Atlanta Urban Debate League

Pandemic AFF

High School Junior Varsity

2022 - 2023

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Pandemic 1AC (Argument Overview)

Summary

The Pandemic Affirmative contains five parts: a plan, Inherency, Solvency, a Disease Advantage, and a Biological Terrorism Advantage. The purpose of the Affirmative is to learn from the challenges of COVID-19 and help the North Atlantic Treaty Organization (NATO) prepare for the next pandemic. Specifically, the plan calls for the United States to increase its security cooperation with NATO to stockpile supplies, develop technology, and prepare logistical support for the next pandemic.

Inherency: Inherency is the problem in the status quo (the current state of things) that the affirmative plan will help to alleviate/fix and proof that the plan is not already being done. In this 1AC, the De Maio evidence says that NATO itself has admitted that the alliance was not prepared for COVID-19. In particular, the evidence concludes that the organization did not have the means or political will to respond to COVID-19.

Solvency: Solvency is proof of why the proposed plan will work and solve the harms/problems that would happen without the plan. In this 1AC, the Levy evidence says NATO can do three things to help prepare for the next pandemic. First, NATO can work through its Science & Technology Organization to develop technology and help with disease surveillance. Second, NATO can leverage its Science for Peace & Security program, which helped develop rapid COVID-19 tests during the pandemic. Third, the author concludes that NATO can help with logistics and supply stockpiles through its Euro-Atlantic Disaster Response Coordination Center.

Advantage (Disease): An advantage explains the benefits gained from doing the plan and is sometimes called “Harms” because the plan avoids something harmful that would happen in the status quo. Advantages end with an **Impact.**

In this 1AC, the Disease Advantage makes three claims. First, the Rogers evidence says that disease outbreaks are inevitable as more and more diseases jump from animals to humans. As a result, only new investment in public health can prevent the next pandemic. Second, the Levy evidence cites NATO’s success in responding to COVID-19 as proof that the organization should receive new investment. Third, the Wade evidence concludes that pandemic prevention is a racial justice issue, since people of color are significantly more likely to bear the costs of a pandemic.

Advantage (Biological Terrorism): An advantage explains the benefits gained from doing the plan and is sometimes called “Harms” because the plan avoids something harmful that would happen in the status quo. Advantages end with an **Impact.**

In this 1AC, the Biological Terrorism Advantage makes three claims. First, the Iftimie evidence says that the widespread impact of COVID-19 will create an incentive for terrorist groups to conduct biological attacks against NATO countries. Second, the second piece of Iftimie evidence says that NATO needs more investment to stockpile supplies, development technology, and expand biodefense programs to prevent biological terrorism. Finally, the Millett and Snyder-Beattie evidence concludes that as technology develops, it will be increasingly easy for terrorist groups to conduct deadly attacks.

Deterrence Disadvantage (Argument Overview)

Summary

The Deterrence Disadvantage contains four parts: Uniqueness, Link, Internal Link, and Impact. A Disadvantage argues that the costs of the Affirmative plan are more important than (outweigh) the potential benefits (advantages). In particular, the Deterrence Disadvantage argues that by forcing NATO to spend limited funds on public health, the plan trades off with NATO's core mission, which is protecting the alliance from foreign threats like Russia.

Uniqueness: Uniqueness is the argument that the status quo (current state of things) is good now but could take a turn for the worse if the plan were to happen. In the Deterrence DA, the Lasconjarias evidence says that COVID-19 has hurt the economy of European countries, leading to high levels of debt and smaller budgets. In fact, the author concludes that any further cuts to defense spending by European countries would harm the security of NATO.

Link: A link is the negative change to the status quo made by the Affirmative plan. In the Deterrence DA, the Ceccoruli evidence argues that NATO cannot do everything. By expanding NATO's mission to include public health concerns like pandemic prevention, the plan forces NATO to spend limited funds on items not related to deterrence. As a result, the plan trades of with NATO's core mission, which is to secure the alliance from foreign threats like Russia.

Internal Link: An Internal Link is the series of events that takes place between the change made by the plan (Link) and the ultimate negative consequence of that change (Impact). In the Deterrence Disadvantage, the Kochis et al. evidence says that Russia is a serious threat to the existence of NATO countries, and that NATO must refocus its spending on its core mission to deter future conflict.

Impact: An Impact is the ultimate negative consequence of the change to the status quo made by the plan. In the Deterrence Disadvantage, the Schlosser evidence says that the invasion of Ukraine proves that Russia is not only aggressive, but will be under pressure as the war drags on to attack NATO supply lines. The author concludes that this risks World War 3, especially given Russia's history of threatening nuclear attacks.

Public Health Disadvantage (Argument Overview)

Summary

The Public Health Disadvantage contains three parts: Unique-Link, Impact, and Turns Case. A Disadvantage argues that the costs of the Affirmative plan are more important than (outweigh) the potential benefits (advantages). In particular, the Public Health Disadvantage argues that the plan, by using a military alliance to respond to a pandemic, sets a precedent that allows the military to take over public health, which has historically been managed by civilian governments.

Unique-Link: Uniqueness is the argument that the status quo (current state of things) is good now but could take a turn for the worse if the plan were to happen. A link is the negative change to the status quo made by the Affirmative plan. In the Public Health Disadvantage, the first piece of Gibson-Fall evidence argues that many countries turned to their militaries for support during the pandemic. The plan, by having NATO take a leadership role in pandemic response, continues this trend and allows a global military takeover of public health.

Impact: An Impact is the ultimate negative consequence of the change to the status quo made by the plan. In the Public Health Disadvantage, the second piece of Gibson-Fall evidence argues that NATO frames the pandemic as a security threat. This transforms treating disease into fighting a war, which not only risks authoritarianism, but could increase tensions with other countries by increasing the scope of Western military deployments.

Turns Case: Turns Case is an argument that the impact to the disadvantage makes the harms of the Affirmative worse. In the Public Health Disadvantage, the final piece of Gibson-Fall evidence says that, given limited resources, militaries will use pandemic response as a justification to secure funding for themselves at the expense of civilian public health initiatives. As a result, the plan cannot solve the harms of the status quo because NATO pandemic response makes pandemic more likely.

Treaty Counterplan (Argument Overview)

Summary

The Treaty Counterplan contains three parts: Counterplan Text, Solvency, and Net-Benefit. A counterplan proposes an alternative policy to resolve the harms identified by the Affirmative. In particular, the Treaty Counterplan argues that international cooperation through a treaty supported by the World Health Organization is a better option than the plan to prepare for future pandemics and biological terror attacks.

Text: The Counterplan Text identifies the specific policy that the Negative will propose as an alternative means to resolve the Harms of the Affirmative. In the Treaty Counterplan, the Counterplan Text identifies that the member states of the World Health Organization should sign and ratify a treaty a treaty to prepare for future pandemics.

Solvency: Solvency is how the counterplan will resolve the harms of the Affirmative. In the Treaty Counterplan, the Bainimarama et al. evidence argues that a pandemic treaty will strengthen international cooperation and improve key initiatives like research, data-sharing, and vaccine production. In addition, the second piece of Bainimarama et al. evidence argues that international cooperation is critical to promote the development and universal distribution of vaccines, which is critical to stop future pandemics.

Net-Benefit: A Net-Benefit is a reason to prefer the counterplan over the plan. In the Treaty Counterplan, the net-benefit is that the counterplan does not link to the Deterrence DA and the Public Health DA. The Treaty Counterplan avoids the Deterrence DA since it does not expand NATO's mission or trade off with funding for defense budgets. The Treaty Counterplan avoids the Public Health DA since it does not use NATO (a military organization) to conduct public health policy and instead focuses on international public health institutions like the World Health Organization.

Racism Kritik (Argument Overview)

Summary

The Racism Kritik contains four parts: Link, Impact, Alternative, and Framework. A Kritik argues that the assumptions or mindset of the Affirmative are problematic and should be rejected in favor of an alternative way of thinking. In particular, the Racism Kritik argues that the disproportionate impact of covid-19 on racial and ethnic minorities proves that race-neutral public health policy like the plan continues a fundamentally unjust system. As a result, the Racism Kritik concludes that we should instead dismantle status quo institutions and create a new system of health care that promotes social justice.

Link: A Link is an example of how the Affirmative makes problematic assumptions or has a flawed mindset. In the Racism Kritik, the Devakumar evidence makes two arguments. First, acknowledging the disproportionate racial effects of the pandemic without taking concrete action to change the system allows white supremacy to continue. Second, race-neutral policies like the plan mask the structural inequality that is fundamental to public health policy.

Impact: An Impact is the ultimate negative consequence of the problematic assumption made by the Affirmative. In the Racism Kritik, the Devakumar evidence says that racism is a public health crisis for two reasons. First, the author cites studies that prove racial and ethnic minorities have worse health outcomes according to nearly every measure. Second, the evidence concludes that the trauma of racism not only leads to excess deaths and suffering, but also leads to intergenerational trauma that impacts future peoples.

Alternative: An Alternative is how one should resolve the problematic mindset or assumption of the Affirmative. In the Racism Kritik, the Devakumar evidence says that instead of continuing a deeply problematic system, we should instead dismantle systems of oppression and advocate for concrete change that promotes racial justice. As a result, the author concludes that solving systemic racism is a pre-requisite to effective public health policy.

Framework: Framework is an argument that the Judge should evaluate the debate in a specific way, and is usually provided as an alternative to traditional “cost-benefit analysis,” in which the benefits of the plan (advantages) are compared the costs of the plan (disadvantages). In the Racism Kritik, the Ndumbe-Eyoh evidence argues that the judge should vote for the team that best promotes racial justice. In particular, the author argues that racism is a system maintained by race-neutral education and public health policy. As a result, we have an obligation as students and educators to prioritize analysis of structural racism in order to transform public health.

Pandemic Affirmative (1AC Shell)

Pandemic 1AC — 1/8

Greetings! My partner and I propose the following plan:

> **The United States federal government should substantially increase its security cooperation with the North Atlantic Treaty Organization (NATO) to fully fund and support pandemic response and prevention programs under Article 3 of the Washington Treaty.**

Contention One is Inherency:

NATO is not prepared for the next pandemic. It lacks the funding and capacity to manage future crises

De Maio 2020 – Nonresident Fellow at the Brookings Institution

(Giovanna, Nonresident Fellow At The Brookings Institution. NATO's Response To COVID-19: Lessons For Resilience And Readiness. Foreign Policy at Brookings Institution. October 2020. https://www.brookings.edu/research/natos-response-to-covid-19-lessons-for-resilience-and-readiness/)

LESSONS LEARNED **A military alliance such as NATO is not a first responder in a health crisis**, as most tasks must be implemented at the domestic level. **However, given the impact** and the spillover effects **of COVID-19 on** the very day-to-day operations of **the alliance** — military personnel are not immune from viruses — **as well as** on supply chains, and **economies and societies around the world, it was paramount for NATO to take initiative** both **to protect its member states** against malign actors and to offer crucial support in the spirit of solidarity. **In spite of these** successful **initiatives, the Operations Division of NATO headquarters in Brussels has admitted**64 **that the alliance was ill-prepared to handle such a crisis.** As Rittimann noted, **the alliance lacked its own means and political bandwidth to do more.**65 **For this reason, NATO and its member states should not miss the opportunity that the COVID-19 crisis offers to set up more structured plans to ensure readiness in crisis management.** In particular, they should expand the concept of security to include the most pressing non-military global security threats: climate change, health risks, and social resilience against disinformation.

