

INFECTIOUS DISEASES AS THREAT TO INTERNATIONAL SECURITY-THE CASE OF WEST AFRICA

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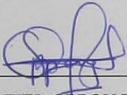
**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY
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LEGON

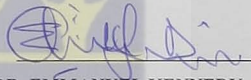
JULY 2016

DECLARATION

I, SAMUEL OPPONG hereby declare that except for references to other publications and materials which have been duly acknowledged herein, this work in its entirety, is the result of an original research conducted by me under the supervision of Dr. Emmanuel Kennedy Ahorsu.



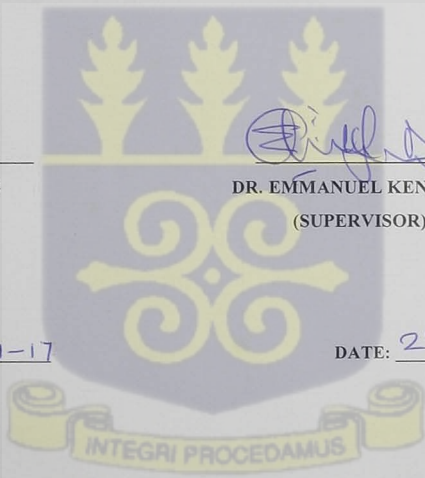
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DEDICATION

I dedicate this work to my unborn children; Ofotsu and Asɔ



THE DEPARTMENT OF POLITICAL SCIENCE AND ADMINISTRATION

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I appreciate immensely, my Supervisor Dr. Emmanuel Ahorsu for his guidance, reviews and thoroughness throughout the period of my studies. Also, I acknowledge the various personnel from NADMO, IOM, Ghana Health Service, the National Security Council Secretariat and the Senegalese Embassy for their contributions towards the purposes of the study.



LIST OF ACRONYMS AND ABBREVIATIONS

| | | |
|--------|---|--|
| AIDS | - | Acquired Immune Deficiency Syndrome |
| ASEAN | - | Association of South East Asian Nations |
| CDC | - | Centers for Disease Control and Prevention |
| CAF | - | Confederation of African Football |
| CHS | - | Commission on Human Security |
| CS | - | Copenhagen School |
| DA | - | Document Analysis |
| ECOWAS | - | Economic Community of West African States |
| ETC | - | Emergency Treatment Centers |
| EVD | - | Ebola Virus Disease |
| GOARN | - | Global Alert Response Network |
| HAART | - | Highly Active Anti-Retroviral Therapy |
| HIV | - | Human Immunodeficiency Virus |
| IHR | - | International Health Regulations |
| IO | - | International Organization |
| IOM | - | International Organization for Migration |
| KII | - | Key Informant Interview |

| | | |
|--------|---|---|
| MDR | - | Multi-Drug Resistant |
| MOH | - | Ministry of Health |
| NADMO | - | National Disaster Management Organization |
| NTS | - | Non-Traditional Security |
| PPE | - | Personal Protective Equipment |
| SARS | - | Severe Acute Respiratory Syndrome |
| TB | - | Tuberculosis |
| TRIPS | - | Trade Related Intellectual Property Rights |
| WAHO | - | West African Health Organization |
| WHO | - | World Health Organization |
| WHOER | - | World Health Organization Emergency Response |
| UN | - | United Nations |
| UNAIDS | - | The Joint United Nations Programme on HIV/AIDS |
| UNMEER | - | United Nations Mission For Emergency Ebola Response |
| UNSC | - | United Nations Security Council |

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ABSTRACT

The 2014 Ebola Virus Disease emerged as a landmark representation of the threat of infectious diseases within the sub-region. The disease was dominant in Guinea, Liberia and Sierra Leone and threatened the internal security of numerous states within the region. Over the 2 year span of the disease, it resulted in over 11,300 deaths and left behind devastating socio-economic impacts. The period of the outbreak called for much global attention and the eventual securitization of the disease by ECOWAS and the United Nations Security Council. The study seeks to explore the consciousness of the West African public in conceptualizing the Ebola Virus Disease (EVD) as a threat to security. It further examines the influences of socio-cultural factors in the securitizing the disease. The study employs a qualitative method in the gathering and analysis of data. Information was obtained from key informants and through the analysis of relevant data. Findings of the study elucidate the various factors that fueled the threat of the Ebola Virus Disease. Amidst the existent weak public health systems of most West African states, there were numerous socio-cultural factors that impeded the successful containment of the disease within sub-region. Some of these factors largely bordered on rites of passage and the ordinary practices of the communities within most states. The beliefs of sections of communities also vehemently opposed the tenets of the instituted containment measures within states. In essence, the conceptualization of the disease by the public and some state institutions hugely undermined the efforts of the various actors in containing the disease. Although securitized by major global actors, the consciousness of the public of the disease as a security threat was at variance the securitization act. Also, ECOWAS as a regional actor demonstrated significant frailties in offering adequate support to contain the disease. The study recommends that ECOWAS dedicates substantial resources by way of a health fund in order to forestall similar impacts in future occurrences of pandemics. Also, peace education should be advanced within communities to heighten awareness and consciousness of such threats in sustaining the region.



CHAPTER ONE

RESEARCH DESIGN

1.1 Background

Security is of vital importance to the survival of states. The realists have long viewed security and the need for state protection as essential to the existence of societies¹ This has accounted for the synonymy of the term with national security. Security has traditionally been associated with military actions by states to protect their territorial integrity and safeguard their sovereignty.² Following the end of the Cold War, inter-state conflicts declined with an upsurge of intrastate conflicts and challenges threatening the lives of individuals within states.³ These forms of conflicts did not necessarily require the military defence of national borders as the threats posed emerged from within the states. The issue of security therefore begged the need for a more expansive definition to address issues that threatened the lives of people in a state in the absence of intra-state conflicts.

Human security emerged as a suitable coinage to address the shifting paradigm of security issues.⁴ Human security has since been defined amongst many others as 'protecting people from critical (severe) and pervasive (widespread) threats and situations using processes that build on people's strengths and aspirations'.⁵ Inferably, human security offers an explicit scope of security issues beyond the traditional concerns of national security and strategic military defence to a people centred approach. The concept therefore offers a broader understanding of threats as sources of insecurities to include non-conventional security sectors such as health, the environment, food and the economy.⁵ It further seeks to offer comprehensive approaches to addressing such threats as a means of securing lives. The Commission on Human Security

therefore outlines the cardinal features of the concept as being multi-sectorial, comprehensive, context-specific and prevention-oriented.⁵ Thus, the concept focuses on multidimensional aspects of human development while identifying varying sources of threats. Factors that negatively impact on the integrity of the variables of human development could vehemently threaten the security of a state.

Threats to security may assume different forms. They could result from an implosion within a state and hugely risk the lives of individuals. Often, such issues are contained domestically. On the other hand, security threats may transcend territorial boundaries and co-exist within states, ravaging regions within the international system.⁶ They may be coordinated or uncoordinated leaving behind heinous impacts. These are known as transnational security threats.⁶ Admittedly, not all diffusible challenges to security in the international system can be regarded as threats. Before a transnational security issue assumes the status of a threat it must have the propensity to traverse borders either actively or passively and threaten the political and social integrity or the health of the inhabitants of the state.⁷ As forms of security threats, they could demonstrate the domino effects and leave behind widespread damages to various aspects of society. Hinging on enhanced transnational flow of goods, funds and people, the drug trade for instance is facilitated between cartels in Latin America to Europe and Asia adopting West Africa as a conduit.⁸ These have demonstrated huge regional and global implications. Coordinated across borders, drug trafficking in Guinea Bissau creates roots for incidents of regional tension within West Africa.⁹ The past decade has also witnessed the global impacts of other transnational threats to security such as climate change¹⁰, terrorism and infectious diseases.¹¹

Infectious diseases as a form of transnational threat have assumed much prominence on the global scene.¹² They have significantly threatened the security of societies in the recent past. These are diseases transmitted either directly or indirectly from an individual to another through contacts and interactions.¹³ Initially regarded as surmountable public health threats in the developed countries, infectious diseases continually demonstrate relevance on the global agenda.¹⁴ This is as observed in the emergence and re-emergence of the diseases. A number of factors have accounted for such resilience of infectious diseases in the global spheres and these include climate change, resistance to antibiotics and mutation of microbes.¹⁵ Additionally, transnational movement of humans across borders heavily propagates and leads to the progression of most diseases. Starting from the Justinian plague in the 6th century, the world has seen the emergence and re-emergence of numerous epidemics.¹⁶ These include localized ones such as cholera, typhoid and malaria to more diffused ones such as the Avian Flu, Severe Acute Respiratory Syndrome (SARS), Human Immunodeficiency virus (HIV) and Ebola Viral disease (EVD).¹⁷ Irrespective of the aetiology of the disease there is a primary security concern that these diseases present to the world; the premature and unnecessary loss of lives. Such concerns have informed responses to the emergence of numerous epidemics. The Bubonic plague of the 14th century saw the first institution of quarantine methods as means of avoiding the cross-border transmission of the infections. Subsequently, there have been numerous treaties and international protocol to appropriately situate infectious diseases within the security agenda as exemplified in the promulgation of the 1969 International Health Regulations (IHR) ¹⁸ which focussed on Yellow fever, Cholera and the Plague.¹⁹ Similarly, the emergence of the HIV/AIDS pandemic in the late 1980s has resulted in numerous global responses in attempts to mitigate its ravaging

impact across the globe.²⁰ In more recent times, the re-emergence of the Ebola Viral Disease has further drawn attention to the global impact of a single infection.

First discovered in 1976, the trajectory of the Ebola Viral Disease span the borders of Africa.²¹ The first outbreak was recorded in Sudan and Zaire (Now the Democratic Republic of Congo) in Central Africa.²¹ The outbreak in Sudan claimed about 150 lives.²² There have been numerous other isolated outbreaks across the continent recorded in Congo, Uganda and Gabon.²² These cases also demonstrated the different strains of the virus that emerged. The largest outbreak of the EVD started in 2013 when the first case of an infection was recorded in Guinea.²³ Later, it peaked in 2014 with the emergence of the disease in Liberia. Subsequently, Sierra Leone, Nigeria, Senegal and Mali recorded cases of the disease as the infection burgeoned into a crisis with few recorded cases in Spain and the United States.²⁴

The direct impact of the disease threatened the lives of numerous populations within and beyond the affected region. The ability of a single agent to threaten directly the lives of a significant population of a state renders it a security threat.²⁵ The impact of the EVD incited panic that resulted in numerous social and political upheavals in unaffected states. Due to the cross border spread of the disease, numerous travel bans were issued to restrict the movement of persons along certain routes. This consequently impacted on state relations with negative effects on the economy of states. For instance in 2014, Morocco declined hosting the 2015 Confederation of Africa Football (CAF) tournament giving reasons of fears of spread the epidemic to the state.²⁶ Morocco subsequently suffered punitive actions from the regional football governing body

CAF.²⁷ Such measures threatened the realisation of regional integration. Also, the outbreak fostered acts of violence, civil unrests²⁸ and social violence in parts of West Africa.²⁹

1.2 Statement of the Problem

The end of the Cold War marked significant changes in the conceptualization of security issues.² With enhanced cross border interactions, non-traditional security threats assumed a transnational status.³⁰ Public health issues such as infectious diseases have therefore been increasingly conceptualised as threats to international peace and security.

The West African sub region has been hugely plagued with infectious diseases such as Malaria, Cholera and HIV/AIDS over the past two (2) decades. In 2014, the Ebola Virus disease was particularly dominant on the scenes within the sub region. This had huge implications on the development of states along numerous facets. With an emergence in Guinea and subsequent transmission in neighbouring Liberia and Sierra Leone, the EVD affected over 28,000 persons claiming circa 11,300 lives and left behind unassessed devastating impacts.³¹

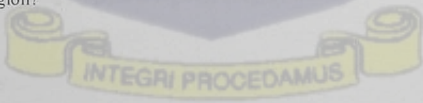
In line with the international trend of conceptualising infectious diseases, the EVD was securitized by numerous actors as a threat to international peace and security. This was first declared by the Economic Commission of West African States (ECOWAS)³² and later the WHO³³ and United Nations Security Council.³⁴ Despite the securitization of the disease by various actors, the progression of the disease within the sub-region remained unabated and essentially challenging to control. This is as observed in its spill over effects spread across states.

Securitising the EVD and the apparent international responses thereof could not suffice in containing the spread of the disease.

This calls for an examination of the consciousness of the West African public to the challenge of infectious diseases as they are moved from a mainly public health domain into a securitized problem. There is also the need for an understanding of the strengths or otherwise of structures of societies (institutions, regulations, resources) in supporting the securitization move as well as the socio-cultural responsiveness of West African societies to the securitization process in addressing the challenge of infectious diseases.

1.3 Research Questions

- What are the probable pandemics in the sub region?
- How are infectious diseases conceptualized as security threats in West Africa?
- Do the structural, cultural and circumstantial conditions promote or inhibit infectious diseases as plausible and feasible threats to the sub region?
- What are the available policies and strategic plans for infectious disease containment within the sub-region?



