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*Published in:*  
Global Public Health

*DOI:*  
[10.1080/17441692.2012.725752](https://doi.org/10.1080/17441692.2012.725752)

*Publication date:*  
2012

*Citation for published version (APA):*  
Kamradt-Scott, A., & McInnes, C. J. (2012). The securitisation of pandemic influenza: Framing, security and public policy. *Global Public Health*, 7(Supplement 2), S95-S110. <https://doi.org/10.1080/17441692.2012.725752>

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European Research Council



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public policy**

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**Published version available:**  
**<http://www.tandfonline.com/doi/full/10.1080/17441692.2012.725752>**

**This research has been made possible through funding from the European Research Council  
under the European Community's Seventh Framework Programme – Ideas Grant 230489 GHG.**

**All views expressed remain those of the author(s).**

## **The framing of pandemic influenza as a security threat and its impact on public policy<sup>1</sup>**

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In late 2005, the international community agreed to the creation of a new United Nations office – the United Nations System Influenza Coordination (UNSIC). The new office’s mission, to help combat the spread of avian and human pandemic influenza, was to be achieved through the more effective coordination of the multiple UN agencies engaged in strengthening pandemic preparedness. Commensurate with the establishment of this new office, and the appointment of David Nabarro as the first UNSIC coordinator, several major donor countries allocated over US\$4.3 billion between 2005 and 2009 to strengthen global influenza surveillance and response capacity. This massive mobilisation of resources occurred despite the worst global financial crisis since the Great Depression. What can account for this significant (re)allocation of resources? In this paper, we examine how the framing of pandemic influenza as a ‘threat’ to international peace and security has shaped (and arguably distorted) global public policy responses towards this infectious disease, and what the implications have been, not only for the public health community, but also for governments and the security community.

**Keywords:** pandemic influenza; security; framing; global health; public policy

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The practice and discipline of security has changed markedly over the past two decades. Security is no longer restricted to the narrow confines of military threats, and health issues are now regularly cited as one amongst a number of non-traditional security concerns that include the environment, energy, food, and migration (Collins 2006, Booth 2007). Within this, attention has primarily focused on health ‘threats’ that range from the more traditional (military) security concerns of biological weapons and bioterrorist attacks, through to what are often described as ‘naturally occurring’ emerging and re-emerging infectious disease outbreaks (see McInnes and Lee 2006). In more recent years, the health security agenda has begun to be expanded even further, with scientific laboratories, food, agriculture, and even certain non-communicable diseases such as diabetes and obesity identified as posing ‘a global threat’ (Zimmet and Alberti 2006, WHO 2007, Katona, Sullivan and Intrilligator 2010). A persistent theme throughout all this discussion to date, however, has been the threat presented by pandemic influenza.

Pandemic influenza remains feared by health practitioners, policymakers, security experts, and politicians alike. In the previous century alone, three influenza pandemics in 1918, 1957 and 1968 contributed to millions of human fatalities, as well as causing widespread social and economic disruption. Even prior to the 1918 pandemic, which remains arguably one of the most devastating events in recorded human history, the threat of pandemic influenza was well documented. Although pandemic influenza has therefore been recognised as a public health hazard for centuries it has not always been constructed as a security threat risking political, economic or social stability. Most notably during the Cold War when the threat of superpower confrontation dominated Western security thinking, pandemic influenza was not considered a security threat at all, despite calls from some for it to be recognised as such. And even when it has been successfully securitised, the cyclical nature of the epidemic has been replicated by a period of de-securitisation. Therefore, by the

1990s, despite pandemic influenza having been recognised as a public health hazard for centuries and despite past attempts at securitisation, it does not follow that the disease had been institutionalised as a security issue.

This paper traces how pandemic influenza has been framed as a security threat over the past two decades and the eventual success (and limitations) of this framing. In so doing the article draws its theoretical inspiration from the Copenhagen School's securitisation theory (Buzan *et al.* 1998). Buzan *et al.* describe their project as to 'explore the logic of security itself to find out what differentiates security...from that which is merely political' (p. 5). They argue (p. 26) that labelling an issue as 'security' takes it beyond the realm of normal political discourse and allows exceptional actions to be undertaken. Crucially, '[an] issue becomes a security issue... not necessarily because a real existential threat exists but because the issue is presented as a threat' (p. 24). The process by which this happens is securitisation: 'the positioning through speech acts (usually by a political leader) of a particular issue as a threat to survival, which in turn (with the consent of the relevant constituency) enables emergency measures and the suspension of "normal politics" in dealing with that issue' (McDonald 2008, p. 567). It is the (re)presentation of an issue as an *existential threat* which makes a speech act a securitising move.<sup>2</sup>