Contention Two is Solvency:

NATO programs are critical to pandemic prevention, but status quo support fails. Only the plan revitalizes NATO and prevents future crises

Levy 2021 – Leadership Fellow at the Atlantic Council

(Jaclyn, Millenium Leadership Fellow At The Atlantic Council And The Director of Public Policy At The Infectious Diseases Society of America. The Best Defense: Why NATO Should Invest In Resilience. New Atlanticist. June 10, 2021. https://www.atlanticcouncil.org/blogs/new-atlanticist/the-best-defense-why-nato-should-invest-in-resilience/)

NATO should start advancing resilience by leveraging and strengthening **the following** policies, **programs,** and partnerships**: The NATO Science & Technology Organization (STO) develops** innovative **solutions with** global **experts to ensure** that **the Alliance's technological capacity meets its needs** in a quickly changing world. Allied governments contributed approximately 500 million euros to STO last year, forming a pool of already-allocated funding that could support resilience-building efforts. **To advance** and sustain **technological innovation** that enhances global resilience, **the STO**'s Science and Technology Board **should push for** a sustained allocation of **funding** specifically **for** resilience research, **biomedical research** and development, **and** ambitious pilot **programs focused on** sharing **pathogen surveillance** data between countries and their health systems, **developing** biomedical **research** infrastructure, **and conducting training** simulations **for** biothreat and **public-health emergencies. The NATO Science for Peace and Security (SPS) Programme**, as defined by the Alliance, promotes dialogue and cooperation "based on scientific research, technological innovation, and knowledge exchange. [It] offers funding, expert advice and support to… security-relevant activities that respond to NATO's strategic objectives." During the pandemic, SPS **led efforts to** advance the **develop**ment of **rapid COVID-19 tests**. In the future, **SPS should invest in ways to** identify and **combat** swiftly **rising global antimicrobial resistance**, **synthetic** biology **threats**, and agricultural vulnerabilities; **it should also invest in** assessments and fortifications of medical and **biosecurity stockpiles. The Euro-Atlantic Disaster Response Coordination Centre (EADRCC) has experience supporting responses to infectious-disease outbreaks,** which threaten to increase as a consequence of climate change, industrialization, and global migration. **EADRCC** activities **leverage emerging technologies to enhance resilience and build capacities for crisis response**. Previous joint exercises with the SPS Program have included testing innovative telemedicine and communications platforms. **EADRCC's successful logistical coordination during the COVID-19 pandemic underscores its unique value; in the future, the EADRCC should expand its role in international cooperation and information-sharing between military medical services and civilian health systems.** The Joint Chemical, Biological, Radiological, and Nuclear Defence (JCBRN) Centre of Excellence, a NATO military body focused on CBRN defense advice, education, training, and exercises, can convene member states and partners for training simulations and security activities related to novel threats in the context of regional and global issues. JCBRN should act on this capacity, in coordination with the Crisis Management and Disaster Response Centre of Excellence, to ensure that NATO member countries are prepared to combat future outbreaks and biological events. **Strengthening bio-preparedness** efforts **through modeling and planning will help drive** a resilient **crisis response**. Established during the pandemic, **the NATO Pandemic Response Trust Fund** stockpiles medical equipment and supplies for members of the Alliance and partners in need. Beyond the current pandemic, it **can** help **defend against future** chemical, biological, radiological, nuclear, and public-health **threats—only if NATO maintains and adapts these stockpiled resources for** other **critical public-health** and infrastructure **needs.** Looking ahead, the NATO 2030 initiative aims to elevate democratic leadership around the world, advance biomedical science and global technology, and position NATO and its partners to tackle novel global security challenges through a lens of flexibility and adaptation. **Strategic investments** in these efforts **will establish resilient frameworks for addressing emerging threats**, **which is critical for successful collective defense. Realizing the full potential of these** and other **programs will require additional support** from NATO operations, planning, policy, and civilian divisions. **Allies** and international organizations **should** also **continue working with NATO on the ground** to support equipment procurement and regional needs. In today's unpredictable security environment, successfully responding to threats requires resilience—and **NATO is well-positioned to make resilience a reality.**

Advantage One is Disease:

First, disease outbreaks are inevitable. Only investment in public health can prevent the next pandemic and save millions of lives

Rogers 2022 – Journalist For CNN Health

(Kristen, Journalist For CNN Health. There Will Be Another Pandemic, Infectious Disease Experts Say. Here Are 6 Ways We Can Prepare For It. CNN Health. June 1, 2022. https://www.cnn.com/2022/06/01/health/prepare-for-next-pandemic-life-itself-wellness/index.html)

More than **two years into the** Covid-19 **pandemic**, **we have reached a crossroads**. On one hand, "**this is the most teachable moment the world has had about** the importance of **public health in 100 years**," said Dr. Tom Frieden, former director of the US Centers for Disease Control and Prevention. "On the other hand, **we're** really **at risk of heading full steam ahead into the** neglect phase of the **'panic-neglect cycle.**' " The panic-neglect cycle is the habit of underinvesting or paying inadequate attention to the public health infrastructure and functions needed to prevent, identify, contain and respond to infectious disease outbreaks. **Another pandemic seems inevitable. We "live in an age of pandemics,"** said Dr. Larry Brilliant, an epidemiologist and CEO of Pandefense Advisory, an interdisciplinary network of experts engaged in pandemic response. **More than six out of every 10 infectious diseases originated in animals and jumped to humans**. **This risk has "been increasing for the last 20 years,"** Brilliant said. **"Every year, the risk increases more."** Public health "certainly had a number of missteps" during the Covid-19 pandemic, but the experience has offered lessons, Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, said at the Life Itself conference, a health and wellness event presented in partnership with CNN. "The **investment in** basic and clinical **biomedical research allowed us to, with unprecedented speed, develop highly effective vaccines** that essentially, (we never would) have imagined you could have done it that quickly," he added. "**We need to keep making those investments, not only in science ... but in** the **public health infrastructure.**" We must also remember "what it means to have a public health system that was not able to respond in a manner that was matching to the challenge that we're facing," he said. "What we don't want is to have our children, and perhaps our grandchildren, forget what we've been through." **Whether we're going to apply lessons from the current pandemic remains to be seen**, Frieden said, **but doing so is key to ending that cycle, so that outbreaks don't become pandemics with countless consequences -- including millions of lives lost and drastic effects on health care, mental health, the economy, education, relationships and careers.**

Second, NATO investment under Article 3 solves. Preparation for the next pandemic is key

Levy 2021 – Leadership Fellow at the Atlantic Council

(Jaclyn, Millenium Leadership Fellow At The Atlantic Council And The Director of Public Policy At The Infectious Diseases Society of America. The Best Defense: Why NATO Should Invest In Resilience. New Atlanticist. June 10, 2021. https://www.atlanticcouncil.org/blogs/new-atlanticist/the-best-defense-why-nato-should-invest-in-resilience/)

There are many lessons from the last fifteen months, but among them is a time-honored proverb: **an ounce of prevention is worth a pound of cure.** Many **public-health** and security **crises are a product of** critical **infrastructure vulnerabilities**, **but a**n expanded **focus on resilience** in developing a global security strategy **can prevent the next crisis. Responding to** emergencies such as **pandemics is far more expensive than preventing them** and creates additional costs such as strained political cohesion and waning support for public institutions. Policies emphasizing resilience should fundamentally aim to minimize damage, restore stability quickly, and generate improved strategies for similar issues. To this end, there are several steps NATO can take to build a preventive, resilience-based approach to emerging global challenges. **Article 3 of the North Atlantic Treaty includes resilience as a critical element of its mission to achieve collective defense, and the Alliance supports multiple programs to build resilience against non-traditional threats.** At its 2016 Warsaw Summit, NATO committed to "continue to enhance our resilience against the full spectrum of threats, including hybrid threats, from any direction," and added that "resilience is an essential basis for credible deterrence and defence and effective fulfilment of the Alliance's core tasks." In June, NATO Secretary General Jens Stoltenberg said during an appearance at the Atlantic Council that a critical part of the Alliance's agenda over the coming decade is to support "resilience technologies." The COVID-19 pandemic has made clear NATO's value in an unpredictable world. **In 2020, NATO troops supported civilian efforts to combat the spread of COVID-19 by airlifting patients and** medical **equipment, building** field **hospitals, distributing supplies**, repatriating civilians, **establishing quarantine facilities** and triage centers, assisting with decontamination, **and sharing** medical **expertise. After this pandemic** recedes, **NATO**'s proposals for responding to biothreats and other novel challenges **should include investments in resilience to help combat "black swan" events, which may turn** existing **health** or environmental **emergencies into security crises.** "**Resilient societies are our first line of defense,"** said NATO Deputy Secretary General Mircea Geoană in December, adding that "**we have to put a much greater emphasis on resilience"** across government, the private sector, and civil society.

Third, pandemic prevention is key to racial justice. Systemic racism means people of color are uniquely at risk

Wade 2020 – Contributing Correspondent at Science Magazine

(Lizzie, Contributing Correspondent for Science. From Black Death To Fatal Flu, Past Pandemics Show Why People On The Margins Suffer Most. Science Magazine. May 14, 2020. https://www.science.org/content/article/black-death-fatal-flu-past-pandemics-show-why-people-margins-suffer-most)

But careful archaeological and **historical work** at East Smithfield and elsewhere **has revealed** that intersecting **social and economic inequalities shaped the course of the Black Death and other epidemics**. "Bioarchaeology and other **social sciences have repeatedly demonstrated** that **these** kinds of **crises play out along the** preexisting **fault lines of** each **society,"** says Gwen Robbins Schug, a bioarchaeologist at Appalachian State University who studies health and inequality in ancient societies. **The people at greatest risk were often those already marginalized**—the **poor and minorities who faced discrimination in ways that damaged their health or limited their access to medical care** even in prepandemic times. In turn, the pandemics themselves affected societal inequality, by either undermining or reinforcing existing power structures. **That reality is on stark display during the COVID-19 pandemic.** Although **the disease** has memorably struck some of the world's rich and powerful, including U.K. Prime Minister Boris Johnson and actor Tom Hanks, it **is not an equal-opportunity killer**. **In** hard-hit **New York City, Latino and black people have been twice as likely to die from COVID-19 as white people. Cases** there **have been concentrated in poorer ZIP codes, where people** live in crowded apartments and **can't work from home or flee to vacation homes.** "The ways that **social inequalities** are manifested … **put people at higher risk,**" says Monica Green, an independent historian who studies the Black Death. "**We should all be learning in our bones, in a way that will never be forgotten, why [the coronavirus pandemic] has happened the way it has."**

Advantage Two is Biological Terrorism:

First, status quo risk of biological terrorism is increasing. We're not prepared for future attacks

Iftimie 2020 – Visiting Scholar at the NATO Defense College

(Ion A., Visiting Scholar at the NATO Defense College. The implications of COVID-19 for NATO's counter-bioterrorism. COVID-19: NATO in the Age of Pandemics. NATO Defense College. 2020. https://www.jstor.org/stable/resrep25148.12)

NATO biodefence and deterrence in the post-COVID-19 security environment **The negative** social and economic **implications of** the **COVID-19** crisis **will result in growing intent by terrorist groups to use biological agents against NATO member states** for the purpose of achieving their goals. **In the words of** the **UN Secretary-General** Antonio **Guterres, "the weaknesses and lack of preparedness exposed by this pandemic provide a window onto how a bioterrorist attack might unfold – and may increase its risks"**.7 **Terrorist organizations in the Middle East and North Africa** (MENA) **region are already describing COVID-19 as a weapon** "used by God" against the enemies of Islam (or against the "crusaders"). **The resulting increase in the threat of bioterrorism** – that is, **the "deliberate release of viruses, bacteria, or other germs (agents) used to cause illness or death** in people, animals, or plants"8 – **also means that NATO's collective capabilities to defend against any future spread of biological agents are expected to be significantly enhanced.**

Second, NATO is key to respond to biological terrorism, but status quo investment isn't enough. Only the plan can revitalize NATO and protect the alliance

Iftimie 2020 – Visiting Scholar at the NATO Defense College

(Ion A., Visiting Scholar at the NATO Defense College. The implications of COVID-19 for NATO's counter-bioterrorism. COVID-19: NATO in the Age of Pandemics. NATO Defense College. 2020. https://www.jstor.org/stable/resrep25148.12)

