

# **Bradford Regime Review Paper No.1**

## **Securitization of International Public Health – Implications for Global Health Governance and the Biological Weapons Prohibition Regime**

University of Bradford

**By**

**Alexander Kelle  
Queen's University Belfast**

May 2005

## **1. Introduction**

Public health and biological weapons arms control on first sight are two distinct policy arenas with little, if any, overlap in terms of actors involved, problems to address and solutions to be proposed in order to better the human condition. At least historically, security from biological weapons and security from disease were pursued by different actors both on the domestic and the international level. For the former biodefense and biological weapons (BW) arms control policies were formulated by the military and diplomatic communities, while responsibility for security from disease fell to the public health sectors of individual states, or international organisations, like the World Health Organisation (WHO) and others. This strict separation is becoming increasingly blurred.

Starting in the mid-1990s the possibility of terrorism with biological and chemical weapons has evolved into the number one security threat for military planners and decision-makers in many countries, most notably the United States of America. This dramatic shift in threat perception, which was fuelled first and foremost by the Aum Shinrikyo 1995 sarin gas attack in the Tokyo subway system and the 2001 Anthrax containing letters sent through the US mail system, had two so far not thoroughly analysed effects: first, it shifted the balance between biodefense and BW arms control in the fight against biological warfare towards biodefense. Traditionally, biodefense and

BW arms control have existed in a kind of equilibrium alongside each other, with states' right to biodefense activities expressly acknowledged in the 1972 Biological Weapons Convention (BWC). The process of readjusting this equilibrium in favour of biodefense has brought with it the second effect: the drafting of public health to fight bioterror.<sup>1</sup> While in the past biodefense activities had been geared towards hostile states employing BW, and thus had focussed on troop protection in the field by the military forces themselves, the parameters underlying this approach were deemed no longer valid in the age of global bioterrorist threats. At risk from biological warfare was no longer a small subsection of the population – the armed forces – but the population as a whole. Consequently, in this reasoning, protective measures had to extend to the whole population as well: enter the public health infrastructure. In order to better capture and analyse the processes related to this “drafting” of the public health sector, or parts thereof, the concept of “securitization” will be applied in this series of three briefing papers.<sup>2</sup>

The term “securitization” was introduced into the security studies discourse during the 1990s by a group of scholars including Ole Waever and Barry Buzan, which, at that time, were located at the Copenhagen Peace Research Institute in Denmark.<sup>3</sup> Implicitly accepting Wolfer's claim formulated more than three decades earlier, that security is basically a contested concept, Waever and his colleagues from the so-called Copenhagen school reject the uncritical broadening of the meaning of security by merely

---

<sup>1</sup> This wording is in analogy to the title of a study by Elin A. Gursky, *Drafted to Fight Terror. U.S. Public Health on the Front Lines of Biological Defense*, Washington, D.C.: ANSER, 2004.

<sup>2</sup> Briefing papers 2 and 3 in this series will deal with the securitization of public health in the US, and Europe and other major states, respectively.

<sup>3</sup> For an accessible summary of the argument see Ole Waever, *Securitization and Desecuritization*, in Ronnie D. Lipschutz (ed.), *On Security*, New York: Columbia Univ. Press, 1995, pp.46-86.

adding the adjectives economic, environmental and so on to the term security as it had traditionally been understood.<sup>4</sup> Instead, Waever proposes to concentrate on the specificity of security studies and reformulate the concept of security on that basis. According to Waever's understanding two operations are crucial to the field of security studies: speech acts (uttering security) and modalities (threat-defense sequences).<sup>5</sup> When regarded as a speech act, "security is not of interest as a sign that refers to something more real; the utterance itself is the act. By saying it, something is done (as in betting, giving a promise, naming a ship)."<sup>6</sup> If a securitizing speech act is performed successfully – and this is by no means always the case – the threat-defense sequence, which has been characterizing traditional thinking about security, has been successfully put into action. To put it differently, new issues will only be securitized successfully if they can be "staged as existential threats to a referent object by a securitizing actor, who thereby generates endorsement of emergency measures beyond rules that would otherwise bind."<sup>7</sup>

To illustrate the point: during the Cold War Western military planners clearly perceived the Soviet nuclear threat as the predominant danger to state survival and security. In order to securitize Soviet nuclear weapons, their existence had to be portrayed/communicated as an existential threat to the wider public. Only on the basis of the public's acceptance of this threat presentation could Western military policies be justified. Had the issue of Soviet nuclear weapons not been successfully securitized and remained in the realm of the political, the arms build-up in the West and the concomitant

---

<sup>4</sup> Waever, *Securitization and Desecuritization*, p.47.

<sup>5</sup> *Ibid*, p.51.

<sup>6</sup> *Ibid*, p.55.

<sup>7</sup> Barry Buzan, Ole Waever, Jaap de Wilde, *Security: A New Framework for Analysis*, London: Lynne Rienner, 1998, p.5.

huge military expenditures to counter these weapons would have been next to impossible to justify.

It will be argued in this series of three briefing papers that threats to public health through the deliberate spread of disease have partially become and are still in the process of being similarly securitized. The focus of this paper will be on the securitization of international public health. As outlined above, the emergence of the bioterrorist threat in the mid- to late-1990s has led to a reduced reliance on BW arms control in addressing the spectre of biological warfare. Instead, biodefense measures, with the concomitant securitization of public health have taken center-stage in the effort to counter the newly identified existential threat of bioterrorism. As defenses against biological warfare remain in the national domain, and are not being dealt with in a systematic way on the international level, the “drafting” of public health can be expected to be more pronounced on the national level – yet attempts at securitization are still discernible on the international level as well.

In order to map the changes in international public health discourse in the course of its securitization and the implications this has for the international regime to prohibit BW, the next section will provide an overview of the issue area public health has been drafted to fight – the deliberate spread of disease as biological warfare. The following two sections will then provide in summary fashion a description of the tools to fight deliberate disease – BW arms control, and biodefense measures – and international public health prior to the emergence of bioterrorism as existential new security threat. The subsequent section will describe the emergence of bioterrorism as security threat and the securitization of public health on the international level, focussing on the institutional

settings of the World Health Organisation and the community of BWC member states. The concluding section will discuss some possible implications for the global governance of public health and BW arms control that can be inferred from the public health securitization process on the international level. At this stage these findings can only be of a provisional character: as the distinction between the national and international level to some degree is an analytical one which is not matched by a similarly clear-cut distinction in the real world, where foreign and security policies, obviously have a profound impact on the content and structure of any international issue area. Accordingly, the question of the impact of the securitization of public health on the future of the BW arms control regime will have to be revisited at a later point in time, after an analysis of the BW and public health policies of the US, Europe and other major countries will have taken place.

## 2. Biological Warfare as “Deliberate Disease”

The use of disease causing biological agents, or pathogens, in warfare goes back at least several hundred years.<sup>8</sup> However, only with the advances in the scientific understanding of life and its underlying processes did the systematic utilization of pathogens and naturally produced toxic substances for warfare purposes become possible.

Biological warfare agents are usually grouped into five categories: 1) bacteria, such as *Bacillus anthracis*, the causative agent of anthrax, *Yersinia pestis* which causes bubonic plague, and *Francisella tularensis* which causes tularemia; 2) viruses, such as

---

<sup>8</sup> See Mark L. Wheelis, ‘Biological Warfare Before 1914’ in Erhard Geissler and John Ellis van Courtland Moon (Eds.), *Biological and Toxin Weapons: Research, Development and Use from the Middle Ages to 1945*, SIPRI Chemical & Biological Warfare Studies, No.18, Oxford, Oxford University Press, 1999, pp.8-34.

the ones that cause smallpox, Ebola, and Venezuelan equine encephalitis; 3) rickettsiae which can cause Q-fever, and typhus; 4) fungi, such as the *Aspergillus* fungi; and 5) toxins, which are non-living products from micro-organisms but also plants or animals, like botulinum toxin, ricin, or saxitoxin, respectively. So, most biological warfare agents are not only different from CW agents<sup>9</sup>, but it is a diverse group in and of itself, in which some agents are mostly incapacitating, while others have a rather high lethality. Also, some biological warfare agents will be localized in their effects while others – due to their contagiousness – may cause widespread epidemics. Following from this diversity, biological warfare agents can be employed in a number of attack scenarios, ranging from assassinations of individuals to large-scale aerosol releases, which could theoretically cover whole population centres and affect many thousand people.<sup>10</sup>

To make efforts to implement the prohibitory norm against biological warfare even more complicated, the material, technologies, and know-how needed for offensive military BW-programs or the pursuit of terrorist BW attacks are of a so-called dual-use character. Not only can they be used for offensive purposes, but many of the ‘ingredients’ of a BW program have perfectly legitimate applications. Thus, it cannot be deduced from the mere presence of a seed culture of a particular pathogen or a specific type of equipment that a state pursues an offensive BW program. This material and equipment might be employed in a perfectly legitimate civilian use such as the production of dairy products or vaccine production. Or a state might be engaged in military biodefense activities – which are permitted under the provisions of the BWC.