Much of the Copenhagen School's work concerns the *process* of securitisation, and it is the process of securitising pandemic influenza that is the focus of this paper. At the heart of securitisation theory is a 'triology' (Stritzel 2007 p. 358, 362) of speech act (the securitising move, which as Williams (2003 p. 524-8) notes may use images and other 'communicative practices' rather than or as well as words<sup>3</sup>); the securitising actor (who makes the speech act); and the audience (who accept or reject the securitising move). This allows us in this paper to adopt a heuristic divide between the securitising move, made by an actor who can speak with authority on the issue; and successful securitisation, which is the acceptance of the

securitising move by an epistemic community (the audience) which can then take emergency action on the issue. Five points should however be noted at the outset. First, although the Copenhagen School have provided one of the most compelling accounts of how issues can be successfully framed as security issues, large elements of securitisation theory remain contested (see for example: McSweeney 1996, Hansen 2000, Williams 2003, Stritzel 2007, McDonald 2008, Ciută 2009). Of particular importance to this paper is that this includes the conditions necessary for successful securitisation. In this we follow the work of Balzacq (2005, 2011) in arguing that context and material events play a role in the securitising process. Second, and following on from this latter point, not all securitising moves are successful. There was therefore no guarantee that calls for pandemic influenza to be treated as a security threat meriting emergency actions would create a pathway for policy responses. Third, and related to this, securitisation is not a binary condition whereby an issue is either securitised or not, but a continuum where different elements of the audience may hold different positions, and along which a consensus may shift over time (McInnes and Rushton forthcoming). Fourth, although the securitising act and its acceptance may be usefully considered as distinct for heuristic purposes here, this distinction is not always clear cut especially if the acceptance by an epistemic community at one level (e.g. within a state or an organisation) then becomes a securitising move for another level (e.g. internationally, see McInnes and Rushton, forthcoming). Finally, the Copenhagen School is a normative project which emphasises that securitisation is not necessarily a desirable state given the negative consequences involved (including suspension of basic rights and freedoms); rather they promote ideas of 'de-securitisation'. This theoretical move allows us to introduce the idea that securitisation may not always be a linear event whereby once an issue has been securitised it will remain so. Rather, given the fact that the process is largely contingent upon audience acceptance and recognition, de-securitisation can also occur. As a result, the process

is best understood as a cyclical event, one where a process of re-validation must take place in order for an issue to remain securitised.

### **The historicisation of pandemic influenza as a security threat**

The framing of pandemic influenza as a security threat is not, by any means, a recent phenomenon. Indeed, due to the persistent nature of the hazard, the perceived ‘threat’ arising from pandemic influenza has become institutionalised – that is, embedded to such an extent that ‘it is implicitly assumed that when we talk about this issue we are by definition in the area of urgency’ (Buzan *et al.* 1998, p. 28). Much of the institutionalisation can be attributed to the fact that influenza epidemics and pandemics have been a persistent feature of recorded human existence for the better part of a thousand years (Kamradt-Scott 2011). Throughout the majority of those centuries, the etiological agent responsible (a virus from the Orthomyxoviridae family) remained unknown; yet, the symptoms of the disease were well recognised, so much so that the impact of influenza epidemics upon civilian populations has been extensively documented. Added to this, the frequency with which influenza pandemics have occurred (most notably in 1557-80, 1781-82, 1830-33, 1889-92, 1918-19, 1957, 1968, and 2009) broadly suggests that such events can be expected to occur approximately every 40 to 50 years. As a result of such frequency, since the late 18th century most generations have experienced an influenza pandemic at some point throughout their lives, and have most certainly been affected by seasonal variants.