Revisiting NATO's collective biodefence awareness, capabilities and engagements As part of its forward-looking reflection process, **NATO would be well-advised to pay** particular **attention to the growing bioterrorist threat** in the **post-COVID-19** security environment. This implies to continue to improve NATO's situational awareness of the bioterrorist threat, its capabilities to address it and its international engagements, in line with the 2012 Chicago Summit decisions. As seen above, **NATO can complement national** situational **awareness through surveillance, intelligence-sharing and risk assessments that are vital for NATO biodefence.** Initial dysfunctional and uncoordinated responses of the Allies to the COVID-19 pandemic highlighted, however, that much more can be done in the areas of cooperation, information sharing and identification of emerging biological threats. **NATO's capabilities and rapid response times must also be enhanced. NATO has extensive experience with combating epidemics and pandemics, responding to terrorist attacks and CBRN incidents, and protecting critical infrastructure**. But the failure of most Allies to meet the 2 percent threshold on defence spending also resulted in fewer capabilities to address the growing bioterrorist threat in the post-COVID-19 security environment. Already, **NATO's inability to invest in building a stockpile of medical equipment impacted responses to the current bio-crisis**. **Increased investments in medical and technical capabilities, and in databases/systems developed and maintained by NATO are critical to further enhance situational awareness, command and control, interoperability and synchronization efforts between Allies during future bioterrorist attacks.** Furthermore, NATO must continue to grow its engagements with both national as well as regional entities (such as the EU Emergency Response Coordination Centre) and international ones (such as the UN Office for the Coordination of Humanitarian Affairs) that can supplement national biodefence efforts. **Its cooperation mechanisms for collective biodefence, as seen with requests received by the EADRCC during the COVID-19 pandemic, ensure that Allies can assist each other with both situational awareness and capability development.** Through these national, regional and international engagements, NATO can further strengthen both its presence and posture leading to increased bioterrorism defence and deterrence. Similarly, the various partners and joint practices involved help improve interoperability in countering bioterrorism activities. Finally, NATO's ability to conduct well-coordinated strategic communication campaigns to combat disinformation must be consolidated, as such disinformation may weaken the effectiveness of both defence and deterrence efforts, including in combating CBRN threats. ***Conclusion*** NATO's recent responses during terrorist attacks, chemical incidents, epidemics and the COVID-19 pandemic illustrate the role of the Alliance in ensuring collective biodefence and deterrence. In these end states, the Allies will continue to play the most central role. However, NATO's own mandate for biodefence and deterrence means that the Alliance should be prepared (if called upon) to assist members and partner nations during growing threats in the biosphere or in the germs domain, recently described by the Commander of the Allied Joint Force Command in Naples as the "7th domain of warfare".20 **While NATO's responses during** the **COVID-19** crisis **attest** to the fact **that Allies** and partner nations **are** probably **better off with NATO's** support **to** deter and **defend from future bioterrorist attacks** than without it – **more must be done to ensure that the Alliance is fully prepared to respond to biological attacks** across the whole spectrum of operations. **Enhancing NATO**'s complementary situational awareness, capabilities and engagements, as agreed upon during the 2012 Chicago Summit, **is critical** in at least four lines of effort identified in this chapter: first, to prevent the increase in intent and capabilities of terrorist entities; second to pursue indicators and warnings of bioterrorism activities; third **to protect civilians and critical infrastructure of NATO members** (and partner nations); **and** fourth **to prepare for future bioterrorism attacks**. The post-COVID-19 crisis era offers a good moment for lessons to be identified and learned, and for these issues to be actively considered and acted upon, for the next biological attack may be even more deadly and destabilizing.

Third, biological terrorism risks extinction. Non-state actors are a critical threat

Millett and Snyder-Beattie 2017 – Researchers at the University of Oxford

(Piers, Senior Research Fellow At The University of Oxford. Andrew, Director of Research At The Future of Humanity Institute AT The University of Oxford. Existential Risk and Cost-Effective Biosecurity. Health Security. 2017, August 1; 15(4) 373-383. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5576214/)

While these arguments point to a very small risk of human extinction, they do not rule the possibility out entirely. Although rare, **there are recorded instances of species going extinct due to disease**—primarily in amphibians, but also in 1 mammalian species of rat on Christmas Island.7,8 **There are** also **historical examples of large human populations being almost entirely wiped out by disease**, especially when multiple diseases were simultaneously introduced into a population without immunity. **The most striking examples** of total population collapse **include native American tribes exposed to European diseases**, such as the Massachusett (86% loss of population), Quiripi-Unquachog (95% loss of population), and the Western Abenaki (which suffered a staggering 98% loss of population).9 **In the modern context**, no single disease currently exists that combines the worst-case levels of transmissibility, lethality, resistance to countermeasures, and global reach. But many diseases are proof of principle that each worst-case attribute can be realized independently. For example, **some diseases exhibit nearly a 100%** case **fatality ratio** in the absence of treatment, such as rabies or septicemic plague**. Other diseases** have a track record of **spread**ing **to virtually every human community worldwide,** such as the 1918 flu,10 and seroprevalence studies indicate that other pathogens, such as chickenpox and HSV-1, can successfully reach over 95% of a population.11,12 Under optimal virulence theory, natural evolution would be an unlikely source for pathogens with the highest possible levels of transmissibility, virulence, and global reach. But **advances in biotechnology might allow the creation of diseases that combine such traits.** Recent controversy has already emerged over a number of scientific experiments that resulted in viruses with enhanced transmissibility, lethality, and/or the ability to overcome therapeutics.13-17 Other experiments demonstrated that mousepox could be modified to have a 100% case fatality rate and render a vaccine ineffective.18 In addition to transmissibility and lethality, studies have shown that other disease traits, such as incubation time, environmental survival, and available vectors, could be modified as well.19-21 Although these experiments had scientific merit and were not conducted with malicious intent, their implications are still worrying. This is especially true given that there is also a long historical track record of state-run bioweapon research applying cutting-edge science and technology to design agents not previously seen in nature. The Soviet bioweapons program developed agents with traits such as enhanced virulence, resistance to therapies, greater environmental resilience, increased difficulty to diagnose or treat, and which caused unexpected disease presentations and outcomes.22 Delivery capabilities have also been subject to the cutting edge of technical development, with Canadian, US, and UK bioweapon efforts playing a critical role in developing the discipline of aerobiology.23,24 While there is no evidence of state-run bioweapons programs directly attempting to develop or deploy bioweapons that would pose an existential risk, the logic of deterrence and mutually assured destruction could create such incentives in more unstable political environments or following a breakdown of the Biological Weapons Convention.25 The possibility of a war between great powers could also increase the pressure to use such weapons—during the World Wars, bioweapons were used across multiple continents, with Germany targeting animals in WWI,26 and Japan using plague to cause an epidemic in China during WWII.27 **Non-state actors may** also **pose a risk,** especially those with explicitly omnicidal aims. While rare, there are examples. **The Aum Shinrikyo cult in Japan sought biological weapons for the express purpose of causing extinction**.28 **Environmental groups,** such as the Gaia Liberation Front, **have argued** that "**we can ensure Gaia's survival only through the extinction of the Humans as a species** … we now have the specific technology for doing the job … several different [genetically engineered] viruses could be released"(quoted in ref. 29). **Groups such as R.I.S.E. also sought to protect nature by destroying most of humanity with bioweapons**.30 Fortunately, **to date, non-state actors have lacked the capabilities needed** to pose a catastrophic bioweapons threat, **but this could change in future decades as biotechnology becomes more accessible** and the pool of experienced users grows.31,32

Pandemic Affirmative (2AC)

2AC Case (Disease)

Outbreaks are inevitable. Only investment in public health can make COVID-19 the last pandemic

Gates 2022 – Co-Founder of Microsoft

(Bill, Co-Founder of Microsoft / Billionaire Philanthropist. Let's Make This The Last Pandemic. GatesNotes: The Blog of Bill Gates. May 2022. https://www.gatesnotes.com/How-to-Prevent-the-Next-Pandemic)

The great epidemiologist Larry Brilliant once said that "**outbreaks are inevitable, but pandemics are optional**." I thought about this quote and what it reveals about the COVID-19 pandemic often while I was working on my new book. On the one hand, it's disheartening to imagine how much loss and suffering could've been avoided if we'd only made better choices. **We are** now more than **two years into the pandemic. The world did not prioritize global health until it was too late, and the result has been catastrophic. Countries failed to prepare** for pandemics, **rich countries reduced funding for R&D, and most governments failed to strengthen their health systems**. Although we're finally reaching the light at the end of the tunnel, COVID still kills several thousand people every day. On the other hand, Dr. Brilliant's quote makes me feel hopeful. **No one wants to live through this again—and we don't have to. Outbreaks are inevitable, but pandemics are optional.** The world doesn't need to live in fear of the next pandemic. **If we make key investments that benefit everyone, COVID-19 could be the last pandemic ever.**

The threat of biological terrorism has never been greater

Lalwani et al. 2021 – Staff Editor at Foreign Affairs

(Nikita, Staff Editor At Foreign Affairs. Alasdair Phillips-Robins, Hansell Fellow At The Center For Global Legal Challenges At Yale Law School. Sam Winter-Levy, Ph.D. Candidate In Politics At Princeton University. A Pandemic Isn't The Only Kind of "Catastrophic Risk." It's Time To Prepare More Seriously For The Next. Just Security. June 15, 2021.
https://www.justsecurity.org/76824/a-pandemic-isnt-the-only-kind-of-catastrophic-risk-its-time-to-prepare-more-seriously-for-the-next/)

Bioterrorism and Biological Warfare **Natural pandemics are not the only biological threat.** **As early as 600 B.C.E., armies were using primitive biological weapons** — "filth and cadavers, animal carcasses, and contagion" — against their enemies. During the Middle Ages, an attacking Tartar force, weakened by an epidemic of the plague, weaponized their dead by throwing the bodies into the city they were besieging to start an outbreak there. **In the last century, biological weapons have become far deadlier and easier to manufacture. During the Cold War, the Soviet Union maintained the world's largest biological weapons program**, employing over 50,000 people at more than 50 production facilities, including one near Yekaterinburg that leaked spores of anthrax that may have killed up to 105 people in 1979. **Such weaponry might be child's play compared with the capabilities that exist today.** **In 2016,** for example, **virologists** in Edmonton, Canada, **synthesized** the now-extinct **horsepox virus** in six months **from genetic materials they ordered in the mail**. The whole operation cost about $100,000, and scientists said that a **similar method could be used to manufacture smallpox, one of history's deadliest diseases.** North Korea, meanwhile, has at least 10 facilities it appears to be using to research and produce various biological agents, including those responsible for the plague and hemorrhagic fevers. And **the gene editing tool CRISPR is likely to make the creation of biological weapons even easier.** As Alan Shaffer, then the deputy undersecretary of defense for acquisition and sustainment, told Congress last year, "**Science is revealing the means to weaponize biology and chemistry in ways that were purely theoretical only 10 years ago."**

First, disease outweighs war. The benefits of the plan are greater than the costs

Lodovico and Sabeti 2022 – Researchers At Harvard

(Yolanda, Policy Lead in The Sabeti Lab At The Broad Institute of MIT and Harvard. Pardis, Professor of Biology At Harvard. Breakthrough Technologies for Pandemic Preparedness. Breakthrough: The Promise of Frontier Technologies for Sustainable Development. P. 23 – 46. The Brookings Institution. Note: This evidence has been modified for grammar.)

