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SPECIFICITY OF SECURITISATION OF HEALTH SECURITY RISKS

Abstract: Health security is a dimension of security, a consequence of the securitisation of its threats. It is proposed to be included in the second generation of security dimensions, conditioned more by the processes of globalisation and global mobility. The first generation includes the dimensions proposed by the Copenhagen School, conditioned primarily by the end of the Cold War. The assumption was made that health security is the result of the securitisation of its threats by policy actors formulating the speech act and, at the same time, playing the role of public opinion, accepting the speech act. In view of this, the assumption was formulated that the securitisation of security threats by policy actors, with the limited presence of academia, is specific to second-generation security dimensions. The aim of the article is to identify the specificities, unique features, of the securitisation of health risks. The focus is on: firstly, reconstructing the assumptions of the concept of securitisation as a research tool, the importance of the speech act, the role of public opinion with emphasis on the positional power of the subject formulating the speech act. Secondly, the object of securitisation was analysed in the form of health threats, identifying their scope, but also emphasising that these threats, while being destructive directly to human health and life, are also destructive to social systems, but are also conditioned by the quality of these systems such as globalisation processes. Thirdly, the process of securitisation of health threats by policy actors, mainly the United States, was the subject of analysis.

Keywords: health security, health security threats, securitisation, positional power, Covid-19.

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INTRODUCTION

Health security is another, one of the latest securitised, non-military dimensions of national or international security (Pietraś, 2022, pp. 15–50). It confirms that security, while being one of the most important values in the life of society, is at the same time a dynamic process of broadening and deepening its material scope by further dimensions or sectors and its subjective scope, going beyond the earlier state-centric understanding. This means that the dynamics and variability of the subject and object scopes of security is a dependent variable, conditioned by an independent variable in the form of changing social reality, the dynamics of intra-state and international social life. This is an important methodological assumption of this article, as is the analytical application of the concept of securitisation proposed by the Copenhagen School (Waever, 1995, pp. 46–86; 2004, pp. 17–20; Taureck, 2006, pp. 53–61; Buzan *et al*., 1998, pp. 32–36).

In the 21st century, under the conditions of the end of the Cold War and globalisation processes, health threats – along with terrorism and cyber threats – have shown the greatest dynamics of growth. This is confirmed, for example, by the Covid-19 pandemic of global scope, preceded by numerous epidemics in various regions of the globe. This is a time of relative growth in the importance of health threats, also known as the microbiological turn in security studies. It should therefore come as no surprise that these threats have been securitised, becoming another dimension of broad (*comprehensive*) security, contributing to its progressive complexity.

In view of the above, it is assumed that each dimension or security sector is distinguished by its own specific characteristics. In other words, each dimension is specific, acquiring distinct, autonomous characteristics that distinguish it from other dimensions. It is proposed that the health dimension be counted among the second generation of security dimensions (Pietraś, 2023, p. 7) conditioned primarily by the processes of globalisation and the new quality of social life inherent in them. It is proposed that the five dimensions of security identified by the Copenhagen School (Bu zan *et al*., 1998, pp. 32–36), dimensions conditioned primarily by the end of the Cold War, be counted in the first generation.

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In the context of the assumption of autonomy, the specific characteristics of the different dimensions of security, the aim of this article is to analyse the distinctiveness, the specificity of the securitisation of the health dimension, i.e. the integration of security into the field of security studies and practice. In order to realise this objective, the subject of analysis will be: 1) the essence of securitisation; 2) the specificity of the object of securitisation, which are health security threats; 3) the specificity of the process of securitisation of these threats; 4) the specificity of the notion of "health security", which is the result of the securitisation process.

THE ESSENCE OF SECURITISATION

Health problems were included in the analysis of security studies, securitised, after the end of the Cold War, in a radically changing international environment and accompanying change in the understanding of security. During the Cold War, health threats were categorised as *'low politics'* (Fidler, 2005, p. 180; Farrell, 2018, p. 554), recognising that they were humanitarian rather than political problems (Youde, 2018, pp. 535–536). Probably for the first time in the documents of international organisations, the term *'health* security' appeared in the report of the United Nations Development Programme (UNDP) published in 1994. It was used in connection with the proposal of the concept of *human security*, considering it as one of its 7 components (UNDP, 1994, pp. 24–26).

To explain the change in attitudes towards health risks and their securitisation, two factors appear to be relevant. Firstly, a change in social reality. Coupled with a general trend towards an increase in the importance of non-military dimensions of security, the variety, intensity and number of victims of human health threats has increased as a result, above all, of the increasing number of epidemics. Secondly, philosophical inspiration and associated with it a kind of acquiescent intellectual climate in the form of the biopolitisation of security and politics (Dillon, 2008, pp. 265–266, 269). This implies a kind of synergy of factors relevant to and for the earlier identification of

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non-military dimensions of security in the form of changing realities, resulting new threats and intellectual acceptance.

The aforementioned factors created the rationale for, but did not determine, the integration of health threats into security thinking and practice. This happened as a result of the securitisation of these problems, i.e. the recognition of them as existential threats to national and international security. Securitisation, following the intellectual legacy of the 1960s (Austin, 1969), was proposed and popularised by the Copenhagen School of Security Studies in the late 1980s and early 1990s (Buzan *et al*., 1998, pp. 32–36; Waever, 1995, pp. 46–86). It provides a theoretical framework for integrating threats into the field of security analysis and political responses to them, being a discussion-provoking concept for changing security thinking (Stritzel, 2007, p. 357; Yuk-pink Lo & Thomas, 2018, p. 568; Taureck, 2006, p. 55). By proposing the concept of securitisation, the Copenhagen School has made an important contribution to redefining security, broadening its material scope by including further non-military dimensions (Ziętek, 2017, pp. 23–42) including health security.

An analysis of the specificity of health security securitisation requires a reconstruction of the assumptions of the Copenhagen School understood as a research tool. Ole Waever and Barry Buzan defined securitisation as an effective speech act (*speach act*) through which a specific social phenomenon, e.g. a public health threat, is intersubjectively treated by a specific subject as an existential threat to a designated object of reference, e.g. the state, in order to justify the application of extraordinary measures to counter this threat (Buzan & Waever, 2003, p. 491). What is important is therefore the subjective feeling (Williams, 2011, pp. 454), and through it and its verbalisation the social construction of the dimensions of security, without them being determined solely by material conditions (Balzacq & Guzzini, 2015, p. 99).

