Health Security Takes on New Vivid Forms

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Disease is among the oldest and most elemental threats to human society. Diseases like plague and smallpox shaped the course of human history, shattered societies, and transformed populations. The flu pandemic of 1918 killed as many as 50 million people worldwide, dwarfing the 17 million death toll of the “Great War” that just preceded it. Disease can strike rich and poor, east and west with impunity—but it preys most cruelly on the weak, the vulnerable, and the poor. Given the power of disease over society, it is no surprise that health care, along with food, water, and shelter, is among the most basic and vital service people require and a fundamental test of the value of governments and institutions entrusted with providing it. Mother Nature can wreak havoc enough, but she is by no means the only threat. The deliberate, malicious use of disease is among the gravest and most horrifying of national security threats—against which our defenses are limited at best. The 2001 anthrax attacks only resulted in five deaths but gripped the nation in fear, brought the postal system to a near standstill, and cost the nation more than $1 billion in response and recovery. Fourteen years hence, it is still prudent and chilling to weigh the implications of a larger more effective attack or one involving a contagious pathogen.

The last century has marked stunning progress in man’s conquest over disease—antibiotics, vaccines, and a host of health improvements have transformed the disease landscape, aided by scientific and technological advances and the maturation of public health institutions. Smallpox has been eradicated and polio nearly eliminated. A decade and a half ago, HIV/AIDS was seen as a grave threat and source of hopelessness: today 15 million persons living with HIV are on life-sustaining treatment. The march of progress against disease, however, is under threat in varied and unprecedented ways. New, naturally occurring disease threats such as H1N1, MERS, and Ebola are emerging, their spread accelerated by today’s urbanized, globalized, and highly mobile world. Accordingly, the time and space between outbreak and epidemic is shrinking. The use or manipulation of disease for nefarious purposes is easier and more accessible than ever, while treatment grows more challenging as antimicrobial resistance has worsened. The natural incubators of both disease and terrorism—weak, poor, fragile, and conflict-ridden states—are spreading rapidly across Africa and the Middle East, along with unprecedented flows of refugees and displaced populations. In a world where biological threats may be one plane ride away, even wealthy, prosperous nations need reminding of how fragile and interdependent health security is today.
The recent West Africa Ebola outbreak serves as a vivid demonstration of what’s at stake. In December 2013, a two-year-old child died in a remote corner of Guinea, the index case for the first recorded Ebola outbreak in West Africa. By late summer 2014, the disease was razing in its wake the marginal public health systems of Guinea, Sierra Leone, and Guinea, gravely disrupting agriculture, mining, tourism, and the normal flow of people, goods, and services. As the fall unfolded, the region witnessed an enormous, often chaotic and ad hoc international response, including, fortunately, the essential deployments of 750 UK troops and 2,800 U.S. defense and military personnel. Ultimately, more than 62 countries participated in the international response, at an estimated cost that today exceeds $5 billion. 11,000 have died, 27,000 have been infected, and 13,000 survivors struggle with the grave physical and mental health consequences. No senior World Health Organization (WHO) official has been fired or resigned, while the fight to get “to zero” continues. The specter looms that Ebola may indeed prove endemic to the region. How that might be managed, and what the long-term implication might be, remain unclear.

Inside the United States, the fear that Ebola triggered had profound, complex impacts. The two American missionaries medevacked in late July 2014 to Atlanta brought the nation to the edge of its seat. Thomas Eric Duncan’s tragic death at Texas Presbyterian Hospital in Dallas, followed by the secondary infection and survival of two valiant nurses (one of whom ventured to Cleveland to plan her wedding) created chaos. The subsequent case of a young doctor who returned to (and circulated around) New York City after having become infected while providing care for Ebola victims in West Africa frayed the patience of Governor Andrew Cuomo of New York. That was just before Traci Hickox, a headstrong media-savvy nurse, returned from West Africa, stared down an angry and exasperated Governor Chris Christie of New Jersey and prevailed in court in Maine, all the while antagonizing much of the American public. These events disrupted the U.S. public health and health care communities, damaged the standing of the Centers for Disease Control and Prevention (CDC), generated acute panic, and required multiple interventions by the president and senior officials to restore calm. They fed directly into congressional approval in mid-December of a $5.4 billion Ebola emergency appropriation, which for the first time, dedicated $800 million to creating health security capacities in Ebola countries, their neighbors, and more distant fragile states.

