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Rapid response units under the BWC: benefits and challenges of putting a vision into action

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Ladies and gentlemen,

In my presentation I will touch upon some salient points of the mobile biomedical units concept whose examination is part of the BWC's intersessional programme of work under the cluster of Assistance, Response and Preparedness.

Before we proceed to the nitty-gritty, let me thank the organisers for the opportunity to share my perspective on this topic which for the past several years has been the focus of the Russian diplomatic effort.

It is also my great pleasure and privilege to be in the same session with Dr John Walker whose many contributions to the realm of arms control and disarmament are well recognised and whose sterling work has been a source of inspiration for many. Russia and the UK have been co-operating in the BWC on promoting the examination of the best way forward for emergency assistance and Article VII measures. Such a partnership has demonstrated that the BWC community can be effective once we commit to working together in good faith to achieve the objectives of this Treaty.

In terms of historical background, Russia introduced its initial concept papers on mobile biomedical units in 2016 in the preparatory process for the Eighth Review Conference. They were drawing heavily on the lessons learned, bad and good, by the international community in responding to the devastating Ebola outbreak in West Africa. On the invitation of one of the affected states, Guinea, Russia's Health Protection Agency/Rospotrebnadzor deployed its mobile laboratory and rapid reaction personnel to help in the mitigation and eradication effort. That mission lasted for more than a year and a half and reaffirmed the relevance of the doctrine, training and equipment employed by Russia for its domestic programme of infectious disease surveillance and response. Beyond that, it has also presented evidence of the utility of a capability of this kind in the international arena including in the field of the prohibition of biological weapons.

Let us look at the validity of such an argument.
To begin with, the use of biological weapons is likely to manifest itself in the spread of an infectious disease, potentially an epidemic that will require a robust public health response. Even with an effective verification regime which is nowhere in sight for this Treaty the risk of using biological agents as weapons cannot be completely discounted as regards states and especially non-state actors. An additional complexity exists due to the fact that the use of biological weapons may be carried out clandestinely to be disguised as a natural outbreak while the perpetrators depending on their calculus may or may not claim responsibility afterwards. The conclusion, therefore, is that whatever the overall BWC’s implementation architecture may be, assistance and protection capability should always complement prevention measures. It must be an additional safeguard should prevention fail and also deterrence to a would-be attacker creating credible defences against nefarious action.

Infectious outbreaks, natural or man-made, have a tendency to spread over time unless contained and suppressed by relevant authorities. The deficit of such urgent and robust action was keenly felt in West Africa's Ebola epidemic when insufficient national public health capacities quickly became overwhelmed by the scale and scope of the disease while the international community and the responsible agencies found it difficult to mobilise in a timely manner an effective emergency relief package. As a consequence, Ebola claimed more than 11,000 lives many of them otherwise could have been saved. The above narrative reinforces the rationale for a rapid reaction assistance mechanism under Article VII of the BWC.

In the past, Article VII implementation measures, modelled on the provisions of the Chemical Weapons Convention, were part of the Ad Hoc Group negotiations in 1995-2001 on a supplementary Protocol to the Convention. However, it did not come to pass. As a result, the issues have remained outstanding and topical as evidenced by the States Parties’ common understandings arrived at during the intersessional process.

With respect to Article VII, States Parties agreed that even where national capacity is strong, further international assistance may be required by the affected State Party. Such assistance should be provided rapidly to heal the sick and prevent the spread of infectious disease outbreak. Therefore, there is value in having such rapid response capability in advance of Article VII being invoked/before it is required along with the agreed mechanism for its deployment. Inadequacy of the current situation having been exposed in the light of many problems from the Ebola crisis in
West Africa reaffirmed the need of addressing the lack of ready operational capability. In this connection, States Parties noted with regret that there is no institutional mechanism under the Convention to undertake relevant activities. Consequently, they agreed to exploring what role, if any, the Implementation Support Unit should play within this mechanism and any additional resources for enabling such a role.

Relevant international actors active in emergency public health response may certainly be of help if and when an Article VII situation should occur. But the assurance of the availability of their resources and timeliness of delivery should not be taken for granted. It is noteworthy that the WHO prefers to distance itself from assuming any formal commitments to extending emergency assistance under the BWC and so it is incumbent upon States Parties themselves to address this task. This is a fair approach especially given the fact that the WHO does not possess a public health response capacity of its own but relies on the offers of its member states. Global Outbreak Alert and Response Network is one such voluntary endeavour whose action is based on the preparedness of its constituents to commit resources to the WHO-harmonised activities around the world. Unlike that, the provisions of Article VII constitute a legal obligation by all Parties to the Convention to provide or support assistance to the affected state. Therefore, a binding nature of the implementation is clear once the United Nations Security Council adopts the relevant decision.

