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Questioning health security: Insecurity and domination in world politics

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Abstract. It has become common to speak of health security, but the meaning of the latter is often taken for granted. Existing engagements with this notion have been constrained by an excessive focus on national security and on the securitising efforts of elites. This has led to an increasingly sceptical outlook on the potentialities of security for making sense of, and helping to tackle, health problems. Inspired by the idea of security as emancipation, this article reconsiders the notion of health security. It takes as its starting point the concrete insecurities experienced by individuals, and engages with them by way of an analytical framework centred on the notion of domination. Domination deepens analysis by connecting individual experiences of insecurity, the social interactions through which these are given meaning, and the structures that make them possible. Domination also broadens the remit of analysis, shedding light on the multifaceted nature of insecurity. The analytical benefits of this framework are demonstrated by two examples: HIV/AIDS; and water and sanitation. The lens of domination is also shown to bring benefits for the political engagement with global health problems.

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Introduction

The attention given to health as an international political issue during the twentieth century cannot be separated from the presence of security concerns. In 1946, the Constitution of the World Health Organization (WHO) claimed that the 'health of all peoples is fundamental to the attainment of peace and security', before identifying inequality in health promotion and disease control as a 'common danger'.[1] The links between health and security have since become more specific, with diseases being explicitly connected with other threats. The United States of America has a National Health Security Strategy that assumes an 'interdependent relationship between national security, homeland security, and national health security', and whose goal is to tackle 'large-scale incidents that have threatened human health, such as natural disasters,

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[1] World Health Organization, 'Constitution of the World Health Organization' (1946), available at: {http://whqlibdoc.who.int/hist/official_records/constitution.pdf} accessed 24 February 2014.

disease outbreaks, and terrorism, including the use of weapons of mass destruction'.[2] The European Commission also has a Health Security Committee, equipped with 'mechanisms and tools for Europe-wide coordination of prevention, preparedness and response' to threats like 'communicable diseases and substances related to chemical, biological and radio-nuclear (CBRN) agents'.[3] The Global Health Security Initiative – which includes the US, the UK, Canada, Japan, Germany, France, Italy, Mexico, the European Commission, and the WHO as an observer – seeks to enhance cross-border preparedness and response to threats of biological, chemical, radio-nuclear terrorism, and pandemic influenza.[4] In sum, the notion of 'health security' has become common parlance in policymaking circles. This is particularly visible since 9/11 and the 2001 anthrax attacks on the United States, which placed health squarely within the context of broader security anxieties.

Notwithstanding its prominence, health security has been taken for granted in both post-WWII and post-9/11 iterations. In the original WHO Constitution, uncontrolled disease was generically presented as a threat to international stability and peace. One commentator argued that '[t]he connection between health, peace and security is self-evident when diseases coupled with poverty and other social ills destabilize governments and societies.'[5] The assumption that the security aspects of health are self-evident is still present in recent formulations, where health is seen to fall within the remit of security inasmuch as it connects with other 'hard' threats. The current WHO position asserts 'an inevitable linkage between public health security and bioterrorism', whilst arguing that poor health can be one of the 'contributors to conflict and international terrorism'.[6] Similarly, for policymakers in the US and the EU, health seems to have been subsumed into existing security rationales and agendas. By hinging on emergency preparedness against issues like bioterrorism or weaponised disease agents, understandings of health security reflect the spill-over into the health sector of a traditional set of assumptions: threats are to be judged on the extent to which they endanger national security, territorial integrity and/or social stability.

This combination of vague statements and unquestioned premises has meant that fundamental questions have remained largely unaddressed. How is health a matter of security? What are the analytical benefits of approaching health in this way? And what are the implications – for both health issues and for politics more broadly – of using a security lens in this case? This leads to a normative line of enquiry: should health be seen as a matter of security in the first place? At a time when some health issues – like HIV/AIDS, pandemic influenza, or multidrug-resistant tuberculosis – have become the focus of great media attention and even international tension, and given the persistence of staggering health inequalities in the world, it is essential that these questions are addressed. Only then it will be possible to determine whether the

[2] United States Department of Health and Human Services, 'National Health Security Strategy of the United States of America' (2009), available at: {http://www.phe.gov/Preparedness/planning/authority/nhss/Documents/nhss0912.pdf} accessed 24 February 2014.

[3] Commission of the European Communities, 'Health Security in the European Union and Internationally' (2009), available at: {http://ec.europa.eu/health/preparedness_response/docs/commission_staff_healthsecurity_en.pdf} accessed 24 February 2014.

[4] Global Health Security Initiative, 'Overview: Global Health Security Initiative', available at: {http://www.ghsi.ca/english/background.asp} accessed 24 February 2014.

[5] Frank P. Grad, 'The preamble of the constitution of the World Health Organization', *Bulletin of the World Health Organization*, 80:12 (2002), pp. 981–4, 981.

[6] World Health Organization, 'Foreign Policy and Health Security', available at: {http://www.who.int/trade/glossary/story030/en/index.html} accessed 24 February 2014.

notion of health security can help us to understand and tackle health challenges – or whether it actually contributes to obscuring and worsening them.

This article questions and reconsiders the notion of health security. It sets out to avoid the route usually taken by the International Relations (IR) literature on the topic, so far very sceptical of the connection between health and security. The argument shows that there are clear analytical and normative benefits in clinging to the notion of health security – albeit in a revised form. It starts with the observation that existent engagements with this notion are constrained by a narrow understanding of security and a deterministic appreciation of its effects. Seeking to address this problem and provide an alternative approach to health security, the article takes inspiration from the idea of 'security as emancipation' and rethinks the meaning of insecurity.

Insecurity is approached using the lens of domination. The domination perspective enables a simultaneously deeper and broader engagement with insecurity, shedding light on dimensions and issues that so far have been neglected or insufficiently addressed in IR. On the one hand, domination connects individual experiences of insecurity with broader dynamics in world politics, paving the way for a richer understanding of structural causality and agency. On the other, it allows for health insecurity to be considered alongside systematically-produced life conditions combining harm (and vulnerability), unpredictability (and lack of control), and inequality (and disadvantage). The domination perspective on health security – here illustrated by the examples of HIV/AIDS and water and sanitation – enables a fresh look at global health issues and provides valuable lessons for political change.

Approaches to health security

The importance of health security in policy discourse has been acknowledged in the IR literature. In a recent survey, Colin McInnes and Kelley Lee included security as one of five fundamental 'frames' that shape existing understandings of global health – the others being evidence-based medicine, human rights, economism, and development.[7] Studies of global health governance have also recognised the importance of the security marker.[8] It has even been argued that security should be seen as a broad imaginary, with a long-standing social and cultural ancestry, shaping the way diseases are perceived and health policies are designed.[9]

In fact, the IR engagement with health is inextricably linked with security. It originally developed out of a concern with the impact of diseases upon national security, particularly state stability and the preparedness of armed forces – a concern that speaks to the post-Cold War anxiety with 'new' and 'emerging' challenges.[10] Health

[7] Colin McInnes and Kelley Lee, *Global Health and International Relations* (Cambridge: Polity Press, 2012), pp. 18–19, 130–57.

[8] Sophie Harman, *Global Health Governance* (Abingdon: Routledge, 2011), pp. 19–23; Jeremy Youde, *Global Health Governance* (Cambridge: Polity Press, 2012), pp. 132–43.

[9] João Nunes, *Security, Emancipation and the Politics of Health: A New Theoretical Perspective* (Abingdon: Routledge, 2013), pp. 72–5.

