The Securitization of Communicable Disease

As the fighting of the First World War drew to an end, the world was on the brink of a devastating new catastrophe. This time, the enemy would be internal and invisible to the naked eye: a virus. Within just a few years, over 40 million people had died as a result of the global 'Spanish Flu' pandemic (Enemark 2009: 193). Figures remain uncertain, partly due to the devastation caused by the pandemic, but recent scholars have estimated that between 50 and 100 million people died in the 1918–19 outbreak (Barry, 2004). Many victims died within hours of coming into contact with the virus. This global pandemic was not the first of its kind, and will not be the last. During the 14th century, bubonic plague wiped out up to 60% of the population of Europe and more recently, Ebola, MERS, Swine Flu, Avian Flu, and SARS have caused death and panic across the world. The increase in global communication, as people and goods circulate with unprecedented speed, is a source of serious concern for epidemiologists who predict another, more deadly, pandemic in our future.

Communicable diseases are not a new threat to human security, but the ways in which pandemics occur, their scale, and our responses to them have changed substantially. Perhaps the most important biological development in the field of Health Security is the arrival of the Human Immunodeficiency Virus (HIV) in the late 20th century. HIV is the virus responsible for AIDS and the emergence of the HIV/AIDS pandemic has done more than any other disease to shape the development of health security as a concept. With over 30 million casualties to date, HIV remains one of the most serious threats to human life on the planet. It destroys communities, stunts economic growth, and has even been charged with undermining the military capacity of states (see Barnett & Prins 2006). But unlike influenza, the HIV virus is not airborne or even easily transmitted. Worryingly, it is altogether feasible that a new virus could evolve to be more deadly and more infectious than anything we have so far experienced. Grave as this threat is, we remain uncertain as to how we should address pandemic disease in the future. Is our health a matter of national security? Should our bodies be the responsibility of the state? And how can we fight an enemy that travels silently across borders, and resides invisibly within us?

This case study looks at health as a security issue, using the Copenhagen Theory of Securitization from Chapter 12. The HIV/AIDS pandemic is included to illustrate the key features of Securitization Theory, including the all-important **speech act,** the concept of **persuasion**, and the intersection between health and national security. Perceptions of risk are explored as we ask how our understandings of security become politically important, and how this affects security in different sectors.

What is Securitization?

Not everything is a matter of security. Supplies of chocolate for instance, do not feature on the security agendas of states at the United Nations Security Council (UNSC). But what if the cocoa trade is essential for the economic stability of a country? Or if the governing party was elected on the promise of supporting the domestic confectionery industry? What if a shortage of chocolate had led to civil unrest and rioting? Would these then become legitimate security concerns?

Securitization Theory provides an explanation of how anything (in theory) can become a matter of security. Since the end of the Cold War, with its bipolar security balance and military-centred preoccupations, the question of 'what do we mean by security?' has become more prominent. In 1998, a group of scholars known as the Copenhagen School came up with an answer of sorts. In their book *Security: A New Framework for Analysis*, Barry Buzan, Ole Waever, and Jaap de Wilde published a new model that theorized how just about any issue could become one of the utmost importance and significance to states.

The Securitization Model, or Securitization Theory, as it is popularly known, explains the transition by which an issue, such as influenza or cocoa trading, can be moved from the non-political sphere to the political sphere, and ultimately into the realm of security (see Fig. 1 below). The key theoretical underpinnings of the model are as follows: 1) Security is constructed by the actions and beliefs of human societies; 2) there is no objectively 'real' security threat. Instead an issue is only a matter of security when we perceive it to be so; 3) security issues are the most important, the most urgent, and have the greatest priority of all matters; 4) security issues are threats to the existence of something (e.g., to the existence of a state, an economy, or a rare species); they are **existential threats**; 5) in dealing with security issues, normal boundaries and rules can be broken because the problems are, by their nature, so serious.

The result of these radically constructivist ideas about security is that the securitization process is one in which security issues are produced (by collective belief) rather than objectively identified. They are built in the minds of a community or group of people who learn to recognize something as being an existential threat. This learning and recognition is a form of persuasion; a securitizing actor makes claims about the severity of an issue and the consequences of inaction in an attempt to convince an audience that the threat posed warrants recourse to extraordinary measures for defence. For instance, in order to securitize HIV/AIDS in 2000, then US Vice President Al Gore told the United Nations Security Council (UNSC) that '[HIV] threatens not just individual citizens, but the very institutions that define and defend the character of a society … weakens workforces and saps economic strength…. It strikes at the military, and subverts the forces of order and peacekeeping.' He delivered his speech to the assembled members, asking them to take the extraordinary step of including a public health issue on their agenda which had otherwise been the reserve of military and traditional security issues.

