

Securitizing Global Health: A View from Maternal Health

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Over the last 15 years public health challenges have increasingly been framed as security threats, arguably leading to increased political relevancy and funding for such public health challenges as HIV/AIDS. While maternal health has not yet been securitized, there are several reasons to believe that it could be in the future. Such a securitization of maternal health could increase funding and political relevancy, important for improving maternal health outcomes. At the same time, we believe there are many unconsidered risks of such an approach. The risks we have identified are long-term unknowns from a lack of research, increased politicization of aid at the expense of effective programs, unexpected funding challenges due to geopolitical priorities, gender concerns, and the blurring of civilian and military institutions. Our goal is not to present a structured framework for analyzing the securitization of maternal health, but to begin a debate about the positive and negative aspects of securitization, and the dangers of securitization that we believe have been inadequately considered to date.

INTRODUCTION

With the increasingly globalized and interconnected world, what were once viewed as isolated public health issues to be dealt with by public health organizations have begun to be viewed as global security threats to be countered by security organizations. Policy-makers, public health organizations and academics are redefining security to include public health concerns as threats to national and international security. The 2010 U.S. National Security Strategy cites the need to “strengthen health systems and invest in interventions to address areas where progress has lagged, including maternal and child health” as a key component to countering security threats.¹ At the same time, international health organizations are redefining public health concerns as threats to international security. The World Health Organization (WHO), the directing authority for health within the United Nations (UN), now lists “fostering health security” and “strengthening health systems” as the second and third points of its six-point agenda. Some academics within security studies are further arguing that public health issues pose real threats to security that have long been ignored by policy-makers.²

Although the WHO does not argue that strengthening health systems and improving maternal and child health is necessary for security reasons, it's possible that it, or other organizations, will do so in the future. In certain situations, several of which will be discussed below, individuals and organizations have already begun to describe poor maternal health care as a critical security threat. In addition, recent research has demonstrated that infant mortality, which is linked (directly or indirectly) to maternal mortality,³ is a significant indicator of future instability in a country.⁴ This link between health and stability was central in securitizing HIV/AIDS and could be so for maternal health as well. Moreover, since securitization in such areas as HIV/AIDS and other infectious disease outbreaks has been largely successful in gaining access to resources

and increasing political relevancy for these issues,⁵ there would seem to be a strong allure for securitizing maternal health as well. Improving maternal health is the 5th Millennium Development Goals (MDG) and, according to the WHO, “Maternal health remains the MDG target for which progress has been most disappointing.”⁶ Many have argued that the primary reason for the disappointing progress is that improving maternal health has not received the financial backing or political support it needs.

While the reframing of maternal health as a security issue could lead to increased funding and policy relevance, there are also significant risks in taking such an approach. The following article will focus on these potential opportunities and risks. In the process it will shed light on two questions: Why Securitize Maternal Health? and Why Not Securitize Maternal Health? The article will do this by first giving a brief overview of how security and public health have been recently reframed, particularly since the introduction of the concept of securitization by what has been defined as the, “Copenhagen School,” led by Ole Waever and Barry Buzan.⁷ The article will then introduce the current state of maternal health, including the generally agreed upon causes of and solutions to improving maternal health. The article will then go into depth on the possible advantages (the *why*) and disadvantages (the *why not*) of reframing maternal health as a security issue. The analysis presented in this article is not meant to encourage or discourage the securitization of maternal health, nor is it meant to imply that the securitization of maternal health is certain to be widely used as a strategy for gaining relevancy, or will gain widespread legitimacy if it is used as a strategy. While it is beyond the scope of this article to fully debate whether or not maternal health will be securitized in the way HIV/AIDS has been, for our purposes we assumed that such a securitization is possible. As such, this article aims to be forward-leaning in providing insights for decision-makers on the potential opportunities and dangers of such an approach to addressing maternal health care.

SECURITY AND SECURITIZATION

Within a networked global society the distinct levels of individual, national, and international security are increasingly interconnected.⁸ In speaking to the UN General Assembly in September 2009, President Barack Obama stated:

More than at any point in human history—the interests of nations and peoples are shared. The religious convictions that we hold in our hearts can forge new bonds among people, or tear us apart. The technology we harness can light the path to peace, or forever darken it. The energy we use can sustain our planet, or destroy it. What happens to the hope of a single child—anywhere—can enrich our world, or impoverish it.⁹

The end of the Cold War and the increase of globalization processes have changed the objects of security from the strictly national to also include the individual or the international system. While most security policy is still developed and implemented by national institutions, policies have increasingly focused on transnational threats. Although threat assessments have always been highly subjective, this shift in policy emphasis has furthered the complexity in deciding what is a threat, and to whom, and what can and should be done to counter the threat. As then Secretary of State Colin

Powell admitted in 2004 speech at Princeton University, “Yes, we are well beyond the World of the Cold War...[but] it hasn’t been easy to rename the world we are in.”¹⁰

Policy-makers and academics in security studies have attempted to adapt to these challenges through a variety of conceptual frameworks and adjustments to policy and theory. Although there is still widespread debate within security studies about the right paradigm for a globalized world, the various positions can be divided into two main camps, the *traditionalists*—led by Stephen Walt—who focus on state-power and military conflict and the *wideners* who seek to expand the definition of security to include a variety of transnational issues.¹¹