[10] Laurie Garrett, 'The return of infectious disease', *Foreign Affairs*, 75:1 (1996), pp. 66–79; Andrew T. Price-Smith, *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development* (Cambridge, MA: MIT Press, 2001); David Heymann, 'The evolving infectious disease threat: Implications for national and global security', *Journal of Human Development and Capabilities*, 4:2 (2003), pp. 191–207.

issues have also been discussed from the standpoint of human security, that is, as threats to the welfare of individuals and groups.[11] With the growth of securitisation theory, the status of health as a matter of security was subject to a more radical line of questioning.[12] Instead of being concerned with the identification of health-related security threats, securitisation scholars turn to the processes through which health issues emerge as security problems, as well as to the political implications of this.[13] Securitisation-inspired studies thus place the emphasis on the ways in which actors represent health problems as threats to security. Reflecting the popularity of this approach, securitisation has arguably become the most prevalent framework in analyses of health security in IR.[14]

Securitisation theory has enhanced our understanding of the health-security nexus. To begin with, it shows that this nexus is not self-evident. Diseases are not threats 'out there', waiting to be observed; rather, they emerge as such because of social processes of representation – which may be explicit or implicit, intentional or not. The framing of disease as a threat to security does not describe a reality, inasmuch as the register of 'threat' is involved in constituting the reality it purports to describe. A second contribution of securitisation is, therefore, that it allows us to see health security as a political modality for dealing with issues. Linking health with security is not only the result of a process; it also has an impact. When seen through the prism of securitisation, health security is thus conceived as a set of understandings and practices that shape political practice and the political realm more broadly, helping to justify certain policies and agendas, garner resources, or alter political priorities.

Nonetheless, there are drawbacks to this vision of health security. Securitisation theory has opened fruitful lines of enquiry but it has also foreclosed an engagement with important aspects. This is because this approach follows a restrictive reading of security as a political modality that brings with it dangerous or undesirable effects – a reading that harks back to a reluctance to conceive security as 'a good to be spread to ever more sectors'.[15] For securitisation scholars, security has an overwhelmingly negative logic. It leads to issues being seen either as existential threats demanding exceptional measures or as technical questions. This, in turn, allows for normal democratic procedures, legal requirements, or international custom to be circumvented or reinterpreted.

[11] Lincoln Chen and Vasant Narasimhan, 'Human Security and global health', *Journal of Human Development and Capabilities*, 4:2 (2003), pp. 181–90.

[12] Perhaps the most influential statement of securitisation is Barry Buzan, Ole Wæver, and Jaap de Wilde, *Security: A New Framework for Analysis* (Boulder, CO and London: Lynne Rienner Publishers, 1998).

[13] See, for example, Mely Caballero-Anthony, 'Combating infectious diseases in East Asia: Securitization and global public goods for health and human security', *Journal of International Affairs*, 59:2 (2006), pp. 105–27; Sara E. Davies, 'Securitizing infectious disease', *International Affairs*, 84:2 (2008), pp. 295–313; Stefan Elbe, *Virus Alert: Security, Governmentality and the AIDS Pandemic* (New York: Columbia University Press, 2009); Melissa G. Curley and Jonathan Herington, 'The securitisation of avian influenza: International discourses and domestic politics in Asia', *Review of International Studies*, 37:1 (2011), pp. 141–66.

[14] Health security has also been approached from the perspective of risk. See Stefan Elbe, 'Risking lives: AIDS, security and three concepts of risk', *Security Dialogue*, 39:2–3 (2008), pp. 177–98; Sonja Kittelsen, 'Conceptualizing biorisk: Dread risk and the threat of bioterrorism in Europe', *Security Dialogue*, 40:1 (2009), pp. 51–71.

[15] Buzan, Wæver, and de Wilde, *Security: A New Framework for Analysis*, p. 35.

This premise results in a pessimistic reading, inasmuch as the securitisation lens is particularly concerned with identifying the harmful results of ideas and practices of health security. Establishing a linkage between health and security – so this argument goes – makes it more likely that measures of containment, vigilance, exclusion, and even coercion are used to deal with health problems. Securitisation-inspired scholars thus tend to reject health security on the grounds of its political undesirability.[16] This sceptical view dovetails with charges put forward by authors writing from the standpoint of national security. For Susan Petersen, for example, health security brings no clear added value in both analytical and political terms.[17] She highlights the drawbacks of mobilising security when dealing with health issues like infectious diseases – namely that it may result in security dilemmas and create a competitive logic that hinders cooperation.

In general, then, it may be argued that the IR literature tends towards a deeply suspicious view of health security. This vision restricts the meaning of health security in at least two ways. First, it privileges the standpoint of the nation-state and of other powerful actors that are able to undertake securitising moves.[18] Second, it presents a deterministic reading of the political effects of health security, assuming that the latter necessarily entails unchecked measures or the sacrifice of rights and liberties. What is lacking is an appreciation of the different meanings that 'being secure' can have in the case of health. A government's concern with health security in relation to the preparedness of its armed forces in the face of infectious disease is different from that of a family without basic sanitation, or that of a person without access to affordable health care. For individuals, health security pertains to a life condition characterised by assuredness, predictability, or stability in relation to one's present and future status – and not to the ability to project force or maintain social cohesion. Different understandings of what health security means result in different ideas about what it may entail politically. Achieving health security does not necessarily imply restrictions upon democratic deliberation, the empowerment of an elite or forceful measures. It can actually mean the opposite: the broadening of democratic scrutiny upon health policymaking; a more participated debate about health provision; and a more solidaristic public sphere. The pessimistic reading of the assumptions and implications of health security may have become prevalent in the literature, but it is far from telling the whole story.[19]

In order to do justice to the multiple facets of health security, one needs to go beyond the analyses available in the IR literature – be they inspired by securitisation theory or by more traditional, national security concerns. Ultimately, this entails questioning existing understandings of what security and insecurity might mean in the case of health. Seeking to shed light upon dimensions that so far have been

[16] For a more nuanced analysis, see Stefan Elbe, 'Should HIV/AIDS be securitized? The ethical dilemmas of linking HIV/AIDS and security', *International Studies Quarterly*, 50:1 (2006), pp. 119–44.

[17] Susan Peterson, 'Epidemic disease and national security', *Security Studies*, 12:2 (2002), pp. 43–81.

[18] When Peterson speaks of the linkage of health and security she is predominantly considering the mobilisation of the 'rhetoric of national security' to deal with health problems. Ibid., p. 80. The prioritisation of powerful actors has been one of the main criticisms directed at securitisation theory. See Lene Hansen, 'The Little Mermaid's silent security dilemma and the absence of gender in the Copenhagen School', *Millennium: Journal of International Studies*, 29:2 (2000), pp. 285–306.

[19] In her contribution to this Special Issue, Alison Howell also discusses some of the limitations of securitisation theory when applied to health. In her argument, at the crux of the securitisation of health literature lies a problematic distinction between norm and exception, and a restricted vision of the relationship between politics and security.

neglected, the present argument advances an alternative approach to health security. This approach has two assumptions: firstly, the primary referent for thinking about security is the human being and not the nation-state. Therefore, in this article health security, and the lack thereof, refer to conditions experienced by individuals in context. The second assumption is connected: going beyond securitisation theory and its focus on social processes of representation, security and insecurity are approached as bodily experiences. Thinking about health security cannot be reduced to analysing securitising processes because people are and feel more or less assured about their present and future health regardless of whether problems are being securitised or not.

In addition to starting from these assumptions, the reconceptualisation suggested in this article is inspired by the idea that achieving security entails opening up space for individuals to make decisions and act in matters pertaining to their own lives. Individuals who are more secure are generally more able to influence in a meaningful way the course of their lives – free from social constraints like physical aggression, political persecution, poverty, or ill health, as well as from the broader structures and relations that make these constraints possible. Security is thus intrinsically connected with (context-specific) emancipatory politics.[20] The idea of security as emancipation has the potential to offer fresh insights into the case of health, by shifting the focus towards the embodied reality of insecurity as a 'life-determining condition' of individuals.[21] The commitment to take insecurity – and not some *a priori* notion of security – as the starting-point is a novelty in the analysis of health. It distinguishes security as emancipation from other approaches in the IR literature – like national or human security – that assume that health threats derive in a self-evident way from pregiven definitions of security. Instead, for an emancipation-oriented approach, one should start from the bottom-up. Before considering what health security can mean, one must first unpack the meaning of insecurity.

