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## **Ebola Does Not Fall from the Sky: Structural Violence & International Responsibility**

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# Ebola Does Not Fall from the Sky: Structural Violence & International Responsibility

*Matiangai Sirleaf\**

## ABSTRACT

*This Article challenges the conventional understanding that international crises are limited to instances of direct physical violence. Instead, it argues that the disproportionate distribution of infectious diseases like Ebola is a form of structural violence that warrants international intervention. In the field of global public health, structural violence is a concept used to describe health inequities and to draw attention to the differential risks for infection in the Global South, and among those already infected, for adverse consequences including death, injury, and illness. This Article clarifies how the concept of structural violence can be operationalized in law. It illustrates the ways in which actors can facilitate conditions for structural violence by analyzing the international public health and peace and security regimes.*

*This Article has several important contributions. First, the way international actors conceptualize crises should be expanded beyond merely addressing direct physical violence, but to also include remedying structural violence. Additionally, this study in-*

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*dicates that the complicated relationship between infectious diseases and conflict deserves more robust attention and resources. Moreover, this study examines the limits of the law governing international responsibility and concludes that shared international responsibility norms should be developed to assist in expanding the tools available for the protection of human rights. Lastly, this Article finds that the burgeoning field of international disaster law holds promise for responding to the challenges posed by infectious diseases like Ebola and the alleviation of large-scale human suffering caused by such diseases.*

## TABLE OF CONTENTS

I. INTRODUCTION .....	3
II. THEORETICAL & LEGAL FRAMEWORK.....	7
A. Conceptual Framework: Structural Violence ...	7
B. Legal Framework: International Law.....	13
III. WARS DECLARED AND UNDECLARED & THE EBOLA EPIDEMIC.	14
A. Guinea, Liberia & Sierra Leone before Ebola ..	15
1. Underdevelopment in the Sub-Region .....	15
2. Conflict in the Sub-Region .....	22
3. Post-Conflict Reconstruction in the Sub-Region.....	24
B. Guinea, Liberia & Sierra Leone in the Time of Ebola .....	28
1. Ebola's Trajectory in the Sub-Region.....	29
2. Post-Conflict Legacies & the Ebola Epidemic .....	32
3. Ineffectual Local Responses to Ebola .....	34
IV. THE INTERNATIONAL REGIMES FOR HEALTH AND SECURITY & THE SPREAD OF EBOLA .....	39
A. International Health & the Regulation of Highly Infectious Diseases like Ebola.....	39
1. The WHO's Emergency Powers .....	40
2. The WHO's Failure to Manage the ... Ebola Epidemic.....	42
C. International Security & the Regulation of Highly Infectious Diseases like Ebola .....	53
1. United Nations' Emergency Powers.....	53
2. International Peace and Security Regime's Response to Ebola.....	55
V. THEORETICAL & POLICY IMPLICATIONS.....	68
A. The Limits of International Responsibility .....	68

B. Complex Relationship between Infectious Diseases & Conflict.....	73
C. International Disaster Law & Responding to Epidemics .....	76
VI. CONCLUSION .....	81

## I. INTRODUCTION

Today, infectious diseases cause approximately 25 percent of all deaths around the world,<sup>1</sup> and over thirty infectious diseases have emerged during the last twenty years.<sup>2</sup> Due to the increasing interconnectedness of the world, the need for effective international regulation of highly infectious diseases cannot be overstated, especially for developing countries in the Global South.<sup>3</sup> As Jim Yong Kim, President of the World Bank (WB), remarked, the “Ebola crisis in Guinea, Liberia and Sierra Leone taught all of us that we must be much more vigilant to outbreaks and respond immediately to save lives and also to protect economic growth.”<sup>4</sup> Indeed, recent economic studies indicate that the annual cost of moderate to severe pandemics globally is roughly USD 570 billion.<sup>5</sup> Moreover, threats to global public health pose significant challenges for human security,<sup>6</sup> which underscores the need for effective international regulation of pandemics.

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<sup>1</sup> Nicholas Israel Nii-Trebi, *Emerging and Neglected Infectious Diseases: Insights, Advances, and Challenges*, BIOMED RES. INT’L, 2017, at 3; see generally Haidong Wang et al., *Global, Regional, and National Life Expectancy, All-cause Mortality, and Cause-specific Mortality for 249 Causes of Death, 1980–2015: A Systematic Analysis for the Global Burden of Disease Study 2015*, 388 THE LANCET 1459 (2016).

<sup>2</sup> Nii-Trebi, *supra* note 1, at 1; Lawrence O. Gostin, *Why Rich Countries Should Care About the World’s Least Healthy People*, 298 J. AM. MED. ASS’N 89, 90 (2007).

<sup>3</sup> This Article uses the terms “Global North” and “Global South” as devices to describe divisions that exist between the generally developed North and the generally less developed South, but these characterizations overly simplify and paper over wide disparities and diversity that exist in each category.

<sup>4</sup> Press Release, World Bank Group Launches Groundbreaking Financing Facility to Protect Poorest Countries against Pandemics, World Bank Press Release No. 2016/HDN/383 (May 21, 2016), <http://www.worldbank.org/en/news/press-release/2016/05/21/world-bank-group-launches-groundbreaking-financing-facility-to-protect-poorest-countries-against-pandemics> [https://perma.cc/C4MS-T75P] (archived Jan. 29, 2018). The WB’s Pandemic Emergency Financing Facility will create the world’s first insurance market for pandemic risk. *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> The concept of “human security” was first popularized by the United Nations Development Program in the early 1990s. Human security, like structural violence moves away from conventional understandings of violence that are rooted primarily in military aggression vis-à-vis other states, to one that focuses on the security of the individual. See

The Ebola epidemic laid bare the weakness of global mechanisms to respond adequately to public health crises. Ebola is an infectious disease that manifests as a severe hemorrhagic fever, which is often fatal without proper clinical care, such as providing fluids and maintaining blood pressure and oxygen levels. Because the early symptoms resemble common diseases like malaria, many do not realize they are infected and do not seek treatment at a hospital. The virus is spread in humans through direct contact with broken skin, blood, bodily fluids, or contaminated objects, and possibly through sexual contact.<sup>7</sup> Between 2014 and 2015, West Africa had the largest outbreak of the disease in history.<sup>8</sup> The World Health Organization (WHO) estimates that this outbreak resulted in 28,616 cases of Ebola, and 11,310 deaths in Liberia, Sierra Leone, and Guinea alone.<sup>9</sup> Yet the comparatively trivial number of cases that occurred in Europe (three) and the United States (four)<sup>10</sup> spurred international action and resulted in large-scale militarized responses. The full toll of the epidemic in West Africa is still being uncovered—with recent reports showing that Ebola can linger in survivors’ eyes causing painful disease, cataracts, and potential blindness in the young and old.<sup>11</sup>

This Article argues that the disproportionate distribution of infectious diseases like Ebola is a form of structural violence. Structural violence is a term that is little explored in law but well developed by scholars of development and global public health. Influential peace scholar Johan Galtung argued that structural violence is unique in that the violence is built into the structure and manifests as “unequal

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U.N. TRUST FUND FOR HUM. SEC., HUMAN SECURITY IN THEORY AND PRACTICE: AN OVERVIEW OF THE CONCEPT AND THE UNITED NATIONS TRUST FUND FOR HUMAN SECURITY 5 (2009), [http://www.un.org/humansecurity/sites/www.un.org.humansecurity/files/human\\_security\\_in\\_theory\\_and\\_practice\\_english.pdf](http://www.un.org/humansecurity/sites/www.un.org.humansecurity/files/human_security_in_theory_and_practice_english.pdf) [https://perma.cc/UY43-9TTR] (archived Jan. 29, 2018).

<sup>7</sup> See *Ebola Virus Disease Transmission*, CTR. FOR DISEASE CONTROL (July 22, 2015), <http://www.cdc.gov/vhf/ebola/transmission/index.html> [https://perma.cc/GB2D-X6VT] (archived Jan. 29, 2018).

<sup>8</sup> See Melissa Leach, *The Ebola Crisis and Post-2015 Development*, 27 J. INT’L DEV. 816, 816 (2015) (internal citations omitted).

<sup>9</sup> See *Ebola Outbreak 2014–2015*, WORLD HEALTH ORGANIZATION [WHO], <http://who.int/csr/disease/ebola/en/> (last visited Feb. 7, 2018) [https://perma.cc/S4XM-ZV4A] (archived Jan. 29, 2018).

<sup>10</sup> See *2014 Ebola Outbreak Case Counts*, CTR. FOR DISEASE CONTROL, <https://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html> (last updated Apr. 13, 2016) [https://perma.cc/N333-HAVC] (archived Jan. 29, 2018).

<sup>11</sup> Denise Grady, *Ebola’s Legacy: Children with Cataracts*, N.Y. TIMES (Oct. 19, 2017), <https://www.nytimes.com/2017/10/19/health/ebola-survivors-cataracts.html> [https://perma.cc/C22V-AYPG] (archived Jan. 29, 2018).

power and consequently as unequal life chances.”<sup>12</sup> Paul Farmer’s work in the field of global public health has been helpful in elucidating the concept of structural violence to the spread of epidemic diseases.<sup>13</sup> This Article draws on the structural violence literature to reveal the ways in which the international legal architecture facilitates the conditions for global health inequities, and in particular for infectious diseases to reach epidemic levels in the Global South. It demonstrates this by utilizing a case study of the 2014–2015 Ebola epidemic in West Africa. The Ebola epidemic reflects the unfortunate pattern where “the fruits of medical and scientific advances are stockpiled for some and denied to others.”<sup>14</sup>

This Article addresses gaps in the literature by writing on an epidemic that has received scant attention in legal scholarship.<sup>15</sup> In contrast, there has been much scholarship on other epidemics like HIV/AIDS,<sup>16</sup> Avian Flu, and Severe Acute Respiratory Syndrome (SARS). Moreover, while the concept of structural violence is well established in the fields of development and health, most analyses elide the role of the law in facilitating structural violence.<sup>17</sup> This Article departs from this practice and analyzes how the concept of structural violence can be operationalized in law. It demonstrates how international law and its various actors can facilitate structural violence through analyzing the case study of the Ebola epidemic.

This Article considers the following issues: How is violence conceptualized internationally? When and why do states, international institutions, and other nonstate actors intervene in violent crises? What should such intervention look like? This Article explores these lines of inquiry by examining the global public health and international peace and security regimes’ responses to the Ebola epidemic. This Article has many important contributions. First, the way international actors conceptualize crises needs to be expanded beyond merely addressing direct

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<sup>12</sup> Johan Galtung, *Violence, Peace, and Peace Research*, 6 J. PEACE RES. 167, 171 (1967).

<sup>13</sup> Paul Farmer et al., *Structural Violence and Clinical Medicine*, 3 PUB. LIBR. SCI. MED. 1686, 1686–91 (2006).

<sup>14</sup> Paul Farmer, *Pathologies of Power: Rethinking Health and Human Rights*, 89 AM. J. PUB. HEALTH 1486, 1488 (1999).

<sup>15</sup> See, e.g., Alison Agnew, *A Combative Disease: The Ebola Epidemic in International Law*, 39 B.C. INT’L & COMP. L. REV. 97 (2016); J. Benton Heath, *Global Emergency Power in the Age of Ebola*, 57 HARV. INT’L L. J. 1 (2016).

<sup>16</sup> See, e.g., Emily Mendenhall & Shane Norris, *When HIV is Ordinary and Diabetes New: Remaking Suffering in a South African Township*, 10 GLOBAL PUB. HEALTH 449 (2015); Joia S. Mukherjee, *Structural Violence, Poverty and the AIDS Pandemic*, 50 DEV. 115 (2007); Rudolf V. Van Puymbroeck, *Beyond Sex: Legal Reform for HIV/AIDS and Poverty Reduction*, 15 GEO. J. POVERTY L. & POL’Y 781 (2008); Ayaz Qureshi, *Structural Violence and the State: HIV and Labour Migration from Pakistan to the Persian Gulf*, 20 ANTHROPOLOGY & MED. 209 (2013).

<sup>17</sup> See generally Anne Wilkinson & Melissa Leach, *Briefing: Ebola—Myths, Realities, and Structural Violence*, 114 AFRICAN AFF. 136 (2014).

physical violence internationally, but to also include remedying structural violence. Additionally, this Article finds that it is more useful to theorize violence as a continuum—with the narrower end of the spectrum having the minimal conceptualization of violence (direct, physical and psychological) and the other end of the spectrum having the broader conceptualization of structural violence. Moreover, this study of the Ebola epidemic indicates that the complicated relationship between infectious diseases and conflict warrants more robust attention and resources. Finally, shared international responsibility norms should be developed to respond to epidemics more effectively and to assist in addressing the accountability gaps that arise in international law with issues of structural violence.

This Article's analysis of the Ebola outbreak brings into stark focus the illusory international community. It is only when infectious diseases like Ebola come perilously close to impacting countries in the Global North that the international community and its various actors muster the political will to act. The sad reality is that infectious diseases are left to run rampant for years in countries in the Global South where disposable bodies of people of color are disproportionately affected. To be sure, there are a range of domestic factors from inadequate health policies, to corruption, to poor governance, amongst others that help to account for the current distribution of infectious diseases, and there are undoubtedly variations within countries in the Global South. Yet recognizing the existence of a state's duty to address these failures does not preclude "a full investigation into the ways in which international actors can be deeply implicated in the deprivation suffered."<sup>18</sup>

This Article is organized as follows: Part II provides the theoretical framework of structural violence, its contenders, and its use in various fields. Part II also provides the legal framework in international law. Part III analyzes the *ex ante* factors that enabled structural violence resulting in differential risks for infection and more adverse consequences from Ebola among the impacted countries—Guinea, Liberia, and Sierra Leone. Part IV examines the international regimes for health and security and demonstrates how these regimes facilitated the conditions that worsened the 2014–2015 Ebola epidemic and analyzes their responses to mitigate the harm. Part V discusses the theoretical and policy implications of this study, examining the limits of the law governing international responsibility and the promise of international disaster law to respond to the challenges posed by diseases like Ebola. The ease with which the Ebola virus spread makes this Article

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<sup>18</sup> Margo E. Salomon, *From NIEO to NOW and the Unfinishable Story of Economic Justice*, 62 INT'L COMP. L. Q. 31, 33 (2013).

timely, and of scholarly and policy interest, both nationally and globally.

## II. THEORETICAL & LEGAL FRAMEWORK

### A. *Conceptual Framework: Structural Violence*

Violence is traditionally conceptualized as direct physical or psychological violence.<sup>19</sup> Structural violence expands the orthodox view of violence and is used to describe indirect violence that is not necessarily tied to an identifiable human actor.<sup>20</sup> Structural violence complicates conventional wisdom because it does not conceive of violence as spectacular, sensational, or hyper visible.<sup>21</sup> Galtung conceptualized structural violence in the field of peace-building as present “when human beings are being influenced so that their actual . . . realizations are below their potential realizations.”<sup>22</sup> Galtung’s conceptualization of structural violence as social injustice is overly broad.

Paul Farmer improved upon the theory and applied it in the field of global public health. He defined it as a “way of describing social arrangements that put individuals and populations in harm’s way . . . . The arrangements are structural because they are embedded in the political and economic organization of [a society]; they are violent because they cause injury to people.”<sup>23</sup> Structural violence manifests in global public health with the differential risks for infection and, among those already infected, for adverse consequences including death, injury, and illness.<sup>24</sup>

Structural violence is linked intimately with social inequality because “these conditions are the cause and result of . . . wars both declared and undeclared.”<sup>25</sup> Structural violence manifests in many forms, from gross inequality in the distribution of incomes to heavily skewed literacy and education rates, or uneven distributions of epidemic rates.<sup>26</sup> And, because structural violence is often silent or otherwise obscured, the object(s) of it as well as others may not perceive it

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<sup>19</sup> Galtung, *supra* note 12, at 171.

<sup>20</sup> *Id.*

<sup>21</sup> See ROB NIXON, SLOW VIOLENCE AND THE ENVIRONMENTALISM OF THE POOR 13 (2011).

<sup>22</sup> Galtung, *supra* note 12, at 168.

<sup>23</sup> Farmer et al., *supra* note 13, at 1686.

<sup>24</sup> See Paul Farmer, *An Anthropology of Structural Violence*, 45 CURRENT ANTHROPOLOGY 305, 308 (2004).

<sup>25</sup> *Id.* at 317.

<sup>26</sup> Galtung, *supra* note 12, at 177.



as violence at all, or presume that the status quo distribution of social, economic, legal, and political structures is natural.<sup>27</sup> Yet structural violence is not simply about the unequal distribution of resources, but about the *power* to decide over the distribution of resources.

Scholars and practitioners use the concept of structural violence in the areas of transitional justice and human rights,<sup>28</sup> where much of my prior writing has focused. It is also reflected in the work of 2004 Nobel Peace Prize laureate Wangari Maathai, whose Greenbelt Movement illustrated the connection between structural violence and environmental concerns. Additionally, it is commonly used in the work of postcolonial scholars.<sup>29</sup> There are a number of complementary and competing frameworks to structural violence.<sup>30</sup> For example, the notion of social (structural) determinants of health is an analogous concept to structural violence.<sup>31</sup> It refers to the complex and overlapping social and economic structures that are responsible for most health inequities.<sup>32</sup> Social (structural) determinants of health are shaped by the distribution of money, power, and resources throughout local communities and nations globally.<sup>33</sup> It is sometimes used in the public health literature in lieu of structural violence.

Some scholars have critiqued structural violence as a concept that is too much of a black box. A few commentators label structural vio-

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<sup>27</sup> *Id.* at 173.

<sup>28</sup> See, e.g., Louise Arbour, *Economic and Social Justice for Societies in Transition*, 40 N.Y.U. J. INT'L L. POL. 4, 48 n.22 (2007); Matthew Evans, *Structural Violence, Socioeconomic Rights and Transformative Justice*, 15 J. HUM. RTS. 1, 2 (2016); Wendy Lambourne, *Transitional Justice and Peacebuilding After Mass Violence*, 3 INT'L J. TRANSITIONAL JUST. 28 (2009); Rama Mani, *Dilemmas of Expanding Transitional Justice or Forging the Nexus Between Transitional Justice and Development*, 2 INT'L J. TRANSITIONAL JUST. 253, 254–55 (2008).

<sup>29</sup> See, e.g., ACHILLE MBEMBE, *ON THE POSTCOLONY: STUDIES ON THE HISTORY OF SOCIETY AND CULTURE* (2001).

<sup>30</sup> See NIXON, *supra* note 21, at 3.

<sup>31</sup> See generally COMMISSION ON SOCIAL DETERMINANTS OF HEALTH, WHO, *THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH* (2007), [http://www.who.int/social\\_determinants/resources/csdh\\_framework\\_action\\_05\\_07.pdf](http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf) [<https://perma.cc/W923-57NE>] (archived Jan. 29, 2018).

<sup>32</sup> See, e.g., Lawrence O. Gostin, *Meeting the Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health*, 96 GEO. L. J. 331, 333 (2008).

<sup>33</sup> See, e.g., Lant Pritchett & Lawrence H. Summers, *Wealthier is Healthier*, 31 J. HUM. RESOURCES 841 (1996); A. PRÜSS-ÜSTÜN & C. CORVALÁN, WHO, *PREVENTING DISEASE BURDEN THROUGH HEALTHY ENVIRONMENTS: TOWARDS AN ESTIMATE OF THE ENVIRONMENTAL BURDEN OF DISEASE* (2006), [http://www.who.int/quantifying\\_ehimpacts/publications/previdisexecsume.pdf](http://www.who.int/quantifying_ehimpacts/publications/previdisexecsume.pdf) [<https://perma.cc/H2HG-FZS6>] (archived Feb. 8, 2008).

lence as a concept that “has no meaning” and a categorization of violence as simply what the “user of the term does not like.”<sup>34</sup> By calling something “violent,” the speaker implicitly seeks to designate the issue with a certain importance that escalates it up the policy agenda. These commentators admonish that all social ills need not be considered “violent” in order to recognize that they bring human suffering and need to be eradicated.<sup>35</sup> Further, due to the limitations of international law in addressing instances of mass direct violence, commentators may be reluctant to embrace structural violence as a conceptual matter or otherwise. The fear is that an expanded conceptualization of violence might detract attention from “real” violence and the much-needed resources and political will that are necessary to address it. Yet this presents a false dichotomy—by zeroing in on the narrow conceptualization of violence, it is as if international coordination and action can only galvanize towards one goal.

On the other hand, direct or physical violence corresponds with intuitions around “what *drama* is.”<sup>36</sup> While both direct and indirect violence involve harm to individuals, there is an assumption that direct violence causes more suffering than structural violence.<sup>37</sup> This dichotomy between direct and indirect violence reflects the bias and hierarchy internationally in which situations involving mass personal violence are crises that require urgent international action, while structural violence becomes quotidian and less susceptible to redress.<sup>38</sup> Structural violence as a frame assists with this unmasking and challenges the “normal state of affairs,” which can produce death on a massive scale<sup>39</sup> without an international response because visibility is otherwise obscured.

Further, how violence is theorized is important because it shapes perceptions of the world and defines permissible and impermissible actions. The minimalist and the expansive understandings of violence have different starting points—the former from the point of view of the perpetrator (violence as intentional), and the latter from the point of

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<sup>34</sup> Kjell Eide, *Note on Galtung's Concept of "Violence,"* 8 J. PEACE RES. 71, 71 (1971); see also JOHN KEANE, REFLECTIONS OF VIOLENCE (1996); C.A.J. Coady, *The Idea of Violence*, 3 J. APPLIED PHIL. 3, 4 (1986); Jean-Pierre Derriennic, *Theory and Ideologies of Violence*, 9 J. PEACE RES. 361, 362 (1972); Claire Thomas, *Why Don't We Talk about "Violence" in International Relations?*, 37 REV. INT'L STUD. 1815, 1825 (2011).

<sup>35</sup> See, e.g., Thomas, *supra* note 34, at 1832.

<sup>36</sup> Galtung, *supra* note 12, at 171.

<sup>37</sup> *Id.*

<sup>38</sup> See Benjamin Authers & Hilary Charlesworth, *International Human Rights Law and the Language of Crisis* 15 (Ctr. for Int'l Governance & Just., Working Paper No. 18, 2013).

<sup>39</sup> See, e.g., AKHIL GUPTA, RED TAPE: BUREAUCRACY, STRUCTURAL VIOLENCE, AND POVERTY IN INDIA 72 (2012).

view of the victim (violence as violation).<sup>40</sup> It may seem impossible to bridge the gulf between the ideological and methodological approaches to violence. This Article challenges this false dichotomy where violence is either narrowly understood or broadly conceptualized. Instead, it argues that it is more illuminating to theorize violence as a continuum—with the narrower end of the spectrum having the minimal conceptualization of violence (direct, physical, and psychological) and the other end of the spectrum having the broader conceptualization of structural violence. Violence as a continuum facilitates coherence around the range of human experience with violence—from the physical, to the psychological, to symbolic, systemic, and structural. Theorizing violence as a continuum also allows consideration of accumulated actions or inactions over time that produce culpable harm, as opposed to the narrow conceptualization which conceives of violence as immediate, evident, and instantaneously registered.<sup>41</sup> Further, violence as a continuum allows focus on the discursive and ideological processes by which everyday violence is “normalized” and “naturalized” in public consciousness.<sup>42</sup> Viewing violence as a continuum does not lead to false equivalencies between concepts that need to be differentiated.

Yet the narrower end of the spectrum comports with how many conceptualize violence—where there is a clear causal connection between the subject, the object, and an action.<sup>43</sup> While structural violence does not ordinarily involve cognizable crimes, criminal law doctrine is nonetheless helpful in better understanding the role of causation in structural violence. In other words, one automatically wonders, if the actor(s) refrained from action, would the result of structural violence have occurred anyway? However, structural violence tends to involve issues of overdetermination, or too much causation. By directing attention to the arrangements of and relationship between the parts or elements of a complex whole, structural violence contemplates as a foundational matter that many causes can lead to the same outcome.<sup>44</sup>

As such, structural violence as a concept requires the right inquiries about causation. Under traditional principles of criminal law, in the face of instances of too much causation, different questions apply:

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<sup>40</sup> See Vittorio Bufacchi, *Two Concepts of Violence*, 3 POL. STUD. REV. 193, 196 (2005).

<sup>41</sup> Galtung, *supra* note 12, at 171.

<sup>42</sup> See, e.g., Nancy Scheper-Hughes, *Dangerous and Endangered Youth: Social Structures and Determinants of Violence*, 1036 ANN. N.Y. ACAD. SCI. 13–46 (2004).

<sup>43</sup> Galtung, *supra* note 12, at 171.

<sup>44</sup> See, e.g., Dennis F. Thompson, *Moral Responsibility of Public Officials: The Problem of Many Hands*, 74 AM. POL. SCI. REV. 905 (1980).

- (1) whether the actor's actions were a substantial factor in producing the result, regardless of whether the outcome might have occurred anyway;
- (2) whether the actor's actions hastened the result; or
- (3) whether the actor's actions made survival less likely as a result.<sup>45</sup>

These inquiries are important because without examining them one would tend to stop at the first-level question—whether the result would have occurred but for the actor's actions. Yet situations of structural violence would not satisfy the first-level inquiry, because it appears that the outcome would have occurred regardless of the actor's actions. Seemingly, the actions of the actor(s) made no difference to the resulting structural violence, but this would be an incorrect conclusion and elide the realities of situations of overdetermination. Because structural violence is characterized by overdetermination, it is critical to delve deeper than when ordinarily conceptualizing violence. Failure to ask the right queries may lead to inaccuracies in identifying what actor or actors are responsible for what.<sup>46</sup> Moreover, in determining responsibility in criminal law—causation cannot be established if the result is so remote that it makes holding the actor accountable illegitimate.<sup>47</sup> In other words, if the result was reasonably foreseeable to the actor, then the actor's actions are considered sufficient to establish causation, and it is considered fair to hold the actor accountable.

Criminal law doctrine is also helpful in better understanding what to make of failures to act, when the result is structural violence. Under general principles of criminal law, actors can directly perpetrate crimes through affirmative voluntary acts or through not acting, when there is a duty to do so.<sup>48</sup> Similarly, structural violence can be perpetrated through both commission and omission. Where structural violence occurs as the result of a failure to act, there is greater risk that the culpable harm occasioned by this failure will be misattributed or not attributed at all to the relevant actor(s) than in cases of direct violence. The established criminal law rules for deciding omission liability are similarly helpful in determining when an actor's failure to act can be considered blameworthy for the resulting structural violence. Generally, in criminal law an actor is not required to act unless there is:

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<sup>45</sup> JENS OHLIN, CRIMINAL LAW DOCTRINE, APPLICATION, AND PRACTICE 192, 198 (2016).