1.4 Objectives

To address the aims of the study the following objectives shall be employed

- Identify the probable pandemics in the sub region.
- To identify how infectious diseases are securitized in containing the impacts of pandemics.

- Identify the structural, cultural and circumstantial factors that promote and inhibit the progression of these threats, if any.
- Identify available policies that assist in the containment and management of the threat of pandemics in West Africa.

1.5 Rationale of the Study

The West African sub-region has suffered the impact of numerous pandemics over the years. Within the past fifteen years, it has grappled with the impact of tuberculosis, malaria, HIV/AIDS and Ebola. These challenges have been fuelled largely by heightened cross-border interactions and weak structural systems. As such national strategies in handling these pandemics could threaten the realization of the Protocols on movement and regional integration. The effects of most pandemics within the sub-region have the potential of scaling back years of development within the sub-region. This study therefore seeks to bring to the fore, the security risks and concerns in relation to pandemics within the sub region. The findings of the study could contribute to knowledge, practices and future research. This will further inform governments and policy makers in developing appropriate structures in handling epidemics as a security threat while at the same time protecting progress in regional integration.

1.6 Scope of the Study

The study focusses on the Ebola Virus Disease that occasioned West Africa in 2014. Despite the relatively short duration of the EVD in West Africa the burden of impact it posed to the sub region renders it a major infectious disease to investigate in this regard. Within the sub-region, the study focusses on Ghana, Liberia and Senegal. Liberia was severely affected by the disease

with high mortality rates due to the disease. Senegal had one (1) record of the disease while Ghana had no record of the disease during the period. The relatively different levels of exposure and incidents of the diseases within these states offers a better appreciation of the security implications of the disease across the region.

1.7 Hypothesis

Pandemics pose real threats to human security within West Africa due to structural inadequacies and socio-cultural practices within the region.

1.8 Theoretical Framework

The study is conducted within the framework of the securitization theory. Developed by the Copenhagen School of Security Studies (CS), it offered a more comprehensive method of analyzing security issues. Issues of security have often been expressed within the realms of military power as representing war and peace.³⁵ Following the end of World War II, security studies became synonymous with strategic studies with a focus on the military.³⁶ This development was demonstrated with the protection of the state from threats and the preservation of the status-quo. This reflected the traditional definition of security as 'freedom from any objective military threat to the survival of the state in the international system.'³⁷ However, such constructions of security appeared narrow amidst the changing nature of threats to the International System. Subsequently, there was an upsurge in devotion of scholarly work to economic, social and environmental issues as opposed to the previously held military agenda which had dominated discourses.³⁸ This latter school of thought was labelled as the 'wideners' who argued for a broader concept of security in addressing issues of the International System.³⁷

In addition to this, there was the need for the expansion of the referent objects in the concept of security to encompass individuals and humanity other than the state alone.³⁷ In this regard, the Copenhagen School of Security Studies (CS) offered a more expansive method of assessing security with the development of the securitization theory.³⁵

The securitization theory as defined by the CS is the “socially constructed process by which a threat to a particular referent object is acknowledged and deemed worth protecting.”³⁶ This is premised on the fact that the securitization process is an ensuing discourse between a securitizing actor and an audience who has a choice of either recognizing or declining a given situation as a threat. The definition of the audience herein does not necessarily refer to only the larger state population.³⁵ Rather, it comprises political elites and relevant state institutions as well.³⁹ Even when an issue is rejected as a security issue by the masses, the audience of political elites, policy makers and institutions can legitimize the securitization move.³⁵ The theory makes room for the acknowledgement of numerous other referent objects other than the state. These include national sovereignty, economies, collective identities and the environment. Buzan *et al* assert that securitization moves issues within these categories from the political arena onto the security platform.³⁸ To this end, Waever intimates that securitization is a speech act. That is, an issue becomes securitized by labelling it as such.⁴⁰ In order to avoid the wanton application of the theory, Buzan *et al* offer ways of assessing issues as worthy of securitization.³⁸ First, an existential threat should be identified for which an emergency action is desired. Additionally, it must be recognized that such actions as a matter of necessity could affect inter-unit relations without necessarily being rule-bound.³⁸ It is therefore not enough securitizing an issue due to the presence of an existential threat. Rather, the threat should be accompanied by emergency

responses that subverts the usual political process.³⁵ Transnational crimes, pandemics and economic crisis can therefore be suitably securitized.

With emphasis on the levels of states and individuals, infectious diseases can be securitized with regard to the threat they pose to inhabitants of states. They directly threaten the lives and welfare of individuals as regards social relations and economic activities.⁴¹ They could also result in potential decline in the productivity of the working populace. Within a state, infectious diseases come along with increasing public health challenges and economic burden in attempts to mitigate their impacts.⁴² Such issues are further heightened due to the fluidity of borders between states.⁴³ In West Africa, enhanced integration enables movement across borders. Forced migration as a result of conflicts and weak states as witnessed in Liberia and Sierra Leone is rife within the sub region.⁴⁴ As such, infectious diseases no longer pose only national threats but could assume an international dimension for which emergency responses are desired.

The securitization theory has been critiqued by numerous scholars largely on its scope and applicability.⁴⁵ Balzacq asserts such bandwidth of the theory makes it inapplicable in real world situations.⁴⁶ McDonald expresses three (3) fundamental ways by which the theory appears limiting and narrow.⁴⁷ Outlining that language is only one medium of communicating meaning, he highlights the flaws of the theory in being a speech act. That is, the fact that it takes political leaders and other dominant actors to declare an issue as being a threat before it can be securitized excludes other legitimate voices and media of communicating.⁴⁷ Also, attention is drawn to the fact that the theory is primarily developed for the moment of intervention and does not regard the potential of security issues to be constructed incrementally over time.⁴⁷

Additionally, the centrality of threats to the theory is viewed problematic. That is, security only acquires relevance through the imminence of a threat. These notwithstanding, the securitization theory adequately addresses the subject of this study.

With the outbreak of the Ebola Viral disease, there was the need for an earlier securitization of the disease once it emerged within the sub-region. Securitization of the disease in this regard was initiated at the national level by the governments of the affected states. Later, the ECOWAS and UNSC securitized it as threat to International Peace and security. Despite these moves, the conceptualization of the disease by the public did not adequately complete the process of securitization. Such actions resulted in the widespread and devastating impacts the EVD demonstrated within the affected states and beyond.

1.9 Clarification of Concepts

Infectious disease: These are diseases that are transmitted either directly or indirectly physically from one person to another and are caused by microorganisms such as viruses, bacteria, fungi and parasites.

Epidemic: An occurrence of an infectious disease in a community or country at a particular time.

Pandemic: An epidemic of infectious diseases that has spread across large geographic regions to include multiple states.

International Security: Measures taken by states and international organizations to foster survival and safety.

1.10 Literature Review

This section explores existing literature and academic work in relation to the objectives of the study.

1.10.1 Global Health Security and Securitization of Infectious Disease

The concept of Global Health Security has been assessed by various scholars to be rooted in the amalgamation of principles of public health⁴⁸ and the latter development of human security concept.⁴⁹ Lorna Weir offers a genealogy of the concept by tracing its development to events of the 19th century.⁴⁸ Accordingly, International Health Law tasked International Health Organizations with the duty of protecting member states against the cross border transmission of identified communicable diseases. Founded on principles of public and collective health, the establishment of the WHO as a global health body further assumed this role with the promulgation of the International Health Regulations (IHR). The IHR offered directives as to the means of addressing outbreaks of cholera, plague, yellow fever and small pox as emergency health issues. This was to ensure that epidemics do not escalate into cross border threats to health.¹⁹

Chen & Narasimhan offer an understanding of how global health was situated on the security agenda.⁴⁹ Their work explores the significant changes in the conceptualization of security and the subsequent evolution of the human security concept with health as a key variable or determinant of human security. It identifies the linkages between health and security as hinging on violence, global infections and poverty. Violence as a major determinant of population health eroded the strengths of health systems and heightened vulnerabilities to ill health. This assertion is further

corroborated by the findings of Valenti *et al.*⁵⁰ The global spread of infections deliberately as weapons of terrorism established a linkage between health and security.⁴⁹ Subsequent to this, was the carnage of HIV/AIDS and its eventual securitization by the United Nations Security Council. Finally, the study draws on poverty as breeding conditions for the inaccessibility to quality health, increased death and economic tolls from diseases. In this regard, the authors posit that socio-economic development is closely linked to the health and security of states. However, Katz & Singer offer a more nuanced assessment of how health issues could be accorded security considerations.⁵¹ In the study, a public health issue does not necessarily assume security relevance by virtue of the fact that it demonstrates negative human impact. Rather, such elevations may occur if the health issue has implications for national security and with a propensity to galvanise funding, political responses and attention from policy-makers. Citing the example of Poliomyelitis infections, Katz & Singer note that efforts from stakeholders were primarily geared toward the goal that eradicating the disease will amount to the public good and not necessarily in any economic or security ramifications of the disease. Premised on such arguments, further studies therefore sought to elucidate the basis for the appropriate securitization of diseases as they confronted society.

1.10.2 Emerging and Re-emerging Diseases

Although numerous diseases have plagued the world, events of these periods have significantly illustrated grappling attempts by individuals, institutions and states in addressing infectious diseases.⁵² These later offered meanings to the recent coinages that have been employed to qualify the terminology: emerging and re-emerging.⁵² The mid-20th Century promised to establish a total eradication of major infectious diseases.¹⁷ Characteristically, this had been

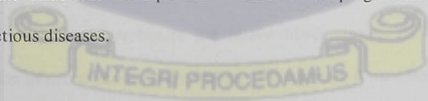
championed by leading scientists who made pronouncements indicative of the arrival of a panacea to the global carnage. Principally, the success in managing malaria had been extrapolated as a yardstick in the declaration of a solution to other infectious diseases most of which had relatively narrowed impact.¹⁷ Gaining from hindsight, Frank Snowden refers to this period as the age of hubris where scientists underestimated the replicative strength of microbes.⁵³ As further expressed, the last 20 years of the 19th century was studded with a significant rise in the incidents of infectious diseases; HIV/AIDS in 1983, the Indian Plague in 1994 and Ebola haemorrhagic fever in 1995.⁵³

Events of the 21st Century demonstrate heightened occurrence and re-emergence of infectious diseases, often escalating into epidemics and pandemics. Authors indicate that the first infectious disease to have plagued the century is the Severe Acute Respiratory Syndrome (SARS) which was prominent in Asia. SARS as an infectious respiratory disorder was airborne and as such threatened to spread at a much faster rate than malaria and HIV/AIDS which are not. It claimed 774 lives until it was successfully contained. Although contained, vestiges of its impacts upon assessment were dire. Sub-Saharan Africa, on the hand, grapples with the re-emergence of diseases such as malaria, tuberculosis, Lassa fever, cholera and the Ebola virus disease.

Following such unfriendly records, much insights have been sought into the possible factors that could be fuelling the emergence and re-emergence of these diseases and more importantly, their propagation across the globe. David Fidler groups these factors into four.¹⁴ First, he explores the contribution of the microbial world to the menace of pandemics. With the increasing microbial resilience, issues of antimicrobial resistance contribute to the emergence and re-emergence of

most infectious diseases. That is, with continual adaptability of microbes to antimicrobial drugs, there is the likelihood of incidents of resistance. The issue of antimicrobial resistance has presented perennial challenges to the control of infectious diseases. It alters the dynamics of treatment while establishing more complicated presentations of infections. Also, he identifies the upsurge of multiple partner sexual practices as being responsible for the re-emergence of HIV/AIDS especially across the globe.

He further focuses on the contributions of socio-economic and governmental activities on the emergence of infectious disease. To this, the depletion of natural resources and environmental degradation in pursuit of economic agenda create the appropriate ambience for some microbes to resurface or thrive. Finally, he identifies international travel as an ideal means for the emergence of most infections. Studies by Burman *et al* corroborate the findings of Fidler.⁵⁴ Similarly, he identified three (3) contributory factors for the progression of infectious diseases. More prominently, he highlights the lack of education and the dominance of cultural barriers to education as factors leading to the emergence of infectious diseases. However, while Fidler reveals the complacency of governments in the developed world in addressing these issues, Burman *et al* outline the structural inadequacies of most developing states as fuelling the emergence of most infectious diseases.



