The role of the Biological Weapons Convention in disease surveillance and response

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This article assesses the role and significance of the Biological Weapons Convention (BWC) with respect to infectious disease surveillance and response to outbreaks. Increasingly, the BWC is being used as a platform for addressing infectious disease threats arising naturally as well as traditional concerns about malicious dissemination of pathogenic microorganisms. The latter have long had a place on the security agenda, but natural disease outbreaks too are now being partially ‘securitized’ through the use of the BWC as a forum for exchanging information and ideas on disease surveillance and response. The article focuses on two prominent issues discussed at recent meetings of BWC member states: enhancing capacity for disease surveillance and response; and responding to allegations of biological weapons use and investigating outbreaks deemed suspicious. It concludes, firstly, that the BWC supports the efforts of international health organizations to enhance disease surveillance and response capacity worldwide. And secondly, that the BWC, rather than the World Health Organization (WHO), is the appropriate institution to deal with biological weapons allegations and investigations of suspicious outbreaks. The overall message is that securitization in the health sphere cuts both ways. Adding a security dimension (BW) alongside the task of detecting and responding to naturally occurring disease outbreaks is beneficial, but requiring a non-security organization (the WHO) to assume a security role would be counterproductive.

Keywords Infectious diseases, biological weapons, public health, international law

KEY MESSAGES

- The 1972 Biological Weapons Convention (BWC) is increasingly being used as a platform for addressing infectious disease threats arising naturally as well as from malicious human action.

- The BWC supports the efforts of international health organizations to enhance disease surveillance and response capacity worldwide. Such support constitutes partial securitization of naturally occurring infectious disease threats.

- The BWC, rather than the World Health Organization (WHO), is the appropriate institution to deal with allegations of biological weapons use and investigations of suspicious outbreaks of disease. Requiring the WHO to perform a security role would undermine the Organization’s humanitarian mission and thus diminish its ability to perform effectively.
Introduction

This article assesses the role and significance of an international arms control and disarmament treaty, the 1972 Biological Weapons Convention (BWC), with respect to infectious disease surveillance and response to outbreaks. The BWC is the main instrument of international law banning biological weapons (BW). Increasingly, however, the Convention is being used as a platform for addressing infectious disease threats arising naturally as well as traditional concerns about malicious dissemination of pathogenic microorganisms. The latter have long had a place on the security agenda, but natural disease outbreaks too are now being partially ‘securitized’ through the use of the BWC as a forum for exchanging information and ideas on disease surveillance and response. The article focuses on two prominent issues discussed at recent meetings of BWC member states, with particular regard to the views expressed by states in East Asia: enhancing capacity for disease surveillance and response; and responding to allegations of BW use and investigating outbreaks deemed suspicious. It concludes that: the BWC supports the efforts of international health organizations to enhance disease surveillance and response capacity worldwide; and the BWC, rather than the World Health Organization (WHO), is the appropriate institution to deal with BW allegations and investigations of suspicious outbreaks. The overall message of the article is that securitization in the health sphere cuts both ways. Adding a security dimension (BW) alongside the task of detecting and responding to naturally occurring disease outbreaks is beneficial, but requiring a non-security organization (the WHO) to assume a security role would be counterproductive.

The Biological Weapons Convention

In the ongoing struggle between humans and pathogenic microorganisms, the BWC was born in an era very different from the present. The opening of the Convention for signature in 1972 was preceded and facilitated by US President Richard Nixon’s decision in 1969 to abandon the American offensive BW programme. In the same year, US Surgeon-General William H Steward testified before Congress that he was ready to ‘close the book’ on infectious disease (Moore 2001: 1). Such optimism derived from widespread confidence (in the developed world at least) that new and improved antibiotics and vaccines would bring about a lasting victory of man over microbe. Today, however, the BWC operates in an era of emerging and re-emerging infectious diseases which impose a heavy health burden and defy many existing forms of medical treatment. To an increasing extent, the worsening threat of naturally occurring disease outbreaks is being considered alongside traditional BW concerns at meetings of BWC member states. In accordance with an agreement reached at the Fifth BWC Review Conference in Geneva in 2002, member states met in 2004 to ‘discuss and promote common understanding and effective action’ on:

- 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 (BWC 2002: 3–4).