The threat of pandemic influenza to the state has also manifested itself in much more explicit security terms though as well. In 1485, the coronation of Richard III was reportedly temporarily postponed due to an outbreak of the ‘English Sweating Sickness’ amongst troops that some have since speculated was influenza (Quinn 2008). Irrespective of the accuracy of this claim (Wylie and Collier 1981), governments have certainly paid close attention to the

impact of influenza epidemics and pandemics on military readiness since at least 1782 (Hirsch 1883, Parsons 1891). Similarly, a reluctance to announce the adverse effect of influenza on troop numbers has been cited as one reason why the influenza pandemic of 1918 that killed approximately 50 million people worldwide was erroneously named the ‘Spanish Flu’. For although the pandemic is believed to have originated in the United States before then spreading to the United Kingdom and France, authorities in these countries were reluctant to reveal any information that may signify military weakness (Potter 1991). Thus, when the Spanish authorities declared that they were experiencing a nation-wide epidemic they were the first to do so; the consequence, however as Beveridge aptly noted, was that ‘this misleading name stuck’ (1977, p. 42).

In fact, in many respects the 1918 Spanish Flu pandemic has become a watershed event in the securitisation of pandemic influenza. Not only did this one event spur tremendous scientific advances such as the discovery of the influenza virus in both animals and humans, but even contemporary health practitioners, policy-makers and security experts continue to refer to the 1918 pandemic to substantiate the existential threat and justify extraordinary measures. In many ways, this is not particularly surprising given the magnitude of human fatalities throughout the 1918 influenza pandemic. By 1919 when the pandemic waned, citizens across a multitude of countries had also been subjected to and had eagerly embraced a wide range of emergency measures. For while the causative agent still remained a mystery, by the early 20th century the majority of the medical profession had arrived at a consensus that a virus was most likely responsible for causing influenza, that the disease was airborne, and that influenza could be spread by close contact with infected individuals or by contact with contaminated objects such as door handles (Barry 2005). To counter the impact of the disease, governments required their citizens to wear facemasks whenever they ventured outside their homes; emergency hospitals were built; mass gatherings such as church services



were cancelled; and facilities such as libraries, schools, theatres, and public halls were closed to the public (Arrowsmith 2007).

In the aftermath of the 1918 Spanish Flu pandemic, influenza also attracted the reputation as a ‘war disease’ (Francis 1947, p. 10). Indeed, arriving as it did at the end of the First World War, the 1918 pandemic ‘irrevocably linked those two catastrophes. It demonstrated that virulent influenza may be more devastating of human life than war itself’ (Francis 1958, p. 85). It was on the basis of this widespread concern that when the Second World War broke out, the United States Army established a special research and development division to create and trial an effective vaccine (Francis 1947). By 1944, medical professionals were arguing that ‘pure and applied science’ was ‘fundamentally related to national security and well-being’ in order to counter the hazard posed by influenza and other air-borne diseases (Mudd 1944, p. 445). In 1946 the interim committee charged with overseeing the creation of a new universal health organisation – the World Health Organisation (WHO) – was directed to immediately create a new influenza research and surveillance centre based in London (Payne 1953). Over time, as further research centres and laboratories joined the WHO’s efforts, a new global influenza surveillance network was created – a network that currently comprises over 135 public and private research institutions based in over 105 countries around the world (WHO 2011). Moreover, the risk that the world may experience a repeat of the 1918 pandemic has been periodically used as justification for free mass vaccination campaigns such as the 1976 Swine Flu Campaign in the United States (Kavet 1977, Pyhälä 1980), and the suspension of normal pharmaceutical regulatory practices such as the distribution (without prescription) of antiviral medications throughout the United Kingdom in 2009 (UK Government 2009, Elbe 2011).

These various developments have understandably served to further consolidate the historicisation of pandemic influenza-as-a-security-threat. Even by the 1950s, medical

professionals had explicitly adopted security-related terminology such as ‘threat’ to describe the danger posed by pandemic influenza (Nelson 1958). Over the next three decades concerns about the disease were overshadowed by more conventional security concerns related to the Cold War; nevertheless, periodic references to the ‘threat’ of pandemic influenza continued to appear and, as might be expected, were particularly intense following the influenza pandemics of 1957 and 1968. Frequently in these accounts, the 1918 pandemic was used to illustrate the wider societal (catastrophic) consequences of influenza pandemics, usually in an attempt to heighten political interest in, and argue for, increased resources for surveillance and/or vaccination programs (Pyhälä 1980), or simply to elevate awareness and general concern (Walters 1978). These attempts to portray the disease as an ‘existential threat’ had limited impact though in light of the threat posed by nuclear annihilation. But by the early 1990s, as governments were attempting to grapple with the multitude of new ‘non-traditional’ security threats such as emerging and re-emerging infectious diseases (ERIDs), pandemic influenza once again began to feature as a key threat (Glezen 1994, Gensheimer *et al.* 1999). Yet despite the level of apparent awareness, in 1997 when a new strain of H5N1 influenza appeared in Hong Kong that killed six out of 18 people infected, the international community was ill prepared to respond.