The securitisation process combines three elements: 1) speech acts, utterances, declaring the referenced phenomenon, the process of action, to be an existential threat; 2) the securitising subject, formulating the speech act; 3) the public, the audience, who accept or reject the content of the speech act. According to the Copenhagen School, the securitising subject is the one who, by formulating the speech act, declares that someone

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or something, being the object of reference, is existentially threatened. A feature of securitisation processes is the variety of actors involved. It can be the state, an international institution, an NGO, academic institutions, individuals, etc. The object of reference, in turn, can be mainly entities that are perceived as existentially threatened, having a right to survival (Buzan *et al.*, 1998, pp. 36–40). The object of reference and the existential threats to it are diverse and depend on the dimension or sector of security. It can be the state, its sovereignty, but also the national economy, national identity, the state of the environment, but also the state of the health of society with possible consequences for other sectors (Emmers, 2008, p. 110).

The dynamics of the securitisation process consist of two stages. The first is the speech act, the discursive presentation of a particular phenomenon, entity, etc. as an existential threat to the object of reference. It has even been formulated in this context that security is seen as something that is created by language (Hansen, 1997, p. 381), and therefore a speech act. This is half-hearted and simplistic thinking, as 'language' merely verbalises an emotion, a fear of a particular phenomenon, an action perceived as a threat. It is therefore more reasonable to say that security is created by emotions verbalised by a speech act. India Wright has even formulated the view that security is a discursive practice (Wright, 2021), but conditioned by emotions. It has also been noted in the literature that the language of security and health discourse contains common concepts like defence, containment, elimination, front line. Infectious diseases can be an instrument of warfare (Howell, 2014, p. 977).

Using the language of security does not mean that a defined threat must automatically become part of security thinking and provision. Stage two occurs when the subject of securitisation is effective in convincing the audience, i.e. the public, politicians, international officials, and others, that the object of reference is existentially threatened. This means that the Copenhagen School sees security, its threats, as socially constructed through securitisation (McDonald, 2008, p. 563). Existential threats are intersubjectively recognised as such by the subject securitising them, but also by the public to whom the speech act is addressed. Consequently, each act of securitisation reflects

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a social or political preference and is a type of decision most often with serious consequences for political practice (McDonald, 2008, p. 112–114).

An important element in the analysis of securitisation processes – also in relation to health security – is the actor initiating the speech act. Representatives of the Copenhagen School suggest paying attention to who is privileged in the formulation of the speech act, i.e. the articulation of a sense of existential threat. They emphasise the need to take into account the securitisation of the behaviour of the centres of political power in the analysis, considering them as having priority in the formulation of the speech act. For this reason, they treat the area of security as 'structured' in that certain actors such as the state apparatus are particularly privileged in the formulation of the speech act, the articulation of speech (Buzan *et al.*, 1998, pp. 31–32).

A valuable proposal, which is a modification of the assumptions of the Copenhagen School, was proposed by Holger Stritzel. He considered securitisation to be a three-layered process involving text, context and the positional power of the subject formulating the speech act. The socio-linguistic context is important, i.e. the narrative accompanying the verbalisation of an existential threat, the content of the speech, the concepts used, but also the historical moment, the context of the situation, thinking in terms of an idea whose time has come in the sense of reflecting social or political expectations. These are essential elements for understanding the speech act, the message addressed to the public. The positional power of the subject of securitisation, on the other hand, is conditioned by the socio-political context of its functioning, prestige, authority, position in the hierarchy of social life (Balzacq, 2005, pp. 180–181). This context is important for the effectiveness of securitisation, for the potential for influence of the securitising subject and the construction of the speech act, but also for its reception by the public (Stritzel, 2007, pp. 364–370). Thinking in terms of positional power is crucial for analysing the specificity of the securitisation process of health security threats. This is discussed later in the article.

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SPECIFICITY OF THE SUBJECT OF SECURITISATION, I.E. HEALTH SECURITY RISKS

An important element of the analysis of securitisation is to identify its object, i.e. to answer the question what is or has been securitised? Answering this question involves identifying the risks specific to each security dimension. F. X. Kaufman defined them as the possibility of one of the negatively valued phenomena occurring (Kaufman, 1970, p. 167). This means that they do not have to be identified exclusively with an enemy acting intentionally, creating existential threats, but also with phenomena, processes that are not necessarily intentional, that can cause an existential effect or such subjective perception of them. In order to identify the specificity of securitised health threats, it is proposed to focus on three elements: 1) the health risks that directly affect people's health and lives, 2) the impact of these risks on social life with the potential to destabilise it, 3) the determinants, the context of social life that favours health risks.

With regard to health threats directly affecting human health and life, it should be emphasised that their feature is their complexity and "hybrid nature". They combine non-intentional processes, phenomena with the possibility of intentional, hostile application, and to this is added the diversity of threats, their wide range of subject matter. These include, first and foremost, as if by way of a matter of course, infectious diseases taking the form of epidemics or pandemics and, in their context, the problem of crossing the species barrier, the phenomenon of bioinvasion, the problem of increasing resistance to antibiotics, as well as bioterrorism and the possibility of using biological weapons.

Infectious diseases are a particular threat to health security. The HIV/AIDS epidemic set in motion the securitisation of health threats, and the Ebola epidemic reinforced this process. Epidemics with even global proportions of their victims occurred in the 20th century, already overloading the health systems of many countries (Rockenschaub *et al.*, 2007, p. 20). Since the beginning of the 21st century, the diversity and intensity of epidemics has clearly increased, reflecting several trends. Firstly, new pathogens such as Nipah virus, Marburg, Ebola,

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MERS-Cov. virus, coronavirus, SARS, A/H5N1 influenza, but also A/H1N1, A/H7N9, A/H5N6 in different parts of the globe have emerged (Gostin *et al*., 2017, p. 53). Secondly, there were recurrences of previously known infectious diseases like cholera, tuberculosis, influenza, measles, meningitis, yellow fever. Thirdly, there has been an intentional use of anthrax bacteria (Rockenschaub *et al*., 2007, p. 16).

One example of the potential for threats to national and international security caused by epidemics is the Ebola virus and the Covid-19 pandemic. The Ebola virus was identified in Africa in the mid-1970s. The Ebola outbreak that broke out in Guinea in March 2014 had significant international consequences. It spread to other West African countries such as Sierra Leone, Liberia, Nigeria, Mali, Senegal, and outside Africa it reached Spain, Liberia, the UK and the US. The number of infections is calculated at 28616 and the death toll at 11310. This epidemic has caused: 1) threats to the national security of these countries; 2) the potential to destabilise the region; 3) threats to international security on a global scale (Ifediora *et al*., 2017, p. 226). In comparison, the number of cases of Pandemic Covid-19 as of mid-April 2024 is 704753890 cases and 7010681 fatalities (Worldometer, 2024).

The spectacularity of infectious diseases, borne out by the Covid-19 experience, the global nature of this pandemic, the variety of impacts and the global media portrayal cannot overshadow the threats posed by non-communicable diseases. In a report for *the World Economic Forum* published in 2011 on the burden of these diseases on the world economy. It projected a reduction in global GDP of up to $46.7 trillion between 30 February 2010 (Bloom *et al*., 2011).