<sup>46</sup> Cf. André Nollkaemper, *Political Economy and the Responsibility of States: The Problem of Many Hands in International Law*, in THE POLITICAL ECONOMY OF INTERNATIONAL LAW: A EUROPEAN PERSPECTIVE 278, 289–97 (Fabbriotti ed., 2016).

<sup>47</sup> OHLIN, *supra* note 45, at 209.

<sup>48</sup> *Id.* at 116–17.

- (1) some law that imposes a duty;
- (2) a relationship status recognized by law as imposing a duty;
- (3) a contractual duty;
- (4) an actor who voluntarily assumes care secluding the person from receiving care from a third party; or
- (5) an actor who has created the harm in the first place.<sup>49</sup>

These criminal law concepts are helpful for elucidating the forms of structural violence that can occur via omission.

This Article employs these principles to reveal how certain international actors enabled structural violence with Ebola through omission. Further, criminal law doctrine provides important guidelines about how the concept of structural violence can be operationalized in law and may assist with showing causation for structural violence more generally. However, this does not suggest that the appropriate response to structural violence once attribution of responsibility has occurred is to resort to criminal law or even tort law as a form of securing redress for structural violence internationally. This is because internationally few forums, if any, exist that would have both subject matter and personal jurisdiction over claims involving structural violence. As noted earlier, structural violence does not necessarily involve cognizable crimes domestically or internationally. Accordingly, this Article prioritizes legal reform initiatives aimed at bettering the legal regimes that are charged with responding to the structural violence witnessed with epidemics. Additionally, this Article calls for an expansion of the current frameworks for international responsibility and international disaster law in order to better address incidents of structural violence seen with infectious diseases.

This Article utilizes the concept of structural violence as a literal and rhetorical tool to highlight the harm caused by the operation of international law and actors through action and inaction during the West African Ebola outbreak. Structural violence as a framework in this Article helps to draw attention to the arrangement of and relationship between the parts or elements of complex legal regimes. This framework aids in foregrounding the background—the human-made laws, policies, and conditions that gave rise to the Ebola epidemic. This Article employs the concept to help to expose the fallacy of infectious diseases as purely biological or naturally occurring events<sup>50</sup> and instead highlights the lethal interaction between inequality and infec-

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<sup>49</sup> See *People v. Beardsley*, 113 N.W. 1128, 1129–30 (Mich. 1907) (describing the conditions under which a person is required to act).

<sup>50</sup> See Susan Marks, *Human Rights and the Bottom Billion*, 1 EUR. HUM. RTS. L. REV. 37, 47 (2009).

tious diseases. Structural violence as a framework assists with identifying actors, actions, laws, policies, and omissions that might otherwise be unacknowledged. In this way, the concept assists with apportioning partial responsibility and undermining simplistic accounts where epidemics like Ebola just happen spontaneously, like manna from the sky, or at most due to local backwardness. In sum, this subpart clarified the framework of structural violence, discussed how it can be operationalized in law, and concluded that theorizing violence as a continuum better comports with people's lived experiences with violence.

### B. *Legal Framework: International Law*

This Article uses the legal framework of international law because international law increasingly addresses almost every type of human activity, including those typically considered within the exclusive domestic jurisdiction of states—like health. States turn to international law and institutions to achieve common aims, solve shared problems, promote compliance with norms, reduce transaction costs, provide information, and coordinate orderly and peaceful dispute resolution.

Yet international law and its various participants are by no means neutral. Instead, international law reflects important sites of power contestation between the Global North and the Global South, among other cleavages.<sup>51</sup> These cleavages have historical roots in patterns of domination and exploitation by countries in the Global North: from the plunder of resources, to slavery, to colonialism, and to neocolonialism.<sup>52</sup> Generally speaking, the Global South has had to function as “international law takers” on a range of social, political, and economic issues.<sup>53</sup> These rules are backed by coercion from the ever-expanding conditionalities imposed by international organizations (IOs), or from the neglect of attention paid to social and economic realities in much of the Global South by these institutions.<sup>54</sup> IOs and international law more generally have functioned in a way that enables questions of social and economic inequality to be treated as solely a matter of concern and responsibility of the territorial state, which has freed them from having to mitigate the social and economic inequalities that result from

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<sup>51</sup> Notably, the least advantaged are not always located outside of the “developed” North. See, e.g., Volker Heins, *Realizing Honneth: Redistribution, Recognition, and Global Justice*, 4 J. GLOBAL ETHICS 141, 146 (2008).

<sup>52</sup> See Makau Mutua, *Critical Race Theory and International Law: The View of an Insider-Outsider*, 45 VILL. L. REV. 841, 843–44 (2000).

<sup>53</sup> See generally Andrew Hurrell, *Global Inequality and International Institutions*, 32 METAPHILOSOPHY 34 (2003).

<sup>54</sup> See *id.*

the functioning of international law, IOs, and state and nonstate actors.

Historically, the field of international law has deprioritized issues of structural violence that underpin everyday life.<sup>55</sup> Accordingly, economic and social rights, no matter how prolonged or systematic, recede drably into the background.<sup>56</sup> And, international actors view human rights law violations affecting civil and political rights as more severe and deserving of action. In part, this is due to the view that determining accountability for breaches of civil and political rights appears more straightforward than for economic and social rights. And, the preoccupation with direct physical violence in international law restricts it through its inattentiveness to persistent patterns of violations of economic, social, and cultural rights. While on occasion violations of these rights are imbued with the rhetoric of crises (for example, in the case of natural disasters, famine, or infectious diseases), the longer the situation persists, the more the sense of urgency dissipates.<sup>57</sup> Accordingly, violations of economic and social rights are perceived as less susceptible to international coordination, action, and reform.<sup>58</sup> This neglect of the importance of the economic and social sector has rendered already fragile countries in the Global South ill-equipped to deal with pandemics, which was witnessed during the Ebola epidemic. However, highly infectious diseases do not respect borders and pose transnational challenges that require international cooperation and action.

### III. WARS DECLARED AND UNDECLARED & THE EBOLA EPIDEMIC

The Ebola epidemic vividly illustrates the relationship between war and disease. In some sense it is not coincidental that the epidemic most impacted three post-conflict countries struggling to rebuild—Liberia, Sierra Leone, and Guinea. This Part demonstrates how the failure to conceptualize violence as a continuum may lead to haphazard and incomplete post-conflict measures and interventions that may help the sore, but do not heal the wounds. It examines how the international community's focus on stemming "real" violence deprioritized addressing structural violence impacting the social and economic sectors. Post-

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<sup>55</sup> See Hilary Charlesworth, *International Law: A Discipline in Crisis*, 65 MODERN L. REV. 377, 391 (2002) ("One way forward is to refocus international law on issues of structural justice that underpin everyday life.").

<sup>56</sup> See Authers & Charlesworth, *supra* note 38, at 14.

<sup>57</sup> *Id.* at 17.

<sup>58</sup> *Id.* at 20.

conflict interventions effectively ignored the decimated health care system left in the aftermath of years of neglect and conflict and created fertile ground for the Ebola pandemic.

### A. *Guinea, Liberia & Sierra Leone before Ebola*

This subpart analyzes the *ex ante* factors that enabled structural violence resulting in differential risks for infection from Ebola among the impacted countries. Underdevelopment, conflict, and failures of post-conflict reconstruction meant that Liberia, Sierra Leone, and Guinea were subject to more adverse consequences from structural violence during the 2014–2015 Ebola epidemic.

#### 1. Underdevelopment in the Sub-Region

While diseases can affect all countries, poorer countries tend to suffer the greatest impact and are more vulnerable in cases of epidemic diseases.<sup>59</sup> The Ebola epidemic was able to wreak havoc in Guinea, Liberia, and Sierra Leone in large part because these are some of the poorest countries in the world, with Liberia ranking 175 out of 187 countries on the UN Development Program's Human Development Index, just in front of Sierra Leone at 177 and Guinea at 178.<sup>60</sup> Historically, these countries have had their rich natural and human resources extracted for the benefit of local elites and foreigners.<sup>61</sup> This pattern of exploitation left a lasting legacy on the sub-region. Some commentators have painted this region of West Africa as remote or removed from the world and the forces of globalization.<sup>62</sup> Yet this region has been very connected: serving as a central place in the transatlantic slave trade, part of the West African trading empires in the eighteenth and nineteenth centuries, and a source of supply for labor and commodities to Britain, France, and American-Liberian powers.<sup>63</sup>

Yet even after formal independence, similar patterns of exploitation persisted. For example, the dominance of extractive industries has continued—with huge international mining corporations, oil interests, and logging and other industries controlling significant sectors of the

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<sup>59</sup> See Puymbroeck, *supra* note 16, at 783.

<sup>60</sup> See Daniel G. Bausch & Lara Schwarz, *Outbreak of Ebola Virus Disease in Guinea: Where Ecology Meets Economy*, 8 PUB. LIBR. SCI. NEGLECTED TROPICAL DISEASES 4 (2014).

<sup>61</sup> See Wilkinson & Leach, *supra* note 17, at 137.

<sup>62</sup> See, e.g., Bausch & Schwarz, *supra* note 60.

<sup>63</sup> Leach, *supra* note 8, at 820.



economy.<sup>64</sup> The historical reliance on the extractive sector for economic development led to wealth for a few individuals, while most were subjected to precarious lifestyles outside of the formal economy in overcrowded urban areas.<sup>65</sup> For instance, despite being rich in natural and mineral resources, Guinea has the eighth lowest gross national income per capita in the world, and poverty has been on the rise since 2003.<sup>66</sup> Further, a survey in 2011 found large income gaps across all three countries with the top 20 percent earning between 40 and 46 percent of national income, and the bottom 20 percent earning between 20 and 22 percent.<sup>67</sup> Moreover, even though Liberia and Sierra Leone had some of the highest growth rates globally, the vast majority of people's lived experiences was and is defined by continued or growing poverty.<sup>68</sup>

Further, Cold War politics meant that the Global North often dispensed international aid to support authoritarian regimes in the sub-region from Siaka Stevens in Sierra Leone, to Samuel K. Doe in Liberia, to Lansana Conté in Guinea. Stevens and the other leaders were allowed to appropriate aid revenues and to undermine state services, in return for allegiance.<sup>69</sup> The money lent to these corrupt and undemocratic regimes to build white-elephant infrastructure projects served dubious purposes and had limited utility.<sup>70</sup> The payments for these projects, combined with the perpetually imbalanced trade patterns between the countries in the sub-region who relied on exporting extractive and agricultural goods and importing informational and industrial goods from the Global North, resulted in a chronic cycle of unsustainable debt where countries borrowed to pay their debts.<sup>71</sup>

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<sup>64</sup> See *id.* at 820–21; see also INST. OF DEV. STUDIES, EBOLA AND EXTRACTIVE INDUSTRY (2015).

<sup>65</sup> See Leach, *supra* note 8, at 822.

<sup>66</sup> See Bausch & Schwarz, *supra* note 60, at 5.

<sup>67</sup> *Bottom 20% Incomes*, WORLD BANK, <https://data.worldbank.org/indicator/SI.DST.FRST.20> (last visited Feb. 8, 2018) [<https://perma.cc/7WQA-QVLM>] (archived Jan. 29, 2018).

<sup>68</sup> See INT'L MONETARY FUND [IMF], WORLD ECONOMIC OUTLOOK: RECOVERY STRENGTHENS, REMAINS UNEVEN 69 (2014).

<sup>69</sup> Dele Ogunmola, *From Civil War to Political Parties: A Comparison of Insurgent Movements in West Africa, Liberia, Sierra Leone, and Côte d'Ivoire, and Their Metamorphosis Into Political Parties*, 14 GLOBAL J. OF HUM. SOC. SCI. 4, 5 (2014).

<sup>70</sup> See Brook Baker, *The Impact of the International Monetary Fund's Macroeconomic Policies on the AIDS Pandemic*, 40 INT'L J. HEALTH SERV. 347, 349 (2010).

<sup>71</sup> *Id.*

Adding to this vulnerability in the region were reform policies of international financial institutions, which undermined already compromised health systems.<sup>72</sup> These reform policies affirmatively enabled structural violence in the public health sector. The International Monetary Fund (IMF) has been active in West Africa for decades, with its first loan in Liberia beginning in 1963.<sup>73</sup> Similarly, since 1984 the IMF has given consistent support to Sierra Leone and Guinea.<sup>74</sup> The IMF provided loans to encourage the “structural adjustment” of an economy as a condition for extending and refinancing debt. The austerity measures included cutting the budget deficit and improving the balance of payments. This was accomplished through budget ceilings, wage caps, and/or reductions in wages in the public sector.<sup>75</sup> These restrictions prioritized short-term economic objectives over longer-term investments in public health, and the result predictably hollowed out the flailing health sector.<sup>76</sup> For example, an independent evaluation of the IMF’s loan programs surveyed twenty-nine countries in sub-Saharan Africa between 1999 and 2005 and found that 37 percent of all annual aid increases were diverted to beefing up currency reserves, with another 37 percent going to repay debts in line with the dictates of structural adjustment—leaving only 27 percent for health and other pressing developmental needs.<sup>77</sup>

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<sup>72</sup> *Id.* at 347.

<sup>73</sup> See *Liberia History of Lending Arrangements as of November 30, 2013*, IMF, <http://www.imf.org/external/np/fin/tad/extarr2.aspx?memberKey1=600&date1key=2013-11-30> (last visited Feb. 8, 2018) [<https://perma.cc/9QLJ-JXUY>] (archived Jan. 29, 2018); see also *Liberia: Transactions with the Fund from May 01, 1984 to August 31, 2017*, IMF, <http://www.imf.org/external/np/fin/tad/extrans1.aspx?memberKey1=600&endDate=2017-08-31> (last visited Feb. 8, 2018) [<https://perma.cc/T7JB-WRRJ>] (archived Jan. 29, 2018).

<sup>74</sup> See *Guinea: Transactions with the Fund from May 01, 1984 to August 31, 2017*, IMF, <http://www.imf.org/external/np/fin/tad/extrans1.aspx?memberKey1=380&endDate=2017-08-31> (last visited Feb. 8, 2018) [<https://perma.cc/3P58-PNWF>] (archived Jan. 28, 2018); see also *Sierra Leone: Transactions with the Fund from May 01, 1984 to August 31, 2017*, IMF, <http://www.imf.org/external/np/fin/tad/extrans1.aspx?memberKey1=850&endDate=2017-08-31> (last visited Feb. 8, 2018) [<https://perma.cc/QL8A-YF4U>] (archived Jan. 29, 2018).

<sup>75</sup> Baker, *supra* note 70, at 347.

<sup>76</sup> Leach, *supra* note 8, at 823; see David Stuckler et al., *The International Monetary Fund's Effects on Global Health: Before and After the 2008 Financial Crisis*, 39 INT’L J. HEALTH SERV. 771 (2009); DAVID GOLDSBOROUGH, CTR. FOR GLOBAL DEV., DOES THE IMF CONSTRAIN HEALTH SPENDING IN POOR COUNTRIES? EVIDENCE AND AN AGENDA FOR ACTION (2007), [http://www.cgdev.org/doc/IMF/IMF\\_Report.pdf](http://www.cgdev.org/doc/IMF/IMF_Report.pdf) [<https://perma.cc/34US-2SVH>] (archived Feb. 8, 2018).

<sup>77</sup> See generally JOANNE SALOP ET AL., INDEP. EVALUATION OFFICE, IMF, THE IMF AND AID TO SUB-SAHARAN AFRICA (2007), <https://www.imf.org/external/np/ieo/2007/ssa/eng/pdf/report.pdf> [<https://perma.cc/K2X9-UQLV>] (archived Jan. 29, 2018) [hereinafter IMF 2007 INDEPENDENT EVALUATION].

The IMF responded to concerns about its programs from actors like the Jubilee Campaign, an international NGO network,<sup>78</sup> and provided partial debt relief through the Heavily Indebted Poor Countries (HIPC) Initiative.<sup>79</sup> Liberia, Guinea, and Sierra Leone all had unsustainable debt burdens and met the criteria for HIPC assistance.<sup>80</sup> By September 2012, all three countries had successfully completed HIPC.<sup>81</sup> This meant that they had established a good track record of performance under IMF and WB sponsored programs, had satisfactorily implemented key reforms, had adopted a poverty reduction strategy paper, and had implemented its recommendations for at least one year.<sup>82</sup> Debt relief from HIPC is supposed to free up funds for countries to use on social spending including health, with the money saved from servicing debt.<sup>83</sup> While the IMF and WB provided partial debt relief under HIPC, full debt relief for most countries is still elusive because creditor participation is voluntary and a number of smaller multilateral institutions and bilateral and commercial creditors have not delivered the anticipated relief. Furthermore, one-third of these creditors have delivered no relief at all.<sup>84</sup>

Due to the limitations with HIPC, the Group of Eight created the Multilateral Debt Relief Initiative (MDRI) in 2005 to allow for further debt relief from the WB, the IMF, and the African Development Fund on eligible debt for countries that successfully completed HIPC.<sup>85</sup> In order to qualify for this initiative, countries needed to have a per capita income under USD 380 as well as have outstanding debt to these institutions in 2004.<sup>86</sup> Countries also had to demonstrate success in the

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<sup>78</sup> See, e.g., *South-South Summit Declaration: Towards a Debt-Free Millennium*, WORLD COUNCIL OF CHURCHES (Nov. 21, 1999), <https://www.oikoumene.org/en/resources/documents/wcc-programmes/public-witness-addressing-power-affirming-peace/poverty-wealth-and-ecology/finance-speculation-debt/south-south-summit-declaration> [https://perma.cc/P2XG-9MKM] (archived Jan. 29, 2018).

<sup>79</sup> *Debt Relief Under the Heavily Indebted Poor Countries Initiative Fact Sheet*, IMF (Apr. 8, 2016), <https://www.imf.org/external/np/exr/facts/hipc.htm> [https://perma.cc/8WWK-TMLB] (archived Jan. 29, 2018) [hereinafter *HIPC Fact Sheet*].

<sup>80</sup> See *id.*

<sup>81</sup> See *HIPC Initiative: Publications of Country Cases Considered Under the Initiative*, IMF, <http://www.imf.org/external/np/hipc/eng/pdf/hipccountries.pdf> (last visited Feb. 8, 2018) [https://perma.cc/6YDV-RVTB] (archived Jan. 29, 2018).

<sup>82</sup> *HIPC Fact Sheet*, *supra* note 79.

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

<sup>86</sup> *Multilateral Debt Relief Initiative Fact Sheet*, IMF, <https://www.imf.org/external/np/exr/facts/mdri.htm> (last visited Feb. 8, 2018) [https://perma.cc/M8P3-TD9E] (archived Jan. 29, 2018).

IMF and WB's stipulated macroeconomic policies, implement a poverty reduction strategy program, and successfully manage public expenditures.<sup>87</sup> All three countries in the sub-region were eligible for the MDRI.<sup>88</sup> And, the IMF delivered to Liberia USD 172 million beyond-HIPC debt relief on June 30, 2010.<sup>89</sup>

However, irrespective of the labeling that the IMF and the WB used to describe their programs—from structural adjustment, to good governance, or poverty reduction—the underlying logic and macroeconomic policies remained the same.<sup>90</sup> Although the IMF has attempted to respond to the criticism leveled against it, it continues to prioritize “macroeconomic stability above all else.”<sup>91</sup> Indeed, prior to the Ebola outbreak, although all three countries had successfully met the IMF's macroeconomic policy prescriptions, they had all failed to meet targets for social spending, including health.<sup>92</sup>

Moreover, to keep government spending low, the IMF placed limitations on public-sector wages, which meant that money to employ and adequately remunerate doctors, nurses, and other health care professionals was limited.<sup>93</sup> As health care employment opportunities lessened, health care quality and a capable health care workforce concomitantly decreased. Furthermore, depressed wages in the public health system contributed to the brain-drain problem in the health sector (where indigenous talent leaves for greener, more prosperous pastures).<sup>94</sup> For instance, even before the Ebola epidemic hit, in a survey of health care workers for every thousand persons found, Guinea could

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<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> See Daniel W. Muriu, *The Imperial-Emancipatory Paradox of International Human Rights: How Useful is the Right to Health in Sub-Saharan Africa?*, 9 INT'L COMM. L. REV. 387, 401 (2007).

<sup>91</sup> See Baker, *supra* note 70, at 354, 356.

<sup>92</sup> IMF, *Guinea: Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding* (Feb. 1, 2014); see also IMF, *Liberia: Third Review under the Extended Credit Facility Arrangement and Request for Waiver of Non-observance of Performance Criterion and Modification of Performance Criteria*, Country Report No. 14/197 (Jul. 11, 2014); IMF, *Sierra Leone: First Review Under the Extended Credit Facility Arrangement, Request for Modification of Performance Criteria, and Financing Assurances Review* (Jun. 26, 2014).

<sup>93</sup> See IMF 2007 INDEPENDENT EVALUATION, *supra* note 77.

<sup>94</sup> See Karen McColl, *Fighting the Brain Drain*, 337 BRIT. MED. J. 958, 958 (2008); D. McCoy et al., *Salaries and Incomes of Health Workers in sub-Saharan Africa*, 371 LANCET 675 (2008); ERIC FRIEDMAN, PHYSICIANS FOR HUMAN RIGHTS, AN ACTION PLAN TO PREVENT BRAIN DRAIN: BUILDING EQUITABLE HEALTH SYSTEMS IN AFRICA (2004), <http://allafrica.com/download/resource/main/main/ids-00010242:21e6b22646882263f8b7aa73a71c810c.pdf> [https://perma.cc/8B73-R6N8] (archived Jan. 29, 2018).

only count 0.1 doctors, Liberia 0.014, and Sierra Leone 0.022.<sup>95</sup> In Sierra Leone, the structural adjustment policies of the IMF between 1995 and 1996 required the reduction of public employment, which resulted in the retrenchment of 28 percent of governmental employees,<sup>96</sup> with limits on wages continuing into the 2000s.<sup>97</sup> This directly affected health, as statistics provided by the WHO show a reduction of community health workers from 0.11 per 1,000 population in 2004 to 0.02 in 2008.<sup>98</sup> While it is impossible to isolate how much of the lack of health workers was caused by structural adjustment, it seems plausible that these reform policies were at least a substantial factor in producing this result.<sup>99</sup> Accordingly, the effect of structural adjustment reforms were detrimental for the supply of health services—by insisting on cuts in health spending to manage public expenditures.

Additionally, structural adjustment reforms also had a negative impact on the demand for health services—by reducing household income, thus leaving people with less money for health. Due to the IMF's and the WB's policies, public health was transformed into a commodity and an individual responsibility.<sup>100</sup> For example, in Sierra Leone, despite the government's introduction of a free health care initiative, it continued to charge fees for services, which limited access.<sup>101</sup> This was influenced by the IMF's admonition to “carefully assess the fiscal implications” of providing free health care services.<sup>102</sup>

Indeed, studies have shown that the IMF's policies have slowed down improvements in, or worsened, the health status of people in

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<sup>95</sup> *Global Health Observatory Data Repository: Density per 1,000, by country*, WHO (Feb. 2, 2017), <http://apps.who.int/gho/data/view.main.92100> [<https://perma.cc/249X-MNSG>] (archived Feb. 8, 2018).

<sup>96</sup> IMF, *Sierra Leone: Midterm Review Under the Second Annual Arrangement Under the Enhanced Structural Adjustment Facility and Request for Waiver of Performance Criteria*, IMF Doc. No. EBS/96/155 (Sept. 25, 1996).

<sup>97</sup> IMF, *Sierra Leone: 2006 Article IV Consultation, First Review Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility, Financing Assurances Review, and Request for Waiver of Nonobservance of Performance Criterion* (Feb. 16, 2007).

<sup>98</sup> Alexander Kentikelenis et al., *The International Monetary Fund and the Ebola Outbreak*, 3 *THE LANCET* 69, 69 (2015).

<sup>99</sup> See McColl, *supra* note 94.

<sup>100</sup> Wilkinson & Leach, *supra* note 17, at 142.

<sup>101</sup> See generally AMNESTY INT'L, *AT A CROSSROADS: SIERRA LEONE'S FREE HEALTHCARE POLICY* (2011).

<sup>102</sup> IMF, *Sierra Leone: Sixth Review Under the Arrangement Under the Extended Credit Facility*, IMF Country Report No. 10/176 (May 19, 2010).

countries implementing them.<sup>103</sup> The results elsewhere reportedly include increased incidences of infectious diseases like tuberculosis.<sup>104</sup> It is not a far stretch to see how the depletion of investment in health services contributed towards higher incidences of Ebola in the sub-region. In Guinea, for example, beginning in the 2000s, the IMF promoted fiscal and administrative decentralization.<sup>105</sup> The idea behind decentralization is presumably to make care more responsive to local demands; however, this move also makes it difficult to plan a coordinated response to an epidemic like Ebola.<sup>106</sup> Five years after Guinea complied with IMF dictates to transfer budgetary responsibilities from the central government to the local level,<sup>107</sup> an IMF mission to the country found governance problems, ineffective decentralization, and deterioration of the quality of health-service delivery.<sup>108</sup> While correlation does not equal causality, the analysis above indicates that the collective effects of the structural adjustment programs potentially made survival from an epidemic disease in the impacted countries less likely. During the midst of the Ebola crisis, the IMF belatedly recognized the connection between its policies and the outbreak. IMF Director Christine Lagarde said at a meeting on the epidemic, “It is good to increase the fiscal deficit when it's a matter of curing the people, of taking the precautions to actually try to contain the disease. The IMF doesn't say that very often.”<sup>109</sup>

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<sup>103</sup> See David Stuckler et al., *International Monetary Fund Programs and Tuberculosis Outcomes in Post-Communist Countries*, 5 PUB. LIBR. SCI. MED. 1079, 1086 (2008) (showing the connection between IMF programs and the worsening of tuberculosis incidence, prevalence, and mortality rates).

<sup>104</sup> *Id.*; see also *IMF Casts Doubt on TB Study*, IMF (July 23, 2008), <https://www.imf.org/en/News/Articles/2015/09/28/04/53/sores072308a> [<https://perma.cc/XG6C-94LH>] (archived Jan. 30, 2018).

<sup>105</sup> Kentikelenis et al., *supra* note 98.