In some cases, the widening of security has come from outside of security studies itself. Formed out of Amartya Sen’s ideas of economic development,¹² *human security* seeks to complement traditional security by shifting the emphasis of security, “from the state to the security of people.”¹³ According to the United Nations Report of the Commission on Human Security entitled ‘Human Security Now,’ this shift focuses specifically on individuals and, “connects different types of freedoms - freedom from want, freedom from fear and freedom to take action on one’s own behalf.”¹⁴ Anything that threatens these freedoms, to include traditional state security structures are seen as threats to human security.¹⁵

Within the field, the expansion of security has led to what has been defined as the *securitization* of issue areas previously thought of as distinct. According to Ole Waever, who coined the term *securitization*, it is the:

*Discursive and political process through which an intersubjective understanding is constructed within a political community to treat something as an existential threat to a valued referent object, and to enable a call for urgent and exceptional measures to deal with the threat.*¹⁶

More simply, securitization elevates a particular issue in, “urgency and precedence” by reframing the issue as a security threat, be it to individuals, states, or the international system.¹⁷ Of particular relevance for this article is the recent securitization of public health issues and the potential for the inclusion of maternal health to these discussions.

SECURITIZATION OF PUBLIC HEALTH

Public health is the practice of protecting and improving the health of communities through advocating for and implementing preventative measures such as improving sanitation, infection control, health education, and disease surveillance.¹⁸ It seeks to protect the health of the public and assure both the health of whole communities and the health of the individual, through effective community efforts.¹⁹ Since the end of the Cold War, and even more so since the Al-Qaeda attacks against the United States on September 11, 2001, public health issues and efforts have become increasingly linked to foreign policy and security interests. Public health strategies that may have once been viewed as solely protecting the health of individuals and communities are now viewed as necessary for the protection of peoples and states globally.²⁰ As we will discuss in the following sections, broadly, this has made global health issues more politically relevant. However, using the strategy of securitization has raised a number of important questions, a few of which will be discussed below.

To begin, because there is no formally agreed upon securitization process, it is often unclear whether and to what extent securitization is occurring. Ole Waever and the Copenhagen School initially argued that a “speech act,” or the words by which a particular issue is socially (re)constructed as a security issue, is all that is necessary for an issue to be securitized.²¹ More recently, however, the Copenhagen School has expanded its concept of securitization to include the audience of the speech act, or the external actors who decide whether or not the reconstruction of a security issue, such as reframing high maternal mortality rates as a threat to security, is valid. Building off of the Copenhagen School, Holger Stritzel argues that speech acts “need to be related to their broader discursive contexts from which both the securitizing actor and the performative force of the articulated speech act/text gain their power.”²²

Given the diversity of decision-makers and policy-actors, this definition explains little about the level of securitization occurring in a particular discourse at a specific time, or how broadly the link between security and a particular issue such as maternal health is accepted (or not). Furthermore, it does not distinguish between securitization at the local, national, or international level, or between individuals and large organizations. Moreover, it has been argued that the definition discounts the diversity of speech acts that occur in policy debates, as well as the non-speech methods, such as imagery, by which securitization occurs.²³ While strategy documents, policy statements, and public reports are clear indicators of securitization, unless a policy-maker directly states securitization as the primary reason for a particular policy action - like a new policy agenda or direct funding to counter the security threat in question - there is no way to definitively measure securitization.²⁴ This is important because maternal health, as an issue and potential threat, may not ever be defined as a primary threat to global or national security. It could however be defined as a secondary threat to global or national security, or as a primary threat to local security.

In addition, because the securitization of public health is a relatively new phenomenon, there is little research on the impact the securitization process may have on public health efforts and interventions. Despite these concerns, the securitization of public health appears to have continued each year, with public health issues developing stronger linkages to security issues and more organizations adopting the language of security, adding urgency and relevancy to their debate. While addressing this range of public health/security issues is beyond the scope of this paper, by presenting several prominent examples the following section will briefly introduce the process by which public health issues have been reframed as security issues since the end of the Cold War. This overview of the securitization process will lay the foundation for our subsequent analysis of why (or why not) maternal health may (or may not) be securitized in the future.

Securitization From 1994 to 2010

Although it could be argued that public health has long been relevant in foreign policy and international security debates, throughout the Cold War it was, like many issues, overshadowed by the specter of nuclear war between the United States and the Soviet Union. According to Andrew Price-Smith, even though linkages between public health and governance have been made for centuries, “issues of public health...were typically consigned to the realm of “low politics”” during the Cold War and only began to

“ascend on the international agenda” in the early 1990s.²⁵ The 1994 United Nations Development Program (UNDP) report, “New Dimension of Human Security” marks the beginning of the link between public health and foreign security policy. The report highlighted 7 categories of threat to human security – including health.²⁶ In discussing health security, the report highlighted a diverse range of threats, including infectious and parasitic diseases, lack of access to healthcare, and maternal mortality.²⁷ The UNDP report additionally shifted the concept of security from the territory or nation to the individual, laying the foundation for a stronger connection between health and security.²⁸