Crossing the species barrier is becoming a significant threat to health security. Consequently, the interdependence between human, animal and environmental health is increasing. However, the problem is the limited level of knowledge about the relationship between these elements. In addition, the processes of globalisation, increased human and animal mobility are increasing the vulnerability and susceptibility in the relationships between humans, animals, the population and the environment. As a result, the risk of epidemics is increasing (Bouskill *et al*., 2019, p. 2).

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Another threat is invasive alien species previously in a particular environment. Their spread is called bioinvasion and is the result of the deliberate introduction of some species by humans in order to control others. Applied as early as the first half of the 20th century, it was regarded as a biological problem. Over time, it came to be seen as an economic problem, linked to globalisation processes and a security problem. In an environment of globalisation processes, there is a concern that these microbes can spread globally, and hence are called pathogens of globalisation (Bright, 1999, pp. 51–64). Hence, an important problem related to bioinvasion is included in the question of risks to human health. These pathogens are also a significant problem for food security and a growing problem for the national security of states. The opinion is being formulated that they pose a threat to the strength of a state, undermining its economic potential and the health of its population, i.e. its demographic potential, and consequently bring an element of biosecurity into thinking about state security (Stoett, 2010, pp. 103–110).

Antibiotic resistance is also considered a threat to health security. Antibiotic-resistant infectious diseases emerging in one country mean a threat to health and economic processes in other countries. It is estimated that in the second decade of the 21st century, drug-resistant pathogens were responsible for the deaths of approximately 700,000 people each year. G8 health ministers in 2013 identified antibiotic resistance as a major health security challenge for the 21st century. This threat is distinguished by several specific features. Firstly, there is no country of origin with which this threat can be identified. Second, antibiotic resistance arises in multiple ways and simultaneously among humans and animals. Third, the linking of this resistance to the food chain implies the need for complex solutions that address different areas of society, rather than simple ones) (Yuk-pink Lo *et al.*, 2018, pp. 570–571, 574).

Health security threats also include bioterrorism, meaning the intentional use of biological agents, such as bacteria, to cause casualties, intimidation and trigger expected behaviour. In the late 20th and early 21st century, several such cases were recorded in the United States. After the terrorist attacks of 11 September 2001, cases of letters containing anthrax bacteria were

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recorded in New Jersey. Five people died and 17 became ill. Panic was caused among civilians, and several contaminated facilities including Supreme Court buildings and post offices were closed, disorganising community life.

When identifying threats that directly negatively affect people's health and lives, it is important to bear in mind their potential to affect social life with the possibility of destabilising it. This means that they can act as an independent variable with destructive potential, exposing the vulnerability and susceptibility of the organisation and functioning of social life in individual countries, but also regions and even on a global scale. The opinion is even being formulated that pandemics can cause destruction of social life, economic activity comparable to wars, natural disasters or financial crises. This in turn reinforces the argument that these threats, not only because of their health costs, but also because of their economic and political costs, should be treated as a security problem and not as a simple health phenomenon (Gostin *et al.*, 2017, p. 57).

In assessing the social impact of the Covid-19 pandemic, attention has been paid to the destabilising effects at the level of states and to the effects at the level of the international system. With regard to the state level, the vast majority of states under Covid-19 saw restrictions on civil liberties and the introduction of repressive law enforcement measures. There were social protests in many African states. The social and economic impacts were particularly felt in many countries of the Global South, reflecting the asymmetry of vulnerability and resilience of many of these countries to epidemics under lower levels of development. In sub-Saharan African countries, 13.5 million jobs were lost during the Covid-19 pandemic between 2020 and 2021, and 5 million people were placed in extreme poverty (Paul, 2024). And in Africa, the pandemic hit young people hard, limiting access to education and making it difficult to access education.

At the level of the international system, the Covid-19 pandemic was the cause of the global recession, the downgrading of the GDP of many countries, and had geopolitical effects, contributing to the deterioration of relations between the great powers amid a reduction in economic ties between them, especially between the United States and China. Economic ties weakened

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and nationalisms in the Eurozone were unleashed. The pandemic became a factor in accelerating the geopolitical changes taking place at the level of the global international system. It contributed to increased instability, disrupted supply chains, reduced food supplies and rising inflation. Food insecurity and political instability and conflict were feared (Nkang *et al.*, 2022, p. 37).

In the context of the negative effects on social life of health security threats, the opinion is even being formulated that pandemics can cause its destruction comparable to wars, natural disasters or financial crises. This in turn reinforces the argument that these threats, not only because of their health costs, but also because of their economic and political costs, should be treated as a security problem and not as a simple health phenomenon (Gostin *et al.*, 2017, p. 57).

An analysis of the specificity of health security threats, of what is being securitised, requires consideration of the social context that favours epidemics or any of the other threats mentioned earlier. Enabling factors operate both at the level of the interior of states and at the level of the international system. At the level of the interiors of states, socio-economic conditions such as poverty, unemployment, migration, difficult housing conditions, limited access to health systems, social exclusion and armed conflict are relevant. Urbanisation processes, large urban centres, *megacities* with the concentration of millions of people in a small space, are important for the spread of epidemics.

Important determinants of the acceleration of the spread of epidemics and the rise of health threats operate at the level of the international system. The increased global mobility of people has made the world more vulnerable and susceptible to infectious diseases that are increasingly difficult to contain within national borders. Former UN Secretary-General Kofi Annan called epidemics 'problems without a passport' that require a collective global response. Part of the problem of global human mobility is migration. However, it is important to remember that global human mobility is facilitated by the environment of globalisation processes. This is because of the squeezing of time and space that is characteristic of them, reducing the importance of the previously inhibiting mobility barriers of space, distance and time required to overcome them. Globalisation processes have

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also contributed to the formation of a culture of consumption and unhealthy lifestyles (Jenkins *et al.*, 2016, p. 334).

SPECIFICITY OF THE PROCESS OF SECURITISATION OF HEALTH SECURITY RISKS

The process of securitisation, according to the Copenhagen School, involves the act of utterance, the verbalisation of emotions related to the perception of an action or phenomenon as an existential threat, and the acceptance of this utterance by the so-called audience to which it was addressed. These elements will be the subject of an analysis of the process of securitisation of health security threats, taking into account its specificity. It has been assumed that besides the content of the speech act, i.e. the object of securitisation, the specific element of this process is the subject formulating the speech act. In the case of the securitisation of health risks, the involvement of policy actors in this process is specific. The analysis will also take into account the distinctiveness of Covid-19 securitisation, especially the rhetoric of the speech act of politicians. The reaction of 'public opinion' to the securitisation of health risks also needs to be analysed.

