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Globalization and Global Public Health

In providing a social scientific account of the WHO's reaction to H1N1, the organization's self-proclaimed role as a coordinator of 'global health' is key to explaining its decision-making process. The global health paradigm, which replaced earlier conceptualizations of 'international health', was fundamental to the WHO's management of H1N1. This is both because pandemics are essentially globalized diseases and because the organization strongly subscribes to the new global health perspective. It characterized H1N1 as particularly 'global' in nature. This characterization led the WHO to emphasize global cooperation and interdependence in the management of the pandemic. In respect to this global management strategy, it presented its own role as one of coordination and facilitation rather than one of action. In fact, using the lens of the global health paradigm, the WHO characterized the reaction to H1N1 as the responsibility of state governments and not its own. This distancing of responsibility was key to the WHO's narrative of H1N1. It reflects the institutional attempts to adapt to the new structuring of global health. However, the organization's positioning was somewhat ambiguous as it was perceived to be a directive body by outside actors (exemplified by the Council of Europe's narrative), where the WHO's recommendations were understood as explicit instructions. Simultaneously, the organization struggled discursively to project its role as one of coordination rather than command, despite the member states' interpretation. This struggle reflects the ambiguity of institutional roles within contemporary global public health.

The WHO's characterization of itself as being responsible for delivering information to other global health actors was also problematic. In fulfilling this role the organization rendered the processes behind the construction of H1N1 transparent. Through attempts to provide

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information and illuminate events, the very transparency of concepts that actually should have been black-boxed (e.g. severity) made closure surrounding the event unattainable. The obvious discursive 'constructedness' of the threat, which had come to light through the public nature of the WHO's discussion of its decision-making, rendered the WHO's account more open to deconstruction by outside actors. This attempt at transparency was a reaction to the organization's repositioning as a coordinating and information-disseminating body within the new global health paradigm. In this way the underlying globalization process, and the management of H1N1 as an outcome of the resultant restructuring of public health, was central.

This expansion of the global economy has led to greater global interdependence and had a significant impact on the effects and experience of infectious disease (Lee, 2003). The demographic changes and increased flow of people and commerce that characterize globalization have created a new vulnerability to the spread of emerging or re-emerging infectious agents, since the growth in international trade and travel facilitates the swift transmission and geographical spread of infectious disease (Lee, 2005; Woodward & Smith, 2003). For this reason, combined with a renewed political focus in the context of security, infectious diseases have recently gained greater traction as global health priorities (Ollila, 2005). The current notion of 'pandemic', mirroring ideas of global spread, reflects a particularly contemporary understanding of globalization. Both the experience and the management of infectious disease are underpinned by globalization. Furthermore, the individual and institutional perception and discourse of globalization fundamentally influence actions and reactions towards infectious disease threats (King, 2002; Petersen, 1996).

Within the social sciences, 'globalization' is a highly disputed concept. For example, many sociologists subscribe to Giddens' (1991) argument that globalization is a development which is intimately embedded within the processes of modernity, while other theorists, such as Robertson (1995), suggest that it is a trend that pre-dates modernity (Bancroft, 2001). Indeed, despite the current understanding of infectious disease as uniquely globalized, from the social history of infectious disease it is arguable that the spread of communicable agents from the 15th century onwards (through European economic and cultural expansion) was analogous to contemporary processes (Watts, 2003). Combined with the tendency for the globalizing process itself to reflect inherent contradictions, definitions of the phenomenon are often somewhat ephemeral (Bauman, 1998; Lee, 2003). However, with respect to H1N1 and its

management, there are a number of aspects of globalization which are pivotal. The greater global interdependence in the management of infectious disease threats is evident. Disease events in areas which had once been spatially and temporally distant can cause disproportionate effects elsewhere in the globe (Ali & Keil, 2006). This propensity for the quick spread of disease is evident in understandings of the H1N1 pandemic. Important too is the fact that, mirrored by the pandemic itself, globalization differentially affects different nations and subpopulations but nevertheless impacts all of the global population to some extent (Giddens, 1991). Furthermore, the discourse of globalization (and perceptions about the impact of globalization) is also important because it informs management strategies.

Globalization has had a major impact on the contemporary structuring of scientific enterprise. In particular, the institutional management of globalized risk (e.g. H1N1) is explicable from a co-productionist framework. The argument is that, while the risks and the accompanying science are globalized, global politics has failed to settle into a stable institutional network. As seen in the case of H1N1, divisions of authority between global and national institutions (i.e. the WHO and national governments) is often unclearly defined (Miller, 2004), leading to confusion surrounding roles and jurisdiction (Szlezak et al., 2010). In cases such as H1N1, nation states might cede considerable power to global actors, experts and expert knowledge, but still be accountable to their citizens for the results of actions taken. This can lead to animosity between states and the managing institution (here, the WHO), as evidenced in Chapter 6 through the Council of Europe's account. In this chapter the WHO's response to this tension within global health is explored.

Regarding the question of such divisions of authority, the co-productionist investigation of issues of boundary maintenance provides some interesting insights. A pertinent argument from this perspective is the institutional ordering of these risks as 'global' in the first instance. For example, Miller (2004) argues persuasively that the 'global' nature of climate change is born from the drawing of boundaries of authority surrounding the phenomenon. Miller shows how the Intergovernmental Panel for Climate Change (IPCC) itself constructed the issue as a global one by forwarding a globalized discourse of irregular climate. The IPCC then articulated a new model of science and politics surrounding the issue – namely a global politics based upon (politically neutral) expert knowledge. This case study shows how the IPCC built institutional authority as it simultaneously constructed the globalized problem

of climate change. The phenomenon of climate change exemplifies the shift of the sociocultural account of risks from local to global problems (Nowotny et al., 2001).

The example of climate change indicates significant parallels to changing discourses in infectious disease, as evidenced in this chapter through the WHO's account. Miller argues that the 'globalized' nature of climate change is itself a manifestation of institutional organization. In the same way, it can be seen that historical incidences of disease (e.g. bubonic plague, smallpox or even Spanish flu) could have been considered global phenomena at the time but were rather treated as state concerns (managed by national public health regimes) due to the lack of a globalization discourse (Barry, 2004; Crosby, 1976; Zinsser, 1942). The assumption that H1N1 was a global threat, and its management as such, could be seen as a result of both a discourse of globalization and a globalized public health organization (the WHO). Furthermore, according to co-productionist theorists, the making or solving of a scientific problem lies not in a set of actions but in drawing and maintaining boundaries between multiple sources of authority. In the case of H1N1, unlike the IPCC, the institution of the WHO pre-existed the phenomenon. Nevertheless, the nature of the knowledge produced by the WHO surrounding the H1N1 risk presupposed methods through which that risk could be managed. Effectively, risks become defined in such a way as to be made manageable by (preformed) institutional structures. In this case, the pre-existing structures and aims of the WHO as a global public health institution defined the nature and management of H1N1, which was understood as a global pandemic to be managed through its recurrent strategies of mass vaccination.