With these words, Al Gore presented HIV as a threat not only to individual lives, but also to economies, societies, and military forces. If this **speech act** is successful, the audience will be convinced of the severity of the threat posed by HIV and the issue will be securitized. But how can we gauge whether an audience is convinced? This is a difficult question, especially where that audience is a larger population; it could, for instance, be necessary to persuade the voters of a democratic country, rather than just a small group of political elite such as the members of the Security Council.

The answer provided by the Copenhagen School is perhaps the most interesting part of securitization studies; they claim that the issue is successfully securitized when that audience is persuaded to allow **extraordinary measures** in response to the threat. In dealing with a security issue, the boundaries of normal political power, laws, and norms are deemed to be less important than tackling the existential threat at hand. So in dealing

with security issues, those taking action no longer have to adhere to the rules of normal operation. As a result, legitimate responses in a democratic state could include detention without trial, the use of torture or extraordinary rendition, or the curtailment of civil liberties and the right to protest.

Considering the power that accompanies such emergency measures—the power to legitimately break rules in the name of 'security'—it is no wonder that scholars and policy makers are so interested in studying securitization. This topic becomes even more controversial and interesting when we intersect security with 'health'. Health as a topic essentially concerns human bodies, what we do with them, and how we avoid death and prolong life. It is easy to see why the politics of health—an issue that requires restricting or controlling people's management of their own bodies—becomes problematic. The case study below introduces some of the key ideas and issues in this field, but there is also a lively debate in the academic and political communities about global health and this makes for interesting further reading.

Fig. 1

The Securitization Spectrum

1. **Non-politicized**
   A non-politicized issue is not included in public debate and the state does not deal with this issue.

2. **Politicized**
   The issue is managed within the standard political system—it requires resource allocation and attention from the government.

3. **Securitized**
   The issue has been framed as a security threat—it has been articulated as an existential threat to a referent object.

Health and National Security

Traditionally, security studies has used state-centric models and narrow definitions of security. Referent objects are the economy or military resources of the nation state, and the means of securing these are the traditional apparatus of state power, particularly the military. However, there is increasing recognition that communicable disease and pandemics can constitute a threat to both traditional and non-traditional sectors of security. This has become especially apparent during the HIV/AIDS pandemic over the last three decades.

Traditional security analysis places the state and military forces at its centre and the most drastic intersection between traditional and non-traditional security in terms of health comes from the impact of HIV/AIDS on the armed forces of a state. Governments across the world have recognized the detrimental impact that HIV can have on their military

population, not only in immediate terms—as disease wrecks the physical capacity required to perform duties—but also through the political consequences of overseas troop deployment, and the provision of healthcare to seriously ill staff. In Russia, over 9,000 potential draftees were rejected for service after testing HIV positive between 2001 and 2006, and India and China continue to closely monitor infection rates within their military forces (Feldbaum et al., 2006). The continuing concern over and attention to HIV in the military is reflected in the US Department of Defense's HIV/AIDS Prevention Program (DHAPP) which assists foreign military partners with HIV/AIDS prevention, care, and treatment. It recognizes that 'the HIV/AIDS epidemic has a devastating impact on many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities' (Military Health System, 2018).

The popular belief that military populations have higher levels of HIV infection than non-military groups has been challenged in recent years, but the correlation between infection and United Nations Peacekeeper missions remains a source of serious concern and international attention. Peacekeepers are thought to be particularly at risk of contracting and transmitting HIV, and this issue has become widely politicized with challenging implications for international security. Deployment of troops from nations with high rates of infection is resisted by host states, and Peacekeeper forces are stigmatized as vectors of disease.