Even **before the next** outbreak or **pandemic strikes, immediate action** to advance the recommendations of both panels are **[is] critical** for a number of reasons. Most evidently, **infectious disease has generated more personal and economic devastation than any war in modern history. Every year, the impacts of annual infections eclipse those of all major wars, but traditional defense budgets, including that of the United States, contribute very little to combating the** bioterror **threat posed by infectious pathogens**. **The cost of crisis response**, once a major outbreak hits, **far exceeds that of building resilient health systems for pandemic preparedness.** In 2016, the Commission on a Global Health Risk Framework for the Future explained why an additional US$4.5 billion dedicated to pandemic preparedness each year would considerably improve global resilience against infectious disease.5 By comparison, **the 2014–16 Ebola outbreak in West Africa cost** an estimated US**$53 billion** in economic losses **and 11,300 deaths.**6 **One year into the COVID-19 pandemic, estimated economic losses thus far have reached several trillions of dollars and deaths have surpassed 4 million,** with extensive morbidity beyond.7,8

Second is non-unique: NATO spending has skyrocketed after Russia's invasion of Ukraine

Mackenzie 2022 – Journalist for Breaking Defense

(Christina, Journalist For Breaking Defense. Seven European Nations Have Increased Defense Budgets In One Month. Who Will Be Next?. Breaking Defense. March 22, 2022.
https://breakingdefense.com/2022/03/seven-european-nations-have-increased-defense-budgets-in-one-month-who-will-be-next/)

The war in Ukraine has been a strong wake-up call for a number of **European countries who'd been** basking in post-Cold War comfort **thinking that** armed conflict was relegated to history and that **spending on defense could be minimal. The turnaround since Russia's Feb. 24 invasion of Ukraine has been nothing less than stunning, to the point that six NATO members have now pledged defense increases of $133 billion so far**; **militarily neutral Sweden has also pledged an increase**. **And more nations seem poised to follow suit in the days and weeks to come. The first to make a 180° turnaround was Germany. Just four days after Russia's invasion began, Chancellor** Olaf **Scholz announced his government would ramp up its defense spending in 2022 alone by** €100 billion **($112 billion)** taking defense spending from 1.53% of GDP to above 2%. That is the figure recommended by NATO estimated to have been only met in 2021 by the US, Greece (3.82%), Croatia (2.79%), the United Kingdom (2.29%), Estonia (2.28%), Latvia (2.27%), Poland (2.10%), Lithuania, (2.03%), Romania (2.02%) and France (2.01%), according to NATO statistics. (That Germany had not met that threshold was a major political sticking point during the Trump administration, leading to tensions between Washington and Berlin.)

Third, no link. NATO pandemic response does not trade off with deterrence

Jovic-Lazic 2021 – Senior Research Fellow

(Ana, Senior Research Fellow At The Institute Of International Politics And Economics. The COVID-19 Pandemic And Its Impact On NATO. International Organizations And States' Response To COVID-19. Article 8 (p. 145-161). https://doi.org/10.18485/iipe_response2covid19.2021.ch8)

According to the Special Report of the Defense and Security Committee of the NATO Parliamentary Assembly from November 2020, **NATO's pandemic crisis response policy does not jeopardize its ability to provide credible and effective deterrence** and that its forces remain on alert in case of an attack. Also, as further stated, **missions and operations critical to the Alliance's security are fully staffed and focused on fulfilling their goals** (Mesterhazy, 2020). **For the Alliance, it was critical to demonstrate to the international community and its allies that NATO used its capabilities and resources to directly participate in the fight against COVID-19 while also remaining ready to fulfil its primary missions of collective defence, crisis management, and cooperative security** (NATO, April 2020).

Fourth, no impact. Putin won't risk nuclear escalation with the West

Vershbow and Lodal 2022 – Researchers at the Atlantic Council

(Alexander, Distinguished Fellow At The Atlantic Council. Jan, Former President of The Atlantic Council. Will Putin Use Nuclear Weapons In Ukraine? Our Experts Answer Three Burning Questions. Atlantic Council. May 10, 2022. https://www.atlanticcouncil.org/blogs/new-atlanticist/will-putin-use-nuclear-weapons-in-ukraine-our-experts-answer-three-burning-questions/)

In my view, **the probability is very low**—not zero, but less than 5 percent. **Putin's nuclear saber-rattling has been aimed at deterring the United States and its allies** from escalating their involvement in the war and introducing advanced military capabilities that could give Ukrainian forces a decisive advantage. **If Russian forces suffered another humiliating defeat** in the campaign to control [the southeastern Ukrainian region of] Donbas, **Putin could be pressed by hardliners** to deliver on his nuclear threats; **but he is unlikely to do so, since this would only galvanize a harsh US and allied response without providing any significant military advantage**. **Even in the wake of a major military setback, Putin would not likely run the risk of uncontrolled escalation by being the first to break the nuclear taboo**. He is more likely to escalate conventional attacks on Ukrainian civilians and infrastructure, as well as against allied [weapons] resupply operations. —Alexander Vershbow is a distinguished fellow at the Council's Scowcroft and Eurasia centers, served as US ambassador to Russia from 2001 to 2005, and was deputy secretary general of NATO from 2012 to 2016. **The likelihood is very low. Nuclear deterrence works in peacetime, and it has worked to prevent the use of such weapons in past crises and confrontations (such as in Cuba, on the Korean peninsula, and in Vietnam).** —Jan Lodal is a distinguished fellow at the Scowcroft Center and was president of the Atlantic Council from 2005 to 2006.

First, non-unique. Military pandemic response has been happening for years

Kalkman 2020 – Professor of Military Sciences

(Jori Pascal, Professor of Military Sciences At The Netherlands Defence Academy. Military Crisis Responses To COVID-19. Journal Of Contingencies And Crisis Management. September 27, 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7537208/)

The militarization of COVID-19 is not unprecedented. Earlier disease outbreaks have been coined in security terms by employing wartime discourse. **This happened during outbreaks of Ebola** (Roemer-Mahler & Elbe, 2016; Walsh & Johnson, 2018), **Asian influenza** (Curley & Herington, 2011), **Zika** (Wenham & Farias, 2019), **pandemic influenza** (Kamradt-Scott & McInness, 2012; Watterson & Kamradt-Scott, 2016) **and in response to the spread of HIV/AIDS** (Sjöstedt, 2008). **And if there is an "enemy" to be "fought" in "battle" or "war," which organization would be better suited to take the lead than the military? During the Ebola crisis, Liberia and Sierra Leone activated their armed forces, while Western governments likewise deployed thousands of military units** (Roemer-Mahler & Elbe, 2016). **In response to the Zika crisis, the Brazilian military was also sent onto the streets to "combat" the "enemy,"** while simultaneously signalling the gravity of the situation to the population (Wenham & Farias, 2019). Indeed, **the framing of an infectious disease outbreak in military terms has legitimized military involvement in the past and has done so as well during the COVID-19 outbreak.**

Second, no impact and turn: Military pandemic response is good. Three warrants:

A. **No tradeoff. The plan supports civilian public health**

Kalkman 2020 – Professor of Military Sciences

(Jori Pascal, Professor of Military Sciences At The Netherlands Defence Academy. Military Crisis Responses To COVID-19. Journal Of Contingencies And Crisis Management. September 27, 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7537208/)

One main **motivation for deploying armed forces in response to the COVID-19 outbreak is the fact that armed forces have specific capabilities that civilian health agencies lack** (in sufficient quantity). The examples in the opening paragraph show that **armed forces have specific expertise and slack resources that can crucially support and complement civilian response endeavours. Medical facilities and services are easily overwhelmed when a pandemic breaks out, while armed forces are capable of rapidly mobilizing significant (medical) resources and are comparatively well-organized to operate under conditions of uncertainty and stress.** In addition, they may conduct activities that contribute to the health efforts but fall outside the scope of health organizations (e.g. enforcing a lockdown) (Watterson & Kamradt-Scott, 2016). In other words, the COVID-19 crisis resulted in a need for military assistance.

B. Crisis response. Only militaries have the capacity to respond rapidly

Watterson and Kamradt-Scott 2016 – Public Health Researchers

(Christopher, Research Fellow At The Centre For Science At Security Studies At King's College London. Adam, Professor of Global Public Health At European University Institute. Fighting Flu: Securitization And The Military Role In Combating Influenza. Armed Forces & Society. 2016. Vol. 42 (1): 145-168. https://journals.sagepub.com/doi/full/10.1177/0095327X14567364)

Militaries also stand to **make significant contributions to pandemic response measures**, **where their capacity to marshal resources and expertise can ameliorate civil efforts to contain outbreaks.** The onset of **pandemics can rapidly overwhelm medical facilities**, **upset logistics and supply chains, interrupt essential services, and** in severe cases **lead to the breakdown of public order**.123 **The operational self-sufficiency, capacity to rapidly mobilize, and independent medical capabilities that are essential to armed forces will also make them preferred agents for emergency relief in the event of a**n influenza **pandemic,**124 **particularly where the requirements of the emergency go beyond the standing capabilities of the public health sector**, or fall outside the usual remit of such actors, for example in mollifying civil disobedience.

C. Global disease surveillance and response

Watterson and Kamradt-Scott 2016 – Public Health Researchers

(Christopher, Research Fellow At The Centre For Science At Security Studies At King's College London. Adam, Professor of Global Public Health At European University Institute. Fighting Flu: Securitization And The Military Role In Combating Influenza. Armed Forces & Society. 2016. Vol. 42 (1): 145-168. https://journals.sagepub.com/doi/full/10.1177/0095327X14567364)

How then, do such concerns play out in the international response to pandemic influenza? **Governments around the world are increasingly engaging their military forces in influenza planning and preparation**,116 **surveillance,**117 **research**,118 **response,**119 **and mitigation**.120 Should such efforts be endorsed? Or do they present, as the criticisms hold, an unacceptable risk to public health outcomes and a drain on limited military resources? This article has sought to add perspective to this debate by drawing on the historical record to demonstrate where **militaries have, historically, had both a positive role to play** in fighting influenza and an independent interest in doing so. Though the role of militaries in fighting pandemic influenza was somewhat diminished in the post–World War II era, **the current reengagement of armed forces presents a number of opportunities to draw on the demonstrable strengths of these forces to the mutual benefit of both public and military health**. **One such example** is in the field of **influenza surveillance, where militaries are able to** strengthen the GISN (now renamed GISRN) by **providing additional reach in remote or insecure areas through sample collection and strain identification activities at military outposts**. **Indeed, the WHO has advocated for the integration of international medical military facilities into its global surveillance networks on the basis that military laboratories are often better equipped than civilian equivalents, particularly in developing nations**.121 **One example** of such activity **is the US Department of Defense Global Laboratory–Based Influenza Surveillance Program** (initiated in 1997), **which has, through its network of international laboratories, made significant contributions to influenza monitoring and vaccine selection**.122

First, permutation: do both. We can't wait years for a pandemic treaty. Only the plan prepares us for the next crisis

Voss et al. 2022 – Managing Director of the German Alliance on Climate Change

(Maike, Managing Director of the German Alliance On Climate Change And Health. Claire Wenham, Associate Professor of Global Public Health Policy At LSE. Mark Eccleston-Turner, Senior Lecturer In Global Health Law At King's College London. Rithika Sangameshwaran, German Chancellor Fellow AT The Alexander von Humboldt Foundation. Bianka Detering, German Alliance On Climate Change And Health. A New Pandemic Treaty: What The World Health Organization Needs To Do Next. London School of Economics. March 30, 2022. https://blogs.lse.ac.uk/covid19/2022/03/30/a-new-pandemic-treaty-what-the-world-health-organization-needs-to-do-next/)

Next steps **It will** likely **take years to negotiate the treaty**. **The world cannot wait until 2024.** The minimum outcome of the treaty negotiations are trustworthy relations between the global south and the global north; the maximum outcome must be trust, built by a process that leads to a pandemic treaty with teeth, and a sensible incentive regime. To get there, negotiators and all WHO member states need to be willing to compromise and to collectively chose a set of rules with which they are willing to comply in both health emergencies and 'peacetime'. **At the same time, a treaty cannot and will not bind together all the proposed initiatives, and will not fix all the challenges the WHO and global health face**. **The world cannot wait for the pandemic treaty to be implemented to accelerate the response to the current pandemic, but we believe that in the process of developing it, trust can be (re)built.**

Second, the counterplan can't solve. Three warrants:

A. Compliance. States don't follow current international public health law

Voss et al. 2022 – Managing Director of the German Alliance on Climate Change

(Maike, Managing Director of the German Alliance On Climate Change And Health. Claire Wenham, Associate Professor of Global Public Health Policy At LSE. Mark Eccleston-Turner, Senior Lecturer In Global Health Law At King's College London. Rithika Sangameshwaran, German Chancellor Fellow AT The Alexander von Humboldt Foundation. Bianka Detering, German Alliance On Climate Change And Health. A New Pandemic Treaty: What The World Health Organization Needs To Do Next. London School of Economics. March 30, 2022. https://blogs.lse.ac.uk/covid19/2022/03/30/a-new-pandemic-treaty-what-the-world-health-organization-needs-to-do-next/)

The justification for a pandemic treaty is that whilst the technical expertise on how to govern and end a pandemic exists, the political will to do so is missing. **A new pandemic treaty cannot stand on its own and will not be the solution to all failures in global health.** Nonetheless, the INB, WHO member states and in particular the German government in its current G7 presidency can take concrete next steps, without stretching a treaty's mandate so far as to make it unachievable. A shared understanding of the problem that needs to be fixed **A lack of clarity and coherence on the specific problems the treaty aims to resolve risks rendering it futile. The IHR [international health regulations] failed to prevent COVID-19 becoming a global pandemic**. **Multiple contraventions included (presumed) limitations on sharing of information of infectious disease outbreaks; the implementation of travel and trade restrictions despite the WHO not recommending them; and a failure to follow the other temporary recommendations issued by the WHO IHR Emergency Committee.** Furthermore, IHR obligations are heavily tailored towards prevention and detection of pathogens, and very limited on response stages to prevent transmission. However, to date there is no comprehensive analysis as to why governments failed to comply with their IHR obligations.