---

<sup>9</sup> There is indeed an area of overlap in the category of toxins which fall under the regulations of both the BTW convention and the CW convention, the latter of which lists two toxins – ricin and saxitoxin – on its Schedules of CW agents.

<sup>10</sup> See Dean Wilkening, ‘BCW Attack Scenarios’, in Drell/Sofaer/Wilson (eds.), *The New Terror. Facing the Threat of Biological and Chemical Weapons* (Stanford, CA, 1999), pp.76-114.

Furthermore, the nature and scope of biological warfare has changed dramatically by the revolution in the life sciences. As Dando has shown for the ‘three generations of offensive biological warfare programs’ of the 20<sup>th</sup> century, all the military programs were ‘developing on the back of growth in scientific knowledge.’<sup>11</sup> According to this account, military BW programs in the 20<sup>th</sup> century first followed scientific discoveries in the areas of bacteriology, laying the ground for the BW based sabotage activities during World War I. Such activities were undertaken by Germany and France<sup>12</sup> Secondly aerobiology provided the knowledge to spread biological warfare agents over large geographic areas, which gave of non-contagious agents, such as *bacillus anthracis* their potential to be used as mass casualty weapons. Last, but not least genetic engineering played an important role in the offensive military BW program of the former Soviet Union. According to one insider account, the Soviet program contained genetically modified pathogens such as “antibiotic-resistant strains of plague, anthrax, tularemia, and glanders.”<sup>13</sup>

The scientific and technological advances on which the offensive Soviet BW programme could build, date back to the early 1950s when the ladder-like double helix structure of DNA was discovered by James Watson and Francis Crick. This revelation was complemented by the discovery by Daniel Nathans of the first restriction enzyme, which can cut genetic material into pieces. In 1973 Stanley Cohen and Herbert Boyer “developed a laboratory process for joining and replicating DNA from different

---

<sup>11</sup> Malcolm Dando, ‘The Impact of the Development of Modern Biology and Medicine on the Evolution of Offensive Biological Warfare Programs in the Twentieth Century’, in *Defense Analysis*, Vol.15, No.1 (1999), pp.43-69, quotes from p.51.

<sup>12</sup> See Mark Wheelis, ‘Biological sabotage in World War I’, in Erhard Geissler and John Ellis van Courtland Moon (Eds.), *Biological and Toxin Weapons: Research, Development and Use from the Middle Ages to 1945*, pp.35-62.

<sup>13</sup> See Jonathan Tucker, ‘Biological Weapons in the Former Soviet Union: An Interview with Dr. Kenneth Alibek’, in *The Nonproliferation Review*, Vol.6, No.3 (Spring-Summer 1999), pp.1-10, quote from p.2.

species”;<sup>14</sup> called recombinant DNA technology, and widely considered to mark the birth of modern biotechnology. They completed the first successful genetic engineering experiment by inserting a gene from an African clawed toad into bacterial DNA. In 1977 William Rutter and Howard Goodman isolated the gene for rat insulin and transplanted it into bacteria. Five years later, genetically engineered human insulin goes on the market.

Since then, the number of new drugs based on biotechnological production methods has increased dramatically, as has the number of companies in the biotechnology sector. While only a few start-ups populated the commercial biotechnology scene in the late 1970s and early 1980s, by the end of the century most major pharmaceutical companies had moved into the area and the worldwide number of biotech companies had grown to several thousand:

“Less than 30 years ago the industry began with a handful of U.S. start-ups using genetic engineering to manufacture commercial quantities of well-characterized human protein drugs. Today the global biotech industry includes more than 4000 companies throughout the U.S., Canada, Europe, Australia/New Zealand and Asia applying revolutionary discovery science to tackle the planet’s toughest healthcare, agricultural, industrial and environmental challenges.”<sup>15</sup>

With the large number of new processes and applications in the biotech field have also come more opportunities for misuse of these advances for malign purposes.<sup>16</sup> As a panel of life sciences experts concluded in a recent assessment of the threat of advanced BW based on biotechnological methods and processes that was conducted for the CIA:

---

<sup>14</sup> Sally Smith Hughes, ‘Making Dollars Out of DNA. The First Major Patent in Biotechnology and the Commercialization of Molecular Biology, 1974-1980’, *Isis*, Vol.92, 2001, pp.541-575; quote on p.541.

<sup>15</sup> Ernst & Young, *Beyond Borders. The Global Biotechnology Report 2002*, p.11.

<sup>16</sup> See section 3.2.1. below for an appreciation

“... other classes of unconventional pathogens that may arise in the next decade and beyond include binary BW agents that only become effective when two components are combined [...]; “designer” BW agents created to be antibiotic resistant or to evade an immune response; weaponized gene therapy vectors that effect permanent change in the victim’s genetic make up; or a “stealth” virus, which could lie dormant inside the victim for an extended period before being triggered.”<sup>17</sup>

### **3. Tools to Fight Deliberate Disease: Biological Weapons Arms Control and Biodefense**

#### **3.1. Biological Weapons Arms Control**

##### *3.1.1 The Structure of the BW Prohibition Regime*

First efforts to prohibit biological (and chemical) warfare were undertaken after World War I with the 1925 ‘Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous, or Other Gases, and of Bacteriological Methods of Warfare’<sup>18</sup>. It entered into force in 1928 and has currently 133 member states.<sup>19</sup> Upon ratification or accession to the Geneva Protocol many states issued unilateral declarations laying down restrictions under which they would themselves consider to be bound by the provisions of the Protocol.<sup>20</sup> As a result, it has been widely regarded as an agreement that provides for no-first use of CBW among states parties to the Protocol. This assessment had to be modified in recent years as a number of states have given up their reservations.<sup>21</sup>

<sup>17</sup> Central Intelligence Agency, Directorate of Intelligence, *The Darker Bioweapons Future*, unclassified, Washington, D.C., 3 November 2003, p.1f., last accessed on 10 March 2004 at [www.fas.org/irp/cia/product/bw1103.pdf](http://www.fas.org/irp/cia/product/bw1103.pdf).

<sup>18</sup> Henceforth called the ‘1925 Geneva Protocol’, original text in *League of Nations Treaty Series*, Vol.94, available on numerous websites.

<sup>19</sup> See the list of states parties at <http://projects.sipri.se/cbw/docs/cbw-hist-geneva-parties.html>.

<sup>20</sup> See R.R. Baxter and Thomas Buergenthal, ‘Legal Aspects of the Geneva Protocol of 1925’, in *American Journal of International Law*, Vol.64, No.4 (1970), pp.853-79, esp. pp.869-73.

<sup>21</sup> According to Sims this number amounts to 12 states who have withdrawn their Geneva Protocol reservations since 1986; see Nicholas A. Sims, *The Evolution of Biological Disarmament*, SIPRI Chemical and Biological Warfare Studies, no.19, Oxford: Oxford University Press, 2001, pp.152-162.