Insecurity and domination

According to security as emancipation, the insecurity of individuals is to be prioritised and individuals may be considered insecure when they are prevented from freely determining their own lives.[22] However promising, this perspective still suffers from insufficient detail, so that realising its potential requires further theoretical work. In order to advance security as emancipation, and following the latter's injunction to take insecurity as a starting-point, this article develops an analytical lens for the study of concrete insecurities – that is, the situations one is to be emancipated from.

The concept of power – and, in particular, the notion of power as a form of domination – offers a useful lens with which to explore insecurity. Viewing power as domination is not the same as conceiving it in simplistic terms as a repressive or coercive force. Rather, domination is here understood as a multilayered concept that comprises, first, the shaping of action. In this 'surface-level' sense, power consists in

[20] Ken Booth, *Theory of World Security* (Cambridge: Cambridge University Press, 2007); Soumita Basu, 'Security as emancipation: A feminist perspective', in J. Ann Tickner and Laura Sjoberg (eds), *Feminism and International Relations: Conversations about the Past, Present and Future* (Abingdon: Routledge, 2011), pp. 98–114; Matt McDonald, *Security, the Environment and Emancipation: Contestations Over Environmental Change* (Abingdon: Routledge, 2012).

[21] Booth, *Theory of World Security*, p. 101.

[22] See Ken Booth, 'Security and emancipation', *Review of International Studies*, 17:4 (1991), pp. 313–26.

the quality or property of an actor, which is wielded with the objective of shaping the actions of others by coercion or threat, by the delimitation of the field of acceptable and desirable action, and by foreclosing alternatives. This view of power is present in the work of Steven Lukes.[23] For Lukes, power is not just as an overt intention leading to certain decisions or actions on the part of those affected. Power also operates by investing intentions with an aura of necessity or desirability, thus preventing dissent. Power is conceived as 'the ability to constrain the choices of others, coercing them or securing their compliance, by impeding them from living as their own nature and judgment dictate'.[24]

Lukes's view dovetails with existing accounts of security as emancipation insofar as it is reliant upon the assumption that power works primarily via the imposition of constraints upon people's lives. The picture is, however, more complex than this. Michel Foucault and other authors working with the governmentality approach have advanced the idea of power as a productive force involved in the constitution of subjects.[25] For these scholars, power consists in the mechanisms and strategies 'shaping and governing the capacities, competences and wills of subjects'.[26] Power should not be seen merely as a question of prohibition or repression because it can also denote the fostering of behaviours, tastes, and dispositions. Instead of defining subjects as mere recipients or targets of power – that is, as pregiven entities that are constrained in the free course of their lives – this view argues that subjects are also constituted, in their capacities and self-understandings, through power relations. As Foucault has put it:

> [t]he individual is not to be conceived as a sort of elementary nucleus ... on which power comes to fasten or against which it happens to strike, and in so doing subdues or crushes individuals. In fact, it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals. The individual, that is, is not the vis-à-vis of power; it is, I believe, one of its prime effects.[27]

The discussion of how subjects are constituted has often been framed in the governmentality literature by an understanding of power relations as essentially 'horizontal'. Power – so this argument goes – does not simply emanate from the government or the sovereign ruler. Instead, power is something that circulates between nodes in society: hospitals, schools, churches, or civil society organisations. Individuals are not helpless targets, but rather conduits that always have the capacity to resist power to some extent. However important this horizontal element of power relations might be, it runs the risk of neglecting the hierarchical element that often permeates these relations. By stressing the relational nature of power/resistance, the view of power as constitution of subjects very often overlooks the fact that not all actors may be considered equally powerful.

[23] Steven Lukes, *Power: A Radical View* (2nd edn, New York: Palgrave Macmillan, 2005).
[24] Ibid., p. 85.
[25] Colin Gordon, 'Governmental rationality: An introduction', in Graham Burchell, Colin Gordon, and Peter Miller (eds), *The Foucault Effect: Studies in Governmentality* (Chicago: University of Chicago Press, 1991), pp. 1–51; Mitchell Dean, *Governmentality: Power and Rule in Modern Society* (London: SAGE, 1999).
[26] Nikolas Rose, 'Governing "advanced" liberal democracies', in Andrew Barry, Thomas Osborne, and Nikolas Rose (eds), *Foucault and Political Reason: Liberalism, Neo-Liberalism and Rationalities of Government* (London: UCL Press, 1996), pp. 37–64, 58.
[27] Michel Foucault, 'Two lectures', in Michael Kelly (ed.), *Critique and Power: Recasting the Foucault/Habermas Debate* (Cambridge, Mass. and London: MIT Press, 1994 [orig. pub. 1976]), pp. 17–46, 36.

Exploring how action is shaped and subjects are constituted should therefore be supplemented by a consideration of the ways in which power relations are sometimes skewed towards certain outcomes. This is why it is necessary to dig deeper into a third layer of power. The shaping of action and the constitution of subjects are embedded within a context in which unequal life conditions are structurally induced. Power relations occur in, and are themselves involved in the production of, an uneven field in which certain groups are systematically placed in a position of subordination in relation to others. Put differently, one of the components of power is a certain measure of domination.[28]

Domination can be defined as the systematic production of the privilege of some groups at the expense of others, via the exercise of arbitrary influence or as a result of existing rules in society. This means that decisions are made or effects are produced to the benefit of certain groups, without the constraint of effective rules or within a legal and institutional framework that fails to consider and protect the wellbeing of all affected parties. Dominated groups are thus vulnerable to decisions and outcomes with a high impact upon their lives, and which they cannot control or even predict. Domination entails an unequal relationship: the groups involved have different degrees of control over the relationship, so that some are systematically placed in a subordinate position. This does not necessarily entail the existence of a binary relationship between a dominated group and a consciously dominating one. As Jonathan Hearn has noted, strategic control is one possible face of domination, which can also occur via the sedimentation of advantageous positions, through (unintended) malign influence or by the sheer negligence of privileged groups or of those in positions of responsibility.[29] Moreover, domination can occur at the level of behaviours (by directly shaping action); interests (by shaping what is seen as possible and desirable); and subjectivities (by shaping self-understandings and worldviews, which in turn impact upon interests).

Domination is a more comprehensive view of power than those currently available in security studies. Its main advantage is that it combines three approaches to power that, to a great extent, have been kept separate in this literature: power as the shaping of action (as in Lukes), power as constitution of subjects (as in Foucault), and power as the systematic production of privilege and subordination.[30] Traditionally, security studies tended to read power as the property of a nation-state, and to assume that it entails the shaping of another state's behaviour via a combination of coercion and enticement, in the context of a struggle for the maximisation of utility.[31] The constitutive face of power is a concern shared by poststructuralists and some constructivists.[32] Feminist works have offered the most systematic engagements with

[28] Works that address this layer of power (without necessarily using the term 'domination') are Ann E. Cudd, *Analyzing Oppression* (Oxford: Oxford University Press, 2006); Frank Lovett, *A General Theory of Domination and Justice* (Oxford: Oxford University Press, 2010); and Iris Marion Young, *Justice and the Politics of Difference* (Princeton and Oxford: Princeton University Press, 2011 [orig. pub. 1990]).

[29] Jonathan Hearn, 'What's wrong with domination?', *Journal of Power*, 1:1 (2008), pp. 37–49.

[30] In the broader field of IR, a combination of the first two approaches is provided in Michael Barnett and Raymond Duvall, 'Power in international politics', *International Organization*, 59:1 (2005), pp. 39–75.

[31] As one scholar argued, '[p]ower directs attention towards the means by which individual states can both be controlled internally, and pursue their competitive interests within the state system … in such a way as to maximise their own advantage.' Barry Buzan, 'Peace, power and security: Contending concepts in the study of International Relations', *Journal of Peace Research*, 21:2 (1984), pp. 109–27, 112.

[32] David Campbell, *Writing Security: United States Foreign Policy and the Politics of Identity, Revised Edition* (Manchester: Manchester University Press, 1998); Jutta Weldes, *Constructing National Interests: The United States and the Cuban Missile Crisis* (Minneapolis: University of Minnesota Press, 1999).

the (gender-based) production of subordination.[33] Domination succeeds in bringing these views together.

