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The Securitization of Global Health and the threat of Bioterrorism: Could Ebola be Weaponised?

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Abstract

This paper explores the risk of bioterrorism with particular reference to the Ebola virus in Africa considering the active transnational terrorist groups on the continent. Using the statist, globalist and human rights approaches, the paper examines the global right to health and notes the increasing propensity of developed nations to frame Emerging Infectious Diseases, (EIDs) as security threats and consequently focus their response on protecting their national security and economic interests from the spread of these EIDs. The 2014-2015 Ebola Crisis in West Africa illustrates the current state of the global health system with reference to EIDs. This paper considers the perils of this securitized approach to global health, which could potentially provide a slip road for terrorist groups to take advantage of the porous borders and fragile health systems to procure the Ebola virus for bioterrorist purposes in the event of another outbreak in Africa. Considering the ease with which EIDs can spread across borders in today's globalized world, the writer vouches for a collective investment in robust health care systems globally, especially in fragile countries where EID outbreaks easily get out of hand and could fall into the hands of terrorist groups. Ensuring effective public health globally would, after all, benefit all nations, and its dividends would include better health, security and enhanced trade for the entire global community.

Introduction

The accelerated pace of globalization, spurred by increased international trade and growing migration, has blurred sovereign borders more decidedly than ever before in human history. Holm and Sørensen

(as cited in Lia, 2010:18) define globalization as “the intensification of economic, political, social and cultural relations across borders.” The spread of globalization has been greatly helped by both the establishment of global financial markets following the end of the Cold War, as well as the rapid technological developments that have enabled transport and telecommunications industries at the global level (p. 18). The overall outcome has been increased interplay between domestic and foreign affairs (Katz, Kornblet, Arnold, Lief and Fischer, 2011: 504), effectively inclining states towards closer cooperation and a more peaceful coexistence in their shared determination to maintain a state of equilibrium that favours both their domestic and international prospects.

Lia (2010), however, senses a dichotomy in the outcome of globalization, arguing that it has stretched beyond its basal economic underpinnings to straddle the long established cultures of the various peoples of the world. In Lia’s view, globalization has on the one hand created a global culture of sorts, while on the other stoking a backlash of countercultures as exemplified by the resurgence of Islamic militancy and the rise of anti-globalization movements in various parts of the world (p. 19). Some of the groups at the forefront of the anti-globalization drive have adapted terrorist tactics or have gone ahead to fashion themselves into outright terrorist organizations. In his prognosis on the future of terrorism, Lia postulates that incidences of mass-casualty terrorism are likely to remain problematic because the motivations of many actors behind these terrorist groups go beyond a mere disdain for the assault of globalization on their cultures. Lia asserts that a great many of these actors are motivated systemic, multi-level and structural factors, which he summarizes as “an exclusionist and interventionist world order, weak transnational states, non-state actors in global politics, globalization of organized crime, privatization of policing and warfare, Middle East oil dependence, migration and ethnic heterogenization of Western societies, growing information interconnectedness and proliferation of deadly technologies” (Lia, 2010: 187). Lia’s perspective provides an opportunity to

contemplate why the resurgence of mass-scale terrorism has become a significant consequence of globalization.

For a long time, transnational terrorism was associated with the Middle East, Europe and parts of Asia (Davis, 2010: 139). This is not to mean that terrorism is a new phenomenon in Africa. Terrorism has long existed in Africa as well, particularly during the Cold War era and its messy aftermath. Davis (2010) cites the terrorist campaigns of the various armed groups in the Eastern Democratic Republic of Congo (DRC), the warlords in post-Siad Barre Somalia, and rebel groups such as the Revolutionary United Front (RUF) in Sierra Leone and the Lord's Resistance Army (LRA) in Uganda (p. 134). The difference is that while terrorism in Africa was largely domestic in nature—typically meted out by armed groups on civilian populations within their home states for political or other gain—what has changed is that Africa has in recent decades come to play a central role in international terrorism (p. 133).