The BW prohibition regime in its current form eventually took shape with the 1972 Biological and Toxin Weapons Convention. It entered into force in 1975 and has 143 states parties. It is based on the recognition that the use of BW agents constitutes an abhorrent act of warfare and is therefore prohibited. At the same time, peaceful uses of the biosciences are regarded as a legitimate undertaking. According to BWC Article I,

“Each State Party to this Convention undertakes never in any circumstances to develop, produce, stockpile or otherwise acquire or retain:

(1) Microbial or other biological agents, or toxins whatever their origin or method of production, *of types and in quantities that have no justification for prophylactic, protective or other peaceful purposes*” (emphasis added)

This so-called general-purpose criterion not only makes it clear that peaceful uses of the biosciences are legitimate undertakings for states parties to the BWC, but also allows the use of pathogenic organisms or toxins in quantities and for purposes other than use as weapons.

From this reasoning, it can be inferred that states subscribing to the regime regard defences against the threat or use of BW as permitted. This principle is rooted in the belief that the peaceful uses of biosciences cannot be taken for granted – be it for the lacking universality in membership or for a state party not living up to the obligations it has assumed.

As the above quoted Article I makes clear, five activities related to BW – development, production, acquisition by other means, stockpiling, and retention – are explicitly banned. Yet, the scope of the BW control regime is wider than these five activities and the treaty contains several more normative guidelines for state action. Central to the BW control regime is the non-use norm, which is explicitly spelled out in the 1925 Geneva Protocol and implicitly contained in Article I of the BWC.

The disarmament norm is contained in Article II of the BWC. It requires that all states parties either destroy or divert to peaceful purposes all agents, toxins, equipment and means of delivery related to their BW holdings within nine months after entry into force of the BWC. According to the non-transfer norm, which is contained in BWC Article III, states parties forswear to “transfer to any recipient whatsoever, directly or indirectly, and not in any way to assist, encourage, or induce” any actor to acquire any of the items specified in Article I of the BWC. The non-transfer norm is strengthened through Article IV of the BWC, which calls for national implementation measures to put the basic obligations under the Convention into effect. In addition, Article X of the BWC contains the cooperation norm, which, from the point of view of some BWC states parties from the developing world represents the flip side of the deal with the non-acquisition and non-transfer norms. Article VII contains the assistance norm, according to which states parties will come to each other’s assistance in case of the use or threat of BW against one of them. The consultation norm is spelled out in Article V of the BWC, in which states parties agree to “consult one another and to co-operate in solving any problems which may arise in relation to the objective of, or in the application of the provisions of, the Convention.” Furthermore, the harmonization norm guides the behavior of a sub-set of regime members, i.e. states participating in the Australia Group, which have agreed to harmonize their export control policies, to share information on “suspicious” requests for supplying CBW-related dual-use items and technologies, and to consult one another in case of export denials of certain dual-use items and technologies to states of proliferation concern.<sup>22</sup> Last, but not least, Article IV of the BWC stipulates that

---

<sup>22</sup> On the Australia Group see Robert J Mathews, *The Development of the Australia Group Export Control Lists of Biological Pathogens, Toxins, and Dual-Use Equipment*, in *The CBW Conventions*

states parties have to internalize the prohibitions of the BWC and prevent the activities banned under the BWC from taking place on their territory. Yet, how this internalization norm is to be put into effect is left to the interpretation of states parties.

### *3.1.2 Efforts to Strengthen the BW Prohibition Regime*

The two central weaknesses of the BW control regime – the absence of a verification principle and precise rules and procedures that would specify how to implement the norms of the regime in everyday state practice – came to the fore soon after entry into force of the BWC in 1975. The confidence building measures (CBM) agreed upon during the Second and Third BWC Review Conferences in 1986 and 1991 represent one attempt to remedy the BWC's shortcomings. However, as one review of the data submissions up to 1995 revealed, the turn-out of the CBMs was disappointing at best.<sup>23</sup>

In parallel to these CBMs a process was initiated which initially looked into the technical feasibility of potential verification measures for the BWC (during 1992/3) and led to negotiations on a verification protocol, which lasted from 1995 to 2001. Yet, even the formulation of the negotiating mandate proved to be difficult. First of all, the U.S. was highly skeptical of the AHG to negotiate 'verification'-measures, because it rejected the idea that the BWC is verifiable on principled grounds.

---

*Bulletin*, Issue No.66, December 2004, pp.1-4.

<sup>23</sup> Iris Hunger, Article V: Confidence Building Measures, in G. Pearson/M. Dando (eds.) *Strengthening the Biological Weapons Convention. Key Points for the Fourth Review Conference*, Geneva: QUNO, 1996, pp.77-92, quote from p.78; see also Marie I. Chevrier/Iris Hunger: Confidence-Building Measures for the BTWC: Performance and Potential, in *The Nonproliferation Review*, Vol.7, No.3, 2000, pp.24-42.

As a result of the U.S. approach to what it considers to be ‘effective verification’<sup>24</sup>, the AHG was tasked to negotiate ‘measures to enhance compliance’ with the BWC. Secondly, Russia insisted that the AHG consider ‘definitions and objective criteria’ in its mandate. Thirdly, a number of states of the Non-Aligned Movement (NAM) did not see the necessity of the whole exercise in the first place. Many of them do not see BW as a threat to their national security and therefore had to be brought into the process by including into the mandate the negotiation of measures to strengthen international cooperation in the peaceful uses of the biosciences.<sup>25</sup> Lastly, the already existing – but poorly implemented – CBMs should be taken into account by the negotiators of the AHG and new CBMs should be considered.<sup>26</sup>

Negotiations started in January 1995 and progressed until July 2001. In order to speed up negotiations the chairman of the AHG developed a compromise text which he presented to delegations in spring of 2001.<sup>27</sup> The July 2001 session of the AHG was scheduled to have a debate of the compromise text submitted by the AHG chairman. While practically all delegations supported the approach taken by Ambassador Toth, the

---

<sup>24</sup> The requirements for effective verification were spelt out for example by Ambassador Mahley during the 1994 Special Conference of the States Parties to the BWC. See *Statement of U.S. Representative Donald A. Mahley to the Committee of the Whole, September 22, 1994*, document BWC/SPCONF/WP.16, last accessed 10 March 2004 at [www.opbw.org](http://www.opbw.org).

<sup>25</sup> On this latter point see Thomas Bernauer, ‘Verification of Compliance with the Biological Weapons Convention: Developing Countries Between Passive Participation and Obstruction’, in Oliver Thränert (ed), *The Verification of the Biological Weapons Convention: Problems and Perspectives*, Report No.50, Bonn: Friedrich Ebert Foundation, 1992, pp.55-67.

<sup>26</sup> The text of the mandate is contained in: Special Conference of the States Parties to the Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on Their Destruction, Geneva, 19–30 Sep. 1994, *Final Report*, BWC/SPCONF/1. For a recent critical assessment of the mandate see Kenneth D. Ward, *The BWC Protocol: Mandate for Failure*, in *The Nonproliferation Review*, Vol.11, No.2, pp.183-199.

<sup>27</sup> Jenni Rissanen, Chair Releases his ‘Composite Text’ for Verification Protocol, in *Disarmament Diplomacy*, Issue No. 55, London: Acronym Institute, March 2001. See also the assessment given by Graham S. Pearson/Malcolm R. Dando/Nicholas A Sims, *The Composite Protocol Text: An Effective Strengthening of the Biological and Toxin Weapons Convention*, Evaluation Paper No.21, Bradford: University of Bradford, July 2001.

US Ambassador Donald Mahley, concluded in his remarks that the overall approach taken in the negotiations up to that point was flawed and the draft protocol text would reduce and not increase security against BW.

When the 5<sup>th</sup> BWC Review Conference convened in November 2001 its diplomatic machinery worked well over its two week duration and good progress was made on a final declaration.<sup>28</sup> On the very last day of the Conference the US came forward with a proposal to terminate the AHG for good. The content of this proposal ran counter the tacit understanding not to touch the topic of the AHG in order to avoid a breakdown of the review process as well. What is more, the US obviously did not inform any of its allies in advance about content or timing of the proposal. Not surprisingly, this created the impression that the US delegation deliberately attempted to wreck the Review Conference. The only way to prevent a diplomatic disaster was to adjourn the Conference and to decide to reconvene one year later in November 2002.<sup>29</sup>

### **3.2. *Biodefense***

Biodefense has always been regarded as a legitimate undertaking by states. Biodefense in fact predates the 1972 BWC. When it was concluded and ratified by some signatory states, such as the United States, the point was emphasised that the BWC would not undermine states' ability to engage in biodefense activities.