Therefore, when looking at issues from a security-as-emancipation perspective, the use of domination as an analytical lens allows for a more sophisticated investigation of insecurity. This lens sheds light upon the structural conditions that enable certain courses of action whilst constraining others, and that promote certain subjectivities as possible and desirable – in the context of an unequal playing field. This enhances our understanding of the shaping of action, by allowing us to consider the ways in which certain groups are made subordinate, and are thus prevented from deciding and acting in matters pertaining to their own lives. Furthermore, because it highlights the connection between structural conditions and accompanying processes of subject-formation, the lens of domination also allows us to go beyond a strict focus on external constraints. It paves the way for a consideration of individual perceptions and the processes through which subjects are constituted (or constituting themselves) as secure or insecure – perceptions and processes that, in turn, impact upon how insecurities are experienced. The lens of domination thus incorporates the view of power as constitution of subjects, and yet goes beyond it by drawing attention to the power inequalities that confront subjects at the moment of their constitution. Overall, then, with these features the lens of domination emerges as a particularly promising resource for the investigation of insecurity in the case of health.

Deepening and broadening health insecurity

It is important to emphasise that what is being suggested is not that domination is the true nature of health insecurity, or that the latter can simply be explained by tracing a causal link to domination. Rather, domination is here approached as a distinctive perspective that enables a more comprehensive engagement with insecurity, thus bringing to light facets so far neglected or insufficiently addressed in the IR literature.

What can domination bring to the analysis of health insecurity? To begin with, domination deepens analysis by allowing us discern different levels. Firstly, by highlighting the shaping of action and the constitution of subjects, domination underscores the subjective level of insecurity. This level refers to insecurities as they are experienced – both directly by those who live them and indirectly by those who acknowledge them. Secondly, by considering the social setting in which subjects are positioned and constituted, domination highlights the intersubjective level of insecurity. This level refers to the social processes that mediate subjective experience and that shape the perception and representation of issues as matters of security.

Thirdly, domination draws attention to the underlying conditions that enable or constrain individual experiences of insecurity and the 'voicing' and 'listening' of these experiences in the social sphere. This leads us to the structural level of insecurity, which refers to the material and ideational structures that confront actors as sedimented prior to their perceptions and interactions. Material entities – an infectious disease, for example – may affect our security regardless of what we think or say

[33] See, for example, Gunhild Hoogensen and Svein Vigeland Rottem, 'Gender identity and the subject of security', *Security Dialogue*, 35:2 (2004), pp. 155–71; Annick T. R. Wibben, *Feminist Security Studies: A Narrative Approach* (Abingdon: Routledge, 2011).

about them. Our knowledge about how these entities operate may provide us with tools with which to adapt; however, their existence imposes limits on what we can do. In addition, there are ideational entities – for instance, ideas and fears about disease transmission – that affect our experience of insecurity. Even though ideas are ultimately the result of human interaction, they cannot be simply wished away. Their existence and capacity to influence outcomes are not totally dependent on the consciousness and interaction of those specific individuals that are affected by them.[34]

In practical terms, this tells us that health insecurities do not derive self-evidently from the emergence of biological entities (such as a new virus strain) or from material conditions (such as poverty). At the same time, there is more to health insecurity than the (intersubjective) securitising moves through which certain problems are framed as threats. Finally, health insecurity is more than the reflection of subjective fears and experiences. Rather, health insecurity may be said to emerge from different combinations between the subjective, intersubjective, and structural levels. Anxieties regarding disease transmission illustrate some of the possible overlaps and disjunctures between these levels. The (subjective) fear of infection can express an individual anxiety or respond to a wider social unease, which in turn can be reproduced by the interplay of media accounts, government responses, and the interests of powerful actors like pharmaceutical companies (pandemic scares related to influenza strains are recent examples of this). This process may or may not speak to actual risks and vulnerabilities: consider, for instance, myths about disease transmission by hugging or using public toilets (HIV/AIDS, discussed in more detail below, has been a fertile ground for these panics). Moreover, in some situations actual risks and structural vulnerabilities are not translated into societal anxieties and into changes in behaviour (as evidenced by the case of noncommunicable ailments like cardiovascular disease, particularly in low- and middle-income countries).

Looking at the subjective, intersubjective, and structural faces of health insecurity is not the same as considering different 'levels of analysis' or 'images' in the Waltzian sense.[35] Instead, what is envisaged is what Heikki Patomäki has termed 'interpretive depth-explanations'.[36] In these kinds of explanations, the analysis of particular issues is connected with an investigation of structural causality and agency. An awareness of structure and agency is important when analysing health insecurity inasmuch as it allows us to go beyond the descriptive stance of merely identifying threats in a top-down manner. It becomes possible to scrutinise the specific interactions between structures and agents in the reproduction or contestation of insecurities. In other words, the door is open for an exploration of how insecurities emerge, how agents interpret them, and what the possibilities are for overcoming them.

[34] Claiming that insecurity has a structural level that is not completely dependent upon subjective representation or intersubjective mediation by specific actors is not the same as saying that it is independent of human activity (broadly conceived). It merely reminds us that our experiences and interactions are always enabled or constrained by entities that confront us as already existent prior to our specific thoughts and actions. See Colin Wight, *Agents, Structures and International Relations: Politics as Ontology* (Cambridge: Cambridge University Press, 2006); Jonathan Joseph, 'Philosophy in International Relations: A scientific realist approach', *Millennium: Journal of International Studies*, 35:2 (2007), pp. 345–59.

[35] Kenneth Waltz, *Man, the State and War: A Theoretical Analysis* (New York: Columbia University Press, 1959). For a discussion, see J. David Singer, 'The level-of-analysis problem in International Relations', *World Politics*, 14:1 (1961), pp. 77–92.

[36] Heikki Patomäki, 'How to tell better stories about world politics', *European Journal of International Relations*, 2:1 (1996), pp. 105–33, 127.

Thus, on the one hand, making sense of health insecurity requires an analysis of the ways in which structures – material entities and resources, institutions, or ideas – impact upon individual experiences of insecurity. They do so not necessarily by causing them in a direct 'push and pull' manner, but by functioning as enabling or constraining conditions of particular forms of subjectivity and action.[37] On the other hand, these structures of insecurity are themselves reproduced through the practices of agents embedded in a network of structural possibilities and limitations. This means that structures can be challenged and even transformed by signifying practices and transformative struggles of agents acting in a social context. In sum, the lens of domination allows for agents and structures to be considered in conjunction, with their varying articulations reflecting different distributions and manifestations of power (and counter-power).[38] This perspective enables a richer account of the conditions in which insecurities occur, and of the social processes through which they are reproduced and contested. Individual experiences of insecurity and 'macrolevel' dynamics in world politics can thus be tied more closely.

In addition to deepening, the lens of domination also broadens the remit of analysis, allowing for a nuanced appreciation of the meanings of insecurity in relation to health. At first glance, the health insecurity of individuals might simply be considered the actual or potential disruption of their wellbeing by an infirmity or by a change in the circumstances impacting upon such wellbeing. The lens of domination allows us to unpack this rather vague view of the meaning of health insecurity. It does so by revealing three ways in which insecurity can manifest itself. Each of these faces of insecurity includes not only actual threats, but also a dynamic element comprising 'upstream' conditions leading to actual insecurity and 'downstream' capacities for its transformation. This approach to health security builds upon Jonathan Wolff's argument that wellbeing depends not only on present states, but also on the ability to secure future states.[39]

Harm – an inflicted injury – is the first, and often the most visible, face of insecurity. Harm is more than the physical, coercive type: it also encompasses indirect or insidious injuries, not necessarily intended. Andrew Linklater has offered a typology of harm that includes psychological harm (for example, stigmatisation or humiliation); inadvertent harm (harm caused without the intention of causing suffering); negligent harm (resulting from the failure to take precautions to avoid harming others); exploitative harm (when groups profit unfairly at the expense of others); complicit harm (when groups are associated with institutions and practices that disadvantage others); omissive harm (harm caused by acts of omission); public harm (damage to institutions responsible for avoiding harm); and structural harm (when groups are affected by the rules and institutions in a society).[40]

[37] This view of causality is laid out in Milja Kurki, *Causation in International Relations: Reclaiming Causal Analysis* (Cambridge: Cambridge University Press, 2008).