### **Securitising pandemic influenza: actors and context**

Human agency is a critical factor within any framing activity, including that of securitisation. But it is only one side of the coin. As Williams has observed, the process of securitisation is ‘structured by the differential capacity of actors to make socially effective claims about threats, by the forms in which these claims can be made in order to be recognized and accepted as convincing by the relevant audience, and by the empirical factors or situations to which these actors can make reference’ (2003, p. 514). Similarly Balzacq (2005, 2011) has

argued that context plays a role in successful securitising moves. Therefore, although human agency through the speech act is integral to the process of framing and in endorsing (or not) the frames being produced, equally important is the need for the frames to be based on an accepted empirically valid reality or within a suitable context.

Nevertheless, actors remain crucial to the securitisation of pandemic influenza in framing the disease as an existential threat requiring emergency action. The implication of this is that pandemic influenza is not *naturally* a security threat but rather needs to be *constructed* as such. DeLacy has argued, for instance, that in the eighteenth century influenza was not understood as posing a direct threat to social stability but rather ‘doctors and patients alike knew that it was persuasive but rarely fatal... For most people it was a nuisance, not a disaster’ (1993, p. 63-64). The 1918 influenza pandemic however provided the context for subsequent generations of health practitioners and academics, often using economic modelling and statistical studies, to begin framing influenza as a security threat through not simply its effect on morbidity and mortality, but through its potential effects on economic and social stability. This framing was, however, a slow process that accelerated around the turn of the millennium with events such as the 1997 H5N1 outbreak, the 2003 SARS outbreak, the global dissemination of the H5N1 influenza virus, and the 2009 influenza pandemic providing a context of renewed urgency (see Tables 1 - 3). But what was also vital was the mix and extent of actors engaging in securitising speech acts which, when combined with the positions of authority they maintained, helped guarantee that the threat claims were widely accepted. As Marston and Watts (2003) have observed, ‘Formal hierarchies in policy communities are... potentially important factors in framing policy problems and solutions. Ministerial advisers, senior public servants, and other ‘insiders’ or ‘policy elites’ have greater access and authority in decision-making processes than members of the public or service users’ (p. 145). Moreover, the agents engaging in these securitising moves extended from

individuals to professional groups to global institutions. At the individual level, actors engaging in securitising moves have ranged from prominent health and medical practitioners such as Michael T. Osterholm, Kathleen F. Genshimer, and Anthony S. Fauci, to academics such as Lawrence Gostin, David P. Fidler, Stefan Elbe, Andrew T. Price-Smith and Christian Enemark (Koblentz 2010), through to senior policymakers and politicians such as former Democratic Senator and now US President Barack Obama (see Obama and Lugar 2005). Similarly, journalists such as Laurie Garrett, who serves as an advisor to the US Council of Foreign Relations and has addressed US Senate Committees on the ‘threat’ of pandemic influenza, further reinforced the securitisation framing (Garrett 2005a, 2005b). The threat nature of pandemic influenza has been repeatedly emphasised by the medical profession (Vance 2011).

In addition, various armed forces have been complicit in framing pandemic influenza as a security threat. In 1997, for example, the US Department of Defense established a military-operated Global Laboratory-based Influenza Surveillance Program (Owens *et al.* 2009), partly in response to an outbreak of influenza on a US navy vessel in 1996 that affected approximately 42 per cent of the 600-person crew (95 per cent of whom had received influenza vaccinations) (Amelio *et al.* 2002). The core function of this program, which was further expanded upon in 1998 with the creation of the Global Emerging Infections Surveillance and Response System (DoD-GEIS), is to conduct surveillance for influenza-like illnesses (Sueker *et al.* 2010). Adding even further weight to these claims has also been several very prominent institutions, the most notable including the WHO, which asserted that pandemic influenza existed as ‘the most feared security threat’ (WHO 2007, p. 45); the US National Intelligence Council that identified pandemic influenza one of the ‘most dangerous’ threats to US national interests’ (NIC 2000, p. 6); and the United Nations which

established an entirely new supra-institutional office to respond to the pandemic influenza threat.