Security against BW and security against natural disease outbreaks have traditionally been pursued by different sets of actors on both the domestic and international levels. Biodefence and BW arms control are usually the preserve of the military and diplomatic communities, and disease prevention and mitigation are the responsibility of state public health sectors and international institutions like the WHO. As Alexander Kelle has observed, however, ‘[t]his strict separation has become increasingly blurred’ (Kelle 2007: 217). The 2004 BWC meeting engaged a diversity of individuals, government departments and non-government organizations (NGOs) beyond those few arms control officials usually associated with the Convention and its implementation (United States 2004; European Union 2006: 5). The WHO, the Food and Agriculture Organization, the International Committee of the Red Cross and the World Organization for Animal Health were granted observer status to participate in the meeting. Also in attendance were 14 NGOs and research institutes (BWC 2004: 2).

Subsequently, at the Sixth BWC Review Conference in 2006, member states agreed that the topic discussions of 2004 ‘functioned as an important forum for exchange of national experiences and in-depth deliberations among States Parties’ (BWC 2006: 19). For this reason they agreed, prior to the Seventh Review Conference in 2011, to ‘discuss, and promote common understanding and effective action on:

- in 2009: ‘promoting capacity building in the fields of disease surveillance, detection, diagnosis, and containment of infectious diseases’; and
- in 2010: ‘Provision of assistance and coordination with relevant organizations... in the case of alleged use of biological or toxin weapons, including improving national capabilities for disease surveillance, detection and diagnosis and public health systems’ (BWC 2006: 21).

This article explores international attitudes to these two issues, as expressed in a BWC context, with particular regard to the views of states in East Asia. The picture that emerges is that the Convention plays a supportive role in championing enhanced disease surveillance and response capacity, and that the BWC is preferable to the WHO as a platform for investigating BW allegations and outbreaks deemed suspicious. Explained in the terms of ‘securitization’ theory, the partial securitization of disease surveillance and response via the BWC is beneficial. But requiring the WHO to perform a security role would undermine the Organization’s humanitarian mission and thus diminish its ability to perform effectively. In other words, in the health sphere, appeals to security can cut both ways.

Infectious diseases and securitization theory

The idea of linking health and security concerns, as a matter of academic analysis and public policy, has received support from two directions. On the one side is the public health sector, some
members of which see the language of security as a means of rallying political support and financial resources to address neglected health issues. On the other side is the security sector, where some argue that the impact of particular health challenges is sufficiently serious as to warrant the prioritization traditionally accorded to the use of armed force (Enemark 2009: 195). Infectious disease is the health issue which has received most attention in security-oriented policy documents and scholarly debates. And for the purposes of this article, the infectious disease issue of BW is the vehicle for framing disease surveillance and response in security terms.

The theory of securitization derives principally from the work of Barry Buzan, Ole Waever and Jaap de Wilde (Buzan 1991; Waever 1995; Buzan et al. 1998). According to these authors, for threats to count as security issues they must be distinguished from issues that are merely political. Specifically, they have to 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’ (Buzan et al. 1998: 5). This theoretical formula appears to assume that the treatment of an issue can only move from ‘politicalized’ to ‘securitized’ in a single bound. An alternative view is that only rarely does an issue move from being addressed within the realm of ‘normal’ politics to suddenly requiring emergency measures (Haacke and Williams 2008: 782). For Rita Abrahamsen, the theoretical insistence on defining security as ‘existential threat’ and distinguishing sharply between normal, everyday politics and ‘emergency action’ means that ‘many of the processes and modalities whereby issues come to be feared and experienced as potentially dangerous cannot be adequately captured within [the] perspective [of Buzan and his co-authors]’ (Abrahamsen 2005: 59). She goes on to argue that most security politics is concerned with mundane risk management rather than emergency action, and that ‘security issues can be seen to move on a continuum from normalcy to worrisome/troublesome to risk and to existential threat—and conversely, from threat to risk and back to normalcy’ (Abrahamsen 2005: 59). In line with such reasoning that the process of securitization is gradual and incremental, it is plausible to conceive of a political gesture towards security or ‘partial’ securitization.