1.10.3 Infectious Diseases in a Globalized World

Globalization as a major driver³³ has been implicated in the spread and challenges in the containment of most infectious diseases.⁵⁵ According to Owen & Roberts, globalization refers to the 'opening of economies, increasing flows across borders and increasing interdependence

from places'.⁵⁶ With regard to infectious diseases, Saker *et al* define globalization as transnational flows that potentially erode and redefine territorial boundaries leading to changes in the experiences of states.⁵⁷ Prior to the transnational progression of infectious diseases, they are recognized to have been brewed aggressively in states or domestic localities. Studies have shown that this is particularly the case in most developing states before it ripples to the developed world.⁵⁸ Interestingly, urbanization in developing states does not necessarily spell development across all facets of life. Described as an increase in urban settlements, Neiderud identifies it as a key factor in the emergence of infectious diseases in developing states.⁵⁹ In the study, he identifies the gradually burgeoning size of the urban population across most states. Emphasis is laid on the disparities between the social classes within the urban population with regard to living conditions. Particularly, issues of overcrowding, insanitary conditions and weakened public health structures often characterize the urban populations of most developing countries. Studies show that 96% of Central African Republic's and 60% of Nairobi's urban population were slum inhabitants.⁶⁰ Such communities are easily plagued with infectious diseases such as diarrheal disease, tuberculosis and malaria. Tuberculosis has been more prevalent in urban centres than rural areas within affected states.⁶¹

Research by Emile *et al* further corroborate the above observations. Although the study highlights the contribution of urbanization to the spread of infections, it narrows the spectrum of such incidents to developing states while acknowledging the reverse on the developed world.⁶² In a broader view, studies have elucidated the numerous reasons responsible for the progression of epidemics as transnational challenges. Largely, technological advancement coupled with globalization³⁵ have contributed to the transnational status of most infections especially when

experienced in the developed world.⁵⁵ The element of technology is observed in the development of advanced transport and communication systems while globalization is seen with the enhanced interactions vis-à-vis trade and social relations. Global travel has increased over the decades by means of migration and tourism. Factors such as short term supply of skilled labour, human trafficking and scholarship abroad also contribute to global travel. Tourism as a major contributor in this regard has been seen to be increasing on continual basis.⁶³ In assessing SARS as it plagued Asia, the impact of heightened interactions is outlined.⁶⁴ Asia as a trade hub welcomed visitors from within and beyond the continent. Consequently trade and economic relations hugely fuelled the pitching of most domestic infections into a regional crisis. Particularly, tourism as an essential element of economic relations within the continent contributed immensely to the spiralled infections. Similarly, there has been heightened migration principally due to unequal economic growth, environmental and climatic instability,⁴⁰ and conflicts popularly referred to as forced migration.⁴¹

Forced migration is a common syndrome in conflict laden states and amongst people within unfavourable environmental or climatic conditions.⁶⁵ During conflicts, violence erodes healthcare structures which results in the degradation of safe environmental conditions.⁶⁶ Similarly, events of drought, famine and natural disasters have the propensity to threaten the public health of states. While Connolly *et al* studied forced migration as a product of complex emergencies, McMichael examined forced displacement as a corollary of climate change and climate related civil conflicts.⁶⁵ Admission is made of the fact that irrespective of the aetiology of forced migration, it is a good conduit for most communicable diseases.⁴² The resulting migrants herein are incubators of most vector borne diseases which are transmitted to

destination.⁴² Connolly *et al* assessment of climate-related forced migration examines the experiences and conditions that render migrants vulnerable to infections during transit and even within the host populations.⁴² Incidents of overcrowding which often results in poor ventilation in settlements render most migrants vulnerable to infectious diseases. Also, lack of basic necessities such as food and water compromises the immunity of most migrants hence heightening their vulnerability to infections. Beyond the migrant settlements, the study identifies a high propensity of infections to spread within the host populations. This could be partly due to inadequate public health resources and the health behaviours of the population. Consequently, the spread of infections becomes rife amongst the surviving populace and beyond. In sub-Saharan Africa, forced migration has occasioned incidents of adverse climate change and conflicts. Studies following the Rwandan crisis indicate that numerous deaths from cholera and dysentery were recorded within refugee camps when over a million people fled to Zaire.⁶⁷ Also, reports from Darfur show that numerous deaths amongst internally displaced persons were due to infectious diseases such as diarrhoeal diseases and measles.⁶⁸ Persistent drought within the Horn of Africa had huge implications on transmission of communicable diseases.⁶⁵ Dabaab, the highly populated refugee camp was fraught with most diarrheal and infectious diseases arising from and propagated by issues of forced migration.⁶⁹

Cultural practices, especially, within sub-Sahara Africa have been observed to either contribute to the spread of infections or hamper eradication strategies.⁷⁰ These often involve practices that are associated with the institutions of marriage, death and puberty. Sexual cleansing, associated with widowhood rites is a practice common to most East African cultures.⁷¹ It is basically the warding off of the dead from the widower through sexual intercourse with a cleanser.⁷² The

cleanser is a male, hired by the village to have sex with a woman before she is deemed befitting of the status of a widow.⁷² Over the years, it has resulted in about 19.6 million deaths⁴⁹ and spread HIV/AIDS at incredible rates.⁷² Amongst the Chewa of Zambia, there are practices of puberty rites that have been observed to possibly lead to the spread of HIV/AIDS. The *Kutha Cinamwali* which climaxes puberty rites involves sexual intercourse between a teenage girl and a hired male to offer her strength as she launches into womanhood.⁷³

The burial practices in most culture within West Africa are recorded to have fuelled the spread of the Ebola Viral disease. One of such practices is the bathing and cleaning of corpses by relatives of the dead as observed in parts of Sierra Leone.⁷⁴ Findings by Manguvo et al highlight the impact of religious and traditional practices within some cultures in West Africa on the transmission of the EVD.⁷⁰ Common to most West African cultures is the linkages between sickness and metaphysical causes. During the period of the outbreak, observers of such cultures were observed to have repelled scientific explanations and methods to addressing the diseases and rather fell on faith healers for assistance. This posed huge challenges to public health interventions. Faith based or traditional healing was subsequently identified as a means of transmitting the disease. With much trust reposed in the healing powers of diviners and pastors, they were often the first point of call in times of sicknesses. Claiming curative ends to the disease, these healers detained most sick people and maintained physical contacts with the sick through the application of potions and prayer sessions. Consequently, such periods offered sufficient incubation times for the disease leading to a transmission to some healers and relatives of the sick. Also, the practice of 'love touch' was recorded in some cultures where relatives washed their hands in a common bowl and touched the face of corpse as a gesture of farewell.⁷⁰

Anthropological studies by Fairhead within Sierra Leone, Guinea and Liberia offer much insight into the oppositional dynamics between culture and the option of scientific methods.⁷⁵ Amongst the Guerze of Liberia, Kissi of Guinea and Kouranko Sierra Leone, life after death is the commencement of ancestor roles and the dead must be initiated through the performance of certain rituals. Amongst the Kissis for instance, when a man dies, it is the duty of his brother to close his eyes. Later, the body is washed at home, oiled and wrapped in a cloth prior to burial. Graves, are dug in a family compound, under porches or places as may have been predetermined by the deceased. Although the practices varied across the three (3) cultures, similar principles underpinned the rituals. The direct touching of corpses which was common to all three cultures served as means of contaminating unaffected individuals with the EVD. Since such practices were religiously backed, the adherents repelled any form of education that run counter to their beliefs and practices. These accordingly, accounted for attacks on some medical personnel and three journalist in Womey, Guinea during the Ebola outbreak. In another study, a cluster of the infection was traced to a single traditional funeral ceremony in the Moyamba district of Sierra Leone.⁷⁶ Enhanced physical interactions and contacts as characteristic of numerous African funeral ceremonies contributed to that. Beyond these, beliefs myths that surround most infections hamper the acceptance and progress of public health education in times of infections.⁷⁰

1.10.4 The Threat of Infectious Diseases

Until the advent of the HIV/AIDS pandemic, issues of health lacked the attention as security issues. To an extent, the utterance of Vice-President Al Gore in 2000 laid foundations for the consideration of the HIV pandemic and by extension other pandemics as threats to security.⁷⁷ It hinged on the principle that such issues threaten not only the survival of humans but of

institution, systems and states. This has subsequently been reflected in the adoption of resolutions by the UN Security Council following the HIV and Ebola pandemics.⁷⁸ Numerous authors have therefore further explored the threats posed by infectious diseases.

Impacts of pandemics on morbidity and mortality rates within states have been examined in numerous studies. Within the sub-Sahara, malaria and tuberculosis have been recorded as having the greatest burden. Largely, the working population is affected and this could have negative implications on states. These tend to have implications on the economy as the productive sectors of the populace is affected. Conversely, the argument re-orientes when the issue of non-communicable diseases wade in. Researches in some developing states in South Asia and sub-Saharan Africa provide evidence to this effect. In what is called the transitioning of disease burden, Islam *et al* provide an understanding in the shift within Bangladesh and other developing Asian states.⁷⁹ Similarly, Maher *et al* acknowledge the wave of a health transition within Africa leaning towards non-communicable diseases.⁸⁰ This notwithstanding, the sweeping effects of most infectious diseases over a relatively short span could render them more heinous than statistically represented.

The impact of most pandemics the world over have been assessed across various sectors. Children are highly affected by most pandemics especially in sub-Sahara Africa.⁸¹ This has been realised as a trickling down effect when the parenting population is affected. First, children are seen to shoulder most of the household workload when their parents are sick or invalid as a result of HIV/AIDS.⁸² Such responsibilities are often borne by the adolescents. To augment income, some of these children engage in income-generating activities to fend for families.⁸² The impact

of HIV/AIDS in this regard has contributed to the increased street children in Africa particularly Zambia and Zimbabwe.⁸² Wagt and Connolly outline an array of problems that confront HIV orphaned children within the sub-Sahara. These included food insecurity, stigmatization, unstable education and sexual abuse. Other studies further affirmed these. A study conducted in Uganda assessed the impact of orphanhood or living with HIV infected parents had on children.⁸³ Of the 495 children of persons living with AIDS, 26% reported a decline in their school attendance while 27.6% reported a decline in academic performance following the condition of their parents. They enumerated emotional distress, care giving and lack of funds for school fees as accounting for such shortfalls in their education. The nutrition profile of these children also demonstrated a significant deficiency in their upkeep. Over 30 % of the children reported of inadequate food to satiate their hunger. Due to inadequate funds, children are often forced to stay out of school until an alternative source of funding occurs. More directly, a Kenyan study identified poorer performance among children living with HIV/AIDS. Also, malnutrition has been widely recorded amongst both children living with infected parents and those affected by HIV/AIDS.⁸¹

Several studies conducted in West Africa estimated the linkages between infectious diseases and economic variables.⁸⁴ Bollinger *et al* conducted an assessment of the economic impact of HIV/AIDS in Cote d'Ivoire.⁸⁵ In viewing the economic impact of the disease, the study focussed on the impacts on households, firms, agriculture and the macroeconomic indices. Once a member of a household suffered the disease, there is an initial burden on other family members with regard to finances and time. Expenses on the healthcare of the invalid often weighed heavily on the family. It was estimated that the average expenditure in catering for an adult patient was

about 25% of the annual net income of small farms in the area. This subsequently had rippling effects on school children when funds for their education are channelled into catering for an affected member. Often, other members of the household were compelled to miss work in order to cater for the sick. This reflected in the incremental losses of productive hours with the emergence of the diseases. Cote d'Ivoire's vibrant agricultural industry suffered a 6% loss in the agricultural labour force following the HIV/AIDS pandemic.⁸⁴ Subsequent observations indicated a significant reduction in the amount of cash crops produced. Such records were also partly due to the fact that the system of agriculture was labour intensive and as such, affected persons could hardly be involved. Studies conducted in Abidjan further explored the impact of HIV/AIDS on firms.⁸⁵ It was observed that the average direct costs to firms was between 29 and 125 dollars. There were also significant indirect costs which were due to absenteeism, stigmatization and re-organization of work structures.

1.11 Research Methodology

Data for the study was obtained from both primary and secondary sources. Primary sources of data took the form of unstructured interviews with key informants such as officials of the Public Health Division of the Ministry of Health of Ghana, the Director for Disease Control and Epidemiology at the National Disaster Management Organization (NADMO), the Culture attaches at the Senegalese Embassy in Ghana, officials from the National Security Secretariat and Global Health officials of the International Migration Organization. Secondary sources include a thorough review of existing documents on the subject matter issued by relevant institutions. These included but were not limited to the United Nations Library, University of Ghana Medical School Library, The Public Health Information desk of the Korle-bu Teaching Hospital The

World Bank, UNAIDS, Centre for Disease Control, the Ministries of Health of countries involved and West African Health Organization.

A qualitative in-depth interview technique known as Key Informant Interview (KII) was adopted to obtain information from persons within the afore-mentioned institutions. To achieve this, face-to-face and telephone interviews was conducted with the participants involved. The interviews were conducted using unstructured interview guide. The KII method was employed in combination with Document Analysis (DA) approach. The DA is a systemic procedure to review or evaluate both printed and electronic materials such as policy papers, press releases, news articles, communiques and other secondary sourced documents for the study.

1.12 Organization of Chapters

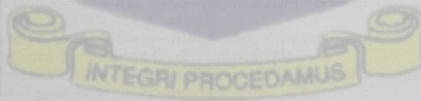
The study comprises the following Chapters:

CHAPTER 1- Research Design

CHAPTER 2- Overview of Transnational Security Threats

CHAPTER 3- West Africa and the Threat of Infectious Disease

CHAPTER 4 – Summary of Findings, Conclusion and Recommendations.