B. Recent history. The WHO failed to stop Covid-19

Good 2021 – PhD in Comparative Politics

(Elizabeth, PhD In Comparative Politics From Northwestern University. The World Health Organization And The Response To The COVID-19 Pandemic: How The WHO Failed And Why It Doesn't Matter. Weinberg College Center For International And Area Studies. Northwestern University. May 2021. https://wccias.northwestern.edu/covid-19-research/the-world-health-organization-and-the-response-to-the-covid-19-pandemic-how-the-who-failed-and-why-it-doesnt-matter.html)

Rather than focusing on whether the Organization failed, **I** choose to **take the WHO's failure as a given.** I support this assumption by referring to the corresponding economic decline - the global economy is estimated to have contracted by 4.3% in 2020 as a result of the pandemic.[5] More importantly, **the 150 million individuals infected and over 3 million dead across 223 countries and territories clearly illustrates the WHO's failure to contain the coronavirus**. Therefore, it is less interesting to argue if the Organization failed than it is to determine how the Organization failed. Section two begins by outlining the WHO's response to COVID-19 and what emergency measures were implemented. Section three explores how the organization responsible for containing pandemics failed to do so and ultimately argues that the WHO was designed to fail. The WHO followed its own rules and did not deviate from their detailed pandemic emergency protocol. **Three** design **features of the WHO produced the failure: the cost of designating a public health emergency** of international concern (PHEIC); **the Organization's federal structure**; **and the prioritization of states' capacity to cooperate rather than addressing states' willingness to cooperate** ultimately **resulted in a chain of events similar to the 2002-2003 SARS outbreak**, albeit with graver consequences. **Poor organizational structure and misguided emergency preparation is entirely the fault of the WHO's decision-making and if done differently could have lessened the harm caused by COVID-19**. However, section four argues all International Organizations are inherently constrained by sovereignty and bureaucratic limitations. These findings suggest that while the World Health Organization failed to successfully prevent the COVID-19 pandemic, no International Organization would have been successful. In other words, the current model of inter-state global governance is unable to respond successfully to global challenges. This consequently opens the door to debate the purpose of International Organizations (IOs) in times of global crises. Does the value of IOs stem from their ambition to build a better future or from their realistic capacity to fix problems on the ground? This paper briefly outlines this deliberation in section five.

C. State sovereignty. The WHO has no authority to make policy

Good 2021 – PhD In Comparative Politics

(Elizabeth, PhD In Comparative Politics From Northwestern University. The World Health Organization And The Response To The COVID-19 Pandemic: How The WHO Failed And Why It Doesn't Matter. Weinberg College Center For International And Area Studies. Northwestern University. May 2021. https://wccias.northwestern.edu/covid-19-research/the-world-health-organization-and-the-response-to-the-covid-19-pandemic-how-the-who-failed-and-why-it-doesnt-matter.html)

International Organizations (IO) are not independent entities **from** their **member states**, but rather are comprised of member states. While this may seem obvious, it is necessary to recognize that IOs do not have the ability to act independently from member states. In other words, **the World Health Organization is unable to override state sovereignty. This means the Organization cannot force states to**: **implement policy; allow the WHO** unfettered **access to** state-specific **information**; **or provide the WHO with funds.** Therefore, even if the Organization had prioritized state willingness by giving the IHR teeth or increasing the legal obligation of states to report to and abide by the WHO, the consequences for member states defecting on IO agreements or treaties is limited. **As a result, IOs generally resort to naming and shaming** or restricting state participation within IO councils **to pressure state compliance**. **However, these tactics are less influential during a crisis where the international community only becomes aware of a state's failure to report a viral outbreak once it's too late**. Although IOs inability to force state compliance complicates emergency response (particularly when dealing with a virus transmitted by human-to-human contact in a globalized world), this limitation is for good reason since no one votes for the WHO's Executive Board. This limitation is not specific to the World Health Organization but rightly constrains all IOs. Consequently, the WHO's commitment to preventing pandemics may have been overly ambitus. Overall, **IOs ability to respond to global crises is largely dependent on the good faith of member states.** Specifically, the WHO's ability to respond to health emergencies is conditional on information shared by member states and the capacity and willingness of member states to implement WHO recommendations such as travel and trade closures, issue early warnings, or pre-deploying staff and equipment. In other words, while the WHO has the power to ring the alarm, share information, and contribute to mitigating the spread of infection by supporting health infrastructure, the effectiveness of this system is determined by the cooperation of sovereign member states.

First is Framework: The judge should evaluate the consequences of the plan. Policy analysis is necessary to train students to create realistic solutions to real-world problems

Hird 2017 — Professor Of Political Science At The University of Massachusetts

(John, Professor of Political Science At The University of Massachusetts Amherst. "How Effective Is Policy Analysis?". *Does Policy Analysis Matter? Exploring Its Effectiveness In Theory And Practice.* University of California Press. P. 75-76.)

Classical policy analysis, however absent from actual policy making, remains an important vehicle for teaching policy analysts the connections between their analysis and the policymaking world in which their recommendations would live. **Even if it implies more power than analysts will ever have, classical policy analysis** teaches that politics, law, implementation, social structures, organizational behavior, and other factors are critical to policy outcomes and **must play key roles in thinking through possible ways to address policy problems**. **Bringing policy ideas to fruition, bridging the worlds of research and policy making, is a critical skill for analysts to develop**. In addition, policy schools are instilling in prospective policy analysts the structure and habits of mind to engage successfully in the policy enterprise. 28 Teaching disciplined thinking for public service is important. Policy analysts not only have a problem-oriented, interdisciplinary approach to policy and the ability to synthesize and bring policy relevance to problems that social scientists are not trained for, but they understand the "rational lunacy of policy-making systems" (Weiss 2009). In the absence of written classical policy analyses, **policy analysts** become their human embodiment. Their training will provide a mental picture of how a classical policy analysis should be performed. They can derive elements of policy analysis from writing position papers, briefing policy makers, and controlling meetings. They **anticipate counterarguments and frame their analyses recognizing alternative options**. In short, **the mental map of a policy analysis allows good policy analysts not only to be effective in their jobs but also to advance into the public debate** the appropriate elements of a policy analysis. **Further, the problem orientation of policy analysis focuses at least some attention on social problems, not just political expediency**. **The role of policy analysts is not merely to translate research for policy makers, but to use creative means to turn available knowledge about the implications of various policy options into actionable policy recommendations** appropriate for their clients. This is a subtle skill requiring attention to both political realities and the best available research. Finally, prospective policy analysts are instructed repeatedly about the importance of their relationship to the client(s), yet far less attention is paid to the other part of the policy analyst's relationship: to the community of knowledge producers. **Policy analysts play critical roles as intermediaries between "custodians of the knowable" and policy makers.** Their training should include the ability to understand and interpret the academic literature on a topic at a far deeper level than most journalists have the time or, often, the analytic skill set to uncover. Identifying and connecting pertinent knowledge and analysis with policy makers should be a core principle of a public policy education. Policy analysts may offer the central means to provide policy makers with the key elements of classical policy analysis, though not in the way, through written reports, it was originally conceived. Creating a profession for committed, accomplished, and well-trained individuals to participate in the world of public policy may be among the most important contributions of policy analysis education.

Second, permutation: do both. Doing the plan with a focus on health equity solves

Hall et al. 2016 — Researchers At the Centers for Disease Control and Prevention

(Mary, Office of Minority Health and Health Equity. Corinne Graffunder, Office of the Associate Director For Policy. Marilyn Metzler,National Century For Injury Prevention And Control. Policy Approaches To Advancing Health Equity. Journal of Public Health Management and Practice. 2016 Jan-Feb., 22 Supplemental 1:S50-9. https://pubmed.ncbi.nlm.nih.gov/26599030/)

Public health policy approaches **have demonstrated** measurable **improvements in population health**. Yet, "one-size-fits-all" approaches do not necessarily impact all populations equally and, in some cases, can widen existing disparities. It has been argued that interventions, including policy interventions, can have the greatest impact when they target the social determinants of health. The intent of this article was to describe how selected current policies and policy areas that have a health equity orientation are being used with the aim of reducing health disparities and to illustrate contemporary approaches that can be applied broadly to a variety of program areas to advance health equity. **Applying a health equity lens to** a Health in All **Policies** approach **is** described as **a means to develop policies across sectors with the explicit goal of improving health for all while reducing health inequities. Health equity impact assessment** is described as a tool that **can be effective in** prospectively **building health equity into policy planning**. The discussion suggests that eliminating health inequities will benefit from a deliberate focus on health equity by public health agencies working with other sectors that impact health outcomes. **Policy implementation has long been** recognized as **one of the important cornerstones of public health** and, together with assessment and assurance, makes up the core functions of public health.1 The US Centers for Disease Control and Prevention (CDC) defines policy as "a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions."2 It further states that "health can be influenced by policies in many different sectors, e.g. transportation policies can encourage physical activity (pedestrian- and bicycle-friendly community design); policies in schools can improve nutritional content of school meals."2 Several policy approaches have demonstrated effectiveness at the level of the general population.3 For example, several of what are considered the 10 greatest public health achievements of the 20th century are due, in part, to policies such as seat belt and child restraint laws and smoke-free policies.4,5 However, policy interventions can impact communities differentially and, in some cases, can widen health disparities.6 There is some evidence that **"downstream" interventions, which focus on change at the individual level, are more likely to increase health inequality than are "upstream" interventions, which focus on** social change or **policy change**.6 The intent of this articlewas to describe how selected current **policies** and policy areas **that have a health equity orientation are** being used with the aim of **reducing health disparities** and to illustrate contemporary approaches that can be applied broadly to a variety of program areas to advance health equity.