[38] This view of structure and agency is inspired by critical realism, according to which it is problematic to consider agents and structures as separate because 'agents always bring their structures with them, and structural causal power is only ever exercised through the practices of agents'. Wight, *Agents, Structures and International Relations: Politics as Ontology*, p. 296. It is equally problematic to collapse the two: whilst dependent upon structures, agents are not reducible to them, whilst 'structures have a mode of being and a set of causal powers that are not reducible to the individuals upon whose activity they depend'. Ibid. The disjunction between agents and structures prevents this account from being deterministic.

[39] Jonathan Wolff, 'Disadvantage, risk and the social determinants of health', *Public Health Ethics*, 2:3 (2009), pp. 214–23.

[40] Andrew Linklater, *The Problem of Harm in World Politics: Theoretical Investigations* (Cambridge: Cambridge University Press, 2011), pp. 49–61.

This typology shows the different ways in which an individual's health may be adversely affected by material and ideational structures and by the social relations embedded in these structures. For example, in addition to the physical injury of disease an individual might suffer from the psychological harm of being stigmatised and segregated because of prevalent ideas and prejudices. The harm she suffers may be the result of a deliberate action (as in the release of a toxic agent) or inadvertent (the unintended transmission of a disease). Sometimes, this harm may be the result of negligence or omission on the part of those responsible for avoiding it (as in the case of industrial accidents stemming from unsafe conditions). Harm to health can also result from social relations that systematically place certain groups in harm's way so that others can benefit (for example, the case of miners exposed to fumes and radiation). Health can also be affected by damage being done to public health services, or by the rules and pay-walls determining access to healthcare.

These forms of health-related harm are insecurities because – going back to the notion of security as emancipation that inspires this article – they constitute impediments to the ability of individuals to make decisions and act in matters pertaining to their own lives. But they can also be recognised as insecurities when one considers their 'upstream' and 'downstream' elements. This is why the analysis of harm needs to be supplemented by an acknowledgment of existing vulnerability, that is, of a group's or an individual's susceptibility to harm.[41] In its most basic sense – that is, as the possibility of being harmed – vulnerability is an intrinsic part of being human because we are all connected to, exposed to and dependent upon others. Vulnerability may be considered a dimension of insecurity when it assumes a systematic character, that is, when certain groups are structurally positioned so that they are more prone or likely to being harmed. In addition to being an 'upstream' condition of susceptibility, vulnerability also encompasses a relative lack of capacity to 'bounce back' and overcome it.[42] This is because, in many cases, harm reinforces vulnerability. Take, for example, the case of uninsured individuals who see their lives disrupted by an accident requiring substantial medical bills, and who as a result end up with further vulnerabilities (such as homelessness).

The lens of domination reveals a second, interconnected face of health insecurity: unpredictability. Feeling and being secure requires certainty, that is, a set of stable expectations about what is likely to occur in the future, assuming that certain circumstances remain the same.[43] In order to feel secure, individuals and groups rely upon a measure of predictability in their lives – which in turn cannot be separated from suitable conditions in society. Even though unexpected things happen, being able to reasonably expect that a given outcome will follow from certain circumstances is a fundamental condition of security. Being relatively assured about their surroundings

[41] See Robert E. Goodin, *Protecting the Vulnerable: A Reanalysis of Our Social Responsibilities* (Chicago and London: University of Chicago Press, 1985).

[42] Wolff engages with this by way of the concept of resilience, which he associates with the capacity to overcome the consequences of ill health as well as the 'costs and difficulties of taking steps to mitigate those consequences'. Jonathan Wolff, 'Health risk and health security', in Rosamond Rhodes, Margaret P. Battin, and Anita Silvers (eds), *Medicine and Social Justice: Essays on the Distribition of Health Care* (2nd edn, Oxford: Oxford University Press, 2012), pp. 71–8, 76.

[43] Some scholars have addressed this question via the notion of 'ontological security', defined by Jennifer Mitzen as the security 'of the self, the subjective sense of who one is, which enables and motivates action and choice'. Jennifer Mitzen, 'Ontological security in world politics: State identity and the security dilemma', *European Journal of International Relations*, 12:3 (2006), pp. 341–70, 344.

allows individuals to make decisions and go about their lives without the constant fear of sudden disruption or even death. When lived in a situation of systematic unpredictability, individuals and groups are constantly placed at the threshold of survival – a permanent source of insecurity. The relevance of unpredictability when looking at health insecurity is illustrated by the case of the numerous individuals dependent on welfare provision and public health services. In times of austerity, with these safety nets being scaled back or eliminated altogether, life becomes extremely uncertain for many.

The 'upstream' and 'downstream' elements of unpredictability may be approached via the notion of lack of control. Chronically insecure individuals and groups normally have little control over their surroundings and little voice in decisions with a potentially harmful impact. They are inordinately affected by chains of events triggered by other actors' actions and choices; and, to make things more complicated, these decisions are sometimes taken at a great spatial and temporal distance. Because their opinions and interests are seldom considered, they are frequently unable to predict the impact of these decisions. Their powerlessness and lack of control are perpetuated by the uncertain situation in which they find themselves, and which forces them to devote their time, energy, and resources to meeting the demands of survival.

The third face of health insecurity unveiled by domination is inequality. Inequality relates to a deep-seated discrepancy in the possession or access to different types of resources (economic, for example). It also relates to an imbalance in societal perceptions and self-understandings (ideas of racial superiority, for instance), which may condition access to and use of resources by some groups. Finally, inequality also relates to the relative weight of these resources in terms of actors' capacity to influence outcomes. Whilst inequality relates to a set of relations already in place, the notion of disadvantage pertains to the likelihood that certain individuals and groups will find themselves in a position of inequality (the 'upstream' dimension). It also pertains to the possibilities for overcoming a situation of inequality or maintaining a more or less equal playing field (the 'downstream' dimension). Disadvantage very often translates as actual inequality, which in turn breeds further forms of disadvantage.

Inequality and disadvantage may be seen as faces of health insecurity because they place constraints upon the range of available options and opportunities. They do so by limiting access to the material resources needed for a healthy life-style, for instance, or by shaping subjectivities and self-perceptions in unequal ways, thus impacting upon some people's understandings of acceptable and desirable behaviour (one example is the unequal access to family planning and education, which leads to higher teenage pregnancy rates in some deprived sectors of the population). Moreover, inequality and disadvantage are also faces of insecurity because they interact with the two faces highlighted above: they leave subordinated individuals and groups in a position of greater vulnerability and lack of control over their surroundings. To a certain degree, harm, vulnerability, unpredictability, and lack of control are the result of fundamental inequalities. At the same time, this relation can be turned on its head, with disadvantage resulting from, or being perpetuated by, other insecurities.[44]

[44] Jonathan Wolff and Avner De-Shalit suggest that 'exposure to risk constitutes or causes disadvantage', not only by endangering achieved ways of being – thus resulting in anxiety and, sometimes, in the inability to adequately plan and control life – but also because steps to reduce risk can have detrimental costs and consequences. Jonathan Wolff and Avner De-Shalit, *Disadvantage* (Oxford: Oxford University Press, 2007), pp. 68–9.

In sum, the lens of domination broadens the remit of analysis by allowing us to zoom in on the different ways in which health insecurity is connected with the (re)production of subordination. Domination reveals that insecurity also resides in particular articulations of structures and social relations that are systematically skewed towards the benefit of some at the expense of others. Those in a position of subordination see their life-chances curtailed because they are systematically vulnerable or harmed, unable to assert a degree of control or predictability over their lives, and/or chronically placed in positions of disadvantage and inequality.