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CHAPTER TWO

AN OVERVIEW OF TRANSNATIONAL SECURITY THREATS

2.1 Transnational Security Threats

The development of the concept of transnational security resides in the dual structuring of earlier security issues: the internal security and external security.¹ Internal security comprised social security as well as public security and was observed with the institution of norms and rules by governments.¹ Conversely, the external security focused on discourses on war, the military and the actions of adversaries against states.¹ In the 18th century, the invasion by foreign marauders and gangs within certain sovereigns of Europe was perceived as a prime security threat. This led to the establishment of numerous internal security measures as means of curtailing the activities of these external threats. Political crimes² and international crimes particularly constituted transnational security threats. As a means of safeguarding their respective internal securities, states concluded numerous extradition and extradition treaties within the circles of Europe.³ This subsequently birthed the awareness of international security and the establishment of transnational security measures.³

Transnational security threats are “non-military threats that cross borders and either threaten the political and social integrity of a nation or the health of that nation’s inhabitants”.⁴ The development and subsequent recognition of transnational security threats have been informed by two major developments in international relations; Non-Traditional Security (NTS)⁵ and globalization.⁶ In the 20th Century traditional security primarily mirrored the realist construction of security which positions the state as the referent object.⁷ Thus, security issues largely focused on the protection of states from external threats. It focused on deterrence, balance of power and

designing of military strategies. Following the end of the Cold War, the traditional construction of security suffered adulterations with the introduction of the concept of non-traditional security (NTS). The paradigm of NTS saw the reconstruction of security issues to encompass areas of politics, environment, health and the economy. These represented areas within which the security of the state and its inhabitants could be guaranteed independent of military strategies and involvement.

Globalization is defined as the creation of a variety of transboundary mechanisms for interaction that affect and reflect the acceleration of economic, political and security interdependence.⁸ It primarily hinges on the increased relations between individuals of different states and the gradual yet significant erosion of state borders.⁹ Globalization is not a new phenomenon but rather appears hastened after the Cold War and the subsequent creation of a new world order. Thomas Friedman accentuates this position with the assertion that globalization is the international system that replaced the Cold War system.¹⁰ Characteristically, there have been numerous revolutions in communication, technology and transportation which have hugely impacted the global environment.¹¹ These have fueled further interactions across borders. In increasing mobility of goods and persons, globalization has further heightened the vulnerability of states to various orientations of threats. Industrial activities in the developed world have negative repercussions for the climate in the Sub-Saharan Africa.

By means of globalization, a new wave of security challenges therefore confronts states. Challenges confronting people are executed by multiple actors and traverse borders at uncontrolled rates. Rooted in the construct of modern society are constant interactions which

lever the activities of the actors involved. This could either be harnessed by individuals, groups or states to present security risks. On the other hand, certain factors may inadvertently pose security threats by mere fact of their propagation across territories. With the focus on non-traditional security issues, transnational security threats were thus conceptualized within international relations.

2.1.1 Forms of Transnational Security Threats

Transnational security threats may assume different forms. The various forms of transnational security threats that may prevail in an instance are largely informed by the availability of conditions suitable for its propagation across borders. The fluidity of certain forms of threat could easily escalate a confinable national security threat into an international threat.¹² By their nature, transnational security threats deconstruct the initial compartmentalization of issues within domestic locales or even specific areas such as the military, environment or health.¹² Consequently such ominous flows have the propensity to threaten the functional integrity of states and regions as well as the lives of individuals present.⁶ Transnational security threats may either take the form of criminal activities or may be due to natural causes. Forms of criminal or coordinated transnational security threats may include Terrorism, Drug Trafficking, Cybercrimes and Piracy. On the other hand, natural causes of transnational security threats include threats due to Climate Change, Natural Disasters and Pandemics. Conditions for the emergence of the natural sources of threats may be aided or unaided by human activities. For the purposes of the study, pandemics as transnational security threats constitute the major highlight.

2.2 Infectious Diseases As Transnational Security Threats

The microbial world offers the most diffusible form of threats to society. By their very nature, microbes could directly engulf large populations, traverse borders or leverage on vectors such as humans in their propagation across borders. Throughout history, infectious diseases have presented the most daunting threat to human populations. The impacts of certain infectious diseases over a relatively short duration could be hugely devastating outweighing the impact of wars and other direct forms of threat. They continue to emerge, re-emerge and persist within and across states¹³. Issues of adaptability, mutation, climate conditions¹⁴ and human interactions account for the resilience of microbes and their entrenchment within certain societies.¹⁵ They have demonstrated sufficient capacity to erode state structures, threaten lives and brew insecurities within states.¹⁶ Infectious diseases have therefore assumed much notoriety with huge social, economic, political and security implications across the globe. The 21st Century has witnessed the emergence, re-emergence and persistence of numerous infectious of International concern.

The emergence and re-emergence of infectious diseases has increased the global awareness to the potential impacts of pandemics. Estimated to demonstrate devastating effects than the toll of wars, some states, regional organizations and international bodies have been involved in securitising various pandemics. The process of securitizing infectious diseases as a global threat has been the initiative of the WHO with much support from the developed world. Often, such discourses have excluded contributions of the developing states.

The realization of infectious diseases as security threats was accompanied by two (2) major events: the revision of the International Health Regulations (IHR) and the elevation of pandemics

to the security agenda of developed states. The IHR was founded on principles of public health to avoid the international spread of diseases once they emerged within states. It appeared sustainable and assisted in the containment of epidemics within states in the 1970s. However, following the emergence of HIV/AIDS and the re-emergence of Tuberculosis, Malaria and Dengue fever in the 1980s, it became evident that the scope of the IHR was inadequate to address the impacts of outbreaks. As a global governing body, the WHO therefore sought to revise the IHR to avert, not only the international transmission of the diseases but also, the socio-political impact thereof. The IHR sought to among other things, make the WHO responsible for the declaration of health emergencies and threats as national governments (especially in the developing world) were not necessarily cooperative in securitising diseases. Before the WHO makes such a declaration, there is the need for a notification from the affected state and a latter confirmation by the global body. As a means of subverting the constraints of states in surveillance and detection, the WHO instituted the Global Outbreak Surveillance Network which aids offering prompt alerts to supplement the functions of the IHR.

The globalization of infectious diseases is not a new phenomenon. However, increased population movements, whether through tourism or migration or as a result of disasters; growth in international trade in food and biological products; social and environmental changes linked with urbanization, deforestation and alterations in climate; and changes in methods of food processing, distribution and consumer habits have reaffirmed that infectious disease events in one country are potentially a concern for the entire world.

2.2.1 HIV/AIDS

The outbreak of the Human Immunodeficiency Virus (HIV) was recorded in the mid-1980s.¹⁷ The progression of the virus within infected individuals produced the AIDS syndrome.¹⁸ This presentation of the infection is what rendered the disease catastrophic. As an outward demonstration of the disease, AIDS was the resultant of a highly compromised immune system plagued with opportunistic infections. This further led to a physical deprivation of the being and

a higher propensity of virulence in the affected individual. Like most infectious diseases, the outbreak of the HIV/AIDS disease struck the world unawares and demanded strategic responses from affected states. However, due to the long incubation period of the virus in an individual prior to its demonstrable symptoms, detection was delayed and as such most states envisaged it as a surmountable health issue.¹⁹ Consequently, within two decades of the outbreak, its ravaging effects became demonstrable.²⁰ The first decade primarily witnessed its propagation across the globe and its entrenchment within societies¹⁸ whilst second the decade largely demonstrates its impact²⁰ until it was eventually securitized by the United Nations Security Council.²¹

Africa remains the epicenter of HIV/AIDS accounting for over 70% of the burden of the disease.²² The progression of the disease within the continent has been daunting. Within the first decade of the emergence of the disease, numerous states projected from very low to higher incident rates. South Africa and Botswana each had soaring rates from 1% to 20% and 38.5% respectively.²³ With an average prevalence rate of 8.8%, it claimed 16.7 million lives affecting 29 million lives.²⁰ Amongst the global representation of the countries struck by the disease, the region housed the seven most afflicted with an average prevalence of 20%.²⁰ All seven countries were located in the Southern belt of the continent. East Africa similarly had higher incident rates within the first decade of the epidemic which receded within the following decade.²⁰ This notwithstanding, the sub-region had higher incidents relative to West Africa which kept a subtle profile.²⁰ Within this period, there was a general diffusion of the epidemic across the continent. This is due in part to the fact that as the epidemic continued to mature, the conditions for its propagation within some regions further worsened. That is poverty, weak health systems and migration provided the requisite ambience.²³ Additionally, although alarms had been raised,

some governments refused to acknowledge the looming threat of the disease, treating it as a matter of public health concern.

In Asia, there was an increasing rate of infection amongst the population, although marginal.²⁰ This was often due to the practice of drug injection and sexual practices amongst individuals. As such, the prevalence rates for South East and East Asia were 0.07% and 0.56 % respectively.²⁰ The most infected countries within the region were Thailand, Myanmar and Cambodia.²⁰ In the developed world of Europe and North America, an estimated total of 75000 persons were infected in 2000 summing up the count of incidents to 1.46 million.²⁴ While the developing world was battling with decreasing mortality due to the disease, these regions were concerned with prolonging the periods of survival with the development of the Highly Active Anti-Retroviral Therapy (HAART).²⁵ However, even within Europe, the dynamics of the epidemiology of the disease altered amongst the poorer populations due to constraints in drug accessibility.²³ Higher incident rates crept within the vulnerable and poorer populations.

The impacts of HIV/AIDS on security structures and the sustenance of the modern states are dire. In sub-Saharan Africa, the impact of HIV/AIDS has been described by numerous scholars and institutions as capable of rolling back years of development within the region.²⁶ Such reversals are much attributable to the events of the first decade. Clearly, HIV affects human security considering its swooping morbidity rates and the antecedent mortalities. An indicator of such effects is the life expectancy level.²⁷ Assessing this indicator within sub-Saharan Africa, a comparative analysis indicates that general life expectancy in the year 2000 had declined relative to marked periods within the respective countries.²³ In Malawi, life expectancy fell to the level in

1969 while Zimbabwe had a life expectancy decline of 23 years as compared to the pre-HIV era. Such analysis firm up assertions that the impact of HIV/AIDS within sub-Saharan Africa outweighs the mortality associated with civil wars within the continent.²⁶

Upon recognition of the existential threats HIV posed to states, national responses were deemed essential to the survival of the state. Funds were pooled from the global coffers and national governments to assist in tackling the disease. Often and especially amongst the developing states such funds were emergency expenses in response to a disease that had the potential of causing catastrophic damage to the fiber of the state. In 2012, global investment towards the containment of the pandemic exceeded 16 billion dollars. Domestic contributions have often been scaled up following political discourses that continually pitched the disease on the security agenda of states. The UNAIDS particularly played a role in re-orienting the discourses of the HIV/AIDS within a security framework. This subsequently influenced the policy of state institutions. Also, the urgency of response elicited by the threat of the disease as a security issue further caused the UNAIDS to circumvent the bureaucracies of the UN by overriding the decisions taken by disinterested ministers of health.

A significant stride in the global response to the threat of HIV/AIDS was the breach of Intellectual Property Laws in the pursuance of global accessibility to affordable HAART.²⁸ The development of the HAART in 1996 came along with associated costs and financial burden. A cost of 1000 dollars for a month supply of medications impeded accessibility to the developing states which were hardest hit by the disease.²⁸ It therefore became expedient that drugs be made more affordable to increase accessibility in these regions. However, due to the international trade

agreement of the international property rights, the major actors continually hampered the development of generic substitutes for use in the developing world. South Africa made the first move of importing generically produced HAART which was coldly received by the pharmaceutical companies as contravening the provisions of the TRIPS agreement.²⁸ Subsequent to the UNSC resolution on HIV/AIDS, the security status assumed by the disease afforded South Africa and later other developing states, the opportunity to violate the agreement on the basis of an emergency response to a real threat. These actions are moves to outside the ordinary scheme of things, to ensure that, an impending threat does not scale up to have detrimental effects on states. Such actions are affirmed by Buzan *et al* as constituting securitizing an issue.

2.2.2 Severe Acute Respiratory Syndrome

The Severe Acute Respiratory Syndrome (SARS) is a highly contagious viral respiratory infection that occurred predominantly in parts of Asia in 2003.²⁹ Although the first record of the disease was made in November 2002 in China its recognition as a disease of public health concern was rendered in 2003 with the major outbreaks.³⁰ SARS is airborne and primarily aided by contacts with mucus membranes and respiratory droplets from infected persons.³¹ Due to its mode of transmission, the infection had higher incident rates over the relatively short period it occurred. It was therefore easily diffused across borders.