Soon after, biological attacks such as Aum Shinrikyo’s 1995 sarin gas attack on the Tokyo subway system and the anthrax attacks through the U.S. mail system in September 2001 showed the security community – and greater international community – the relevance of public health issues.²⁹ Since these attacks, improvements have been made in emergency preparedness for biological attacks, including access to medication, human resources and health warning and communication systems, deemed necessary to protect individuals and the nations as a matter of national security concern. Biological weapons have long been a security concern as seen with their use being officially prohibited after World War I by the 1925 Geneva Protocol and their development, production, and stockpiling being prohibited by the 1972 Biological and Toxin Weapons Convention (BTWC), with much of the previous attention on the use of biological weapons by national militaries.³⁰ Since being reframed as a transnational security threat, countering biological attacks by non-state actors has clearly gained increased relevance in policy and academic debates, as well as increased funding from national governments and international institutions.³¹

In 2000 the United Nations Security Council (UNSC) adopted Resolution 1308, *Responsibility of the Security Council in the Maintenance of International Peace and Security: HIV/AIDS and International Peacekeeping Operations*. The adoption of this resolution represented the first time that the UNSC directly addressed a health issue.³² This not only affected future security policies and the priorities of other international organizations, but it also made public health issues a direct concern of military forces and peacekeeping operations. According to the resolution, the UNSC was not only recognizing that combating HIV/AIDS requires a coordinated international effort and that “the spread of HIV/AIDS can have a uniquely devastating impact on all sectors and levels of society,” but it also stressed that “the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security.” HIV/AIDS was then placed on the UNSC’s list of ‘threats of international peace and security.’³³ As a result of resolution 1308, increased focus was placed on health education for military forces and peacekeeping operations to be able to protect themselves from HIV/AIDS, as well as developing protocol for the prevention and reduction of HIV/AIDS within the larger population.³⁴

In the 2000s, a series of infectious diseases that spread throughout the world such as Severe Acute Respiratory Syndrome (SARS), H1N1 (Swine Flu), the Avian Flu and HIV/AIDS gave policy-makers, international organizations, security and public health experts further justified the need to frame public health issues as security threats. Today, “there is increasing acceptance that health is a legitimate foreign policy concern.”³⁵ Terms mixing health and security such as ‘Health Security,’ ‘Global Public Health Security,’ ‘Health and Security’ and the need to strengthen health systems are now commonly found in the flagship publications and national security documents and

development reports of national and international organizations. These publications can have a profound effect on the direction of international policies and funding. According to Maureen Mackintosh of the Open University and Meri Koivusalo of the National Research and Development Centre for Welfare and Health,

These publications raise issues and reshape intellectual agendas; they seek to extend or reshape the mandate of particular organizations; they raise the policy profile of organizations' activities, and are an important element of organizational claims to status and funding. They can contribute to major policy shifts, altering the intellectual 'common sense' that shapes broad policy fields.³⁶

In sum, they can reinforce the securitization of public health and redefine how and why public health issues receive political attention and funding.

The theme of the WHO's 2007 World Health Report and World Health Day, "International Health Security" is one such example of the securitization of public health. The report focused on eight international security issues including emerging diseases, economic stability, chemical radioactive and biological terror threats, HIV/AIDS and building health systems. In the 2007 Issue Report, the WHO states that UNSCR 1308 demonstrated,

A broader security agenda had to encompass new pandemics as well as the emergence of drug-resistant strains of parasites, viruses and bacteria that pose renewed threat to health globally...[and] the discussion opened the door for health in general to be looked at through a new lens. Public health, was no longer seen as irrelevant to security or as its by-product; it had become an essential ingredient.³⁷

The 2007 Report emphasizes that other emerging diseases, such as varieties of the avian flu, drug resistant TB and Ebola, pose a similar threat and require international cooperation, just as for HIV/AIDS.³⁸

At the national level, since taking office, U.S. President Barack Obama has expanded on the President's Emergency Plan for AIDS Relief (PEPFAR), established by President Bush to combat HIV/AIDS, launching the Global Health Initiative (GHI) in 2009.³⁹ Framing functioning health systems generally as important for countering potential security threats, through the GHI the administration, "seeks to achieve improved disease prevention and treatment, strengthened health systems, enhanced maternal and child health, improved outcomes for neglected tropical diseases, and increased research and development."⁴⁰ With its Quadrennial Diplomacy and Development Review (QDDR), the State Department further supported the idea of viewing public health broadly as a foreign and security issue saying, "We invest in global health to strengthen fragile and failing states, to promote social and economic progress, to protect America's security, as tools of public diplomacy, and as an expression of our compassion."

The above events represent just a handful of the policy statements, speeches, and reports that have securitized public health over the past 15 years. In the following section, we will look at maternal health specifically, discussing the challenges that have

prevented improvements in maternal health during this same time, as well as the solutions the public health community has developed for overcoming these challenges.

FRAMING MATERNAL HEALTH

Maternal mortality is a serious international public health issue. Over 350,000⁴¹ women die each year from pregnancy related causes and 99%⁴² of these deaths occur in developing countries. Maternal mortality is defined as “the death of a woman while pregnant or within 42 days termination of pregnancy, irrespective of the duration and site of the pregnancy from any cause related to or aggravated by the pregnancy or its management but not accidental causes.”⁴³ Since 2010, maternal deaths where HIV complicated the pregnancy or childbirth are now included in the total number of maternal deaths.⁴⁴ The majority of maternal deaths occur in developing countries, with the lifetime risk of maternal death ranging from 1 in 120 to the 1 in 37 in the least developed countries.⁴⁵ Over the past 20+ years there have been a series of calls to action by international organizations to reduce or eliminate maternal mortality and improve women’s health. Yet progress has been slow. MDG 5, to reduce the maternal mortality ratio (MMR) by 75% between 1990 and 2015, continues to fall behind the other MDGs.⁴⁶ This lag is not due to a lack of knowledge on what is necessary to reduce the MMR, but rather a lack of funding and political priority. Despite the many global efforts over the past decades to heighten awareness of maternal health challenges, the issue has failed to garner the level of interest required to receive the political and financial support it needs.