The presence of policy actors in the formulation of the speech act in the securitisation of health risks seems to be a role reversal compared to the securitisation of security dimensions proposed by the Copenhagen School and with the suggestion of being included in the first, post-Cold War generation of security dimensions (Pietraś, 1997). At that time, the speech act was uttered by academics, with politicians acting as the accepting audience. As early as 1977, Lester Brown of the *Worldwatch Institute* called for a redefinition of national security and the inclusion of economic, energy, environmental and food depletion threats in its understanding (Brown, 1977). Jessica Mathew-Tuchman in 1989 suggested broadening national security to include economic, ecological and demographic dimensions (Mathews-Tuchman, 1989, p. 162). These suggestions were accepted by politicians acting as an 'audience'. They were reflected – i.e. they were securitised – in UN General Assembly resolutions, in the 1991 NATO security strategy, in the early 1990s in CSCE

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documents and in the security strategies of many countries, including Poland's 1992 security strategy.

What is surprising is the absence significant limitation of the scientific community, its proper epistemic communities in the securitisation of health threats and the assumption of the role of formulating the speech act by politicians, who address the securitisation mainly to other politicians and the public opinion of their own countries, but also of the global one. In view of this, in relation to further dimensions of security, beyond those proposed by the Copenhagen School and conditioned more by globalisation processes than by the end of the Cold War and proposed to be called second-generation dimensions, is political will crucial? Does the involvement of the political actor in the securitisation of health threats, by bringing political pragmatism to the process, confirm the general trend of the increasing importance of political actors, their interests, their need to influence public opinion, in the formulation of the 'speech act' for further non-military dimensions of security?

In relation to a policy actor formulating a speech act that recognises a particular phenomenon as an existential threat, the thinking proposed by Holger Stritzel in terms of the actor's positional power is relevant. This thinking is relevant to answering the question who initiated the securitisation of health threats? In answering this question, it should be recalled that the concept appeared in a United Nations Development Programme (UNDP) report published in 1994, but in the context of the category of *human security* and not on its own. It also does not appear that the UNDP had, at that time and in the then state of low health risks of pandemics, sufficient political positional power to securitise these threats.

To answer the question of the speech act formulator with the intention of securitising health threats, it is important to analyse the relationship between these threats and the foreign policy interests of the United States as the hegemon of the international system at the time and the speech act formulator. As early as the late 1990s, the country recognised that health and threats to it were a legitimate foreign policy and national security concern (Katz, 2007, p. 233). The US National Security Council in 1999 for the first time recognised the health problem of HIV/AIDS as

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a national security threat. It decided to include the problem of the cross-border spread of infectious diseases and the protection of poor people living in failing states in the scope of US foreign policy (Aldis, 2008, p. 372). The US National Intelligence Council in early 2000 assessed that infectious diseases were complicating US and global security, causing threats to US citizens, its armed forces and destabilising the international environment. It recognised that the importance of infectious diseases as a national security threat had increased (Gannon, 2000). In 2001. Secretary of State Colin Powell recognised that the HIV/AIDS epidemic in Africa was a national security issue (Peterson, 2002, p. 44). The speech acts of US institutions and politicians in favour of securitising infectious diseases are unequivocal (see: Pietraś, 2022, p. 22 *et seq*).

The rationale for such thinking by politicians in the United States, but also in many other Western countries, has created fears among the populations of these countries conditioned by media messages. They activated social pressure on the centres of political power. This in turn conditioned the rationality of politicians and also their decisions at the level of the international system, including their actions in the forum of international organisations. It was in the context of such rationality and preferences of societies and politicians of Western countries that the agenda of international organisations in security matters began to be shaped (McInnes, 2008, p. 284). An explanation for this has also been sought in the views of Michel Foucault and the post-structuralists who believe that the discussion of health security is reflexive thinking about the power structures and interests of highly developed states seeking to protect their populations from emerging diseases in developing states (Kamradt-Scott, 2018, p. 509). The latter, on the other hand, focus on health security primarily from the perspective of development processes and the need to build national health capacities.

The US foreign and national security policy preference for health security, shaped under these conditions, began to be reflected in its actions at the level of the international system, especially at the UN and Security Council, in a situation of the country's hegemonic position. The US ambassador to the UN from 1999 to 2001 argued to UN Secretary-General Kofi Annan, who resisted this argument, that HIV/AIDS – by taking

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a significant part of a country's population and destabilising its social life – was not a humanitarian problem but a security problem (Youde, 2018, p. 537). In 2000, Vice President Al Gore, in a speech at the UN Security Council, advocated an understanding of security that included infectious diseases (Peterson, 2002, p. 43). This meant that the United States stopped treating public health threats caused by epidemics as humanitarian problems, treating them as national and international security problems. With the exception of Donald Trump's presidency, they have acted as a leader in global health efforts.

Under the conditions of unquestionable 'positional power' resulting from being the hegemon of the international order at the dawn of the 21st century, the national perception of health threats as a security problem, especially threats caused by epidemics, the United States began to transfer to the decisions and actions of international institutions, especially the UN, including the Security Council. Taking advantage of the latter's 'institutional position', they reinforced the speech act and process of securitisation of health threats and, more specifically, the HIV/AIDS epidemic. For this process, 10 January 2000 was a historic moment. It was the first meeting of the Security Council in the new millennium, in the 21st century, and the first in the history of the UN after more than 4,000 meetings, when a health problem was discussed as a security problem in the context of the HIV/AIDS epidemic. It was felt that there was no greater threat at the time than the HIV/AIDS epidemic being both a development and security crisis (Security Council, 2000). As a result of the discussion, on 17 July 2000. The Security Council passed Resolution 1308, which recognised HIV/AIDS as a threat with the potential to have a devastating impact on national and international security (Resolution 1308, 2000). Once again, poverty, infectious diseases with HIV/AIDS and environmental degradation were recognised as threats to international security in a UN General Assembly resolution passed on 2 December 2004 (United Nations, 2004).

It should be emphasised that the securitisation of health threats by the UN, including the Security Council, under conditions of US 'positional power' at the beginning of the 21st century, was carried out primarily in relation to such a threat as the

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HIV/AIDS epidemic, i.e. an infectious disease with the potential for cross-border spread. It does not seem surprising, therefore, that health care issues came up at the Security Council in the context of subsequent epidemics. In 2014, the Ebola virus outbreak in Liberia, Guinea, Sierra Leone and Nigeria. Resolution 2177 identified this epidemic as a threat to international peace and security, highlighting its potential to destabilise the situation in the affected region, cause social tensions and reduce security (Resolution 2177, 2014).

The securitisation of Covid-19, compared to the securitisation of HIV/AIDS or Ebola, proceeded in a specific way. Firstly, after the experience of previous epidemics, the speech act was formulated tardily by policy actors and, once formulated, the rhetoric of verbalising this threat was distinguished by its sharpness. Second, once formulated, the language of politicians was dominated by the rhetoric of war.