Ebola rocked West Africa, shook us at home, forced us to think and act in new ways about the intersection of health and security, and ignited a process of serious introspection over what it will take to better protect ourselves against dangerous, unforeseen outbreaks. The international response to Ebola has raised important questions about the capacity of future responses, trust and confidence in WHO, and if international leadership will seize on the moment to reform practices to ensure future responses are competent, orderly, accountable, and transparent. No fewer than four international panels have been convened to analyze the root causes of the Ebola catastrophe and advise on concrete steps to create a more reliable system of international preparedness and response.

But as awful as the Ebola outbreak was, it could have indeed been far worse. Weak and impoverished, Liberia, Sierra Leone, and Guinea could not manage the outbreak for their own
citizens, let alone the world. But they welcomed the assistance of the international community, which operated freely and at modest security risk. Health care workers bore significant risk of infection—over 500 died, of the more than 800 who contracted Ebola—but violent episodes and refugee flows were limited.

Elsewhere in the Middle East, Africa, and South Asia, a widening arc of violent instability is generating broken, chaotic, fragmented states, often with a heavy radical Islamic dimension. We see the disturbing evidence of the deteriorating security environment in several dramatic ways. There are today 60 million refugees and displaced persons worldwide, the highest level seen since the end of World War II. That has given rise to the illicit trafficking of the desperate from the Middle East and the Horn of Africa, crossing from Libya and Turkey into Europe, that exceeds 350,000 thus far in 2015. In Syria alone, more than 250,000 people are estimated to have died since the internal war ignited in March 2011. Presently, more than half of the Syrian population—almost 8 million internally displaced and 4 million now refugees—comprise a vast human catastrophe that imposes enormous financial, health, and political burdens—within Syria, on already vulnerable neighboring countries, and now extending into Europe.

At its core, the problem driving the new global political disorder is not an alien pathogen, but rather the dissolution of mal-governed states—Syria, Iraq, Yemen, Libya, northeast Nigeria, Mali, Afghanistan, South Sudan, Somalia, Central African Republic, eastern Ukraine—and the rise of new quasi-sovereign dangerous forms of extremism, most notably the Islamic State (ISIS). In the past five years, 12 new wars have broken out—the most virulent being the post-9/11 wars and the Arab Spring failures—adding to the several unresolved, long-term conflicts.

ISIS, now in the control of over one-third of Syria and Iraq, with external recruits exceeding 25,000, has displaced 3 million people and aspires to create franchise affiliates elsewhere, in North and West Africa and the Middle East. Syria as a sovereign entity has shrunk to a fraction of its previous dimensions. Increasingly, in these regions where governments and institutions can no longer meet the basic health needs of their citizens, terrorist, militant, or insurgent entities are stepping in to fill the void and curry favor. Moreover, as these substate and nonstate actors increasingly “govern” territory they hold and control, their ability to manipulate and control science and health related facilities and expertise for nefarious purposes is growing as well. A case in point is Mosul University in Iraq, taken over by ISIS during the summer of 2014, which provides ISIS unprecedented access to bench science and research facilities and a trained research faculty. With money, facilities, and skilled personnel in hand, ISIS has the potential to pose a serious biosecurity challenge. News reports now point to multiple alleged chemical weapons attacks in the last month by ISIS using sulfur mustard, possibly independently developed and weaponized by the organization. If true, the international community should be legitimately concerned that the biological weapons domain could come next.