The troubled relationship between international Peacekeeper forces and health has been tragically demonstrated in recent years following the aftermath of the Haitian earthquake. In Haiti, the arrival of Peacekeepers has been blamed for the devastating outbreak of cholera that hindered recovery work. In addition to exacerbating the human security problems faced by Haitians, the cholera epidemic also took on a political dimension, causing tensions at both the international and domestic level about the deployment and suitability of UN forces. When a population is affected by high levels of disease, the economic consequences are also expansive. The labour force and healthcare systems become depleted if disease burden is unusually high for long periods of time and in resource-poor settings the risk to these vital institutions is greater. As evidenced through the recent emergence of Ebola in West Africa, countries with poor healthcare systems and weak economies are hardest hit by pandemic disease, which kills directly and indirectly through the destruction of communities and livelihoods. For example, in Sierra Leone, Liberia, and Guinea, the Ebola outbreak overwhelmed healthcare provision, caused a detrimental breakdown in people's trust in health institutions, and reduced healthcare utilization (including maternal care and vaccination coverage). It also had broader societal impacts, such as loss of education, increased unemployment, reduced life expectancy and a reduction in the cohesion of communities (Elston et al., 2017).

The economic impact of HIV is long term and pervasive. The HIV virus is transmitted through exchanges of bodily fluid, most commonly during sex, and this means that sexually active people are most at risk. These people are typically the part of a population which is most economically active, so their illness or death has a direct impact on the economy of their community or state. In most parts of the world where HIV infection rates are high, the people most at risk of transmission are young, have young children, or are working for income. This is particularly problematic because without diagnosis and

treatment, infection with HIV means that people who would otherwise be going to work or caring for their families instead become chronically sick and die.

HIV infection is greatest in less economically developed states where the ability to produce labour and food is crucial to human survival. Often the state lacks the infrastructure to provide welfare or support to sick individuals and their families in these cases, exacerbating the vulnerability of a population to disease. Being vulnerable, unable to make informed choices, and being at risk of exploitation, all increase risk of HIV infection, but there is also a notable impact of HIV-related illness and mortality amongst middle classes. Skilled workers such as teachers, doctors, and lawyers, are harder to train and when HIV prevalence is high there is a decline in productivity in these crucial sectors. This threatens community and economic cohesion and is often presented as a risk to security at both the local and national level.

Fig. 2

The Securitizing Speech Acts of HIV/AIDS

In January 2000 the United Nations Security Council held an historic meeting; for the first time the Council declared a health issue, that of HIV/AIDS, to be a security threat (Elbe 2006: 121). This crucial step in the securitization process took place as James Wolfensohn, who was then president of the World Bank, declared that AIDS had come to represent '**a major development crisis, and more than that, a security crisis'.** By transcending the boundaries of a normal 'health issue', HIV/AIDS became a subject for discussion amongst members of the Security Council which ultimately led to the adoption of UN Security Council Resolution 1308 (2000) in July 2000.

Wolfensohn explicitly called for a reconceptualization of the risks posed by the disease **'many of us used to think of AIDS as a health issue. We were wrong … Nothing we have seen is a greater challenge to the peace and stability of African societies than the epidemic of AIDS'** (Elbe 2006: 121).

These speech acts present HIV/AIDS as a threat to stability and peace at the global level. Where HIV had previously been thought of as a threat to the individual, it was now framed as a much wider risk and society as a whole became the referent object, with all the relevant implications for international security in a globalized world.

Accompanying Wolfensohn's speech at the Security Council meeting was the declassification of *The Global Infectious Disease Threat and Its Implications for the United States*, a National Intelligence Estimate that reported the effects of HIV/AIDS and other infectious diseases on US national security (Elbe 2006: 121). During the following months HIV/AIDS was declared a national security threat by the American government; the securitization process had begun and by 2006 the United Nations Security Council had met three more times to discuss HIV/AIDS. Eleven years after the adoption of Resolution 1308 (2000), the Security Council passed Resolution 1983 (2011), proving the persistence of the securitization and continued emphasis on HIV/AIDS as a security threat.

Securitization and the Perception of Risks

Notable benefits that accompany the securitization of an issue include raising awareness of a problem, gaining political support for action, and attracting resources to deal with it. Once defined as an existential threat, the subject warrants attention and funding, and is prioritized as a matter of concern and action. This added attention can facilitate the management of securitized issues, which are often complex and require expertise and the substantial investment of resources. Elbe (2006: 120) identifies the positive aspects of securitization and identifies the subsequent economic, social, and political benefits as 'vital' for the millions of people affected by HIV/AIDS. Similarly, Caballero-Anthony (2005: 476) advocates the securitization of severe acute respiratory syndrome (SARS) following the global outbreak in 2002–3, claiming that by adopting a security framework governments would be better prepared to handle the sudden and urgent existential threats posed by the disease.