The intent behind these actions has, in many instances, been deliberate. For example, Andrew Cassels, WHO Director of Strategy for the Office of the Director-General, recently commented in relation to the WHO that,

The security and economic arguments have gone hand in hand. First of all it was about bringing HIV/AIDS to the forefront of the agenda, but then it expanded to include deliberate release, all of that kind of stuff. In part though, it has also been about securing political and financial support for the organisation. Bringing health issues into the security domain has been a fairly deliberate strategy - one that has been criticised by some Member States admittedly, but one that has probably been inevitable (Interview 22 March 2010).

At the same time, other actors suggest that it has been less about strategic framing per se, but rather about using the most appropriate language to communicate effectively with stakeholders, as David Nabarro, Executive Director of UNSIC, recalled,

We have found that when we're talking to a larger group of stakeholders we have to modify our language a lot... and I am very, very keen that we take a broader disciplinary, or multi-disciplinary approach to dealing with pandemic influenza. Sometimes, in this context, we have to modify not just the title that we use with codenames like 'health security', but also the nature of our discourse (Interview 27 October 2010).

Importantly, however, although such an approach is more nuanced, by intentionally re-moulding the language to suit a particular audience these actors are still engaging in a framing exercise. Moreover, the objective – namely, to highlight a particular issue that requires resources and/or emergency measures – frequently remains the same, irrespective of whether the framing exercise was overt or not. As Ann Moen, Deputy Chief of the Influenza Branch for the US Centres for Disease Control and Prevention, summarised, 'Any chance to

get funding and resources, that also spotlights flu is good for [us]' (Interview 20 October 2010).

Collectively, the securitising speech acts by this wide range of actors and the frequency with which they have been deployed since 1997 have had a demonstrable impact, revealing a measure of audience acceptance. Evidence of this can be found in three key areas. First, according to UNSIC, most governments have adhered to the advice of the WHO and now developed national pandemic preparedness plans (UNSIC and World Bank 2010). Second, the majority of countries that possessed the financial means to do so, entered into advance purchase agreements with pharmaceutical manufacturers worth billions of dollars in order to secure access to antiviral medications and influenza vaccines to protect their respective populations (Mounier-Jack *et al.* 2007). Third, between 2005 and 2009 governments pledged US\$4.3 billion towards strengthening global pandemic preparedness, and by 2010, some US\$2.7 billion of this had already been disbursed (UNSIC and World Bank 2010). In short, the securitisation of pandemic influenza had a remarkable effect, mobilising considerable resources, prompting extensive planning and preparation including the passage of new regulations and laws that, importantly, justify and codify a range of emergency measures that extend from social distancing practices to law enforcement and quarantine. In other words, securitising pandemic influenza appeared to create a pathway for emergency responses to be undertaken outside the normal planning realm.

### **Pandemic influenza securitised: the impact on public policy**

The 1997 H5N1 influenza outbreak in Hong Kong marked the beginning of a new cycle in the securitisation of pandemic influenza. As the lead technical agency charged with coordinating international health work, the WHO was caught unprepared at the time of the outbreak, having reduced the number of influenza-dedicated staff in the WHO headquarters

in Geneva, Switzerland, reportedly to just one individual (Kamradt-Scott 2011). However, due to a concurrent process that had been initiated in 1995 to revise the International Health Regulations (IHR) and the WHO's outbreak response policies, the organisation was able to rapidly assemble a Pandemic Task Force and, following a formal request from the Hong Kong administration, send an investigative team to assist health authorities contain the outbreak (Snacken *et al.* 1998). Although controversial at the time, the decision by Hong Kong's then health minister, Dr Margaret Chan, to eliminate the territory's entire poultry population contained the outbreak, and no further cases of human or avian H5N1 cases were recorded.

The 1997 outbreak spurred considerable activity in pandemic planning and preparation. In 1999, for example, the WHO published its first official guidance document in which the organisation outlined a number of pandemic 'phases', and articulated a clear need for all countries to develop national pandemic plans and strengthen their response capacities against the 'pandemic threat' (WHO 1999). Using Vuori's (2008) classification, this appears to be a 'claim speech act' in that it attempted to raise an issue on decision maker's agendas. With such claims 'the speaker has to present or to have proof for the truth of his/her claim and it should not be obvious to both the speaker and the hearer that the hearer knows the truth of the claim already' (Vuori 2008: 77). Events such as the 2001 anthrax letter attacks in the United States further reinforced the need to develop health security-related contingency plans (Gensheimer *et al.* 2003); and in the immediate years that followed, governments, particularly of Western populations, launched a raft of initiatives aimed at developing and testing national pandemic influenza contingency measures. Plans were developed using scenarios supported by epidemic modelling and clinical attack rates, often based on the 1918 pandemic, to predict the extent of projected human morbidity and mortality (Tam 1999). Economic studies examining potential impacts to national productivity, and social and