After the experience of the ambiguity of the response to the Ebola virus, the slowness and restraint of the UN Security Council's response to the Covid-19 outbreak is surprising. The subject was not addressed by the body until July 2020. Earlier, on 3 April 2020. The UN General Assembly adopted a resolution identifying the Covid-19 pandemic as a global problem requiring global cooperation (United Nations, 2020). The Security Council on 1 July 2020 passed resolution 2532, which stressed that the unprecedented scope of the Covid-19 pandemic could threaten the maintenance of international peace and security. It also demanded the cessation of existing armed conflicts in order to create the conditions for cooperation to counter the pandemic (Resolution 2532, 2020). The surprising, although explainable political positioning of China as the site of the pandemic's emergence in Wuhan, the failure to clearly identify the Covid-19 pandemic as a threat to international security and the tardiness of the response to this threat, has been criticised by analysts (Charbonneau, 2021, pp. 6–16). What role did China, as a permanent member of the Security Council, play in the context of the tardy response? The occasion set in motion a discussion on the Security Council's powers over non-military security threats (Pobjie, 2020).

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However, once the speech act was formulated, recognising Covid-19 as a security threat, statements by politicians of individual countries, but also by officials of international institutions, were dominated by the rhetoric of war. President Donald Trump considered the coronavirus outbreak more destructive than the attack on Pearl Harbour, the attack on the World Trade Center, and there was no more destructive attack in US history (BBC, 2020). China's President Xi Jinping summoned the country's citizens to a decisive battle in the war against the Covid-19 pandemic (Lun Tian, 2020). In France, President Manuel Macron acknowledged that the country was at war with the coronavirus (Erlanger, 2020). Italy's Prime Minister at the time, Giuseppe Conte, exhorted Italians to stay at home as the country undergoes its most important test since the end of World War II (Lowen, 2020).

Similar views were formulated by officials of the UN system. The organisation's Secretary-General Antonio Guterres said that in the context of the Covid-19 pandemic, the UN was undergoing its toughest test since its inception in 1945. The pandemic has created a significant threat to peace and security. For this reason, political leaders should pool resources for a generational fight (Guterres, 2020). In turn, WHO Secretary-General Tedros Adhanom Ghebreyesus called the Covid-19 pandemic an enemy of humanity. Seeking to reflect the destructiveness of the pandemic, he compared it to war.[1]

Supported by the United States with the involvement of the UN Security Council, the securitisation of health threats, a 'speech act' formulated by these actors, has met with acceptance from the international community, mainly in the form of decisions by international organisations. In 2004, the UN Secretary-General's report *A more secure world: Our Shared Responsibility,* using the category of 'threats without borders' and referring mainly to the example of HIV/AIDS, highlighted the links between health and security (United Nations *et al.*, 2004, p. 12). WHO has made the health security debate a priority in its

[1] Remarks to the Security Council on the COVID-19 Pandemic,https://www.un.org/sg/en/content/sg/speeches/2020–04–09/remarks-security-council-covid-19-pandemic, accessed 3 August 2024.

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2006–2015 programme (WHO, 2006). ASEAN, as a regional organisation, securitised health issues during the SARS epidemic in 2003 (Caballero-Anthony, 2018, p. 602). NATO's 2010 Security Strategy identified 'health risks', identifying threats at the international system level (BBN, 2010). References to health security were not found in the 2003 and 2016 European Union security strategies. The issue of health security using this category appeared in the European Commission's communication of 11 November 2020, i.e. during the Covid-19 pandemic, on the European Health Union and enhancing EU resilience to cross-border health threats (EU Monitor, 2020).

The concept of health security is gaining increasing public acceptance. Under the conditions of the Covid-19 pandemic, the links between the spread of the virus and threats to national and international security were not questioned. However, in the earlier stages of the securitisation of health threats, the involvement of the United States in these activities with its political motivation, there was opposition from some countries in the Global South to the notion of 'health security' and the equating of health and security activities, or justifying to the latter the need for global cooperation in health matters (Aldis, 2008, p. 370). The reasons for the opposition were varied. On the one hand, there was the lack of a universally accepted definition of health security, but especially the differences in its definition between countries in the West and the Global South. On the other hand, many countries of the Global South interpreted thinking in terms of health security as an expression of a partisan definition of interests by Western countries seeking to protect themselves from diseases, epidemics emerging in countries of the Global South and having the capacity to spread across borders (Kamradt-Scott, 2018, p. 501). It has been argued that global health issues only become a priority when developed Western states are threatened. In the case of the Ebola epidemic, media coverage of the epidemic turned it from a problem affecting African states into a problem for Western states, their societies and their security (Roemer-Mahler *et al.*, 2016, p. 376).

Particularly opposed by countries of the Global South, especially Brazil, India, Indonesia, Thailand, was the proposal and attempt by developed countries, mainly the United States, to

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introduce the term '*global health security*' (GHS). It has been suggested that this should be an umbrella category for health security, organising international cooperation to counter health threats (Aldis, 2008, p. 372). As a result of 'opposition' from the aforementioned and other countries, WHO even refrained from using the term '*health* security' in the documents it adopted (Kamradt-Scott, 2018, p. 501). However, after the Ebola outbreak in 2014, the opposition of countries in the Global South both to the use of the term 'global health security' and to linking health problems to security weakened. This happened because, the Ebola outbreak began to be seen as a global crisis, as a problem exposing social inequalities within and between countries and the weaknesses of the global health governance system, but also the weaknesses of a security-conditioned approach to global health crises (Roemer-Mahler *et al.*, 2016, p. 373). During the Covid-19 pandemic, the links between the spread of the coronavirus and security were not questioned, given the number of deaths and the devastating impact on social life at the level of states and at the level of the international system.

Within the milieu of political elites, who both formulated the speech act and acted as 'public opinion', a political consensus was reached on the presentation of public health threats with the language of security (Roemer-Mahler *et al.*, 2016, p. 510). This was reflected in the decisions and actions of states and international organisations. In February 2014 The United States launched the *Global Health Security Agenda*. It was conceived as an effort by states, international organisations and civil society organisations to promote global health security, reduce threats from epidemics and promote and implement the WHO International Health Regulations (GHSA, 2022). Initiated and supported by the United States, this programme has contributed to integrating action on health security at the level of the global international system.

In summary, the process of securitisation of health risks is distinguished by several features. Firstly, it is the political actor that is the United States with its strategic preferences and the resulting structure of interests. Developed Western countries perceived epidemics primarily as a threat emerging from countries in the Global South. It was feared that, with the increasing global

mobility of people, this threat could be transmitted to developed countries. The view was even formulated that securitisation – while on the one hand contributing to increasing the attention of the media, political elites and societies on health issues, increasing their funding and the actions of certain international institutions, on the other hand, meant focusing on the concerns of the 'West' and seeing the 'South' as the source of the disease threat (Weir, 2015, p. 20).