<sup>106</sup> *Id.*

<sup>107</sup> See IMF, *Guinea: Request for a Three-Year Arrangement Under the Poverty Reduction and Growth Facility*, IMF Doc. No. EBS/01/57 (Apr. 18, 2001) (containing Guinea's application for the arrangement); IMF, *Guinea: Staff Report for the 2002 Article IV Consultation; First Review Under The Poverty Reduction and Growth Facility; and Requests for Waiver of Performance Criteria, Second-Year Program Under the Poverty Reduction and Growth Facility, and for Additional Interim Assistance Under the Enhanced Initiative for Heavily Indebted Poor Countries*, IMF Doc. No. EBS/02/126 (Jul. 11, 2002) (detailing the results of Guinea's first review).

<sup>108</sup> IMF, *Guinea: Staff report for the 2007 Article IV Consultation and Requests for Three-Year Arrangement Under the Poverty Reduction and Growth Facility and for Additional Interim Assistance Under the Enhanced Heavily Indebted Poor Countries Initiative*, IMF Doc. No. EBS/07/140 (Dec. 7, 2007).

<sup>109</sup> *Managing Director's Remarks on the Impact of Ebola*, IMF, <http://www.imf.org/external/mmedia/view.aspx?vid=3830643908001> [<https://perma.cc/K2K3-B35Q>] (archived Jan. 20, 2018).

The analysis above briefly examines how underdevelopment shaped the trajectory of the sub-region. The effects of historical exploitation, structural adjustment, and the debt crises are cumulative causes, contributing substantially to the structural violence witnessed during the Ebola epidemic. These factors aggravated the course of the disease because they enabled the bankrupting of the public health sector, which lacked preparedness and robustness to cope with the Ebola outbreak once it hit. Moreover, the resulting structural violence that occurred was a foreseeable result of the actions of the international actors discussed above.

## 2. Conflict in the Sub-Region

Uneven development, the neglect of rural areas, and exclusionary governance also created ripe conditions for conflict in all three countries and continued insecurity afterwards. The conflicts in Liberia and Sierra Leone were interrelated wars resulting in over three hundred thousand deaths (approximately fifty thousand in Sierra Leone<sup>110</sup> and over two hundred fifty thousand in Liberia),<sup>111</sup> creating millions of refugees and internally displaced people.<sup>112</sup> Liberia and Sierra Leone quickly deteriorated as warlords throughout each country competed for political power and economic resources, which decimated each country's flailing infrastructure and left each country without electricity, sewage, or running water. The war in Sierra Leone is internationally known for mass amputations and the forcible recruitment of children. Other violations included forced cannibalism, sexual slavery, assault, torture, rape, and looting as well as property destruction.<sup>113</sup> Similar human rights violations were committed in the civil war in Liberia.<sup>114</sup> The conflicts in Liberia and Sierra Leone had a spillover effect into

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<sup>110</sup> John Bellows & Edward Miguel, *War and Institutions: New Evidence from Sierra Leone*, 96 AM. ECON. REV. 394, 394–99 (2006).

<sup>111</sup> Evelyne Schmid, *Liberia's Truth Commission Report: Economic, Social, and Cultural Rights in Transitional Justice*, 24 FLETCHER J. HUM. SEC. 5, 9 (2009).

<sup>112</sup> *Id.*; see also Nsongurua J. Udombana, *Globalization of Justice and the Special Court for Sierra Leone's War Crimes*, 17 EMORY INT'L L. REV. 55, 74 (2003).

<sup>113</sup> See SIERRA LEONE TRUTH & RECONCILIATION COMM'N, WITNESS TO TRUTH: VOLUME THREE (2004), [http://www.sierraleonetr.com/index.php/view-report-text-vol-3a/item/volume-three-a-chapter-four?category\\_id=3](http://www.sierraleonetr.com/index.php/view-report-text-vol-3a/item/volume-three-a-chapter-four?category_id=3) [<https://perma.cc/987X-UVWX>] (archived Jan. 20, 2018).

<sup>114</sup> See TRUTH & RECONCILIATION COMM'N OF LIBERIA, CONSOLIDATED FINAL REPORT 262 (2009), <http://www.pul.org.lr/doc/trc-of-liberia-final-report-volume-ii.pdf> [<https://perma.cc/Y287-WZEU>] (archived Feb. 8, 2018).

neighboring Guinea.<sup>115</sup> The conflict in Guinea led to the death of over one thousand Guineans and displacement of more than one hundred thousand Guineans.<sup>116</sup>

In the aftermath of the conflicts in Guinea, Liberia, and Sierra Leone, many vital state institutions were nonexistent or significantly weakened. For example, in 2008, the Index of State Weakness in the Developing World (Index), which ranks all 141 developing countries according to their performance in four key areas—economics, politics, security, and social welfare—ranked Liberia ninth, Sierra Leone thirteenth, and Guinea twenty-third (with a lower ranking representing poorer performance).<sup>117</sup> The Index categorized all three countries as “critically weak states,” defined as those states “least capable of fulfilling most, if not all, of the four critical functions of government.”<sup>118</sup> Guinea, Liberia, and Sierra Leone were ranked in the bottom percentage of all states in providing social welfare to its citizens, with Sierra Leone faring the worst.<sup>119</sup> The Index considered six factors: child mortality,<sup>120</sup> primary school completion, prevalence of undernourishment, access to improved water sources, and improved sanitation facilities, as well as life expectancy.<sup>121</sup> This provides some sense of the level of comparative social deprivation in Guinea, Sierra Leone, and Liberia prior to the Ebola outbreak.

This subpart briefly highlights how conflict exacerbated uneven development in the sub-region. Direct physical violence was a substantial factor in producing the resulting structural violence in all three countries. The legacies of wars both declared and undeclared resulted in differential risks for infection in the impacted countries during the Ebola epidemic, and among those already infected—harmful consequences including death, injury, and illness. The resulting structural violence that occurred following the direct violence perpetrated by governmental and insurgent actors was reasonably foreseeable. Accordingly, their actions are sufficient to establish causation, and it is fair to hold them responsible. The subpart below analyzes how the failures

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<sup>115</sup> See *West Africa Leaders Pledge Border Peace*, BBC NEWS (Feb. 28, 2002), <http://news.bbc.co.uk/2/hi/africa/1843775.stm> [<https://perma.cc/P4PJ-4HV5>] (archived Jan. 20, 2018).

<sup>116</sup> *Guinea Conflict*, GLOBAL SEC., <http://www.globalsecurity.org/military/world/war/guinea.htm> (last updated Nov. 7, 2011) [<https://perma.cc/A3NQ-PBK4>] (archived Jan. 20, 2018).

<sup>117</sup> See SUSAN E. RICE & STEWART PATRICK, BROOKINGS INST., INDEX OF STATE WEAKNESS IN THE DEVELOPING WORLD 3, 39, 41 (2008) [hereinafter INDEX OF STATE WEAKNESS].

<sup>118</sup> *Id.* at 10, 39, 41.

<sup>119</sup> *Id.* at 39, 41. The Index gave a composite score of 0.76 to Sierra Leone, 1.25 to Liberia, and 3.61 to Guinea on a scale of one to ten, based on their performance in the provision of social welfare.

<sup>120</sup> *Id.* at 35 (relying on UNICEF, THE STATE OF THE WORLD'S CHILDREN 2007 (2006)).

<sup>121</sup> *Id.* (relying on WORLD BANK, 2007 WORLD DEVELOPMENT INDICATORS (2007)).



of post-conflict rebuilding compounded structural violence and vulnerability in the sub-region enabling Ebola's spread.

### 3. Post-Conflict Reconstruction in the Sub-Region

Many post-conflict or transitional justice mechanisms are aimed primarily at securing negative peace—the absence of violence and the cessation of hostilities.<sup>122</sup> Yet the concept of positive peace encompasses not simply the removal of physical violence, but also the removal of structural violence,<sup>123</sup> which enables consideration of the importance of both observable as well as latent violence.<sup>124</sup> Further, following a conflict there is a need to alleviate not only the injustices caused by the conflict, but also the injustices that caused the conflict.<sup>125</sup> And, in societies that have not experienced a recent history of conflict, the insecurity and instability that may result from structural violence merit close attention not only from a conflict prevention perspective, but also from a social justice perspective. Yet much of the existing scholarship and practice ignores the priorities and realities of post-conflict societies when designing peace-building efforts.

This bias towards privileging direct violence occurred when UN agencies, donor countries, and a number of international NGOs spearheaded the post-conflict recovery process in the sub-region. For example, post-conflict interventions focus on the Disarmament, Demobilization, and Reintegration (DDR) of former combatants by providing them with skills training, education, and financial incentives to turn in their weapons to promote their return to civilian life.<sup>126</sup> The DDR programs supported by the international community in Sierra Leone provided a low salary, tool kits, and skills training to fifty-three thousand ex-combatants. In Liberia, the programs disarmed approximately 103,101 ex-combatants and provided them with USD 300 as well as some skills training. A survey conducted by the Human Rights Center at the University of California at Berkeley in 2011 in Liberia found that one of the top priorities for post-conflict reconstruction was the health sector

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<sup>122</sup> Galtung, *supra* note 12, at 183.

<sup>123</sup> *Id.*

<sup>124</sup> *Id.* at 172.

<sup>125</sup> See Jon Elster, *Land Justice and Peace*, in *DISTRIBUTIVE JUSTICE IN TRANSITIONS* 16 (Morten Bergesmo et al. eds., 2010).

<sup>126</sup> See CHANDRA LEKHA SRIRAM, *TRANSITIONAL JUSTICE AND PEACEBUILDING ON THE GROUND: VICTIMS AND EX-COMBATANTS* 159, 167 (Chandra Lekha Sriram et al. eds., 2013).

(42 percent).<sup>127</sup> Yet recovery efforts did not properly address this and other high-priority issues like lack of employment and education.<sup>128</sup> Akin to post-conflict reconstruction elsewhere, the processes in Liberia and Sierra Leone focused on security sector reform. This usually entails a mixture of recruiting, retraining, and removing alleged human rights abusers from positions in the police and the army. Moreover, following the transition from conflict, the focus was on accountability mechanisms like trials and truth commissions—both of which occurred in Sierra Leone, while Liberia had a truth commission. The neglect of the importance of restructuring the economic and social sectors in the sub-region rendered already fragile countries ill-equipped to deal with the Ebola outbreak.

Indeed, focusing on direct violence and alleged perpetrators obscures the consequences of structural violence. This bias in turn may result in “catching the small fry and letting the big fish loose.”<sup>129</sup> Accordingly, the failure to conceptualize violence as a continuum led to incomplete post-conflict measures primarily focused on direct physical violence; this omission exacerbated deeply rooted social inequalities that pre-dated the conflicts.<sup>130</sup> The emphasis on post-conflict reconstruction presumed that the existing structures in society were all equally worth rebuilding and had not contributed to marginalization and disaffection of individuals and communities. Additionally, the weight placed on rebuilding state institutions failed to take into account that the “state” is an entity that was and continues to be distant from the lives of most people in the sub-region.<sup>131</sup> As a matter of survival, people have had to depend on themselves, their communities, social networks, and other informal institutions to meet their daily needs. This is especially true for the younger members of Liberian and Sierra Leonean societies whose formative development took place during conflict.<sup>132</sup> Even after nominal peace, life remained strikingly similar for many. Although violence decreased, people’s levels of insecurity and vulnerability persisted.

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<sup>127</sup> See PATRICK VINCK ET AL., TALKING PEACE: A POPULATION-BASED SURVEY ON ATTITUDES ABOUT SECURITY, DISPUTE RESOLUTION, AND POST-CONFLICT RECONSTRUCTION IN LIBERIA 25 (2011).

<sup>128</sup> See Leach, *supra* note 8, at 826.

<sup>129</sup> Authers & Charlesworth, *supra* note 38, at 17.

<sup>130</sup> INST. OF DEV. STUDIES [IDS], RETURN OF THE REBEL: LEGACIES OF WAR AND RECONSTRUCTION IN WEST AFRICA’S EBOLA EPIDEMIC 19 (2015) [hereinafter IDS, RETURN OF THE REBEL].

<sup>131</sup> See *id.* at 2.

<sup>132</sup> *Id.*

The failures of post-conflict reconstruction and the remoteness of the state<sup>133</sup> were especially evident in the health sector. Following the implementation of structural adjustment programs, the decreased role of the state in providing health services meant that NGOs overtook this basic welfare function.<sup>134</sup> The beleaguered health systems enabled by structural adjustment were even worse following the conflicts in the region. A loose arrangement of international institutions led by the United Nations Mission in Liberia and in Sierra Leone and composed of international NGOs as well as donor countries became responsible for managing the state and the health care sector.<sup>135</sup> In many ways, this network voluntarily assumed care and functioned as the *de facto* government during post-conflict reconstruction. The accumulated actions and omissions of this coalition of international actors over time facilitated structural violence seen during the Ebola outbreak. For example, in Liberia this coalition of actors was conflicted about maintaining long-term assistance to the public health sector.<sup>136</sup> Instead, they devised an *ad hoc* system, which consisted of a loose collection of clinics and hospitals run primarily by international NGOs.<sup>137</sup> The fragility of this system of health care provision was apparent in 2007 when Doctors Without Borders left the country following the conflict. The lack of the vital services they provided resulted in the closure of regional and urban hospitals in Liberia. This, concomitant with the closure of thirty World Vision clinics in the capital of Liberia, undermined the already teetering system.<sup>138</sup>

The loose coalition called an emergency donor conference in 2007 to avert the burgeoning public health crisis. Donors agreed to provide financing, human resources, and medical support to Liberia's health sector through the Liberia Health Sector Pool Fund.<sup>139</sup> Donors developed this fund to provide humanitarian health assistance. Under it, the Liberian government and the international development actors determined national health priorities, and the Ministry of Health oversaw the numerous international NGOs operating in Liberia to provide

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133 *Id.*

134 Tsung-Ling Lee, *Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak*, 49 VAND. J. TRANSNAT'L L. 931, 972 (2016).

135 See Sharon Abramowitz, *How the Liberian Health Sector Became a Vector for Ebola*, Ebola in Perspective Series, CULTURAL ANTHROPOLOGY (Oct. 7, 2014), <https://cultural-anth.org/fieldsights/598-how-the-liberian-health-sector-became-a-vector-for-ebola> [https://perma.cc/2TPY-3ELE] (archived Jan. 20, 2018).

136 *Id.*

137 *Id.*

138 *Id.*

139 *Id.*

health services to the populace. Access to the funds was tied to mandatory health sector decentralization in order to promote post-conflict reconstruction and democratization.<sup>140</sup> Liberia implemented a number of reforms under the Pool Fund, but the public health system remained “fragmented, underfunded and understaffed.”<sup>141</sup> This did not stop an enormous bureaucracy from developing in the Ministry which envisioned functions for various health sectors, which due to a lack of resources existed on paper and on the doors of empty offices, but not in reality.<sup>142</sup> This façade of a health care system has been characterized as a literal “application of ‘structural violence’ with the state becoming a “vector of disease.”<sup>143</sup>

The legacy of structural adjustment and post-conflict reconstruction efforts combined to undermine state capacity and reinforce the state’s remoteness from the populace, by restricting the space for the state to be involved in the provision of health services.<sup>144</sup> Consequently, aid organizations delivered more and more services to the poor, since governments were shrinking their spending on public services.<sup>145</sup> This has meant that pre-epidemic contexts and now public health centers and hospitals are regarded in Liberia, Sierra Leone, and Guinea as places to be avoided and even resisted.<sup>146</sup>

Yet the countries in the sub-region were viewed in many sectors as success stories for post-conflict reconstruction.<sup>147</sup> This was exemplified when two Liberian women won the Noble Peace Prize in 2011—President Ellen Johnson-Sirleaf and peace activist Leymah Gbowee. Both Liberia and Sierra Leone avoided relapse into widespread conflict and held peaceful elections, indicating that they had turned the page. For example, Sierra Leone organized its own election in 2012, and the United Nations successfully completed its formal withdrawal of its peacekeeping operation from the country in 2014.<sup>148</sup> Things improved in Guinea as well, especially foreign relations within the sub-region following the conflicts. Following several coups and some instability,

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<sup>140</sup> *Id.*

<sup>141</sup> *Id.*

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> Muriu, *supra* note 90, at 401–02.

<sup>145</sup> See Wilkinson & Leach, *supra* note 17, at 142 (discussing the causes and consequences of government underfunding of the healthcare system).

<sup>146</sup> *Id.*

<sup>147</sup> See, e.g., *Background*, U.N. MISSION IN SIERRA LEONE [UNAMSIL], <https://peacekeeping.un.org/en/mission/past/unamsil/background.html> (last visited Feb. 8, 2018) [<https://perma.cc/FLK2-8376>] (archived Jan. 21, 2018) (describing it as a “success story in peacekeeping”).

<sup>148</sup> IDS, RETURN OF THE REBEL, *supra* note 130, at 2–3.

the political situation had since steadied. Despite these real improvements across the sub-region, Ebola threatened to upend these gains.

The devastating results of the fractured system of health care delivery permitted by limited post-conflict reconstruction created conditions for structural violence and facilitated Ebola's spread. This potentially occurred through accelerating the harm caused by the Ebola epidemic and/or reducing the likelihood of survival due to the lack of resilient health systems. The counterfactual is a ready objection to the arguments put forward in this Part, because one can never know what would have happened if the coalition of international actors had not engaged in post-conflict reconstruction in the sub-region, or if the IMF and WB had not required structural adjustment reform policies. On this view, it is possible that the resulting harm from the Ebola epidemic might have been much worse but for structural adjustment and post-conflict reconstruction efforts. It is futile to attempt to disprove a counterfactual given the impossibility of knowing what would occur in this alternative universe. More importantly, it seems clear that narrow post-conflict reconstruction, structural adjustment policies, and legacies of conflict were at least substantial factors in producing the resulting structural violence in all three countries: differing risks for infection in the impacted countries during the Ebola epidemic, and serious adverse consequences among those already infected. Causation is established here because the structural violence that occurred during the Ebola epidemic was not too accidental in its occurrence to have a just bearing on the responsibility of the actors discussed above.

#### B. *Guinea, Liberia & Sierra Leone in the Time of Ebola*

The Ebola epidemic implicates a number of fundamental human rights, including protections against the arbitrary deprivation of life<sup>149</sup> and the right of everyone to the enjoyment of the highest attainable standard of physical and mental health under international human rights law.<sup>150</sup> A fundamental principle of economic social and cultural rights is that states “undertake to take steps . . . to the maximum of its available resources, with a view to achieving progressively” the right to health as well as other economic, social, and cultural rights.<sup>151</sup> This

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<sup>149</sup> International Covenant on Civil and Political Rights art. 6(1), Dec. 16, 1966, 999 U.N.T.S. 171.

<sup>150</sup> International Covenant on Economic, Social and Cultural Rights art. 12(1), Dec. 16, 1966, S. TREATY DOC. NO. 95-19, 993 U.N.T.S. 3 [hereinafter ICESCR].

<sup>151</sup> *Id.* art. 2.

includes the prevention, treatment, and control of epidemic diseases.<sup>152</sup> Accordingly, under international law the primary responsibility for responding to pandemics lies with the affected state(s). This subpart analyzes the factors that influenced the disproportionate risks for infection from Ebola among the impacted countries. It analyzes the vulnerabilities in the sub-region that permitted the epidemic to spread so quickly, probes the connection between infectious disease and conflict, and analyzes how the lackluster local response facilitated structural violence.

### 1. Ebola's Trajectory in the Sub-Region

Ebola first appeared in 1976 in separate outbreaks in South Sudan and the Democratic Republic of Congo (DRC). Practitioners have speculated that perhaps the virus was able to migrate to West Africa from the DRC through fruit bats and was then transmitted to humans through deforestation that led to increased hunting and consumption of bats.<sup>153</sup> This narrative has been challenged as inaccurate because it pretends as if people have only recently encountered bats and have not cohabitated with them for centuries in the forest.<sup>154</sup> It is also problematic because it led to misguided admonitions to not consume "bush meat," which denied an important source of protein to people in conditions of food scarcity.<sup>155</sup> Moreover, even if the initial event that led to infection in humans was due to animal-human transmission, this is largely irrelevant for addressing an epidemic that primarily spread through human-to-human contact.<sup>156</sup>

Whatever the biological or ecological origin of the virus in West Africa, it was the socio-political and legal landscape that influenced whether the virus would lead to a couple of isolated cases or become a full-scale outbreak.<sup>157</sup> One of the reasons the epidemic was able to spread so easily was because of the concentration of people in urban areas due to decades of governmental neglect of rural areas as well as displacement of many during the conflicts in the sub-region.<sup>158</sup> Porous borders between the three countries that had historically facilitated the transfer of people and goods during the conflict years aided the spread of arms, insurgents, and war economies; and during the Ebola

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<sup>152</sup> *Id.* art. 12(2)(c).

<sup>153</sup> See Bausch & Schwarz, *supra* note 60, at 1.

<sup>154</sup> See Wilkinson & Leach, *supra* note 17, at 145, 145 n.48.

<sup>155</sup> *Id.*

<sup>156</sup> See Leach, *supra* note 8, at 818.

<sup>157</sup> See Bausch & Schwarz, *supra* note 60, at 4.

<sup>158</sup> See Leach, *supra* note 8, at 822.

outbreak enabled the spread of disease and death. All three countries closed their borders with each other attempting to contain the spread of the disease.

During the epidemic, a pattern of transmission from rural to urban areas eased Ebola's spread. Emile Ouamouno ("Patient Zero") is a two-year old child who got infected with a mysterious fever that spread to his family members, a rural health facility, and then a health worker's funeral, and through related familial, social, and trading networks to the Liberian, Guinean, and Sierra Leonean borders.<sup>159</sup> This trajectory—where an infected person goes to an under-resourced health facility without clean needles, a supply of gloves, or other necessities for successful treatment and containment of the disease, rendering both the patient and health care providers vulnerable and susceptible to transmission—resulted in the disease inevitably being transmitted and the cycle repeated.<sup>160</sup>

It took three months for the mysterious fever found in Guinea in December 2013 to be confirmed as Ebola in March of 2014.<sup>161</sup> Between March and May of 2014, Guinea, Liberia, and Sierra Leone identified hundreds of Ebola cases. At the height of the epidemic, Sierra Leone alone was experiencing 250 new cases per week and an epidemic doubling time of approximately thirty days.<sup>162</sup> Remarkably, a 2015 Afrobarometer study indicated that 35.8 percent of Sierra Leoneans and 44.8 percent of Liberians surveyed knew a close friend or relative

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<sup>159</sup> Michelle Faul, *The Village of Meliandou: Guinea's Ground Zero for the Ebola Virus*, ASSOCIATED PRESS (Oct. 12, 2014), [http://en.radiovaticana.va/news/2014/12/10/the\\_village\\_of\\_meliandou\\_guineas\\_ground\\_zero Ebola\\_/1114310](http://en.radiovaticana.va/news/2014/12/10/the_village_of_meliandou_guineas_ground_zero Ebola_/1114310) [<https://perma.cc/5JJV-D2WB>] (archived Jan. 21, 2018).

<sup>160</sup> See Bausch & Schwarz, *supra* note 60, at 4.

<sup>161</sup> See Wilkinson & Leach, *supra* note 17, at 137.

<sup>162</sup> WHO Ebola Response Team, *Ebola Virus Disease in West Africa—The First 9 Months of the Epidemic and Forward Projections*, 371 NEW ENG. J. MED. 1481, 1486 (2014).

infected with Ebola.<sup>163</sup> Tragically, roughly the same percentage of respondents knew someone who died of Ebola: in Sierra Leone approximately 33.4 percent, and in Liberia 40.8 percent.<sup>164</sup>

Moreover, the collateral effects of Ebola were quite dramatic. Indeed, more than 60 percent of respondents to the Afrobarometer surveys in both Sierra Leone and Liberia indicated that they were unable to work several or many times due to Ebola.<sup>165</sup> Because of Ebola, the tourist and service industries were also depressed in the sub-region.<sup>166</sup> Additionally, the disease reduced agricultural production, which contributed to food prices increasing by an estimated 24 percent across the sub-region, leading to fears of malnutrition and famine.<sup>167</sup>

Further, the Ebola epidemic attacked informal networks of care by targeting women, who constituted up to 75 percent of those infected.<sup>168</sup> These women were the numerous mothers, sisters, daughters, grandmothers, aunts, wives, and girlfriends who bear primary responsibility for caregiving work. Informal systems of caregiving became particularly salient when the local and international systems of health care protection had receded or abandoned Ebola patients. Women often functioned as the last line of care. But, the way the disease is transmitted threatened this, which meant that physical touch to comfort and show concern and affection was also off-limits. Ebola educational campaigns stressed this—“no hugging, no handshakes, no

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<sup>163</sup> See *Online Data Analysis Tool*, AFROBAROMETER, <http://afrobarometer.org/online-data-analysis/analyse-online> (last visited Feb. 8, 2018) <https://perma.cc/2RLW-ZHXE> (archived Feb. 15, 2018) [hereinafter *Afrobarometer 2015 Survey Results*] (relevant data found at Q83a-Lib and Q83a-SRL). In Liberia, the latest round of surveys was done on a nationally representative sample of 1,200 adult citizens between May 6<sup>th</sup> and May 22<sup>nd</sup>, 2015. AFROBAROMETER, DATA CODE BOOK FOR A ROUND 6 AFROBAROMETER SURVEY IN LIBERIA 2 (2016), [http://afrobarometer.org/sites/default/files/data/round-6/lib\\_r6\\_codebook.pdf](http://afrobarometer.org/sites/default/files/data/round-6/lib_r6_codebook.pdf) [<https://perma.cc/VHV7-68XC>] (archived Feb. 8, 2018). In Sierra Leone, the latest round of surveys was done on a nationally representative sample of 1,200 adult citizens between May 22<sup>nd</sup> and June 10<sup>th</sup>, 2015. AFROBAROMETER, DATA CODE BOOK FOR A ROUND 6 AFROBAROMETER SURVEY IN SIERRA LEONE 2 (2016), [http://afrobarometer.org/sites/default/files/data/round-6/srl\\_r6\\_codebook.pdf](http://afrobarometer.org/sites/default/files/data/round-6/srl_r6_codebook.pdf) [<https://perma.cc/SB2N-CVMA>] (archived Feb. 8, 2018).

<sup>164</sup> See *Afrobarometer 2015 Survey Results*, *supra* note 163, at Q83b-SRL, 163 Q83b-Lib.

<sup>165</sup> *Id.* at Q84b-SRL, Q84b-Lib.

<sup>166</sup> See James G. Hodge, Jr. et al., *Efficacy in Emergency Legal Preparedness Underlying the 2014 Ebola Outbreak*, 2 TEX. A & M. L. REV. 353, 359 (2015).