Lia (2010) forebodes that just as the global theatres of transnational terrorism are likely to keep changing, the trends, patterns and tools of terrorism are similarly likely to keep mutating (p. 187). The use of biological weapons is one possible trend that could emerge from the changing tactics of terror that could occur. Of critical interest is the potential use of Emerging Infectious Diseases (EIDs) such as Ebola in bioterrorism.

One might argue that the notion of organized bioterrorism is far-fetched but considering the presence of the “global health” approach adopted in the 1990s post-Cold War period, states recognized that in the newly globalized world, a consequential health situation in one country could easily impact on another state beyond its borders (Kerouedan, 2013, as cited in Ventura, 2016). The “global health” approach has been cited a lot in the face of EIDs such as HIV-AIDS, Anthrax, Influenza ‘A’ (H1N1),

poliovirus, and more recently, Ebola and Zika. The easy seep of these EIDs beyond national borders has confirmed that infectious diseases pose an existential threat in the epoch of the global village.

The potential ‘weaponization’ of Ebola is of particular concern because all recorded outbreaks of the virus have occurred in African states that are geographically close to countries in which active transnational terrorist groups thrive. Secondly, despite the much-touted interlink between health and foreign policy at the global level, many developed states respond to EID outbreaks from a national security perspective, their priority being to prevent the outbreak from leaving its region of origin. Many African states however lack the robust health facilities required to effectively contain EID outbreaks domestically, and most have porous borders that terrorist groups could easily infiltrate in attempts to obtain the Ebola virus as an addition to their terror arsenals. This article examines the possible ‘weaponization’ of Ebola by terrorists and terrorist groups and the vulnerability in the governance of global health that renders Africa unprepared for a vanguard against the possibility of Ebola bioterrorism.

Current Approaches to Global Health: Statist, Globalist and Human Rights Perspectives

Although the threat posed by EIDs has motivated the international community to develop closer cooperation on health issues at the global level, Katz et al (2011: 504) note that in practice, most developed states tend to frame global health within the context of their national security and trade interests rather than a universal priority in its own right. This framing has somewhat kept the global health agenda on the back burner, subordinate to the national security and economic interests of developed nations (Bustreo and Doeblner, 2010: 54). As such, global health is routinely perceived by foreign policy decision makers in the developed world as a luxury to be addressed only when it does not compete with other “more important” foreign policy priorities (p. 38).

Davies (2010) postulates two broad perspectives on global health within the international system, which she terms the “statist” and “globalist” approaches (p. 1170). In Davies’s theorization, the statist perspective places the state as its principal focus, and considers global health a national security element within the state’s defence and foreign policy (p. 1170). The state only takes action on global health situations that directly affect its economic, political or military interests (pp. 1170-1171). Although such action, when taken, most often involves cooperation at the international level, the statist approach places priority on the national security of the state (pp. 1170-1171). The globalist perspective on the other hand places the health needs of the individual at its core, then, takes into account the role that various global actors and structures can play in addressing matters of global health.

Although the role of the state still remains critical in the globalist perspective, globalists perceive the state as just one among a raft of actors that may include international organizations, multinational corporations and pharmaceutical companies (pp. 1171; 1189). Davies however clarifies that both the statist and globalist approaches perceive EIDs such as HIV-AIDS, Ebola and the Zika Virus as security threats (p. 1189). The key difference between the two paradigms is that while statists tend to rationalize the protection of their citizens and interests by deliberately securitizing certain infectious diseases, globalists consider any infectious disease a problem in its own right, without considering the nationalities of the afflicted populations (p. 1189).

Bustreo and Doebliner (2010) make a cogent case for a human rights approach, which they are convinced will help compel states to make global health a foreign policy imperative (p. 47). Their argument is based on the little-discussed fact that the “right to health” is a well-established concept

within international law, codified in various legally binding documents that have been ratified by most UN and WHO member countries. The concept is explicit in both the Universal Declaration of Human Rights (UDHR) and the WHO Constitution, as well as in various other international covenants and treaties. Article 25 of the (UDHR) states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family...,” and further stresses that this right is particularly of avail “...in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (UN, 1948). The preamble to the WHO Constitution closely affirms that the “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” (WHO, 1946).