With the simultaneously deeper and broader view afforded by the lens of domination, we are in a better position to unpack the abstract idea of health insecurity as a disruption of wellbeing. It becomes possible to approach health insecurity, not simply as the experience or threat of illness, but more comprehensively as a situation of domination through which life chances are constrained. Health issues can be considered matters of security if they restrict in a decisive manner the ability of those involved – individuals, families and/or groups – to shape the course of their lives, either by determining their action or by steering their conduct. This is not a question of the seriousness of the illness, but of its ability to impact upon the lives of those affected. For many people the simplest health problem can be a major constraint and even a watershed: someone in a precarious job, for example, may run the risk of being made redundant after calling in sick because of a flu or an upset stomach.

Health issues can also be seen as matters of security when they connect with broader political structures and relations. These go a long way in determining who is vulnerable to or harmed by disease, how systematically, and what opportunities and resources there are with which to deal with the occurrence of disease. When one is placed in a situation of disadvantage or inequality, it becomes more difficult – if not impossible – to have access to preventive measures, receive state-of-the-art treatment (and even any treatment at all), and benefit from compensation. When there is a situation of lack of control, one is unable to influence the external factors that condition exposure to illness; sometimes, this also entails the inability to recognise and predict the very factors that will affect one's health.

Finally, health issues are questions of security insofar as they may contribute to the reproduction of broader relations and structures of domination. By curtailing the ability of individuals and groups to make decisions and act in matters pertaining to their own lives, diseases reproduce disadvantage and actual inequality. Diseases may also reproduce systematic vulnerability and harm: for instance, incapacitating illnesses impact upon people's ability to work and to contribute to the subsistence of their households. Diseases may also increase one's lack of control over life and one's ability to adjust to exogenous shocks.

The value of health security

The approach to health security advanced in this article faces two sets of challenges. First, to what extent does it deliver fresh insights in the analysis of specific health problems? And second, what is the added value of mobilising security? Put differently, what does the vocabulary of security/insecurity tell us that other concepts – like development, human rights or equality – cannot? In order to tackle these challenges, the argument considers two illustrative examples: HIV/AIDS; and water and sanitation.

Revisiting HIV/AIDS

HIV/AIDS is widely recognised as one of the most important issues in global health. An array of high-profile measures has been put forward to address this issue, ranging from celebrity-backed fundraising initiatives – such as the (RED) campaign – to multimillion-dollar governmental programmes (like the United States President's Emergency Plan for AIDS Relief, PEPFAR) and international institutions (like UNAIDS or the Global Fund to Fight AIDS, Tuberculosis and Malaria). The unanimous adoption of UN Security Council Resolution 1308 in July 2000 not only marked the entry of HIV/AIDS into the highest levels of international diplomacy, but also underscored security as one of the most prevalent frames for dealing with this disease.

In keeping with this, many authors in IR have approached HIV/AIDS as a security issue. These engagements have followed the two general trends in the health security literature that were identified earlier in this article. A significant part emphasises the national and/or international security implications of HIV/AIDS, namely its impact on the preparedness of armed forces and on state and regional stability.[45] Other scholars approach this disease from the perspective of securitisation.[46] Even if this latter perspective has yielded nuanced analyses, the overall picture still falls short of providing a complete picture of HIV/AIDS as a security issue. Overwhelmingly, the literature tends to privilege powerful voices and the views of (national and international) elites, whilst at the same time remaining deeply suspicious of the political implications of the security framing. A simultaneously broader and deeper reading of HIV/AIDS as a security issue is needed, and using domination as an analytical lens makes such reading possible. This lens allows for different levels to be discerned and for different faces of insecurity to be recognised.

HIV/AIDS should be approached first and foremost as a lived and embodied condition, one that resonates primarily as a subjective experience of insecurity. As a disease that is still incurable, it determines the lives not only of those who suffer from it but also of their families and carers. HIV/AIDS is surrounded by various forms of harm in addition to the bodily harm of being infected. It is still accompanied by prejudice and stigmatisation (forms of psychological harm). Stigmatisation is in turn accompanied, in many countries, by a culture of omission and outright negligence, which facilitate the spread of disease and make it more difficult for those living with it to access adequate treatment (witness for example the growth of HIV/AIDS denialism in South Africa under Thabo Mbeki). In the wake of the recent financial turmoil, and with the scaling back of many public health services, forms of public and even structural harm (related to rules of access to treatment) have also become increasingly relevant. These forms of harm also mean that HIV/AIDS effectively functions as a multiplier of disadvantage, lack of control, and vulnerability. A good example of this is the impact of HIV/AIDS on orphanhood and on the reproduction of child vulnerability.[47]

[45] See, for example, Robert L. Ostergard, 'Politics in the hot zone: AIDS and national security in Africa', *Third World Quarterly*, 23:2 (2002), pp. 333–50; P. W. Singer, 'AIDS and international security', *Survival*, 44:1 (2002), pp. 145–58; Stefan Elbe, *Strategic Implications of HIV/AIDS – Adelphi Paper No. 357, International Institute for Strategic Studies* (Oxford: Oxford University Press, 2003); Tony Barnett and Gwyn Prins, 'HIV/AIDS and security: Fact, fiction and evidence – a report to UNAIDS', *International Affairs*, 82:2 (2006), pp. 931–52.

[46] Elbe, 'Should HIV/AIDS be securitized?'; Colin McInnes and Simon Rushton, 'HIV/AIDS and securitization theory', *European Journal of International Relations*, 19:1 (2012), pp. 115–38.

[47] Geoff Foster, Carol Levine, and John Williamson (eds), *A Generation at Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children* (Cambridge: Cambridge University Press, 2005).

HIV/AIDS is thus more than a bodily condition. It can also be considered an instance of insecurity at the intersubjective level. This disease has always been accompanied by intense societal anxiety, a fear-based imaginary fuelled by moral panics (for example, prejudices against homosexuals, sex workers, and drug users) and, in some cases, by myths regarding the transmission of the disease.[48] These narratives still shape societal reactions and go a long way in determining not just the exposure to infection but also the experience of those infected. Consider, for instance, the religious injunctions that in some places restrict knowledge about the disease and the availability and acceptability of prophylactics (like condoms). As the case of PEPFAR shows, religious-based considerations can have an effect upon aid provision and, hence, upon people's lives and wellbeing.[49] The framing of HIV/AIDS as a punishment of God impacts upon the spread of the disease and contributes to casting infection as a personal fault, that is, as the result of 'irresponsible' or 'immoral' behaviour. This may contribute to entrenching a vicious cycle of harm, vulnerability, and disadvantage.

HIV/AIDS is also a case where structural elements of insecurity are in place. Material and ideational structures function as enabling and constraining conditions for individual experiences of HIV/AIDS, whilst also shaping how the disease is given meaning in society. Examples of these structures are the international laws and the economic dynamics governing the supply and access to antiretroviral treatments.[50] Another important structural element is gender. On the one hand, gender plays a significant role in the patterns of vulnerability to this disease. For instance, many women live in economic and cultural settings in which they are unable to control the sexual behaviour of their partners; patriarchy and misogyny in society reinforce a culture of sexual violence against women, which in turn functions as a vector of transmission. On the other hand, in countries where there is a high-prevalence of the disease – and particularly in situations of conflict or postconflict – women are often more vulnerable to deprivation and sexual violence.[51]

In sum, the lens of domination allows us to consider three interconnected levels in the case of HIV/AIDS, whilst showing how this disease manifests itself in different faces of insecurity. Domination also enables a richer discussion of HIV/AIDS by shedding light on causality. What 'causes' HIV/AIDS as a multifaceted insecurity is not merely the sharing of needles or unprotected sex, but also the broad set of material and ideational conditions that shape how HIV/AIDS is experienced and

[48] See Charles E. Rosenberg, *Explaining Epidemics, and Other Studies in the History of Medicine* (Cambridge: Cambridge University Press, 1992), pp. 278–92; Susan Sontag, *Illness as Metaphor & AIDS and its Metaphors* (London: Penguin, 2002 [orig. pub. 1991]).

[49] Helen Epstein, *The Invisible Cure: Africa, the West and the Fight Against AIDS* (London: Penguin, 2007), pp. 186–201.