<sup>167</sup> *Id.*

<sup>168</sup> See Paul Farmer & Joia Mukherjee, *Ebola's front lines*, BOSTON GLOBE (Sept. 24, 2014), <https://www.bostonglobe.com/opinion/2014/09/23/responding-ebola-countries-need-staff-stuff-space-and-systems/ugSFKkOw9S7Ser0p8PGeOK/story.html> [<https://perma.cc/YBK3-968B>] (archived Jan. 21, 2018) (highlighting the disease's impact on caregivers).



caring for the ill, and no handling of the dead” in preparation for burials.<sup>169</sup> Markets and social places were deserted as government restrictions and fears about congregating in public led people to avoid many everyday interactions.<sup>170</sup> The Afrobarometer survey results indicate that more than 60 percent of respondents in Sierra Leone were unable to attend social gatherings several or many times due to Ebola.<sup>171</sup> As such, the disease impacted much more than physical bodies, striking also at the fabric of social life instilling fear around everything from making love to shaking hands.<sup>172</sup> In this way, Ebola not only threatened communities of care, but what it means to be human—challenging how people greet and interact with strangers and loved ones and what it means to die with dignity and respect.

## 2. Post-Conflict Legacies & the Ebola Epidemic

Statistically, disease is a more formidable and deadly opponent than war.<sup>173</sup> Like war, disease has the ability to completely upend governments by creating power vacuums, reducing life expectancy and concomitantly the available productive workforce and capacity, which impedes economic growth, threatens food security, and erodes confidence in government institutions.<sup>174</sup> Naturally, the metaphor of conflict was employed to describe the fight against Ebola and legacies of violence influenced governmental responses.<sup>175</sup> Countries declared themselves “at war with an enemy we don’t see,” conjuring up images of the “invisible rebel.”<sup>176</sup> Others drew parallels between how earlier insurgencies had come from the border areas to threaten urban areas, and how Ebola’s spread in Guinea, Liberia, and Sierra Leone followed

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<sup>169</sup> Catherine E. Boltan, *Articulating the Invisible: Ebola Beyond Witchcraft in Sierra Leone*, CULTURAL ANTHROPOLOGY (Oct. 7, 2014), <https://culanth.org/fieldsights/596-articulating-the-invisible-ebola-beyond-withcraft-in-sierra-leone> [https://perma.cc/N4FT-4JHV] (archived Jan. 21, 2018).

<sup>170</sup> See Hodge et al., *supra* note 166, at 359.

<sup>171</sup> *Afrobarometer 2015 Survey Results*, *supra* note 163, at Q84c-SRL.

<sup>172</sup> See Leach, *supra* note 8, at 818.

<sup>173</sup> See Lauren Asher, *Confronting Disease in a Global Arena*, 9 CARDOZO J. INT’L COMP. L. 135, 135 (2001).

<sup>174</sup> See Agnew, *supra* note 15, at 122.

<sup>175</sup> See Leach, *supra* note 8, at 826.

<sup>176</sup> Leah Breen, *Fighting Ebola, Liberia’s “Invisible Rebel,”* WASH. POST (Aug. 29, 2014), [https://www.washingtonpost.com/news/monkey-cage/wp/2014/08/29/fighting-ebola-liberias-invisible-rebel/?utm\\_term=.ede30926db71](https://www.washingtonpost.com/news/monkey-cage/wp/2014/08/29/fighting-ebola-liberias-invisible-rebel/?utm_term=.ede30926db71) [https://perma.cc/CD93-2K8F] (archived Jan. 21, 2018).

this same trend.<sup>177</sup> Resistance strategies were also eerily similar with some Liberian women gathering in all white at the same location they used during the conflict to protest and pray for peace. But this time they focused their prayers on divine intervention to overcome Ebola.<sup>178</sup> Additionally, Ebola survivors faced several of the same re-integration issues as former combatants, due to the myths, stigma, and social ostracization that accompanied the disease.<sup>179</sup> Both the former combatant and the Ebola survivor had had contact with the unknown and instilled fear and anxiety in people.<sup>180</sup>

The governments in the sub-region resorted to war-like and authoritarian tactics including aggressive policing, closed borders, and restrictions on people's movement.<sup>181</sup> The security forces in Liberia even fired live rounds at people who were attempting to remove the barricades from their quarantine in one of Liberia's largest slum areas.<sup>182</sup> This use of force gave the impression that the Liberian government was attacking poor urban dwellers and not the virus. Governments that have been perceived and experienced by their publics as detached for decades were now supposed to be responsible for the provision of care and relief.<sup>183</sup> The governments predictably resorted to authoritarian techniques. For example, Sierra Leone's army reportedly cordoned off rural areas where Ebola was present, indiscriminately trapping infected and uninfected individuals in and limiting their freedom of movement.<sup>184</sup> After the looting of a medical ward in Liberia, the government instructed the armed forces to "shoot on sight" anyone

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<sup>177</sup> See IDS, RETURN OF THE REBEL, *supra* note 130, at 1–2.

<sup>178</sup> See Breen, *supra* note 176.

<sup>179</sup> See IDS, RETURN OF THE REBEL, *supra* note 130, at 3.

<sup>180</sup> See *id.*

<sup>181</sup> See, e.g., Donald G. McNeil Jr., *Using a Tactic Unseen in a Century, Countries Cordon off Ebola Racked Areas*, N.Y. TIMES (Aug. 13, 2014), <http://www.nytimes.com/2014/08/13/science/using-a-tactic-unseen-in-a-century-countries-cordon-off-ebola-racked-areas.html> [<https://perma.cc/4KUA-25LH>] (archived Jan. 21, 2018) (noting that West African governments implemented "cordon sanitaire" which has not been used in a century and involves the government drawing a line around the quarantined area where no one is allowed to cross); Adam Nossiter, *Lockdown Begins in Sierra Leone to Battle Ebola*, N.Y. TIMES (Sept. 20, 2014), <http://www.nytimes.com/2014/09/20/world/africa/ebola-outbreak.html> [<http://perma.cc/N7TK-QKTX>] (archived Jan. 21, 2018) (explaining that west African governments, especially in Liberia, Guinea, and Sierra Leone, closed their borders in response to the Ebola outbreak).

<sup>182</sup> See IDS, RETURN OF THE REBEL, *supra* note 130, at 3.

<sup>183</sup> See Wilkinson & Leach, *supra* note 17, at 143.

<sup>184</sup> James G. Hodge, Jr. et al., *Global Emergency Legal Responses to the 2014 Ebola Outbreak*, 42 J. L. MED. & ETHICS 595, 599 (2014).

entering the country from Sierra Leone without proper documentation.<sup>185</sup> That these countries relied heavily on military and policing when faced with Ebola is not shocking considering that these institutions were the only relatively strong ones following limited post-conflict reconstruction.

### 3. Ineffectual Local Responses to Ebola

The epidemic overwhelmed the governments in the sub-region and re-exposed the fragility of the state apparatus. In part, this was because post-conflict reconstruction efforts were focused on rebuilding, retraining, and integrating disparate groups into the police and the military with little to no investment in the health sector. All three countries imposed a state of public emergency that combined impacted millions of people.<sup>186</sup> Sierra Leone declared a national “stay at home day” and ordered a three-day lockdown during which time the populace was to remain indoors, while outreach workers attempted to identify cases, engage in public sensitization, and assist with the removal of bodies of Ebola victims.<sup>187</sup> In Sierra Leone, the Afrobarometer survey results indicate that 50.6 percent of respondents were unable to attend school many times due to Ebola.<sup>188</sup> Similarly, Guinea closed all schools and universities for an indefinite period of time to attempt to halt the transmission of the virus.<sup>189</sup>

The governments’ conduct in attempting to eradicate Ebola engendered and reinforced deep public suspicion and mistrust of the state. For example, many Liberians believed that the Ebola virus was a new method the government had concocted to derive money from its international backers.<sup>190</sup> Early denials of Ebola in Sierra Leone and Guinea were similarly influenced by fears that the government was trying to rid itself of an opposition stronghold through depopulation of particular regions.<sup>191</sup> In Guinea, residents’ fear was also partially informed by their experience with noninclusive state socialism under post-independence leader Sekou Touré.<sup>192</sup> This experience led them to

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<sup>185</sup> *Id.*

<sup>186</sup> *Id.* at 596–97.

<sup>187</sup> See Asher, *supra* note 173, at 164.

<sup>188</sup> *Afrobarometer 2015 Survey Results*, *supra* note 163, at Q84a-SRL.

<sup>189</sup> See Asher, *supra* note 173, at 160–61.

<sup>190</sup> See Wilkinson & Leach, *supra* note 17, at 144.

<sup>191</sup> *Id.*; Faul, *supra* note 159.

<sup>192</sup> See Leach, *supra* note 8, at 827.

believe that Ebola was a government effort to take over their markets.<sup>193</sup> Others in Guinea suspected that Ebola was designed by white mining interests in order to be able to exploit iron ore deposits.<sup>194</sup> Similar to the commonplace myth with HIV/AIDS, many across the sub-region also suspected that Ebola was disseminated by Whites in order to kill off Blacks.<sup>195</sup> These rumors, political myths, and conspiracy theories helped to fill the void and make sense of the mysterious phenomena of Ebola. It would be too simplistic to dismiss these perceptions as mere superstition or ignorance. These sentiments stem from people's experience of structural violence and perceptions of state and foreign actors as "alien, oppressive, and self-serving."<sup>196</sup> This alien-ness was literally reinforced by the "space-suit like" protective gear donned by Ebola outbreak teams.<sup>197</sup>

Individual and community-level responses to Ebola cannot be divorced from people's lived realities. For instance, in Liberia, an uncle of a family of young orphans explained that the mother of the children contracted Ebola from an aunt who had died, and that the family had called the Ministry of Health's Ebola hotline when the mother began showing symptoms.<sup>198</sup> No one came from the treatment unit, but a burial team came to take her body away when she died. Subsequently, the children's father also became ill with Ebola, and the family again called the hotline for days without response.<sup>199</sup> When the children's father died, a burial team came a couple of days later to retrieve the body. This led the uncle to chase away a health care worker when the children began showing early signs of Ebola and to exclaim that the Ministry of Health appears to care "more for the dead than the living."<sup>200</sup>

Ebola exposed the façade of the formal health system and demonstrated quite vividly how much actual health care provision depends on the informal system. This was particularly true for those living in rural areas, as the distance to get to a health facility is daunting—especially due to poor roads that are often impassible during the rainy season, as well as the need to arrange for private transport.<sup>201</sup> Consequently, some people rely on informal drug suppliers and traditional

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193 *Id.*

194 Faul, *supra* note 159.

195 *Id.*

196 Wilkinson & Leach, *supra* note 17, at 144.

197 Leach, *supra* note 8, at 821.

198 See Abramowitz, *supra* note 135.

199 *Id.*

200 *Id.*

201 See Wilkinson & Leach, *supra* note 17, at 143.

healers because of the paucity of clinics and pharmacies.<sup>202</sup> The Afrobarometer survey confirms this, with approximately 20–30 percent of respondents in Sierra Leone and Liberia, respectively, finding traditional medicine practitioners to be somewhat to very effective in providing care for Ebola victims.<sup>203</sup> Reliance on the informal system is sensible in a context where it is common practice for government officials and the well-to-do to go overseas to seek medical care in Ghana or South Africa, or in Europe and the United States.<sup>204</sup> This tendency increased during the outbreak, with many sending their families abroad if not leaving themselves.

The informal health system had more legitimacy than the formal health system in part because the latter had proved to be deficient in a myriad of ways. Treatment facilities did not have enough beds or staff to care for the sick across the sub-region.<sup>205</sup> Additionally, many clinics were forced to close because they became sites of transmission and death as opposed to places to receive care. This occurred due to the formal health sector's general lack of personal protective equipment as well as "staff, systems and stuff."<sup>206</sup> For example, one of the hospitals responsible for the provision of care to 330,000 people in Liberia was forced to close due to the lack of personnel to run the hospital.<sup>207</sup> The Afrobarometer survey results demonstrate that more than 60 percent of respondents in Liberia and Sierra Leone believed they were unable to get medical care for other health problems several or many times due to Ebola.<sup>208</sup> This meant that those that were suffering from more prevalent and common illnesses like malaria, typhoid, or pneumonia were dying in even more alarming numbers because they were unable

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<sup>202</sup> See IDS, RETURN OF THE REBEL, *supra* note 130, at 2.

<sup>203</sup> See *Afrobarometer 2015 Survey Results*, *supra* note 163, at Q85c-SRL (11.5% very effective and 7.8% somewhat effective for Sierra Leone); see also *id.* at Q84d-Lib (10.1% very effective and 19.6 somewhat effective for Liberia).

<sup>204</sup> See Breen, *supra* note 176 ("Citizens know that government officials often leave Liberia for the United States or Europe to seek medical attention.").

<sup>205</sup> See Konye Obaji Ori, *Liberia: Ebola Threatens Statehood Success, Post-Civil War*, THE AFR. REP. (Oct. 14, 2014), <http://www.theafricareport.com/West-Africa/liberia-ebola-threatens-statehood-success-post-civil-war.html> [<https://perma.cc/HB2G-QVT2>] (archived Jan. 21, 2018).

<sup>206</sup> Farmer & Mukherjee, *supra* note 168.

<sup>207</sup> Hodge et al., *supra* note 184, at 358.

<sup>208</sup> See *Afrobarometer 2015 Survey Results*, *supra* note 163, at Q84d-SRL; *Afrobarometer 2015 Survey Results*, *supra* note 162, at Q84d-Lib.

to receive proper care.<sup>209</sup> Likewise, gains that were made reducing maternal deaths were being reversed.<sup>210</sup>

Thus, instead of the negative individual and community reaction towards health care workers and centers symbolizing a rejection of Western medicine,<sup>211</sup> a more nuanced analysis would situate this backlash as a form of resistance against structural violence after decades of neglect and exploitation. For example, allegations of corruption that led to the suspension of donor funds to the Ministry of Health and Sanitation in Sierra Leone in 2013 reinforced earlier worries of governmental malfeasance.<sup>212</sup> Fears of corruption in Sierra Leone also led international accounting firm KPMG to withdraw from the Ebola Fund due to questionable management practices.<sup>213</sup> These fears were not unfounded, with recent audits indicating that fraud by Red Cross workers and others wasted at least USD 6 million meant to fight Ebola in the sub-region.<sup>214</sup>

Accordingly, health care centers were increasingly viewed with suspicion, because people were accustomed to fending for themselves and were skeptical of their governments' newfound care and concern.<sup>215</sup> The Afrobarometer survey results corroborate this, finding that the perceived effectiveness of local private or public hospitals and clinics provision of care to Ebola victims is dismal when contrasted with the perceived effectiveness of international organizations.<sup>216</sup>

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<sup>209</sup> Farmer & Mukherjee, *supra* note 168.

<sup>210</sup> *Id.*

<sup>211</sup> See, e.g., Rukmini Callimachi, *Fear of Ebola Drives Mob to Kill Officials in Guinea*, N.Y. TIMES (Sept. 19, 2014), <http://www.nytimes.com/2014/09/19/world/africa/fear-of-ebola-drives-mob-to-kill-officials-in-guinea.html> [https://perma.cc/3289-PS3W] (archived Jan. 21, 2018); Emma Farge, *Exclusive: Guinea Says Ebola Patients Sent Home After Botched Blood Tests*, REUTERS (Mar. 2, 2015), <http://www.reuters.com/article/us-health-ebola-guinea-exclusive-idUSKBN0LY20Y20150302> [https://perma.cc/ZDS7-6R8M] (archived Jan. 21, 2018) (discussing an incident in Guinea when workers in a facility run by Doctors Without Borders, accidentally put blood samples in the wrong test tubes, leading to the release of at least four patients who tested positive for Ebola and the death of two of these individuals).

<sup>212</sup> See *GAVI Review of Health System Strengthening in Sierra Leone*, GAVI VACCINE ALLIANCE (Apr. 11, 2013), <http://www.gavi.org/library/news/statements/2013/gavi-review-of-health-system-strengthening-in-sierra-leone/> [https://perma.cc/H7BJ-GLED] (archived Jan. 21, 2018).

<sup>213</sup> Wilkinson & Leach, *supra* note 17, at 144.

<sup>214</sup> See *IFRC Statement on Fraud in Ebola Operations*, INT'L FED'N OF THE RED CROSS (Oct. 20, 2017), <http://media.ifrc.org/ifrc/ifrc-statement-fraud-ebola-operations/> [https://perma.cc/P3DF-EQYE] (archived Jan. 15, 2018).

<sup>215</sup> See, e.g., Breen, *supra* note 176.

<sup>216</sup> *Compare Afrobarometer 2015 Survey Results*, *supra* note 163, at Q85a-SRL (39.6% of Sierra Leonean respondents noted that private hospitals and clinics were not at all effective in providing care to Ebola victims), and *id.* at Q85b-Lib (33.4% of Liberian respondents noted that public hospitals and clinics were not very effective and 32.7%

These issues conspired to make the populace view their “health system” with derision due either to peoples’ experience with it or inability to access it because of economic, logistical, or other constraints.<sup>217</sup> Sadly, only a little more than a third of respondents surveyed by the Afrobarometer in Sierra Leone were very confident that their government was prepared for a future Ebola outbreak.<sup>218</sup>

The synopsis above is necessary to begin to understand the sub-region’s extreme vulnerability to crises and why the Ebola epidemic had such devastating consequences in this part of the world. This sub-part analyzed how the ineffectual local governmental responses to Ebola resulted in structural violence in all three countries, exacerbating the adverse consequences of the disease. It seems that the governments’ affirmative conduct was a substantial factor in producing the resulting structural violence in all three countries, the disproportionate risks for infection during the Ebola epidemic, and the associated harms. Moreover, the resulting structural violence that occurred following the governmental responses to Ebola was not so remote to render it unforeseeable to governmental actors. Accordingly, it is fair under the circumstances to hold governmental actors responsible for contributing to structural violence committed during the Ebola epidemic.

But, as other scholars have eloquently put it, “[v]ulnerabilities do not just fall from the sky.”<sup>219</sup> While undeniably the spread of the Ebola epidemic is due to a combination of domestic factors, the tendency has been to focus almost exclusively on local actors and factors as a way to distance, differentiate, and other the spread of the disease.<sup>220</sup> Such analyses serve to obscure the functioning of the international system—as if no institutions or other actors influenced this result through actions, decision making, laws, policies, and omissions. The next Part turns to this unmasking.

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thought they were only somewhat effective in providing care to Ebola victims), *with id.* at Q85e-SRL (66.9% of Sierra Leonean respondents noted that international organizations were very effective in providing care to Ebola victims).

<sup>217</sup> See Wilkinson & Leach, *supra* note 17, at 142–43.

<sup>218</sup> *Afrobarometer 2015 Survey Results*, *supra* note 163, at Q86f-SRL.

<sup>219</sup> Jesse Ribot, *Vulnerability Does Not Just Fall From the Sky: Toward Multi-Scale Pro-Poor Climate Policy*, in *SOCIAL DIMENSIONS OF CLIMATE CHANGE: EQUITY AND VULNERABILITY IN A WARMING WORLD* 47 (Robin Mearns & Andrew Norton eds., 2009).

<sup>220</sup> See Obijiofor Aginam, *International Law, HIV/AIDS, and Human Rights in Africa: A Post-Colonial Discourse*, 100 *AM. SOC’Y INT’L L.* 350, 351 (2006) (discussing the rhetoric on HIV/AIDS as a unique problem to “savage African cultures that encourage promiscuity, male domination, polygamous relationships, infidelity, and wife inheritance”).

#### IV. THE INTERNATIONAL REGIMES FOR HEALTH AND SECURITY & THE SPREAD OF EBOLA

This Part draws attention to international legal and institutional frameworks that influence and sustain structural violence. While these international processes might be done without malicious design, it is important to analyze the role of international law to counteract the sense that the way the Ebola epidemic unfolded is demonstrative of how bad things “just happen.”<sup>221</sup> Failure to interrogate both the role of local and international action and inaction relegates us to an unsatisfactory world in which diseases like Ebola cannot be overcome or defied—like gravity.

This Part focuses on the international regimes for health and security because these regimes’ mandates charge them with responding to the Ebola epidemic in varying ways. The WHO’s primary role is to direct and coordinate international health within the United Nations’ system, while the United Nations Security Council’s (UNSC) primary responsibility is the maintenance of international peace and security. Given their mandates, this Part analyzes what obligations these regimes have to respond to the Ebola epidemic, whether these regimes discharged their responsibilities during the epidemic, and, if they failed to do so, whether the failure to act was a substantial factor and/or an accelerating factor in the resulting structural violence that occurred. Additionally, this Part considers whether it is fair under the circumstances to hold the actors within these regimes responsible for contributing to structural violence. Finally, this Part analyzes whether their responses *ex post facto* will positively impact the likelihood of survival from other epidemics.

##### A. *International Health & the Regulation of Highly Infectious Diseases like Ebola*

The ineffectual role played by the WHO in regulating infectious diseases has been well documented elsewhere.<sup>222</sup> For example, the devastating toll of HIV/AIDS, one of the worst pandemics in history, threatened to eclipse the role of the WHO.<sup>223</sup> Yet following the WHO’s

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<sup>221</sup> See Marks, *supra* note 50, at 48 (advocating treating phenomena like famine and poverty as historical processes rather than objects).

<sup>222</sup> See, e.g., David Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT’L L. 325 (2005) (analyzing the International Health Regulations [IHRs]).

<sup>223</sup> See Lindsay Wiley, *Moving Global Health Law Upstream: A Critical Appraisal of Global Health Law as a Tool for Health Adaption to Climate Change*, 22 GEO. INT’L ENVTL. L. REV. 439, 462 (2010) (recounting the history of the WHO and the IHRs).



successful fight against SARS in 2003, members empowered the organization to declare and manage global public health emergencies. This subpart analyzes the emergency powers granted to the WHO under the International Health Regulations (IHRs) in 2005<sup>224</sup> and examines the WHO's failure to adequately manage the Ebola crisis and to discharge its responsibilities.

### 1. The WHO's Emergency Powers

The World Health Assembly is the governing body for the WHO and has significant regulatory powers.<sup>225</sup> However, the WHO has made limited use of its constitutional powers.<sup>226</sup> For example, in 1951 the International Sanitary Regulations were enacted, which were renamed the International Health Regulations (IHRs) in 1969 and revised in 2005.<sup>227</sup> The IHRs were aimed primarily at controlling communicable diseases, although the 2005 revisions expanded the scope of health issues covered.<sup>228</sup> The basic premise of the system worked via notification requirements which would then trigger an international response that imposed travel and trade restrictions in order to control the spread of certain named diseases like cholera, yellow fever, and the plague.<sup>229</sup> While the list of diseases expanded over the years, the IHRs became mainly superfluous.<sup>230</sup> Scholars have demonstrated how increasing flows of trade and travel made quarantine and isolation provisions obsolete, and medical advances like antibiotics and vaccinations required a drastically different approach than those initially envisioned by the IHRs.<sup>231</sup>

The IHRs of 2005 empower the Director General of the WHO Secretariat, in conjunction with a committee of mostly medical experts, to

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<sup>224</sup> See generally WHO, INTERNATIONAL HEALTH REGULATIONS (3rd ed. 2005), <http://apps.who.int/iris/bitstream/10665/246107/1/9789241580496-eng.pdf?ua=1> [<https://perma.cc/3BCX-XMQS>] (archived Jan. 16, 2018) [hereinafter IHRs 2005] (containing the entire 2005 record of International Health Regulations).

<sup>225</sup> See, e.g., WHO Constitution arts. 19, 21, July 22, 1946, 14 U.N.T.S. 185 [hereinafter WHO Constitution] (stating that the Health Assembly has the authority to adopt conventions, agreements, and regulations).

<sup>226</sup> See David Fidler, *International Law and Global Public Health*, 48 KAN. L. REV. 1, 2 (1999) (describing the genesis of the WHO Constitution); see also The Framework Convention on Tobacco Control, May 21, 2003, 2302 U.N.T.S. 166.

<sup>227</sup> See Wiley, *supra* note 223, at 461.

<sup>228</sup> See *id.* (discussing how the IHRs also cover chemical and radio-nuclear issues).

<sup>229</sup> See *id.* at 462 (describing the developments of the IHRs over time).

<sup>230</sup> *Id.*

<sup>231</sup> *Id.*

declare an international state of emergency as well as provide temporary recommendations once the emergency has been declared.<sup>232</sup> They also require the Director General to consult with the committee of experts before deciding whether to terminate an emergency or to modify a previously issued recommendation.<sup>233</sup> Under the IHRs, all recommendations are to sunset after three months, subject to extensions that cannot continue over two years.<sup>234</sup> If the Director General wants to issue standing recommendations, they must be approved by a plenary body of the WHO.<sup>235</sup> The WHO's emergency response is subject to review by an expert committee that can issue a non-binding report.<sup>236</sup>

The procedures and framework that are set out in the IHRs provide only the broad parameters for emergency decision making, and they do not determine *when* an emergency should be declared. Moreover, the concept of crisis is an inherently political and legal construct that allows for the justification of extraordinary power. While the WHO is primarily controlled by physicians, scientists, public health specialists, and other experts who tend to emphasize a scientific or medical approach to addressing public health emergencies, tensions inevitably arise because of the essentially legal and political nature of emergencies.<sup>237</sup> The WHO is a secretariat that is responsive to member states and specifically the ministries of health of different countries, which often have varying interests and priorities.<sup>238</sup> And powerful states can always exert influence because they are more likely to have nationals who are WHO experts and personnel.<sup>239</sup>

The IHRs of 2005 define a Public Health Emergency of International Concern (PHEIC) broadly as “an extraordinary event, which is determined . . . (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response.”<sup>240</sup> Under the regulations, the WHO can make wide-ranging recommendations concerning travel advice, restrictions on travel in certain regions, quarantines, customs restrictions, vaccination protocols, as well as measures relating to food

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<sup>232</sup> See IHRs 2005, *supra* note 224, arts. 12–17, 48–49.

<sup>233</sup> *Id.* art. 48(1).

<sup>234</sup> *Id.* art. 15(3).

<sup>235</sup> *Id.* arts. 16, 53.

<sup>236</sup> *Id.* arts. 50–53.

<sup>237</sup> See, e.g., Asher, *supra* note 173, at 148.

<sup>238</sup> Notably, one of the experts on the Emergency Committee must be nominated by the state giving rise to the emergency. IHRs 2005, *supra* note 224, art. 48(2).

<sup>239</sup> See Heath, *supra* note 15, at 11 (“[T]he relative autonomy of international bureaucracies may create inequality among states (or among other relevant actors), insofar as some states have greater capacity to influence experts.”).