These two seminal documents have over time been backed by additional covenants and treaties. Among these are the International Covenant on Economic, Social and Cultural Rights (ICESCR); the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; the International Labour Organization Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries; the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families; and the Convention on the Rights of Persons with Disabilities (Bustreo and Doebliner, 2010: 50-51).

Even the most cursory study of these covenants and treaties confirms that the right to health is well established in international law. Bustreo and Doebliner (2010) further note that developed states are required, under international law, to provide the necessary resources that will ensure the achievement of the right to health both domestically and internationally (p. 52). This obligation is hardly mentioned by politicians, diplomats and foreign policy decision makers, and individual states as such retain the discretion to decide whether or not to take action in global health emergencies (p. 50). The result is

that an estimated 30 percent of the world's population does not have access to life-saving medication (Schroeder, 2013: 205), let alone primary healthcare.

Dealing more specifically with the matter of biological weapons is the 1972 Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their Destruction, better known as the Biological Weapons Convention (BWC) or the Biological and Toxin Weapons Convention (BTWC). The Convention was developed and ratified in Geneva by 175 UN Member States. It was intended to be an important instrument for addressing the proliferation of weapons of mass destruction by prohibiting the "development, production, acquisition, transfer, retention, stockpiling and use of biological and toxin weapons" (UN, 1972). Despite the broad ratification of the Convention, several signatory states continued researching and producing biological agents, even as recently as the 1980s (Lim, Simpson, Kearns and Kramer, 2005: 584). Even worse, recent years have seen an increasing number of non-state (and particularly terrorist) actors attempting to obtain and offensively utilize biological weapons (Lim et al, 2005: 584).

Scholars like Bustreo and Doeblbler appear to suggest that making global health a foreign policy imperative at the global level will help bring the concept of universal health care closer to reality. However, the Westphalian tradition gives states the right to choose their courses of action (or inaction) as rational actors within the anarchical international system. A second challenge is the fact that not all sovereign states have ratified all the international agreements. For instance, the United States, Cuba and South Africa have not ratified the International Covenant on Economic, Social and Cultural Rights and as such have no obligation to fulfil its provisions (Schroeder, 2013: 207).

Who, then, is responsible for ensuring the realization of universal health care? Within the sovereignty paradigm, the provision of health services is naturally the obligation of the state. This is however not automatically possible in the case of fragile states, some of which lack the capacity to provide adequate health systems for their citizens, as was the case of Guinea, Liberia and Sierra Leone during the 2014-2015 Ebola Crisis (Harmon et al, 2015: 6). Schroeder (2013) supports the view that all governments have the obligation to ensure access to adequate health services for their citizens, but asserts that developed countries have the additional obligation of providing international assistance to less endowed countries (p. 206). Over the years, there have also been calls on Non-Governmental Organizations (NGOs), pharmaceutical companies and even the world's highly affluent minority to make a bigger contribution towards global health. Schroeder (2013) singles out and commends the immense role played by NGOs in helping the estimated ten million people who lack access to life-saving medicines, but offers a reminder that the work of health sector NGOs is a voluntary commitment rather a stringent obligation (pp. 211-212).

There have been even more intense demands on the pharmaceutical industry to commit more resources towards global health. For instance, a 1998 editorial in the influential medical journal, *The Lancet*, asserted that while the obligation to improve access to essential medicines lies with the state, the pharmaceutical industry must share this responsibility with the state (The Lancet, 1998). The most explicit demand from the international community came with the adoption of the Millennium Development Goals (MDGs) in 2000. Target E of MDG 8 called on governments “in cooperation with pharmaceutical companies, [to] provide affordable essential drugs in developing countries” (Schroeder, 2013: 212-213). Even though the private sector was generally mentioned in several other MDGs, only the pharmaceutical industry was called upon in such explicit manner (p. 213). Proponents of a broader obligation for the pharmaceuticals, such as Pogge (2001), argue that the

existing international intellectual property rights structure favours the interests of the pharmaceutical industry and the affluent over those of the poor majority (2001: 14). Pogge further postulates that most citizens of developing countries are often disadvantaged right from birth, and have to endure an oppressive life under the rule of governments that are more inclined towards satisfying the interests of powerful foreign agents [such as the pharmaceutical companies and the affluent] (Pogge, 2001, p. 14).