A biodefense programme in general terms is composed of physical barriers for individual or group protection, medical treatments – which again are subdivided into pre-

---

<sup>28</sup> The draft final document of the Conference as issued by the Chairman of the Committee of the Whole is available at [www.acronym.org.uk/bwc/index.htm](http://www.acronym.org.uk/bwc/index.htm)

<sup>29</sup> See Jenni Rissanen, 'Left in Limbo: Review Conference Suspended On Edge of Collapse', in *Disarmament Diplomacy*, No.62, January-February 2002, p.18-32.

exposure and post-exposure responses – and defences in a wider sense including a variety of military options from pre-emptive military strikes to general deterrence of a BW attack.<sup>30</sup> The latter category is also referred to as ‘active defenses’, while the former two are oftentimes grouped under the heading of ‘passive defenses’.<sup>31</sup> It is this category, which is of interest here.

Since practically none of the known biological warfare agents acts through the skin (in contrast to many chemical warfare agents), full-body physical protection measures are not required. Rather, the use of masks or respirators is sufficient for individual protection, preventing aerosolised BW from reaching the intended victims’ lungs. Similarly, for “collective protection, people can enter a building or vehicle equipped with filtration systems that capture the particles of a biological agent.”<sup>32</sup> One essential requirement, though, for these protective measures to be effective is the prior or real-time knowledge of a BW attack. In the absence of such knowledge it will be widely regarded as impractical to equip buildings with such filtration equipment on a permanent basis. Likewise, available respirators for military personnel can be worn for a few hours each time. Therefore, much emphasis has traditionally been placed on the development of medical countermeasures to BW.

Pre-exposure measures that can be taken in anticipation of a BW attack are the administration of vaccines and the provision of prophylactic antibiotics. However, vaccines are available for only a small part of conceivable biological warfare agents, such

---

<sup>30</sup> See Stanley L. Wiener, Biological Warfare Defense, in Raymond Zilinskas (ed.), *Biological Warfare. Modern Offense and Defense*, Boulder: Lynne Rienner, 2000, pp.119-142.

<sup>31</sup> See Graham S. Pearson, The Threat of Deliberate Disease in the 21<sup>st</sup> Century, in Amy E. Smithson (ed.) *Biological Weapons Proliferation: Reasons for Concern, Courses of Action*, Report No.18, Washington D.C: The Henry L. Stimson Center, January 1998, pp.10-36.

<sup>32</sup> Pearson, The Threat of Deliberate Disease, p.24.

as anthrax, plague, Q-fever, and tularemia.<sup>33</sup> Even in the case of these few available vaccines there is concern – for example in the case of the anthrax vaccine –that they may actually not be safe or effective. Likewise, prophylactic antibiotics are not without their drawbacks: they are “expensive, require replacement at their expiration date, cause side effects, and can be rendered useless if agents resistant to antibiotics are used in an attack.”<sup>34</sup>

For medical treatments after exposure to be effective, it has to be established first of all whether an epidemic is caused by the deliberate release of a pathogen as a BW or whether an outbreak is of natural origin. Secondly, the pathogen causing the symptoms has to be identified. Given the flu-like symptoms of quite a few biological warfare agents in their early stages of manifestation this can be a difficult task. Thirdly, treatment, usually in the form of antibiotics, antitoxins, or other chemotherapeutics can be given. However, as a recent review of US biodefense preparedness concluded:

“in order for medical treatment to be an effective component of an integrated BW defense, medical personnel in the field will require adequate facilities and supplies, and support staff will need the logistical capability to evacuate large numbers of casualties. At present, neither of these conditions can be met.”<sup>35</sup>

Apart from raising questions about the effectiveness of the medical components of an expanded US biodefense programme, such programmes have provoked several more criticisms.<sup>36</sup> First of all biodefense efforts are very likely to lag constantly behind

---

<sup>33</sup> See David R. Franz et.al., Clinical Recognition and Management of Patients Exposed to Biological Warfare Agents, in *Journal of the American Medical Association*, Vol.278, No.5, 1997, pp.399-411.

<sup>34</sup> Wiener, *Biological Warfare Defense*, p.121.

<sup>35</sup> Wiener, *Biological Warfare Defense*, p.126.

<sup>36</sup> The following compilation of criticisms is taken from Victor W. Sidel, *Defenses Against Biological Weapons*, in Susan Wright (ed.), *Biological Warfare and Disarmament. New Problems/New Perspectives*, Lanham: Rowman & Littlefield, 2002, pp.77-101.

offensive efforts, because of the multitude of potential biological warfare agents and the possibility that existing pathogens might be genetically engineered or new ones created from scratch. Secondly, biodefense activities can almost inevitably be misused as a cover for offensive activities. In order to know whether an existing vaccine would be effective against a genetically modified organism, such an organism would have to be produced in the first place. Thirdly, biodefense programmes have been criticised as being well suited to create a protective cover for a state with an offensive BW programme who wants to produce vaccines for its own troops or populations. A further criticism maintains that the increased biodefense efforts are based on an exaggerated presentation of the threat. After all, BW have never been used in inter-state warfare and even the terrorist use of BW has not been frequent. With a view to the interrelation of biodefense and public health, critics have argued that biodefense programmes divert resources from essential public health services, that the spill-over benefits of anti-bioterrorism funding into public health may be exaggerated, and that the risks of associating public health programmes with biodefense activities managed by military, law enforcement or intelligence agencies have not been thoroughly analysed.

#### **4. Public Health in the Fight Against Natural Diseases**

##### ***4.1. Formation of the International Public Health Regime***

What is public health? In its most basic form, building on its medical and epidemiological traditions, public health can be understood as the absence of disease in a population. “Increasingly, however, health is seen in its social context, as a human

capacity to cope with the environment and everyday life.”<sup>37</sup> A further dividing line among views about public health is related to the question of whether health is accorded a value in and of itself or whether it is seen “as instrumental value towards other goals, such as economic growth”<sup>38</sup> or, in the context of this paper, national security.

International cooperation to improve public health occurred first in the middle of the 19<sup>th</sup> century, after Europe had to cope with two cholera epidemics in the 1830s and 1840s. When quarantine measures were incapable of stopping the spread of diseases like cholera, plague, and yellow fever, European governments were forced to seek collaboration in their fight against these contagious diseases. Yet, political differences as well as limited scientific understanding let the first six International Sanitary Conferences, which were held between 1851 and 1885, achieve little. Only from the seventh International Sanitary Conference onwards were conventions agreed upon, which *inter alia* regulated the notification of cholera and plague outbreaks. The beginning of the 20<sup>th</sup> century saw the establishment of the first two regional public health organisations, the Office International d’Hygiene Publique (OIHP) in Paris and the Pan American Sanitary Bureau (PASB). During the inter-war years the OIHP successfully prevented its integration into the League of Nation’s Health Organisation and, following the demise of the League after World War II, was instrumental in determining the regionally distributed structure of the newly founded World Health Organisation (WHO).<sup>39</sup>

---

<sup>37</sup> Kimmo Leppo, Introduction, in Meri Koivusalo and Eeva Ollilia, *Making a Healthy World. Agencies, Actors & Policies in International Health*, London: Zed Books, 1997, p.2.

<sup>38</sup> Ibid.

<sup>39</sup> See Javed Siddiqi, *World Health and World Politics. The World Health Organisation and the U.N. System*, London: Hurst & Co., 1995, pp.14-20. The WHO’s six regional offices are located in Copenhagen (Europe), Alexandria (Eastern Mediterranean), Brazzaville (Africa), New Dehli (South East Asia), Manila (Western Pacific), and Washington, D.C. (The Americas).