Regarding the role of the BWC in disease surveillance and response, an arms control and disarmament treaty is an extraordinary mechanism for addressing naturally occurring health threats. Employing such a mechanism does not, however, constitute an ‘emergency measure’ as contemplated by securitization theory in its pure form. Nevertheless, it imbues the response process with more of a security flavour and such partial securitization probably enhances that process. As the next section will show, the threats of deliberate and natural disease create a dual imperative for governments and non-government entities to improve disease surveillance and response capabilities: expenditure on (traditional) security grounds to resist BW is more justifiable financially because it promises also to improve defences against disease outbreaks of natural origin; and expenditure on health grounds to resist natural diseases is made more acceptable politically because its applicability also to defending against biological attacks adds a security element.

It is important to note, however, that securitization to any extent and/or in any form is potentially counterproductive or otherwise harmful. Buzan and his co-authors take the view that ‘Avoiding excessive and irrational securitization is...a legitimate social, political and economic objective of considerable importance’ (Buzan et al. 1998: 208). In the context of HIV/AIDS, Stefan Elbe has warned of the risk that securitization will push responses to that disease towards military and intelligence organizations and away from organizations best suited to dealing with health issues (Elbe 2006: 119). Acknowledging this risk, the final section of this article argues that it would be counterproductive for the WHO—an organization which avoids politics in order to carry out its humanitarian mission—to assume the security role of responding to BW allegations and investigating disease outbreaks deemed suspicious.

### Disease surveillance and response capacity

A recent review of 14 international disease surveillance and response programmes identified deficiencies (particularly in the developing world) in the critical areas of health infrastructure, technical resources, and financial and human resources that pose challenges for effectively detecting and responding to disease outbreaks around the globe (Hitchcock et al. 2007: 221–2). Insofar as framing a problem in security terms has the potential to generate greater attention to and financial resources for solving that problem, the partial securitization afforded by discussing disease surveillance and response in a BWC context is a welcome development.

Regardless of whether an outbreak occurs naturally or as a result of BW use, there is a detection and response imperative. For this reason, broadly applicable measures aimed at limiting vulnerability to infectious disease threats are a worthwhile area in which to invest financial resources and political attention. Many of the basic measures needed to protect populations against naturally emerging infectious diseases—for example, syndromic surveillance, diagnostics and medical therapies—are the same as would be required to mitigate a biological attack. The Chinese Communist Party leader Mao Zedong recognized this as far back as 1952 when, amidst the controversy over alleged biological attacks by the USA during the Korean War (to be discussed later in this article), he launched China’s first Patriotic Hygiene Campaign. The slogan for the campaign was: ‘Mobilise to promote hygiene, to reduce disease, to raise the level of the people’s health, and to smash the germ warfare of the American imperialists!’ (Huang 2003: 2). More recently, China has stated that the ‘fundamental purpose of disease surveillance is to prevent and control the spread of disease, but it is also important in the prevention of bioterrorism attacks’ (China 2004: 3). This resonates with the view of the WHO (Cosivi 2005: 151):

> “Confronted with the potential threat to global health security by the intentional release of biological agents, the World Health Organization ... advocates ‘dual-use’ investment in national, regional and global public health operations and infrastructure for early detection and immediate response. One of the most effective methods of
preparedness against deliberate epidemics is to strengthen public health surveillance and response activities for naturally and accidentally occurring diseases.”

With highly sensitive and well-connected systems for local disease surveillance in place, outbreaks of deadly, contagious diseases could be detected and contained rapidly wherever in the world they occurred. Enhancing disease surveillance sensitivity requires, for example, training clinicians to recognize the signs and symptoms of diseases they would not normally encounter in their medical practices. It also requires expanded local diagnostic capacity worldwide to ensure existing laboratories are not swamped with samples.

In a highly interconnected world, there is an inevitable international dimension to public health responses. An outbreak event inside one country is potentially a problem for others, especially if the disease in question is contagious. In East Asia, the need to prioritize public health responses to infectious disease outbreaks spans the region. Poorer countries such as Cambodia, Laos and Myanmar are particularly vulnerable to disease outbreaks occurring in their territory because of a paucity of health resources. Wealthier countries like Japan, Singapore and South Korea are also vulnerable despite the higher standards of health care enjoyed by their citizens. This is largely because the public health systems of these countries, less accustomed to infectious disease threats, are ill-prepared for dealing with the morbidity, mortality and social anxiety burden of an outbreak. In the case of China, the largest and most populous country in East Asia, its vulnerability to such an event stems largely from the fact that health resources are allocated so unevenly as to open up gaps in outbreak response capacity. The region as a whole would be better able to resist infectious disease threats if wealthier countries worked to enhance the outbreak response capacity of poorer countries’ health systems as well as their own. In addition, well-resourced countries closely connected to but outside East Asia, such as the United States and Australia, have an interest in ensuring an outbreak does not spread within and beyond the region.