But while the pharmaceutical industry plays an important role in innovating, developing and producing drugs and services that improve the quality of human life (Schroeder (2013: 212), their fundamental profit orientation and the dictates of the free market easily offer them the wherewithal to sidestep this suggested obligation, especially in fragile countries with a low-profit potential. Neither would it be reasonable to count on affluent people to help the less fortunate access the health care they require. Schroeder (2013) points out that the contribution of the affluent is more contingent on beneficence than obligation (pp. 208 - 210).

The foregoing discussion reveals a gap in the commitment of the international community to the provision of robust health care at the global level. This gap, which may appear benign, actually increases the prospect of EID outbreaks getting out of control, or even worse, being used as tools of bioterrorism.

Ebola, Globalization and the Threat of Bioterrorism

Ryan (2008) describes bioterrorism as the calculated release of any biological organism, virus, substance or product with the intention of causing death, disease or other biological malfunction in humans, animals, plants or other living things, in most cases for political or other ends (Ryan, 2008:

276-277). Although various forms of biological arsenal have been utilized in human warfare for millennia, Ryan asserts that only a few infectious pathogens are easy for present-day terrorists to procure and disperse and these include zoonoses such as the Ebola virus (p. 276).

It is unfortunate that the likelihood of bioterrorism has largely been downplayed in contemporary world politics and international security (Henderson, 1998: 488). There was some considerable attention towards the possibility of bioterrorist attack focusing mainly on anthrax and smallpox following the September 11, 2001, attacks by Al Qaeda on the U.S. (p. 489), but the prevailing belief has been that the chances of such an attack are low. Maras and Miranda (2016) caution against this line of thought, reminding the world of the existence of states and non-state actors that would be willing to inflict mass devastation using biological, chemical, nuclear and radiological weapons (p. 73).

A few fairly recent events provide a palpable reminder of the potential scale of devastation that biological weapons could inflict if the world remained unprepared for the possible threat of bioterrorism. One occurred at a Soviet bioweapons facility in 1979, when the accidental release of anthrax in aerosol form led to 66 deaths according to official reports (Henderson, 1998: 491). In 1995, Iraq admitted to having produced and deployed weapons containing anthrax and *botulinum toxin* during the Gulf War (p. 488). That same year (1995), the Japanese religious doomsday cult, Aum Shinrikyo, released Sarin nerve gas onto a Tokyo subway, leading to the death of 12 people (Tucker, 1999: 498). Subsequent investigations revealed that the cult had elaborate plans to develop weapons for bioterrorism in their laboratory, even making a mission to the DRC in 1992, in search of samples of the Ebola virus for use in the development of a bioterrorism weapon (Henderson, 1998: 488).

Ebola is a severe, often fatal viral illness that develops rapidly, on average taking anywhere between 2 and 21 days between infection and the manifestation of symptoms (WHO, 2016). The virus was

first identified in two simultaneous outbreaks that occurred in 1976, one at a village near the Ebola River in the DRC (then the Republic of Zaire) and the other one across the border in what is now Nzara, South Sudan (then part of the Republic of Sudan) (WHO, 2016). Since then, scientists have identified five sub-species of the Ebola virus. These are the *Bundibugyo ebolavirus*, the *Reston ebolavirus*, the *Sudan ebolavirus*, the *Taï Forest ebolavirus* and the *Zaire ebolavirus* (Passi, Sharma, Dutta, Dudeja and Sharma, 2015). Each of these five species has its own pathogenic characteristics, and they differ in their scale of impact in terms of human infection and mortality rates (Maras and Miranda, 2016: 72). Of the five subspecies, the *Zaire ebolavirus* is the most aggressive (Passi et al, 2016: 1). Deaths from Ebola infection average about 50 percent (WHO, 2016), although fatalities as high as 90 percent have been recorded in past outbreaks of the *Zaire ebolavirus* (Passi et al, 2016: 1).