<sup>240</sup> IHRs 2005, *supra* note 224, art. 1.

safety.<sup>241</sup> While these recommendations are non-binding,<sup>242</sup> they serve as a baseline for measuring states' responses to PHEICs to the extent they deviate above the recommended actions or below the recommended actions.<sup>243</sup> The main critique of the WHO during the Ebola crisis surrounded the organization's delayed decision making in activating its emergency powers. The subpart below explores the WHO's lackluster response to Ebola and failure to adequately manage relief efforts.

## 2. The WHO's Failure to Manage the Ebola Epidemic

### a. Declaring an Emergency

Ebola was a litmus test for the WHO's newly minted emergency powers. In 1995, when the Ebola outbreak in the DRC occurred, it was not a designated disease for reporting purposes under the then governing IHRs.<sup>244</sup> During the DRC outbreak, the police blocked the road leading to the capital city, resulting in the healthy dying along with those stricken by Ebola.<sup>245</sup> Some commentators have noted that the fear and the desire to control an unknown disease concomitant with the lack of necessary legal structures and policies in place potentially contributed to a greater loss of life than was necessary.<sup>246</sup> Tragically, almost ten years later a similar pattern of structural violence occurred in West Africa.

Poor communications and complacency within the organization resulted in the WHO not convening a regional meeting on the epidemic until three months into the outbreak.<sup>247</sup> The outbreak in West Africa emerged in December 2013,<sup>248</sup> and Doctors Without Borders had been sounding the alarm since March of 2014 that the scale of the outbreak

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<sup>241</sup> *Id.* arts. 15, 18(1).

<sup>242</sup> *Id.* art. 1.

<sup>243</sup> See Heath, *supra* note 15, at 23–24.

<sup>244</sup> See World Health Assembly, International Health Regulations, *adopted* July 25, 1969, 21 U.S.T. 3003 (entered into force Jan. 1, 1971) (defining diseases subject to the IHRs as “cholera, including cholera due to the El Tor vibrio, plague, smallpox, including variola minor (alastrim), and yellow fever”).

<sup>245</sup> Paul Salopek, *Ghastly Ebola Unlikely to be Last of its Kind*, CHI. TRIB. (Jan. 18, 2000), <http://www.chicagotribune.com/news/chi-060826salopek3-story-story.html> [https://perma.cc/Q7UJ-75XC] (archived Jan. 18, 2018).

<sup>246</sup> See Asher, *supra* note 173, at 155.

<sup>247</sup> Leach, *supra* note 8, at 824.

<sup>248</sup> Imogen Foulkes, *WHO Under Fire Over Response to Epidemic*, BBC NEWS (Oct. 20, 2014), <http://www.bbc.com/news/world-europe-29691044> [https://perma.cc/YGA3-K488] (archived Jan. 18, 2018).

in West Africa was “unprecedented.”<sup>249</sup> Yet it was not until August of 2014 that the WHO declared Ebola a PHEIC under the IHRs of 2005. Moreover, it was only at this point that the WHO unveiled a framework for attempting to contain the outbreak.<sup>250</sup>

The WHO missed the opportunity to quickly contain Ebola and bring the outbreak under control. It initially determined that from a numbers perspective, the Ebola outbreak did not rise to the level of urgency that warranted declaring a PHEIC, but this approach failed to take account of the unique characteristics of the outbreak in the sub-region.<sup>251</sup> The Ebola outbreak in West Africa did not occur in a remote area; so for the first time the disease reached a big urban area—Conakry, the capital city of Guinea.<sup>252</sup> Also, because suspected cases were emerging along the border areas with Sierra Leone and Liberia, it would mean having to coordinate the response of three different administrations under circumstances where no government would have incentive to declare an epidemic on its territory because of the economic implications of decreased trade and travel to affected regions.<sup>253</sup> Reportedly, due to Ebola, Liberia, Sierra Leone, and Guinea suffered an estimated USD 2.8 billion in GDP losses (USD 600 million in Guinea, USD 300 million in Liberia, and USD 1.9 billion in Sierra Leone).<sup>254</sup> Most critically, the outbreak was occurring where already damaged health care systems had suffered cumulative effects from underdevelopment, years of governmental neglect, structural adjustment policies, conflict, and narrow post-conflict reconstruction, which could lead to catastrophic consequences if the disease was not contained properly.<sup>255</sup>

In the face of increasing political pressure, the WHO seized on the fact that someone with Ebola traveled on an international flight as an

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<sup>249</sup> See, e.g., *Ebola outbreak in Guinea unprecedented—MSF*, BBC NEWS (Mar. 31, 2014), <http://www.bbc.com/news/world-africa-26825869> [<https://perma.cc/VN9J-V7J6>] (archived Jan. 18, 2018).

<sup>250</sup> Leach, *supra* note 8, at 824.

<sup>251</sup> Sarah Bosley, *Ebola: Government Cuts to the WHO Aided Delays in Dealing with Outbreak*, THE GUARDIAN (Oct. 9, 2014, 1:56 PM), <https://www.theguardian.com/world/2014/oct/09/ebola-who-government-cuts-delays-in-dealing-with-outbreak> [<https://perma.cc/4S7C-293X>] (archived Jan. 18, 2018).

<sup>252</sup> *Id.*

<sup>253</sup> *Id.*

<sup>254</sup> THE WORLD BANK, 2014–2015 WEST AFRICA EBOLA CRISIS: IMPACT UPDATE 2 (2016), <http://www.worldbank.org/en/topic/macroeconomics/publication/2014-2015-west-africa-ebola-crisis-impact-update> [<https://perma.cc/3VWM-AYEX>] (archived Jan. 19, 2018).

<sup>255</sup> See Bosley, *supra* note 251.

opportunity to revise its initial conservative stance toward the disease.<sup>256</sup> Yet this event—in which someone from Liberia who was infected with Ebola traveled to Nigeria—can hardly be viewed as the seminal event in the disease’s trajectory that the WHO purported it was.<sup>257</sup> This is because the epidemic was already international in nature and the PHEIC should have been declared earlier. Certainly, the disease had already traveled across borders to upend things in three countries.<sup>258</sup> The possibility of the disease spreading via air travel was always present.<sup>259</sup> Yet earlier transmission via foot in the sub-region was apparently not sufficient to transform concern about Ebola into a crisis warranting international coordination and decisive action. The fear of transmission via plane was exemplified in the case of Thomas Eric Duncan who arrived in Dallas, Texas from Liberia and caused significant consternation in the United States.<sup>260</sup> The screening, testing, and surveillance measures that were imposed at airports in the sub-region were ineffectual. This is in part due to the incubation period of the disease wherein an infected person could appear asymptomatic, which appears to be what happened with Mr. Duncan. His case further crystalized fears that the disease would not remain localized in “Africa,” but that it might impact countries in the Global North. In this manner, the fear of contact with the Global North transformed Ebola from an unfortunate situation in a “backward” region to a public health emergency of international concern.

Despite the WHO’s recommendations to the contrary, several states imposed travel bans and trade restrictions on the Ebola affected countries.<sup>261</sup> This exacerbated already dire conditions and limited the ability of relief and aid efforts to stem the spread of the epidemic thereby contributing to structural violence. For example, Australia and Canada announced travel restrictions on entry from residents of the

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<sup>256</sup> Heath, *supra* note 15, at 29.

<sup>257</sup> See generally *Factors that Contributed to Undetected Spread of the Ebola Virus and Impeded Rapid Containment*, WHO (Jan. 2015), <http://www.who.int/csr/disease/ebola/one-year-report/factors/en/> [<https://perma.cc/5A3A-HUZZ>] (archived Jan. 18, 2018).

<sup>258</sup> Heath, *supra* note 15, at 30.

<sup>259</sup> *Id.*

<sup>260</sup> Hodge et al., *supra* note 184, at 361.

<sup>261</sup> See Laurence O. Gostin & Eric Friedman, *Ebola: A Crisis in Global Health Leadership*, 384 THE LANCET 1323, 1323 (2014) (“Sierra Leone instituted a national lockdown, Liberia cordoned off swathes of territory, and in Guinea, panicked residents in one village killed a team that had come to raise awareness about the disease.”).

Ebola affected countries.<sup>262</sup> An independent review panel recommended that in the future the IHRs be revised such that sanctions can be imposed on countries that take measures beyond the WHO's recommendations.<sup>263</sup>

The WHO was largely a bystander while more community-driven strategies for disease containment helped to stop the spread of the disease. Notably, a significant number of respondents in the Afrobarometer survey perceived the treatment facilities of local NGOs to be very effective in responding to Ebola.<sup>264</sup> For example, Sierra Leone and Liberia utilized community care centers because individuals suspected of having Ebola had to rely on informal networks of care, which put other household members at high risk of infection.<sup>265</sup> These centers were designed to assist with isolating and providing care for people suspected of having Ebola who had limited access to formal treatment facilities due to a lack of available beds.<sup>266</sup>

Between March and June of 2016, the WHO declared the end of the PHEIC for Ebola in the affected countries—forty-two days after the last person tested positive for the disease.<sup>267</sup> The WHO warned the affected countries to maintain heightened surveillance given the risks of flare-ups and challenges with bringing Ebola completely to heel.<sup>268</sup> The WHO, with the benefit of hindsight, has recognized that it bungled

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<sup>262</sup> Ian MacDonald, *Ebola-Related Immigration Restrictions: Canada, Australia, Singapore and the United States*, GREENBERG TRAUERIG (Nov. 5, 2014), <https://www.gtlaw-insidebusinessimmigration.com/global-immigration/ebola-related-immigration-restrictions-canada-australia-singapore-and-the-united-states/> [https://perma.cc/26WQ-8EE3] (archived Jan. 18, 2018).

<sup>263</sup> Lisa Schnirring, *WHO Independent Panel Calls Out Ebola Response Flaws*, CIDRAP NEWS (July 7, 2015), <http://www.cidrap.umn.edu/news-perspective/2015/07/who-independent-panel-calls-out-ebola-response-flaws> [https://perma.cc/T9KZ-RM9E] (archived Jan. 18, 2018). Currently the 2005 IHRs do not forbid countries from imposing measures beyond WHO's recommendations, it only requires them to report such measures if they do not satisfy certain criteria. See IHRs 2005, *supra* note 3, art. 13.

<sup>264</sup> See *Afrobarometer 2015 Survey Results*, *supra* note 163, at Q85d-SRL (41.7% of respondents in Sierra Leone thought that local NGOs had very effectively responded to Ebola); *id.* at Q85d-Lib (only 36.7% of Liberian respondents thought that treatment facilities provided by local NGOs were very effective).

<sup>265</sup> Susan Michaels-Strasser et al., *Innovation to Confront Ebola in Sierra Leone: The Community-Care-Centre Model*, 3 THE LANCET 361, 361 (July 2015).

<sup>266</sup> *Id.*

<sup>267</sup> *Ebola Outbreak 2014-2015*, *supra* note 9.

<sup>268</sup> See Abdur Rahman Alfa Shaban, *WHO Declares Sierra Leone Ebola Free, but Warns of Reemergence*, AFRICANEWS (Mar. 17, 2016), <http://www.africanews.com/2016/03/17/who-declares-sierra-leone-ebola-free-but-warns-of-reemergence/> [https://perma.cc/RF64-2CG2] (archived Jan. 18, 2018) (warning of a possible re-emergence).

the response to Ebola.<sup>269</sup> The WHO's omission likely led to greater illness and death than would otherwise have resulted if the WHO had acted much earlier. Accordingly, the WHO's failure to timely act was a substantial factor in the resulting structural violence that occurred during the Ebola epidemic. Moreover, the WHO's failure to act in a timely fashion frustrated a more effective response to the Ebola epidemic. The structural violence that occurred because of the WHO's inaction during the Ebola epidemic was not too accidental in its occurrence to have a just bearing on the WHO's responsibility.

b. Explanations for the Botched Response

Many explanations have emerged to account for the WHO's failure to properly discharge its obligations in the face of Ebola. Prior to the Ebola epidemic, the WHO had only issued a PHEIC two other times since its inception: once for the Swine Flu epidemic in April 2009, and again for the resurgence of polio in May of 2014. Some commentators have pointed to the WHO's hesitance in declaring a PHEIC with Ebola due to the stinging criticism it faced for overhyping Swine Flu.<sup>270</sup>

Additionally, the organization identified its institutional culture and politics as hindering its response to Ebola.<sup>271</sup> For instance, the WHO has increasingly become a technocratic organization as opposed to one responsible for ensuring global public health.<sup>272</sup> It suffers from politicization and intra-organization challenges between headquarters in Geneva and regional and country offices.<sup>273</sup> For example, some commentators have faulted African regional personnel for lacking technical knowledge and expertise as well as independence.<sup>274</sup> These individuals appeared to be captured by political interests, which resulted

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<sup>269</sup> See Associated Press, *WHO Draft Report: We Botched the Response to Africa's Ebola Outbreak*, DENVER POST (Oct. 17, 2014, 2:20 PM), [http://www.denverpost.com/nation-world/ci\\_26750734/who-draft-report-we-botched-response-africas-ebola](http://www.denverpost.com/nation-world/ci_26750734/who-draft-report-we-botched-response-africas-ebola) [https://perma.cc/2A4G-K52W] (archived Jan. 18, 2018).

<sup>270</sup> See Daniel Flynn & Stephanie Nebhay, *Aid Workers Ask Where Was WHO in the Ebola Outbreak*, REUTERS (Oct. 5, 2014), <http://www.reuters.com/article/2014/10/05/us-health-ebola-who-idUSKCN0HU03Q20141005> [https://perma.cc/5UPF-V65F] (archived Jan. 18, 2018).

<sup>271</sup> See, e.g., EBOLA INTERIM ASSESSMENT PANEL, WHO, REPORT OF THE INTERIM ASSESSMENT PANEL ¶ 13 (July 2015), <http://www.who.int/csr/resources/publications/ebola/ebola-panel-report/en/> [https://perma.cc/P24L-PQGV] (archived Jan. 18, 2018) [hereinafter WHO, EBOLA INTERIM REPORT].

<sup>272</sup> See Gostin & Friedman, *supra* note 261, at 1323; Wilkinson & Leach, *supra* note 17, at 140.

<sup>273</sup> Wilkinson & Leach, *supra* note 17, at 140.

<sup>274</sup> See Bosley, *supra* note 251.

in contradictory communications from the regional offices and at times downplayed the severity of Ebola.<sup>275</sup>

Moreover, WHO personnel initially did not recognize the reality that basic and essential medical supplies were lacking in the affected countries.<sup>276</sup> For example, nurses in Liberia were cutting up old uniforms to protect their faces when working with Ebola patients.<sup>277</sup> This disconnect had dire consequences on the ground with an estimated 512 health care workers dying due to lack of adequate protective gear while combatting Ebola in the sub-region.<sup>278</sup> Reportedly, more than 10 percent of deaths from Ebola were of health care workers, who the affected countries could not afford to see die before their time.<sup>279</sup> The increased risk for health care workers resulted in strikes with the workers demanding increased pay for treating Ebola cases, as well as more protective equipment and insurance.<sup>280</sup> Yet health care workers were not the only ones impacted. As discussed in Part II, the disease threatened systems of social and communal care. However, because structurally the WHO is not equipped to carry out field level support and the Geneva-based technocrats had little logistical experience working in West Africa, the institution responsible for formulating the global response to the Ebola epidemic was disconnected from the realities on the ground.<sup>281</sup>

Moreover, the WHO had notice about widespread unpreparedness. The IHRs of 2005 require that state parties develop, strengthen, and maintain their capacity to “respond promptly and effectively to public health risks and public health emergencies of international concern.”<sup>282</sup> Under Article 54 of the IHRs, countries are to annually self-report their implementation status to the World Health Assembly.<sup>283</sup> Countries are required to develop, strengthen, and maintain the capacity to “detect, assess, notify and report events” under the IHRs.<sup>284</sup> Yet

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<sup>275</sup> See Heath, *supra* note 15, at 29; Wilkinson & Leach, *supra* note 17, at 141.

<sup>276</sup> Lee, *supra* note 134, at 947.

<sup>277</sup> Hodge et al., *supra* note 184, at 596.

<sup>278</sup> *Ebola Situation Report*, WHO (Aug. 12, 2015), <http://apps.who.int/ebola/current-situation/ebola-situation-report-12-august-2015> [<https://perma.cc/8CTA-UW3H>] (archived Jan. 18, 2018).

<sup>279</sup> Leach, *supra* note 8, at 823.

<sup>280</sup> See Ori, *supra* note 205 (discussing Liberia's National Health Workers Association's strike demands).

<sup>281</sup> Lee, *supra* note 134, at 947–48.

<sup>282</sup> IHRs 2005, *supra* note 224, art. 13(1).

<sup>283</sup> *Id.* art. 54.

<sup>284</sup> *Id.* art. 5(1); see also Agnew, *supra* note 15, at 120 (noting that detection of potential health crises is essentially a domestic concern).



in 2009, an Independent Review Committee warned the WHO following the H1N1 influenza outbreak that the world was “ill-prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public health emergency.”<sup>285</sup> It also found that health capacities were nowhere near “a timely path to implementation worldwide.”<sup>286</sup> Further, capacity deficits are especially acute in many developing countries.<sup>287</sup> The lack of capacity in many states in the Global South is in part due to historical vulnerability from slavery, colonialism, neocolonialism, bad governance, and neoliberal reform policies like structural adjustment. Accordingly, in 2013 prior to the Ebola outbreak, no African state had fully implemented the IHRs core capacity requirements.<sup>288</sup> And these gaps in core capacities were especially pronounced in Guinea, Liberia, and Sierra Leone because, concomitant with the structural factors discussed above, the sub-region had a recent history of conflicts and narrow post-conflict reconstruction, which cumulatively hollowed out the health sector. Ebola was occurring in a region with severely compromised health systems and with states that lacked the capacity to prevent the domestic and transnational spread of the disease.<sup>289</sup> The WHO apparently recognized this vulnerability when it eventually declared a PHEIC for Ebola. Margaret Chan, Director-General of the WHO asserted that the countries affected by the epidemic “simply do not have the capacity to manage an outbreak of this size and complexity on their own” and urged the international community to provide support.<sup>290</sup>

However, the financial crisis had recently hit global markets and left the WHO on precarious footing to respond to emergencies as it was severely understaffed and underfinanced.<sup>291</sup> For example, the United Kingdom, the United States, and some European governments reduced

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<sup>285</sup> WHO, REPORT OF THE REVIEW COMMITTEE ON THE FUNCTIONING OF THE INTERNATIONAL HEALTH REGULATIONS (2005) IN RELATION TO THE PANDEMIC (H1N1) 2009 (2011), [http://www.who.int/ihr/WHA64\\_10\\_HVF\\_2011.pdf](http://www.who.int/ihr/WHA64_10_HVF_2011.pdf) [<https://perma.cc/B2DL-M2WL>] (archived Jan. 18, 2018) [hereinafter REVIEW COMMITTEE 2009 REPORT].

<sup>286</sup> *Id.*

<sup>287</sup> See Gostin & Friedman, *supra* note 261, at 1323.

<sup>288</sup> See Steven J. Hoffman, *Making the International Health Regulations Matter: Promoting Compliance Through Effective Dispute Resolution*, in HANDBOOK OF GLOBAL HEALTH SECURITY 239 (2015) (stating that many countries did not meet June 2012 requirements and requested extensions).

<sup>289</sup> Gostin & Friedman, *supra* note 261, at 1323.

<sup>290</sup> Bosley, *supra* note 251.

<sup>291</sup> See, e.g., Sheri Fink, *WHO Leader Describes the Agency's Ebola Operations*, N.Y. TIMES (Sept. 4, 2014), <https://www.nytimes.com/2014/09/04/world/africa/who-leader-describes-the-agencys-ebola-operations.html> <https://perma.cc/D8Y2-78M9> (archived Feb. 15, 2018) (Interview with Dr. Margaret Chan, Director General of the WHO).

contributions to WHO, due not only to austerity, but also to their belief that the organization needed to engage in essential reforms.<sup>292</sup> As such, it was forced to go through dramatic restructuring following the financial crisis in order to streamline its operations in line with the reduced contributions it faced.<sup>293</sup> For example, in 2011 the organization lost USD 1 billion in funding from core areas and had to cut 300 jobs.<sup>294</sup> One of the main areas that was hit by these shifts was the WHO's emergency response. Remarkably, the outbreak response team was dismantled as the organization shifted priorities away from communicable diseases and hemorrhagic fevers—resulting in a significant loss of institutional memory.<sup>295</sup>

The WHO was already on notice that its budget could not be easily repurposed for emergency use.<sup>296</sup> The WHO reportedly only controls a mere 30 percent of its budget,<sup>297</sup> and its funders have competing priorities. For example, private foundations wield significant influence over WHO decision making due to their substantial contributions.<sup>298</sup> The WHO experienced budgetary limitations when the SARS outbreak began in China and spread worldwide, resulting in the deaths of some 775 people.<sup>299</sup> SARS occurred approximately a decade before Ebola, and the WHO needed to secure extra funding to fight it.<sup>300</sup> Despite this circumstance, it was not a wake-up call for the WHO. The WHO pointed to indifference at the international level, which further impeded its ability to effectively fight Ebola.<sup>301</sup> This was evident when

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<sup>292</sup> See Bosley, *supra* note 251.

<sup>293</sup> See Leach, *supra* note 8, at 824 (“The WHO had been through dramatic restructuring and cuts as a result of reduced contributions after the financial crisis.”).

<sup>294</sup> Bosley, *supra* note 251.

<sup>295</sup> Wilkinson & Leach, *supra* note 17, at 140.

<sup>296</sup> See Charles Clift, *The Role of the World Health Organization in the International System* 43 (Working Grp. on Governance, Ctr. on Glob. Health Sec., Working Paper No. 1, Feb. 2013).

<sup>297</sup> See WHO, Proposed Programme Budget 2014–2015, at 2, WHO Doc. A66/7 (Apr. 6, 2013), [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) [https://perma.cc/332R-3T4M] (archived Jan. 18, 2018) (stating that 77% of WHO's budget will have to be financed by voluntary contributions).

<sup>298</sup> See CHARLES CLIFT, CHATHAM HOUSE, WHAT'S THE WORLD HEALTH ORGANIZATION FOR? 28–29 (2014) (noting that the Bill and Melinda Gates Foundation had become the single largest contributor to the WHO in 2012).

<sup>299</sup> Bosley, *supra* note 251.

<sup>300</sup> *Id.*

<sup>301</sup> See WHO, EBOLA INTERIM REPORT, *supra* note 271, ¶22 (“Although WHO drew attention to the “unprecedented outbreak” at a press conference in April 2014, this was not followed by international mobilization and a consistent communication strategy.”).

the United Nations created the Ebola Relief Fund,<sup>302</sup> as there were a paltry number of initial donations dedicated to it.<sup>303</sup>

A Review Committee prior to the Ebola outbreak had recommended that the WHO create a rapid-response emergency fund.<sup>304</sup> The demand for dedicated funds for public health emergencies was essentially ignored as the WHO's 2014–2015 budget for health crises was a mere USD 228 million for the entire world—half of what had been allocated the previous year.<sup>305</sup> By way of comparison, the WHO's budget is only a third of the operating budget of the United States' Centers for Disease Control and Prevention (CDC) even though the WHO's work is far more expansive than just dealing with infectious diseases.<sup>306</sup> Consequently, severe underfinancing of the WHO created ripe conditions for devastating consequences that would accompany the Ebola epidemic. The WHO had misplaced faith in its ability to quickly secure funds in the event of an emergency and this led to structural violence during its response to Ebola.<sup>307</sup>

c. Responding to Failure

The WHO approximates that it needs more than 30 percent of its budget to come from mandatory contributions for it to function at full capacity.<sup>308</sup> This would enable the organization to be nimbler and have a reliable source of funding to respond to epidemics like Ebola. Accordingly, the WHO proposed a 5 percent increase of member states' mandatory contributions to it, but this proposal was rejected by the World Health Assembly.<sup>309</sup> Instead, after the Ebola epidemic, the World Health Assembly approved the creation of a Contingency Fund for Emergencies (CFE) in May 2015.

The CFE is supposed to provide the resources necessary to scale up the initial response to outbreaks by funding the first three

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<sup>302</sup> Wilkinson & Leach, *supra* note 17, at 141.

<sup>303</sup> *Id.*

<sup>304</sup> REVIEW COMMITTEE 2009 REPORT, *supra* note 285.

<sup>305</sup> Proposed Programme Budget 2014–2015, *supra* note 296, at 8.

<sup>306</sup> Gostin & Friedman, *supra* note 260, at 1323.

<sup>307</sup> *See id.*

<sup>308</sup> *See* Proposed Programme Budget 2014–2015, *supra* note 297 (stating that 77% of WHO's budget will have to be financed by voluntary contributions).

<sup>309</sup> *See* WHO EBOLA INTERIM REPORT, *supra* note 271, ¶ 36 (noting that Director's 5% increase proposal was rejected); *see generally* WHO, Draft Proposed Programme Budget 2016–2017, WHO Doc. EB136/34 (Jan. 16, 2015), [http://apps.who.int/gb/ebwha/pdf\\_files/EB136/B136\\_34-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB136/B136_34-en.pdf) [<https://perma.cc/GY74-ZDRT>] (archived Feb. 9, 2018) (containing the proposed budget increases).

months.<sup>310</sup> The WHO contends that the CFE will enable it to deploy its experts as well as other stakeholders<sup>311</sup> to work in areas where epidemics are burgeoning.<sup>312</sup> The CFE is part of the WHO's effort to improve the way that it responds to epidemics, and it falls under the organization's new unified Emergency Program. The WHO anticipates that the CFE will assist with alleviating suffering, providing medical care to those in need, enabling preparedness and surveillance in surrounding areas at high risk, and addressing factors that could lead to escalation of an emergency.<sup>313</sup> The CFE is financed through voluntary contributions, with a capitalization target of USD 100 million.<sup>314</sup> As of February 2017, states contributed only approximately USD 33 million towards this goal.<sup>315</sup> The sustainability of the CFE given this critical funding gap is likely to remain a crucial issue moving forward.<sup>316</sup>

The CFE shows little promise of reducing the incidence of epidemics and avoidable deaths from infectious diseases like Ebola in vulnerable countries. The CFE is a reactionary mechanism. The CFE does not prioritize building horizontal capacity across the health sector, and the WHO does not have other funding dedicated to the horizontal development of strong domestic health systems<sup>317</sup> to assist with preparedness and prevention. As currently designed, the CFE is a stop-gap measure that does not address the root causes of structural violence witnessed with the Ebola epidemic and effectively ignores global health inequities in state capacities. Since the WHO contributed to the structural violence witnessed, its response needs to do more to mitigate the harm caused.