The global public health paradigm

In part a result of globalization, public health has undergone significant changes in conception and organization over time. The most prominent of these is the shift from 'international health' towards 'global health'. This global public health paradigm has important consequences for the management of infectious disease threats. Brown, Cueto and Fee (2006) have demonstrated that 'global health' has thoroughly replaced 'international health' in public discourse. While the term 'global' was sometimes used before the 1990s, there are now frequent references to global health in the discourse, with allusions to 'international health' declining (Brown et al., 2006). This shift is not only semantic but it also reflects wider structural changes. The term 'global health' emerged

as a consequence of the impact of the broader historical, economic and political processes that are embedded within globalization. 'International health', which referred to the control of epidemics across the boundaries of a nation state, was the predominant concept during the 19th and 20th century. In contrast, 'global health' implies the needs of a global population which supersede the interests of individual nation states (Brown et al., 2006; Yach & Bettcher, 1998b).

In a discursive sense, the global public health paradigm is important because of the way in which this institutionalized discourse implicitly contains value-laden suggestions of the (proper) organization of health systems. The concept refers to a consciousness that the world is a single networked space, which in turn implies political assumptions about how public health should be ordered (Keane, 1998). The predominance of 'global health' suggests that public health issues should be understood and managed on a global scale. This understanding changes the role of the nation state, and of transnational actors, as the domestic and global spheres of policy and action become entangled (Walt, 1988; Yach & Bettcher, 1998). These changes also reflect tangible alterations in the structure of public health. Due to the impacts of globalized interdependence, the number and scale of health concerns (particularly in the context of infectious disease) is growing (Taylor, 2005). Infectious agents can indeed move more swiftly across the globe, rendering national boundaries meaningless in the management of pandemic disease (Brown et al., 2006; Buse & Walt, 2000; Janes & Corbett, 2009; Taylor, 2005). This has created an emphasis on global health governance. Critically, this has changed the nature and role of the WHO.

There has been a move from 'international governance' towards 'global governance' in the management of disease threats (Brown et al., 2006; Fidler, 2004). International governance, the past structuring of public health, reflected governance structures focused on the sovereignty of the nation state, and included the association of intergovernmental agencies, such as the WHO (as it was then conceptualized) (Brown et al., 2006; Taylor, 2005). Contemporarily, global governance refers to the repositioning of state actors and intergovernmental (now global) organizations, and the inclusion of a range of non-state actors such as NGOs and multinational corporations (Brown et al., 2006; Buse & Walt, 2000; Maguire & Hardy, 2006; Taylor, 2005). Health policy is now formed at the global level through networks of private-public partnerships. Some commentators have particularly emphasized the changing role of the private sector, where private actors (including and especially pharmaceutical corporations) have gained increasing power over the governance of public health (Buse & Walt, 2000; Taylor, 2005).

Importantly, public health management has become increasingly fragmented and verticalized (Ollila, 2005), with emphasis being placed upon selected interventions (particularly with respect to infectious disease) through a growing number of public-private partnerships.

It is clear that the WHO subscribed to the understanding of public health as 'global'. The notion of 'global health' came to the forefront at many stages of the WHO's discussions. This can be evidenced most directly in that the H1N1 threat and associated reactions were frequently referred to by the WHO using the specific term 'global' (this is evident throughout this chapter). The shift towards a global worldview is apparent in the following examples:

> In the face of this, WHO strongly emphasizes that continued global cooperation is really the essential basis for fighting this pandemic. And not just this pandemic but also future health challenges.
>
> (Fukuda, 03/12/09)

This quote shows the basic understanding of public health responses as inherently 'global' in nature. The extract below further demonstrates the effect of this characterization. Here the characterization of the problem as global is manifested in the management through global partnerships.

> We actively embrace the idea, that working with a broad coalition of partners, in this instance really a global coalition of partners, is essential for handling these kinds of threats. Now this approach is definitely necessary for the current pandemic, but I think it's also clear that it's going to be necessary for the future global health threats as you can appreciate I think, that we have been a very highly connected and fast-moving, globalized world right now, and WHO considers that working in isolation is not really an option.
>
> (Fukuda, 03/12/09)

The WHO understood the phenomenon of H1N1 through the lens of global health and managed it accordingly. This perspective was integral to key decisions that it made.

The global threat

The global health paradigm implicitly rests upon the perception of the effects of globalization. The H1N1 threat, like many widespread infectious disease events, had clearly been described as a globalized disease. The WHO's narrative reflected an understanding of H1N1 as global in nature. For example, one of the aspects of the virus that was most

heavily emphasized was its ability to cross boundaries and affect diverse populations. This formed the mechanism through which the risk was characterized as global in nature. Thus

> Influenza pandemics, whether moderate or severe, are remarkable events because of the almost universal susceptibility of the world's population to infection. We're all in this together, and we will all get through this, together.
>
> (Chan, 11/06/09b)

Furthermore, in addition to H1N1 being characterized as a global threat, the WHO also suggests that the pandemic itself was the result of globalization. Here it was suggested that globalization increased the potential impact of H1N1 in that

> The world today is more vulnerable to the adverse effects of an influenza pandemic than it was in 1968, when the last pandemic of the previous century began.
>
> (Chan, 11/06/09)

This is because

> The speed and volume of international travel have increased to an astonishing degree . . . The radically increased interdependence of countries amplifies the potential for economic disruption [caused by pandemic disease].
>
> (Chan, 11/06/09)

In this way the notion of globalization was prevalent and was referred to in the texts in order to convey both risk and an understanding of the need for cooperation.

Characterizations of the globalized nature of the threat also occurred through the WHO's linking of H1N1 with other global disasters, notably the 2008/2009 global financial crisis. In analogy to that crisis, H1N1 was described as 'another global contagion' (Chan, 11/06/09) and it was suggested that

> these crises come at a time of radically increased interdependence among nations, their financial markets, economies, and trade systems. All of these crises are global, and will hit developing countries and vulnerable populations the hardest. All threaten to leave this world even more dangerously out of balance.
>
> (Chan, 11/06/09)

In this way the idea of global interconnectedness was used to reinforce the notion that H1N1 could hold significant implications worldwide – and this global nature in itself characterized the virus as a risk.

Moreover, infectious disease threats in general were represented as highly globalized. The fear of an influenza pandemic was therefore (at least partially) represented as a consequence of a fear of globalized threats. Past global infectious disease threats were invoked by the WHO in relation to H1N1, and with regard to consequences of such global threats:

> What the SARS and avian influenza epidemics both showed is that when this new kind of threat can appear, they can threaten large numbers of countries in many different ways, not just the disease, but the fear these diseases can have effects on economies, on societies, and . . . the world is really interconnected at many different levels . . . And so these new emerging infectious disease threats are truly international and global [in] scope.
>
> (Fukuda, 28/04/09)

This statement shows the strong link between H1N1 and globalization. The idea of global spread is key to the risk surrounding the pandemic, an event which mirrors the fear and distrust surrounding the process of globalization itself (Bauman, 1999; Beck, 1992).