From the 1970s to 2010

Since the mid 1970s there have been a number of initiatives to make maternal health more relevant to the international community. The United Nations Decade for Women (1976 – 1985) called for an end to maternal mortality by 2000. In 1987 the WHO, United Nations Population Fund (UNFPA) and the World Bank sponsored the International Safe Motherhood conference, marking the first major international conference dedicated to improving maternal health. During the conference the Safe Motherhood Initiative was created, calling upon heads of state and governments to take action to cut maternal mortality in half by 2000.⁴⁷ The Women’s Global Network for Reproductive Rights and the Latin American & Caribbean Women’s Health Network/ISIS International drew attention to maternal deaths in Latin America through declaring May 28th 1990 the International Day of Action for Women’s Health. ⁴⁸ At the 1994 International Conference on Population and Development (ICPD), and again with the establishment of MDG 5 in 2000, declarations were made to reduce the MMR by 75%. Since 2000, newer initiatives including, but not limited to, the Partnership for Maternal, Newborn and Child Health, Maternal Health Task Force, Women Deliver, and the White Ribbon Alliance have emerged, all with the aim to increase awareness and act on improving maternal health.

The causes of maternal deaths, and the elements necessary to prevent them, are well known.⁴⁹⁻⁵⁰ Seventy percent of all deaths stem from indirect causes, including excessive bleeding, infection and high blood pressure, and most maternal deaths occur between late pregnancy and the end of the first month of the child’s life. Access to

emergency obstetric care, skilled attendance at birth, and family planning services, all of which are components of a functioning health system, are vital to preventing maternal deaths.⁵¹ Most maternal deaths occur during labor, delivery or the first 24 hours after birth and modern life-sustaining procedures can prevent death.⁵² Complications are difficult to predict and in many rural areas in developing countries, hospitals are often too far away for women to arrive quickly when complications do arise. The ability to reach a facility with antibiotics, blood, and other drugs could help prevent 30% of all of the maternal deaths each year.⁵³ Additionally, access to health care facilities also facilitates the delivery of pre and antenatal care that can help identify life-threatening problems. Evidence has shown that when women have access to these services, they opt to use them.⁵⁴ Campbell, et al state that the “main priority should be for women to have the choice to deliver in health centers.” Without such a strategy they suggest, “substantial declines in maternal mortality are unlikely in the next 10 – 20 years.”⁵⁵

The international maternal health community has agreed that preventing maternal mortality is founded in a sustainable health system that can provide access to emergency obstetric care, skilled birth attendants and family planning to all women.⁵⁶ As Lynn Freedman states,

Maternal mortality is different from other major maternal and child health problems in at least one important respect: A functioning health care system must be at the center of the solution. No amount of information and education or community mobilization or even poverty reduction will make a major dent in maternal deaths in high-mortality countries unless it is accompanied by a health care system that makes emergency obstetric care widely available.⁵⁷

According to the WHO,

A health system is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction. And it needs to provide services that are responsive and financially fair, while treating people decently.⁵⁸

Gerein, et. al state that the main objective of a health system is to “produce good health.”⁵⁹ In line with the health systems approach, producing “good health” requires the resources and support to make health services, supplies and staff available, a commitment from governments to provide resources and implement sound policies to promote health services, community participation and other social services such as clean water and education.⁶⁰

The need for functioning health systems further reinforces the conclusion that there is no simple solution or single intervention that will eliminate maternal mortality. The greatest cause of maternal death, post-partum hemorrhage, accounts for only 25% of all deaths, leaving the others to be a combination of indirect and direct causes. The adoption of a health systems approach to maternal health and a commitment from the global community is vital to reducing maternal mortality and reaching MDG 5.⁶¹ Increased funding for maternal health that is focused on health systems would enable the development of a diverse range of programs that tackle the complexities of providing

adequate maternal care. It would for example, enable developing countries to increase the number of available skilled birth attendants who are able to provide emergency obstetric care, the provision of essential drugs and consumables and allow for the expansion of transportation services to the facility. Thus far, efforts to encourage policy-makers to commit to improving maternal health have been largely unsuccessful. The Gates Foundation's 2010 \$1.5 billion pledge "over the next five years for family planning, maternal and child health and nutrition in developing countries"⁶² is a strong start but must be supplemented by policy and the support of other necessary actors. While resources for countering HIV/AIDS, biological attacks, and pandemic disease have rapidly increased since 2002, funding for maternal health continues to remain low. According to UNFPA and the Guttmacher Institute, a \$12 billion yearly increase is needed to reduce maternal mortality.⁶³

In the FY11 State and USAID budgets, out of a total \$8.2 billion, \$641 million has been allotted for Maternal and Child Health and \$595 Million for USAID Family Planning as compared to the \$4.7 billion allotted to PEPFAR.⁶⁴ Seeing this disparity, individuals and organizations concerned with improving maternal mortality may begin to view securitization as a viable way to gain political relevancy and the funding that follows.