When the WHO was set up in 1948 its members agreed *inter alia* on the principles that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” and that the “health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States.”<sup>40</sup>

#### **4.2. From International Health Regulations to Health for All**

During the first three decades of its existence the WHO attempted to implement its mandate through a disease-oriented policy. This rather technical approach found its expression in the adoption of the International Sanitary Regulations in 1951, whose name was changed in 1969 to International Health Regulations (IHR). In it WHO member states agree to two normative guideposts for their public health policy: first, they agree to notify the WHO of outbreaks of diseases covered by the IHR. Initially six diseases were subject to this notification norm: smallpox, typhus, relapsing fever, cholera, malaria, and yellow fever. Since another modification of the IHR in 1981 only the latter three have to be notified to the WHO. The primary goal of the IHR “is to ensure the maximum security against the international spread of diseases with minimum interference with world traffic”.<sup>41</sup> In addition, the IHR was designed to interfere only marginally with how WHO member states organized their domestic health policies. Rather, its primary target has been to prevent the trans-border movement of disease causing organisms. Only a limited set of requirements – this represents the second, much weaker, normative guidepost the

---

<sup>40</sup> See the principles contained in the preamble of WHO’s constitution, available online at [http://policy.who.int/cgi-bin/om\\_isapi.dll?infobase=Basicdoc&softpage=Browse\\_Frame\\_Pg42](http://policy.who.int/cgi-bin/om_isapi.dll?infobase=Basicdoc&softpage=Browse_Frame_Pg42)

<sup>41</sup> <http://www.who.int/csr/ihr/en/>, last accessed 24 March 2005.

IHR contains – has been imposed by the IHR on states to undertake certain public health measures at ports and airports. However, as Fiddler summarizes, the “IHR failed massively to achieve their objective.”<sup>42</sup> This failure is first and foremost due to the widespread non-compliance of member states with the reporting requirements under the IHR. Secondly, the large number of newly emerging or re-emerging infectious diseases, especially the emergence of HIV/AIDS demonstrated the growing irrelevance of the reduced list of diseases that were to be reported. The World Health Assembly (WHA), the WHO’s highest governing body, acknowledged this failure in 1995 and tasked the WHO with revising the IHR.<sup>43</sup> In 2001 an intergovernmental working group has been set up to revise the IHR and the adoption of the new regulations is scheduled for submission to the next WHA meeting in May 2005.<sup>44</sup>

Programs to eradicate specific diseases have been departing from this inter-state focus of WHO activities and attempted to interfere much more deeply with member states’ capacity building efforts and the organisation of their public health systems. The programs to eradicate smallpox and malaria are two examples of success and failure, respectively, of such programs. The malaria eradication program started in 1955 and received the largest commitment in terms of countries involved and resources allocated. After initial successes by the late 1960s a report of the Director General of the WHO outlined a host of operational, technical, planning and budgetary problems afflicting the eradication effort. This led to a revision of the strategy, which henceforth sought malaria

---

<sup>42</sup> David P. Fidler, *SARS, Governance and the Globalization of Disease*, Basingstoke: Palgrave Macmillan, 2004, p.35.

<sup>43</sup> *Ibid.*, p.61f.

<sup>44</sup> See *Review and approval of proposed amendments to the International Health Regulations: draft revision*, WHO document A/IHR/IGWG/3, Geneva, 30 September 2004.

eradication where possible and a return to the containment or control of the disease in all other areas. By the mid-1970s many national eradication programmes had been converted into control programmes, so that the achievement of malaria eradication was relegated to an alleged long-term goal contained in political declarations.<sup>45</sup> In the case of smallpox eradication, on the other hand, the programme which started in 1959, led to a successful outcome. Whereas the initial results of the programme did not warrant such an expectation, the WHA decided in 1966 to intensify the eradication effort. This intensified eradication programme eventually allowed the WHA in 1980 to declare the world free of smallpox.<sup>46</sup>

A more general shift to vertical strategies and a move away from the horizontal strategies, based on intergovernmental relations, as embodied in the IHR was signalled by the “Health for All” declaration agreed upon in 1978 in Alma Ata. As Fiddler points out with respect to this shift in priorities: “The need of the great powers for the kind of international cooperation embodied in the IHR had all but vanished, leaving the regime without its traditional political engine.”<sup>47</sup> This opened the political space for changing priorities and for reaffirming health as a fundamental human right, whose realization cannot be tied only to the monitoring and reporting of three communicable diseases. The linkage between health and human rights was further strengthened when the WHO integrated into its policies to address the HIV/Aids pandemic efforts to stop the discrimination of those affected by the disease. This clearly represents a further step in

---

<sup>45</sup> See the in-depth study of the malaria eradication program in J. Siddiqi, *World Health and World Politics. The World Health Organization and the UN System*, London, Hurst & Co., 1995, pp.123-191.

<sup>46</sup> See F. Fenner et al., *Smallpox and its Eradication*, Geneva: WHO, 1988

<sup>47</sup> Fiddler, *SARS, Governance and the Globalization of Disease*, p.40f.

eroding the sovereignty of states to deal with a crucial public health issue on their own terms.<sup>48</sup>

#### **4.3. From International to Global Public Health?**

In more general terms international public health policies came under increasing pressure from processes related to globalisation in a number of different dimensions. As Dodgson and Lee have pointed out “globalisation has introduced or intensified trans-border health risks” which include “emerging and re-emerging infectious diseases, various non-communicable diseases ... and environmental change”.<sup>49</sup> Especially the issue of emerging and re-emerging diseases has since the early 1990s occupied a large part of public health discourse, both nationally and internationally.<sup>50</sup>

This discourse increasingly involves a multitude of non-state actors in the form of both health-oriented not for profit NGOs and multi-national corporations<sup>51</sup>. The variety of emerging public-private partnerships has led to a “hybridization of governance mechanisms”, which in turn raises questions about “appropriate representation, participation, accountability and transparency.”<sup>52</sup>

---

<sup>48</sup> J.M. Mann, Human Rights and Aids: The Future of the Pandemic, in J.M. Mann et al. (eds.), *Health and Human Rights: A Reader*, London: Routledge, 1999, pp.216-226.

<sup>49</sup> Richard Dodgson and Kelley Lee, Global Health Governance. A Conceptual Review, in Rorden Wilkinson and Steve Hughes (eds.), *Global Governance. Critical Perspectives*, London: Routledge, 2002, pp.92-110, quote on p.98.

<sup>50</sup> See for example Institute of Medicine (IOM), *Emerging Infections: Microbial Threats to Health in the United States*, Washington D.C.: National Academy Press, 1992; World Health Organisation, *World Health Report: Fighting Disease, Fostering Development*, Geneva: WHO, 1996; Madeleine Drexler, *Secret Agents. The Menace of Emerging Infections*, Washington, D.C.: Joseph Henry Press, 2002; IOM, *Microbial Threats to Health: Emergence, Detection, and Response*, Washington, D.C.: National Academy Press, 2003.

<sup>51</sup> On the involvement of the latter see Yves Beigbeder, *International Public Health. Patients' Rights vs. the Protection of Patents*, Aldershot: Ashgate, 2004.

<sup>52</sup> Dodgson and Lee, *Global Health Governance*, p.98.

Thirdly, there is a clear negative feed-back loop between globalisation and already existing socio-economic of environmental problems, such that globalisation leads to “worsening poverty, marginalisation, and health inequity.”<sup>53</sup>

Lastly, globalisation has reduced state capacity to adequately address problems in a variety of issue areas, public health among them. As Dodgson and Lee explain:

“Infectious diseases are perhaps the most prominent example of this diminishing capacity, but equally important are the impacts on non-communicable diseases (such as tobacco-related lung cancer), food and nutrition, lifestyles and environmental conditions.”<sup>54</sup>

Acknowledging this decreased state capacity, non-state actors have already been brought into the international public health arena as information providers. This has begun to change the processes of international public health policy making away from a purely state-centric approach. Fidler aptly illustrates this trend with the example of NGO-generated disease surveillance data that is now being utilized by the WHO and fed into its Global Outbreak Alert and Response Network (GOARN). The need to harness this additional source of information was identified early in the process of revising the International Health Regulations, but the process for formalizing the use of data from non-state actors then took on a life of its own with a dedicated search engine being set up to collect data on disease outbreaks from a variety of sources like *inter alia* email services, websites, internet discussion groups, and online newspapers. This use of non-governmental disease surveillance data started in 1997, was approved by the World

---

<sup>53</sup> Dodgson and Lee, p.99.