This issue of **urgency** is a key theme in the debates of securitization and health. A sense of immediacy must be awarded to an issue in order to achieve securitization and one of the most alarming characteristics of pandemic disease is the potential speed with which infection can spread. As emphasized in the World Health Organization's *checklist for pandemic influenza risk and impact management*:

> 'Once a novel influenza virus is able to infect and be transmitted between humans, a pandemic is likely to occur. Because people will have little or no immunity to the new virus, influenza pandemics will affect a large proportion of the global population and put significant stress on health-care systems. A moderate or severe pandemic will also strain other essential services and cause substantial social and economic impacts. Countries should therefore have multisectoral preparedness and response plans that outline their policies, strategies and operations to manage this all-of-society emergency.'
>
> (WHO, 2018: 3)

There exists a particular sense of panic and fear surrounding communicable disease for three reasons. First, because fear of ill health is part of our biological conditioning and has particular resonance for us as human beings. Second, the fast paced globalization of the world has led to an anxiety amongst its population, in this case due to the speed at which pandemic viruses can spread across long distances. Globalization has created a world in which no human being is completely isolated from another; the physical routes of

communication through travel, and the distribution of goods and people, mean that a pandemic infection could spread more widely and quickly than ever before.

In addition to enhancing the means of transmission, globalization has also created a world in which the daily lives of the global community are interconnected; financial systems, trade, fuel, and food distribution are just some of the ways in which we rely on the global community to support local infrastructures. In short, a disaster in one part of the world will have immediate and serious consequences elsewhere. Finally, there is an increased awareness thanks to media and political rhetoric that biological weapons may be used with devastating effect by terrorist organizations.

Enemark (2009) identifies the fear incited by perceived risks of infection to be a substantial contributor to the risks that these health issues pose to the state. He argues that the difference between the perception and actual material risk posed by communicable disease is the foundation on which health can be securitized (2009). Elbe (2009) claims that, in addition to the speed with which severe pandemic infection could take hold in a modern society, it is a more innate fear of microbes and germs that inspires our dread of disease. Our willingness to address health issues in terms of national security is motivated partly by this innate fear, allowing us to adopt potentially disproportionate and even militarized approaches to deal with pathogens.

The Copenhagen School regards security as a socially constructed concept, and as such, what constitutes an existential threat is considered to be subjective, depending on a shared understanding of what constitutes a danger to security. One criticism of the securitization process is that by presenting an issue as a threat, and by sanctioning or conducting emergency measures to secure the referent object, a general perception of risk, dread, or fear is exacerbated and can itself present a risk to security. The city of Surat in India witnessed a plague epidemic in 1994 in which 25% of the city's population fled within four days, prompting the government to mobilize forces and effectively quarantine the population. In his study of pandemics, Enemark points out that by implementing extraordinary measures, human security may be undermined, as 'the sight of troops on the street might exacerbate rather than assuage popular anxiety' (2009: 199).

Of great concern to health security analysts is that 'the risk of approaching pandemic influenza as a security issue is that this could lead to emergency responses which are ineffective, counterproductive or unjust' (Enemark 2009: 199). Although there are situations in which mobilization of military forces may be unavoidable in the pursuit of security, the danger of infringing civil liberties and the abuse of 'special powers' of authority is of great normative concern, especially for those who value liberal democratic principles in governance. The Copenhagen School themselves advocate the desecuritization of securitized issues wherever feasible, arguing that a return to 'normal' politics is better than the legitimization of extraordinary power (Buzan et al., 1998).

Limitations of Securitization theory in Health

Infectious disease poses a new type of security problem because it is transnational in nature; diseases and pandemics cross international boundaries with no respect for sovereignty or state borders. The common misconception that states can protect themselves from global pandemics by closing their borders is scientifically unfounded. It is

also emblematic of a narrow, national-security mindset being applied to a threat that is inherently transnational in scope and that requires more complex and sophisticated responses (Enemark 2009: 204). Infectious disease, especially when pandemic, presents a serious challenge to the traditional state-centric responses to security and thus to the traditional security framework itself.