WHY SECURITIZATION? WHY NOT?

Having introduced the concept of securitization, its application in public health over the past 15 years, and the challenges of maternal health, this section will focus on the potential motivations for the securitization of maternal health, as well as the possible advantages and disadvantages of such an approach. Despite the difficulties in reducing the MMR internationally, maternal health has not been securitized in the same way that HIV/AIDS and disease outbreak have been. However, given that a lack of funding and lack of political will are commonly cited as central impediments to improved maternal health outcomes, it is possible that efforts to securitize maternal health will increase in the future. For example, in a statement from February 2011, H.E. Mr. Palitha T.B. Kohona, the Permanent Representative of Sri Lanka to the United Nations, stated that reduced maternal mortality through government policies was a key indicator that the Sri Lankan government recognizes, "Economic development as a vital precondition to achieving security and normalcy. In fact, stability and economic development were used as incentives to encourage the Tamil civilians to leave the grip of the Liberation Tigers of Tamil Eelam (LTTE) during the conflict."⁶⁵ Similarly, in pushing for compensation for the families of victims of maternal death in Uganda, Kaitiritimba Robinah, the Executive Director of Uganda National Health Consumers and Users organization, stated, "Health and [the] death of women and children are major security issues."⁶⁶ In addition, infant mortality rates, which are closely linked to maternal mortality rates, were found by the U.S. government sponsored State Failure Task Force to be one of the primary indicators of likely state failure.⁶⁷ Preventing state failure has, in turn, been recognized as a high-priority of national and international security policy.⁶⁸

Although such a reframing of maternal health challenges as potential international security threats could lead to increases in funding and political will for improving maternal health, as it has done with HIV/AIDS, there are also significant

risks associated with such an approach. These and potential benefits will be discussed below.

Why Securitization?

As discussed in the previous section, the causes of maternal health are known and the solutions to decreasing the global MMR exist. With political pressure from the international global health community and the European Union, United States, and UN as well as from state governments, coupled with adequate funding, maternal deaths could become a development issue of the past. However, as previously stated, adequate funding is not available and maternal health lacks the necessary political relevancy to gain that funding. Additional funding is necessary to provide access to family planning and maternal and newborn health care services. Securitizing maternal health, through focusing on the health systems necessary for positive maternal health outcomes and their impact on government stability may begin to bring the amount of funds necessary to reduce the MMR. This is not to imply that there are not alternative strategies for obtaining the necessary political relevancy and funding that maternal health requires. Discussing these alternatives, however, such as viewing health as a global public good,⁶⁹ or improving coordination and message within and between maternal health advocacy groups,⁷⁰ is beyond the scope of this paper.

It is evident that maternal health has thus far lacked the political relevancy and priority to gain the international awareness and funding described by UNFPA and the Guttmacher Institute as necessary to reduce the majority of maternal deaths. The experiences of Egypt, Sri Lanka and Malaysia, prove that efforts to reduce maternal mortality are successful when backed by the necessary financial resources and political will. In the early 1990s, the Egyptian Ministry of Health and Population scaled up efforts to prevent maternal deaths with funding from the Safe Motherhood Initiative. According to the WHO, Egypt's MMR decreased by 52% between 1992-93 and 2000. During this time there was an increase in the number of hospital beds, amount of available blood for transfusions, and the overall number of facilities. This led to an increase in pre and antenatal doctor's visits and a 50% increase in deliveries that took place in health care facilities. More births were assisted by skilled birth attendants leading to a reduction in deaths due "to a decrease in substandard care by health providers from 505 (71%) to 386 (66%)" reflecting a gradual improvement of health care services.⁷¹ to more women seeking medical care during pregnancy.⁷² Similarly, in Sri Lanka and Malaysia, Jerker Liljestrand and Indra Pathamanathan conclude that both countries "demonstrated an early commitment to maternal and child health through sustained financial, managerial, and political support."⁷³ They used these resources to increase access to skilled birth attendants for the rural poor, those who were most highly affected by MMR. In doing so, they have been able to half the MMR every ten years and continuously improve their health delivery system.⁷⁴

Given the need for relevancy and funding, it is possible that policy-makers or individuals working within the maternal health community may consider securitizing maternal health. For example, although he does not advocate for securitization, Jeremy Shiffman of the Maxwell School at Syracuse University claims, "Attaining public health goals is as much a political as it is a medical or technical challenge; success requires not only appropriate technical interventions but also effective political strategies."⁷⁵

Understanding the need for effective political strategies, it is certainly possible that the strategy of securitization has been considered by individuals and organizations, or will be considered in the future.

This article has already argued that the securitization of public health by security practitioners, governments, and aid organizations, particularly the securitization of HIV/AIDS since the adoption of UN Resolution 1308, has increased since the end of the Cold War. As HIV/AIDS became more politically relevant, funding for programs dealing with HIV/AIDS increased dramatically, from approximately \$300 million in 1996 to \$15.6 billion in 2008.⁷⁶ In addition, much of this increase in funding occurred from 2002 to 2008, the same time that HIV/AIDS was being framed as a security issue.⁷⁷ It is impossible to know exactly how much this funding was impacted by security arguments, as opposed to economic, human rights, or social arguments, for example. However, it is clear that the framing of HIV/AIDS as a security threat dramatically increased the political relevancy of HIV/AIDS that helped lead to major increases in funding.