Arguments along these lines are routinely advanced at meetings of international health organizations like the WHO. However, the BWC is increasingly being used as an additional forum for states and NGOs to exchange information and ideas on detecting and responding to disease outbreaks, be they of natural or deliberate origin. In addition to standard arms control provisions banning BW possession and proliferation, Article X of the BWC requires that member states ‘facilitate, and have the right to participate in, the fullest possible exchange of equipment, materials and scientific and technological information for the use of bacteriological (biological) agents and toxins for peaceful purposes’ (BWC 1972). At the Fourth BWC Review Conference in 1996, member states acknowledged ‘worldwide concern about new, emerging and re-emerging infectious diseases’ and regarded international responses to these as offering ‘opportunities for increased cooperation in the context of Article X application and of strengthening the Convention’ (BWC 1996: 25). The Conference welcomed efforts to establish a system of global monitoring of disease and encouraged member states to support WHO programmes ‘to strengthen national and local programmes of surveillance for infectious diseases and improve early notification, surveillance, control and response capabilities’ (BWC 1996: 25).

The 2004 meeting of BWC member states was an opportunity to focus on the details of potential public health capabilities that would be useful in the event of a major disease outbreak, however caused. In one sense, states’ contributions to this meeting consisted simply of reports on what each was doing or would do for foreign policy, humanitarian or self-interest reasons. With respect to recent outbreaks of SARS and avian influenza in East Asia, for example, Japan reported that it had ‘strengthened national response measures, and during these outbreaks, provided medical equipment and medicines, as well as dispatching experts to affected countries’ (Japan 2004). Nevertheless, it was genuinely helpful for individual states to learn more about foreign systems, institutions, laws, policies and capabilities for disease surveillance and response. The message of the USA to other delegates was that the 2004 meeting was an opportunity ‘to share insights that will greatly improve the ability of the international community to respond to dangerous outbreaks of disease, whether naturally occurring or deliberate’ (United States 2004). The South Korean delegate noted (Republic of Korea 2004) that the meeting:

“brought us a better understanding of the diverse systems and mechanisms for the surveillance, detection, diagnosis and combating of infectious diseases and for responding to, investigating and mitigating the effects of alleged use of biological weapons or suspicious outbreaks of disease. As a consequence, we now know more clearly what has to be done and what remains to be done for the improved effectiveness of those systems and mechanisms.”

Some states, however, were interested in receiving more than just information and ideas. Indonesia, for example, called for enhanced laboratory capacity in developing countries (Indonesia 2004), and Malaysia was adamant that ‘the outcome of all research regarding the surveillance, detection, diagnosis and combating of infectious diseases affecting humans, animals and plants should also be made available to all [BWC] states parties on a non-discriminatory basis’ (Malaysia 2004). China called for wealthier BWC member states to fund improvements in disease surveillance and response in poorer states, and for assistance (in the form of technology, resources and information) to be provided ‘on the basis of equality, cooperation and mutual respect’ (BWC 2004: 21–2). China also suggested that BWC member states share their experiences in disease prevention and control by promoting technological cooperation and personnel exchanges (BWC 2004: 27). Some developed countries seemed receptive to such ideas, with the US representative remarking: ‘We too see utility in the provision of technical assistance… particularly in framing and/or expanding… national systems of disease surveillance and response’ (United States 2004). Australia in turn took the view that the 2004 meeting of BWC member states had ‘usefully informed initiatives to improve disease surveillance and diagnostic laboratory capacity in the Asia-Pacific region’ (Australia 2004).

Finally, in a consensus statement on the topic of disease surveillance and response, the BWC member states attending
the 2004 meeting recognized that ‘strengthening and broadening national and international surveillance, detection, diagnosis and combating of infectious disease may support the object and purpose of the Convention’ and that ‘scientific and technological developments have the potential to significantly improve disease surveillance and response’ (BWC 2004: 4). They consequently ‘agreed on the value’ of supporting the existing networks of international health organizations ‘for the surveillance, detection, diagnosis and combating of infectious diseases’ and ‘improving... national and regional disease surveillance capabilities’ (BWC 2004: 4). Subsequently, at the Sixth BWC Review Conference in 2006, the Non-Aligned Movement (NAM)\(^2\) (NAM 2006: 3) urged BWC member states:

“to develop a framework to provide technical and financial resources, including through voluntary contributions, for States Parties to support an international system for the global monitoring of emerging and re-emerging diseases in humans, animals and plants and to support other specific programmes to improve the effectiveness of national and international efforts on the surveillance, diagnosis, prevention and treatment of diseases caused by microbial and other biological agents and toxins, in particular infectious diseases, including collaborative vaccine research and development and relevant training programmes.”