[50] James Orbinski, 'Health, equity and trade: A failure in global governance', in Gary P. Sampson (ed.), *The Role of the World Trade Organization in Global Governance* (New York: United Nations University Press, 2001), pp. 223–41; Jan Peter Wogart et al., 'AIDS and access to medicines: Brazil, South Africa and global health governance', in Kent Buse, Wolfgang Hein, and Nick Drager (eds), *Making Sense of Global Health Governance: A Policy Perspective* (Houndmills: Palgrave Macmillan, 2009), pp. 137–63. For a detailed analysis of the political economy of this disease, see Colleen O'Manique, *Neoliberalism and AIDS Crisis in Sub-Saharan Africa* (Houndmills: Palgrave Macmillan, 2004).

[51] Anne V. Akeroyd, 'Coercion, constraints, and "cultural entrapments": A further look at gendered and occupational factors pertinent to the transmission of HIV in Africa', in Ezekiel Kalipeni et al. (eds), *HIV and AIDS in Africa: Beyond Epistemology* (Oxford: Blackwell Publishing, 2004), pp. 89–103; Hakan Seckinelgin, Joseph Bigirumwami, and Jill Morris, 'Securitization of HIV/AIDS in context: Gendered vulnerability in Burundi', *Security Dialogue*, 41:5 (2010), pp. 515–35.

represented as a problem. These, in turn, impact upon the measures that are seen as possible or desirable to tackle this problem. HIV/AIDS should therefore be considered a question of security not simply because it may affect state functions, social cohesion and international stability, or because it has been framed as such by securitising processes. HIV/AIDS is a security threat because it is a complex lived experience of individuals, enveloped by structures and relations, which places inordinate constraints upon some people's capacity to freely shape the course of their own lives.

Addressing neglect: water and sanitation

In addition to enabling a fresh perspective into health problems that have already been approached as matters of security, the lens of domination allows one to scrutinise neglected health insecurities. These neglected issues have not been accompanied by narratives of urgency that normally surround national security concerns. Moreover, they have not been objects of successful securitising moves, either because experiences of insecurity remain silent or because they are not seen as relevant by actors with the ability to shape outcomes. There is a whole range of health insecurities that do not receive the degree of attention from the media, the public, or policymakers that would be expected given their actual burden on individuals and societies. These insecurities have also, to a great extent, remained invisible for the health security literature in IR.

One example is water and sanitation. According to the WHO and the United Nations Children's Fund (UNICEF), in 2011 around 2.5 billion people did not use an improved sanitation facility, that is, one that hygienically separates human excreta from human contact.[52] Inadequate sanitation is directly related to poor water quality: also in 2011, and according to the same study, 768 million people did not use an 'improved source for drinking water' – one that is protected from outside contamination, in particular by faecal matter. Poor sanitation and insufficient access to safe water are the direct causes or underlying conditions of a number of diseases.[53] A foremost example is diarrhoea, the second leading cause of death in children under five years old (around 760,000 child deaths annually).[54] Several neglected tropical diseases (NTDs) are also connected to water and sanitation: examples include trachoma (the world's leading cause of preventable blindness) and soil-transmitted helminth infections (namely hookworm infection, ascariasis, and trichuriasis).[55] It has been estimated that around 530,000 people die annually from NTDs; these diseases result in the loss of 56.6 million disability-adjusted life years – higher than

[52] World Health Organization and United Nations Children's Fund, 'Progress on Sanitation and Drinking-Water – 2013 Update' (Geneva and New York: World Health Organization, 2013).
[53] D. D. Mara and R. G. A. Feachem, 'Water- and excreta-related diseases: unitary environmental classification', *Journal of Environmental Engineering*, 125:4 (1999), pp. 334–9.
[54] World Health Organization, 'Diarrhoeal disease', available at: {http://www.who.int/mediacentre/factsheets/fs330/en/index.html} accessed 28 April 2014. See also United Nations Children's Fund and World Health Organization, *Diarrhoea: Why Children are Still Dying and What Can be Done* (New York and Geneva: World Health Organziation, 2009).
[55] Duncan Mara et al., 'Sanitation and health', *PLoS Medicine*, 7:11 (2010), p. e1000363.

the 46.5 million attributable to malaria.[56] Overall, improving sanitation and access to safe water – when combined with improvements in hygiene habits – could potentially prevent around 9.1 per cent of the world's disease burden and 6.3 per cent of deaths.[57]

Problems deriving from water and sanitation should be approached as insecurities because they constitute a life-determining condition for individuals and groups. As a subjective experience, this insecurity pertains not only to the bodily harm resulting from water-related diseases. It is also connected with scarcity of water for consumption and irrigation, which leads to reduced life expectancy, stunting in children and malnutrition. It also pertains to water availability, that is, to the distance between people's place of residence and a water source, as well as to the amount of time spent daily in the procurement of water. As a result of this, issues of water and sanitation are not only insecurities but also harbingers of further insecurity. Unavailability of water has been tied to school absenteeism and to the exacerbation of gender inequalities in education: women and children are often enrolled in the task of procuring water, and lack of water for hygiene in schools has more profound impacts on female attendance.[58] NTDs reproduce poverty by reducing productive capacity, reducing school attendance and causing cognitive impairments.[59] In other words, these issues are multipliers of harm, vulnerability, and disadvantage.

Furthermore, the neglect surrounding these issues is in itself a marker of insecurity. As noted, neglect is at odds with the global burden of these issues. Instead of reflecting their intrinsic importance, neglect is socially produced: it results from the intersection of social processes of meaning-construction and existing political, economic, and institutional structures. At the intersubjective level, water and sanitation suffer from the traditional skewing of the global health agenda towards communicable diseases – a process with deep roots in historical narratives of health and disease. Issues related to water and excreta are deemed less worthy or less appealing, not only to politicians but also to the media and to opinion-makers like celebrities, who tend to gather around 'safer' causes.[60]

Neglect is also embedded within economic and political structures that epitomise inequality and disadvantage. On the one hand, problems related to inadequate water and sanitation are, to a great extent, issues of poverty. They arise from the unequal access to material resources, such as adequate housing and sewage infrastructure; they reveal discrepancies in access to education, namely education in hygiene that could greatly reduce incidence and mortality. On the other hand, global health policies are determined by the interests of (nonaccountable) private donors and of richer

[56] Peter J. Hotez, *Forgotten People, Forgotten Diseases: The Neglected Tropical Diseases and Their Impact on Global Health and Development* (2nd edn, Washington, DC: ASM Press, 2013), p. 10. Disability-adjusted life year (DALY) is a measurement of disease burden expressed as the number of years lost due to ill health.

[57] Annette Prüss-Üstün et al., 'Safer Water, Better Health: Costs, Benefits and Sustainability of Interventions to Protect and Promote Health (Geneva: World Health Organization, 2008).

[58] Christine L. Moe and Richard D. Rheingans, 'Global challenges in water, sanitation and health', *Journal of Water and Health*, 4:1 (2006), pp. 41–57; Jamie Bartram and Sandy Cairncross, 'Hygiene, sanitation, and water: Forgotten foundations of health', *PLoS Medicine*, 7:11 (2010), p. e1000367; Paul R. Hunter, Alan M. MacDonald, and Richard C. Carter, 'Water supply and health', *PLoS Medicine*, 7:11 (2010), p. e1000361.

[59] Hotez, *Forgotten People*, p. 11.

[60] A notable exception is the nonprofit organisation Water.org, cofounded by Hollywood actor Matt Damon.

nations, where water and sanitation do not pose substantial challenges.[61] The detrimental impact of donor-driven policymaking upon water and sanitation is exemplified by the funding structure of the WHO, which tends to privilege 'vertical' programmes of disease eradication (mostly those diseases that pose a threat to richer countries), in detriment of 'horizontal' interventions on infrastructure, primary health care and the strengthening of health systems.[62]

In sum, neglected issues like water and sanitation are not only clusters of insecurities, but they are also connected to global structures and relations that systematically reproduce the insecurity of some. The domination lens reclaims these issues from their relative invisibility in security studies and IR.