economic functioning were similarly used to evaluate mitigation strategies (such as vaccination programs), to inform policy, and justify the need for further pandemic planning (Meltzer *et al.* 1999, Gust *et al.* 2001). These modelling exercises and scenarios, many of which were government-initiated or commissioned by state-sponsored research funding, frequently emphasized the catastrophic consequences of a widespread pandemic. In so doing, they further bolstered the case that pandemic influenza not only presented an immediate threat to human well-being, but also directly threatened the state via massive social and economic disruption.

Despite these indications that pandemic influenza had been securitised – in that governments were taking emergency actions in response to securitising claims – ultimately between 1997 and 2003 the extent of the response was limited. Indeed, even though a wide range of actors including government officials, health practitioners, policymakers, representatives of international and regional organisations, and scholars had been fully complicit in framing pandemic influenza as a security threat, and that decision makers appeared to have been successfully persuaded of this, resulting in the authorisation of new pandemic plans, ultimately practical measures in strengthening international response capabilities (such as enhancing overall global vaccine production capacity) were comparatively few. Thus although pandemic influenza had been securitised, the priority given to it appeared low in comparison with other threats. This supports the idea articulated earlier that securitisation is not a binary condition but a continuum along which consensus over the issue and over the necessity for emergency action may vary. At this time, pandemic influenza clearly appeared to be only part way along the continuum to full securitisation.

In November 2003, confirmation that a new, highly virulent strain of H5N1 avian influenza had begun infecting humans and was spreading progressively throughout Asia provided the material event allowing pandemic influenza to move further along this



continuum to full securitisation. Importantly, however, this occurred within the context of heightened security anxieties and of increased global sensitivities over infectious disease. The September 11, 2001 terrorist attacks on New York and Washington, the war with Afghanistan and then in March 2003 the invasion of Iraq following concerns over its development of weapons of mass destruction, all provided a context of heightened anxiety over security. Contemporaneous with the invasion of Iraq, a novel pathogen began spreading internationally from Hong Kong. The subsequent global dissemination of the SARS-associated coronavirus between March and July 2003 proved a distressing reminder of the human, economic and social consequences that accompanied disease outbreaks in a highly interconnected world. The entire global outbreak resulted in just over 8,000 cases and approximately 800 fatalities, and yet the economic damage to the Asia-Pacific region alone from SARS was estimated at over US\$30 billion (WHO 2007). To many health practitioners and policy-makers SARS was seen by as a 'wake up call' (Campbell 2004, p. 5); and the outbreak generated significant political commitment not only to conclude revising the IHRs, but also to ensure greater international cooperation in tackling disease threats (Kamradt-Scott 2010). Within a few months of SARS having been successfully contained, however, several small outbreaks of the H5N1 avian influenza virus (which later became commonly referred to as 'Bird Flu') were recorded in Southeast Asia. Throughout 2004 the number of outbreaks increased, and despite several containment exercises targeting domestic bird populations, several countries that had never previously recorded outbreaks began reporting new human cases of H5N1 (Webster and Govorkova 2006). As a result, new pressure was brought to bear on politicians both domestically and internationally to better respond to what was clearly being portrayed as an emerging threat.

By 2005, persuaded of the growing threat of H5N1 influenza (Obama and Lugar 2005), governments the world over implemented a range of new pandemic planning and

preparation activities. Moreover, government officials were so persuaded by the threat of pandemic influenza that the need for comprehensive pandemic planning was presented to citizens as self-evident (Stephenson and Jamieson 2009). At the urging of several Southeast Asian countries, the Secretary-General of the United Nations established a new department – the United Nations System Influenza Coordinator, or UNSIC – to coordinate the multiple UN agencies engaged in activities related to preventing avian influenza. The creation of this supra-organisational entity coincided with the founding of the International Partnership on Avian and Pandemic Influenza by US President George W. Bush, and the allocation of significant US government funds for strengthening international surveillance, detection, and response (Osterholm 2007). Around the world individual governments sought to strengthen their own domestic response capacity such as implementing H5N1 testing of domestic poultry, and agreeing contracts worth billions of dollars with pharmaceutical manufacturers to purchase large quantities of antiviral medications and influenza vaccines (Lam 2008, Mounier-Jack *et al.* 2008). Intergovernmental organisations such as the WHO, the Association of Southeast Asian Nations (ASEAN) and the Asia-Pacific Economic Cooperation (APEC) received new injections of financial support from their respective member states to enhance pandemic influenza preparedness and response capabilities. Various local, national, regional, and international plans were developed, and in a number of instances exercised. Consultation meetings were convened; new laws and regulations were passed. In short, the international community entered what may be described as pandemic overdrive, pledging between 2005 and 2009 approximately US\$4.3 billion to enhancing global pandemic preparedness (UNSIC and World Bank 2010).