<sup>54</sup> Ibid.

Health Assembly in 2001, and thus preceded the conclusion of the IHR revision process by several years.<sup>55</sup>

## **5. The Emergence of Bioterrorism and the Securitisation of Public Health**

The use of biological weapons by terrorists has intermittently, but repeatedly, surfaced as a potential security threat in academic discourses since at least the 1970s.<sup>56</sup> However, as a comprehensive review of all “bioagent” cases – including bioterrorism and the criminal use of biological agents – throughout the 20<sup>th</sup> century shows, bioterrorism was a non-event up until at least the end of the 1960s.<sup>57</sup> For the 1970s eight cases are reported, the most “famous” of which saw the Bulgarian dissident Georgi Markov as the victim of an assassination in London with the toxin ricin.<sup>58</sup> For the 1980s nine incidents involving bioagents are discussed, among them a case of food poisoning in a salad bar in Oregon in 1984, committed by members of the Rajneeshees cult, in order to influence the outcome of a local election.<sup>59</sup>

Figures for bioagent incidents skyrocketed during the 1990s with much of the increase in numbers occurring during the second half of the decade. Carus reports a total of 153 cases for the 1990s, which brings the total for all of the 20<sup>th</sup> century to 180. However, many of these “cases” only took place in the perpetrators’ minds or were

---

<sup>55</sup> Fidler, *SARS, Governance and the Globalization of Disease*, pp.66f.

<sup>56</sup> See Ron Purver, *Chemical and Biological Terrorism: The Threat According to the Open Literature*, Ottawa: Canadian Security Intelligence Service, June 1995.

<sup>57</sup> See W. Seth Carus, *Bioterrorism and Biocrimes. The Illicit Use of Biological Agents Since 1900*, Washington, D.C.: National Defense University, February 2001, especially the table on p.11.

<sup>58</sup> Carus, *Bioterrorism and Biocrimes*, pp.58-60.

<sup>59</sup> *Ibid*, pp.50-58.

hoaxes: Carus puts 137 out of the 180 reported cases in this category.<sup>60</sup> Twelve of the more plausible cases where there exists evidence that CBW acquisition and use was at least seriously contemplated, were investigated in depth by a group of US scholars.<sup>61</sup>

All the increased research activities and other attempts to establish whether the new fear of bioterrorism was grounded in reality or was “hyped”<sup>62</sup>, was triggered by the Aum Shinrikyo attack in March 1995, in which the nerve agent Sarin was released in commuter trains of the Tokyo subway system. This release, which killed 5 people, was preceded by several years of attempting to acquire pathogens for use as biological weapons on part of the Aum cult, including anthrax, botulinum toxin, Q-fever, and ebola. However, all of these previous attempts were unsuccessful and the rather crude dispersal of Sarin represented Aum’s fall-back position.<sup>63</sup> While Aum’s Sarin gas attack – in conjunction with the Oklahoma City bombing – led in the US from the mid-1990s onwards to more and more calls for expanded measures to counter potential bioterrorist attacks, including the “drafting”<sup>64</sup> of the public health system for this purpose,<sup>65</sup> no comparable trend to elevate bioterrorism to the number one security threat and corresponding efforts to securitize public health were visible at the international level.

Such a trend occurred on the international level only after the World Trade Center attacks in the US on September 11, 2001 and the subsequent anthrax letters sent through

---

<sup>60</sup> Ibid, p.8.

<sup>61</sup> See Jonathan Tucker (ed.), *Toxic Terror. Assessing Terrorist Use of Chemical and Biological Weapons*, Cambridge, MA: MIT Press, 2000.

<sup>62</sup> See Brad Roberts (ed.), *Hype or Reality: The New Terrorism” and Mass Casualty Attacks*, Alexandria, VA: Chemical and Biological Arms Control Institute, 2000.

<sup>63</sup> See Milton Leitenberg, The Experience of the Japanese Aum Shinrikyo Group and Biological Agents, in Roberts (ed.), *Hype or Reality*, pp.159-170.

<sup>64</sup> The term is taken from Elin Gursky, *Drafted to fight Terror. U.S. Public Health on the Front Lines of Biological Defense*, Washington D.C.: ANSER, August 2004.

<sup>65</sup> The second briefing paper in this series, to be published later in 2005 will address the shift in discourse and policy in the US in greater detail.

the US mail system. Although attempts to securitize public health manifested themselves on a number of levels and led to a variety of institutional responses, such as the G-7 health security initiative, and a variety of policy measures on European Union level (like for example the setting up of a European Center for Disease Control in Sweden), the focus here will be on the two institutional settings with the clearest mandate to address on the international level both public health and the biological weapons threat, i.e. the World Health Organisation and the community of states parties to the BWC.

### ***5.1. WHO activities***

On first glance it may seem that the World Health Assembly (WHA) at its 54<sup>th</sup> session in May 2001 was anticipating the events to occur during the following fall when it passed a resolution entitled “Global health security: epidemic alert and response”.<sup>66</sup> Closer scrutiny reveals, however, that the resolution is focusing on the ongoing revision of the International Health Regulations, newly emerging and re-emerging infectious diseases, and antimicrobial resistance. Nowhere in the document is reference made to the deliberate spread of biological agents or the supporting role public health might assume in the case of a bioterrorist event. It seems then that the labelling of the resolution and the inclusion of the term “security” represents a manifestation of what in security studies discourse has come to be known as the broadening of the concept of security, its

---

<sup>66</sup> See WHO document WHA54.14, available at [http://www.who.int/gb/ebwha/pdf\\_files/WHA54/ea54r14.pdf](http://www.who.int/gb/ebwha/pdf_files/WHA54/ea54r14.pdf)

extension beyond the purely military sphere, to encompass issue areas like the environment or health.<sup>67</sup>

The WHO's first response to the anthrax letters in the US took the form of the release of a pre-publication version of its "Public health response to biological and chemical weapons: WHO guidance" in late 2001. This publication represents the 2<sup>nd</sup> edition of the 1970 WHO publication "Health aspects of chemical and biological weapons", whose revision had been under way for some years prior to the 2001 anthrax letters sent through the US mail. The final version of the 2<sup>nd</sup> edition was eventually published in 2004.<sup>68</sup>

In the spring of 2002 the WHO secretariat in preparation of the 55<sup>th</sup> WHA produced a report on the "Deliberate use of biological and chemical agents to cause harm".<sup>69</sup> In it the WHO acknowledges that the scenarios usually employed to assess the preparedness of public health systems for the deliberate spread of diseases "would pose extreme difficulties for public health systems" should they ever materialize.<sup>70</sup> It continued by pointing out that a "deliberate release of a biological, chemical, or radiological agent would likely be considered initially as a natural event, unless the agent had been spread overtly or on a massive scale." In response to such an incident the WHO's response is to "strengthen public health disease alert systems at all levels, as such a system will detect and respond to diseases that may be deliberately caused."<sup>71</sup> In case

---

<sup>67</sup> See Keith Krause and Michael C. Williams, Broadening the Agenda of Security Studies: Politics and Methods, in *Mershon Review of International Studies*, Vol.40, No.2, 1996, pp.229-254.

<sup>68</sup> See <http://www.who.int/csr/delibepidemics/biochemguide/en/index.html>

<sup>69</sup> See WHO Document [http://www.who.int/gb/ebwha/pdf\\_files/WHA55/ea5520.pdf](http://www.who.int/gb/ebwha/pdf_files/WHA55/ea5520.pdf)

<sup>70</sup> Ibid, p.1.

<sup>71</sup> Ibid, p.2.

the United Nations were tasked to investigate a disease outbreak, the report foresees that the

“WHO could be asked to provide technical expertise or to make available its existing resources and mechanisms. Non-public health issues related to investigations of reports on possible use of chemical and bacteriological (biological) or toxin weapons, however, remain the responsibility of the United Nations. If such a request were made, information about the public health response, including the results of epidemiological and laboratory investigations, would be reported by WHO to the government of the country or countries where the event was occurring.”<sup>72</sup>

With this the WHO clearly stresses its public health mandate and positions itself outside the biological weapons arms control context. An expansion of WHO’s mandate to function as a substitute verification organisation for the BWC is clearly rejected in the report.