In this way the H1N1 threat was clearly characterized within discourses of globalization. This understanding of H1N1 as a globalized threat was fundamental to the characterization of management and the roles of various key actors within the global public health structure. The WHO's reaction was underpinned by these understandings of globalized risk.

The role of the WHO

At key points in its history, the WHO has led, reflected or adjusted to changes in the wider structuring of public health (Brown et al., 2006). The recently changing context of public health necessarily resulted in shifting governance structures, including shifts in the structures and practices of the WHO. In fact, the rise of the global public health paradigm was deeply influential in the institutional arrangement of the WHO. Principally, the WHO's structures changed as a reaction to the appearance of new players in the global health arena (Kickbusch & de Leeuw, 1999; Maguire & Hardy, 2006; Szlezak et al.,

2010; Taylor, 2005). Prior to the late 1990s, the WHO had been recognized unquestioningly as the leader of international health. However, by 1998, it was seen as an organization in crisis (Brown et al., 2006). The dominance of global health had resulted in the diminishing of the WHO's status. New actors, such as private corporations and global NGOs, had risen up and implicitly challenged the WHO's authority over the management of public health policy and its actions (Brown et al., 2006; Szlezak et al., 2010). As a reaction to this, the WHO began to change its role to suit the new global health environment. Instead of presenting itself as a key decision-making body, it began to reconstruct itself into the role of coordinator and strategic planner. This is clearly evident (below) in the WHO's narratives of its own role and actions.

The tension between globalization as a lived reality and its governance is clear in this case study. The erosion of the jurisdiction of the nation state, and the rise of health problems which transgress national boundaries, left authority over public health increasingly ambiguous (Szlezak et al., 2010; Taylor, 2005). This tension has given rise to new institutional forms, including shifts in the WHO's own structures. Some commentators have suggested that we are currently experiencing a flux in institutional arrangements, as the management system transitions into a more authentic 'global health' situation (Szlezak et al., 2010). The H1N1 example appears to indicate that this is indeed the case since part of the WHO's difficulty with regard to the pandemic was the ambiguity of its new role. Currently, public transnational organizations such as the WHO serve as mechanisms for the facilitation of multilateral cooperation and action (Taylor, 2005). This allows for the WHO to negotiate arrangements between diverse stakeholders and to facilitate global action. In this way it has shifted from an authoritative force to acting increasingly as a coordinating body. Its ability to fulfil a directive leadership role had been based upon the political support of its member states (and especially those that supply the bulk of the funding) in the international health paradigm (Taylor, 2005). In the context of global health, the input and effect of increasing non-state actors has diluted this initial mandate.

The WHO now perceives itself as primarily concerned with the coordination and facilitation of dialogue among various global public policy networks, which include not only state actors but also corporations, NGOs and other elements of civil society. Thus, although some authors have suggested that increasing interdependence strengthens the role of organizations such as the WHO (particularly due to their perceived

neutrality) (Taylor, 2005; Walt, 1988), there has been an overall weakening of authority which has relegated the organization to a 'facilitator' rather than a leadership position. The rise of authority in global public-private partnerships (and the effective exclusion of the WHO as a determining force in some of these) has distanced the influence of the organization (Buse & Walt, 2000; Kickbusch & de Leeuw, 1999; Szlezak et al., 2010; Taylor, 2005). In this way, diverse actors within global health, including in this case pharmaceutical corporations, are treated as 'partners' in accordance with the new paradigm (Buse & Walt, 2000; Ollila, 2005), and this is evident in the WHO's narratives of such actors (refer to the depiction of vaccine manufacturers in Chapter 5).

Within this new structure, the WHO has put itself forward as responsible for managing and disseminating public health information, and organizing global partners during times of crisis. These assumed roles within global health have been specified and strengthened in the revised 2005 International Health Regulations (IHRs). These specify the legal obligations of both the WHO and its member states in relation to the management of public health. The 2005 version reflects a shift towards global health through the recognition of the erosion of state sovereignty in this area, and an increase of the jurisdiction of the WHO in its 'coordinator' capacity (Baker & Fidler, 2006; Mack, 2006/2007). This came in the form of an emphasis on global surveillance, where states are now under an obligation to notify the organization of all events which may constitute a global health problem (Baker & Fidler, 2006). The WHO is then responsible for organizing the reaction to this reporting. In this way it has positioned itself as the primary coordinating global health body. This presumed role within the new global health system is evident throughout its references to its own actions.

The new structuring of the WHO as a result of the rise of global health is evident in the management of H1N1. Fundamentally, the WHO depicted itself as contributing to global health primarily through coordinating diverse public health organizations and governments. Its self-adopted role was thus to coordinate global efforts against disease – coordination and assistance were emphasized as opposed to delivering recommendations or engaging in direct action. This distinction was illustrated throughout the texts in suggestions such as those below:

> this is a time in which we can work with countries to be as prepared as possible. That is the bottom line. Our bottom line is that there

> are things that countries can do, that we can help them with, to get them prepared for this kind of potential increase in people getting sick. And this is why we are so serious about this event.
>
> (Fukuda, 07/05/09)

This quote suggests that the role of the WHO was to assist countries in preparation, not to make decisions in and of themselves. This is evidenced again below:

> This is one of the core areas where WHO typically spends a lot of its efforts, trying to identify from country to country [their capacities and resources], what are the needs there, and then to bring together the international community. So this may mean working with donors, it means working with technical partners. It means working with all of those different entities out there that can provide help – UN organization sisters and so on.
>
> (Ben Embarek, 04/05/09)

> and say what is most important, the most important things are that, countries are as prepared as possible. This is a single most important action and this is a single biggest help that WHO can provide to countries.
>
> (Fukuda, 02/05/09)

These quotes emphasize the importance placed by the WHO upon coordination and information-gathering rather than in action. The adherence to principles of global public health is thus clear. They also show that the countries, not the WHO, are liable for the implementation of protective measures.

The role of coordination is also apparent in the WHO's narratives of pharmaceutical corporations and other private-sector actors. Instead of managing these actors, or providing direction to them, the organization presents itself as simply bringing the stakeholders together:

> A third parallel process related to vaccines is very close contact between WHO and other public health agencies and with the private sector, with the manufacturers out there. One of the things we are simply trying to do is that in this kind of extraordinary situation, make sure that the public sector and private sector are very well coordinated. So that they understand what are the priorities for the public health side and we understand what are the priorities and realities for

> the private sector, for the manufacturers. This is where there really has been an extensive amount of discussion and collaborate work between vaccine manufacturers and public health.
>
> (Fukuda, 22/05/09)

This narrative suggests that coordinating (not instructing) these actors is the primary goal, emphasizing the 'partnership' nature of global public health.