Securitization Theory offers a new framework for security analysis that intends to deal with health and other non-traditional threats, but it has been challenged for failing to account for the broadening of the security framework in a meaningful way. Peterson (2002) claims that the securitization of health issues can divert attention away from the human as referent object, legitimizing costly defence only where security on a broader scale is threatened (Enemark 2009: 199). Similar criticisms of the theory highlight the creation of a narrow security perspective that is either promoted or justified by the process of securitization. Defining the health risk (which typically demands a complex and broad-based solution) as a threat in terms of traditional security, means that appropriate responses can be hindered in favour of adopting narrow and often militarized responses. In the case of HIV/AIDS, Elbe (2006: 120) contrasts the securitization of HIV as an exceptional threat, with the efforts of grassroots activists who are working to normalize social perceptions of HIV. Grassroots activists do so in order to support HIV positive individuals and in an attempt to secure their personal, societal, and human security. In contrast, framing HIV/AIDS as a national security risk requires invoking a sense of fear and anxiety about the disease; Elbe (2006) argues that this can directly undermine campaigns to normalize perceptions of the disease and serves to increase stigma and discrimination, with detrimental impacts on rates of transmission as well as individual and community security.

Elbe (2006: 128) also contends that the special authorities warranted through the securitization process can allow the infringement of civil liberties, posing a particular risk to HIV positive individuals who, viewed through this narrow framework of security, could be wrongly identified as the risk rather than referent object. Peterson (2002) worries that by viewing health issues through the lens of national security, we risk absolving states of their moral responsibility to address the security needs of those citizens outside their own state borders (see Elbe 2006: 123). The transition of communicable disease from the medical to security sphere also risks removing agency from those in the health community (Katz & Singer, cited in Enemark, 2009: 199) and prioritizing the welfare of the privileged few. Defining health as a security issue through the process of securitization could potentially legitimize the reallocation of government funding toward military spending and other approaches that are not best suited to addressing the complexity of these risks. A gender analysis supports this perspective. For example, it reveals how the (re)framing of HIV/AIDS as a security issue by the UN Security Council in 2011 empowered peacekeepers as protectors rather than victims of disease, aligning with logics of ‘masculinist protection’ and ‘war/peace’. According to Jansson (2017: 82), ‘this militarization boosts the significance and the legitimacy of the Security Council, as it widens its responsibilities while maintaining the conceptualization of security as linked to conflict and solved or supported by military means’. In addition to fears that it can hinder the transnational co-operation that is essential for securing health (Enemark, 2009: 192), a national security approach to pandemic disease may also be ineffective and even counterproductive.

Conclusion

Historically there have been many instances in which pandemics have threatened security across the globe, both at a national and more regional level. In recent years, the outbreaks of Ebola, MERS, SARS, and the H1N1 and H5N1 viruses have served as a warning for the global community. States, healthcare professionals, and the security community should take note about the potential scale and impact of future catastrophic pandemics, which many believe to be inevitable.

In light of these developments, and in no small part because of the recent moves to securitize HIV/AIDS, governments across the world now articulate health issues in the language of security, proposing militarized and extraordinary measures in the event of pandemic disease and recognizing the broad array of security impacts that such outbreaks can have (see for example, US Strategic National Risk Assessment 2011; The National Security Strategy of the United Kingdom 2015). In light of this new security environment, shaped by the globalized world in which economies and societies rely on complex international interactions, new ways in which to address health and security must be developed. Those who espouse the benefits of securitization must also recognize the potential limitations of this theory. It is true that the Securitization model can be useful for addressing what is essentially a new type of security risk, but infectious disease threatens a new type of global community and thus demands a new type of response, one that encompasses the complexities of the issues at hand.

Key terms

Speech act
A discursive representation of a certain issue as an existential threat to security. When a securitizing actor **says** something is a security threat, this could be a speech act.

Extraordinary measures
Actions that exceed the normal boundaries and rules of governance. What constitutes 'normal politics' is a matter of some contention, and varies from case to case.

Existential threat
Threats to the continued existence of a referent object. Individuals face an existential threat when they are threatened with death; states face an existential threat when, among other things, they are threatened with external invasion and conquest. Existential threats are the most serious threats a referent object can face, and thus justify the most extensive measures to secure against them.

Referent Object
Common to most notions of security is the *protection* of some thing from a threat of some kind. The thing to be protected is the referent object. In conventional security studies the referent object is generally considered to be the state. Other approaches to security consider other referent objects e.g., individuals, societies, economies, or the environment.

Politicized issue
An issue becomes politicized when it is part of public policy and managed within the standard political system.

Non-politicized issue
An issue is said to be non-politicized when it is not a matter for state action and is not included in public debate.