The Ebola virus can be contracted through contact with fruit bats of the *Pteropodidae* family, believed to be natural carriers of the virus (WHO, 2016). The primary leap to human beings is believed to occur through contact with infected fruit bats; contact with infected apes; and consumption of “bush meat” from infected wild game (WHO, 2016). Direct human-to-human transmission of Ebola can occur through sexual contact or other direct contact with bodily fluids of an infected person, but Ebola is also easily contracted from surfaces and materials such as clothes and beddings used by infected persons (WHO, 2016).

The first diagnosis of Ebola in the 2014-2015 out-break in West Africa was that of a two-year-old boy in Meliandou, a small village in Guinea, in December 2013 (Saéz et al, 2014: 18). Epidemiologists suggest that the virus emanated from fruit bats mentioned above in a single zoonotic transmission event to the boy (Saéz et al, 2014: 18). From this small village in Guinea, the virus subsequently spread, mainly through human-to-human transmission, across land borders to Sierra Leone and

Liberia (WHO, 2016) and additionally infected 19 Nigerian nationals, seven Malians, four Americans, one Senegalese, one Spaniard, one Briton and one Italian (CDC, 2016). Within the course of one year, there were 17,145 cases and 6,070 deaths as of December 2014 (Saéz et al, 2014). Alarmed at the rapidity of transmission and the high mortality rate, health experts warned of the real possibility of the Ebola virus spreading throughout the world before an effective vaccine, treatment, or cure could be developed and distributed widely enough to contain it (Saxena and Gomes, 2016: 96).

It is worth noting that all recorded outbreaks of the Ebola virus have occurred close to African countries where active transnational terrorist groups operate. In West Africa, Boko Haram, a militant Islamist group from Nigeria, declared allegiance to the Islamic State in Iraq and the Levant (variously referred to as ISIL, ISIS or Daesh), joining the existing militant groups from Egypt, Libya, Algeria, Morocco and Tunisia that had already previously pledged allegiance to ISIL. Initially formed in opposition to Western education and culture in Northern Nigeria, Boko Haram has now become a threat to the national security of Cameroon, Chad and Niger (Ewi, 2015). ISIL has embraced Boko Haram and declared that its ambitions to create a caliphate will now include a Western Africa province (Ewi, 2015). In addition to Boko Haram, there is also al-Qaeda in the Islamic Maghreb (AQIM) and Al-Murabitun in North Africa, as well as the Al-Qaeda-affiliated Somali militant group, Al Shabaab, in Eastern Africa (Maras and Miranda, 2016: 74). It appears quite possible that such groups such as Boko Haram, al-Qaeda in the Islamic Maghreb (AQIM), Al-Murabitun and Al Shabaab could attempt to obtain and use the Ebola virus from these regions as a tool of bioterrorism (Maras and Miranda, 2016: 74).

According to Henderson, the detection and prevention of bioterrorist attack would be quite difficult, considering the ready availability of recipes for biological weapons online and the easy

interconnectedness provided by social media and the internet in general (Henderson, 1998: 489). Recognizing the reality of the threat, Henderson contends that the first line of defence against any bioterrorist attack would be health workers in hospital emergency rooms (p. 489). Given that all African countries that have suffered outbreaks of the Ebola virus are fragile and have weak public health facilities, the looming question is whether the world is ready to contain an Ebola bioterrorist attack were it to occur on a mass scale. More important is the willingness of developed countries in preventing EID outbreaks from leaving their regions of origin. This was the case during the 2014-2015 Ebola Outbreak in West Africa, which is discussed in greater detail in the next section.

The Securitized Response to the 2014-2015 Ebola Crisis in West Africa

The 2014-2015 out-break was the largest and most intricate in the history of the Ebola virus (Laverack and Manoncourt, 2015: 1). It claimed an estimated 11,310 lives out of the 28,616 recorded infections (CDC, 2016; WHO, 2016), exposing both the frailty of the global health system and the indifference of developed nations to the health plight of the citizens of developing countries (Harmon, Gostin, Grant, Gillies and Laurie, 2015: 17). Ventura (2016) argues that the Ebola crisis in West Africa demonstrated a new trend towards the securitization of international responses to health emergencies, a pattern she also observed in the 2016 Zika virus outbreak in the Americas and the Pacific. (p. 1). In both the Ebola and Zika out-breaks, Ventura (2016) notes that they were socially constructed as security threats (p. 1). Bustreo and Doeblbler (2010) argue that framing health emergencies through the security lens inevitably shifts the focus towards halting the spread of the EID as an immediate threat, rather than addressing the presence and danger of long-existing diseases that afflict people in developing countries which impedes the improvement of global health on a broader scale (p. 48). This was certainly the case in the 2014-2015 Ebola crisis in West Africa.