However, although the purely coordinating role was held as ideal, it was not consistent in the discussion of all contexts. At a few particular points the WHO presented itself instead as a vital actor and decision-maker. For instance, in narrating the general mobilization in reaction to H1N1, it portrayed itself as the responsible actor in the face of global emergencies. For example, in one reference to the morale of staff during the development of the H1N1 threat it was stated:

> Now, having said all that we are tired, the odd loud word is said, but what we have is had lots of practice unfortunately, with SARS, with tsunamis, with major responses to epidemics. We vaccinate millions of people every year in response to meningitis epidemics, we can move millions of vaccines and we can mount mass campaigns to vaccinate people, we can contain outbreaks of Ebola in the rain forest. . . . In SARS we got very tired and many of us appeared to have reached burn-out, this time we intend to be able to maintain this pace for as long as is necessary to provide our public service to our Member States and to communities.
>
> (Ryan, 02/05/09)

Here the WHO is forcefully portrayed as an important and active agent in managing health crises. This is presented again here, where it was asserted that:

> this is our business really, and WHO mobilizes to handle sudden emergencies. We do this very often, whether this is Ebola (haemorrhagic fever) in Africa or the Tsunami spread over a very wide area. Some countries fortunately can deal with a crisis once in a century. As Mike pointed out we [the WHO] deal with 250 events a year. And that isn't just reporting an event, that is responding to an event.
>
> (Ryan, 02/05/09)

In total:

> In a sense really being prepared for public health issues is a never ending job. Because the diseases change, the scope of the problem changes, the world changes and public health has to keep up with it. The bottom line message is that the kinds of dangers we face are changing in the modern world. Of course public health has to change to keep up with it. It is a kind of dog race.
>
> (Fukuda, 07/05/09)

The organization's perception of itself as actively working in a struggle against infectious disease (more synonymous with its previous, more central role within structures of international health) was presented here. However, in general the 'active' potential of the WHO was rarely emphasized.

References to itself as an active decision-making agent were rare in the organization's texts. Instead, in general, the WHO minimized any suggestion of responsibility for the events. In this regard, the case of vaccines is again pertinent. It can be argued that the WHO is the primary agency for making decisions regarding which vaccines are manufactured and which viral strains are focused upon. This is because it monitors and releases data about which strains are prevalent and are considered potential threats. However, this responsibility for vaccine manufacture was not acknowledged by the WHO in the case of H1N1. Instead, the lack of authority over the use and implementation of vaccines was constantly emphasized (even before their use had been widely criticized). The WHO positioned itself as a source of information rather than advice. This is a pivotal distinction. It demonstrates a key aspect of the global health paradigm – responsibility (like risk) is spread across a multitude of actors and stakeholders, including the WHO and national governments, but also the media and industry. This dissemination and diminishing of ultimate responsibility was emphasized in the WHO's texts.

Instead of making decisions, the WHO considered itself as primarily providing information. This position was highlighted by statements such as the following:

> I think that the job of public health is really to alert the public when there are significant dangers to which they may be exposed and then also to identify the options and the things that people can do to protect themselves against that danger. For example, with the pandemic situation, getting useful information, accurate information out to the

> populations is one of the basic jobs to public health and this is both true for national groups as well as for WHO.
>
> (Fukuda, 17/12/09)

This quote provides a clear indication of the role that the WHO has adopted. As with the management of most risks (as suggested by Beck, 1992, 1999), information is socially perceived to be crucial to harm minimization, and the WHO positioned itself as a critical organization in the management of globalized risks by suggesting that it provides access to vital information.

The global health paradigm was emphasized through the organization's allusions to the collaborative nature of risk management. In addition to coordinating other public health bodies, the WHO's actions were depicted as a result of these multiple perspectives. Thus, for example, although the director-general appeared to take responsibility when she suggested that 'The decision to declare an influenza pandemic will fall on my shoulders [and] I can assure you, I will take this decision with utmost care and responsibility' (Chan, 08/05/09), there is also a distinct sense in which the position of the WHO was dependent upon the actions of member states and other stakeholders, such as pharmaceutical corporations. In this way, Chan simultaneously asserted that she 'will follow your [national health official's] instructions carefully . . . in discharging my duties and responsibilities to Member States.' Furthermore, the input of multiple partners was emphasized. For example, in announcing the decision to call a pandemic, Chan suggested that the organization had 'conferred with leading influenza experts, virologists, and public health officials' (Chan, 11/06/09). This impression of the WHO's actions as being dependent upon and a result of the input of multiple individuals, governments and organizations was clearly distinct from the narratives of critics and commentators more generally, who tended to portray the WHO as solely responsible for making the decision to call a pandemic and dictating reaction. It also lends to the primacy of the globalized public health paradigm, which constructs reactions to global health threats as interdependent upon the actions of multiple stakeholders.

As a whole, the importance of global public health was reinforced throughout the texts. The notion that public health is a neglected area was also often highlighted. Thus it was suggested that

> Time and again, health is a peripheral issue when the policies that shape the world are set. When health policies clash with prospects

> of economic gain, economic interests trump health concerns time and again. Time and again, health bears the brunt of short-sighted narrowly focused policies made in other sectors.
>
> (Chan, 11/06/09)

And furthermore:

> All [of the present global crises] will show the consequences of decades of failure to invest in health systems, decades off failure to consider the importance of equity, and decades of blind faith that mere economic growth is the be-all, end-all, cure-for-all. It is not.
>
> (Chan, 11/06/09)

In this way the WHO perceived its handling of the H1N1 pandemic as critical both to producing increased attention to public health and to managing perceptions of its own institutional relevance. Chan suggested that 'How we manage this situation can be an investment case for public health' (Chan, 11/06/09). The H1N1 pandemic was therefore perceived as pivotal to the wider perception of global public health and the role of the WHO.

The WHO narrated its role, then, as being a champion in the cause of global public health and a coordinating body within these structures. Critically, this served as a measure to diffuse responsibility across multiple actors, as the WHO was depicted as coordinating actors rather than an organization which presented edicts that determined action. This role signifies the shift in global health, where globalized cooperation is understood as the mechanism through which global risks should be managed.

Globalization and cooperation

The shift towards global health carried important consequences for the structuring of public health actions. The increased emphasis upon coordination and cooperation was central to the WHO's discourse of health management. The United Nations system as a whole began to collaborate increasingly with private interests towards the end of the 20th century for a variety of practical and political reasons (Ollila, 2005). Combined with the discourse of global health, this meant that the nature of public health shifted radically, with the rise of global public-private partnerships (GPPPs). These denoted a shift away from nation-based policy-making towards the increasing collaboration of

private partners (Buse & Walt, 2000; Janes & Corbett, 2009; Ollila, 2005). The traditional actors within public health – the WHO and nation states – were thereby being joined (and challenged) by a growing number of elements within civil society (including NGOs, corporations and religious groups) (Reinicke, 1999; Szlezak et al., 2010). In fulfilling its role of coordinating body, the WHO must emphasize the continued potential for cooperation between these diverse actors. It is clear that GPPPs reflect an increasing interdependence between a variety of state and non-state actors. Furthermore, there are changing relationships between the actors, such that the formal and informal norms and expectations have become vague (Szlezak et al., 2010). This has created challenges for the WHO in terms of coordination. One way in which the WHO had attempted to negotiate this was through its discursive practice, constructing the problem in such as way was to render it manageable. In the case of H1N1, the organization repeatedly insisted on the importance of partnerships and cooperation in the conduct of public health policy.