In the resolution of the World Health Assembly, which is based on this report, member states are urged

“(1) to ensure they have in place national disease-surveillance plans which are complementary to regional and global disease-surveillance mechanisms, and to collaborate in the rapid analysis and sharing of surveillance data of international humanitarian concern;  
(2) to collaborate and provide mutual support in order to enhance national capacity in field epidemiology, laboratory diagnoses, toxicology and case management;  
(3) to treat any deliberate use, including local, of biological and chemical agents and radionuclear attack to cause harm also as a global public health threat, and to respond to such a threat in other countries by sharing expertise, supplies and resources in order rapidly to contain the event and mitigate its effects;”<sup>73</sup>

---

<sup>72</sup> Ibid, p.3.

<sup>73</sup> See [http://www.who.int/gb/ebwha/pdf\\_files/WHA55/ewha5516.pdf](http://www.who.int/gb/ebwha/pdf_files/WHA55/ewha5516.pdf), p.2.

In addition, the WHO director general was requested:

“(1) to continue, in consultation with relevant intergovernmental agencies and other international organizations, to strengthen global surveillance of infectious diseases, water quality, and food safety, and related activities such as revision of the International Health Regulations ...

(2) to provide tools and support for Member States, particularly developing countries, in strengthening their national health systems, notably with regard to emergency preparedness and response plans, including disease surveillance and toxicology, risk communication, and psychosocial consequences of emergencies;

(3) to continue to issue international guidance and technical information on recommended public health measures to deal with the deliberate use of biological and chemical agents to cause harm, and to make this information available on WHO’s web site;

(4) to examine the possible development of new tools, within the mandate of WHO, including modeling of possible scenarios of natural occurrence, accidental release or deliberate use of biological, [and] chemical agents ... that affect health, ...”<sup>74</sup>

The Department of Communicable Disease Surveillance and Response in the WHO Secretariat had already set up its *Programme for the Preparedness of Deliberate Epidemics* (PDE) in response to the anthrax attacks in the US. Following the above-mentioned WHA resolution PDE was developed into three main areas<sup>75</sup>:

- International coordination and collaboration: this involves the contribution of WHO staff to a variety of meetings organized in the context of the BWC, the North Atlantic Treaty Organization, or the Red Cross.
- National capacity strengthening on preparedness for and response to the deliberate use of bioagents: in this area the WHO issued recommendations on the development

---

<sup>74</sup> Ibid.

<sup>75</sup> See WHO, *Preparedness for Deliberate Epidemics. To support Member States in enhancing their preparedness and response programmes for the possible deliberate use of biological agents that affect health. Report of activities for the biennium 2002-2003*, Geneva: WHO, 2004, document WHO/CDS/CSR/LYO/2004.7

of guidelines, expert networks and training. One concrete example involved the *Guidelines for Assessing National Health Preparedness Programmes for the Deliberate Use of Biological and Chemical Agents*.

- Public health preparedness for diseases associated with the deliberate use of biological agents: in this context “WHO is strengthening selected disease-specific networks, starting with anthrax. Other priority diseases – identified by a WHO risk assessment – include plague, tularemia, brucellosis, glanders, melioidosis, Q fever, typhus fever, ... and smallpox.”<sup>76</sup>

All the activities conducted under PDE are being funded by extra-budgetary resources, which are donated by member states with an interest in these issues. The original programme budget for the biennium 2002-2003 was below US\$ 1 Million<sup>77</sup> and although this has increased for the period 2004-2005, it is still a small team only dedicated to preparedness for deliberate diseases.

More recently the WHO’s potential role in the fight against the deliberate spread of disease featured in the UN Secretary General’s *High Level Panel on Threats, Challenges, and Change*, which was established in November 2003 and delivered its report in December 2004.<sup>78</sup> That public health would feature one way or another in the Panel’s report could almost be expected, as one of the panel members was former WHO Director General Gro Harlem Brundtland. In Part 2 of the report on *Collective security and the challenges of prevention* several paragraphs are expended to address the challenges of

---

<sup>76</sup> Ibid, p.5, available at [http://www.who.int/csr/delibepidemics/preparedness/WHO\\_CDS\\_CSR\\_LYO\\_2004\\_7.pdf](http://www.who.int/csr/delibepidemics/preparedness/WHO_CDS_CSR_LYO_2004_7.pdf)

<sup>77</sup> Ibid., p.6.

<sup>78</sup> See *A More Secure World: Our Shared Responsibility. Report of the Secretary-General’s High Level Panel on Threats, Challenges and Change*, New York: United Nations, 2004.

poverty reduction, sustainable development and the prevention of the spread of infectious disease. Under the heading of *New Initiatives*, the panel argues that

“International donors, in partnership with national authorities and local civil society organizations, should undertake a major new global initiative to rebuild local and national public health systems throughout the developing world.”<sup>79</sup>

In addition, “members of the World Health Assembly should provide greater resources to the WHO Global Outbreak Alert and Response Network to increase its capacity to cope with potential disease outbreaks.”<sup>80</sup> Lastly, and more problematically, the Panel recommends that:

“In extreme cases of threat posed by a new emerging infectious disease or intentional release of an infectious agent, there may be a need for cooperation between WHO and the Security Council in establishing effective quarantine measures.”<sup>81</sup>

This notion of WHO-Security Council collaboration is reinforced further down in the report where under the heading of *Better public health defenses* the Panel suggests that the “Security Council should consult with the WHO Director General to establish the necessary procedures for working together in the event of a suspicious or overwhelming outbreak of infectious disease.”<sup>82</sup> As Pearson has pointed out, the Panel with this last statement is “treading on dangerous ground” as it threatens to undermine the WHO’s “political neutrality and the widespread recognition that its purpose is to provide

---

<sup>79</sup> Ibid, p.29.

<sup>80</sup> Ibid, p.29f.

<sup>81</sup> Ibid, p.30.

<sup>82</sup> Ibid, p.47.

assistance to its member States when they are faced with outbreaks of disease.”<sup>83</sup> It also stands in stark contrast to the WHO’s self-image as evidenced in the above-quoted 2002 report of the WHO Secretariat, with which the organisation clearly tried to keep its distance from verifying compliance with the BWC.

## 5.2. *The BWC Intersessional Process*

When the second part of the BWC Review Conference eventually took place in late 2002, BWC member states decided by consensus:<sup>84</sup>

“(a) To hold three annual meetings of the States Parties of one week duration each year commencing in 2003 until the Sixth Review Conference, to be held not later than the end of 2006, to discuss, and promote common understanding and effective action on:

- i. the adoption of necessary national measures to implement the prohibitions set forth in the Convention, including the enactment of penal legislation;
- ii. national mechanisms to establish and maintain the security and oversight of pathogenic microorganisms and toxins;
- iii. enhancing international capabilities for responding to, investigating and mitigating the effects of cases of alleged use of biological or toxin weapons or suspicious outbreaks of disease;
- iv. strengthening and broadening national and international institutional efforts and existing mechanisms for the surveillance, detection, diagnosis and combating of infectious diseases affecting humans, animals, and plants;
- v. the content, promulgation, and adoption of codes of conduct for scientists.”<sup>85</sup>

---

<sup>83</sup> Graham S. Pearson, *The UN Secretary-General’s High Level Panel: Biological Weapons Related Issues*, Strengthening the Biological Weapons Convention Review Conference Paper No.14, Bradford: Department of Peace Studies, University of Bradford, May 2005, p.16.

<sup>84</sup> On the split 2001/2002 BWC review conference see Marie I. Chevrier, *Waiting for Godot or Saving the Show? The BWC Review Conference Reaches Modest Agreement*, in *Disarmament Diplomacy*, No.68, December 2002/January2003, pp.11-16; Jez Littlewood, *The Biological Weapons Convention. A Failed Revolution*, Aldershot: Ashgate, 2005.