The spread of SARS was initiated from Hong Kong where a number of persons had lodged in a Hotel together with an infected physician from Guandong, China.³² Contacts with the physician led to the spread of the disease to 12 persons. These persons later served as vectors of transmission of the disease to other states in within the subsequent weeks. As such, the initial

spread of the disease was recorded in Vietnam, Singapore, Taiwan and Canada. Delays in detection of cases and the onset of symptoms accounted for the spiralled spread of the disease within certain populations. With a case fatality ratio of 9.6%, the highest record of cases was observed in China (5327 persons). Aided largely by transportation and tourism SARS was widespread affecting over 28 countries globally and accounting for about 8300 cases and 783 deaths.³³ Of the recorded cases, 1755 were observed in Hong Kong, 238 in Singapore, 251 in Canada, 346 in Taiwan, 63 in Vietnam and 14 in the Philippines.³⁴

Studies indicate that the fallout from the SARS outbreak could have been averted should the crisis have been viewed within the ambit of security and not solely as a public health issue.³³ Breaking out first in China, the medical authorities sought to contain the disease with the requisite medical response.³⁵ Notably, upon recognition of the outbreak, the Chinese Public Health personnel obliged to bureaucratic requirements of the International Health Regulations in classifying diseases and rendering mandatory reports.³⁶ Due to limitations of the scope of the IHR in this regard, categorization and response strategies delayed more than should have been.³⁶ Consequently, the Chinese authority could only make official reports to the WHO four months after it recorded an outbreak.³³ Clearly, there was the need for the securitization of the disease as part of responses in mitigating its effects. The threat of SARS therefore was propelled from China's challenges and later brewed intense security issues within the region and across the globe.³⁵ The impact of SARS was therefore demonstrable beyond counts of death since it affected the economy, politics and the state.

Due to the porosity of borders and enhanced international travel, transmission of the disease was accelerated through cross-border trade and other means of movement.³⁷ Tourism facilitated movement was particularly responsible for the spread of the infection within Asia.³⁸ Travel restrictions were issued by several countries to prohibit movement of their nationals to affected states and also, to prevent the reverse.³³ These states included Vietnam, China, Philippines and Canada. The implications of such moves by states were daunting on their respective economies and state relations.⁵ Notably, the relations between China and Malaysia stood threatened upon Malaysia refusal to grant access to Chinese migrants through its borders.³³ A rebuttal from the Chinese government resulted in a prevention of its citizens from travelling to Malaysia and Thailand. Also, the tourism industry in most affected Asian states was observed by the World Tourism Organization to have declined by 50% in their fortunes. Additionally, the services and retail sectors of most economies halted in operation.³⁹ These moves were adopted by citizens to reduce physical contacts to avoid contracting the disease. This further posed challenges to integration as emergency response strategies demanded the cancellation of several international events of regional relevance within the continent. Travel alerts served by global bodies further affirmed this.⁴⁰ Clearly, the emergence of SARS on the continent called for corresponding responses albeit unfavorable, in ameliorating the impact of the existential threat.

The mass media played a significant role in heightening the scare and panic of SARS. The psychological ripples caused by the media has been assessed by scholars. Wilson *et al* observed that newspaper headlines during the outbreak bore words such as 'deadly' in referring to the disease.⁴¹ In some regions, the disease had been couched in military terms with governments intending to wage wars against it.⁴² Such pronouncement contributed to the securitizing of the

disease by the larger audience. Consequently, individuals and governments had to adopt measures that significantly altered the standard way of life. At the individual level, people had to mask their heads and wear other protective clothing to bar themselves from contracting the infection.⁴³ States employed quarantine methods that were viewed as an infringement of the freedom of individuals resulting in loss of time, resources and stigma in some instances.⁴³ Quarantine measures clearly defied societal order so as to contain the disease. Canada for instance had to amend its Quarantine Act⁴⁴ so as to admit SARS within the jurisdiction of Public Health Authority.⁴⁵ Also, the disease surveillance methods such as the usage of thermal imagers in scanning individuals at airports and other entry points presented challenges to the personal liberties of individuals. These notwithstanding, they were expedient measures necessitated by the floundering threat of the disease.

China as the cradle of SARS³⁵ suffered stringent monitoring measures by neighboring states and the international community.³³ The reality of the threat therefore altered the political measures taken by the government as a means of curtailing the further progression of the disease.⁴⁶ That is, the apparent mishandling of the outbreak resulted in the removal from office, the health minister, the mayor of Beijing and 120 other Chinese officials found culpable of the mismanagement of the disease.³³ In Taiwan, tension brewed between the civil society and the government as the former battled with the government for relenting in efforts at combatting the disease.⁴⁷

The global spread of SARS evoked a coordinated regional and global response to address it as a security threat. The successful containment of the pandemic within a relatively short period is often attributed to the coordinated international responses developed. The Association of South

East Asian Nations (ASEAN) countries forged alliances with China, Korea and Japan in developing regional measures and protocol for the disease. Notably, there was a conference of health ministers held in Kuala Lumpur in April 2003 which was later reinforced by a summit of the ASEAN leaders in Bangkok.³³ The fallout of the meetings included developing efficient communication networks and improving cooperation amongst member states through the harmonization of migration and travel procedure, health systems and detection techniques.³³ In addition, an ASEAN SARS fund was set up to cater for the spill of the threat.³³ An ASEAN diseases surveillance website was developed to further enhance the cooperation. Beyond the regional response, the WHO and the Global Alert Response Network (GOARN) worked closely with the Regional ad-hoc bodies in responding to the threat.⁴⁸ The western pacific regional office of the WHO saw to the deployment of over 115 field experts to the affected region.⁴⁸ The GOARN also offered technical assistance in the detection and surveillance of the disease. This was primarily achieved through an electronic networking of clinical specialists and other public health experts to proffer technical assistance on a daily basis. Peripheral network included one for epidemiologist and another for laboratory scientists to aid in mapping out and diagnosing the threat respectively.⁴⁸ The Center for Disease Control (CDC) offered assistance through its disease surveillance portal. It engaged in the training of detectives, efficient data collection and offering laboratory services for case identification and viral diagnosis. On July 5 2003, the WHO declared that the epidemic had been contained however, there was the need for sustained public health measures to avert a resurgence.⁴⁹

2.2.3 Tuberculosis

Tuberculosis (TB) is an airborne infectious disease caused by the *Mycobacterium tuberculosis*.⁵⁰ Due to the etiology of the infections, incidents of mass movement, overcrowding and constant interactions serve as substrates for its propagation.⁵⁰ In low income countries where such conditions are rife, TB transmission was at a higher rate than in the developed world.⁵¹ Poverty as a single factor breeds much room for factors such as malnutrition and insanitary conditions.⁵² With development of drugs and discovery of chemotherapy, it was anticipated that the global spread of TB will be minimized prior to the end of the 20th century.⁵² Although such declines were observed in the developed world, weak health systems and insanitary practices within most developing states sustained the progression of the disease.⁵² Tuberculosis therefore became the leading cause from a single infection in most of these states threatening the lives of its citizens.⁵³ The WHO reports indicate that TB claims 9 million live annually of which 80% cases and deaths are concentrated in Low and Middle Income Countries.⁵¹ Also, about 80% of the global burden of the disease is in 22 countries, 20 of which are in Asia and Africa.⁵¹ Ensuring human security in this regard was therefore essential to the survival of the state.

Tuberculosis is highly contagious and airborne hence its transmission is easily aided by enhanced interactions and movement of people. It particularly thrives in regions of endemic poverty and influenced by lower indices of socio-economic development. TB is more prevalent in the developing world. This accounts for about 80% of the burden of the disease. Globally, the incidence rate of TB increased between 1990 and 1999 with a subsequent fall in the 21st Century. Statistical representations indicate that there were 7.5 million incident cases in 1990 of which 65% were concentrated in South East Asia and the Western Pacific Regions, 13% in Sub-

Saharan Africa and 3% each in Eastern and Western Europe. Since the year 2000, the incident rates of the disease has been falling at an average of 1.5% per year. This translates as a world average incidence of 9 million despite the burgeoning global population. Of this, Asia accounts for 56%, 29% in Sub-Saharan Africa and 8% is concentrated in Europe. The global threat of TB has largely been due to two major factors; the concurrent incidents of HIV infection⁵⁴ and the persistent incidents of drug resistance.⁵⁵ Anti-infective drug resistance has emerged as a challenge to response measures to TB containment and treatment. It refers to the decline in the efficacy of a single agent against the causative organism.⁵⁵ This form of drug resistance further deteriorated to multi-drug resistance (MDR) in the early 1990s and a subsequent recognition of a state of extreme drug resistance (XDR) by the WHO.⁵¹ These developments presented grappling challenges as the heightening intensity of resistance had the potential of eroding earlier efforts in combatting the disease.

The upsurge of cases of drug resistance as an imminent threat informed the WHO declaration of TB as a global public health emergency in April 1993.⁵⁶ This was the first of such declarations to be made by the global body.⁵² This consequently aided in the devotion of resources by national and regional bodies in response to the disease. Significant progress was subsequently made in most regions of the world as the mortality rate due to TB fell by 45% since 1990 with an accompanying decreased incident rate.⁵¹ The threat of MDR-TB is demonstrable in the efforts made by numerous states in curtailing the rampage. Notably, these were measures that starkly defied human rights and violated the freedoms of individuals through examination, screening, isolation, treatment and vaccination. For instance, South African governmental policies required that confirmed cases of MDR and XDR-TB were isolated for at least six months.⁵⁷ In high-

burden countries like Armenia, Ukraine and Georgia governments had instituted compulsory isolation laws to detain all confirmed cases of individuals.⁵⁸ Also, Israel approach to handling lost-to-follow up cases was the issuance of court orders for the detention of such persons.⁵⁹ Failure to comply resulted in being hospitalized in prison.⁵⁹ In effect, the untoward measures were taken by states amidst its ramifications on the rights of individuals so as contain the existential threat of MDR-TB. Within the past decade, an estimated 37 million case recoveries have been made through effective management procedures established through national and regional legislations and collaboration.⁵¹

2.3 Epidemics Within West Africa From 2000-2014

The health situation within West Africa has been characterized by the dominance of major diseases both communicable and non-communicable. Within the period under review, there have been the emergence and reemergence of about ten major infectious diseases within the sub-region. Although most of these infections initially existed as localized epidemics within the affected states, they subsequently progressed beyond the confines of state borders to assume international relevance as pandemics.

2.3.1 Poliomyelitis

Poliomyelitis has been endemic within West Africa for about 25 years. The disease resulted in compromised nervous function in children leading to paralysis. Numerous collaborative efforts have been initiated towards eradication and mitigation of its effects on individuals. These resulted in various campaign strategies designed within the respective health sectors of most West African states. Between 2003 and 2007, events in Nigeria almost scaled back the efforts at

containing the epidemic within the region.⁶⁰ Notably, a strain of the disease originating from Nigeria spread to unaffected countries within West Africa including Benin, Burkina Faso, Ghana, Niger, Mali and Togo. This necessitated numerous immunization and preventive campaigns in Ivory Coast and Ghana. Despite such efforts at combatting the disease, there were significant records of cases of reinfection within 11 other countries within West Africa, further hampering progressive efforts at curtailing the outbreak.⁶¹ These incidents called for intensified collaboration that saw to the widespread immunization and subsequent ablation of the disease progression. In September 2015, the WHO announced a successful eradication of the disease in Nigeria, a major regional hub of the disease. In a collective sense, it accorded the sub-region a clearance from the disease. Numerous factors had been observed to account for the persistence of the disease as summed up by the WHO:

The entire region is seeing large-scale population movements due to insecurity in Mali, the Sahel crisis and the upcoming rainy season—these movements could easily transport the polio virus right back across the entire region. And finally, a lack of funds this year has forced the cancellation or scaling back of key immunization activities in 24 high-risk countries including many areas of West Africa. This is leaving more children needlessly vulnerable to polio.⁶¹

Particularly, Northern Nigeria has been cited as a source of reinfection for former polio free countries and hampered global efforts at eliminating the disease. Muslim religious leaders were reported to have discouraged efforts at immunization alluding to contamination with HIV/AIDS, infertility drugs, etc.⁶²

2.3.2 Cholera

Cholera has remained a persistent infection within West Africa. In the 21st Century, the sub-region has reported over 60 outbreaks of the disease. The reemergence of cholera within the region has been fueled by the persistent insalubrious environmental and health conditions and the

weakened public health systems for adequate prevention and treatment. Cholera has accounted for high casualties within states. Due to the high mortalities from the disease, it was declared a national emergency in Sierra Leone in 2012. In 2014, the death toll in Nigeria and Ghana were ranked highest on the continent with counts of 755 and 247 respectively. These figures represented increases in the mortality and incident cases despite efforts at addressing the outbreak in previous years. However in 2015 the total number of cases fell significantly with records of 205 deaths in the region.⁶³

2.3.3 Meningitis

A common disease within West Africa is the outbreak of Meningitis. This often affects the 'meningitis belt' of Africa which stretches from Senegal to Ethiopia.⁶⁴ It is a viral infection that affects the meninges (membrane of the brain and spinal cord) of infected individuals. Bacterial strains of the disease also do occur. Meningitis demonstrates a high fatality rate of 50% in the absence of prompt treatment.⁶⁵

Largely aided by dry climatic conditions the disease often occurs between December and June. In 2009, the largest meningitis of the century struck West Africa, it claimed over 1500 lives with a total of over 50000 cases recorded.⁶⁵ Nigeria was the most affected, followed by Niger and Burkina Faso.⁶⁶ After the 2009 outbreak there have been a few seasonal outbreaks in parts of Nigeria⁶⁷ and Ghana⁶⁸ as well as other states within the region. Outbreaks of meningitis particularly have impacts on the health systems of the affected states. This is largely because the treatment and management of the disease often results in halting almost every other public health activities such as routine immunizations so as to contain the disease.⁶⁹ Time lost to other

conditions is vital in the containment of an epidemic. A major barrier to successful containment of the disease within the region is adequate surveillance and the development of a vaccine for the right strain of the causative microbe.⁶⁷

2.3.4 HIV/AIDS

HIV/AIDS has been a challenging infectious disease for most West African states following its emergence in the mid-1980s. With collaborative efforts between international organizations and national governments, the nature of the disease has changed considerably within the region.⁷⁰ Although the profile of the disease in West Africa is better than the other regions of the continent²², HIV/AIDS has diversely threatened the security of lives, states and the region. HIV/AIDS within the sub-region has largely been attributed to sexual practices amongst the population.⁷¹ This has further facilitated the cross-border transmission of the disease as people move within the borders of the region. Also cultural practices in relation to male circumcision has been observed to account for the spread of the disease within the region.⁷²

The past decade has witnessed significant improvement in the management of the disease within West Africa. The disease has been successfully demystified as National policies have been developed in assisting with its management. With Cote d'Ivoire bearing the highest burden of the disease there have been significant improvement in the regions profile following the increasing accessibility to antiretroviral drugs.⁷⁰ An emerging challenge to the management of the disease is the incident of drug resistance.