Seeing the impact that increases in political relevancy had on policies and programs related to HIV/AIDS, it appears that policy-makers are increasingly attuned to the importance of improving health outcomes, and are beginning to offer suggestions. For example, in 2007 the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand issued the Oslo Ministerial Declaration where they stated, “It is generally acknowledged that threats to health may compromise a country’s stability and security. We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda.”⁷⁸ Addressing maternal health, the Ministers argued,

Countries that succeed in meeting the MDGs will experience benefits far beyond the MDGs. The well-functioning health systems that are needed to reduce maternal, newborn, and child mortality and to combat HIV/AIDS, tuberculosis, and malaria will also help countries to cope with other major health concerns such as sexual and reproductive health, newly emerging infectious diseases, accidents and injuries, and chronic non-communicable diseases.⁷⁹

References to the possible security implications of maternal health, and the corresponding need to improve health systems, have also begun to be debated by organizations that have historically been uninterested in maternal health. As previously mentioned, the 2010 U.S. NSS mentioned the need for improved health systems, and a recent report entitled the ‘Strategic Implications of Global Health’ and published by the U.S. National Intelligence Council discussed the impact high MMRs have on U.S. national interests.⁸⁰ Should it continue, this process of reframing health systems and maternal health as potential security threats will almost certainly raise the level of political relevancy of maternal health, and likely increase funding for programs designed to reduce MMRs in developing countries.

Why Not?

While the advantages of securitization tend to appear relatively straightforward—likely increased funding and increased political relevancy—the dangers of securitization are more nuanced. The risks of securitization discussed below are not intended to be

comprehensive. Instead, this section is an introduction into some of the possible risks associated with the use of securitization as a strategy for gaining increased political relevancy and funding. Some of the examples are based on the experiences of the securitization of other public health issues, such as HIV/AIDS and the securitization of general development issues. Other examples are based on the specific dynamics of securitization and of maternal health and health systems, which are distinct from other public health issues and likely to lead to dangers not faced by other issues. In all, we have identified five major risk areas that demand further thought, though there are almost certainly many more. They are:

1. Lack of research
2. Politicization of aid
3. Potential funding challenges
4. Gender considerations
5. Blurring of civilian and military institutions

Lack of Research

Understanding the potential disadvantages and consequences of the securitization of maternal health is difficult primarily due to the concept of securitization being relatively new to both security studies and public health. Securitization itself was only introduced within security studies in 1995 and even now remains primarily a European-based idea overshadowed by revamped versions of traditional security paradigms. In addition, while the concept of securitization within the academic community has been well defined by proponents and critiques of the Copenhagen School, there is no commonly accepted definition within policy circles. This is partially because the process of the securitization of public health, only started to be implemented after UN Resolution 1308 in 2000. The securitization of development issues more broadly has increased dramatically since the Al-Qaeda attacks against the United States on September 11th, 2001. Because of the limited duration of securitization processes, there is a high level of uncertainty with the use of securitization as a method for increasing funding and political relevancy. Moreover, given the difficulty in deciphering levels of securitization, few studies have been undertaken to better understand how the securitization of a particular development issue has impacted the specific policies, programs, and funding levels that are meant to counter the newly constructed security threat.

One of the few studies that has attempted to better understand the relationship between the securitization of a development issue and the specific policies, programs, and funding levels related to this securitization has been highly critical of the link between security and social challenges. Through comparative field research in Afghanistan, Pakistan and the Horn of Africa, the Feinstein International Center (FIC) at Tufts University has concluded that the U.S. concept of “winning hearts and minds” through development projects is flawed at best and at worst counter-productive.⁸¹ After almost 400 interviews in Afghanistan, Andrew Wilder of FIC concluded, “Instead of winning hearts and minds, Afghan perceptions of aid and aid actors are overwhelmingly

negative. And instead of contributing to stability, in many cases aid is contributing to conflict and instability.”⁸²

Politicization of Aid

In attempting to make maternal health more politically relevant, securitization could subject maternal health to politics. Although aid is always subject to politics, increased political relevancy through security likely means that more policy-makers will feel they have a stake in the fight against maternal mortality. This could ultimately lead to unsustainable funding that is more dependent on current administrations, the political environment, and politicking than on effective programs. The experience of the President's Emergency Plan for AIDS Relief (PEPFAR) is a timely and pertinent example of the potential drawbacks of securitizing an issue to make it more politically relevant. PEPFAR, which has brought valuable resources and programs to highly affected countries,⁸³ including over \$32 billion dollars⁸⁴ since 2004 and a commitment by the U.S. congress in 2008 of an additional \$48 billion over five years,⁸⁵ was made possible partly by the increased emphasis placed on overcoming HIV/AIDS after it had been securitized.⁸⁶ However, the increased relevance, and funding, has exposed some programs designed to combat HIV/AIDS to increased fluctuations in funding. For example, the politicized nature of abortion and family planning has limited the use of funding and greatly impacted the effectiveness of local NGOs and programs.⁸⁷ A 2009 study demonstrated that PEPFAR funded interventions for those with HIV/AIDS have helped decrease the number of deaths, but have not helped decrease the prevalence of HIV/AIDS.⁸⁸ In other words, the PEPFAR funding that helps provide anti-retroviral medication and treatment infrastructure has been successful; however the program has had little impact on the number of new infections.