Third, no link and turn: Policy focus solves health inequality. Pandemic response is critical to protect marginalized communities

Berkowitz et al. 2020 — Assistant Professor of General Medicine

(Seth A., Assistant Professor of General Medicine At The University of North Carolina Chapel Hill School of Medicine. Crystal Wiley Cene, Associate Professor of Epidemiology At UNC Chapel Hill School Of Medicine. Avik Chatterjee, M.D. / M.P.H. COVID-19 And Health Equity --- Time To Think Big. The New England Journal of Medicine, 383:e76. September 17, 2020. https://www.nejm.org/doi/full/10.1056/NEJMp2021209)

Recognizing that **health inequities have structural causes warranting policy-level solutions**, we believe that the **Covid-19** health equity disaster **carries** some **lessons from which we can derive** actionable policy **targets for both advancing health equity and improving** the **pandemic response. The pandemic has demonstrated that our public health response cannot be divorced from public policy** — federal and state legislation, federal and state program administration, and local ordinances. People cannot adhere to social distancing when it means leaving their basic needs unmet. Even before Covid-19, many Americans faced unmet basic needs. Now, one in four workers have lost their jobs, foreclosures and evictions threaten to reach record highs, and the prevalence of food insecurity has tripled, resulting in miles-long queues for food pantries.4 **These devastating effects pressure the people who are most vulnerable to Covid-19 to take health risks** just to make ends meet. Moreover, inadequate federal support for basic needs and insensitivity to variation in what people need to weather this crisis lead to anger misdirected at state-level public health measures such as social distancing. That anger, in turn, contributes to decisions to lift these measures prematurely. Public policy should enable people to socially distance, not motivate them to oppose it. Public policy must also equip state and local governments to respond to Covid-19. The Federal Reserve has made available more than $2.3 trillion to support the financial system during the pandemic but has offered far less support for state and local governments. Often unable to run deficits, these governments must cut spending when revenue declines. Such cuts will probably have several detrimental effects: scaling back public health efforts, defunding state programs addressing basic needs, and spurring public-sector layoffs that stall economic recovery. These **policy failures disproportionately affect marginalized communities** with high rates of underlying medical conditions. Moreover, **in a pandemic**, **anything that increases** the opportunity for **disease transmission affects everyone.** Such is the paradox of inequity: even the well-off are worse off than they would be if systems were more equitable. Beyond revealing the need to integrate public health efforts with broader public policy, Covid-19 has demonstrated once again the outsized roles of structural racism and social determinants of health. When exposed to the same virus, Black, Latinx, and Indigenous Americans have more severe disease and higher mortality than White Americans. These disparities are structured by the conditions in which individuals are “born, grow, live, work, and age.”1,2 Greater investment in hospitals and clinics that serve marginalized communities is sorely needed.3 But clinical care alone cannot compensate for a lifetime of accumulated disadvantage, nor will it dismantle the structures that perpetuate health inequities. **To achieve health equity, we need to** reach beyond the health care system — and **think big**. **New social policies** on a few key fronts **could advance** both **health equity and the Covid-19 response.**

Fourth, case turns the Kritik. Pandemics cause crackdowns on marginalized communities

Amnesty International 2022

(Amnesty International. COVID-19: Pandemic Restrictions Magnified Discrimination Against Most Marginalized Groups. Amnesty International. May 31, 2022. https://www.amnesty.org/en/latest/news/2022/05/covid-19-pandemic-restrictions-magnified-discrimination-against-most-marginalized-groups)

Marginalized groups, including LGBTI+ people, sex workers, people who use drugs, and those experiencing homelessness, **were disproportionately impacted by Covid-19 regulations that exposed them to** further **discrimination and human rights abuses**, Amnesty International said in a new report today assessing the impact of pandemic restrictions across the globe. **Based on a**n online **survey of** 54 **civil society organizations in 28 countries**, **the report documents how an overly punitive approach to** the enforcement of **Covid-19 regulations**—that saw people fined, arrested and jailed for non-compliance with public health measures— **resulted in already marginalized groups facing increased harassment and violence from security forces**. The approach also left them with reduced access to essential services including food, healthcare and housing. **More than two thirds of survey respondents** (69%) **said** that state responses to **Covid-19 had exacerbated the negative impact of pre-existing laws** and regulations **that criminalized and marginalized the people they work with**. Of these, 90% reported that the communities they work with were specifically targeted and/or disproportionately impacted when Covid-19 measures were enforced. Among other punitive measures, organizations reported the widespread use of fines, arrests, cautions, written warnings and police orders to "move on" or stay away from a public place. "Though Covid-19 measures may have varied from country to country, governments' approaches to tackling the pandemic have had a common failing. An overemphasis on using punitive sanctions against people for non-compliance with regulations, rather than supporting them to better comply, had a grossly disproportionate effect on those who already faced systematic discrimination," said Rajat Khosla, Amnesty International's Senior Director of Policy. "When governments use punitive approaches to enforce public health measures, it simply makes it harder to comply. People who lost their livelihoods overnight and people experiencing homelessness were criminalized for not adhering to Covid-19 measures, rather than being supported to access housing or other essentials. "**This short-sightedness left these groups at the mercy of violent and discriminatory policing and drove people to take riskier decisions to meet their basic needs, resulting in preventable illness, deaths and a wide array of human rights abuses."**

Pandemic Negative (1NC)

1NC Disadvantage (Deterrence) – 1/4

First is Uniqueness: NATO defense spending is on the brink. Overstretching budgets will wreck the alliance

Lasconjarias 2022 — Researcher At the NATO Defense College

(Guillaume, Researcher At The NATO Defense College. Working Group Report: Military Instrument of Power and Pandemics: A Long-Term Perspective. Pandemics And International Security: The Outlook For NATO. P. 102 - 112. February 14, 2022. https://www.iai.it/en/pubblicazioni/pandemics-and-international-security-outlook-nato)

In Europe, questions have arisen about the longer-term effects of the pandemic on defence policy and the military: **considering the dramatic increase of sovereign debts in many states, in clear terms, how will the pandemic affect defence capacities and spending** (see Marrone, 2021)? The pandemic has severely affected the economy within the European Union. Some 2020 estimates forecasted that the size of most EU economies would only reach pre-pandemic levels in 2022 or 2023. The speed of the recovery remains in question, but what is clear is that **the combination of high public debt and poor fiscal position will probably lead to budget cuts. Recent history proves that cutting defence spending is sometimes seen as a quick fix solution** to implement austerity measures. **However, in an era where geopolitical uncertainties are becoming the norm, where the rise of systemic rivals is a reality, further reducing defense budgets seems not be an option**. **Even when priorities shift** towards the socio-economic domains, **when it comes to national security and defence, most European Nations are not** 108 PANDEMICS AND INTERNATIONAL SECURITY: THE OUTLOOK FOR NATO **considering to diminish their investment.** As a matter of fact, and even if the effort remains uneven, European nations have begun to adjust their defence budgets since 2014 in a rather constant manner. **The crisis years between 2008 and 2012 already resulted in major cutbacks in budgets and capabilities, and the latter have only just returned to 2008 spending levels**. **Were Europeans to make further major cutbacks in their budgets, they would deal a fatal blow to the most fragile military capacity of some frail states and to Europe's capacity for collective action**. In this respect, **the willingness shown by a large majority of Allies within NATO to maintain the growth of defence expenditures, despite the economic crisis, is a positive sign** that needs to be confirmed in the mid- to long term (see French MoD, 2021).4 Despite the high level of ambition portrayed by the EU for the European Defence Fund (EDF) and the proposed funding for military mobility, cuts have already been made on both initiatives in 2020 because of the Covid-related shift of the EU 2021-2027 budget towards socio-economic priorities.5

Second is the Link: Expanding NATO's mission to include public health trades off with deterrence

Ceccoruli 2022 — Professor of International Relations

(Michela, Senior Assistant Professor of International Relations AT The University of Bologna. Working Group Report: International Cooperation To Address Pandemic. Pandemics And International Security: The Outlook For NATO. P. 46 – 50. February 14, 2022. https://www.iai.it/en/pubblicazioni/pandemics-and-international-security-outlook-nato)

Fit for the purpose…or not? Envisaging **NATO as an active actor in future challenges has required** a close **scrutiny over the possible problems** such an occurrence might cause. Two main concerns were mainly academically driven, one was decidedly more practical and the last one stood in between. All of them made for a rich, variegated and insightful debate in the WG. The opportunity of NATO's involvement was at first evaluated within the broader issue of civil-military cooperation. Indeed, **the military sector has been a constant presence in the governance of the pandemic**, spanning from NATO to national resources. But wondering whether NATO should play a role in the future requires answering to two preliminary questions: has NATO stepped in because it is better at performing some functions? Or instead to fill gaps? The answer stands most likely in between; however, the two inferences imply different arguments and reasonings. In the first case it is possible to imagine a role for NATO in the future, one that is interoperable with other governance tools and that is displayed when asked for. In the second case, instead, participants agreed that there is a major health issue at the basis that has to be fixed, with all related components and consequences. That is, the civil sector has to catch up soon. Somehow **related to the concern of NATO intrusion in a field that is not its own was a second concern, that of the potential securitization of a non-security issue. Engaging NATO would stir the concern of those fearing that appropriate forum of discussion is diverted from "health" to somewhere else, with fundings following suit.** If we proceed in tasking the military, the next crisis is going to be coped with differently, has been pinpointed by some. Also, a pertinent suspicion regarded the consequences of a security framing on transparency and democratic practices, on legitimacy and accountability, as evidence from other securitization processes has made clear. Not all participants, though, were skeptical of "bringing security in": perhaps, a distinction between militarization and securitization, was suggested, could better serve the cause of edging different domains while keeping an eye on potential security repercussions of global challenges. **On a more practical level,** it was suggested that **NATO's involvement in health crises might in fact overstretch its capacities, drain resources and take them out of core and urgent domains/situations**. **NATO cannot defend everything** was repeatedly affirmed during the Conference. **As NATO has already a lot in its plate, diversion of personnel, tools and efforts in general (its sustainability) may be more counterproductive than beneficial to the Alliance**.

Third is the Internal Link: NATO defense spending is key to deter war with Russia

Kochis et al. 2022 — Policy Analyst at the Heritage Foundation

(Daniel, Senior Policy Analyst At The Heritage Foundation. Thomas Spoehr, Director of the Center For National Defense At The Heritage Foundation. Luke Coffey. Patty-Jane Geller, Senior Policy Analyst At The Heritage Foundation. The Russian Threat: Bolstering NATO Deterrence At A Critical Time. Heritage Foundation. March 14, 2022. https://www.heritage.org/defense/report/the-russian-threat-bolstering-nato-deterrence-critical-time)

The security and prosperity **of the transatlantic community**, including the United States, **rests on the foundation of the North Atlantic Treaty Organization (NATO). Russia's** ongoing **war of** naked **aggression against Ukraine**, a NATO non-member state, **should put to rest any lingering questions about the modern utility of the Alliance** and about which threat should be the focus of NATO's upcoming strategic concept. The answer is clear: The U.S. must lead the Alliance to a wholesale refocusing on the organization's raison d'être of collective defense. While the Alliance faces challenges emanating from an unstable Mediterranean basin and terrorism originating from the Middle East, the fact remains that **Russia continues to be the only existential threat to member states**. **NATO must send a strong signal that it is strengthening deterrence measures explicitly in response to the increased threat from Russia. Deterrence measures should include an Alliance-wide recommitment to defense spending**; a persistent and continuing U.S. presence in Eastern European member states; updated Alliance operational planning in light of Russia's position in Belarus and Ukraine; and an increase in U.S. air, ground, and naval forces in the European theater as a sign of continued commitment to the NATO treaty's Article 5. These deterrence measures must be carried out with the recognition that, from a long-term perspective, China is the largest peer challenger from whom the U.S. must expect hostile action. Any improvements to the U.S. force posture must not be to the detriment of the nation's ability to counter China. The Importance of NATO Deterrence Has Only Increased From the Arctic to the Levant, **Russia remains an aggressive and capable threat to NATO** and the interests of its members. For member states in Eastern Europe, Russia represents a real and potentially existential threat. **Russia's entrenched position in Belarus, along with its ongoing actions to cleave Ukraine, a nation that borders four NATO members**, in two, scramble the geostrategic map of Europe and necessitate changes to NATO operational planning, **exemplify**ing **the need for the Alliance to take** swift and resolute **steps to bolster deterrence** measures along its eastern flank.