The international community was slow to respond to the Ebola outbreak in West Africa, and when it eventually did respond, the priority was to contain the epidemic within the three countries it was already ravaging, rather than to accelerate the search for long-term solutions (Harmon et al, 2015: 6). Initial response to the Ebola outbreak was left to the national governments of Guinea, Liberia and Sierra Leone and to NGOs (Laverack and Manoncourt, 2015: 2). Working in concert with a number of NGOs, the three states, all of which had fragile and overstretched health care systems, could only muster a feeble response that allowed the outbreak to metamorphose into a much larger threat with global implications.

The international community's response only gained steam after several American medical workers contracted Ebola (Friedman, 2014). By the time the World Health Organization declared the Ebola outbreak a Public Health Emergency of International Concern (PHEIC) in August 2015 and over 3,000 cases had been confirmed in Guinea, Liberia and Sierra Leone (Ventura, 2016). Moreover, the rationale for the declaration of a PHEIC does not favour developing countries with weak health systems, such as the three most affected. The severity of a disease or level of fatalities it inflicts does not determine the declaration of a PHEIC; instead it is the potential international scope of its reach that determines whether a PHEIC can be declared (Ventura, 2016: 2).

Despite declaring Ebola a PHEIC, numerous challenges faced the WHO's response strategy. In September 2014, UN Secretary-General declared the Ebola outbreak a threat to world peace and security, and with the endorsement of the UN Security Council and the General Assembly, announced the creation of a UN Mission for Ebola Emergency Response (UNMEER), the first-ever emergency health mission since the formation of the UN in 1945 (Ventura, 2016: 1). The creation of UNMEER sidelined the WHO and weakened its fundamental leadership role in health matters within

the UN system (Harmon et al, 2015: 7). This attrition of the WHO's leadership in turn undermined the established practice of multilateralism, paving the way for the subsequent unilateral efforts by the United States and other global powers that were keener to respond to Ebola as a security threat (Ventura, 2016: 1). Secondly, the WHO needed to bring key stakeholders to an agreement, and these include WHO member states, the pharmaceutical industry and willing participants in public–private partnerships to invest in the expedited development of Ebola drugs and vaccines (Saxena and Gomes, 2016: 96). The task of carrying out emergency medical research and clinical trials in the midst of an epidemic appeared doomed right from the beginning, considering that Ebola was already ravaging countries with no experience of conducting clinical trials (p. 97).

It appears from the foregoing that the priority for the developed nations was to prevent Ebola from leaving its epicentres, without regard for the concept of the right to health. Guided by the securitization of the Ebola outbreak, the developed nations found little attraction in confronting the causes of Ebola and other EIDs or in addressing the social determinants, high poverty levels and inequalities that exacerbate these impediments to universal access to health (Ventura, 2016). The securitization of the 2014-2015 Ebola crisis in West Africa was perhaps best illustrated by the selective policy of evacuating health workers and Ebola patients, favouring those from developed nations and neglecting their West African colleagues. Health workers came from many different countries to work alongside local health workers on the frontline of the Ebola response in the three afflicted countries. Over 900 of these health care workers contracted Ebola, a majority of them Africans (World Bank, 2015). Western health workers who contracted Ebola were quickly evacuated to treatment facilities in Europe or the US, where they received treatment using innovative methods and experimental drugs such as ZMapp (Saxena and Gomes, 2016: 96).