In a statement on BWC universality, South Korea\(^3\) suggested that ‘[m]ore specific programs for the implementation of Article X of the Convention on international cooperation need to be developed (e.g. initiatives for capacity building)’ and ‘[e]xchange/training programs for scientists and the sharing of information through various seminars would offer an attractive incentive for non-Parties to join the Convention’ (Republic of Korea 2006: 2–3). Such prescriptions generally found favour at the Conference, the Final Declaration of which encouraged BWC member states ‘to continue strengthening existing international organizations and networks working on infectious diseases’ and ‘to improve communication on disease surveillance at all levels’, between themselves and with international health organizations. There was also consensus that wealthier member states should continue supporting, directly and through international organizations, capacity-building in poorer states ‘in the fields of disease surveillance, detection, diagnosis and combating of infectious diseases and related research’ (BWC 2006: 16). Clearly, the BWC was supporting the efforts of international health organizations to enhance disease surveillance and response capacity worldwide. Partial securitization, effected by discussing natural disease threats alongside BW issues via an arms control and disarmament treaty, appeared to be beneficial.

It is not difficult to see that strong surveillance and response capacity is important to protect not only against disease outbreaks of natural origin but also against the use of BW. And heightened surveillance, in particular, can help distinguish between the two. An increase in illness associated with a biological attack would be more difficult to detect if it occurred during a seasonal surge in naturally occurring infectious disease. For this reason, the WHO emphasizes the importance of routine surveillance for emerging diseases and those prone to epidemics. This would enhance the capacity of public health authorities to detect and investigate outbreaks that are caused deliberately; that is, an unusual disease event would be more easily recognized in the light of background data on the natural behaviour of infectious diseases. Such data include the disease’s geographical and seasonal occurrence, and the characteristic epidemiological, demographic and clinical features of an outbreak (WHO 2002: 2–4).

Certain epidemiological features of an outbreak suggesting an unnatural origin might lead to its description as suspicious. In 1979, for example, there was an outbreak of anthrax in Sverdlovsk in the former Soviet Union. Human and animal cases were distributed in a narrow corridor downwind from a military microbiology facility. Also, a biological agent used in a BW attack might differ from one occurring naturally if it has been genetically engineered or has remained genetically stable in laboratory culture for a long time. In the Sverdlovsk anthrax outbreak, victims were simultaneously infected with several strains of Bacillus anthracis bacteria; something not normally encountered in natural outbreaks (Wheelis 2000: 596). Labelling a disease outbreak as ‘suspicious’, however, can be a political judgment as well as a scientific one. As the next section shows, the investigation of such an outbreak or an allegation of BW use is likely to involve trade-offs between security and public health imperatives. For this reason, the WHO is not a suitable investigatory institution. Rather, such investigations should be carried out only under the auspices of the BWC. If the WHO were to assume this extraordinary (security) role, this would likely undermine the credibility and effectiveness of its humanitarian mission. In other words, securitization of the Organization’s role in disease surveillance and response via the issue of BW would be an unwelcome development.

**BW allegations and suspicious outbreaks**

East Asia has been the scene of biological attacks, actual and alleged, at various times during the last century and BW suspicions persist in the region to this day. From the early 1930s and into the Second World War, the Imperial Japanese Army deployed a large-scale BW programme against China, and at the most recent BWC Review Conference the US government publicly accused North Korea of possessing BW (United States 2006: 2). However, BW allegations are notorious for having political motivations, and investigations of disease outbreaks deemed suspicious face formidable evidentiary difficulties. This is aptly demonstrated by the BW accusations levelled against the USA in the early 1950s and the Yellow Rain (toxin warfare) controversy of the early 1980s.