Moreover, when states fail to meet the capacity requirements of the IHRs, the WHO does not provide sticks or carrots to assist with

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<sup>310</sup> WHO, CONTINGENCY FUND FOR EMERGENCIES [CFE] (Oct. 13, 2015), [http://www.who.int/about/who\\_reform/emergency-capacities/contingency-fund/Contingency-Fund-Emergencies.pdf?ua=1](http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/Contingency-Fund-Emergencies.pdf?ua=1) [<https://perma.cc/G6DG-WUA5>] (archived Jan. 18, 2008) [hereinafter WHO CFE].

<sup>311</sup> See Chiara Giorgetti, *International Health Emergencies in Failed and Failing States*, 44 GEO. J. INT'L L. 1347, 1375–83 (2013) (examining the role played by the Global Outbreak Alert and Response Network in controlling global health emergencies).

<sup>312</sup> See WHO, CFE, *supra* note 310.

<sup>313</sup> *Id.*

<sup>314</sup> *Id.*

<sup>315</sup> *Contingency Fund for Emergencies (CFE): Income and Allocations*, WHO, [http://www.who.int/about/who\\_reform/emergency-capacities/contingency-fund/contribution/en/](http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/contribution/en/) (last updated Dec. 22, 2017) [<https://perma.cc/9MSH-RBDC>] (archived Jan. 18, 2018).

<sup>316</sup> See Lee, *supra* note 134, at 967–68.

<sup>317</sup> See Lawrence O. Gostin, *Towards an International Health Systems Fund*, 384 THE LANCET 49, 49 (2014).

compliance.<sup>318</sup> Yet sanctions as a means of dealing with structural violence that was in part facilitated by global actors seems particularly inappropriate for addressing global health inequities in capacities. The harm likely caused by the economic consequences of sanctions concomitant with the socioeconomic impact of the epidemic would frustrate the affected state's ability to recover.<sup>319</sup> And economic isolation would only exacerbate the problems of countries with PHEICs in attempting to marshal resources to provide treatment and to prevent infectious diseases from spreading further.<sup>320</sup> Such measures would likely prove counterproductive and increase tensions at a time when greater international cooperation is needed to combat disease.<sup>321</sup>

As such, the IHRs should be reformed to provide for greater carrots for states to comply voluntarily with core capacity requirements. This could take the form of capacity building (research and information sharing), technical assistance (training and the provision of expertise), and financial and material assistance, especially where states lack the infrastructure necessary to address epidemics like Ebola domestically. Rather than leaving states solely responsible for addressing health inequities that exist in part because of the functioning of the international system, this approach would potentially broaden the involvement and cooperation of international actors in addressing highly infectious diseases.

This subpart has demonstrated how the global public health regime facilitated structural violence and influenced the global inequities in the distribution of infectious diseases like Ebola. The delayed and fragmented response to Ebola exposed the weakness and fragility of the global public health architecture.<sup>322</sup> It also had real consequences on the likely increased incidence of illness and death that resulted from the inadequate international response in the Ebola-affected countries. Under these circumstances, it is fair to find the actors within this regime responsible for contributing to structural violence witnessed during the Ebola epidemic. Specifically, the WHO failed to appropriately discharge its responsibilities, and its failure to do so was a substantial factor in the resulting structural violence. The result also cannot be considered too remote to have a just bearing on the WHO's responsibility. Moreover, the *ex ante* failure in the international global health regime significantly influenced the course of the Ebola epidemic. Finally,

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<sup>318</sup> See Giorgetti, *supra* note 311, at 1359.

<sup>319</sup> Agnew, *supra* note 15, at 118.

<sup>320</sup> See Marcella David, *Rubber Helmets: The Certain Pitfalls of Marshalling Security Council Resources to Combat AIDS in Africa*, 23 HUM. RTS. Q. 560, 574 (2001).

<sup>321</sup> *Id.*

<sup>322</sup> See Gostin & Friedman, *supra* note 261, at 1323.

the organization's *ex post facto* efforts to mitigate the harm caused by structural violence for future epidemics is not robust enough.

C. *International Security & the Regulation of Highly Infectious Diseases like Ebola*

Applying the framework of structural violence to the international peace and security regime would necessitate the UNSC having a more expansive interpretation of security. Human security seeks to draw attention to the multitude of threats that cut across different aspects of human life including health and related challenges.<sup>323</sup> It seeks to utilize an integrated, coordinated, and people-centered approach to advance peace, security, and development within and across nations.<sup>324</sup> The prioritization of human security is not without its critics, but the relevance of it is clear, because the security of the individual directly impacts the security of the state, and this has strong implications for international peace and security and global public health.<sup>325</sup> In other words, structural violence and human security as organizing principles enable things other than “guns and boots on the ground” to be considered threats to international peace and security, thus warranting an international response.

This subpart uses these concepts to analyze whether the actors within the peace and security regime discharged their responsibilities, and if they failed to do so, whether the failure to act was a substantial factor and/or an accelerating factor in the resulting structural violence that occurred. This subpart evaluates whether it is fair under the circumstances to hold the actors within this regime responsible for contributing to structural violence witnessed during the Ebola epidemic. Lastly, it assesses the organization's *ex post facto* efforts to mitigate the harm caused by structural violence.

1. United Nations' Emergency Powers

Article 24 of the U.N. Charter confers on the UNSC “primary responsibility for the maintenance of international peace and security” on behalf of all UN member states.<sup>326</sup> The UNSC has fifteen members,

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<sup>323</sup> See *What is Human Security*, U.N. TRUST FUND FOR HUMAN SEC., <http://www.un.org/humansecurity/human-security-unit/human-security-approach> (last visited Feb. 8, 2018) [<https://perma.cc/UF48-RF7Y>] (archived Feb. 8, 2018).

<sup>324</sup> See *id.*

<sup>325</sup> See Gian Luca Burci & Jakob Qurin, *Ebola, WHO, and the United Nations: Convergence of Global Public Health and International Peace and Security*, 18 ASIL INSIGHTS 25 (2014).

<sup>326</sup> U.N. Charter art. 24, ¶ 1.

five of which are permanent members (the P5).<sup>327</sup> The ten rotating, non-permanent members represent different regions of the world.<sup>328</sup> UNSC resolutions require the affirmative vote of at least nine members and the “concurring votes” of the P5.<sup>329</sup> Yet unlike the WHO, which can only issue non-binding recommendations, the UNSC has the power to create binding resolutions on all other member states of the United Nations.<sup>330</sup> The UNSC can take a number of binding measures to restore international peace and security including authorizing the use of force and a wide range of actions that do not involve force, such as economic sanctions.<sup>331</sup>

In contrast, the General Assembly (GA) is the main deliberative, policymaking, and representative organ of the United Nations. Each country has a vote, and decisions on important questions, like peace and security, require a two-thirds majority, while decisions on other questions require a simple majority. Under the Charter, the GA can consider and discuss issues pertaining to the maintenance of international peace and security, but the GA is only empowered to make non-binding recommendations to the UNSC or member states.<sup>332</sup> Moreover, where the UNSC is exercising its jurisdiction over a situation, the GA is barred from making any recommendations pertaining to that situation unless the UNSC requests it.<sup>333</sup>

Like the WHO, the procedures and framework that are set out in the U.N. Charter provide only the broad framework for emergency decision making. The provisions in the Charter do not determine *when* a threat to international peace and security should be declared. As discussed above, the concept of crisis is an inherently political and legal construct, which justifies extraordinary power. Unlike the WHO, which is primarily controlled by medical experts,<sup>334</sup> the UNSC is an overtly political body, which is tasked with determining an essentially legal and political question.

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<sup>327</sup> The United States, the United Kingdom, China, Russia and France make up the P5. *Current Members*, U.N. SEC. COUNCIL, <http://www.un.org/en/sc/members/> (last visited Jan. 15, 2018) [<https://perma.cc/6ZU2-HKMF>] (archived Jan. 22, 2018).

<sup>328</sup> The rotating membership on the UNSC is distributed by region: Africa-three; Asia-two; Latin America-two; Western Europe and Other-two; and Eastern Europe-one. *Rules of Procedure*, U.N. GEN. ASSEMBLY, <http://www.un.org/en/ga/about/ropga/elect.shtml#2> (last visited Jan. 15, 2018) [<https://perma.cc/7E87-X9NA>] (archived Jan. 22, 2018).

<sup>329</sup> U.N. Charter art. 27, ¶ 3.

<sup>330</sup> *Id.* art. 25.

<sup>331</sup> *Id.* art. 41 (peace measures), art. 42 (use of force).

<sup>332</sup> *Id.* art. 11, ¶¶ 1–2.

<sup>333</sup> *Id.* art. 12, ¶ 1.

<sup>334</sup> See, e.g., Asher, *supra* note 173, at 149.

The UNSC historically has prioritized abuses involving direct physical violence.<sup>335</sup> The UNSC has generally waited until mass physical violence reached “crisis point” and has traditionally shied away from addressing or even discussing the underlying structural causes of vulnerability.<sup>336</sup> Under Article 39 of the U.N. Charter, the UNSC is responsible for determining “the existence of any threat to the peace, breach of the peace, or act of aggression and shall make recommendations, or decide what measures shall be taken . . . to maintain or restore international peace and security.”<sup>337</sup> This Article has been interpreted quite restrictively, as the Council is not empowered to take enforcement action whenever it desires, and states have vigorously debated what actions fall under a “threat to the peace.”<sup>338</sup>

Historically, this has been limited to only acts or threats of physical violence. For example, the UNSC has been very active in West Africa, passing numerous resolutions relating to the conflicts and post-conflict peace building in Liberia<sup>339</sup> and Sierra Leone.<sup>340</sup> Part II detailed the ways in which the United Nations and other international actors voluntarily assumed care and functioned as the *de facto* government during post-conflict reconstruction. Concomitantly, the United Nations has also engaged in limited post-conflict reconstruction, which ignored issues of structural violence and enabled highly infectious diseases like Ebola to spread in the sub-region.

## 2. International Peace and Security Regime’s Response to Ebola

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<sup>335</sup> See David, *supra* note 320, at 566–68.

<sup>336</sup> See Anna Hood, *Ebola: A Threat to the Parameters of a Threat to Peace?*, 16 MELB. J. INT’L L. 29, 41 (2015).

<sup>337</sup> U.N. Charter art. 39.

<sup>338</sup> See Hood, *supra* note 336, at 35.

<sup>339</sup> The Security Council in 1992 imposed an arms embargo on Liberia. S.C. Res. 788, ¶ 8 (Nov. 19, 1992). In 1993, the Security Council established the United Nations Observer Mission in Liberia (UNOMIL) to help with the implementation of peace agreements, which operated until 1997. See *Liberia - UNOMIL*, U.N. PEACEKEEPING, <https://peacekeeping.un.org/sites/default/files/past/unomilF.html> (last visited Feb. 9, 2018) [<https://perma.cc/H3CT-J6WC>] (archived Jan. 22, 2018). Following renewed fighting in Liberia, on August 1, 2003, the UNSC adopted a resolution authorizing the establishment of a multinational force in Liberia. S.C. Res. 1497, ¶ 1 (Aug. 1, 2003).

<sup>340</sup> The Security Council imposed an oil and arms embargo on October 8, 1997 in Sierra Leone. S.C. Res. 1132, ¶ 6 (Oct. 8, 1997). In 1998, the Security Council established the United Nations Observer Mission in Sierra Leone (UNOMSIL). S.C. Res. 1181, ¶ 6 (July 13, 1998). It replaced it with a much broader mission, UNAMSIL with more military personnel in 1999, to assist the Government and the parties in implementing the peace agreement. S.C. Res. 1270, ¶ 8 (Oct. 22, 1999). The UNSC authorize increases in military personnel in 2000 and 2001. See S.C. Res. 1299, ¶ 1 (May 19, 2000); S.C. Res. 1346, ¶ 2 (Mar. 30, 2001).



This subpart considers whether the peace and security regime discharged its responsibilities during the Ebola epidemic by examining the response of the UNSC, GA, regional organizations, and individual states.

a. United Nations Security Council

Despite periodic efforts to get the Council to prioritize issues that lead to human insecurity, for the most part these efforts have been unsuccessful, and the Council has adopted a conservative interpretation of what rises to the level of a “threat to the peace.”<sup>341</sup> For example, it took twenty years of the HIV/AIDS epidemic ravaging sub-Saharan Africa before the Security Council even met to discuss the disease.<sup>342</sup> The HIV/AIDS epidemic marked the first time that the UNSC issued a resolution on a global public health matter.<sup>343</sup> During the lead up to the UNSC vote on the resolution, Al Gore (then US Vice President) gave a speech where he noted that AIDS was a “global aggressor,” a “threat to international peace and security.”<sup>344</sup> He encouraged the UNSC to expand its agenda to include security threats from diseases that result in “constant fear and degradation . . . [and] loss of the quality of life and liberty of spirit that should belong to all.”<sup>345</sup>

Yet it was not until the Ebola epidemic had reached its peak near the end of 2014 that the UNSC unanimously adopted Resolution 2177, which states “that the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security.”<sup>346</sup> The UNSC Resolution called on states to provide assistance to the affected states and to lift travel restrictions that isolated the sub-region, and it called on the WHO to accelerate its response.<sup>347</sup> The UNSC urged member states “to mobilize and provide immediately technical exper-

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<sup>341</sup> See Hood, *supra* note 336, at 36.

<sup>342</sup> See David, *supra* note 320, at 561.

<sup>343</sup> See generally S.C. Res. 1308 (July 17, 2000).

<sup>344</sup> Press Release, Security Council, Security Council Holds Debate on Impact Of Aids on Peace and Security in Africa, U.N. Press Release SC/6781 (Jan. 10, 2000), <http://www.un.org/press/en/2000/20000110.sc6781.doc.html> [<https://perma.cc/3S6W-U9G5>] (archived Feb. 9, 2018).

<sup>345</sup> Al Gore, U.S. Vice President, Remarks at the U.N. Sec. Council Opening Session, (Jan. 10, 2000), CLINTON WHITE HOUSE ARCHIVES, [https://clinton3.nara.gov/WH/EOP/OVP/speeches/unopen\\_fp.html](https://clinton3.nara.gov/WH/EOP/OVP/speeches/unopen_fp.html) (last visited Feb. 9, 2018) [<https://perma.cc/2RX7-B9FQ>] (archived Jan. 22, 2018).

<sup>346</sup> S.C. Res. 2177, pmb. (Sept. 18, 2004).

<sup>347</sup> *Id.* pmb., ¶¶ 1, 4, 12.

tise and additional medical capacity [. . .] and to provide essential resources, supplies and coordinated assistance to the affected countries and implementing partners.”<sup>348</sup>

Remarkably, the Resolution also encouraged Liberia, Sierra Leone, and Guinea to establish better functioning health systems,<sup>349</sup> as if this could be accomplished simply by UNSC fiat. Moreover, the Resolution essentially ignored the fact that the United Nations and other international actors were in many respects responsible for managing and assisting with rebuilding the state following the conflicts in the sub-region. The large peace-keeping and peace-building missions that the United Nations operated prior to, during, and after the Ebola outbreak in Liberia<sup>350</sup> and prior to the outbreak in Sierra Leone<sup>351</sup> contributed to the undermining of state capacity in the health sector due to a restricted mandate that prioritized responding to direct physical violence.<sup>352</sup> Narrow post-conflict reconstruction was at least a substantial factor in aggravating or accelerating the harm caused by the Ebola epidemic because it reduced the likelihood of resilient health systems that could appropriately respond to pandemics. As discussed in Part II, this resulted in structural violence with differing risks for infection in the impacted countries during the Ebola epidemic, and—among those already infected—serious adverse consequences.

<sup>348</sup> *Id.* ¶ 8.

<sup>349</sup> *Id.* ¶¶ 1–2.

<sup>350</sup> See *UNMIL Fact Sheet*, U.N. PEACEKEEPING, <https://peacekeeping.un.org/en/mission/unmil> (last visited Jan. 16, 2018) [<https://perma.cc/348E-XRCC>] (archived Jan. 22, 2018); see also *UNMIL Background*, U.N. PEACEKEEPING, <http://www.un.org/en/peacekeeping/missions/unmil/background.shtml> (last visited Jan. 16, 2018) [<https://perma.cc/64VP-45J6>] (archived Jan. 22, 2018).

<sup>351</sup> See *Sierra Leone – UNAMSIL - Facts and Figures*, U.N. PEACEKEEPING, <https://peacekeeping.un.org/sites/default/files/past/unamsil/facts.html> (last visited Jan. 16, 2018) [<https://perma.cc/A5YK-67V7>] (archived Jan. 22, 2018); see also *United Nations Integrated Peacebuilding Office in Sierra Leone (UNIPSIL), Background*, U.N. PEACEKEEPING, <https://unipsil.unmissions.org/background> (last visited Jan. 17, 2018) [<https://perma.cc/Y94W-VBMY>] (archived Jan. 22, 2018) (discussing the Security Council’s establishment of a new mission—the United Nations Integrated Office for Sierra Leone in 2005—to help consolidate peace in the country, which was transformed into UNIPSIL in 2008 by the UNSC and operated until March 2014).

<sup>352</sup> See *UNMIL Mandate*, U.N. MISSION IN LIBERIA, <https://unmil.unmissions.org/mandate> (last visited Jan. 17, 2018) [<https://perma.cc/V22W-CDB2>] (archived Jan. 22, 2018) (noting the prioritization of protection of civilians from physical violence and discussing the myriad ways the mission assists with justice and security sector reform amongst others); see also *Sierra Leone - UNAMSIL - Mandate*, U.N. PEACEKEEPING, <https://peacekeeping.un.org/sites/default/files/past/unamsil/mandate.html> (last visited Jan. 17, 2018) [<https://perma.cc/4T72-9D34>] (archived Jan. 22, 2018) (noting the prioritization of security); see also *Mandate and Approach*, U.N. INTEGRATED PEACEBUILDING OFFICE IN SIERRA LEONE, <https://unipsil.unmissions.org/mandate-and-approach-0> (last visited Jan. 17, 2018) [<https://perma.cc/3FUA-EXKV>] (archived Jan. 22, 2018) (discussing justice sector reform amongst others).

One hundred thirty states sponsored Resolution 2177,<sup>353</sup> which is the highest number of states to ever sponsor a UNSC resolution.<sup>354</sup> The historic level of support for this Resolution is only curious if considered when removed from the decades long UN efforts at state building in the sub-region. Indeed, UNSC resolutions have traditionally not extended to diseases. This includes ailments like malaria, which kills far more people per year than Ebola had by the time the UNSC issued Resolution 2177.<sup>355</sup>

States expressed varying rationales when providing explanations for their support of Resolution 2177. Some states evidenced a more traditional understanding of a “threat to peace” by explicitly linking the Ebola outbreak to the prospect of future physical violence. For example, France’s representative indicated that Ebola was “threatening to erase the peace dividends and to reignite chaos” in the affected countries.<sup>356</sup> In this way, Ebola was a “threat to peace” because it was occurring in post-conflict states, whose peace-building efforts might be undermined due to the instability the disease was causing.<sup>357</sup> Other states like Chad did not specifically have a conflict nexus in their rationale, but representatives contended that the economic and social instability engendered by the disease within the affected countries and West Africa more generally posed a threat to peace.<sup>358</sup>

Moreover, many states alluded to the effects Ebola was having on individuals and remarked on the large number of people killed by the disease and its potential to kill even more.<sup>359</sup> For instance, Nicaragua’s representative stated that “the international community must act immediately with the aim of saving as many human lives as possible and prevent the current situation from becoming a humanitarian catastrophe.”<sup>360</sup> Other states emphasized the toll in terms of not only deaths, but also the impact on individuals—China’s representative observed that the disease was “seriously threatening the health and life of [affected] populations.”<sup>361</sup> A few states expressed concern over the

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<sup>353</sup> See S.C. Res. 2177, *supra* note 346.

<sup>354</sup> Hood, *supra* note 336, at 37.

<sup>355</sup> *Id.* at 46.

<sup>356</sup> U.N. SCOR, 69th Sess., 7268th mtg. at 10, U.N. Doc. S/PV.7268 (Sept. 18, 2014) [hereinafter U.N. SCOR, Peace and Security in Africa].

<sup>357</sup> Hood, *supra* note 336, at 38.

<sup>358</sup> U.N. SCOR, Peace and Security in Africa, *supra* note 356, at 19.

<sup>359</sup> Hood, *supra* note 336, at 40.

<sup>360</sup> U.N. SCOR, Peace and Security in Africa, *supra* note 356, at 46.

<sup>361</sup> *Id.* at 15. Morocco also made similar comments. *Id.* at 29–30.

collateral effects of the Ebola outbreak. For example, the representative from the Netherlands remarked, “[I]f we do not act now, people not dying of Ebola may die of starvation.”<sup>362</sup> Still, others considered the psychological effect of the disease on people, with Burundi’s representative commenting that the “widespread panic created by the Ebola crisis in affected countries does not allow people to go about their normal daily productive activities.”<sup>363</sup> Representatives from other states, like Australia and Luxembourg, were of the view that Ebola was a “multi-dimensional crisis” that self-evidently “threatened international peace and security.”<sup>364</sup>

Some states implicitly relied on a conceptualization of Ebola as structural violence, which threatened human security and consequently constituted a threat to the peace. This was reflected in the statements of numerous states’ representatives. For example, Argentina’s representative noted that Ebola was “eroding the possibilities of human social and economic development, which is at the root of most of the conflicts we deal with in this Council, and which may have consequences for security.”<sup>365</sup> Others also implicitly expressed the need to address structural violence that leads to human insecurity. An illustration of this is the representative from China’s statement that the “international community should address both the root causes and symptoms of the problems by assisting African countries in accelerating their economic and social development.”<sup>366</sup> Similarly, Luxembourg’s representative admonished that “[w]e must face up to the structural challenges that condemn the greater part of the citizens of West Africa to live in poverty and precarity and that increase their vulnerability to shocks such as the Ebola epidemic.”<sup>367</sup>

While most accounts were not completely divorced from more traditional security rationales for justifying UNSC action, these statements are still noteworthy because they indicate an implicit acknowledgement of structural violence and its relationship to human security. The implicit conceptualization of Ebola as a form of structural violence, which threatened human security and warranted an international response, was not uniformly held. States like Colombia and Brazil preferred for the Ebola outbreak in West Africa to be understood as a “crisis,” but not one that rose to the level of threatening international

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<sup>362</sup> *Id.* at 34. Burundi, Equatorial Guinea, Nicaragua and Russia also raised concerns about starvation and food crises. *Id.* at 13, 41, 46, 48.

<sup>363</sup> *Id.* at 41.

<sup>364</sup> *Id.* at 16, 18.

<sup>365</sup> *Id.* at 20.

<sup>366</sup> *Id.* at 15.

<sup>367</sup> *Id.* at 18.

peace and security in general.<sup>368</sup> Notwithstanding this, during the debates leading up to the Resolution, many states like South Korea viewed the United Nations as the best platform to coordinate efforts.<sup>369</sup> Similarly, Russia's representative observed that the challenges faced by the affected states required the "coordinated response of the international community" and that the Council's discussion and adoption of the Resolution was justified.<sup>370</sup>

While the UNSC's Resolution 2177 did not alter the legal meaning of a "threat to the peace" on its own, it indicates that states are making implicit, if not explicit, connections between global public health and security. Yet it may seem hollow or empty that the bulk of the analysis above examined the rhetoric of states' representatives in the debates surrounding Resolution 2177. This is particularly so when one considers that following Resolution 2177, after states declared Ebola a "threat to international peace," they decided not to take any enforcement actions.<sup>371</sup>

When faced with threats to international peace and security, the UNSC generally has used three tools to change state behavior—military action, sanctions, and political leadership.<sup>372</sup> The tool most commonly used by the UNSC is the imposition of sanctions.<sup>373</sup> Yet this might lead to more damaging socioeconomic consequences, which would not necessarily contain the spread of Ebola or other diseases, and would likely exacerbate structural violence.<sup>374</sup> Similarly, the authorization of the use of force would be highly inappropriate for dealing with infectious diseases and likely would aggravate direct and structural violence. Changing the underlying structures, institutions, laws, and policies that facilitate structural violence would not be furthered by allowing for military intervention, which may worsen the conditions that led to increased rates of mortality and illness from infectious diseases amongst others. Yet there is no limiting principle that would prevent the UNSC from utilizing one of these unsuitable means of intervening in a public health emergency.

Accordingly, the UNSC's more expansive understanding of security must be approached with trepidation. For example, some view the Council as superfluous—adding an "unhelpful layer of bureaucracy"

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<sup>368</sup> *Id.* at 45.

<sup>369</sup> *Id.* at 13.

<sup>370</sup> *Id.* at 12.

<sup>371</sup> S.C. Res. 2177, *supra* note 346.

<sup>372</sup> David, *supra* note 320, at 573.

<sup>373</sup> See U.N. Charter art. 24.

<sup>374</sup> See discussion *infra* Part IV.B.; see also Agnew, *supra* note 15, at 124–25.

and providing no new resources to international efforts to fight infectious diseases.<sup>375</sup> Further, some contend that public health is essentially a domestic concern, which should remain exclusively in the jurisdiction of the relevant states.<sup>376</sup> Moreover, because the international community has not been able to successfully deal with problems of direct mass personal violence,<sup>377</sup> there is alarm that it will be even less equipped and willing to address problems of structural violence presented by infectious diseases like Ebola.

Further, the UNSC could potentially abuse its newfound power. The UNSC's overt political nature means that it might allow for sovereignty incursions, regardless of whether states in the Global South actually want or need health assistance, and there could be pretextual interventions.<sup>378</sup> For example, the UNSC could improperly exceed its mandate and potentially violate respect for state sovereignty and national autonomy.<sup>379</sup> This could reify geopolitical hierarchies with P5 members exercising oversight of global public health programs aimed at infectious diseases over less powerful regions, and immunize P5 nations and their allies from such health interventions.

These reservations are not frivolous given how the UNSC has operated in instances of direct violence. For example, NATO engaged in regime change in Libya when implementing the UNSC authorization for use of force, which only contemplated the protection of civilians.<sup>380</sup> Further, a fundamental concern with UNSC action is that it allows for selectivity based on power politics, with interventions taking place in Libya, for example, but none in Syria,<sup>381</sup> which is similar or perhaps even worse at the time of writing than things were before the international community's intervention in Libya. In the same way that action at the level of the UNSC is stalled due to the inability to form consensus amongst the P5 members on tougher measures in Syria, a threatened veto could forestall greater responsiveness to structural violence witnessed with other epidemics. As such, equally or perhaps even more devastating situations of structural violence may be unaddressed while more low hanging fruit are prioritized internationally. The potentially

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<sup>375</sup> David, *supra* note 320, at 563.

<sup>376</sup> *See id.* at 566.

<sup>377</sup> *See id.* at 570.