The WHO's texts strongly suggested that the reaction to the threat must be a global one. Corresponding to the discourse of global public health, it was asserted that the threat of H1N1 affected all nations and, furthermore, that the reaction to the threat should be multi-institutional and cooperative. Thus, in keeping with the proposed universal nature of the threat, the concept of 'global solidarity' was key to the WHO's depiction of necessary action against H1N1. It was emphasized that 'An influenza pandemic is a global event that calls for global solidarity' (Chan, 04/05/09) and that

> An influenza pandemic is an extreme expression of the need for solidarity before a shared threat . . . As I said, an influenza pandemic is an extreme expression of the need for global solidarity. We are all in this together. And we will all get through this, together.
>
> (Chan, 11/06/09)

The suggestion that 'we are all in this together' was characteristic of the WHO's depiction of the necessary global reaction to H1N1. In this way, the notion of worldwide vulnerability and the importance of global cooperation was often emphasized through the WHO's account.

The specific term 'global solidarity' was heavily utilized, particularly throughout the director-general's speeches (indicating the organization's most important and public announcements). It was suggested that 'All countries profit from this expression of solidarity' (Chan, 18/05/09),

and the idea of working in cooperation was emphasized throughout. The following quotes illustrate the strong discursive use of the concept of solidarity:

> Above all, this is an opportunity for global solidarity as we look for responses and solutions that benefit all countries, all of humanity. After all, it is really all of humanity that is under threat during a pandemic.
>
> (Chan, 29/04/09)

And:

> Constant, random mutation is the survival mechanism of the microbial world. Like all influenza viruses, H1N1 has the advantage of surprise on its side . . . We have another advantage on our side . . . collaboration and solidarity.
>
> (Chan, 17/08/09)

As these extracts suggest, though the H1N1 virus was depicted as capable of significant disruption and harm, the notions of a common humanity and 'working together' against the virus was invoked as an important protective mechanism. In accordance with its coordinating role within global public health, the WHO emphasized cooperation between actors as a means by which to combat the pandemic.

Mirroring ideas about globalization and global health, it was asserted by the WHO that global cooperation was a key to managing infectious disease threats. Examples of cooperation were celebrated:

> I would like to say that we have seen, if you compare this to previous events, we have seen a remarkable amount of openness and transparency and cooperation between countries.
>
> (Ryan, 02/05/09)

In this way the WHO narrative stressed the importance of global collaboration, mirroring the emphasis of global public health. Thus

> Calling a pandemic is also a signal to the international community. This is a time where the world's countries, rich or poor, big or small, must come together in the name of global solidarity to make sure that no countries because of poor resources, no countries' people should be left behind without help.
>
> (Chan, 11/06/09)

This emphasis helped to sustain the WHO's role as coordinator of global public health efforts and o provide continued meaning to its work, despite its loss of authority and its previous standing within international health.

Both the WHO's characterizations of H1N1 and reactions to the disease emphasized the concept of global public health. The WHO represented itself as a coordinating body which provided a source of global information. With regard to its narrative and practice of global public health, the practical implications of the blurring of the roles of various stakeholders were evident. A good illustration of these implications was the organization's reaction to pharmaceutical manufacturers. The 'global' and cooperative nature of vaccine manufacture was emphasized in the WHO's accounts. For example, it was suggested that

> Development of these actions each involved working with a range of global partners, and this is a general principle that we follow at WHO: to be as inclusive as possible. One of the specific actions taken by WHO was to focus on vaccines.
>
> (Fukuda, 03/12/09)

> making and distributing and administering the pandemic flu vaccine was going to be very complex, difficult and time-consuming task. So from the outset it was clear that we would have to be working with multiple partners, both in the public and private sectors . . . Given these considerations, we did move quickly to mobilize these global partners.
>
> (Fukuda, 03/12/09)

As these quotes show, allusion to global cooperation was one way in which the WHO upheld its vaccination strategy. The role of vaccine manufacturers in this collaborative context was emphasized thus:

> this is one of the key ways in which the public sector and the private sector work together on global health problems. This kind of collaboration is really essential for dealing with a disease like influenza because the information comes from countries through their monitoring and assessment activities and then the vaccines come from the private sector because that is where the manufacturing capabilities are. What we try to do is facilitate and make this process as effective as possible.
>
> (Fukuda, 11/02/10)

> . . . maintaining and engaging the private manufacturing sector has been a very critical step, again, because this group has the unique and essential role in the vaccine manufacturing process . . . . In the first place it's the private sector which makes vaccines . . . Also, this group that has really a unique expertise and knowledge of vaccines because of their manufacturing of the vaccines, it's essential for public health really to act on this kind of knowledge and know-how . . . .
>
> (Fukuda, 03/12/09)

These quotes illustrate a variety of ways in which the WHO narrated the use of pharmaceuticals. These included emphasis upon the 'expertise' and 'knowledge' of corporations in this area and the designation of the private sector as 'partners' in an 'inclusive' manner. This worked to characterize the WHO's role as one of facilitation, distancing perceptions of the organization as the sole responsible actor. These narratives all fit in with the global public health paradigm, which focuses not just on the WHO and nation states but on other global actors, including corporations.

The global public health paradigm and the association of the pandemic with the process of globalization therefore had a strong effect upon the way in which descriptions and reactions to H1N1 were mobilized. In accordance with the new global health, the WHO positioned itself as a coordinating agent. Multiple institutions were therefore conceptualized as partners in the efforts against H1N1. More generally in reference to globalization, a global and coordinated (rather than national) effort was characterized as pivotal.

The relationship of the WHO with national governments

The emphasis on 'solidarity' and treating all actors as 'partners' had important flow-on consequences. One key effect of globalization, and the shift towards global public health, is the changing role of the state. Generally, a significant trend of the globalization process is the increasing influence of supranational organizations (Bauman, 1998). Public health in the West had historically been associated with the needs of national security and commerce, where health policy was based upon the assumption that national governments could control what occurs within their own borders (Bashford, 2002; Bashford & Strange, 2003; Bauman, 1998; King, 2002). However, the globalized nature of infectious disease spread diminishes state capacity to internally manage public health (Kickbusch & de Leeuw, 1999). The present 'global' nature of

public health therefore represents a subversion of state jurisdiction. Though the degree to which the state is threatened remains a subject of intense debate within sociology (Lee, 2003), the reality of contemporary infectious disease does suggest significant erosions in territorial power by restricting the policy-making capacity of governments (Fidler, 2001; Szlezak et al., 2010; Taylor, 2005).