After its 1945 victory over Japan in the Second World War, the US government secretly provided immunity from war crimes prosecution to Japanese army scientists in exchange for their data on BW (Powell 1981). The USA itself was soon afterwards accused of perpetrating biological attacks during the Korean War. In February 1952, North Korean foreign minister Bak Hun Yung and Chinese Premier Zhou Enlai attracted worldwide attention when they made the allegation that the USA deployed BW on an experimental basis in China and North Korea. At the time, Western governments dismissed this as
hostile propaganda based on forced confessions from captured US Air Force pilots (Leitenberg 1998: 170, 172). According to one account, the US military believed at the time that a great advantage of biological warfare would be the enemy’s difficulty in distinguishing it from naturally occurring diseases, especially given the poor sanitary conditions of the enemy’s territory (Endicott and Hagerman 1998: 186). This very factor, however, could be used to support an argument that BW attacks never occurred in China and North Korea. Rather, outbreaks of diseases endemic to the area were probably natural occurrences resulting from the disruption of war, crowding, an increase in the mobility of the population, a breakdown of sanitation, and a lack of pest control and adequate medical services (Wilde and Johnson 1999: 1877–8).

The allegation that the USA deployed BW during the Korean War was most probably a fabrication of huge and elaborate proportions. In January 1998 a reporter for the Japanese newspaper Sankei Shimbun published the findings of 12 documents from former Soviet archives which provide detailed evidence that the allegations were contrived (Leitenberg 1998: 185). The documents describe remarkable measures taken by the North Koreans and Chinese, with Soviet advice, to create false evidence to corroborate their charges against the USA. Moreover, publicly available documents from the Russian Foreign Ministry Archive indicate that Soviet officials were involved in managing the North Korean propaganda campaign about US use of BW so as to prevent the falsity of the claims from being revealed (Weathersby 1998: 176–7).

The USA in turn raised allegations of toxin warfare in the Yellow Rain controversy of the early 1980s. Toxins—poisonous substances derived from a biological source (a microorganism, plant, insect or animal)—are covered by the BWC. On 13 September 1981, US Secretary of State Alexander Haig accused the Soviet Union of supplying trichothecene mycotoxins to its communist allies in Vietnam and Laos for military use against resistance forces in Laos and Cambodia. According to the US government, aircraft were spraying a yellow toxic material that fell like rain, allegedly bringing illness and death to thousands of victims (Robinson et al. 1990: 220). The substance became known as Yellow Rain because samples typically consisted of small yellow spots on leaves and bark. However, the physical evidence supporting this allegation was soon subjected to intense scientific scrutiny and criticism. Scientists outside the US government who studied the Yellow Rain samples were able to conclude instead that the alleged victims had mistaken toxin attacks for harmless showers of yellow honeybee faeces containing digested pollen (Tucker 2001: 26).

The Yellow Rain affair could have been addressed through the BWC, which had entered into force in 1975, but it was not. Under Article V, member states ‘undertake to consult one another and to cooperate in solving any problems which may arise in relation to… the Convention’ (BWC 1972). One such problem is the alleged use of biological or toxin weapons. Article VI provides for the investigation of BWC compliance concerns by the United Nations (UN) Security Council, and under Article VII member states undertake to assist one another in the event that biological or toxin weapons are used (BWC 1972). The Article V consultative process has been used only once. In August 1997, BWC member states met for 3 days to discuss an allegation by Cuba that a US government aircraft had deliberately released over the island a crop-destroying pest (Thrips palmi) in an attempt to inflict agricultural damage. The US rebutted this allegation, and the report on this consultation was inconclusive ‘due, inter alia, to the technical complexity of the subject and to the passage of time’ (Mathews 2005: 172). Neither Article VI nor Article VII of the BWC has ever been invoked.

For Jonathan Tucker, the Thrips palmi allegation experience suggests that ‘a mechanism for addressing BWC compliance concerns can be effective only if implemented by an international organization that is seen as independent, objective, and competent’ (Tucker 2004: 3). In 1997 the UN Secretary-General had standing authorization under General Assembly Resolution 37/98D (December 1982) to investigate, with the assistance of national technical experts, alleged use of BW. However, this authority has never been exercised, not least because of political sensitivities. China, for example, has expressed concern that no Asian or Latin American experts were involved in drafting Resolution 37/98D. As such, it doubts that the Secretary-General’s investigatory authority represents the will of all UN member states (BWC 2004: 38). Regarding a hypothetical UN Security Council investigation under Article VI of the BWC, China has insisted that the state requesting it should provide valid evidence and detailed data to prove that an outbreak of disease is not natural (BWC 2004: 39).