<sup>378</sup> *Id.* at 571.

<sup>379</sup> *Id.* at 562–63.

<sup>380</sup> *See generally* S.C. Res. 1973 (Mar. 17, 2011).

<sup>381</sup> *See, e.g.,* Neil MacFarquhar & Anthony Shadid, *Russia and China Block U.N. Action on Crisis in Syria*, N.Y. TIMES (Feb. 4, 2012), <http://www.nytimes.com/2012/02/05/world/middleeast/syria-homs-death-toll-said-to-rise.html?page-wanted=all> [<https://perma.cc/56L5-24KP>] (archived Jan. 22, 2018).

selective enforcement by the UNSC is a precarious method for preventing the spread of epidemics internationally. Given the above considerations, perhaps the most effective role for the UNSC in combatting infectious diseases is applying varying levels of political leadership and pressure to encourage further cooperation from states.<sup>382</sup>

In sum, this subpart has illustrated how the UNSC contributed to structural violence through an initial narrow framing of what constitutes a “threat to international peace and security.” This unduly strict definition of crises historically perpetuated structural violence and assisted highly infectious diseases to spread, because it prioritized responding to direct violence above all else. In this way, the UNSC helped to create the conditions for structural violence witnessed with the Ebola epidemic through a post-conflict reconstruction that neglected the health sector. Accordingly, while the regime’s response during the epidemic was more robust than it had been for any other disease, this does not absolve it of responsibility for failing to recognize and respond to the complex relationship between conflict and disease originally.

#### b. United Nations General Assembly

In contrast to the UNSC, the GA has been much more willing to prioritize issues that lead to structural violence. For example, in 2000 the GA adopted the Millennium Declaration and in 2015 the Sustainable Development Goals, which reflect a commitment to address issues of both direct and structural violence.<sup>383</sup> The GA’s Resolution on Ebola 69/1 referenced the earlier SC resolution that had determined that Ebola was a “threat to peace” and called on “Member States, relevant United Nations bodies and the United Nations system to provide their full support to the United Nations Mission for Ebola Emergency Response.”<sup>384</sup>

The GA’s Resolution 69/1 also requested the Secretary General to establish the United Nations Mission for Ebola Emergency Response

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<sup>382</sup> See, e.g., *Global Ebola Response Coalition*, U.N. GLOB. EBOLA RESPONSE, <http://ebolareponse.un.org/global-ebola-response-coalition> (last visited Feb. 9, 2018) [<https://perma.cc/9ZFH-FSSC>] (archived Jan. 22, 2018).

<sup>383</sup> See G.A. Res. A/RES/55/2 (Sept. 18, 2000); see also G.A. Res. A/RES/70/1 (Oct. 21, 2015).

<sup>384</sup> G.A. Res. A/RES/69/1, pmb., ¶ 3 (Sept. 19, 2014).

(UNMEER).<sup>385</sup> UNMEER was an attempt to coordinate the UN response to the epidemic through a unified structure.<sup>386</sup> The humanitarian mission reported directly to the Secretary General Ban Ki-Moon, formally solidifying the connection between global public health and international peace and security. The GA created the mission in part because of the WHO's bungling of the initial response and the leadership vacuum this created,<sup>387</sup> but also because of its own failed post-conflict reconstruction.

UNMEER was the institution's first ever emergency health mission and the first system-wide mission of the United Nations. It was launched on September 19, 2014 and closed on July 31, 2015. Its primary objective was to contain and prevent the spread of Ebola through case management and safe burial services, to treat infected individuals, and to provide services to affected communities.<sup>388</sup> The organization touts the initiative as having achieved its objective of scaling up the response to Ebola on the ground.<sup>389</sup> Certainly, UNMEER's mobilization far exceeded that of the WHO, with approximately USD 19 million.<sup>390</sup> The United Nations has lauded the health mission as an innovative approach, which will likely increase "as the nature of global responses are reshaped to meet the complex challenges of this century."<sup>391</sup> Yet this only serves to highlight the fact that the United Nations' prior peacekeeping missions in the sub-region had essentially ignored the importance of health and the particular risk posed by epidemics for fragile states, especially those recovering from a recent history of conflict.

UNMEER was established during an ongoing crisis, with no priors to refer to for guidelines. For example, many humanitarian organizations were used to working with the United Nations' previously estab-

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<sup>385</sup> *Id.*

<sup>386</sup> Statement by the U.N. Secretary-General on the Establishment of the United Nations Mission for Ebola Emergency Response (UNMEER) (Sept. 19, 2014), <http://www.un.org/sg/statements/index.asp?nid=8006> [https://perma.cc/YTG6-TH9B] (archived Jan. 22, 2018).

<sup>387</sup> Lee, *supra* note 134, at 946–47.

<sup>388</sup> *UN Mission for Ebola Response*, U.N. GLOB. EBOLA RESPONSE, <http://ebolaresponse.un.org/un-mission-ebola-emergency-response-unmeer> (last visited Jan. 22, 2018) [https://perma.cc/35M2-HQR4] (archived Jan. 22, 2018).

<sup>389</sup> *Id.*

<sup>390</sup> Lee, *supra* note 134, at 948.

<sup>391</sup> *UN Mission for Ebola Response Highlights New Type of UN Operation – Chef de Cabinet Tells UNMEER Staff*, U.N. NEWS CTR. (Oct. 20, 2014), <https://www.un.int/news/un-mission-ebola-response-highlights-new-type-un-operation-chef-de-cabinet-tells-unmeer-staff> [https://perma.cc/QT7T-K49B] (archived Jan. 22, 2018).



lished global public health institutions, which led to coordination problems with UNMEER.<sup>392</sup> Further, UNMEER prioritized providing humanitarian relief through the delivery and transportation of quantities of food instead of desperately needed medical supplies.<sup>393</sup> These logistical difficulties solidified the view amongst some that other bodies are more well-suited to combatting diseases.

Notwithstanding these logistical challenges, the issues faced are not insurmountable for future humanitarian health missions, especially where things are stalled at the level of the UNSC. In the past, the GA has sought to empower itself to act in the event of UNSC paralysis through its Uniting for Peace Resolution. Under this resolution, the GA resolved that if the UNSC has failed to exercise its primary responsibility for international peace and security where there appears to be a threat to or breach of the peace, or an act of aggression, the Assembly could recommend collective measures to member states to maintain or restore international peace and security.<sup>394</sup> The Uniting for Peace Resolution has been used sparingly in practice and has only been considered legally well-founded where such recommendations are made in the context of the Assembly calling on member states to support the inherent right of individual or collective self-defense under Article 51 of the Charter.<sup>395</sup> Otherwise, the use of the Resolution has been controversial in the use of force context because of its encroachment on the Council's exclusive power to maintain international peace and security.

Nonetheless, there is some potential for the Assembly to make recommendations under the Uniting for Peace framework for collective measures in the face of threats posed by epidemics, and in many respects GA action would be preferable to UNSC action since there is less prospect of the use of blunt measures like sanctions or military interventions. Under the Charter, the GA is empowered to make non-binding recommendations for promoting international cooperation in the

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<sup>392</sup> Lisa Schnirring, *WHO Independent Panel Calls Out Ebola Response Flaws*, CIDRAP NEWS (July 10, 2015), <http://www.cidrap.umn.edu/news-perspective/2015/07/who-independent-panel-calls-out-ebola-response-flaws> [https://perma.cc/JA2R-5F9G] (archived Jan. 22, 2018).

<sup>393</sup> Lee, *supra* note 134, at 947.

<sup>394</sup> G.A. Res. A/RES/377, ¶ 1 (Nov. 3, 1950).

<sup>395</sup> This occurred in 1950 when the Council recommended that Members furnish assistance to South Korea as necessary to repel an armed attack, which was followed-up in 1951 by an Assembly Resolution calling upon States to lend every assistance to the UN action in South Korea. S.C. Res. S/1588, ¶ 1 (July 7, 1950); G.A. Res. A/RES/500(V) (May 18, 1951). Additionally, the Assembly issued a Resolution where it called upon States to provide military assistance to other States for them to defend their sovereignty and territorial integrity against acts of aggression by North Korea. S.C. Res. S/1657 (July 31, 1950).

health field and assisting in the realization of human rights amongst others.<sup>396</sup> Further, the GA is authorized under the Charter to draw the UNSC's attention to threats that are likely to endanger international peace and security.<sup>397</sup> A GA resolution expressing that a particular epidemic is an emerging "threat to international peace and security" and encouraging member states to provide resources to alleviate the crisis or to help slow the spread of the disease could be politically influential for responding to infectious diseases. This could serve as an important signal of the seriousness with which an epidemic is regarded. As this is still uncharted territory, it is not yet clear whether there is an element of Ebola exceptionalism, or whether state practice in the GA will develop to recognize other infectious diseases as emerging threats to international peace and security.

c. Regional Organizations

An alternative way to circumvent UNSC paralysis with addressing structural violence presented by epidemics is to allow regional organizations like the African Union (AU)<sup>398</sup> to act.<sup>399</sup> During the Ebola epidemic, the AU held its first meeting about the outbreak early on in April 2014. It appealed to states with prior experience combatting the epidemic for support. In August 2014, the AU created the Support to Ebola in West Africa (ASEOWA) initiative, which was a military and civilian humanitarian mission with the objective of contributing "to the ongoing efforts of the national and international community to stop the Ebola transmission in the affected member states, prevent international spread and rebuild health systems."<sup>400</sup> Notably, UNMEER was formed a month after the AU's ASEOWA initiative. The AU released USD 1 million from the Special Emergency Fund for Drought and Famine to be dedicated to Ebola relief efforts.<sup>401</sup> This was combined with

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<sup>396</sup> See U.N. Charter, art. 13.

<sup>397</sup> *Id.* art. 11, ¶ 3.

<sup>398</sup> African states founded the AU with a stronger commitment to human rights and democratic governance than its predecessor, the Organization of African Unity. See Constitutive Act of the African Union art. 3(g)–(h), May 26, 2001, 2158 U.N.T.S. I-37733 [hereinafter AU Constitutive Act].

<sup>399</sup> See Nanjala Nyabola, *Ebola: Has the AU Done Enough?*, NEW AFRICAN (Dec. 16, 2014), <http://newafricanmagazine.com/ebola-au-done-enough/#sthash.tkYjXqtw.dpuf> [https://perma.cc/9ZFG-48AZ] (archived Jan. 22, 2018).

<sup>400</sup> Wynne Musabayana, *The African Union's Intervention in the Ebola Crisis was a Game Changer*, AFRICAN UNION COMM'N (Feb. 11, 2016), <https://au.int/en/pressreleases/20160211> [https://perma.cc/6F3S-Y22Z] (archived Jan. 22, 2018).

<sup>401</sup> See Nyabola, *supra* note 399.

donations from the African private sector amounting to USD 15 million.<sup>402</sup> At the peak of the epidemic, the AU reportedly deployed more than 835 African health workers to the affected countries.<sup>403</sup> ASEOWA team members ran Ebola treatment units and helped with community mobilization, they followed up on 49,493 people through contact tracing and provided training to 6,505 local health workers, partners, community workers, traditional leaders, and others.<sup>404</sup> ASEOWA also assisted with the restoration of health services in eighty-eight public clinics and hospitals.<sup>405</sup>

Unlike the Americas, the African Continent did not have a functioning regional body dedicated to health at the time of the Ebola epidemic. Likely influenced by the regional embarrassment of having the United States set up a central command center in Liberia in 2014 to spearhead relief efforts,<sup>406</sup> the AU created the Africa Center for Disease Control (African CDC). The Heads of State of the AU approved the African CDC in January 2015 to improve prevention, detection, and response to public health threats.<sup>407</sup> The AU Assembly approved the statute of the African CDC in January 2016 and is in the process of operationalizing this new institution.<sup>408</sup> As this is a new organization, it is not yet clear how it will impact epidemics that affect the region, or whether other regions will adopt similar organizations.

#### d. Individual States

In the absence of a robust and well-funded international regime for responding to public health emergencies caused by infectious diseases like Ebola, states intervened individually only when their security interests were directly threatened.<sup>409</sup> For example, a few countries like Senegal and Côte d'Ivoire closed their borders during the epidemic,<sup>410</sup> which frustrated humanitarian and aid relief efforts given that they serve as regional hubs for flights to and from the sub-region.

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<sup>402</sup> See Musabayana, *supra* note 400.

<sup>403</sup> Sam Jones, *Ebola: Media Overlooked Africa's Role in Combating Crisis*, THE GUARDIAN (Apr. 7, 2015), <https://www.theguardian.com/global-development/2015/apr/07/ebola-media-overlooked-africas-role-combating-crisis-african-union> [<https://perma.cc/NKM7-9F5N>] (archived Jan. 22, 2018).

<sup>404</sup> Musabayana, *supra* note 400.

<sup>405</sup> *Id.*

<sup>406</sup> Nyabola, *supra* note 399.

<sup>407</sup> Musabayana, *supra* note 400.

<sup>408</sup> *Id.*

<sup>409</sup> See Wilkinson & Leach, *supra* note 17, at 141.

<sup>410</sup> Hodge et al., *supra* note 166, at 373.

Solidarity from across the continent with the affected countries was initially lacking, as many countries sought to distance and differentiate themselves from the Ebola-affected countries out of fears of depressing tourism and their economies more generally. During the epidemic, the countries most affected by Ebola relied predominantly on neo-colonial ties with the United States providing support in Liberia (a country it helped to create), and the United Kingdom in Sierra Leone and France in Guinea, both respective former colonies. The United States became the largest single government donor responding to Ebola by appropriating USD 5.4 billion in emergency funding, the greatest amount of emergency funding ever provided by the US Congress for an international health emergency.<sup>411</sup> Almost all of this funding (USD 3.7 billion) was directed toward international activities, for both the initial response as well as ongoing recovery and rebuilding efforts.<sup>412</sup> Yet when the Zika epidemic hit, a significant amount of US Ebola assistance was clawed back and repurposed for Zika.<sup>413</sup> Accordingly, reliance on individual state action alone is a risky method for preventing the spread of epidemics internationally.

The danger is that the harms from infectious diseases like Ebola may be perceived as localized and concentrated in the affected state(s). Undeniably, most of the containment efforts to date have stemmed from “Not in My Backyard” fears of contagion, and the actors most likely to intervene are those with interests that are not purely, or perhaps not even primarily, humanitarian. Consequently, the perpetual challenge is how to incentivize states, international institutions, and other non-state actors to act, when it is not apparent that it is in their interests to do so.

Overall, the actors in the international peace and security regime—from the UNSC, to the GA, to regional organizations and individual states—responded in diverse ways to address structural violence from Ebola. It is too early to determine whether this indicates an emerging recognition by states that global public health inequities in the spread of epidemic diseases like Ebola can constitute a threat to international peace and security. Instead, there may be Ebola exceptionalism, since other diseases have not been afforded similar treatment. The analysis above indicates that the regime’s historical failure

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<sup>411</sup> JENNIFER KATES ET AL., HENRY J. KAISER FAMILY FOUND., THE U.S. RESPONSE TO EBOLA: STATUS OF THE FY2015 EMERGENCY EBOLA APPROPRIATION 8 (2015), <https://kaiserfamilyfoundation.files.wordpress.com/2015/12/8809-02-the-u-s-response-to-ebola-status-of-the-fy2015-emergency-ebola-appropriation.pdf> [https://perma.cc/3AZ6-W5BL] (last visited Jan. 22, 2018).

<sup>412</sup> *Id.* at 3.

<sup>413</sup> See, e.g., Editorial Board, Opinion, *Stealing From Ebola to Fight Zika*, N.Y. TIMES (May 19, 2016), <https://www.nytimes.com/2016/05/20/opinion/stealing-from-ebola-to-fight-zika.html?emc=eta1> [https://perma.cc/RDW9-SVCL] (archived Jan. 22, 2018).

to recognize that the relationship between infectious diseases and conflict warrants more robust post-conflict reconstruction was the most substantial factor in contributing to structural violence during Ebola. This *ex ante* failure in the international peace and security regime was ultimately significant in influencing the trajectory of the epidemic. The regime's *ex post* response to alleviate the harm caused by structural violence does not negate the impact of the initial harm.

## V. THEORETICAL & POLICY IMPLICATIONS

Because structural violence is viewed as quotidian, it is often not analyzed as amenable to legal reform. Yet structures are created by people, and as such structural violence can be prevented and ameliorated.<sup>414</sup> Structural violence as a framework in this Article helps draw attention to the arrangement of and relationship between the parts or elements of complex legal regimes. Structural violence as an analytical frame in this Article assists with identifying actors, actions, laws, policies, and omissions that might otherwise be unacknowledged. In this way, the concept assists with apportioning partial responsibility. A major implication of this Article is that a reexamination of the current framework for international responsibility is needed to adequately address issues of structural violence witnessed with infectious disease. Additionally, this case study indicates that the complex relationship between infectious diseases and conflict warrants more robust attention and resources. Lastly, this Part finds that current advances in international disaster law hold promise and need to be developed further, with an eye towards better addressing structural violence. This author plans to take up the potential for shared norms of international responsibility and international disaster law to address issues raised by structural violence witnessed with epidemics in future research.

### A. *The Limits of International Responsibility*

The main implications of this study for the law of international responsibility are the need for responsibility to be allocated and the difficulty in apportioning blame for structural violence. Conventional understandings of international responsibility locate responsibility solely at the level of the state.<sup>415</sup> This allows the activities of IOs and

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<sup>414</sup> See DAVID ROBERTS, HUMAN INSECURITY: GLOBAL STRUCTURES OF VIOLENCE 29 (2008).

<sup>415</sup> Int'l Law Comm'n, Rep. on the Work of Its Fifty-Third Session, Draft Articles on Responsibility of States for Internationally Wrongful Acts, U.N. Doc. A/56/10, at 43 (2001) [hereinafter Int'l Law Comm'n, Responsibility of States]

other non-state actors, and the structural violence that results because of their functioning, to go un-scrutinized as seen with the analysis of highly infectious diseases like Ebola. The traditional view of state responsibility under Article 2 of the International Law Commission's (ILC) Draft Articles on Responsibility of States for Internationally Wrongful Acts holds that states are only responsible for conduct attributable to them through action or omission.<sup>416</sup> The general rule is that conduct is attributable to the state under international law when it is committed by an organ of the government or when a person or entity is acting as an agent of the state and exercising elements of governmental authority.<sup>417</sup> However, a state can also be responsible to the extent it fails to take necessary measures to prevent harm, imposing a standard of due diligence.<sup>418</sup> States generally resist principles of responsibility that would hold them responsible for conduct other than their own—whether those other actors are private, IOs, or other state actors.<sup>419</sup> The way the ILC attempts to deal with situations where there are multiple state actors that are responsible for wrongdoing is unsatisfactory because it does not clarify how responsibility is to be allocated.<sup>420</sup> Moreover, states are no longer the only relevant actor in the international order, and injuries are committed by individuals, corporations, other non-state actors, and IOs, amongst others.

Current legal reform efforts at expanding international responsibility are inadequate. For example, the ILC has proposed making states responsible in certain situations where they delegate authority to an IO, which then violates rights.<sup>421</sup> The proposal would hold states accountable even where the injury was solely attributable to the IO.<sup>422</sup> Yet to address many of the most pressing problems, individual states acting alone will be powerless to make any significant difference.<sup>423</sup> Recognizing this, the ILC has also proposed that an IO can be responsible in connection with the wrongful acts of states where, for example, the organization adopts a decision that requires states to commit acts

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<sup>416</sup> *Id.*

<sup>417</sup> *See id.* at 44.

<sup>418</sup> *See generally* Monica Hakimi, *State Bystander Responsibility*, 21 EUR. J. INT'L L. 341 (2010) (providing a framework for determining when a state must protect someone from a third party).

<sup>419</sup> André Nollkaemper & Dov Jacobs, *Shared Responsibility in International Law: A Conceptual Framework*, 34 MICH. J. INT'L L. 359, 386 (2013).

<sup>420</sup> *See* Int'l Law Comm'n, *Responsibility of States*, *supra* note 415, at 55.

<sup>421</sup> *See* Int'l Law Comm'n, *Rep. on the Work of Its Sixty-First Session*, U.N. Doc. A/64/10, at 163–66 (2009).

<sup>422</sup> *Id.*

<sup>423</sup> *See* Nollkaemper, *supra* note 46, at 283.

that contravene international obligations.<sup>424</sup>

IOs like the United Nations have been found to have international legal personality,<sup>425</sup> which enables them to make claims and to have claims made against them. At the same time, IOs are layered organizations that consist of member states. Notably, the Draft Articles on the Responsibility of International Organizations recognize that in situations of internationally wrongful acts where there is concerted action between IOs and states, both the states and the IOs have shared responsibility.<sup>426</sup> The Draft Articles also provide for shared responsibility between IOs and other international organizations, although they do not clarify how these responsibilities are to be allocated amongst other actors.<sup>427</sup> Yet increasingly IOs also have public-private partnerships and rely on private actors, especially in the field of global public health as witnessed with the Ebola epidemic. Furthermore, IOs and private actors like corporations may not necessarily be bound by international law obligations or even soft law in many areas, and if they are, their obligations may not be the same as states.

This has created what one scholar has termed “responsibility gaps.”<sup>428</sup> Such gaps can occur in many ways. One of the main challenges to conceptualizing international responsibility beyond the state is the multiplicity of actors at the international level that may or may not act in concert to produce a single injury; this can include governments acting individually or collectively, international and regional organizations, civil society, corporations, community-based actors, and individuals, amongst others. This occurs with instances of structural violence, where there is overdetermination because there are too many actors involved in the process that caused the harm. This may also lead to challenges in identifying which actor is responsible for what due to lack of information or knowledge about a given situation.<sup>429</sup> Additionally, a responsibility gap may persist because during instances of structural violence, where it is not necessarily obvious who should respond,

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<sup>424</sup> Int'l Law Comm'n, Rep. on the Work of Its Sixty-Third Session, Draft Articles on the Responsibility of International Organizations, U.N. Doc. A/66/10, art. 17 (2011) [hereinafter Int'l Law Comm'n, Responsibility of International Organizations].

<sup>425</sup> See *Reparation for Injuries Suffered in the Service of the United Nations*, Advisory Opinion, 1949 I.C.J. Rep. 174 (Apr. 11).

<sup>426</sup> See Int'l Law Comm'n, Responsibility of International Organizations, *supra* note 424, art. 19.

<sup>427</sup> See *id.* art. 48. For further discussion, see Nollkaemper & Jacobs, *supra* note 419 at 396–97.

<sup>428</sup> See Nollkaemper, *supra* note 46.

<sup>429</sup> See *id.* at 296.

a bystander effect where no actor responds may result.<sup>430</sup>

A responsibility gap may also occur because the individual actions of multiple actors may be distributed in a way that does not meet the requirements of international responsibility, which dictates that responsibility is only assigned to actors whose individual contributions are significant enough to pass the minimum threshold.<sup>431</sup> In other areas of law, problems of overdetermination are dealt with by a number of doctrines—joint and several liability in tort law and joint criminal enterprise in international criminal law, by way of example.<sup>432</sup> These principles have not been incorporated into the international law of responsibility, perhaps for good reasons.<sup>433</sup> In part, this likely reflects the practical consideration that the higher the risks of responsibility, the more cautious actors will be in accepting international obligations. Yet, even if actors are willing to accept higher obligations, all international dispute settlement mechanisms are premised on state consent, and most do not have jurisdiction over other IOs or corporations.<sup>434</sup> Thus, a responsibility gap will likely be maintained where a harm is the result of structural violence, because adjudication of a claim may not be able to proceed against the state if it withholds its consent to jurisdiction and in any event would not include the other international actors involved. This presents seemingly insurmountable challenges for attempting to provide full redress for structural violence witnessed

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<sup>430</sup> See generally Hakimi, *supra* note 418.

<sup>431</sup> See Nollkaemper, *supra* note 46, at 290.

<sup>432</sup> For further discussion, see Nollkaemper & Jacobs, *supra* note 419, at 423 (discussing the substantive and procedural challenges with applying the private law principle of joint and several responsibility into a public international law context); *id.* at 425 (discussing the challenges with applying the principle of joint criminal enterprise to determining the responsibility of states and international organizations given the need to demonstrate *mens rea* and other concepts); see also Roger P. Alford, *Apportioning Responsibility Among Joint Tortfeasors for International Law Violations*, 38 PEPP. L. REV. 233 (2011) (discussing how domestic tort law concepts can be applied to challenges related to apportioning responsibility of international law violations); Kai Ambos, *Joint Criminal Enterprise and Command Responsibility*, 5 J. INT'L CRIM. JUST. 159 (2007) (comparing the doctrines of joint criminal enterprise and command responsibility liability in the prosecution of international crimes); Antonio Cassese, *The Proper Limits of Individual Responsibility Under the Doctrine of Joint Criminal Enterprise*, 5 J. INT'L CRIM. JUST. 109, 110 (2007) (pointing out the difficulties in identifying specific contributions made by each individual party involved in an international crime); Jens David Ohlin, *Three Conceptual Problems with the Doctrine of Joint Criminal Enterprise*, 5 J. INT'L CRIM. JUST. 69, 70 (2007) (analyzing the international doctrine of joint criminal enterprise); Herman G. van der Wilt, *The Continuous Quest for Proper Modes of Criminal Responsibility*, 7 J. INT'L CRIM. JUST. 307 (2009) (identifying the challenges associated with choosing the most proper mode of criminal responsibility in international law).

<sup>433</sup> See Nollkaemper, *supra* note 46, at 303–07.

<sup>434</sup> *Id.* at 307.



with Ebola through traditional principles of international responsibility.

The law of international responsibility, like other areas of international law, is not neutral. It reflects the choices and practices of states and allows states and non-state actors to engage in blame-avoidance and blame shifting for harmful consequences of structural violence and to shield themselves from responsibility.<sup>435</sup> Due to the challenges discussed above, where structural violence results—like the avoidable deaths during the Ebola epidemic—injured parties will be without redress. This could occur either because the conditions for international responsibility are not met or responsibility cannot be determined, and it is also not possible to bring an effective claim against the collectivity as such.<sup>436</sup> Yet one of the underlying principles of attributing responsibility is that every legal injury deserves a remedy to ensure justice to victims.<sup>437</sup>

The dominant paradigm of international responsibility depends on an identifiable actor who acts to produce injury.<sup>438</sup> However, when the actors are too numerous, and/or the injury is embedded in institutions, the dominant paradigm is unable to provide redress and fails to capture the harms caused by structural violence. Thus, the increased rates of mortality and illness from infectious diseases like Ebola are generally unaccounted for. This makes it incredibly difficult to secure effective legal measures for prevention, restitution, and redress for structural violence.<sup>439</sup> The law of international responsibility privileges the status quo and directs attention towards individual claims against specific actors for identifiable harms and away from legal reform efforts and concepts of shared international responsibility,<sup>440</sup> especially in the field of global public health. Because of the limitations in utilizing traditional principles of responsibility, it is necessary to reconceptualize international responsibility. Accordingly, much more research<sup>441</sup> is needed on the potential for shared norms of international responsibility<sup>442</sup> to better respond to structural violence, which this

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<sup>435</sup> *Id.* at 298.