Global health governance is primarily concerned with facilitating multilateral cooperation among nation states and non-state actors (Taylor, 2005). However, importantly, while health appears to be necessarily an area for global action, due in large part to its interrelation with security, it remains a policy and management area which nation states protectively guard (Kickbusch & de Leeuw, 1999). There is therefore a tension between the global nature of infectious disease spread and the desire of national governments to control health. In terms of the WHO's characterization of H1N1 and suggested preparatory actions, this retention of state sovereignty over health has led to uneven implementation of global policy. While globalization and global health tends to weaken the role of the nation state, national governments are ultimately responsible for the implementation of global policy into domestic law and action. The tension between state and the WHO's accounts was therefore clear, and evident in the texts in several instances. Foremost was the critique made by the Council of Europe. However, the tension was also evident within the WHO's own accounts of the H1N1 pandemic.

Globalized public health has led to significant implications surrounding the relationship of the WHO with its member states. As demonstrated throughout this chapter, the WHO positioned itself as an institution that was concerned with collecting and disseminating information rather than providing decisions which determined actions. This was evidenced most starkly in the relationship of the organization with national governments. In several areas the WHO suggested that it acted as a source of information and not action. For example, in explaining of the utility of the Pandemic Alert Phases, it was suggested that

> This entire planning process was really initiated to help countries develop their preparations as much as possible so that in the advent of a pandemic they would be better off than they would be without the process. So the pandemic Phases are really a planning tool for countries and a way to alert them that there is a situation that they need to be aware of and as a tool to make sure that they understand as

> we go into different Phases, there are different actions which should be considered by them and some of them which should be taken.
>
> (Fukuda, 22/05/09)

Here the phases were characterized as a planning tool which provided information to member states, as opposed to concrete statements of action. Again, in the context of characterizing the H1N1 threat, it was stated that

> Basically we have this list of indicators and we use them to assess, first the disease itself, and help countries to assess their own vulnerability. Rather than a guidance, I would say, it is more a concept paper plus some operational tools to make best use of the information we have and to better support countries in planning.
>
> (Fukuda, 13/05/09)

Again, the WHO provides information but the national governments act. On the whole, the WHO did not consider itself to be in a position to offer recommendations to individual countries, but rather suggested that it acted as a source of global information. Governments themselves could choose (how) to act on this information. On one level, this was justified by the WHO's argument that it focused upon the global condition of the threat, and therefore that national governments must assess individual national responses. Thus, for example, with regard to severity (made when the concept was still utilized), it was asserted that

> Severity can be taken in two dimensions: at the global level, that is what WHO is doing, we are reviewing the situation in different countries within the World Health Organization, and we give a global assessment. But we would encourage each country to look at their own situation to make a national assessment on severity; and in continental countries – big countries – they may even consider looking at what would be the severity at sub-national level.
>
> (Chan, 11/06/09)

And again:

> There are different local risks and there are different global risks, so each individual event must be assessed in its own merits and we will be assisting countries with the advice they need to make those decisions.
>
> (Ryan, 02/05/09)

Thus, by positioning itself as a global body, the WHO's responsibility for local actions was absolved. As the quote above clearly suggests, for the organization it was the countries themselves which make decisions in terms of monitoring, risk assessment and ultimate action.

The WHO thus emphasized the independence of national governments in forming reactions to the threat. In some instances throughout the texts, this was stated explicitly. For example, it was suggested that

> governments do not necessarily wait for WHO to make recommendations before they do anything and in fact many governments are very proactively working on the situation now . . . On the other hand, I know that many governments are also looking at what their plans are if the situation escalates and what possible actions they may take. So I think the governments are being very active right now and they are certainly not being passive. Nonetheless, I think they are looking to WHO for guidance . . .
>
> (Fukuda, 26/04/09)

As this quote suggested, the organization depicted itself as providing evidence, and to some extent 'guidance', whereas the governments themselves were portrayed as being responsible for decision-making. The emphasis, then, was upon the autonomy of individual nations to make choices for their citizens. Thus, for example, in response to a question regarding the vaccination of entire populations and whether the WHO would 'think it realistic and do you suggest to [other] governments that they should do the same . . . ' (Keiny, 06/08/09), the representative answered in terms of the individual country's autonomy:

> Some countries have decided to vaccinate their whole population – there is no indication that this would be unsafe so it is again a strategy of a country to protect its population against influenza pandemic. Not all countries which could have access to enough vaccine have chosen to do this, again it is . . . the country's choice . . . the choice of a population to be vaccinated is a national prerogative and each country will have to take this decision in view of their own epidemiological and national characteristics.
>
> (Fukuda, 24/09/09)

There was tension, then, between a global health paradigm (coordinated by the WHO) and an international health paradigm (managed

by individual nation states). The international health paradigm rests upon the protective actions of nation states, whereas the global health paradigm rests upon globalized cooperative action. While the WHO narratives emphasize the important of globalized action, in practice the onus of decision-making is still constructed as a national-level event, and the organization actively distanced itself from decision-making. This shows that the roles of the diverse actors within global health remain in flux.

Furthermore, the distancing of the WHO from the actions of nation states resulted in an important unintended corollary – that is, that the organization did not perceive itself to be responsible for the actions of nations and, furthermore, suggested that it was not in a position to scrutinize the actions of state governments. For example, it was asserted by the WHO that

> Earlier on in this series of press conferences, I said that one of the things I didn't want to do is comment on a particular action being taken by any one country . . . There are very difficult issues for national authorities to weigh. I think it is a little bit hard from outside, simply to say: these are good or bad actions. They are very difficult actions . . . because of on the other hand it turns out many people are very severely ill and they were not jumping on it early, they will also be criticized. I will just stop here and say that these are very difficult issues that the governments wrestle with and of course they try to make the best decisions that they can, given the information they have.
>
> (Fukuda, 07/05/09)

It is clear from this quote that the WHO did not wish to portray itself as being accountable for the results of management decisions. It depicted itself as responsible only for providing information and facilitating dialogue. This statement shows that it attempted to distance itself from national action, even though criticism from the member states and the Council of Europe cited the WHO as the responsible agent.

This detached response to the actions of governments can also be illustrated in specific examples. One was the actions of the Norwegian government, which early on had made the anti-viral oseltamivir available over the counter. The dominant infectious disease perspective on anti-viral use suggests that overusage can directly result in anti-viral resistance (Hayden, 2006; Patel & Gorman, 2009). However, the WHO did not criticize this action, even though it could have had

widespread (global) consequences which could be reasonably argued to be part of the organization's jurisdiction. Here it was suggested that

> we have been in close contact with the Norwegian authorities both to find out about the situation in the country and to discuss whether there is anything that WHO can offer them. One of the interesting things which the Norwegians are doing is to make antiviral drugs more easily available for a limited period of time. The reasons they are doing this is that the stress on the primary health care system is quite high . . .
>
> (Fukuda, 05/11/09)

In this statement, a conciliatory tone is evident and it was clear that the representative had sought to evade any evaluation of the Norwegian government's actions. In other instances, with regard to allegations of favouritism, misinformation or misbehaviour on the part of national governments, the representatives again remained distant in their observations. For example, in response to a question about inaccurate reporting:

> We think that the national health authorities do report accurately to the WHO. As I am sure you know, to confirm a death has been caused by H1N1 needs some confirmation and therefore we may receive it a little bit later but we are confident that the reporting that we get is what is really happening.
>
> (Kieny, 19/11/09)

Here the detached tone which the WHO adopted in relation to the actions of national governments was again evident. Likewise, with regard to the question of whether there might have been bias in vaccine distribution in some countries, it was answered: 'We hope not! The governments are usually very responsible for that' (Fukuda, 25/09/09).