<sup>85</sup> Final Document of the Fifth BWC Review Conference, document BWC/CONF.V/17, p.3, available at <http://disarmament2.un.org/wmd/bwc/pdf/bwccnf17.PDF>

The first two of these topics were dealt with in 2003, items iii and iv on the list were covered in 2004 and the remaining one – codes of conduct - is scheduled to be addressed in July and December 2005. Each meeting of states parties is prepared by a two-week meeting of experts, which are allowed to produce “factual reports describing their work”. The Sixth Review Conference, to be held no later than the end of 2006, has been tasked to “consider the work of these meetings and consider any further action.” This programme of work clearly is a far cry from the comprehensive approach of the AHG to reach agreement on a legally binding Protocol.

The 2003 meetings in the framework of the new intersessional process were generally regarded as having produced only a disappointing “minimalist outcome”, which resulted in a

“one-page political statement urging member states to enact or update national legislation making the prohibitions of the BWC binding on their citizens, imposing penal sanctions for violations, and tightening security over dangerous pathogens and toxins, yet without recommendation or guidelines for how to proceed.”<sup>86</sup>

In contrast, the discussion on the two agenda items for 2004 was conducted in a more cooperative atmosphere and led to the inclusion of several substantive paragraphs into the report of the meeting of states parties.<sup>87</sup> In the report BWC member states recognise that:

“strengthening and broadening national and international surveillance, detection, diagnosis and combating of infectious disease may support the object and purpose of the Convention;

---

<sup>86</sup> Jonathan B. Tucker, *The BWC New Process: A Preliminary Assessment*, in *The Nonproliferation Review*, Vol.11, No.1, Spring 2004, pp.26-39, quotes on p.33.

<sup>87</sup> See United Nations, *Report of the Meeting of States Parties*, Geneva: UN, 14 December 2004, Document BWC/MSP/2004-3, available at [http://www.opbw.org/new\\_process/msp2004/BWC\\_MSP\\_2004\\_3\\_E.pdf](http://www.opbw.org/new_process/msp2004/BWC_MSP_2004_3_E.pdf)

... the primary responsibility for surveillance, detection, diagnosis and combating of infectious diseases rests with States Parties, while the WHO, FAO and OIE have global responsibilities, within their mandates, in this regard. The respective structures, planning and activities of States Parties and the WHO, FAO and OIE should be co-ordinated with and complement one another ...”<sup>88</sup>

In terms of policy measures to follow from this assessment

“The States Parties consequently agreed on the value of:

- a) supporting the existing networks of relevant international organisations for the surveillance, detection, diagnosis and combating of infectious diseases and acting to strengthen the WHO, FAO and OIE programmes, within their mandates, for the continued development and strengthening of, and research into, rapid, effective and reliable activities for the surveillance, detection, diagnosis and combating of infectious diseases, including in cases of emergencies of international concern;
- b) improving, wherever possible, national and regional disease surveillance capabilities, and, if in a position to do so, assisting and encouraging, with the necessary agreement, other States Parties to do the same;
- c) working to improve communication on disease surveillance, including with the WHO, FAO and OIE, and among States Parties.”<sup>89</sup>

The acknowledgement of the existing mandates of WHO, FAO and OIE stands in marked contrast to the High Panel Report, which, through the recommended WHO collaboration with the UN Security Council, was clearly moving beyond WHO’s mandate. The wording in the report of BWC states parties likewise displays greater consciousness in the describing the scenarios in which WHO assistance might be required: it refers to all cases of infectious disease outbreak, not – like the High Panel Report repeatedly – to “suspicious” outbreaks. The latter approach implies already a political judgment, which is anathema to the WHO’s perception of its role and mandate.

---

<sup>88</sup> Ibid, p.4.

<sup>89</sup> Ibid.

## **6. Implications for the Global Governance of Public Health and the BW Prohibition Regime**

In order to assess the implications of the securitization of international public health for the global governance of health and the BW prohibition regime, it is necessary to take a step back and first return to the question to which degree attempts at securitization have been successful.

The securitizing speech acts that could be observed both in the WHO and the BWC context all have international public health as referent object, i.e. as that which is to be secured, not global public health. The central actors in international public health are states, not non-state actors, like in global public health. The state is at the center of preparing emergency measures to counter deliberate epidemics. The WHO, or NGOs, like the networks contributing to the WHO's GOARN only have a supporting role. This does not come as a surprise, as from a states perspective it is often important to retain control over policy and thus to safeguard ones sovereignty. As has been shown for the WHO, its primary concern was the preservation of its neutrality, in order to be able to continue the roles foreseen in its mandate. Being implicated in verifying the use of biological weapons or other aspects of BWC compliance would compromise this neutrality.

From this it follows that so far international public health has not been fully securitized. This assessment is supported by a look at the resource allocation for deliberate epidemics, which does not form part of the regular WHO budget, but is funded by interested member states. This leads to an institutionalization on a lower level which is

more easily reversible in case the specific interests of the states supporting the programme on preventing deliberate epidemics should shift. However, PDE strengthens another area to WHO's portfolio in which inter-governmental mechanisms prevail. Assuming that Fidler and others are correct in pointing out that such an international approach to global public health problems is leading to sub-optimal policy outcomes when compared to an approach which strengthens global governance mechanisms, the continued pre-occupation of parts of WHO's secretariat with BW-related issues poses an obstacle to the transition from international to global public health.

The partial securitization of international public health also means that the threat-defense sequence that is invoked on the basis of the spectre of deliberate epidemics is not an absolute one, which would call much more strongly for measures in the international public health arena beyond "rules that would otherwise bind". As a matter of fact, the only calls in the securitization of public health discourse on the international level that advocate moving beyond established rules or mandates are contained in the UN Secretary Generals High Panel Report.

As to the implications of the attempted securitization of international public health for the future of the BW prohibition regime, a first question to consider is whether and to what extent the emergence of the WHO as a new actor who "speaks security" in this area will have an impact on the regime. On first glance the setting up of new organisational structures in an already existing international bureaucracy might point to the solidification of the securitization of international public health and thus set up a competing actor to a potential future BWC secretariat. However, as the analysis of WHO involvement in the BWC Ad hoc group deliberations and the 2002 report on its PDE

activities have shown, WHO has no intention of taking on the role of verifying the use of BW or other aspects of states' compliance with their obligations undertaken under the BWC. What is more, at current levels of funding and manpower allocation WHO's PDE team would not have the capacity to perform such a function in the first place. In sum then, the WHO is not an actor who could or would want to play a major role in the context of the BW prohibition regime and will therefore not influence regime development in a major way.

As discussed in the section on the BWC intersessional process, "enhancing international capabilities for responding to ... suspicious outbreaks of disease" and "strengthening and broadening ... the surveillance, detection, diagnosis and combating of infectious diseases" had been selected as two of five issue areas for consideration by BWC states parties for the intersessional process leading up to the 2006 BWC Review Conference. This heightened profile of infectious disease surveillance could positively affect the implementation of three core regime norms: the cooperation norm, the assistance norm, and the internalisation norm. However, such a positive effect will depend on the overall approach taken by BWC states parties to utilize the outcomes of the intersessional process. Should BWC states parties for example decide to set up a small secretariat to assist states parties in implementing more effectively the provisions of the BWC in general and the recommendations that might flow from the 2003-2005 intersessional process more specifically, such a secretariat could conceivably also take on a few functions that overlap with or utilize the technical assistance WHO provides to its members. It might for example tap into the information provided by GOARN and act as a clearing house by assisting member states in identifying suspicious outbreaks of disease

from the wealth of information provided by GOARN. This would also relieve the WHO of suspicions that it might be misused as a “Trojan horse” to conduct BWC-related activities in public health guise.

Should the community of BWC states parties not be able to reach consensus during the 2006 Review Conference as to how to build on the work of the intersessional process and utilize the work conducted during the experts’ and states parties’ meetings, the partially securitized international public health regime will not be able to compensate for such a lack of political will. Neither is it to be expected that the international public health regime will weaken the already patchy BWC implementation record of a number of states parties. What the inability to use the potential contribution of international public health – that would respect the mandate and scope of the WHO’s activities – for the strengthening of the BW prohibition regime would amount to, however, is another lost opportunity.