Preventing and responding to disease threats—both naturally occurring and manmade—is exceedingly problematic in these broken and hostile regions. In the wake of these rapidly evolving developments is massive human suffering, breakdown of basic health services, and rising vulnerability to dangerous highly mobile infectious outbreaks. Diseases previously slated
for eradication (polio) or easily treated through modern medicine (measles) may be poised for a comeback in these broken settings. It is not clear how far and how fast the trajectory of this Middle Eastern–centered decay will advance. Nor how the United States, other countries, and international organizations will respond both to address the security threats and ameliorate the human crisis and public health threats.

Today the international humanitarian machinery is increasingly overwhelmed and increasingly constrained by worsening insecurity and the worsening shortfalls in funding, staffing, and operational capacities. The United Nation’s estimated annual humanitarian requirements total $19.2 billion; as of mid-September 2015, pledges amount to only one-third of that need, with the United States covering 50 percent of the load. Other wealthy, developed countries are flagging in their commitments.

Instability directly affects health care providers and relief workers who are operating on the front lines of crisis and conflict around the globe, struggling to save lives and protect public health while coming under fire themselves. The Islamic State’s deliberate, predatory attacks on international humanitarian workers and other personnel of nongovernmental organizations (NGOs), combined with similar attacks by Boko Haram, the Taliban, and Islamic militias in Libya and Yemen, have fundamentally changed the global environment for response. Neutrality and impartiality for health and other humanitarian services have dissolved. International organizations and NGOs have had to shift increasingly to a minimal on-the-ground presence, organizing operations from remote, safe locations, and working through local intermediaries. Inside the International Committee of the Red Cross (ICRC), Doctor without Borders (MSF), UN agencies, and many operational NGOs, there is active soul-searching under way, internal deliberations over how the change in the operational context alters their mission, their assessment of risk, and their programmatic approaches.

Given all these factors, global health security will be an enduring challenge, requiring engagement and thought leadership from both health and security sectors.

The Global Health Security Agenda (GHSA), launched by President Obama in February 2014, has taken several critical steps in the right direction. The GHSA is a multilateral initiative that now brings together more than 44 partner countries and organizations in an effort to better prevent, detect, and respond to infectious disease threats through targeted global capacity building. The agenda focusses on key priorities such as preventing antimicrobial drug resistance, promoting biosafety and biosecurity systems, enhancing biosurveillance and diagnostics and improving emergency response. The Ebola outbreak brought new energy and resources to the agenda—a stunning $800 million dollars in just a few months. But with that new enthusiasm comes concern about sustainability, efficiency, and practicality of a leadership-driven global effort lasting beyond the Obama administration. On September 9, 2015, ministers from around the world gathered in the Republic of Korea to take stock of the initiative and issue the “Seoul Declaration,” an impressive international pledge to advance health security, affirming the initiative’s momentum and deepening commitments. Most notably, President Park Geun-hye of Korea pledged $100 million in capacity-building assistance to 13 countries over the next five
years, while nine countries, including the United States, pledged to permit external assessments, in addition to the five now completed pilot assessments.

The Global Health Security Agenda is a promising, creative effort to focus on the diplomatic, security, and public health requisites to build a safer world, better equipped to cope with both natural and manmade threats. More, however, will be needed to meet the burgeoning demands of a worsening global disorder over the next 5 to 10 years. Looking into the future, the United States will need to think and operate innovatively in its emergency response and preparedness for biological threats, whether at home, abroad, or both, including respective roles for military and health sectors. The United States will need to work with international partners to better support international aid and health providers in broken and fragile societies, where national capacity building is impossible or impractical, where access is challenged, and where multitudes of threats coexist, to prevent the next global health catastrophe. Across all of these efforts that blend health and security considerations will be the need to build solid, enduring bipartisan support for expanded U.S. engagement in health security and to continue using U.S. diplomatic finesse to motivate our partners to do more themselves.

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