2.4 Origin and Transmission of Ebola in West Africa

The 2014 outbreak of the Ebola Viral disease in West Africa is the 25th outbreak of the disease since 1976.⁷³ However, it is the first of such outbreaks in the region and the longest spanning Ebola epidemic. Guinea as the cradle of the outbreak traces the emergence of the disease to Gueckedou, a trading hub of the country that houses traders from Cote d'Ivoire, Liberia, Sierra Leone and other West African states.⁷⁴ The first incident was observed in a 2-year old boy in December 2013 reported to be suffering from an unknown contagious lethal illness.⁷⁴ Although the child eventually passed away, chain incidents of infections were recorded from the mother through other close contacts.⁷⁵ Later in March 2014, the Guinean Ministry of Health reported the outbreak of an illness with a high fatality rate of 59% amongst 49 persons.⁷⁶ Further investigations established the emergence of the EVD in Guinea.

Transmission of the disease amongst humans is primarily from person-to-person.⁷⁶ That is, transmission is enabled through direct contact with body and blood fluids of infected individuals. Although the natural host of the virus remains unknown, human transmission has also been linked to contacts with the carcasses of gorillas, chimpanzees and fruit bats.⁷⁷ With an incubation period of 21 days, transmission could be widespread prior to case detection.⁷⁸ Cross border transmission of the disease began with the report of the first case in Lofa County in Liberia in March 2014.⁷⁹ There were subsequent spread to Monrovia affecting 10 of the 15 Counties of the state by August 2014.⁷⁹ In May 2014 the first records of the disease was made in Sierra Leone. In July, the first air-travel transmission of the EVD was reported with Nigeria's first register of an Ebola case.⁸⁰ This was traced to a visitor who had flown in from Liberia. By August 2014 ten (10) cases had been reported with 2 death casualties.⁸⁰

Extensions of the spread within West Africa include records of cases in Senegal⁸¹ and Mali⁸² in August and November 2014 respectively. Both cases could be traced to visitors from Guinea. Notably confirmed cases of the EVD outside Africa were made in Spain, Italy, United Kingdom and the United States.⁷⁶ The infected persons were known to have had previous contacts with person (s) from the infected West African states within a month of the detection. The end of the outbreak in the three most affected states was declared by the WHO on January 14th 2016.⁸³ However, by April 2016, there had been records of flare-ups in Liberia and Guinea which have been duly contained.⁸⁴ The WHO finally declared the end of the outbreak of the disease on 9th June 2016 for which a 90-day surveillance period is in session.⁸⁵



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CHAPTER THREE

PRESENTATION AND DISCUSSION OF RESULTS

This chapter addresses the issue of infectious diseases as threats to international security within West Africa with much focus on the Ebola Virus Disease outbreak of 2014. The major themes of the findings explore the objectives of the study in first exploring the extent of consciousness of the disease as security threat by major actors (International Organization, National Institutions and the Public) and identifying the factors that promote and inhibit the progression of infectious diseases within the region. Respondents for the study comprised personnel from National Disaster Management Organization (NADMO), the National Security Council Secretariat of Ghana, the Senegalese Embassy, the Ebola Response Team and the International Organization for Migration.

3.1 Ebola Virus Disease As A Threat To Security

3.1.1 The Threat of The Ebola Virus Disease

Fragile or weak states have been progenitors of security threats.¹ Marked by poor indices of poverty, violence, public health systems and health infrastructure, external challenges that confront the states have sufficient substrates to thrive upon.² During the outbreak of the EVD Guinea, Liberia and Sierra Leone suffered numerous circumstantial and structural challenges that rendered them prone to the impact of the disease. Similarly, some unaffected West African states including Ghana and Gambia envisaged an overwhelming effects of the disease should it invade their territories. The study therefore explored people's consciousness of the disease as a health threat within the affected sates and beyond. Much understanding of the

threat posed by the disease was understood to be in relation to the direct impact of the disease on human lives.

When a single disease demonstrates such capabilities then it is certainly a threat. It literally started wiping people off within days and made governments look on helplessly. There wasn't a single clue as to how to address it at the initial phase...and just by mere contact, you have it, and then you are gone. It demanded urgent response else we would all have been wiped off without trace. (Personnel, National Security Council Secretariat, Ghana).

In an extended breadth, the threat of infectious diseases was perceived in the light of the incident socio-economic impacts on states. This could in part be due to the loss of individuals who may constitute the working force or the marked disruptions in socio-economic activities of states.

When we talk about threats, we talk about security I think the case is still being made for the linkage between infectious diseases and the national security. But from where I stand there is the issue of cost and damage to the economy because both in terms of ...the cost of actually dealing with those can be enormous infections could break the health system or break the economy of the state. And then there is the cost we may have seen in the affected zone the Ebola affected zone...where crops go unharvested, productivity decreases because people aren't going to work, schools don't function...(P.K. Mensah , IOM)

The trajectory of events in Guinea and Liberia demonstrate the movement of issues from the public health arena into a political discourse. The initial incidents in either states was confined within the realms of public health albeit poorly until it was seen to threaten directly, the lives of contacts traced. Similarly, the consciousness of the threat of the EVD in Liberia persisted months after the state had been declared free of the disease. That is, the threat was viewed from the destructive capabilities of the disease following its impact. Having witnessed the havoc wreaked by the disease, people got sensitized to it as a threat.

3.1.2 National Responses

The EVD epidemic in Liberia assumed numerous phases within the period. The first wave of the disease which lasted an average of a month was contained within the public health structures of the state. This marked an elevation of the issue onto the national platform with the setting up of a national taskforce that sought to develop strategies to address the impending threat of the disease. The national taskforce so established by the MOH comprised personnel from key sectors; Case management, Infection Control and Psycho-social support, Epidemiology and Laboratory, Social mobilization, Media and Communication, and Logistics and Security.³ Subsequently, flaws of the system were advanced by the epidemic to cause the second wave. It did not necessarily elicit a political response until subsequent episodes emerged in more than five other counties in May 2014. On July 26 2014, the Liberian President declared the EVD a national emergency for which the National Taskforce chaired by herself and the Interior Minister was set up.³ These actions offered bold indications of the consciousness of the disease as a security threat by the leaders of the state. The epidemic had therefore assumed relevance on the security agenda of the state. The taskforce saw to the deployment of resources to infected areas in some counties and also assisted with collaborators towards the distribution of logistics for case detection and isolation. Announcing a 90-day state of emergency, the president stated that *“extraordinary measures for the very survival of our state and for the protection of the lives of our people are required”*¹⁴

Subsequently, there were strict restrictions on cross border movement within and outside the state to avoid situations of cross importation of the disease between places. Communities

were quarantined and huge restrictions placed on public gatherings. President Ellen Sirleaf in an address stated that the citizens should be well braced for more stringent measures because there would be the need to curtail civil liberties in order to save the situation.⁴ At this stage, the EVD epidemic had been realised as capable of displacing the entire nation hence, an existential threat to the survival of the state. Responses were therefore deployed however undesirable. Sensitizing the populace to the necessity of trading civil rights amount to extraordinary measures needed in response to an existential threat however inconveniencing. The process of securitizing the EVD had thus been initiated by the President of Liberia. As a major actor, her declaration of a national emergency and subsequent world address in October securitized the disease in Liberia.

In the last few years, Liberia was bouncing back. We realized there was a long way to go, but the future was looking bright. In just over six months, Ebola has managed to bring my country to a standstill. We have lost over 2,000 Liberians..... Now Ebola threatens to erase that hard work. The time for talking or theorizing is over. Only concerted action will save my country, and our neighbours, from experiencing another national tragedy.⁵

National financial resources towards managing the crisis were largely generated from the Ebola Response fund. An amount of \$14.82million was pooled by the government as part of interim internal arrangements to address the crisis.

In Senegal, the National response focused on the identification and tracking of all contacts linked to the single imported case within the country. Much resources were dedicated to this. It also included the setting up of task forces and an enforcement of the Epidemics and disease control department within the Ministry of Health.

Inside the ministry of health there is a special department in charge of epidemics its role is to prevent the spreading of different kind of disease that department and its work is the most relevant measure used to prevent epidemics and when they occurred to find solutions to stop it. There is also a plan named "plan ORSEC" (organisation des secours meaning emergency organization plan) that has compiled members from different sectors of life (ministry of interior, Defense, Health, social action, etc...). (First Secretary, Senegalese Embassy)

The special taskforce was a restructuring of an existing disaster managing body and comprised of representatives from relevant sectors of the state. Senegal further issued bans on all flights to and from the Ebola affected states.⁶ This was in contravention to directives issued by the WHO against travel bans made by some states.⁷

3.1.3 Response From Unaffected States – Exploring Ghana

Having recorded no case by the outbreak of the disease within the sub-region, Ghana learnt from the outcome of events in the Ebola affected states. As such, the state was highly sensitized to the potential impact of the disease, envisaging it as a major threat. Ghana appeared to have had a more sensitized atmosphere than the other states partly due to media reportage, circulating myths and the reality of the swooping effects of the disease on parts of the affected states. Response measures or preparatory strategies developed could therefore be forked along two major areas; Public Health and National Security.

There was established a National Coordinating Committee (NCC) to execute the objectives of a National Preparedness and Response Plan for the Prevention and Control of the EVD under the direct auspices of the National Disaster management organization (NADMO). The objectives of the plan were to be realised through the concerted efforts of various relevant institutions within the country; the Ministries of Interior, Health, Transport and Food and Agriculture, Development Partners and Representatives from the NADMO. The designation of such roles to the office of the NADMO essentially demonstrates the conceptualization of the situation by the government as a potential security threat. The Director for Disease and Epidemic Control at NADMO elucidates it better:

When infectious diseases occur within our communities they are devastating because there are already breeding grounds for their spread. Look at Cholera, Meningitis and the rest.....these could be disastrous. It is a disaster when it moves beyond affecting an individual to affecting an entire community. It does not cease to be a public health issue though. The Ebola epidemic was an impending disaster. Just like disaster do, it could displace individuals, halt movement and disturb the normal societal process. It wasn't just a disease and we needed to look beyond public health alone. (Director, Disease and Epidemic Control NADMO)

This therefore serves as a shift of the discourse of the EVD to a security centred paradigm coordinating the efforts of all sectors necessary. The Ministry of Health was responsible for the National Technical Committee which dealt largely with the requisite Public Health measures. They were involved in the development of resources for surveillance and case management. Ebola treatment centres were set up in the country to serve as a national centre for addressing suspected or confirmed cases. Other health centres were designated as holding bays to temporarily manage suspected cases. Resource development approaches adopted included training of personnel involved in the chain of disease management; doctors, community health nurses, pharmacists, mortuary personnel, ambulance technicians and orderlies. It also included the equitable distribution of Personal Protective Equipment (PPE), bleaches, thermometers amongst others to health facilities, ETCs and holding bays. The entire health system was evidently on edge despite the instituted arrangements to curtail a possible outbreak.

Much as we had training, we were just praying this thing should not happen. Although there were trainings upon trainings, there were still loop holes...I have no idea, whether communication or the channel of procedural things that we do. We demonstrated a trial stuff at Korle-Bu and we realised if this thing should really happen, we are gone. (Member, National Technical Committee).

Additionally, the National Security Council Secretariat coordinated the security operatives within a broader construct of the National Response Team to be engaged in surveillance and enforcement of security measures across the state. These included the Armed forces, Ghana Police Service, the Immigration Service, and Port Authorities. They primarily enforced border

controls, quarantine of contacts and isolation of cases. Unfortunately, the numerous unmanned borders within the state overstretched the resources of the state and continually posed a risk to the state. The guarded borders of the state included Kotoka International Airport, Elubo, Aflao, Paga, Takoradi and Tema.

3.2 International Responses And Securitization Of The Ebola Virus Disease

3.2.2 Economic Community of West African States

West Africa was the epicentre of the 2014 EVD outbreak.⁸ The disease evidently outpaced the strengths of the public health systems of the affected states. With a total count of over 11,310 deaths, the disease demonstrated marked negative impacts within the relatively short duration of the outbreak.⁹ Within months of its emergence, the EVD traversed boundaries resulting in casualties in Senegal, Nigeria and Mali. The EVD therefore exercised the propensity to spiral through the region and therefore begged response from the regional governing body, the Economic Community of West African States (ECOWAS).