Pandemic
A disease epidemic occurs when there are more cases of that disease than normal. A pandemic is a worldwide epidemic of a disease (World Health Organization 2009).

HIV
Human immunodeficiency virus.

AIDS
Acquired immunodeficiency syndrome; the term AIDS applies to the most advanced stages of HIV infection, defined by the occurrence of any of more than twenty opportunistic infections or HIV-related cancers (WHO 2009).

Critical Questions

1. To what extent is pandemic disease a 'new' type of security threat?

2. Why is securitizing health problematic?

3. How do utilitarian principles fit with the management of public health?

4. To what extent do human rights over the body apply in an emergency public health situation?

5. What powers should the state be able to legitimately invoke in a public health emergency?

6. Should international bodies, such as the United Nations, have the power to impose global responses to global pandemics and to sanction states for non-compliance?

7. To what extent do inequalities in global health care systems reflect other types of inequality, such as the global distribution of wealth or human rights indices?

8. What role does private business, such as pharmaceutical companies, have to play in advancing global public health?

9. Are there limits as to what can be considered a security issue? If so, what are these limits and when do they vary?

10. Does securitization theory really broaden our understanding of security, or does it remain traditionally state-centric?

Bibliography

Barnett, T. & Prins, G. (2006) 'HIV/AIDS and security: fact, fiction and evidence—a report to UNAIDS', *International Affairs*, vol. 2, no. 82, pp. 359–68.

Barry, M.J. (2004) 'The site of origin of the 1918 influenza pandemic and its public health implications', *J. Transl Med*, vol. 3 no. 2.

Collins, A. (ed.) (2015) *Contemporary Security Studies*, 4th edn. Oxford University Press, Oxford.

Department of Homeland Security (2011) 'The Strategic National Risk Assessment in Support of PPD 8: A Comprehensive Risk-Based Approach toward a Secure and Resilient Nation'. Available from: https://www.dhs.gov/xlibrary/assets/rma-strategic-national-risk-assessment-ppd8.pdf

Elbe, S. (2006) 'Should HIV/AIDS Be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security', *International Studies Quarterly,* vol. 50, pp.119–44.

Elston, J.W.T., Cartwright, C., Ndumbi, P., and Wright, J. (2017) 'The health impact of the 2014–15 Ebola outbreak', in *Public Health*, Vol. 143. pp. 60 –70.

Enemark, C. (2009) 'Is Pandemic Flu a Security Threat?', *Survival,* vol. 51**,** pp.191–214.

Feldbaum, H., Lee, K., & Patel, P. (2006) 'The National Security Implications of HIV/AIDS', *PLoS Med*, vol. 3, e171.

HM Government (2015) 'National Security Strategy and Strategic Defence and Security Review 2015: A Secure and Prosperous United Kingdom'. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478933/52309_Cm_9161_NSS_SD_Review_web_only.pdf

Jansson, M. (2017) 'The logic of protection: narratives of HIV/AIDS in the UN Security Council', in *International Feminist Journal of Politics*, vol. 19, no. 1. pp. 7–85.

Katz, R. & Singer D.A. (2007), 'Health and Security in Foreign Policy', *Bulletin of the World Health Organization*, vol. 85, no. 3, 233 –4.

McInnes, C. & Lee, K. (2006), 'Health, Security and Foreign Policy', *Review of International Studies*, vol. 32, no. 1, January, pp. 5 –23.

Military Health System (2018) 'Department of Defense HIV/AIDS Prevention Program'. Available from: https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Research-and-Development/Department-of-Defense-HIV-AIDS-Prevention-Program

Peterson, S. (2002) 'Epidemic Disease and National Security', *Security Studies*, vol. 12, no. 2, pp. 43–81.

UN Security Council (2000) 'Resolution 1308'. Available from: http://www.un.org/ga/search/view_doc.asp?symbol=S/RES/1308(2000)

UN Security Council (2011) 'Resolution 1983'. Available from: http://www.un.org/ga/search/view_doc.asp?symbol=S/RES/1983(2011)

Wolfensohn, J. (2000) Speech delivered to the UN Security Council. New York, 10 January

World Health Organization (2009). Available from: http://www.who.int/en

World Health Organization (2018) 'A checklist for pandemic influenza risk and impact management: Building capacity for pandemic response'. Available from: http://www.who.int/influenza/preparedness/pandemic/PIRM_Checklist_update2018.pdf