Out of the seven reported Ebola infections among Western nationals (four Americans, and one case each in Spain, Italy and the United Kingdom), only one death occurred, yet these cases were given more prominence than the 11,316 deaths that occurred to indigenous Africans (Ventura, 2016: 2). Despite decades of lofty rhetoric on the international stage about the universality of human rights, which includes the right to health, infected health workers and citizens from Guinea, Liberia and Sierra Leone had no such lifeline (Friedman, 2014). Hundreds of West African healthcare workers who contracted Ebola were not evacuated, leading to a 57 percent fatality rate among them (WHO, 2016). The three countries, all of which had some of the lowest doctor-to-patient ratios in the world even before the Ebola Outbreak, lost about 50 percent of their doctors and nurses on the Ebola frontline (Harmon et al, 2015: 8-9). Although it is understandable that the WHO may not have had the capacity to evacuate every health worker that contracted Ebola, ethicists have criticized the organization's selective willingness to evacuate foreign health workers (St. Fleur, 2014).

In Sierra Leone, the government's appeal for the evacuation of two infected doctors was turned down by the WHO on the grounds that it was the responsibility of employers to evacuate their infected health workers (St. Fleur, 2014). Indeed, the only two Africans evacuated from Sierra Leone were a Senegalese expert working for the WHO and a Ugandan doctor employed by an Italian NGO (Friedman, 2014). A prominent case in point involved an attempted intervention by Sierra Leone's president to secure the evacuation of Dr. Olivet Buck, one of the country's eminent doctors for treatment in Germany (Friedman, 2014). Worried about the continuing decimation of his country's small team of only 136 doctors for an estimated population of six million (BBC, 2014), President Ernest Bai Koroma wrote to the WHO, seeking help for Dr. Buck's medical evacuation (St. Fleur, 2014). Lack of funding was often cited as the reason for the non-evacuation of West African health workers, but even President Koroma's assurance that his government was going to pay the \$70,000

required for Dr. Buck's evacuation to Germany fell on deaf ears. (St. Fleur, 2014). The WHO firmly declined the president's request and Dr. Buck passed away (Friedman, 2014). For Friedman (2014), this selective evaluation of health workers from developing countries was reminiscent of the 1994 Rwandan Genocide against the Tutsi, which saw Westerners evacuated and local co-workers and friends left behind to face the prospect of death.

The Potential Weaponization of Ebola

From the preceding sections of this article, it appears apparent that globalization has inadvertently made the threat of bioterrorism an increasing reality. Ebola stands out as one of the easier EIDs to be weaponized because of its high fatality rate, lack of a cure, ease of misdiagnosis and propensity to occur in parts of the world that have weak health facilities and inadequate numbers of trained healthcare workers (Maras and Miranda, 2016: 72). As mentioned above, *Zaire ebolavirus* is the most aggressive of the five subspecies and its mortality rates can go up to 90% (Passi et al, 2016: 1). Incidentally, it is samples of the deadly *Zaire ebolavirus* that the Japanese religious-based terrorist group, Aum Shinrikyo, was searching for during its 1992 mission to the DRC. This can be massively devastating if deliberately unleashed on a large civilian population anywhere in the world. Maras and Miranda (2016) opine that human munition is a possible strategy that terrorist groups could use to procure and use the Ebola virus for bioterrorism (p. 75). One way would be to involve deliberate self-infection by individual terrorists, who would then be dispatched to various target destinations of mass infection (p. 75).

Airport screening measures adopted worldwide during the 2014-2015 West African Ebola out-break were largely ineffective. They simply involved taking passenger temperatures, looking out for flu-like symptoms and asking passengers to fill out questionnaires requiring them to indicate if they had had

any contact with infected persons or materials (p. 77). Such screening measures are ineffective because of Ebola's lengthy incubation period which is 8-10 days on average but can at times vary between 2-21 days (Passi et al, 2015: 4) before symptoms become manifest. It is also possible that a passenger may not be aware that they had had contact with an infected person, or may simply fail to respond truthfully to the questionnaire (Maras and Miranda, 2016: 76). This lengthy incubation period can allow terrorists to travel to distant parts of the world without any detectable symptoms of infection. Moreover, the primary symptoms of Ebola resemble those experienced by people with the common cold, flu, or stomach virus (p. 75). An Ebola terrorist would therefore not stand out and could easily melt into the crowd anywhere, unlike, for instance, a smallpox terrorist who would show more visible symptoms such as the characteristic maculopapular rash on the skin (p. 75). It would as such be easy for the Ebola terrorist to reach their destination undetected, and deliberately get into close contact with unsuspecting people, thus further spreading the virus. The result would almost certainly be a rapid massive outbreak among the general population (pp. 75-76).