In this way the WHO's narrative placed the burden of responsibility primarily upon individual nations, and portrayed itself as a source of (objective/scientific) information and a facilitator/mediator of the different stakeholders present in the global public health arena. This served to distance responsibility from the WHO. However, blame for mismanagement was placed on the organization regardless, as seen in the narrative of the Council of Europe. The combination of these depictions shows that the role of actors within global public health was yet

to be consolidated, a factor which contributed to the instability of the H1N1 construct.

Developing countries

The boundaries of authority surrounding the management of H1N1 were indistinct. Although the interdependent and cooperative nature of global health can serve to eradicate boundaries, one of the inherent contradictions of globalization is that it blurs but can also reinforce borders (Bashford & Strange, 2003; Woodward & Smith, 2003). The way in which pandemics spread across previously spatially defined borders is evidence of the blurring effect. However, the definition of space and the maintenance of boundaries are often fundamental to long-held social mores, and boundaries can be strongly protected (Bashford & Strange, 2003). This is evidenced not only in the division of authority between the governments and the WHO but also in the reaction of developed world governments to the developing world. In the case of H1N1, the WHO found that it needed to defend the rights and actions of developing nations. This was particularly evident with respect to discourses of isolation and quarantine. The wider problem of pandemic management reflects contradictions between the ideal of global cooperation and the tendency to reinforce boundaries between the developed and developing worlds.

It is important to note here that public health priorities often reflect the concerns of the wealthy (Ollila, 2005). In this case the advent of a global pandemic would rate as a priority for the West whereas the developing world faces more pressing immediate concerns (despite the fact that a pandemic would affect the developing world, with its lack of health infrastructure, disproportionately). Simultaneously, infectious disease problems are often perceived as originating from the developing world. Fundamental to these perceptions are what King (2002) refers to as the 'emerging disease worldview'. This has arisen in the West and narrates the link between the developed and the developing world through the experience of infectious disease. Here the subjective perception of globalized interdependence is linked with moral narratives locating disease in the Third World to construct a discourse which suggests that the West is increasingly susceptible to infectious disease threats which originated in developing countries (King, 2002). The tendency to see H1N1 as located and arising from the developing world is evident in the WHO's texts, where the organization counsels developed nations against taking drastic actions against (the citizens of) developing countries.

Though the blaming of the developing world is in itself an important aspect of the sociology of infectious disease (Abeysinghe & White, 2011; Bashford, 2002; Foege, 1991; Nelkin & Gilman, 1991), the exploration of this area is not within the scope of this book. What is important in the context of the present discussion is the way in which the WHO managed this blaming. Historically, the WHO has portrayed itself as a champion of the interests of developing nations, and this was also evident in the case of H1N1. It should be noted here that while globalized diseases have the power to affect all nations, some are unequally impacted. Thus the director-general stated that 'It is my duty to help ensure that people are not left unaided simply because of the place where they were born' (Chan, 04/05/09) and she strongly urged wealthy nations to 'look closely at anything and everything we can do, collectively, to protect developing countries from, once again, bearing the brunt of contagion' (Chan, 11/06/09).

Throughout the texts, the representatives emphasized 'the absolute need to extend preparedness and mitigation measures to the developing world' (Chan, 11/06/09) in part because of the unequal impact that pandemic influenza might have under the health conditions found in such regions. Thus it was stated that

> Although the pandemic appears to have moderate severity in comparatively well-off countries, it is prudent to anticipate a bleaker picture as the virus spreads to areas with limited resources, poor health care, and a high prevalence of underlying health conditions.
>
> (Chan, 17/06/09)

As 'we do not know how this virus will behave under conditions typically found in the developing world' (Chan, 17/06/09), the WHO emphasized its potential effect upon developing nations. Again, the notion of variable global severity is highlighted here. Furthermore, the image of the WHO as the protector of developing nation's interests coincided with its wider public goals.

One of the WHO's fundamental goals was to attempt to ensure equitable health outcomes. Where developing countries were referred to, the representatives emphasized the responsibility of the WHO in reducing the vulnerability of these populations. Thus

> One of the important tasks at this point is to anticipate that the needs of countries if we go into that situation. In particular, what we are really focusing on, or beginning to focus on, is the anticipated

> needs of developing countries if the pandemic should develop and if these countries get impacted. We know from history, we know from the analysis of past pandemics, and we also know from many infectious disease and health problems that the poorer and the developing countries are the ones who really get hit the hardest.
>
> (Fukuda, 28/04/09)

Furthermore,

> certainly some developing countries are more vulnerable in a sense that they have a high proportion that is malnourished and that are probably, is more, let us say, fragile for this particular disease.
>
> (Fukuda, 13/05/09)

In this way, though it is arguable that the 2009 H1N1 strain had not placed a huge health burden on affluent nations (and could be reasonably referred to as mild), the global perspective of the WHO might justify its concern over the disease to some extent. The organization argued that it was difficult to predict how the spread of the virus would impact upon developing nations. For example, it asserted that

> perhaps of greatest concern, we do not know how this virus will behave under conditions typically found in the developing world. To date, the vast majority of cases have been detected and investigated in comparatively well-off countries.
>
> (Chan, 11/06/09)

And:

> Although the pandemic appears to have moderate severity in comparatively well-off countries, it is prudent to anticipate a bleaker picture as the virus spreads to areas with limited resources, poor health care, and a high prevalence of underlying medical problems.
>
> (Chan, 11/06/09)

In this way, although critics in affluent nations may have disparaged the actions of the WHO, from the perspective of global health, and particularly the health of developing countries, it was arguable that the H1N1 strain may have caused a dramatic impact in poorly resourced areas.