Secondly, the involvement of a political actor, political will and the associated pragmatism of interests in the securitisation of health threats has drawn attention to the interplay between the securitisation and desecuritisation of these threats. The securitisation of health threats as a side-effect, but also as a consciously pursued goal in itself, can dynamise political action on the desecuritisation of capacity, infrastructure and financial constraints on health action. A tendency towards desecuritisation occurs when existing health risks are controlled. In other words, they are resolved not as a result of emergency action, but as a result of 'normal' policy (Farrell, 2018, pp. 551–553).

Third, a feature of the securitisation of health threats is the large space of influence of the securitised phenomena and the integration of the behaviour of many actors operating at different levels of the organisation of social life, called macrosecuritisation. Critics of the securitisation mechanism have accused it of being Eurocentric in the sense of focusing on security threats existing in or concerning Europe and the actors operating here. Possibly influenced by such views, Barry Buzan and Ole Waever considered that a feature of earlier cases of securitisation was a focus on threats existing at the middle level (*middle-level*) of states and individuals. They proposed the concept of macrosecuritisation (Buzan *et al.*, 2009, p. 257). It is an overarching securitisation that encompasses, relates to and organises several middle-level securitisations. These relationships are not straightforward. Macrosecuritisation can be an intractable phenomenon and prone to centrifugal tendencies. Examples of macrosecuritisation include the Cold War, the war on terrorism, counter-piracy, epidemics and antimicrobial resistance (Yuk-pink Lo *et al.*, 2018, p. 569).

Fourthly, during the Ebola epidemic, it was noted that Western developed countries, when engaging in countering the epidemic,

did not focus on the social, economic and political causes of the weakness of health systems in African countries and their asymmetric resilience against the health systems of Western countries. They focused primarily on the invention of vaccines and medicines. Without denying the importance of vaccines, the interests of Western pharmaceutical companies seem to have been important for such activities. They began to write about the '*pharmaceuticalisation*' (*pharmaceuticalisation*) of global health policy in conjunction with its securitisation. The latter, under conditions of societal concern and associated pressures of political rationality, creates a rationale for technological and pharmaceutical solutions, with a concomitant tendency to lift the restrictions previously imposed on these solutions. The view has also been formulated that the securitisation of health creates solutions that facilitate subsequent pharmaceutical responses (Roemer-Mahler *et al.*, 2016, p. 376).

Fifthly, attention began to be drawn to the fact that focusing on selected health threats, such as epidemics, biological weapons, and therefore sudden, fast-spreading ones, results – as was experienced during the Covid-19 pandemic – in the creation of a kind of ranking, a hierarchy of health problems that does not reflect the real problems in this regard of the majority of the global population (DeLaet, 2014, pp. 339 ff). Concerns have been raised that prioritising diseases in this way, and from the perspective of the sense of insecurity of the populations of Global States, may lead to the neglect of other health problems, more relevant especially for countries with low and medium levels of development (Kamradt-Scott, 2018, p. 509).

SUMMARY

In summary, health security has been included in the second generation of non-military dimensions of security, conditioned more by globalisation processes than by the end of the Cold War, confirming the widening of its material scope. Reflecting the social reality, the new quality of security threats, it has simultaneously become a category of its (security) analysis. The article focuses on identifying the specificity of securitisation of health

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threats with a focus on the concept of securitisation as a research tool, the specificity of the object of securitisation in the form of health threats and the specificity of the process of securitisation of these threats. As a result of the analysis, it was proven that the securitisation of health threats is dominated by policy actors, Western countries concerned about the cross-border spread of health threats arising in countries of the Global South. It was the politicians of Western states, mainly the United States, who formulated the speech act verbalising health threats as security threats. Despite initial opposition from countries in the Global South, under the conditions of the Ebola virus and the Covid-19 pandemic, politicians reached a global consensus on the integration of health threats into security in the broadest sense.

BIBLIOGRAPHY

Aldis, W. (2008). Health security as a public health concept: A critical analysis. *Health Policy and Planning*, *23*(6), 369–375.

Annan, K. (2009, November 9). *Problems Without Passports*. Foreign Policy.

ASEAN (2018). *ASEAN Post-2015 Helth Development Agenda 2016–2020*. ASEAN Secretariat.

Austin, J. L. (1962). *How to Do Things with Words*. Harvard University Press.

Balzacq, T. (2005). The Three Faces of Securitisation: Political Agency, Audience and Contex. *European Journal of International Relations*, *2*(11), 171–201.

Balzacq, T., & Guzzini, S. (2015). Introduction: What kind of theory – if any – is securitisation. *International Relations*, *1*(29), 97–102.

BBC (2020, 7 May). *Trump Says Coronavirus Worse 'Attack' Than Pearl Harbor*. www.bbc.com/news/world-us-canada-52568405 (03–08–2024).

BBN (2010). *NATO Strategic Concept 2010*. https://www.bbn.gov.pl/download/1/15758/conceptstrategicnanato.pdf (03–08–2024).

Binczycka-Anholcer, M., & Imiołek, A. (2011). Bioterrorism as one form of modern terrorism. *Hygeia Public Health*, *3*(46), 326–333.

Bloom, D. E., Cafiero, E. T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., Fathima, S., Feigl, A. B., Gaziano, T., Mowafi, M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A. Z., & Weinstein, C. (2011). *The Global Economic Burden of Non-communicable Diseases*. World Economic Forum and Harvard School of Public Health.

Pietraś, M. (2025). Specificity of securitisation of health security risks. In: Marzęda-Młynarska, K., Węgrzyn-Odzioba, L., Wójciszyn-Wasil, A., Kięczkowska, J. (eds). (2025). *Health security and cyber innovations in health care* (pp. 11–38). Wydawnictwo Academicon. https://doi.org/10.52097/acapress.9788367833257-2

Bond, K. (2008). Health security or health diplomacy? Moving beyond semantic analysis to strengthen health systems and global cooperation. *Health Policy and Planning*, *23*(6), 376–378.

Bouskill, K., & Smith, E. (2019). *Global Health and Security. Threats and Opportunities*. Rand Corporation.

Bright, Ch. (1999). Invasive species: Pathogens of globalisation. *Foreign Policy*, *116*, 50–64.

Brown, L. (1977). *Redefining national security*. Worldwatch Paper 14.

Brown, T., Curto, M., & Fee, E. (2006). The World Health Organization and the transition from "international" to "global" public health. *American Journal of Public Health*, *1*(96), 62–72.

Buzan, B., & Waever, O. (2009). Macrosecuritisation and Security Constellations: Reconsidering Scale in Securitisation Theory. *Review of International Studies*, *2*(35), 253–276.