It is evident from the common understanding by States Parties to the BWC, from activities at the relevant international fora such as the GOARN, and certainly from our respective national experiences that mobile biomedical units may a useful tool for the implementation of Article VII in terms of ensuring preparedness, assistance and response.

One illustrative example of a broad category of mobile units are Specialised Anti-epidemic Teams (SAET) operated by Russia's Health Protection Agency/Rospotrebnadzor. Being an integral part of the national anti-plague system they have accumulated a considerable amount of expertise in monitoring, evaluation and response under various conditions and situations including emergency environment.

Since 1963 when they were raised, such units have taken part in mitigating over 120 public health emergencies both nationally and abroad. Their operations are distinguished by high mobility, self-sufficiency, multi-purpose functionality, employment of high-tech equipment, observance of biosafety norms, modular deployment approach, and diversified training of their personnel.
Main areas of SAET activities include:

- laboratory diagnosis of infectious agents from human biomedical samples and analysis of environmental samples;
- determining cause-effect connection of outbreaks of infectious diseases of various etiology;
- development and implementation of emergency anti-epidemic measures;
- temporary substitution of depleted local public health personnel in emergencies.

Each of Russia's five regional anti-plague institutes has two mobile biomedical units. The unit’s complement is 35 staff who are mounted on heavy trucks including six specialised modules, among them a BSL-3 laboratory for the analysis of infectious samples. The purchasing cost of the full set of vehicles and equipment is around 3 million USD while annual maintenance cost is around 70,000 USD. In Russia's 2016 working paper we presented projections of financial implications of some operational scenarios, for instance - the deployment of a full strength Russian biomedical unit including vehicles and personnel by 10 flights of medium lift aircraft such as Ilyushin-76 to a distance of up to 5,000 km and its self-sustained operation in an emergency area for up to two weeks would cost around 440,000 USD.

While full strength deployment may be warranted by the seriousness of the situation on the ground, Russia has also developed and put into use a methodology for customised deployment of the unit's elements to respond to public health emergencies. Depending on the nature of a given situation, it allows to selectively dispatch personnel and supporting laboratory modules. Russian anti-plague institutes have facilities to train foreign personnel for public health work in emergency situations.

In the countries that have such a capability, rapid response biomedical teams are constituted differently in terms of their complement, capacities, deployability, etc. For instance, Russian ones are different from the UK's Public Health Rapid Support Team. What they have in common is that all units belonging to the category of quick reaction public health can complement each other and be useful in an Article VII situation or ensuring preparedness for it.
John has already spoken about the core elements of the effective Article VII response and mobile units have been identified by the UK and Russia as being part of that category.

If that is so, what are the options for the operationalisation of this concept? Over the past several years that the discussion on the topic has been under way two approaches have been identified and explored.

First, that mobile units may be established by States Parties centrally as part of a future BWC implementing body and its secretariat. The implication of that would be centralised recruitment of staff and its training, purchase of specialised equipment, office and storage arrangements, and sustainment of the programme from assessed contributions based on the UN scale of assessments. This is, of course, a very ambitious vision for the way ahead and to be feasible it requires a level of commitment by States Parties which is not available at the moment. A comparable centrally maintained capacity is not without precedents in other relevant fora and the OPCW’s Rapid Response Assistance Teams are one such example. Therefore, exploring that approach in the BWC is viable but at the same time its prospects are dependent upon a serious investment of political will which is a rare commodity in the biological arms control of today.

Another option, and the one that is gaining increased traction at the moment, is less far-reaching but at the same time more feasible in the prevailing environment. In essence, it envisages the assignment of nationally operated and funded rapid response biomedical teams to the BWC-maintained roster or database, be that the existing Co-operation and Assistance Database or a future Article VII database. Under the scheme, such units perform their nationally mandated tasks as part of their regular routine but are committed by the respective governments to also engage in the BWC related activities. The latter may include joint training exercises and building interoperability, equipment familiarisation, sharing best practices and lessons learned, capacity building in developing countries upon request, etc. Under the above scenario, additional costs implications of mobile units may be reduced and much of their BWC-related activities may be funded by voluntary contributions of the interested states. Should an Article VII situation be triggered, dispatching such teams to the affected area may become one way to implement States Parties' assistance and protection obligation under the BWC.

It is Russia’s view that further promoting and advancing dialogue on the existing and potential future applications of mobile biomedical units can be one of the areas of convergence among States
Parties to improve the implementation of the BWC. And we look forward to continuing the engagement with all interested parties with a view to arriving at a common understanding and effective action in this regard at the BWC's Ninth Review Conference in 2021.

Thank you.