As a regional body, the ECOWAS treaty implores members in Article 61 (2d) to cooperate and offer assistance on health matters, amongst others.¹⁰ ECOWAS designates the responsibility of mobilizing human and financial resources to the West African Health Organization (WAHO).¹¹ The first collective action taken by ECOWAS was the declaration of the disease as a threat to regional security on 25th March, 2015¹² after the disease had claimed 64 lives in Guinea and Liberia. This was a communique issued by the Ministers of the Mediation and Security Council, authorising the ECOWAS Commission to take the appropriate steps through collaborative means in responding to the disease.¹²

The WAHO exercised oversight over the coordination of response strategies.¹³ It sought an initial fund of \$250000 from the Commission to aid in epidemiological surveillance in the affected states.¹³ There had been international agreement between WAHO, WHO and the African Development Bank which pooled \$3million for the strengthening of technical capabilities within spots of the region.¹⁴ The WAHO as the fronting organization in this regard engaged various stakeholders from member states and International Organizations to offer assistance with regard to the development of policy frameworks and strategies for the containment of the disease. The results of these were communicated as recommendations to the member states. Also, in April 2014, the meeting of Health Ministers culminated in the adoption of the Monrovia declaration on the Management of Epidemics in the region.¹³

3.2.3 World Health Organization

A number of key factors as identified earlier rendered the West African sub-region prone to the crippling effects of the EVD especially at the onset of the outbreak within the affected states. Most importantly, the weakened state institutions and structures exposed the inadequacies of these states and largely, the region in addressing the impact of resilient epidemics within the region. Public health structures of most states had been continually overwhelmed by the impact of epidemics often resulting in the eventual resort to international support in order to ably mitigate the impacts thereof. Although the first case of the disease was observed in December 2013, it was only reported to the WHO in March 2014 by the Guinean health officials.¹⁵ Liberia, on the other hand, confirmed their first case on 30th March although retrospective studies tracked the onset to 13th March 2014.¹⁶ The active presence of the WHO which marked the

commencement of international engagements on the outbreak therefore occurred on March 23, 2014.¹⁶

As a global health governing body, the WHO pooled the efforts of other International Organizations into collaborating towards a obtaining a redress to the epidemic. Starting off, the Lyon Laboratories in France were tasked with diagnosing blood samples of suspected cases to aid in the immediate identification and confirmation of the disease in Guinea and Liberia.¹⁶ The Global Outbreak Alert Response Network (GOARN) and Medicine Sans Frontiers, which already had an established presence in Guinea assisted with case isolation and surveillance for detection of unidentified cases. However, there were rising counts of the disease within the two states principally due to the earlier delay in detection and confirmation which had given room for the spread of the disease. The WHO therefore issued International appeals of \$4.8million to assist in deploying measures to offset the impact of the disease. Contributions from states and developmental agencies were in excess of \$7million.¹⁷ These were made by governments of Canada, Japan, South Korea, Estonia, Italy, Germany and agencies such as ECHO, USAID, CERF, VIVO Energy, Société des mines de fer de Guinée (SMFG), Société Anglogold Ashanti de Guinée (SAG), United Kingdom-Department For International Development (DFID), Vale International Holdings GmbH, United States, and the African Development Bank.¹⁷

Admittedly, such resources did not adequately address the rise of the epidemic. The number of recorded casualties kept rising within the affected states. By May 25, sixteen (16) cases and deaths due to the EVD had been recorded in Sierra Leone.¹⁸ The WHO held a high level ministerial meeting in Accra on 2nd July 2014 to impress upon the various actors towards heightening financial commitment and in developing strategic operational responses to the

outbreak.¹⁷ Amidst such efforts, the first air travel importation of the disease was confirmed in Nigeria on July 23.¹⁹ This presented the disease as a real transnational security threat. On August 8, the WHO declared the EVD 'a public health emergency of international concern' following reports by the IHR Emergency Committee and the fulfilment of conditions warranting such a declaration.²⁰ Notably, the death count had risen to 932 then. Although the efforts of the WHO had been overly criticised for being excessively procedural in their response to an emergency,²¹ the general response of the International community had been described as sluggish and dangerously inadequate.²² The elevation of the disease on a higher plane within public health accorded it much attention but lacked the elements of a security issue to warrant the desired response.

3.2.4 United Nations Security Council

On 18th September 2014, the United Nations Security Council adopted Resolution 2177 declaring the EVD in West Africa as constituting a threat to International Peace and security.²³ This was unanimously adopted and co-sponsored by 130 member states.²⁴ The international spread and the uncontrollably destructive effects of the disease on human lives and societies may have largely accounted for the resolution. The UNSC therefore deployed the United Nations Mission Ebola Emergency Response (UNMEER) tasked with five key priorities ; stopping the outbreak, treating the infected, ensuring essential services, preserving stability and preventing further outbreaks.²⁵

A more expansive analysis of the adoption of Resolution 2177 is found in the much echoed developments of the international system in earlier chapters of the work; the evolution of non-

traditional forms of security and the recognition of transnational security threats. Following the end of the Cold War, the Security Council has presided over a wider scope of security threats as mandated under Article 39 of the UN Charter such as debates on climate change²⁶. Giving the widespread nature of infectious diseases and their impacts, the HIV/AIDS pandemic was declared a threat to international peace and security in 2000.²⁷ The declaration of HIV/AIDS in particular hinged on the spectacular impacts (socio-economic and directly on human lives) the disease demonstrated. This is a disease that was primarily transmitted through contact with body fluids, largely, blood components of infected individuals. Transmission more was driven by physical engagement than through passive means. On a comparative scale, the EBV portended a more intense degree of destruction viewing from the aetiology of the disease and mode of transmission than the HIV/AIDS. Akin to the SARS of 2003 but with a more deleterious leverage, the EVD sprang within a geographical region with some of the weakest public health systems that could easily have fomented a global crisis. It offered narrower policy choices and exercised a potential to stall global socio-economic and political activities. Clearly, the EVD threatened lives, efforts at peace building and development for which it constituted a security threat.

3.3 Factors That Undermined The Securitization Of Ebola Virus Disease

It will be observed from the above that despite efforts at securitising the disease by various actors, the pandemic worsened within the region with increasing counts of fatalities and heightened insecurities. For instance, following WAHO declaration of the disease as a security threat, the number of casualties continued to rise with the importation of the disease to Sierra Leone the following month (May 2014). Similarly, securitization of the disease by the WHO

and UNSC brought aboard numerous assisting IOs but such efforts did not necessarily reflect on the ground. Number of confirmed cases increased by 1417 in December 2014²⁸. This was because various practises of the communities, districts and institutions of the affected states run counter to the measures instituted by these bodies. These were seen in the cultural, sanitary and religious practices of sections of states together with inadequacies of health systems further propagated the disease. That is, although international actors had securitized the disease, responses of the audience demonstrated different conceptualization of the disease as a security threat.

3.3.2 Challenges with Case Detection and Confirmation

The EVD outbreak in West Africa was the largest outbreak of the disease considering its duration and the extent of resultant damage wreaked.²⁹ Characteristically, it demonstrated an exponential progression of incidents within the first three (3) most affected states (Guinea, Liberia and Sierra Leone) until its final containment in 2015. Numerous factors accounted for the recorded pattern of the disease within states and the region. A common foundational challenge to all 3 states was the failure to detect and confirm the initial cases promptly so as to elicit adequate responses.³⁰ In Liberia, the suspected case on 13th March was confirmed 17 days later.³¹ The delay afforded the disease ample time to be transmitted to others especially health workers within the contact radius of the infected. To avert the accompanying challenges and risks of delayed reports and alerts, the WHO promulgated the International Health Regulations (IHR) which stipulates directives for the reporting, screening, surveilling and monitoring the diseases by health officials of the state.³² Unfortunately, the burden of inadequate logistics and expertise often renders arduous, the compliance of the IHR by some developing countries. Liberia

particularly experienced such challenges in the wake of its fragile public health structures. In effect, transmission of the disease furthered unnoticed until a later confirmation of other cases. This was observed later as reported by the WHO.

In mid-August, a WHO team of emergency experts, working alongside staff from the Ministry of Health and other key partners, began a three-week long investigation of the situation in Liberia. That investigation revealed that an outbreak had been simmering in the country for at least several weeks before the first cases in Monrovia were detected, giving the virus a huge head-start on control measures.³³

3.3.3 Public Health Infrastructure

Emerging from protracted periods of conflicts, Liberia's public health structure had been severely damaged bad enough to offer any appreciable redress to public health issues and the general health needs of the populace.³⁴ Despite numerous reconstructive efforts by International Organizations (IO) and states, the country still grapples with the inundating load of public health issues. Notably, malaria, cholera, HIV/AIDS and other communicable diseases continually tend to contest the strengths of public health structures within the country.³⁴ Over the years the government has succeeded in budgetary allocations towards healthcare delivery however paltry. The land mark increment from \$49 million in 2011 to \$67million in 2012 has contributed significantly in the remodeling of the health sector.³⁵ This notwithstanding, Liberia had a famished public health infrastructure during the EVD outbreak. This was starkly inadequate to confront the incidence of the outbreak. Structural indices of the health system speak to this observation

There is a critical health workforce shortagetwenty- nine (29%) of Liberians (1.1 million people) lack access to a health facility within 5 km or a one-hour walk; 65% of households walked to a health facility; 26% of health facilities do not have a sound structure; 45% do not have a primary power source or electricity; 13% do not have access to safe water; and 43% do not have a functional incinerator or waste management system. There is no Laboratory Standard, no maintenance plan and budget, and many health facilities lack periodic maintenance. Most health facilities need extension to accommodate emergency triage, isolation units and the separation of short-

stay males from females and appropriate latrines facilities.... infection prevention and control systems are weak.³⁵

Clearly, the state was unprepared for an infection of such a magnitude as the EVD. Beside the fact that there were inadequate professionals to attend to cases, there was the issue of overcrowding in health facilities, poor isolation procedures and transportation of patients and samples to the respective centres. The counts of death therefore soared within a short period of the infection. The public health system of the state is described by a lead Global Health Security coordinator

When we talk about public health preparedness, there is a huge tragedy. When we look at the countries that were affected. The disease came and affected countries where public health systems were weakest as a result of war and breakdown of public systems, not just the health systems so in Liberia and Sierra Leone they were singularly ill prepared for a major emergency. (P.K. Mensah, IOM).

3.3.4 Beliefs, Traditional and Burial Practices

Traditional and cultural practices are integral aspects of most West African societies. Particularly, rites of passage are accorded much significance within the societies. Burial rites for the deceased are therefore an essential ritual amongst most ethnic groups in West Africa. Such rites are believed to foster better relations between the living and the dead, afford the living an opportunity to make peace with the dead, if need be and also climaxes the life of the deceased as he/she exits the earth. The Mandingos in Lofa and Mende in Montserrado are but a few of the ethnic groups within Liberia that were observed to engage in invasive practices and rituals for the dead.³⁶ These included wrapping of corpses and burial by direct relations or family members. In other groups, rituals included washing and touching of the corpse as ways of bidding farewell. The Ebola Virus is most virulent in the bodies and body fluids of the corpses of infected individuals.³⁷ As such, contacts with biological components of the dead promoted transmission

of the disease within most villages in Liberia. In West Point, a neighbourhood in Monrovia reports indicated that people buried the dead with their bare hands and in their homes.³⁸ Even in events where the government issued directives as to the mass burial of all corpses of the EVD, some families engaged in secret burials, coming into contact with the corpses and heightening the incidence of the disease within the affected communities.

That in itself is actually catastrophic.... They're secretly burying the bodies! (National coordinator of Liberia's Ebola Task Force).³⁸

People who engaged in such practices were only engaging in cultural rites that existed prior to the onset of the outbreak. Clearly, the realities of the threats of the disease did not resonate with the public as much as it did with the securitising actors. Members within the communities therefore saw no need to forgo their usual practices in order to avoid the threats of the disease. Invasive traditional practices are common in most West African cultures and these tend to undermine the threats posed by diseases. For instance during the peak of the HIV/AIDS pandemic, some cultures still retained the practice of female genital mutilation³⁹ which furthered the spread of the disease.⁴⁰ The gravity of the threat of some infectious disease may demand forfeiting certain cultural so as to ensure the survival of the society. Failure to perceive the diseases as such could result in the continual pursuance of culture to the detriment of society.

Also, in West Africa traditional medicine is deep seated in the health practices of most societies. Several groups rely heavily on faith based and spiritual healing for solutions to all forms of ailments particularly the confounding ones. Especially in the period of the EVD outbreak, myths surrounding the disease as well as its fatality rate affirmed the beliefs of most people in the dictates of traditional or faith healers. In one breadth the disease was seen as a curse, in another it was noted as a product of western medicine. Several healers purporting to have had cures to the

disease often spent time with the infected individuals in secluded spaces. Their rituals also included touching and bathing of the sick. These healers in turn got exposed in oblivion and further transmitted to others with time.