Buzan, B., & Waever, O. (2003). *Regions and Powers, The Structure of International Security*. Cambridge University Press.

Buzan, B., Waever, O., & Wilde, de J. (1998). *Security. A New Framework for Analysis*. Boulder.

Caballero-Anthony, M. (2018). Health and human security challenges in Asia: New agendas for strengthening regional health governance. *Australian Journal of International Relations*, *6*(72), 602–616.

Camfield, L., & Skevington, S. (2008–2009). On Subjective Well-being and Quality of Life. *Journal of Health Psychology*, *6*(13), 764–775.

Charbonneau, B. (2021). The COVID-19 test of the United Nations Security Council. *International Journal*, *1*(76), 6–16.

Constitution of the World Health Organisation (1948). OJ., no. 61, item 477.

DeLaet, D. (2014). *Whose Interests is the Securitisation of Health Serving*? In S. Rushton, J. Youde (Eds), *Routledge Handbook of Global Health Security* (pp. 339–348). Routledge.

Dillon, M., & Lobo-Guererro L. (2008). Biopolitics of security in the 21st century. *Review of International Studies*, (34), 265–292.

Elbe, S. (2006). Should HIV/AIDS be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security. *International Studies Quarterly*, *1*(50), 119–144.

Elbe, S., Roemer-Mahler, A., & Long, Ch. (2015). Medical Countermeasures for National security: A New Government Role in the Pharmaceuticalization of Society. *Social Science and Medicine*, (131), 263–271.

Emmers, R. (2008). Securitisation. In A. Collins (Ed.), *Contemporary security studies* (pp. 109–125). Oxford University Press.

Erlanger, S. (2020). *Macron Declares France 'at War' With Virus, as E. U. Proposes 30-Day Travel Ban*. https://www.nytimes.com/2020/03/16/world/europe/coronavirus-france-macron-travel-ban.html (03–08–2024).

EU Monitor (2020). *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. Building a European Health Union: Increasing the EU's resilience to Cross-border health threats*. COM 724 final. https://www.eumonitor.eu/9353000/1/j9vvik7m1c3gyxp/vldpl72emsr4 (03–08–2024).

Farrell, A. M. (2018). Managing the dead in disaster response: A matter for health security in the Asia-Pacific region? *Australian Journal of International Affairs*, *6*(72), 551–566.

Fauci, A. (2007). The expanding global health agenda: A welcome development. *Nature Medicine*, *10*(13), 1169–1171.

Fidler, D. (2005). Health as Foreign Policy: Betwen Principle and Power. *Whitehead Journal of Diplomacy and International Relations*, *2*(6), 179.

Fidler, D. (2010). *The Challenges of Global Health Governance*. Council on Foreign Relations.

Fierke, K. (2010). Critical Theory, Security, and Emancipation. In R. A. Denemark, R. Marlin-Bennett (Eds), *The International Studies Encyclopedia* (vol. 2, p. 718). Wiley-Blackwell.

Foucault, M. (1998). *The History of Sexuality. Vol. 1: The will to knowledge*. Penguin.

Gannon, J. C. (2000). *The Global Infectious Disease Threat and Its Implications for the United States*. https://irp.fas.org/threat/nie99-17d.htm (01–08–2024).

GHSA, (2022). *Global Health Security Agenda: Action Packages*. https://www.cdc.gov/globalhealth/security/actionpackages/default.html (01–08–2024).

Glinski, A., & Żmuda, Z. (2020). Epidemics and pandemics of infectious diseases. *Życie Weterynaryjne*, *9*(95), 554–559.

Gostin, L., & Ayala, A. (2017). Global Health Security in an Era of Explosive Pandemic Potential. *Journal of National Security Law and Policy*, *1*(9), 53–80.

Guterres, A. (2020, April 9). *Remarks to the Security Council on the COVID-19 Pandemic*. https://www.un.org/sg/en/content/sg/speeches/2020–04–09/remarks-security-council-covid-19-pandemic (03–08–2024).

Hansen, L. (1997). A Case for Seduction? Evaluating the Poststructuralist Conceptualisation of Security. *Cooperation and Conflict*, *4*(32), 369–397.

Harman, S. (2012). *Global Health Governance*. Routledge.

Howell, A. (2014). The Global Politics of Medicine: Beyond Global Health, Against Securitisation Theory. *Review of International Studies*, *5*(40), 961–987.

Ifediora, O. F., & Aning, K. (2017). West Africa's Ebola Pandemic: Toward Effective Multilateral Responses to Health Crises. *Global Governance*, *2*(23), 225–244.

Inglehart, R. (1997). *Modernization and postmodernization: Cultural, economic, and political change in 43 societies*. Princeton University Press.

Inglehart, R. (2015). *The Silent Revolution: Changing Values and Political Styles Among Western Publics*. Princeton University Press.

Ingram, A. (2011). The Pantagon's HIV/AIDS Programmes: Governmentality, Political Economy, Security. *Geopolitics*, *3*(16) 655–674.

Jenkins, Ch., Lamazzi, M., Yeatman, H., & Borisch, B. (2016). Global Public Health: A Review and Disscussion of the Concepts Principles and Roles of Global Public Health in Today's Society. *Global Policy*, *3*(7), 332–339.

Kamradt-Scott, A. (2018). Securing Indo-Pacific health security: Australia's approach to regional health security. *Australian Journal of International Affairs*, *6*(72), 500–519.

Katz, R., & Singer, D. A. (2007). Health and security in foreign policy. *Bulletin of the World Health Organization*, *3*(85), 233–234.

Kaufman, F. X. (1970). *Sicherheit als soziologisches und socialpolitisches Problem*. Ferdinand Enke.

Kickbusch, I., Silberschmidt, G., & Buss, P. (2007). Global health diplomacy: The need for new perspectives, strategic approaches and skills in global health. *Bulletin of the World Health Organization*, *3*(85), 230–232.

Kięczkowska, J. (2019). Bioterrorism as a threat to health security. *TEKA of Political Science and International Relations*, *1*(14), 31–43.

Lowen, M. (2020), *Coronavirus: EU Could Fail over Outbreak, Warns Italy's Giuseppe Conte*. https://www.bbc.com/news/world-europe-52224838 (03–08–2024).

Lun Tian, Y. (2020). *'People's War' on coronavirus, Chinese propaganda faces pushback*. https://www.reuters.com/article/world/in-peoples-war-on-coronavirus-chinese-propaganda-faces-pushback-idUSKBN2100NQ/ (03–08–2024).

Marzęda-Młynarska, K. (2014). *Global food security governance at the turn of the 20th and 21st centuries*. Wydawnictwo Uniwersytetu Marii Curie-Skłodowskiej.

Mathews-Tuchman, J. (1989). Redefining security. *Foreign Affairs*, *2*(68), 162–177.