This inability of interventions to reduce infections is at least partly due to the Mexico City Policy, also know as the Global Gag Rule, which began during the Reagan Administration in the mid-1980's and was reinstated during the Bush Administration. According to Pathfinder International, a non-profit organization whose mission, “is to ensure that people everywhere have the right and opportunity to live a healthy reproductive life,” the Global Gag Rule,

*Prohibits US family planning assistance to foreign non-governmental organizations (NGOs) that provide abortion-related information or services, even if these services are legal in their own countries and are funded with their own money. The rule prevents NGOs from even participating in public debates or speaking out on issues concerning abortion.*⁸⁹

This rule led to the closure of clinics and a dramatic cut in funding of NGOs that provided family planning services that would not agree to the Global Gag Rule. Additionally, during the Bush Administration, distribution of free condoms and contraception was dramatically reduced.⁹⁰ The cut of family planning services most likely led to the 2009 studies' findings that PEPFAR had done little to reduce HIV/AIDS prevalence. In addition, while both Presidents Reagan and Bush instated and reinstated the Global Gag Rule, Presidents Clinton and Obama both repealed it. As such, the

stability of international women's health NGOs, funded mainly by the US, has been dependant on the actions and policies of the US administration.

Given that one of the main solutions to reducing maternal mortality is access to family planning, the maternal health community must be aware of the possibility of a similar restriction on maternal health funding. With the increased political relevance that securitization may bring, comes the risk of political fights for funding to be distributed in the necessary places, and subsequent funding fluctuations for programs. While securitization per se is not necessarily the source of these political battles, securitization has arguably made HIV/AIDS more politically relevant. It is this political relevancy, then, that has increased overall funding for HIV/AIDS programs while also increasing possible funding fluctuations by programs supported by this increase in funding.

Focusing on a health systems approach to maternal health, and the development of infrastructure, may be a way for maternal health to avoid being at the center of this debate. Additionally, the possible increased funding due to securitization may outweigh the risk of any subsequent funding uncertainty. However, it is important to note that by making maternal health programs politically relevant, including through securitization, they may be funded and proven successful during one political environment and then dramatically restricted during another.

Unexpected Funding Challenges

The need to prioritize funding further complicates the issue. Inevitably, the national governments and funding institutions will need to weigh geostrategic interests and greatest need when deciding when and where to allocate resources. As with political relevancy, this reality exists regardless of whether or not maternal health is securitized. Also like political relevancy, securitization opens the door for unexpected challenges that come with increased funding based on a threat perspective. In certain locations, such as Afghanistan, the two concerns of geostrategic interests and greatest need will overlap and funding will be high. However, in other situations the two criteria are likely to be at odds, and governments and institutions will be forced into making difficult decisions. When these difficult decisions are being made, it is likely that locations of minimal geostrategic interest will be the first to lose funding, regardless of how high their MMR may be. In some situations, this could lead to a paradoxical situation where relatively stable and free countries receive less funding for maternal health because they are not as threatening as unstable and undemocratic countries.

For example, comparing MMRs and funding levels from USAID in 2008 that were devoted to maternal and child health, almost 40% went to either Afghanistan (21%) or Pakistan (17%)⁹¹. As the country with the highest MMR (~1400), and clear geopolitical relevance, it is not surprising that Afghanistan received more funding than any other country. However, Pakistan has a comparatively low MMR (~260), and is almost certainly receiving large amounts of funding because of its importance in U.S. policy goals to defeat the Taliban and Al-Qaeda. This process of using development aid as a strategic tool is only likely to be enhanced if maternal health is securitized. However, given the current disparity between greatest funding and greatest need, it could be argued that maternal health has been on the losing end of securitization already, and therefore would benefit from securitizing itself.

On the other hand, an increase in the political relevance of maternal health could lead to a situation where maternal health receives more funding than it should in a given location. According to study by Laurie Garrett of the Council on Foreign Relations, this is precisely what happened with HIV/AIDS spending. In a 2007 article published in *Foreign Affairs*, Garret states,

*Today, thanks to a recent extraordinary and unprecedented rise in public and private giving, more money is being directed toward pressing health challenges than ever before. But because the efforts this money is paying for are largely uncoordinated and directed mostly at specific high-profile diseases -- rather than at public health in general -- there is a grave danger that the current age of generosity could not only fall short of expectations but actually make things worse on the ground.*⁹²

In 2009, Raymond Offenheiser of Oxfam America further argued, “Africa is covered with HIV/AIDS money, but they're facing a global food crisis and we don't have a strategy for it.”⁹³

Gender Considerations

An additional unknown of securitizing maternal health is the implications it will have for gender dynamics within the countries in question. If maternal health is successfully securitized, it could lead to a feminization of security, as a distinctly women's security concern (maternal mortality) is brought into security debate, or it could lead to a masculinization of maternal health as the masculine security institutions become involved in countering maternal mortality.