In some societies, there was the belief that the disease was a hoax and a ploy by authorities to destroy them through quarantine and isolation measures.⁴¹ These subsequently led to the invasion of quarantine centres to take infected quarantined relatives away while others looted items from the centres including blood soaked mattresses.²² Untreated isolated individuals and the infected items when taken away could only result in further infections within the society. Clearly, efforts by government authorities had been misinterpreted by the beliefs of the people. Whereas authorities focussed on containing the threat within the community, members of the community conceptualised the disease differently accounting for their unproductive responses.

3.3.5 Cross Border Movements and Interactions

Cross border movement within the region is viewed along two (2) lines; the inland movement within states and migration across states. Either ways, both forms of movement contributed to the brewing of the disease within the region. For numerous reasons, population mobility across West African states is extremely high.³¹ During the outbreak of the EVD, such movements inhibited efforts at containing the disease by making contact tracing difficult to pursue. Also, it led to the exportation of the disease into sections of Liberia undetected. This was largely aided by the inadequacies of disease surveillance mechanisms and detection methods.

One thing peculiar about the Ebola was that so easily and clearly, the spread was linked to the movement of people and migration. Consider the cases of Liberia and Sierra Leone where importations were the primary means...points of entry needed to be monitored and checks enforced. (P.K Mensah, IOM)

Also, domestic movements accounted for a portion of transmission within the state. Due to structural challenges, there were fewer Ebola Treatment Units (ETU) scattered across the state.³⁰ Persons therefore had to commute from ends of the country to the other should there be the need for treatment or clinical assistance for suspected cases. The channel of movement therefore served as means of spreading the disease within the state. Events³⁰ in Lofa County, a site of an ETU bore evidence to this trend.

The community of Kpazagizia and Zolowo in Zorzor districts were quarantined for 21 days after a rise in cases, deaths and contacts as a result of increasingly uncontrolled transborder movement of population between Liberia and Guinea.³⁰

3.4 Factors That Promoted Containment of the Ebola Virus Disease

The EVD epidemic revealed the inadequacies of existing public health structures within most West African states particularly in post-conflict states. Efforts by the public health units in most counties in Liberia demonstrated the overwhelming effect of the disease on state resources. It therefore became expedient that community leaders and groups assumed roles to augment the efforts of public health units within the country.⁴² Community leaders mentioned herein refers to youth leaders, women groups, church based organizations and social groups under the administration of resourceful political figures within the communities. A number of communities in Monrovia and Montserrado are recounted to have developed such structures.⁴² These actions were deployed after the EVD had demonstrated fierce impacts within the society over a period and community leaders had been acquainted with the disease well enough to have demystified it amongst a considerable section of the communities. Community leaders therefore engaged in diverse areas such as public education, transportation services, first aid assistance, community surveillance, offering education on safe burial practices and sanitation. Surveillance methods developed included the barring of strangers from entering the communities and institution of task

forces to exclude such persons when identified. It also included means of monitoring such as house-to-house monitoring of the sick and referral of new cases to ETUs. At large, these developments aided in the containment of the disease within communities so as to avert inland transmission and subsequent escalation beyond borders.

These demonstrated a growing conceptualization of the disease as a security threat by sections of the community. Such forms of consciousness necessitated actions by local authorities to enforce the necessary measures. In the absence of such consciousness, securitization of the disease stood void as it could not evoke adequate responses from the public whose actions and inactions largely affected the progression of the disease.

3.4.2 Border Security

As mentioned earlier, a major suitable condition for the progression of the EVD within the region was the extreme porosity of the borders of most states that were easily permeated without much checks. Considering the mode of entry of the only confirmed case, Senegal embarked on strict border strengthening measures to avert a possibility of another incident. This was recounted by the First Secretary of the Senegalese Embassy.

The first [measure] was the blocus of the border between Guinea and Senegal to avoid other "imported cases" since the only case has come from outside.

Additionally, swift surveillance methods proved beneficial to hampering further incidents of the disease within Senegal. Particularly, identification and tracking of individuals was aggressively pursued in all suspected cases or contacts thereof. Specifically, 74 contacts stemming from the reported case were identified, tracked and monitored for signs and symptoms until certainty about containment was established.⁴³

There were also intensive public health education programs across the Senegalese state. This was a government championed programme through the dissemination of health alerts and information about the disease through text messages.

“This SMS campaign was part of a much larger national project in Senegal focused on awareness, prevention and care for people with Ebola. Other awareness-raising efforts, included radio announcements, flyers and the dissemination of messages on a government-hosted web site”⁴⁴

The platform also afforded citizens avenues to report suspected cases of the disease to assist in case identification, isolation and quarantine. Social media engagements by state institutions created much awareness and demystified perceptions about the disease to assist in containment.

3.5 Extraordinary Measures Towards Containment Of The EVD

The outbreak of the EVD threatened free movement and efforts at regional integration within West Africa. This was seen in direct violations of the Protocol on Movement of Persons, Residence and Establishment.⁴⁵ The protocol affords member states opportunities to move within the region unhindered provided they possess the requisite travel documents and health certificate.⁴⁵ All members are bound to observe the provisions of the protocol. However, migration as a major route of transmitting the EVD caused states to adopt stringent restrictions on movement across their borders. Senegal, Ivory Coast⁴⁶ and Gambia⁴⁷ closed their borders to flights from the affected states in response to the threat of the disease.

The first challenge in the framework of ECOWAS, was to explain and justify the measure of closing the border with Guinea, because it is illegal in regard of ECOWAS free movement protocol. (First Sec, Senegalese Embassy).

These incidents had significant security implications within the region. Travel restrictions issued curtailed civil liberties and freedoms of individuals as persons could not move beyond and even

within the borders of their states during the period. This subsequently affected food security within parts of the region as terrestrial food importation across borders could not take place.⁴⁸

Also, quarantine and isolation methods as employed in Liberia threatened the civil liberties⁴⁹ of individuals identified. In this regard, threats to civil liberties were similar to past incidents of war within the states but in a more widespread manner given the nature of transnational security threats. These were primarily the only means the threat of the disease could be curtailed within states. Quarantines heightened stigmatization and economic distress.⁴⁹ This was particularly so in events where key family figures had been quarantined for a period. Entire communities such as the West Point in Monrovia had to be quarantined, curfews instituted and regular house monitoring and inspection performed to expose all attempts at hiding corpses.⁵⁰ This was done with the assistance of the military as the inhabitants protested heavily against such measures.⁵⁰ Cultural values as pertains to the dead had to be disregarded towards developing safe burial practices. These were contained in earlier directives by the Liberian government for the cremation of all bodies of infected persons who died from the disease.⁴⁹ Inasmuch as appropriate burial rites are integral components of the culture of the people, it had to be usurped by the urgency of the situation.

These untoward actions, authorized by the government as emergency response to the existential threat of the EVD constituted a securitization of the disease at the level of the state. They vividly reflect the eventual stage in the securitization process as espoused by the Copenhagen school.

In conclusion, the chapter presented the perspective of the respondents and analysis of document with regard to the Ebola Virus Disease. The EVD is a threat to human security by way of its

destructive impacts on life and subsequent socio-economic losses. Following the outbreak, there were numerous responses from international organizations to contain the disease within the region. However, numerous circumstantial, structural and traditional practices impeded the efforts at containment. The disease cast a dilemma between culture and the reality for which a large section of the public chose the former. This hampered efforts at securitising the disease.



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SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

4.0 Introduction

The study sought to explore the impact of various forms of household security threat on the health of women in the slums of Accra, Ghana. The study was based on the understanding of the importance of women's health and the role of the household in the health of women. The study was based on the understanding of the importance of women's health and the role of the household in the health of women.

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4.1 Methods of the Study

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CHAPTER FOUR

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

4.0 Introduction

The study sought to explore infectious diseases as a form of transnational security threat within the region. This is premised on the development of non-traditional security and theorized by the securitization theory. Considering the impact of the Ebola Virus Disease within West Africa, the study seeks to test the hypothesis 'Pandemics pose real threats to security within West Africa due to structural inadequacies and socio-cultural practices within the region'. The objectives of the study were to explore the extent of consciousness of the disease as security threat by major actors (International Organization, National Institutions and the Public) and identify the factors that promote and inhibit the progression of infectious diseases within the region.

4.1 Findings of the Study

The outbreak of the 2014 West African Ebola Virus Disease called for numerous responses from states, regional bodies and International Organizations. Across all fronts, the EVD was seen as a major threat. This is primed on the fatality counts of the disease. With the rising numbers of deaths, it demonstrated the capacity to wipe the success of states. Others viewed it in the light of the socioeconomic impacts due to the disease on states.

The ECOWAS was the first institution to have securitized the disease as a threat to Regional Peace and Security. This was a declaration by the Mediation and Security Council of the body in March 2015. ECOWAS funds towards the management was inadequate manage the situation. Following, there were numerous collaborations with International Organizations such as the

African Development Bank and the WHO. As the pandemic spread further with increasing fatalities, the World Health Organization in August 2015 declared the situation a public health emergency for which global responses were desired. In October 2015, the United Nations Security Council by Resolution 2177 declared the EVD as constituting a threat to international peace and security.

However, the study identified various factors that impeded the containment of the disease despite the securitization by these international actors. These factors included the following:

First, there were difficulties in the identification and confirmation of suspected cases. As noted in the events of Guinea and Liberia, the period between the suspicion of the first case and its confirmation was prolonged as in four months in the case of Guinea. These were due to the unfamiliarity with the case, inadequate logistics and training. As such, the long incubation period of the disease caused more rapid transmission amongst contacts within these periods.

Similarly, public health infrastructure in the affected states were ill equipped to adequately handle the condition. This led to high infection rates amongst health personnel who intend transmitted in oblivion. The study observed that the public health sectors of most of these states were laden with challenges of other infectious disease as identified earlier.

Also, traditional beliefs and practices amongst most communities within Liberia fueled the epidemic further. These include funeral rites and burial practices. Also, beliefs in supernatural causes of the diseases served as a barrier to education preventive measure as people resorted to faith healers for assistance

Finally, enhance cross border movements both inland and beyond the territories of states caused a rise in the epidemic and hampered progress. Due to the mode of transmission, cross border movement meant increased interaction amongst people for which transmission could ensue

The study identified that two major factors aided in the containment of the disease. First, there were locally developed interventions by community leaders in sections of Liberia. These were individuals who hitherto played reputable roles in society and commanded authority amongst sections of the community. They served as watchdogs, assisting in surveillance, monitoring, isolation and case transfers.

Also, although inadequate, border security offered some assistance in decreasing the spread of infections across counties in Liberia. Senegal adopted border restraints to prevent the escalation of the disease beyond the count of one (1).

4.2 Conclusion

Infectious diseases as transnational security threats have the capacity to cause widespread effects within a short duration. As such outbreak of such disease demand response as security threats. The 2014 Ebola Virus Disease outbreak received much global attention which resulted in the securitization of the disease by ECOWAS and the UNSC. Although ECOWAS as a regional body securitized the EVD, it lacked the capacity in resourcing measures at containing the outbreak. This impeded efforts at the containment of the diseases amidst the consciousness of the threat by the Organization. The absence of necessary policies and protocol for the containment form part of the challenges of the body at addressing pandemics. Additionally, inadequate funding from the organization stalled efforts at pursuing appropriate response measures in the

wake of the EVD. Despite subsequent securitization by the WHO and financial assistance from IOs, the cultural, traditional and religious practices of the people in most West African states undermined efforts at containing the disease. The threat of the Ebola Virus Disease was therefore reinforced by the poor conceptualization of the disease as a security threat within the region.

4.3 Recommendations

From the findings of the study and the identified existing gaps, the following recommendations are suggested:

- Following the end of the outbreak of the EVD in 2014, there have been numerous flares of the infection in Guinea and Liberia. This calls for sustained surveillance systems and resources lest another epidemic ensues. Further studies need be conducted to examine the sustenance of measures developed and enforced during the outbreak to ascertain the readiness or otherwise of the region in the event of a possible outbreak of a similar magnitude.
- Prior to the emergence of the Ebola pandemic, there were no discrete policies on the management of pandemics of such nature within the region. To forestall the impacts of any future eventualities, there should be developed clear policy guidelines to offer directions to member states in addressing pandemics that emerge within the region.
- Although ECOWAS has instituted a Peace Fund for the maintenance of peace within the region, it appears inadequate. There is the need for the establishment of a Health Fund for purposes of managing pandemics within the region.

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D. INTERVIEWS

- Interview with Papa Kwaw Mensah (Programme Manager, Global Health Security, International Organization for Migration, Ghana) at the IOM office on 15th June 2016 at 10:00am
- Interview with Ms Ruth Arthur (Director of Disease & Epidemics, NADMO) at the NADMO Headquarters on 20th July 2016 at 11:00am
- Interview with Seydina Omar Ndiaye (First Secretary, Senegalese Embassy) on 18th July 2016 via emails.
- Interview with Mrs Frimpomaa Nelson (Public Health Specialist and Member of the Technical Response Team) at Korle-Bu Teaching Hospital on 27th June 2016.