McDonald, M. (2008). Securitisation and the Construction of Security. *European Journal of International Relations*, *4*(14), 563–587.

McInnes, C., & Williams, P. (Eds). (2008). *Health Security Studies. An Introduction*. Routledge.

Nkang, O. N., & Bassey, O. B. (2022). Securitisation of Global Health Pandemic and Reiterating the Relevance of 2005 International Health Regulations: COVID-19 and Human Security in Africa. *African Journal of Empirical Research*, *1*(3), 36–48.

OECD (2013). *Recent Trends in Official Development Assistance for Health*. OECD.

Panas, E. (2021). *Soft power of transnational civil society organisations*.

Paris, R. (2001). Human Security. Paradigm Shift or Hot Air? *International Security*, *2*(26), 87–102.

Paul, M. (2024). *COVID-19 has cost sub-Saharan Africa 13.5 million jobs in working hour losses: ILO*. https://www.downtoearth.org.in/africa/covid-19-has-cost-sub-saharan-africa-13–5-million-jobs-in-working-hour-losses-ilo-81215 (01–08–2024).

Peterson, S. (2002). Epidemic Disease and National Security. *Security Studies*, *2*(12), 43–81.

Pietraś, M. (1997). The post-Cold War security paradigm in statu nascendi. *International Affairs*, *2*, 29–52.

Pietraś, M. (2002). The essence and scope of globalisation processes. *International Affairs*, *2,* 5–34.

Pietraś, M. (2022). The category "health security" in security studies. In H. Chałupczak, K. Marzęda-Młynarska, M. Pietraś, & E. Pogorzała (Eds), *Security threats in globalisation processes. Health threats* (pp. 15–50), Wydawnictwo Uniwersytetu Marii Curie-Skłodowskiej i Wydawnictwo Akademii Zamojskiej.

Pietraś, M. (2023). International health security. *Yearbook of the Institute of Central and Eastern Europe*, *21*(2), 7–34.

Pobjie, E. (2020). *Covid-19 and the scope ot the UN Security Council's mandate to address non-traditional threats to internationl peace and security*. MPIL Research Paper Series No. 41.

Price-Smith, A. (2001). *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development*. Mit Press.

Ray, J. (2001). Integrating Levels of Analysis in World Politics. *Journal of Theoretical Politics*, *4*(13), 355–388.

Regional Office for Europe.

Remarks to the Security Council on the COVID-19 Pandemic (n.d.). https://www.un.org/sg/en/content/sg/speeches/2020–04–09/remarks-security-council-covid-19-pandemic (03–08–2024).

Resolution 1308 (2000). Adopted by the Security Council at its 4172nd meeting, on 17 July 2000, S/RES/1308.

Resolution 2177 (2014). Adopted by the Security Council at its 7268th meeting, on 18 September 2014, S/RES/2177.

Resolution 2532 (2020). Adopted by the Security Council on 1 July 2020, S/RES/2532.

Resolution adopted by the General Assembly on 10 September 2012, A/RES/66/290.

Rockenschaub, G., Pukkila, J., & Profili, M. (2007). *Towards health security. A discussion paper on recent health crises in the WHO European Region*. World Health Organization

Roemer-Mahler, A., & Rushton, S. (2016). Introduction: Ebola and International Relations. *Third World Quarterly*, *3*(37), 373–379.

Rushton, S. (2011). Global Health Security: Security for Whom? Security from What? *Political Studies*, *4*(59), 779–796.

Searle, J. (1969). *Speech Acts: An Essay in the Philosophy of Language*. Cambridge University Press.

Security Council (2000, January 10). *The impact of AIDS on peace and security in Africa*. 4087th Meeting Monday, S/PV.4087.

Singer, D. (1961). The Level-of-Analysis Problem in International Relations. *World Politics*, *1*(14), 77–92.

Stoett, P. (2010). Framing Bioinvasion: Biodiversity, Climate Change, Governance. *Global Governance*, *1*(16), 103–120.

Stritzel, H. (2007). Towards a Theory of Securitisation: Copenhagen and Beyond. *European Journal of International Relations*, *3*(13), 357–383.

Taureck, R. (2006). Securitisation Theory and Securitisation Studies. *Journal of International Relations and Development*, *1*(9), 53–61.

UNDP (1994). *Human Development Report 1994*. Oxford University Press.

United Nations & United Nations Department of Public Information (2004). *A more secure world: Our shared responsibility. Report of the High-level Panel on Threats, Challenges and Change*. United Nations.

United Nations (2004). *General Assembly Resolution* A /59/565.

United Nations (2020). Resolution adopted by the General Assembly on 2 April 2020, A/RES/74/270.

Waever, O. (1995), Securitisation and desecuritisation. In R. Lipschutz (ed.), *On Security* (pp. 46–87). Columbia University Press.

Wæver, O. (2004, March 17–20). *Aberystwyth, Paris, Copenhagen: New Schools in Security Theory and their Origins between Core and Periphe*r'. Paper presented at International Studies Association Conference.

Weir, L. (2015). Inventing global health security, 1994–2005. In S. Rushton, J. Youde (Eds), *The Routledge Handbook of Global Health Security* (pp. 18–31). Routledge.

WHO (2006, April 24). *Eleventh General Programme of Work, 2006–2015*. A 59/25.

Williams, M. C. (2011). Securitisation and the liverism of fear. *Security Dialogue*, *4–5*(42), 453–463.

Worldometer (2024, April 13). *COVID-19 Coronavirus Pandemic*. https://www.worldometers.info/coronavirus/ (31–07–2024).

Wright, I. (2021). *Are We at War? The Politics of Securitising the Coronavirus*. https://www.e-ir.info/2021/01/10/are-we-at-war-the-politics-of-securitizing-the-coronavirus/ (31–07–2024).

Youde, J. (2017). Global Health Governance in International Society. *Global Governance*, (23), 583–600.

Youde, J. (2018). The securitisation of health in the Trump era. *Australian Journal of International Affairs*, *6*(72), 535–550.

Yuk-pink Lo, C., & Thomas, N. (2018). The macrosecuritisation of antimicrobial resistance in Asia. *Australian Journal of International Affairs*, *6*(72), 567–583.

Ziętek, A. (2017). Securitisation of migration in Europe's cultural security. *Teka Komisji Politologii i Stosunki Międzynarodowych*, *3*(12), 23–42.

Pietraś, M. (2025). Specificity of securitisation of health security risks.
In: Marzęda-Młynarska, K., Węgrzyn-Odzioba, L., Wójciszyn-Wasil, A., Kięczkowska, J. (eds). (2025). *Health security and cyber innovations in health care* (pp. 11–38). Wydawnictwo Academicon. https://doi.org/10.52097/acapress.9788367833257-2