In the face of institutional inertia affecting the BWC, and in line with Tucker’s observations, it has been suggested that investigations should instead be conducted by the WHO. Certainly, the WHO already involves itself in BW issues by encouraging disease surveillance to detect suspicious outbreaks and providing advice to its member states on BW preparedness and response programmes. At the 55th World Health Assembly (WHA), Resolution WHA55.16 (18 May 2002) acknowledged that ‘the local release of biological… material designed to cause harm could have serious global public health implications and jeopardize the public health achievements of the past decades’ (WHA 2002). Article 6 of the 2005 International Health Regulations (IHR) requires each WHO member state to notify the Organization of a ‘public health emergency of international concern’. Annex 2 of the IHR, dealing with the criteria for notification, includes the ‘spread of toxic, infectious or otherwise hazardous material that may be occurring naturally or otherwise’ (WHO 2008: 44).

At the 2004 BWC meeting the USA was in favour of ‘updating and providing national expertise and laboratory capacity…to the World Health Organization’ in the context of ‘responding to, and working to mitigate the effects of cases of alleged biological weapons use or suspicious outbreaks of disease’ (United States 2004). Later that year the report of the UN High-Level Panel on Threats, Challenges and Change recommended 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’ (UN 2004: 30). This recommendation, clearly aimed at garnering greater resources and authority for dealing with disease emergencies, nevertheless failed to recognize the
political distinction that may be drawn between a natural outbreak and a biological attack. Health resources and political responses flow differently depending on whether a disease crisis touches the humanitarian nerve or the security nerve of governments. If WHO resources were used to investigate a politically motivated accusation of BW use, for example, this could tarnish the non-partisan image upon which the Organization relies to work effectively. So much of the access and goodwill accorded the WHO is dependent on its reputation as a neutral, scientific body. Too close an association with the Security Council, the least representative organ of the UN, might make some countries reluctant to co-operate with WHO investigations. This is but one illustration of the potential risks of securitization in the health sphere.

It is important to note also that any security-oriented investigation to confirm or rule out BW use would necessarily occur alongside the public health process of establishing the source of the outbreak and containing the spread of disease. The scientific aspects of both would be identical, although the international politics and forensic imperatives accompanying the former would make a big difference. For intelligence officials interacting with public health professionals, the principal challenge would be to overcome cultural, operational and organizational differences. For example, there are potential incompatibilities between the transparency required for public health agencies to operate freely and the confidentiality requirements of intelligence gathering. Related to this, there are also clear differences between law enforcement and public health. A BW attack is a crime as well as a health problem, and evidence in a criminal investigation must be collected within the constraints of legal rules to ensure any prosecution based upon that evidence can withstand scrutiny in a court. By contrast, public health investigators tend not to be so concerned with strict chain of custody requirements. In these circumstances, a worrying possibility is that containment of a disease outbreak and prompt treatment of patients will be compromised by a simultaneous arms control investigation (Wheelis 2000: 598). Moreover, there are a limited number of professionals worldwide with the expertise required to investigate disease outbreaks, so diverting personnel to a BW investigation could amount to wasting investigation resources.

At the 2004 BWC Meeting of Experts, Cuba and Brazil insisted that the WHO and other international health organizations should work only within their mandate and not be given a role in investigating BW allegations (BWC 2004: 40). Likewise, China’s position was that these organizations ‘have no right’ to carry out such investigations but could ‘provide technological assistance’ on request (BWC 2004: 42). At the Sixth BWC Review Conference in 2006, the consensus reached was that ‘achieving the objectives of the Convention will be more effectively realized... through collaboration with relevant regional and international organizations, in keeping within their respective mandates’ (BWC 2006: 9). The reference to ‘mandates’ reflected BWC member states’ desire that the WHO maintain a purely humanitarian role, unburdened by the politicization that traditionally accompanies BW allegations. Indeed, this policy is the same when BW issues are discussed in a WHO context. That is, the WHO ‘focuses on the possible public health consequences of an incident involving biological...agents...regardless of whether it is characterized as a natural occurrence, accidental release or a deliberate act’ (WHA 2002). As Kelle observes, ‘the WHO clearly rejects any attempts at international public health being securitized and positions itself outside the BW arms control context’ (Kelle 2007: 225–6).

