funds from international donors. Nigeria's central bank, for instance, requested a $2.7 billion stimulus from

the International Monetary Fund (IMF), yet there are allegations of massive corruption in the way the money is spent (Bloomberg, 2020). Similarly, Guinea Conakry requested financial assistance from the World Bank to assuage the economic impacts of the pandemic. But in an embarrassing response, the World Bank pointed out that the economic cost of Guinea's COVID-19 action plan was "overpriced and unrealistic".

Implications/Consequences of Public Health Securitization (PHS) in Africa

In that sense, securitising health may easily open doors to corruption at all levels, as allocated funds may escape normal democratic scrutiny, and little or no accountability ensues. This is evident in the corruption cases in South Africa where government officials were accused of stealing a $26.3 billion COVID-19 relief fund (Anadolu Agency, 2020). More apparent is that securitising health could permit carting away public funds meant for fundamental health infrastructure that could support the improvement of sanitation, health education, healthcare services to the people.

The concept of security is still deeply rooted in using military force to address health crises–causing an alarming paradox between health, as a challenge primarily affecting human security, and securitisation as a response grounded in state-centrism and overt militarisation (Robert, 2019). In this light, many African governments and far beyond still hold tight to the 'pax armamenta' approach; thus, prioritising armed force as the chief means to promote stability, even in time of health crisis. The deployment of 3,000 soldiers by the South African government to maintain lockdown order reflects this militarised thinking.

A 1994 report by the United Nations Development Programme (UNDP) on the *New Dimensions of Human Security* identified health as one of the major threats to human security, and clearly distinguished between the idea of human security - an individual, people-centred concept - and the more traditional state-centred concept of security. The report further pointed out that irrespective of the threat, people should be the primary concern of politicians and policymakers. African government should heed these calls. Unfortunately, securitising public health usually leads policymakers to overlook their responsibilities of building resilient healthcare systems and their accountability to the people (see the figure below).

Implications/consequences of public health securitization (PHS) in Africa

PHS and Human Rights Abuses

- Restrictions on civil liberties
- Brutality of law enforcement agencies
- Lack of democratic accountability
- Institutionalized harassment
- Extra-judicial killings
- Etc.

PHS and Failed Health Systems

- Weak and dysfunctional health systems
- Chronically understaffed healthcare facilities
- Unmotivated and ill-equipped health workers
- Insufficient medical supplies
- Etc.

PHS, Politics, Corruption, and National Interests

- Dangerous entanglement between politics and health
- Lack of transparency and democratic accountability
- Skewed public spending
- Corruption
- Etc.

Frame of reference for strengthening public health systems in Africa

This section presents the suggested frame of reference to make African health systems more resilient, effective, and people-oriented. As the illustrative figure at the end of the section shows, the frame of reference calls for a holistic and inclusive approach to healthcare.

One of the most troubling issues with the securitisation of public health challenges is the fact that it is always a reactive move, as opposed to adopting more proactive and sustainable measures that ensure state preparedness. This is especially true in the African continent where states generally lack both the resources and the capabilities to effectively deal with major disease outbreaks. To address this particular challenge and protect vulnerable populations, African countries would do better to intensify and accelerate their efforts and resources in outbreak preventions through capacity building and system reinforcement. Not only will such efforts be more sustainable; but they will also more effectively promote and protect health (Gulati & Voss, 2019). It is worth insisting, however, that these efforts should also take into account the two pillars of public health governance, namely, surveillance and intervention. A well-functioning health system should incorporate the two crucial pillars and ensure its ability to intervene to prevent, protect against, or respond to serious infectious disease outbreaks.

Likewise, though we recognise that the securitisation of health issues can be a useful move in generating interest and mobilising resources, we caution against its thoughtless implementation in the continent that often leads to misallocation of already scarce resources. Instead, to reduce the risk of outbreak and provide better healthcare, there is an urgent need to ensure that the mobilised resources help extend universal health coverage and improve the social determinants of health. There is little doubt that the effects of infectious diseases such as Ebola and HIV/AIDS have been disproportionately felt in many African countries due to a lack of adequate health infrastructure.