Although they do not specifically mention maternal health, according to Hoogensen and Rottem, the securitization of maternal health, which could be described an articulation (speech act) of women's security, may help to empower women in security debates. In an attempt to bring gender into the debate on securitization, Hoogensen and Rottem have argued, “When women's articulations of security are recognized and heard, this results in access to the appropriate resources women need to ensure their security, as well as creating new foundations for theoretical reorientations of security.”⁹⁴ However, Cynthia Enloe has warned, “Militarization is the step-by-step process by which something becomes *controlled by, dependent on, or derives its value from* the military as an institution or militaristic criteria.”⁹⁵ Securitizing maternal mortality could, then, be argued as giving value to maternal health only based upon militaristic criteria, specifically the possible threat it poses to individuals and societies. Feminist scholars in security studies have argued that there are gender biases in the core concepts of security studies, including the state and the definition of security itself.⁹⁶ Framing maternal health as a security threat relies on this gendered terminology and, in doing so, risks defining maternal health through a masculine lens. As such, even though “[f]eminist scholars have embraced the Copenhagen School's interest in broadening what counts as security and whose security matters,”⁹⁷ they must be wary of being, “limited to it or subsumed within it.”⁹⁸

In addition, the securitization of maternal health would likely lead to an increased role of military institutions in maternal health programming. This does not

mean that securitization would lead to a military takeover of maternal health programming, but that defining maternal health, or any issue, as a security threat invites military participation. In turn, the military and armed forces are traditionally male dominated sectors that are known for promoting and maintaining a culture of masculinity. According to Galla Golan, this is the case even when women are an integral part of the military, such as in Israel.⁹⁹

Were the military and armed forces to play a large role in the formulation, implementation and funding of maternal health programs that tend to focus primarily on women, it could have negative social repercussions. This does not mean that the securitization of maternal health will inevitably lead to military institutions controlling maternal health programs. It is clear that this has not been the case with the securitization of HIV/AIDS, and there is no reason to think that maternal health would be qualitatively different. At the same time, it would be naïve to claim that increasing the relevance of maternal mortality as a security threat can occur without increasing the involvement of traditional security institutions.

Civil-Military Relations

The securitization of maternal health could also lead to a shift of maternal health policies and programs from civil society to military institutions. Stefan Elbe, Professor of International Relations at the University of Sussex argues that the securitization of public health programs, specifically HIV/AIDS, risks pulling health issues out of the hands of civil society and putting them into the hands of military and intelligence institutions.¹⁰⁰ This has the danger of not only overextending the capabilities of military forces, but also further delegitimizing the operational independence of maternal health programs. In part, this was one of the primary critiques of securitization theory made by Stephen Walt. Arguing that security is primarily about the use of force, when referring to the Copenhagen School, Walt said,

But this prescription runs the risk of expanding “security studies” excessively; by this logic, issues such as pollution, disease, child abuse, or economic recessions could all be viewed as threats to “security.” Defining the field in this way would destroy its intellectual coherence and make it more difficult to devise solutions to any of these important problems.¹⁰¹

In addition, in conflict situations, conflating security with maternal health could possibly lead to a situation where civilians working on maternal health issues are associated with military force, or where military members are associated with civilian work. This is particularly likely in situations where policymakers hope to legitimize military forces through associating military institutions with development projects. This commonly occurs in US and NATO operations in Afghanistan,¹⁰² and is also evident in the US government’s creation of the African Command (AFRICOM). In his 2011 ‘Posture Statement’, presented to the House Armed Services Committee, AFRICOM Commander General Carter F. Ham said,

U.S. Africa Command’s programs and activities directly support American national security interests...We support the United States Government’s (USG)

*five priorities in Africa: good governance, economic progress, preventing and resolving conflicts, strong public health programs, and helping our African partners develop the capacity to meet the demands of transnational challenges. In supporting these national priorities, U.S. Africa Command focuses on preventing and resolving conflict and helping our African partners develop their own security capacity.*¹⁰³

If it has not already been subsumed into the security mindset, were maternal health to be securitized, it would invite an increased involvement of AFRICOM and the military institutions associated with it.

This is potentially dangerous for many reasons. To begin with, soldiers are usually not adequately trained for maternal health work, and are unlikely to have the necessary skills to help develop health systems and effective maternal health programs. In addition, in such a situation civilians, working with military personnel or receiving funding or logistical support from them, risk being redefined as combatants. The distinction between civilian and combatant is important, not just for legal and moral reasons, but because individuals are viewed by differing sides in a conflict will have direct repercussions on behavior. If civilians are seen as being associated with the military, the likelihood that they will become targets of violence is raised significantly.¹⁰⁴

CONCLUSION

Over the last 15 years security and public health have become increasingly interrelated. Policy-makers and academics have argued for the extension of threat paradigms to issues traditionally viewed as separate from security. This has led to increased political relevance and funding for such public health challenges as HIV/AIDS. While maternal health has not yet been fully securitized, there are several reasons to believe that it could be in the future. Such a securitization of maternal health could be positive for the struggle to improve maternal health globally. At the same time, we believe there are many unconsidered risks of such an approach, risks that have the potential of not only failing to improve maternal health outcomes, but also leading to a number of negative side-effects. In this article we have identified two major opportunities and five major sets of risks that would likely come with the securitization of maternal health. The opportunities are increased funding and political relevance. The risks are: long-term unknowns from a lack of research, increased politicization of aid at the expense of effective programs, unexpected funding challenges due to geopolitical priorities, gender concerns, and the blurring of civilian and military institutions. Our goal was not to present a structured framework for analyzing the securitization of maternal health, but to begin a debate about the positive and negative aspects of securitization, including the likely benefits and many possible risks of securitization that we believe have been inadequately considered to date.

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