In April 2009, the hyperactivity that accompanied the global spread of H5N1 influenza initially seemed to have been validated following the announcement that yet another new strain of H1N1 influenza had successfully begun to infect humans. Within a

matter of weeks, the virus that had originally emerged in Mexico had been detected in multiple countries around the world. As the WHO moved to declare a full-scale pandemic, the governments of affected countries executed their respective pandemic plans and initiated various emergency measures ranging from thermal screening at airports, quarantine and isolation of suspected and confirmed cases, cancellation of mass gatherings, school and child care centre closures, and the procurement of mass quantities of antiviral medications and influenza vaccines. In some instances, governments willingly contravened sound scientific advice by implementing measures such as quarantining all Mexican citizens within their borders, banning the import of all live pigs and pork products, and in the particular case of Egypt, slaughtering the country's entire pig population due to initial depictions of the virus as 'Swine Flu' (Hodge 2010, Katz and Fischer 2010), ostensibly to demonstrate their commitment to protecting populations from infection. Indeed, throughout all this activity Prime Ministers, Presidents, senior government officials, health practitioners, and policymakers were repeatedly observed emphasising the threat the influenza pandemic presented, as well as justifying the various measures they were taking to protect public health.

## **Conclusion**

Unlike the securitisation of HIV/AIDS that others have argued is a recent phenomenon (Elbe 2006, McInnes and Rushton 2011), the process to embed pandemic influenza as a threat to national and international security has been an extensive one, extending over decades as opposed to years. Clearly, the 1918 influenza pandemic has been the key milestone in this framing exercise; but there is little question that the most intensive phase of this process began in the mid-1990s and came to a peak around 2005. This is not to suggest, however, that the process of framing this disease as a security threat has always been successful. Despite the numerous examples of medical professionals in the 1950s using security-related

terminology to describe the hazard posed by influenza, and an acute awareness of the impact that the disease could have on the physical, economic, and social stability of societies, when confronted with the threat of nuclear annihilation brought on by the Cold War governments – perhaps understandably – accorded less attention to the threat of pandemic influenza. By the late 1990s, however, the situation had changed once again, and the disease rapidly became widely accepted as security threat through a blending of real-world events combined with the strategic framing of the disease by socially legitimate agents. In this regard, human agency, while still integral to the process, has not been as significant in the context of framing pandemic influenza as a security threat as it has apparently been in securitising other infectious diseases like HIV/AIDS. Indeed, had it not been for the fact that actors sought to augment their framing attempts by drawing on economic projections and epidemiological studies of the potential catastrophic failure of society, whether the framing of pandemic influenza as a security threat would have been as successful as it appears to have been. The effect of framing pandemic influenza as a threat to national and international security has, however, been profound both in terms of measures undertaken and the global spread of responses. Most states as well as key international institutions have reacted to the construction of pandemic influenza as a threat by establishing emergency planning measures, which take responses to the disease outside the realm of ‘normal politics’. In this respect the successful framing of the disease as a security issue opened up a pathway for exceptional responses.

## **Acknowledgements**

This research has been made possible through funding from the European Research Council under the European Community's Seventh Framework Programme - Ideas Grant 230489 GHG. All views expressed remain those of the author.

## Notes

- (1) This article draws on a range of elite interviews conducted in Geneva, London and Singapore during 2010-11. For reasons of confidentiality agreed with interview subjects, these are generally not cited in the text.
- (2) One implication of this is that the use of the word 'security' is not necessary in the speech act. Indeed with pandemic influenza the operational term appears to have been 'threat'.
- (3) In this context it is interesting to examine David Campbell's work on the 'visual economy' of HIV/AIDS (Campbell 2008).

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