Rehabilitation and (re)construction efforts in these countries should be designed to move them in the direction of “healthy health systems” (Hofman & Au, 2017). But to achieve that goal, the concerned African countries and the international health community will need to proactively

address the root causes of and the underlying conditions for their largely dysfunctional health systems. There is also a need for an informed scientific assessment of health risks that would take into consideration the local contexts to better help prevent disease outbreaks and build resilient and efficient health systems (Gulati & Voss, 2019).

Mistrust of state authority is another major issue African countries grapple with in dealing with the "unpredictable and unknowable" health emergencies (Honigsbaum, 2017). As Hofman & Au (2017) argue, the low levels of trust between the populations and public authorities have been playing a leading role in considerably weakening the ability of health actors to influence individual behaviour and effectively respond to health crises. This is well illustrated by the 2014-2016 Ebola crisis when the already weak health systems crumbled further from the added crises of trust. The current securitisation strategies of health crises, whereby security forces are deployed to enforce response measures, have heightened this trend in many African countries. In an analysis of the Ebola epidemic, Benton (2017) reports that although domestic security forces in the affected countries performed much-needed public health functions and helped enforce emergency measures, their implication in egregious abuses of power has ignited mistrust of state actors and policies related to Ebola prevention and treatment. As such, securitised public health efforts need to be coupled with provisions of care and comfort, especially to the needy and most vulnerable communities. Equally important is that these efforts should be implemented through inclusive and participatory dialogues. After all, public trust is crucial to successfully addressing any crisis, including that of health: "Trust is a necessary component of cooperation, and open communication is a necessary component of trust" (Philips, 2017).

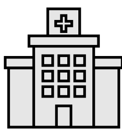
It is also worth remembering that outbreaks of infectious diseases expose people to direct risks of contamination and potential death as well as indirect risks of rising food insecurity and reduced livelihoods that prompt concerns that starvation would pose more of a danger than the disease itself, as well as increased mortality from other diseases as a result of the dysfunction of health systems. To be effective, response policies in Africa need to take into account these risks. Unfortunately, although it is clear that providing a safety net and livelihoods would do much to boost people's trust in their respective governments, it is ignored all too often. Such a measure would also erase the need of deploying large contingents of armed forces to implement and enforce response measures, for the people will listen to the government response measures only when their basic needs and fundamental security are well taken care of.

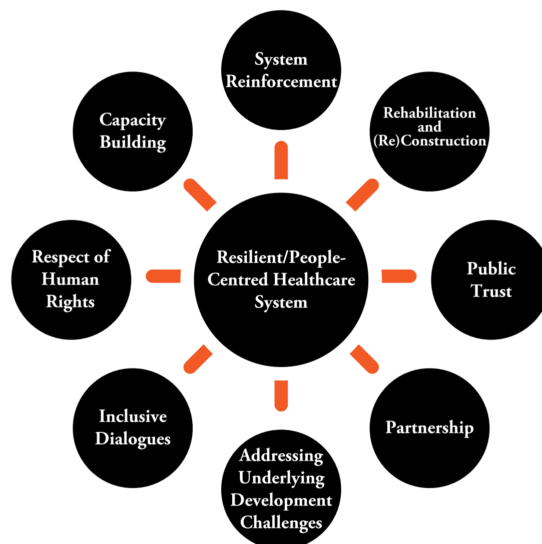
Furthermore, contrary to the current securitisation strategies that solely focus on the treatment and containment of infectious diseases, more sustainable solutions through building resilient, well-functioning, and accessible health systems must be implemented (see figure below). This fosters the implementation of human right to health, creates trust in state structures, and takes into account the security of the general population (Gulati & Voss, 2019). It also takes into account the need to promote peace and stability through accessible health in Africa, including support for healthy living conditions, preventive measures, detection and treatment of acute and chronic diseases, as well as rehabilitation where and whenever the need arises. The ultimate goal should be to establish and sustain resilient, accessible, and well-equipped health systems that care for people's needs and prevent, detect, and respond to infectious diseases while also paying greater

attention to the social function of the health sector as a stabilising factor (Gulati & Voss, 2019). Achieving this will effectively align African health systems with the global recognition that the health of all peoples is a fundamental factor to the attainment of peace and security.