In contrast with other sources of public discourse, which can tend to situate developing nations as scapegoats for the spread of disease,

the WHO's perspective described such nations in the context of profound inequalities. Its advocacy of the interests of developing countries was evident in the discussion of vaccines and anti-virals. Here it was noted that

> in total [the] WHO's global stockpile [is] up to 10 million treatment courses . . . But we don't think that this is enough to meet the needs of the countries. So we have been working with partners and also with other countries who have enough supplies to meet the global need.
>
> (Shindo, 12/11/09)

Thus the 'WHO is really trying to ensure that all countries, including developing countries, will have access to vaccines' (Kieny, 06/08/09). Overall, the question of equity was thus central to the WHO's reaction. With regard to this it was acknowledged that vaccines would not be fairly distributed:

> Who will get the vaccine? Well, of course the first countries to receive the vaccines will be two categories of countries. First are the rich countries, with a high income. These are the ones which have already at the beginning even before the pandemic started, purchase agreements with manufacturers . . . The other type of country to be served very early with the vaccines is the countries that they do not have to be rich, but to have domestic production [e.g. China, which at this point in time had already started mass vaccination campaigns].
>
> (Fukuda, 24/09/09)

Thus 'a final point that I want to make about vaccines is that we are in a situation in which some countries have vaccine available and other countries do not' (Fukuda, 05/11/09). As such, the WHO asserted that it coordinated with manufacturers and more affluent nations to ensure a more just distribution on a global scale. The representatives suggested that the 'WHO is negotiating with the manufacturers to have access to vaccines for developing countries and this is through donations or purchase at a reduced price . . . ' (Kieny, 06/08/09) and that it was

> in line with this and are discussing with manufacturers about having access to their production capacity . . . on behalf of developing countries we are really striving to make sure that the quantity of the vaccine that WHO will be able to access directly, not talking about

> what these countries negotiate themselves, will cover at least these populations.
>
> (Kieny, 06/08/09)

The question of advocacy on the part of developing nations corresponded to the positioning of the WHO within the wider global health arena. However, this image of the developing world as being burdened by contagion and vulnerable to the actions of the developed world contrasts with dominant portrayals of the developing world as the source of contagion, as presented by developed countries.

'International hostilities'

The actions of developing nations were in fact questioned by media queries to the WHO's representatives. For instance, during the early part of the H1N1 threat (though decreasingly as the event went on) there was considerable fear of travellers from developing countries. It was suggested by governments of developing nations in several cases that they had been subject to discrimination through other nations' disease control measures. For example, as the first cases of H1N1 arose in Mexico, that country quickly became a target of sanctions. The WHO, however, failed to react. For example, one reporter (Eva Ussi, Grupa Radio Centro, Mexico) asserted that

> the influenza virus has already caused international hostilities particularly against Mexico, who have seen how Argentina, Cuba, Ecuador and China have cancelled flights to and from this country. China even went further and kept Mexican businessmen and Mexican tourists, around 70 people, secluded in a hotel. They were not infected, nevertheless they could only return to Mexico on a special flight. Mexicans feel hurt because they were unilaterally stigmatized for being Mexicans. This treatment was not given to the United States or Canada [which at this point also had presented cases]. This attitude actually contradicts the recommendations of the WHO, doesn't it?
>
> (Fukuda, 06/05/09)

To which it was answered that

> countries can take additional measures, other than those recommended by WHO that they feel might be necessary to respond to a public health risk. However, countries adopting measures that are significantly different and/or interfere with international traffic must

> provide WHO the public health rationale and relevant scientific information for those measures. We have begun the process of getting more information from a number of countries . . . We do remind you that the IHR does require that Member Countries treat travellers with respect for their human rights, dignity and fundamental freedoms.
>
> (Fukuda, 06/05/09)

In a second instance, the reporter (Frank Jordans, Associated Press) stated that 'we have heard a lot about discrimination against people from certain countries because there are outbreaks there' (Briand, 08/05/09), to which it was replied:

> according to the International Health Regulations a country, if it wants to take health measures above and beyond what is recommended by WHO can do so, but it must justify those in public health terms. Often times, WHO will write to a country asking for justification for these measures. We have done that in quite a few instances already, I don't exactly know how many, and we have received responses . . .
>
> (Briand, 08/05/09)

These quotes suggest, as illustrated elsewhere, that the representatives took great care not to engage in discussion regarding the actions of specific nations and only responded with reiterations of the general actions taken by the WHO with regard to such cases. The described role of the organization in upholding the interests of the developing world therefore clashes with the general stance of disinterestedness, as this example illustrates.

The institutional positioning of the WHO was an important factor in the reaction to the perceived threat. The H1N1 pandemic was both a globalized disease and a product of the perception of globalization. The risk was perceived through the understanding of H1N1 as a consequence of the globalized world. Furthermore, both its characterization and its management were dependent upon the WHO as an institution being heavily influenced by the change to a paradigm of global public health. Acting within this paradigm, the WHO demonstrated a strong subscription to its self-construction as a global coordinator. Combined with the emphasis of the global health paradigm upon cooperation between multiple global actors, it had framed itself as the institution responsible for facilitating global cooperation to combat globalized disease threats. The organization depicted itself as providing information to global

actors but not giving direction or creating expectation. It thereby both distanced itself from responsibility and upheld the primacy of global public health. While the WHO continues to depict itself as a champion of the developing world, this non-directive positioning results in an inability to criticize the actions of member states.

The reaction to H1N1 as a whole was therefore informed through an understanding of the impact of the global health paradigm upon the contemporary management of health threats. Due to the fact that the move towards global health has left the roles of key actors in flux, the rise of the global health paradigm contributed to the contestation of H1N1. Here, in addition to the weak construction of the facts of H1N1 (as demonstrated throughout this book), the ambiguity of the roles and responsibilities of key actors within the framework of global health led to a crisis of management. As Chapter 6 demonstrated, nation states understood the WHO as the responsible agent, while (as shown throughout the present chapter) the organization perceived ultimate responsibility as resting upon national governments. This confusion in roles contributed to the unstable management of H1N1.

Another potentially important sociological point with regard to global health is the transparency of the process. The successful construction of a scientific fact requires the erasure not only of ambiguity surrounding the phenomenon but also of the producer. The producers of the fact need to be erased from the representation of the fact so that the process of construction is hidden (Derksen, 2000; Fleck, 1979; Latour & Woolgar, 1979; Lewin, 1994). Along with its other weaknesses, this may be one of the reasons why the WHO's construction of both the pandemic phases and the H1N1 virus came under contestation – the organization made its actions of construction transparent to the member states and the media. The documents analysed in this book are testament to the fact that the WHO provided a detailed discourse of construction, instead of masking its actions and presenting artefacts such as the pandemic phases and H1N1 as incontestable scientific realities. This is partly due to the effect of risk upon the production of scientific research, as articulated by the co-productionist theories, and partly due to the coordinating role of the WHO within global public health. Contemporary science is more likely to be open to public engagement due to the shifting structures of research (Funtowicz & Ravetz, 1993; Jasanoff, 2004b). The WHO was a victim of this open discourse, and this resulted in the deconstruction of its classificatory scheme by outside actors. Its role as being responsible for disseminating information, as prescribed by global public health,

may in fact have rendered the construction of H1N1 more susceptible to critique.

The WHO's depiction of global public health, and its place within it, was fundamental to its reaction to H1N1, and in part its lack of success in relation to public perception of the pandemic. The WHO understood itself as a coordinator but, as evidenced in Chapter 6, it was widely perceived as giving directives for national governments. Furthermore, the WHO understood its role as one of facilitating dialogue and disseminating information, but in reality it was held to be much more responsible for the results of the H1N1 campaign. The ambiguity of the WHO's role within the emerging structures of global public health thereby underpinned the fragility of the construction of H1N1 as a whole.