Fourth is the Impact: War with Russia goes nuclear. Only NATO can save us from World War 3

Schlosser 2022 — Contributing Editor at The Atlantic

(Eric, Former Contributing Editor At The Atlantic. What If Russia Uses Nuclear Weapons In Ukraine? The Atlantic. June 20, 2022. https://www.theatlantic.com/ideas/archive/2022/06/russia-ukraine-nuclear-weapon-us-response/661315/)

Before the attack on Ukraine, the five **nations** allowed to have nuclear weapons by the Non-Proliferation Treaty (NPT)—the United States, the United Kingdom, Russia, China, and France—**had reached agreement that the use of such weapons could be justified only as a purely defensive measure** in response to a nuclear or large-scale conventional attack. In January 2022, those five countries issued a joint statement affirming Ronald Reagan's dictum that **"a nuclear war must never be fought and can never be won." A month later, Russia** violated norms that had prevailed under the NPT for more than half a century. It **invaded a country** that had given up nuclear weapons; **threatened nuclear attacks** against anyone who tried to help that country; **and committed acts of nuclear terrorism** by shelling the reactor complexes at Chernobyl and Zaporizhzhya. Nunn supports the Biden administration's strategy of "deliberate ambiguity" about how it would respond to Russia's use of a nuclear weapon. But he hopes that some form of back-channel diplomacy is secretly being conducted, with a widely respected figure like former CIA Director Robert Gates telling the Russians, bluntly, how harshly the United States might retaliate if they cross the nuclear threshold. During the Cuban missile crisis, President John F. Kennedy and First Secretary Nikita Khrushchev both wanted to avoid an all-out nuclear war—and still almost got one, because of misunderstandings, miscommunications, and mistakes. Back-channel diplomacy played a crucial role in ending that crisis safely. Nunn describes Russia's violations of long-standing norms as "Putin's nuclear folly" and stresses that **three fundamental things are essential for avoiding a nuclear catastrophe: rational leaders, accurate information, and no major blunders. "And all three are now in** some degree of **doubt,"** he says. If Russia uses a nuclear weapon in Ukraine, Nunn thinks that an American nuclear retaliation should be the last resort. He favors some sort of horizontal escalation instead, doing everything possible to avoid a nuclear exchange between Russia and the United States. For example, if Russia hits Ukraine with a nuclear cruise missile launched from a ship, Nunn would advocate immediately sinking that ship. The number of Ukrainian casualties should determine the severity of the American response—and any escalation should be conducted solely with conventional weapons. Russia's Black Sea fleet might be sunk in retaliation, and a no-fly zone could be imposed over Ukraine, even if it meant destroying anti-aircraft units on Russian soil. **Since the beginning of the invasion, Russia's nuclear threats have been aimed at discouraging the United States and its NATO allies from providing military supplies to Ukraine**. And the threats are backed by Russia's capabilities. Last year, during a training exercise involving about 200,000 troops, the Russian army practiced launching a nuclear assault on NATO forces in Poland. "**The pressure on Russia to attack the supply lines from NATO countries to Ukraine will increase, the longer this war continues,"** Nunn says. **It will also increase the risk of serious blunders and mistakes. An intentional or inadvertent Russian attack on a NATO country could be the beginning of World War III.**

First is the Unique-Link: We're at a crossroads. The plan locks in a military approach to public health that undermines human rights

Gibson-Fall 2021 — Lecturer in Global Health at King's College London

(Fawzia, PhD Researcher / Lecturer In Global Health At King's College London. Military Responses To COVID-19, Emerging Trends In Global Civil-Military Engagements. Review of International Studies (2021), 42:2, 155-170.)

The coronavirus **pandemic stands as a pivotal moment in the** contemporary **presence of militaries in global health. As** confinement measures were enforced and **health systems were put under strain**, **military deployments have unfolded** through three clear trends of engagement: (1) Minimal technical military support; (2) Blended civil-military responses; and (3) Military-led responses. In light of these three levels of participation, it appears that the recourse to military is threefold. First, it follows a country's historical legacy in civil-military relations and perception of military delivery. Various historical and political trajectories led to the institutionalisation of military public health work and subsequent COVID-19 responses. Second, these involvements occur to fill gaps when health systems are overwhelmed. This is universal, follows contagion threat levels and health systems' ability to cope with the epidemic pressure. **This** is also a gradual process, more widespread in states with weaker health systems or where the military has historically run civilian-serving services. A third and important **dynamic is compounded by top-down pandemic preparedness and delivery frameworks. When adopting securitised biomedical responses**, **countries** with weak health systems need to **recourse to top-down (often military) means**. **In COVID-19, these responses are marshalled through the military to enforce measures such as lockdown, surveillance, border closures, or contact tracing.** The ability to command, through **military means**, **remain**s **a double-edged sword**. **It allows for stringent responses but threatens citizenship rights and community trust so crucial in epidemics.** The direct and indirect involvements of the military in COVID-19 national responses have led to increases in policy and practice linking military and health actors. **This is likely to have a normative impact, further entrenching militaries as common actors in the health realm.** Global health and IR scholarship should focus on the ways in which civilian institutional lacunae are compensated through military means. These insights will allow for better societal resilience amid the pandemic and future emergency responses. They will also provide empirical evidence to the wider questions of both if and how militaries have a role in global health.

Second is the Impact: NATO pandemic response risks authoritarianism and war in the name of public health

Gibson-Fall 2021 — Lecturer in Global Health at King's College London

(Fawzia, PhD Researcher / Lecturer In Global Health At King's College London. Military Responses To COVID-19, Emerging Trends In Global Civil-Military Engagements. Review of International Studies (2021), 42:2, 155-170.)

Emerging trends and collective perceptions **Framing the pandemic as a security threat influences policy** and practice **linking health and military realms** amid all types of responses. The wide-reaching socioeconomic effects of COVID-19 and associated emerging hybrid security threats (for example, so-called infodemics and targeted cyber-attacks on research and web entities)107 are leading to new civilian-military response mechanisms. The **North Atlantic Treaty Organisation (NATO), for instance**, **advocates for its members' societal resilience to invisible and hybrid threats amid COVID-19**.108 This comprehensive non-military-centric preparedness approach means governments, militaries, businesses, and civil society work together against emerging threats (such as disinformation campaigns).109 Governments, in task shifting control and treatment measures between civilian public institutions, the military, and community groups (for example, in care homes or for vaccine roll outs) are also creating new civil-society securitised assemblages.110 **This incorporation of** the life sciences and **public health into** the **national security** apparatuses is not new.111 But it **is exacerbated in COVID-19 as security problems and civilian capabilities gaps are merged in militarised language.** The pandemic has fostered examples of think tank publications praising the transferability of military operational culture for civilian institutions.112 These types of discursive acknowledgements of civil-military transferability (through the language of hierarchy, efficiency, and leadership) further normalise the health-military association. **Military** and war **metaphors in** the **public discourse** relating to COVID-19 (**for example, 'invisible enemy'**, 'frontline', 'duty') **reinforce** statist thinking and **state power**.113 These metaphors can risk closing off alternative ways of understanding the disease and what fuels it (for example, the social determinants making populations vulnerable).114 These rapprochements (between health and military sectors) take hold through indirect pathways of language and practices amid civilian entities across all response trends. **Until recently on the fringe of global health scholarship and practice, COVID-19 could normalise the military-health link,** making it more palatable in the public domain. **Military experiences** in COVID-19 responses **will have geopolitical implications.** Military actors' catch-22 lies in the ability to maintain their primary functions of war and deterrence in the midst of internal pandemic pressures.115 Known carriers and vectors of infectious diseases, militaries will seek to prioritise their own personnel's health and operational readiness.116 If the pandemic keeps militaries busy, hence moderating risks of external confrontation, it is also altering the way they operate, perceive themselves and engage with each other.117 Examples of COVID-19 military diplomacy have already taken place. Russian military personnel deployed, for instance in the North of Italy,118 while the Pakistani military donated PPE to the US Army.119 Pending military biomedical innovation (in the form of cures or vaccines) also give the impetus for military presence in the health realm. US OperationWarp Speed, which used military research facilities for vaccine development, is one example of such involvements.120 The advent of the different vaccines might mean further mobilisation of defence institutions to protect stockpiles, enhance laboratory, or supply chain capacity. Grand-scale vaccination rollouts, which necessitate clear chains of command and coordination, make military expertise a go-to in many settings (even if some capacity can exist within civilian organisations). For critics, **these involvements are likely to equate to further** protectionism, border closures, **geopolitical tensions**, mistrust, **or confrontations**.

Third, the disadvantage turns the case. Funding is zero-sum. Military pandemic response trades off with civilian public health

Gibson-Fall 2021 — Lecturer in Global Health at King's College London

(Fawzia, PhD Researcher / Lecturer In Global Health At King's College London. Military Responses To COVID-19, Emerging Trends In Global Civil-Military Engagements. Review of International Studies (2021), 42:2, 155-170.)

Conversely, proponents of inclusive military involvements will see better coordination and efficiency across state apparatuses. **Faced with pandemic-induced economic crisis disrupting military spending**,121 **defence leadership might choose to revaluate domestic roles.** Faced with financial constraints and an enhanced portfolio of activity, positioning the armed forces as population-based health delivery actors could help justify defence funding and expenditure. **Amid ideological privatisation and austerity measures undermining public institutional health capacity, militaries could become the alternative institutional response mechanism.** These potential changes pose fundamental questions for future civil and military health roles (and eventually for cosmopolitanism as military practice). Domestically, COVID-19 **military engagements** are drawing up new internal ethical frameworks and doctrines. These types of military-internal operational frameworks **have**, over the past decade, increasingly been put forward as alternatives to traditional humanitarian guidelines in global health military contexts.122 **Amid this pandemic,** national **emergency**-related **laws have conferred governments further access to martial power**, sometimes **risking** undermining hardacquired **civil liberties**.123 Against a background of fast developing surveillance practices,124 issues of technological control and authoritarianism have raised the world around.125 In some contexts, **the coercive nature of local armed forces and the slippery slope nature of authoritarian measures have led to human rights abuses in the name of public health**.126 New legal and ethical frameworks and instruments relating to COVID-19 measures (for example, ethical medical prioritisation, tracing, surveillance, quarantine) will need to balance human rights protection and inclusive public health promotion.127 **These could in turn lead to** accrued civilian control of military practices, or to **increased military control of civilian affairs**. These new local civil-military frameworks and practices will impact on future international-level civil-military coordination and cooperation.

1NC Counterplan (Treaty) – 1/2

Text: The member states of the World Health Organization should sign and ratify a new international treaty for pandemic preparedness and response.

A pandemic treaty is key to solve. Only global leadership through the World Health Organization can prevent the next pandemic

Bainimarama et al. 2021— Prime Minister of Fiji

(J. V. Bainimarama, Prime Minister of Fiji; Prayut Chan-o-cha, Prime Minister of Thailand; António Luís Santos da Costa, Prime Minister of Portugal; Mario Draghi, Prime Minister of Italy; Klaus Iohannis, President of Romania; Boris Johnson, Prime Minister of the United Kingdom; Paul Kagame, President of Rwanda; Uhuru Kenyatta, President of Kenya; Emmanuel Macron, President of France; Angela Merkel, Chancellor of Germany; Charles Michel, President of the European Council; Kyriakos Mitsotakis, Prime Minister of Greece; Moon Jae-in, President of the Republic of Korea; Sebastián Piñera, President of Chile; Andrej Plenković, Prime Minister of Croatia; Carlos Alvarado Quesada, President of Costa Rica; Edi Rama, Prime Minister of Albania; Cyril Ramaphosa, President of South Africa; Keith Rowley, Prime Minister of Trinidad and Tobago; Mark Rutte, Prime Minister of the Netherlands; Kais Saied, President of Tunisia; Macky Sall, President of Senegal; Pedro Sánchez, Prime Minister of Spain; Erna Solberg, Prime Miniser of Norway; Aleksandar Vučić, President of Serbia; Joko Widodo, President of Indonesia; Volodymyr Zelensky, President of Ukraine Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization. COVID-19 Shows Why United Action Is Needed For More Robust International Health Architecture. World Health Organization. March 30, 2021. https://www.who.int/news-room/commentaries/detail/op-ed---covid-19-shows-why-united-action-is-needed-for-more-robust-international-health-architecture)

To that end, we believe that nations should work together towards **a new** international **treaty** for pandemic preparedness and response. Such a renewed collective commitment **would be a milestone in stepping up pandemic preparedness at the highest political level**. **It would be rooted in the constitution of the World Health Organization**, **drawing in other** relevant **organizations key to this endeavour**, in support of the principle of health for all. **Existing global health instruments**, especially the International Health Regulations, **would underpin such a treaty, ensuring a firm and tested foundation on which we can build and improve. The main goal** of this treaty **would be to foster an all-of-government and all-of-society approach, strengthening national, regional and global capacities and resilience to future pandemics. This includes greatly enhancing international cooperation to improve**, for example, **alert systems, data-sharing, research, and local, regional and global production and distribution of medical and public health counter measures, such as vaccines, medicines, diagnostics and personal protective equipment**. It would also include recognition of a "One Health" approach that connects the health of humans, animals and our planet. **And such a treaty should lead to more mutual accountability and shared responsibility, transparency and cooperation within the international system and with its rules and norms**. To achieve this, we will work with Heads of State and governments globally and all stakeholders, including civil society and the private sector. We are convinced that it is our responsibility, as leaders of nations and international institutions, to ensure that the world learns the lessons of the COVID-19 pandemic. **At a time when COVID-19 has exploited our** weaknesses and **divisions**, **we must seize this opportunity and come together as a global community** for peaceful cooperation that extends beyond this crisis. Building our capacities and systems to do this will take time and require a sustained political, financial and societal commitment over many years. Our solidarity in ensuring that the world is better prepared will be our legacy that protects our children and grandchildren and minimizes the impact of future pandemics on our economies and our societies**. Pandemic preparedness needs global leadership for a global health system fit for this millennium.** To make this commitment a reality, we must be guided by solidarity, fairness, transparency, inclusiveness and equity.