Health and the politics of security

From an emancipation-oriented perspective, HIV/AIDS and neglected health issues are matters of security insofar as they constitute impediments upon people's ability to shape the course of their own lives. The lens of domination unpacks different dimensions of insecurity in these cases, revealing aspects that so far have been insufficiently considered or even neglected. This security-centred approach does not claim to portray the ultimate truth about these issues: in some cases, it may still make sense to address them using other frames such as development or human rights. Nonetheless, this perspective is distinctive in revealing the multifaceted nature of these issues and the interconnection between individual experiences, social interactions, and structures in a context of systematically-produced subordination.

In addition to these analytical advantages, this security perspective also has an important political added-value. As securitisation theory reminds us, security is not merely a description of reality, but also a political modality, that is, a register of meaning that helps to shape politics. Notwithstanding the pessimistic views of securitisation, the political effects of security are not fixed once and for all because the meaning and practice of security depend upon context-specific ideas and interests, whilst also being shaped by social interactions. This means that health security can be conceived without bringing forth a range of emergency measures – such as forced inoculation campaigns, quarantines, or travel restrictions. Rather, the politics of health security can be oriented towards identifying and alleviating the structures and relations that are responsible for the reproduction of concrete insecurities experienced by individuals.

The perspective advanced in this article has the potential to become a tool for political transformation. To begin with, mobilising the lens of domination enables a more sophisticated understanding of health issues. Policymaking is always dependent upon prior definitions of existing problems – such definitions help to shape the political imagination and the range of options that are seen as possible and desirable. This article suggested that health problems should be approached as complex phenomena traversing the subjective, intersubjective, and the structural level; phenomena in which uncertainties, vulnerabilities, and various forms of harm are connected

[61] Colin McInnes and Kelley Lee, 'Health, security and foreign policy', *Review of International Studies*, 32:1 (2006), pp. 5–23; Simon Rushton, 'Global health security: Security for whom? Security from what?', *Political Studies*, 59:4 (2011), pp. 779–96.

[62] See Kelley Lee, *The World Health Organization* (London and New York: Routledge, 2009).

with inequality and disadvantage in an overall context of uneven life chances and subordination. In order to be effective in tackling health problems, policymaking must recognise and engage with this complexity.

In addition to providing the grounds for more informed policymaking, the perspective advanced here has two further political advantages, which derive from the power inherent to the security modality. The first is that the mobilisation of security expedites action that can contribute towards the alleviation of harm and vulnerability. Unlike any other term, security frames issues as questions of life and death.[63] When seen as an existential question, an issue is more likely to be given the attention it deserves, and those responsible for tackling it are more likely to receive the support and resources they need. This means that the widespread acceptance of, for example, water and sanitation as matters of security would raise their profile and enable swifter political action. This swiftness need not necessarily entail exceptional measures contravening democratic procedure (as securitisation scholars would object). Rather, security can work in beneficial ways to raise consciousness about the seriousness of an issue and transcend political deadlocks.

The second advantage is that security can have a positive constitutive effect in the reinforcement of the public sphere. Ian Loader and Neil Walker have argued that security functions as a public good, not simply because it is produced and enjoyed in the public sphere, but also because it is a condition for the realisation of the common good in a society.[64] A strong public sphere depends upon the existence of stable expectations and upon people's ability to cope with, and manage, the inescapable dangers deriving from social life. By ensuring a certain level of predictability and individual control over one's own surroundings, security helps to foster a common ground upon which democracy and public participation depend. As Loader and Walker have put it, the

> actualisation or aspiration [of security] is so pivotal to the very purpose of community that at the level of self-identification it helps to construct and sustain the 'we' feeling – the very felt sense of 'common publicness'.[65]

Reinforcing the public sphere holds great potential for addressing health issues. A particularly interesting development in this regard is the growing importance of civil society movements in health debates and policymaking.[66] Even though some forms of civil society participation can be distracting and detrimental to solving health problems – see, for example, the case of antivaccination groups – in general the democratisation of health debates is to be welcomed. Greater public participation in, and scrutiny of, the mechanisms and blind spots of health provision increases the chances that the multiple faces of harm and vulnerability at the core of health insecurity will be comprehensively engaged with.

[63] Jef Huysmans, 'Security! What do you mean? From concept to thick signifier', *European Journal of International Relations*, 4:2 (1998), pp. 226–55.
[64] Ian Loader and Neil Walker, *Civilizing Security* (Cambridge: Cambridge University Press, 2007).
[65] Ibid., p. 164.
[66] David Kelleher, 'New social movements in the health domain', in Graham Scambler (ed.), *Habermas, Critical Theory and Health* (London and New York: Routledge, 2001), pp. 119–42; Phil Brown and Stephen Zavestoski, 'Social movements in health: An introduction', *Sociology of Health and Illness*, 26:6 (2004), pp. 679–94.

Conclusion

Existing accounts of the notion of health security have been constrained by an excessive focus on national security and on the securitising efforts of elites. This has led to an increasingly sceptical outlook on the potentialities of security for making sense of, and helping to tackle, health problems. In response to this, the article set out to reconsider health security, taking as its starting-point the concrete insecurities experienced by individuals. In order to engage with these insecurities, the article developed an analytical framework centred on the notion of domination. Domination enables a deeper analysis by connecting individual experiences of insecurity, the social interactions through which these are given meaning and the structures that make them possible. Domination also broadens the remit of analysis, shedding light on three interconnected faces of insecurity: harm (and vulnerability), unpredictability (and lack of control), and inequality (and disadvantage).

The analytical benefits of this framework were illustrated by revisiting the oft-debated topic of HIV/AIDS as a security issue, and presenting a reading that addresses dimensions so far overlooked or insufficiently addressed in IR. The argument also identified security dimensions in a health issue that, by and large, has fallen under the radar: water and sanitation. The lens of domination emerged as a distinctive analytical approach to health problems. This lens can also tap into the potential of security as a political modality, contributing to raise awareness, expedite action, and reinforce a public sphere in which issues can be discussed and tackled.

This argument has three implications for IR. The first pertains to security, which in recent years has been met with substantial suspicion in the literature. This article upheld the value of security as a useful conceptual apparatus for making sense of the ways in which the lives of individuals are being shaped and determined. This is not equivalent to turning every problem into a security threat. It makes sense to speak of security and insecurity when structures and relations in world politics are organised in a way that systematically places constraints upon people's ability to freely choose and decide in matters pertaining to their own lives. The notion of health security has a place in the analysis of global health – alongside other notions such as development, justice, or human rights – inasmuch as it allows us to grasp the individual experiences, structures, and relations through which lives are unduly determined. A similar argument could arguably be made in relation to other cases such as environmental security, energy security or economic security.

The second implication concerns emancipation, an underexplored resource in IR. This article has demonstrated the usefulness of the idea of security as emancipation – not simply as an analytical tool for identifying and exploring instances of insecurity, but also as a normative anchor for judgments about what more security could look like in a particular situation. Thus, the goal of 'opening up space for people to freely shape the course of their own lives' can be mobilised in transformative politics. The idea of security as emancipation expands the political imagination in the field of health by showing that there is no inherently dangerous logic in the health-security nexus, and by pointing the way towards a different understanding of this nexus. Emancipatory health security takes as its mainstay the redressing of the structures and relations that are involved in the reproduction of insecurities. These potentialities in security as emancipation go far beyond health.

The final implication concerns health, most precisely the role of health in transformative politics. The article expanded the remit of health security, suggesting that insecurities are connected with wider questions concerning the material and ideational structures that currently define world politics. This also means that health can function as the entry-point for broader political struggles. One can witness this by looking at the practice of health social movements. These movements seldom restrict themselves to one particular issue. Rather, they draw linkages with other health issues and with broader socioeconomic and political concerns, whilst simultaneously revealing intersections with struggles relating to gender, sexuality, ethnicity, age, and class. In this way, health-related social movements are also sites where freedom, citizenship, dignity, and justice are being discussed.[67] This is visible every day around the globe – in the work of LGBT groups, for example, or in discussions about abortion or euthanasia. In these and many other struggles and tensions, the pursuit of health security is at the forefront of political and social change.

[67] See Patrick Hayden, 'The human right to health and the struggle for recognition', *Review of International Studies*, 38:3 (2012), pp. 569–88.