<sup>436</sup> *Id.* at 306.

<sup>437</sup> *Id.*

<sup>438</sup> See Int'l Law Comm'n, Responsibility of States, *supra* note 415, at 43.

<sup>439</sup> See NIXON, *supra* note 21, at 9.

<sup>440</sup> See generally Nolkaemper & Jacobs, *supra* note 419.

<sup>441</sup> See generally Benjamin Mason Meier et al., *Employing Human Rights Frameworks to Realize Access to an HIV Cure*, 18 J. INT'L AIDS SOC'Y 1 (2015).

<sup>442</sup> See, e.g., INT'L COMM'N ON INTERVENTION AND STATE SOVEREIGNTY, THE RESPONSIBILITY TO PROTECT xi (2001) [hereinafter R2P REPORT]; see also U.N. Confer-

author plans to do in future work.

### B. *Complex Relationship between Infectious Diseases & Conflict*

Another implication of this study is the need to acknowledge and appropriately respond to the complex relationship between conflict and infectious diseases. The Ebola case study indicates that emphasizing the link between international peace and security and global public health might motivate countries in the Global North to comply with the IHRs obligations to assist other states with capacity-building of their domestic health sectors.<sup>443</sup> This link seemingly galvanized state and non-state actor action during the outbreak and led to the formation of the Global Health Security Agenda (GHSa) in 2014.<sup>444</sup> The goal of the GHSa is to “advance a world safe and secure from infectious disease threats, to bring together nations from all over the world to make new, concrete commitments, and to elevate global health security as a priority.”<sup>445</sup> Membership in the initiative is open to all countries and at the time of this writing nearly fifty nations are part of the GHSa, along with international organizations like the WHO as well as non-governmental stakeholders.<sup>446</sup>

The GHSa was created to facilitate collaborative, capacity-building efforts to achieve specific targets that are tied to the core capacities under the IHRs. While the IHRs require its 196 state parties to cooperate to help build health capacities,<sup>447</sup> they do not articulate how this is to work in practice.<sup>448</sup> The GHSa fills in this lacuna by creating a framework for countries to address their commitments. The GHSa has eleven Action Packages that are designed to help build state capacity

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ence on Environment and Development, *Rio Declaration on Environment and Development*, U.N. Doc. A/CONF.151/26/ (Vol. I), Annex I, Principle 7 (Aug. 12, 1992). Under the principle, developed countries agree to take on higher obligations to combat environmental concerns like climate change to reflect consumption and production patterns as well as the unequal distributions of risks of climate change which results in more devastating consequences for poorer countries. *See, e.g.*, Paris Agreement to the United Nations Framework Convention on Climate Change art. 2, Dec. 12, 2015, U.N. Doc. FCCC/CP/2015/L.9.; U.N. Framework Convention on Climate Change art. 3, May 9, 1992, S. TREATY DOC. No. 102-38, 1771 U.N.T.S. 107

<sup>443</sup> *See* Gostin, *supra* note 317.

<sup>444</sup> *About*, GLOB. HEALTH SEC. AGENDA, <https://www.ghsagenda.org/about> (last visited Feb. 9, 2018) [<https://perma.cc/C8JQ-PJZT>] (archived Jan. 21, 2018) [hereinafter GHSa, *About*].

<sup>445</sup> *Id.*

<sup>446</sup> *Id.*

<sup>447</sup> Gostin & Friedman, *supra* note 261, at 1323.

<sup>448</sup> *Id.*

to prevent, detect, and respond to threats posed by infectious diseases.<sup>449</sup> Under the GHSA, member countries can utilize a tool that helps to assess baseline national health security capacity. An action plan can then be tailored with five-year targets for states to meet with a set of indicators to measure progress, as well as various activities to support successful implementation. One of the key aspects of the external evaluation tool is the ability to highlight gaps and needs for current and prospective donors, as well as to inform and assist country-level planning and priority setting.<sup>450</sup>

Understandably, the countries most impacted by Ebola—Liberia, Sierra Leone, and Guinea—joined this initiative.<sup>451</sup> For example, during the Ebola epidemic in Sierra Leone in November of 2015, only 35 percent of health facilities reported to their respective districts. By September 2016, with the help of the GHSA, this increased to 96 percent of health facilities.<sup>452</sup> Early indications similarly show the GHSA is having an impact in Liberia. Prior to the 2014 Ebola outbreak, Liberia had very few trained “disease detectives,” but with the support of the GHSA at the end of 2016 the country had a total of 115 trained “detectives” covering all fifteen counties and ninety-two health districts.<sup>453</sup> These initiatives will likely assist with early detection of epidemic diseases.

Additionally, there is evidence suggesting that investment in the promotion of protective and primary care services in the Global South leads to large improvements in public health, which generate benefits

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<sup>449</sup> The prevention action packages cover: antimicrobial resistance, zoonotic diseases like Ebola, biosafety and biosecurity as well as immunization. *Action Packages*, GLOBAL HEALTH SEC. AGENDA, <https://www.ghsagenda.org/packages> (last visited Feb. 9, 2018) [<https://perma.cc/2SAA-CLS4>] (archived Jan. 22, 2018). The detection action packages address: national laboratory systems, real-time surveillance, reporting and workforce development. *Id.* While the response packages focus on: emergency operations centers, linking public health with law and multi-sector rapid response and medical countermeasures and personnel deployment. *Id.*

<sup>450</sup> *Assessments*, GLOB. HEALTH SEC. AGENDA, <https://www.ghsagenda.org/assessments> (last visited Feb. 9, 2018) [<https://perma.cc/V5XF-2FTJ>] (archived Jan. 22, 2018).

<sup>451</sup> *Members & Membership*, GLOB. HEALTH SEC. AGENDA, <https://www.ghsagenda.org/members> [<https://perma.cc/7HDK-GPW3>] (archived Jan. 22, 2018); see, e.g., JOINT EXTERNAL EVALUATION OF THE REPUBLIC OF LIBERIA, WHO, MISSION REPORT (Sept. 2016).

<sup>452</sup> GLOB. HEALTH SEC. AGENDA, ADVANCING THE GLOBAL HEALTH SECURITY AGENDA: PROGRESS AND EARLY IMPACT FROM U.S. INVESTMENT 7, <https://www.ghsagenda.org/docs/default-source/default-document-library/ghsa-legacy-report.pdf?sfvrsn=12> [<https://perma.cc/99ZR-LAU6>] (archived Jan. 22, 2018) [hereinafter GHSA, ADVANCING THE GLOBAL HEALTH SECURITY AGENDA].

<sup>453</sup> *Id.* at 10.

for other states, like containment of epidemic diseases.<sup>454</sup> Accordingly, under the GHSA, member countries can reach their commitments by building capacity nationally, regionally, or globally. For example, the United States made a commitment to assist thirty-one countries and the Caribbean Community to achieve eleven measurable GHSA targets.<sup>455</sup> The United States has invested USD 1 billion in resources across seventeen of these countries that need the most assistance with capacity building to detect and respond to future infectious disease outbreaks.<sup>456</sup> The US rationale for participating in the GHSA is simple: the “most effective and least expensive way to protect Americans from diseases and other health threats that begin abroad is to stop them before they spread to our borders.”<sup>457</sup> Additional donor countries and organizations have provided a collective commitment to assist seventy-six countries to reach the capabilities described in the IHRs. The GHSA is based on the view that global health security is a “shared responsibility” that cannot be achieved by a single actor or sector of government.<sup>458</sup> While neither it nor the IHRs determine how responsibility for capacity building should be allocated,<sup>459</sup> the GHSA is laudable as it is a proactive measure that does not ignore global health inequities in state capacities but instead tries to remedy them.

Yet this initiative might sustain a problematic role between countries in the Global South and Global North, with the former being primarily donor recipients and the latter generally consisting of donors. There is rich foreign aid literature that discusses the mismatch between donor and recipient countries’ priorities, with aid supplanting local needs.<sup>460</sup> For instance, donor governments and NGOs often direct aid to specific health projects and diseases through vertical projects like the Global Fund to Fight AIDS, Tuberculosis, and Malaria.<sup>461</sup> This practice may undermine the development of a comprehensive public health system with the surveillance needed for proper disease prevention. For instance, the proliferation of actors and fragmentation of health delivery prior to the Ebola epidemic meant that there was often a mismatch between national priorities for health development and

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<sup>454</sup> See Agnew, *supra* note 15, at 119.

<sup>455</sup> GHSA, ADVANCING THE GLOBAL HEALTH SECURITY AGENDA, *supra* note 452, at 2.

<sup>456</sup> *Id.*

<sup>457</sup> *Id.* at 10.

<sup>458</sup> GHSA, *About*, *supra* note 444.

<sup>459</sup> See Gostin & Friedman, *supra* note 261, at 1323.

<sup>460</sup> See *The Mismatch Between Donor Priorities and Global Health Needs*, CITIZEN NEWS SERV. (Feb. 2013), <http://www.citizen-news.org/2013/02/the-mismatch-between-donor-priorities.html> [<https://perma.cc/WA5G-E7G9>] (archived Jan. 22, 2018) (discussing the “mismatch between donor priorities and global health needs”).

<sup>461</sup> Wilkinson & Leach, *supra* note 17, at 140.

partner organizations' funding stipulations. Accordingly, the less sexy task of building up the capacity of the state health sector horizontally and shoring up its ability to train, pay, and retain qualified health staff was not prioritized.<sup>462</sup> Thus, there is a danger that this initiative might replicate structural violence.

Additionally, this initiative runs the risk of securitizing health.<sup>463</sup> The move towards securitization means that epidemic diseases will receive more salience under this framework than non-infectious diseases due to the risk of transnational transmission. Yet non-communicable diseases may result in more structural violence than infectious diseases. For example, common ailments like malaria kill far more people per year than Ebola.<sup>464</sup> Further, sovereignty concerns and fears of pretextual and frequent interventions from powerful countries may limit the desire of states to formally expand the relationship between epidemic diseases and conflict. Indeed, treating an epidemic as a security problem could lead to the unhelpful militarization of epidemics and the sending of troops to address public health emergencies as opposed to medical personnel.<sup>465</sup> While military and civilian humanitarian missions were utilized during the Ebola epidemic, it may be ill-conceived to consider security-oriented organizations to have any ability to understand the scope and nature of public health crises and to be able to effectively address them through coherent policies as a regular matter.<sup>466</sup> Although the merits of securitizing issues of health potentially draw additional resources, doing so could lead to inadvertent consequences and can have ramifications of allowing for extraordinary responses typical to how issues of direct violence are addressed,<sup>467</sup> which may be inappropriate for dealing with structural violence. In sum, there is a need to acknowledge the relationship between infectious diseases and conflict. Yet due to the risk of inappropriate responses, the reification of the relationship between conflict and infectious diseases must be approached with trepidation so as not to further structural violence.

### C. *International Disaster Law & Responding to Epidemics*

Finally, this Article finds that much more is needed than reform

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<sup>462</sup> Leach, *supra* note 8, at 823.

<sup>463</sup> See BARRY BUZAN ET AL., *SECURITY: A NEW FRAMEWORK FOR ANALYSIS* 18 (1998) (discussing the issues surrounding the process of securitization).

<sup>464</sup> Hood, *supra* note 336, at 46.

<sup>465</sup> See Agnew, *supra* note 15, at 124–25.

<sup>466</sup> See David, *supra* note 342, at 578.

<sup>467</sup> See Thomas, *supra* note 34, at 1830.

in each of the discrete regimes analyzed. Instead, reexamination of the current framework for responding to crises is needed to adequately address issues of structural violence. International disaster law is a framework for responding to complex international emergencies that spans different regimes and may have utility for addressing issues of structural violence witnessed with the Ebola epidemic. This subpart analyzes the current efforts to address nested domestic and international law failures through non-binding aspirational international law<sup>468</sup> to reduce disasters.

In 2015, states passed a non-binding resolution to reduce the risk of disasters under the Sendai Framework for Disaster Risk Reduction 2015-2030.<sup>469</sup> The goal of the initiative over the next fifteen years is to reduce “disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries.”<sup>470</sup> The third priority area of focus is private investment in disaster risk prevention and reduction through structural and non-structural measures to enhance the economic, social, health, and cultural resilience of persons, communities, countries, and their assets, as well as the environment.<sup>471</sup> The Framework recognizes that states have the primary role to reduce disaster risk but that responsibility should be shared with other stakeholders.<sup>472</sup> Under the Framework, disaster risk reduction is a common concern for all states and calls for sustainable international cooperation towards enhancing the capabilities of countries in the Global South.<sup>473</sup> The Framework is not simply reactionary to structural violence, but seeks to stimulate efforts to build better core public health capabilities for disease surveillance and health systems strengthening. However, many countries in the Global North have generally failed to comply with the IHRs’ obligations to assist other states with capacity-building of their domestic health sectors.<sup>474</sup> The Sendai Framework’s endorsement by the UNGA<sup>475</sup> potentially indicates a willingness for further international cooperation through capacity building for better prevention, detection, and treatment of epidemics.

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<sup>468</sup> Also known as soft law, which seeks to be recognized by states as hard law and to influence state practice.

<sup>469</sup> See generally Third U.N. World Conference, Sendai Framework for Disaster Risk Reduction 2015–2030, U.N. Doc. A./RES./69./283 (June 23, 2015) [hereinafter Sendai Framework].

<sup>470</sup> *Id.* ¶ 16.

<sup>471</sup> *Id.* ¶ 29.

<sup>472</sup> *Id.* ¶ 19.

<sup>473</sup> *Id.*

<sup>474</sup> See Gostin, *supra* note 317.

<sup>475</sup> Sendai Framework, *supra* note 469.

More recently, the ILC adopted the Draft Articles on The Protection of Persons in the Event of Disasters.<sup>476</sup> The Draft Articles are complementary to the Sendai Framework and propose that states “reduce the risk of disasters by taking appropriate measures, including through legislation and regulations, to prevent, mitigate, and prepare for disasters.”<sup>477</sup> This provision potentially protects against the risk that this framework will only apply once an epidemic has emerged. Presumably, the more detailed Sendai Framework will help to clarify the measures states should adopt to meet this duty as well as their obligations under the IHRs to cooperate to help build health capacities.<sup>478</sup> Moreover, the disaster risk reduction framework may be of relevance to post-conflict reconstruction given the lower levels of institutional resiliency.

The Draft Articles define disaster as “a calamitous event or series of events resulting in widespread loss of life, great human suffering and distress, mass displacement, or large-scale material or environmental damage, thereby seriously disrupting the functioning of society.”<sup>479</sup> This definition would likely prioritize situations where structural violence results in extreme threats to human security as the result of pandemic diseases. For instance, the framework could be triggered if the epidemic has reached a point of “disaster,” based on an assessment of: the scope of the structural violence, the severity of the suffering and human rights violations, the causes of structural violence, the states’ (and other actors’) relation to this structural violence, and the existence of feasible solutions. However, the emphasis on “event,” as opposed to the consequences of events, may limit the ability of the Draft Articles to be responsive to structural violence witnessed with infectious diseases. Yet the language of “series of events” may allow enough malleability to apply to slower forming pandemics. Notably, the Articles do not limit the definition of disaster to natural or human-made events, which means that it could apply to issues of structural violence witnessed with epidemics.

Under the Draft Articles, the affected state has a duty to ensure protection to persons and the provision of disaster relief in its territory, but where a disaster manifestly exceeds its capacities, the affected

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<sup>476</sup> See generally Int’l Law Comm’n, Rep. on the Work of Its Sixty-Eight Session, Draft Articles on The Protection of Persons in the Event of Disasters, U.N. Doc. A/71/10 (2016) [hereinafter Int’l Law Comm’n, Protection of Persons in the Event of Disasters].

<sup>477</sup> *Id.* art. 9.

<sup>478</sup> See Gostin & Friedman, *supra* note 261, at 1323.

<sup>479</sup> Int’l Law Comm’n, Protection of Persons in the Event of Disasters, *supra* note 476, art. 3.

state has a duty to seek assistance from other states, the United Nations, and others.<sup>480</sup> However, the Draft Articles are careful not to undermine sovereignty concerns, providing that affected states have the “primary role in the direction, control, and supervision of assistance.”<sup>481</sup> Moreover, the Draft Articles require that the affected state consents to the provision of external assistance but that such consent shall not be withheld arbitrarily.<sup>482</sup> The Draft Articles are compatible with the global public health regime. For example, the WHO is similarly limited by the sovereignty of its member states and cannot act to assist a state in responding to an infectious disease unless the state invites the WHO in to provide assistance.<sup>483</sup> The principle of non-interference is reflected in the statement of Director-General Chan during the Ebola epidemic that affected nations have “first priority to take care of their people.”<sup>484</sup> Yet affected states were not able to effectively implement the WHO’s recommendations of treatment centers, adequate compensation for health workers, and personal protective equipment due to capacity constraints.<sup>485</sup> And no effective governance structures existed internationally to fill the gap between the law in the abstract and the contextual reality of these health deficits.<sup>486</sup> The disaster risk reduction framework presents a possible avenue.

The Draft Articles provide for a duty for states to cooperate amongst themselves, with the United Nations, and with other actors.<sup>487</sup> Yet arguably the U.N. Charter already compels member states to provide international assistance and cooperation.<sup>488</sup> Under Article 56 of the Charter, member states are “to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55.”<sup>489</sup> And Article 55 provides that the United Nations shall promote “solutions of international economic, social, health, and related problems and international cultural and educational cooperation.”<sup>490</sup> Article 55 also provides in relevant part that

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<sup>480</sup> *Id.* arts. 10–11.

<sup>481</sup> *Id.* art. 10.

<sup>482</sup> *Id.* art. 13.

<sup>483</sup> WHO Constitution, *supra* note 225, art. 2(c).

<sup>484</sup> Fink, *supra* note 291.

<sup>485</sup> Gostin & Friedman, *supra* note 261, at 1323.

<sup>486</sup> Wilkinson & Leach, *supra* note 17, at 141.

<sup>487</sup> Int’l Law Comm’n, Protection of Persons in the Event of Disasters, *supra* note 476, art. 7.

<sup>488</sup> U.N. Charter, art. 56.

<sup>489</sup> *Id.* art. 55.

<sup>490</sup> *Id.* art. 55(b).



the United Nations should promote higher standards of living and conditions of economic and social progress and development as well as universal respect for and observance of human rights.<sup>491</sup> Reading these provisions together presumably provides a basis to argue that states are obligated under the Charter to cooperate with the United Nations and other actors to prevent, detect, and arrest pandemics.<sup>492</sup> An obligation to cooperate can also be located under international human rights law. The Committee on Economic Social and Cultural Rights (CESCR) has emphasized that “[s]tates parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health.”<sup>493</sup>

Significantly, the Draft Articles do not establish a duty to provide assistance.<sup>494</sup> Instead, the Draft Articles include a procedural element of proper evaluation of requests for assistance.<sup>495</sup> However, per the CESCR, states have an obligation subject to the availability of resources to “facilitate access to essential health facilities, goods and services in other countries, wherever possible, and [to] provide the necessary aid when required.”<sup>496</sup> Additionally, the Committee has found that states have a “joint and individual responsibility,” under international law, “to cooperate in providing disaster relief and humanitarian assistance in times of emergency.”<sup>497</sup> As such, states are to contribute to this task, giving priority in the provision of international medical aid, distribution, and management of resources and financial aid to the “most vulnerable or marginalized groups of the population.”<sup>498</sup> The Committee also stressed that given that some diseases are “easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem.”<sup>499</sup>

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<sup>491</sup> *Id.* art. 55(a), 55(c).

<sup>492</sup> Some argue that the Charter does not legally empower the UNSC to force member states to provide assistance. *See* David, *supra* note 320, at 574; *see also* MALCOLM LANGFORD ET AL., *GLOBAL JUSTICE, STATE DUTIES* 54–55 (2013).

<sup>493</sup> Comm. on Econ., Soc. and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, adopted at the Twenty-Second Session of the CESCR, ¶ 38, U.N. Doc. No. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, *General Comment No. 14*].

<sup>494</sup> Int’l Law Comm’n, *Protection of Persons in the Event of Disasters*, *supra* note 476, art. 12.

<sup>495</sup> *Id.*

<sup>496</sup> CESCR, *General Comment No. 14*, *supra* note 493, ¶ 39.

<sup>497</sup> *Id.* ¶ 40.

<sup>498</sup> *Id.*

<sup>499</sup> *Id.*

Moreover, the CESCR underscored that state parties to the Covenant in the Global North have a special responsibility and an interest to assist poorer states in the Global South with epidemic diseases.<sup>500</sup>

However, a more expansive notion of responsibility at the international level may lead to calls for the adoption of international Good Samaritan laws.<sup>501</sup> While domestically some states offer immunity to Good Samaritans, sometimes statutes are framed in a way that allows for claims of negligent care, and/or exempt from immunity parties that act in an intentional or reckless manner in rendering aid. Moreover, Good Samaritan laws are usually inapplicable to actors that provide emergency assistance due to obligation (e.g. during the course of their regular employment). Accordingly, increasing international responsibility for structural violence witnessed with infectious diseases may create perverse disincentives for actors to voluntarily render assistance or consent to more robust international responsibility norms. Indeed, how to bridge the gap between law, policy, and reality internationally regarding global health inequities is a fundamental challenge. This author plans to investigate in future works how the disaster risk reduction framework can be developed and applied to effectively respond to structural violence witnessed with epidemics.

## VI. CONCLUSION

This Article maintains that the international community's current approach to addressing infectious diseases like Ebola, as public health crises susceptible to individual country medical interventions, is problematic because it obscures the focus from changing the social, legal, and physical environments that help to produce these epidemics. This Article demonstrates that effectively tackling the disproportionate distribution of infectious diseases within countries in the Global South is a fundamental challenge for international law and international relations.<sup>502</sup>

Further, this Article argues that the way international crises are conceptualized needs to be expanded beyond merely addressing direct physical violence internationally. Instead, this project sustains that international responses must also include remedying structural violence. Structural violence involves multiple harms and injuries, which often

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<sup>500</sup> *Id.*

<sup>501</sup> A Good Samaritan refers to someone who renders aid in an emergency to an injured party on a voluntary basis. The party rendering aid generally has a duty to be reasonably careful, but most states do not require individuals to render aid in the first place.

<sup>502</sup> CESCR, *General Comment No. 14*, *supra* note 493 (referencing the 1978 WHO Alma-Ata Declaration, which stated that gross health inequities between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is of common concern to all countries).

result from numerous actors and institutions. Unlike traditional conceptions of violence, structural violence is unique and is characterized by delayed effects in which both the causes and the casualties are discounted and unremembered. This is especially evident in the distribution of highly infectious diseases. Structural violence as an analytical frame in this Article assists with identifying actors, actions, laws, policies, omissions, and partial and cumulative responsibility that might otherwise be unacknowledged. This Article provides a useful framework for how the concept of structural violence can be operationalized in law.

The concept of structural violence assists with apportioning partial responsibility. Accordingly, a key finding of this Article is that figuring out how international actors should account for structural violence is not at all straightforward. Traditional principles of international law perpetuate the fallacy that states can on their own cope with the problems created by globalization, including the increased incidence of infectious diseases like Ebola. Yet states are not self-sufficient, and this Article shows that the distribution of infectious diseases like Ebola is fundamentally conditioned in part by transnational actors and global institutions. As such, responsibility for addressing this structural violence must be shared across a wide range of actors.<sup>503</sup>

This Article concludes that reconceptualizing international responsibility would require a much more forward-looking approach than conventional approaches to responsibility. This shared approach to responsibility would encapsulate prospective obligations to aid or provide humanitarian and disaster relief. As such, this Article also finds that it is necessary to develop the emerging disaster risk reduction framework in international law to adequately address issues of structural violence witnessed with infectious disease like Ebola.

An expanded conceptualization of responsibility would mean that states, IOs, and other non-state actors would have a moral and undoubtedly contested legal duty to recognize and act upon the threats posed by structural violence. Past practices that led to structural violence impose an obligation to mitigate or remedy the harm caused.<sup>504</sup> This duty as applied to infectious diseases like Ebola would be based

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<sup>503</sup> See Lindsey N. Kingston & Saheli Datta, *Strengthening the Norms of Global Responsibility: Structural Violence in Relation to Internal Displacement and Statelessness*, 4 GLOBAL RESP. TO PROTECT 475, 478 (2012).

<sup>504</sup> See, e.g., Thomas Nagel, *The Problem of Global Justice*, 33 PHIL. & PUB. AFF. 113 (2005) (discussing the role of states to remedy inequities); Thomas W. Pogge, *Responsibilities for Poverty-Related Ill Health*, 16 ETHICS & INT'L AFF. 71, 72–74 (2002) (discussing the role of individual citizens within developed countries to remedy harm).

on not only principles of global justice,<sup>505</sup> but also legal obligations of international cooperation and duties under international human rights law. In addition, this obligation would be rooted in naked self-interest because highly infectious diseases do not respect borders. Ultimately, states are self-interested and do not want to see their “own people” die of Ebola or some other infectious disease.

In the end, it may be that state and non-state action is galvanized to fight pandemics not because of a recognition of the structural violence caused, nor necessarily because of humanitarian impulses or transnational solidarity, nor even because an actor accepts that it has violated an international duty. Instead, it may be that state and non-state action is motivated out of a shared self-interest. Accordingly, it is worth considering what possibilities exist for harnessing this shared self-interest to expand principles of international responsibility in a manner that reduces disasters and better addresses structural violence posed by infectious diseases. In sum, it is vital to reduce the responsibility and accountability gaps in international law, because ultimately “we must assume responsibility for the unintended and invisible consequences of our individual and collective doings.”<sup>506</sup>

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<sup>505</sup> There are several common objections to global justice claims. The most common is the idea that IOs lack the necessary underlying social context of a state for the application of justice— for example the idea of an international society is contested, such that discussions of justice are incoherent, because no community exists to support obligations of justice. Another view contends that global justice is meaningless, because there is not a global social contract to make the concept enforceable. An additional objection questions the existence of a normative consensus to support truly “global” perspectives on justice.

<sup>506</sup> Seyla Benhabib, *The Law of Peoples, Distributive Justice and Migrations*, 72 *FORDHAM L. REV.* 1761, 1780 (2004).