Such a scenario becomes real when one pauses to consider the large number of Western citizens who are getting radicalized and are leaving their home countries to join ISIS and other terrorist groups. According to an October 2015 UN report, an estimated 30,000 radicalized foreign fighters from over 100 countries had travelled to join ISIS (UN, 2015). These foreign fighters could form a formidable pool of recruits for human munition. In the event of another Ebola outbreak in a fragile African country, they could gain easy access to the outbreak zones as volunteers or aid workers. Their citizenship status gives them unfettered access to their home countries, where they could return either as human munition agents or as evacuated staff. Those who choose the human munition route could spread the virus in public places, while those evacuated could use other methods such as infected

vials to transmit Ebola to unsuspecting healthcare providers in their home countries, who would then unknowingly spread the infection to the wider population.

Conclusion

As globalization continues to entrench itself with a particular emphasis on international trade and migration, global health becomes an important aspect of any country's foreign policy. Although health diplomacy will for a long time remain common practice between developed and developing nations, discriminative practices of international bodies such as the WHO and UN may dent the cooperation between and among states. The right to health, although well-founded in international law, is however unlikely to be pursued with the altruism it demands, for the most part due to the attendant economic and national security priorities of the developed nations. This suggests that global health will continue to hold a subordinate role to the national security and economic priorities of sovereign states. It has been argued that the public health system can only be a truly effective vanguard against bioterrorism if it works closely with the authorities responsible for defence and law enforcement (Garrett, 2001: 88-89). Garrett however avers that this close association between public health and national security might hurt the credibility of public health (88-89). This is essentially what has been manifested in the securitization of global health, which seems self-defeatist.

One outright risk of the securitized approach is the possibility of the weaponisation of EIDs by terrorist groups. The 2014-2015 Ebola crisis in West Africa exposed the emptiness of the concept of global health in practice. The securitization of EIDs is essentially a fire-fighting approach that yields temporary solutions to outbreaks and epidemics as they occur. The adoption of systemic changes for better preparedness on the global level would be more effectual in the long run. The experience of the West African Ebola crisis offers an opportunity for the international community to live up to its

human rights obligations in the crucial area of global health. The potential speed with which emerging infections can spread in today's global village costs human lives, affects travel and interrupts trade between interdependent economies (Katz et al, 2011: 504). Even more urgently, it exposes the world to the potential threat of bioterrorism if deadly EIDs such as Ebola fall into the hands of terrorist groups.

The current situation calls for a fresh look at the state of public health globally. Harmon et al (2015) suggest three essential elements for a robust, universal health care system, namely access to essential medicines, the services of a doctor and primary medical care (p. 6). The centre-piece of such an approach would be to tackle inequalities and to strive to raise the health security standards of populations in the developing world. On the EID detection level, Ryan (2008) vouches for closer collaboration between human and veterinary medicine scientists and practitioners, in recognition of the fact that zoonoses such as Ebola are the easiest EIDs for bioterrorists to acquire and use (p. 281). The Ebola crisis, therefore, offers a turning point in terms of the lessons it provided by drawing attention to the tendency of developed nations to either be indifferent towards, or to securitize outbreaks of EIDs when they have already arrived at their doorsteps, as well as the slow response of global actors like the WHO, UN and the World Bank.

Failure to reform the global health system will leave the world susceptible to the possible growth of bioterrorism. It is critical for global actors led by the UN, WHO and developed countries to collectively develop a universal health care system that directly addresses the socioeconomic and contextual factors behind health outbreaks across the world. This is more so in fragile countries where such outbreaks may easily get out of hand and where porous borders could allow easy infiltration by terrorist groups in search of EIDs such as the Ebola virus for purposes of bioterrorism. It is, after

all, in the best interest of all nations, both developed and developing, to have a robust global health system. This is because the dividends of universal health care would include enhanced trade, better health and reduced threat of bioterrorism for the entire global community.

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