As mentioned earlier, there is a consensus that disease outbreaks expose and exploit the vulnerabilities of health systems. In Africa, where flexibility and adaptability of health mechanisms remain distant aspirations, the already poor health systems deteriorate even further in the wake of a major disease outbreak. Underlying this is a combination of political instability, budget limitations, restricted fiscal space as well as the effect of major outbreaks such as Ebola and COVID-19 (Rowden, 2014; Kentikelenis *et. al.*, 2015; and Philips, 2017). Thus, improving the health and well-being of the populations through preparedness to minimise the "knock-on effects"[10] (both direct and indirect) of disease outbreaks on health systems becomes imperative (Philips, 2017). Despite Philips (2017) 's scepticism[11], in the resilience of African health systems, "the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganise if conditions require it" (Kruk et al., 2015), is what is urgently needed. Resilience, in the African context where health systems face problems and challenges left ignored for too long, requires (re) building healthy health ecosystems and adopting a "multi-sectoral integrated approach, one that equips countries to absorb unforeseen severe shocks" (Kieny and Dovlo, 2015). In a nutshell, while it is a useful tactic for resource mobilisation and for building momentum to tackle health challenges, securitisation alone will be insufficient in helping Africa's health systems function better. Thus, mobilisation efforts must be coupled with well-thought-out and flexible planning that reflects on needs and priorities.

A Frame of Reference for Strengthening Public Health in Africa





10 According to Philips (2017) "the majority of people who died during the Ebola epidemic [of 2014-2016] died of something other than Ebola. Many of these deaths were indirectly caused by the crisis."

11 A major "problem with the concept of resilience," Philips (2017) argues, "is that it frames health response on risk rather than need; it is about future strength rather than current vulnerabilities." But it also "de-emphasizes the immediate problems faced by a society for a focus on mitigating against future, potential shocks."

Conclusion

Drawing from the vast body of literature on the securitisation of public health in general and, in particular, the securitisation of infectious diseases in Africa, this paper offers an analysis of the process through which certain health issues—particularly infectious diseases—are perceived as security and existential threats. The paper uses securitisation theory as its theoretical and conceptual foundation to offer a critical analysis of the securitisation of public health crises in the African continent and its implications before presenting a frame of reference, a better and more constructive way of *strengthening* public health systems in the continent. Overall, the paper contributes to the growing body of literature on health securitisation in Africa and could inform policymakers–and other relevant stakeholders–on how to better address public health challenges facing African countries.

Thus, although the securitisation of health can be a useful tactic for generating interest and resources for African governments, our analysis shows that there are a variety of problems associated with it and, therefore, it should be adopted with much caution and more responsibly. The frame of reference we detailed above shows how this can be done. It calls for prioritising the health and well-being of the people (people-centred approach to health) and ensuring that necessary mechanisms are in place to make healthcare a leading factor to Africa's stability, peace, prosperity, and development. Essentially, it could help break the chain of Africa's cycles of fragility. As such, the proposed frame of reference can be a vital tool to prevent the misallocation of scarce resources that undermines efforts to extend universal health coverage in the continent. Equally important, it can help improve the social determinants of people's health while ensuring resilience against and preparedness of healthcare mechanisms for potential future crises.

About the Authors

Abdou Rahim Lema is a PhD student at the University of Montreal and a former Yenching Scholar of Peking University (2018 cohort), where he completed a Master's degree in China Studies. His research work mainly focuses on South-South cooperation, triangular cooperation, and growing Sino-African security and development relations.

Mr. Lukmon Akintola holds a Master's degree in Politics and International Relations from Yenching Academy of Peking University. His research focuses on the intersection between security and development, as well as migration, and international politics. He is the founder of Conflict Free Nation – a non-profit that focuses on promoting sustainable security in Nigeria. Lukmon is the host of African Security Talk–a podcast that focuses on analysing African security challenges. He is currently a Research Associate for Search for Common Ground's research on DDR and SPRR in northern Nigeria. He is also currently a Research Intern with the United Nations Industrial Development Organization (UNIDO) Headquarters, Vienna, Austria.

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