Conclusion

This article illustrates how injecting a security dimension into disease surveillance and response can cut both ways. Addressing a traditional security issue (BW) alongside the task of detecting and responding to naturally occurring disease outbreaks is beneficial, but requiring a non-security organization (the WHO) to assume a security role would be counter-productive. As a platform for addressing infectious disease threats arising naturally as well as from malicious human action, the BWC supports the efforts of international health organizations to enhance disease surveillance and response capacity worldwide. Although discussions of BW are sometimes seen as an undue distraction from the worsening threat of naturally occurring diseases (McInnes and Lee 2006: 15), states are increasingly promoting and benefiting from a ‘dual use’ response as envisaged in the BWC discussion process. Such partial securitization of naturally occurring infectious disease threats is to be welcomed. As for investigating BW allegations and disease outbreaks deemed suspicious, however, it would be a bad idea to contaminate the humanitarian, non-political mission of the WHO by saddling it with a security role. The BWC, for all its imperfections, is still the appropriate institution to deal with this vexed aspect of disease surveillance and response. History suggests that BW allegations will always be politicized, and security imperatives could jeopardize public health imperatives if pursued simultaneously.

Nevertheless, there seems to be no clear solution to this dilemma; in practice, and as a matter of international law, BW-relevant allegations are likely to overlap with core WHO concerns in some way. An IHR notification of a ‘public health emergency of international concern’, specifically the ‘spread of toxic, infectious or otherwise hazardous material that may be occurring naturally or otherwise’ (WHO 2008: 44), prompts a WHO disease-control response regardless of whether such spread is occurring ‘naturally’ or ‘otherwise’. However, a state making such a notification could, on the same basis, additionally request a UN Security Council or Secretary-General investigation of alleged BW use. In March 2010, the then Chairman for the BWC meetings later in the year on ‘alleged use of biological or toxin weapons’ sought to compartmentalize the ‘health’ and ‘security’ dimensions of this topic in an advance brief to BWC member states (Chile 2010). Ambassador Carlos Portales of Chile distinguished between ‘public health’ responses to the ‘effects’ of alleged BW use, including controlling the spread of disease, and finding the ‘cause’ (a ‘criminal investigation’), including identifying the source of the outbreak (Chile 2010). Unfortunately, this distinction is difficult to maintain when, as is likely to be the case, knowing where and how an outbreak started vitally informs efforts to control the spread of disease.
Following the 2010 BWC discussions, the World Health Assembly and the Seventh BWC Review Conference in 2011 would be timely opportunities for WHO and BWC member states, respectively, to discuss further the dilemmas of responding to BW allegations. One way of protecting the WHO from the political ravages of securitization might be to somehow ensure, as China suggested in 2004 (BWC 2004: 42), that the Organization performs only an advisory rather than an investigatory role. For example, the member states of the WHO and/or BWC could agree on a provision whereby the Security Council or the Secretary-General may request a scientific report from the WHO Director-General on the nature, origins and progress of a disease outbreak which is the subject of a BW allegation. Consistent with the neutrality of the WHO, provision of such a report would require the consent of the state(s) in whose territory the outbreak was occurring, the state(s) alleging BW use and the state(s) accused. Alternatively, the report could be provided to the Security Council or Secretary-General at the discretion of the WHO Director-General, again subject to the consent of those states directly concerned. In both scenarios, the WHO would be expressly prohibited from making any determination of wrongdoing; only the Security Council or Secretary-General would be empowered to do so. Further discussions among BWC and WHO member states might yield more or better ideas for the international handling of BW allegations. As regards the health-security nexus, the guiding principle should be that a stronger and more effective WHO is one less burdened by real and perceived politicization.

Endnotes

1 For the purposes of this article, ‘East Asia’ comprises 15 countries: Brunei, Cambodia, China (and Taiwan), Indonesia, Japan, Laos, Malaysia, Myanmar, North Korea, Philippines, Singapore, South Korea, Thailand, Timor-Leste and Vietnam.

2 The Non-Aligned Movement (NAM), founded in 1961, comprises 118 developing countries and aims to represent the political, economic and cultural interests of the developing world. The NAM includes every state in East Asia except China, Japan and South Korea.

3 In consultation with Japan, Australia, Canada, Switzerland, Norway and New Zealand.

References