Specifically, only the counterplan creates universal access to vaccines. No one is safe until everyone is safe

Bainimarama et al. 2021— Prime Minister of Fiji

(J. V. Bainimarama, Prime Minister of Fiji; Prayut Chan-o-cha, Prime Minister of Thailand; António Luís Santos da Costa, Prime Minister of Portugal; Mario Draghi, Prime Minister of Italy; Klaus Iohannis, President of Romania; Boris Johnson, Prime Minister of the United Kingdom; Paul Kagame, President of Rwanda; Uhuru Kenyatta, President of Kenya; Emmanuel Macron, President of France; Angela Merkel, Chancellor of Germany; Charles Michel, President of the European Council; Kyriakos Mitsotakis, Prime Minister of Greece; Moon Jae-in, President of the Republic of Korea; Sebastián Piñera, President of Chile; Andrej Plenković, Prime Minister of Croatia; Carlos Alvarado Quesada, President of Costa Rica; Edi Rama, Prime Minister of Albania; Cyril Ramaphosa, President of South Africa; Keith Rowley, Prime Minister of Trinidad and Tobago; Mark Rutte, Prime Minister of the Netherlands; Kais Saied, President of Tunisia; Macky Sall, President of Senegal; Pedro Sánchez, Prime Minister of Spain; Erna Solberg, Prime Miniser of Norway; Aleksandar Vučić, President of Serbia; Joko Widodo, President of Indonesia; Volodymyr Zelensky, President of Ukraine Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization. COVID-19 Shows Why United Action Is Needed For More Robust International Health Architecture. World Health Organization. March 30, 2021. https://www.who.int/news-room/commentaries/detail/op-ed---covid-19-shows-why-united-action-is-needed-for-more-robust-international-health-architecture)

Today, we hold the same hope that as we fight to overcome the COVID-19 pandemic together, **we can build a** more **robust international health architecture that will protect future generations. There will be other pandemics** and other major health emergencies. **No single government or multilateral agency can address this threat alone.** The question is not if, but when. **Together, we must be better prepared to predict, prevent, detect, assess and effectively respond to pandemics in a highly coordinated fashion.** The **COVID-19** pandemic **has been a stark** and painful **reminder that nobody is safe until everyone is safe. We are**, therefore, **committed to ensuring universal and equitable access to** safe, efficacious and affordable **vaccines, medicines and diagnostics for** this and **future pandemics. Immunization is a global public good and we will need to be able to develop, manufacture and deploy vaccines as quickly as possible.** This is why the Access to COVID-19 Tools Accelerator (ACT-A) was set up in order to promote equal access to tests, treatments and vaccines and support health systems across the globe. ACT-A has delivered on many aspects but equitable access is not achieved yet. **There is more we can do to promote global access.** To that end, we believe that nations should work together towards a new international treaty for pandemic preparedness and response.

Racism is a public health crisis. Public health policies like the plan are complicit in maintaining structures of discrimination and violence against people of color. Only concrete action to dismantle systems of oppression can stop the deaths

Devakumar 2020 — Senior Lecturer in Public Health

(Delan, Senior Lecturer In Public Health. Sujitha Selvarajah. Geordan Shannon. Kui Muraya. Sarah Lasoye. Susanna Corona. Yin Paradies. Ibrahim Abubakar. E. Tendayi Achiume. Racism, The Public health Crisis We Can No Longer Ignore. The Lancet, Correspondence. June 11, 2020. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31371-4/fulltext#articleInformation)

The forms of discrimination and the targets might vary: in some societies they are based on race or ethnicity; in others, colour, caste, religious beliefs, Indigeneity or someone's migratory status. However, the underlying oppression that caused these injustices to occur are largely similar. **Racism and xenophobia** are about division and control, and ultimately power. Together they **constitute a structural** form of **violence that results, at the extreme, in innocent people being murdered**. The **COVID-19** outbreak **has uncovered a crisis in our social and political fabric** extending beyond the outbreak itself**: a**n uncomfortable **propensity towards racism**, xenophobia, and intolerance **exacerbated by** transnational **health challenges** and national politics. Internationally, we have witnessed the vilification of particular nationalities, with overt forms of sinophobia.6 **Politically, xenophobia has been weaponised to enforce border controls against particular nationalities** and undermine migrant rights.7 In the UK, **minoritised ethnic groups are more likely to contract** a severe acute respiratory syndrome **coronavirus** 2 (SARS-CoV-2) infection **and**, subsequently, **face a higher risk of** a **severe** form of **illness**. Why is this? People from minoritised ethnic groups are more likely to work as key workers in frontline jobs that expose them to SARS-CoV-2, and are more likely to live in overcrowded accommodation, meaning social distancing is not an option.8 **They are then more likely to have barriers to accessing health services, meaning** that **they present** late **in a worse condition, and with a** higher probability of underlying illnesses that put them at **greater risk of death.** In some cases, the existence of these comorbidities lowers the chances for intubation and ventilation, resulting in a double burden of being more prone to be severely unwell and less likely to receive intensive care.9 **Beyond these proximal causes** of ill health **lie racism and structural** forms of **discrimination**. **Marginalised groups are disadvantaged in all the social determinants of health**. However, racism is more than this, it is a fundamental cause of ill health.10 **At all socioeconomic levels, people of colour have poorer health outcomes.**11 **Racism cumulates over the lifecourse**, leading to activation of stress responses and hormonal adaptations, increasing the risk of non-communicable diseases and biological ageing.12 **This trauma is also transmitted intergenerationally** and affects the offspring of those initially affected through complex biopsychosocial pathways.13 **The root of these so-called biological causes is racism**, not race itself. **Society is unwell. The symptoms**— racialised violence, and excess morbidity and mortality in minority ethnic populations—**reflect** the cause: **an unjust and unequal society**. **Scientists and doctors, by remaining technocratic and apolitical, are complicit in perpetuating discrimination.** As a health community, **we must do more than simply describing inequities in silos, we must act to dismantle systems that perpetuate the multiple intersecting and compounding systems of oppression that give rise to such inequities and injustices**. To this end, we are producing a series of academic papers to centre the complex challenges of racism and xenophobia in the health discourse. We are working with a diverse team of academics and activists globally to highlight injustices, identify solutions, and enact change. Alongside this, we are launching the Race & Health movement, a multi-disciplinary community of practice that will continue beyond the social media. Our vision is to provide a catalyst in tackling the adverse health effects of racism, xenophobia, and discrimination. Academic outputs on their own are irrelevant. **We must use the evidence to advocate for change and improvements in health.** In this spirit, we are launching a global consultation, asking: what should we do, and how should we do it? **Racism kills, and this is a public health crisis we can no longer ignore.** As a health community, where were we?

First, the status quo solves. We're already preparing for the next pandemic

Schreiber 2022 — Journalist for The Guardian

(Melody, Journalist For The Guardian. America Marks Two Years of COVID – Is It Prepared For The Next Pandemic?. The Guardian. March 14, 2022. https://www.theguardian.com/world/2022/mar/14/america-coronavirus-covid-pandemic-vaccines-public-health)

Now, **even as Covid-19 remains a threat, US** public health **officials and researchers are looking to the next potential pandemic** – whether it's influenza, another coronavirus, antimicrobial resistance, or a different health threat entirely – **as they hope to build on the progress and avoid the pitfalls of the past two years. Knowledge of how** respiratory **viruses work** – **and how to battle them** – **has increased exponentially** during this outbreak. But at the same time, misinformation about infectious diseases, especially vaccines and treatments, has multiplied, presenting new challenges. **Scientists**, several of whom have advised Joe Biden, **recently released a 136-page "roadmap" for moving from Covid crisis to what they term the "next normal". These investments include supporting health workers and strengthening health systems**, as well as supporting survivors with long-term symptoms. **A new disease forecasting center, the Center for Forecasting and Outbreak Analytics, will become part of the US Centers for Disease Control and Prevention (CDC), aiming to prepare for the next big outbreak. And a new bill with strong bipartisan support would create a 9/11-style commission to investigate the Covid response and learn from it.**

Second, NATO pandemic response fails. They can't even protect themselves

Shea 2020 — Senior Fellow at Friends of Europe

(Jamie, Senior Fellow For Peace, Security and Defence at Friends of Europe. Never Waste A Good Crisis: Are Pandemics NATO's New Security Challenge?. Friends of Europe. April 6, 2020. https://www.friendsofeurope.org/insights/never-waste-a-good-crisis-are-pandemics-natos-new-security-challenge/)

NATO has highly professional military **forces to buttress national resilience but they are useless if they cannot be used,** and so another urgent task is to better protect NATO's forces against disease and biological agents. **The military have proven no more resilient to coronavirus than the civilian population**. **A US nuclear-powered aircraft carrier is out of action in Guam with a crew of 4,000 stricken with the virus**. **A Dutch submarine has had to return home and two German corvettes have stopped operation**. **Navies** with their personnel working at close quarters **seem to be particularly vulnerable to diseases. Meanwhile, allies have been withdrawing their contingents home early from important overseas missions in Afghanistan and Iraq.** So, for the first time, allies have to choose between deploying their troops at home or abroad.

First, no impact to biological terrorism

Blum and Neumann 2020 — PhD in Biochemistry & Professor of Security Studies

(Marc-Michael, PhD In Biochemistry. Peter, Professor of Security Studies At King's College London. Corona and Bioterrorism: How Serious Is The Threat. War on the Rocks. June 22, 2020. https://warontherocks.com/2020/06/corona-and-bioterrorism-how-serious-is-the-threat/)

The novel **coronavirus pandemic has put the threat of bioterrorism back in the spotlight**. White supremacist chat rooms are teeming with talk about "biological warfare." ISIL even called the virus "one of Allah's soldiers" because of its devastating effect on Western countries. According to a recent memo by the U.S. Department of Homeland Security, terrorists are "[making] bioterrorism a popular topic among themselves." Both the United Nations and the Council of Europe have warned of bioterrorist attacks**. How serious is the threat? There is a long history of terrorists being fascinated by biological weapons, but it is also one of failures. For the vast majority, the technical challenges associated with weaponizing biological agents have proven insurmountable.** The only reason this could change is if terrorists were to receive support from a state. **Rather than panic about terrorists engaging in biological warfare, governments should** be vigilant, secure their own facilities, and **focus on strengthening international diplomacy.**

Specifically, terrorists lack the technical expertise to carry out an attack

Blum and Neumann 2020 — PhD in Biochemistry & Professor of Security Studies

(Marc-Michael, PhD In Biochemistry. Peter, Professor of Security Studies At King's College London. Corona and Bioterrorism: How Serious Is The Threat. War on the Rocks. June 22, 2020. https://warontherocks.com/2020/06/corona-and-bioterrorism-how-serious-is-the-threat/)

Technical Challenges Ivins' case helps to explain why **so many would-be bioterrorists have failed**. **At a technical level, launching a** sophisticated, large-scale **bioterrorist attack involves a toxin or a pathogen** — generally a bacterium or a virus — **which needs to be isolated and disseminated**. **But this is more difficult than it seems**. **As well as advanced training** in biology or chemistry, **isolating the agent requires significant experience. It also has to be done in a safe, contained environment**, to stop it from spreading within the terrorist group. Contrary to what al-Qaeda said in one of its online magazines, you can't just make a (biological) weapon "in the kitchen of your mom!" **In addition, there is the challenge of dissemination. Unless the agent is super-contagious, a powerful biological attack relies on a large number of initial infections in perfect conditions.** In the case of the bacterium anthrax, for example, only spores of a particular size are likely to be effective in certain kinds of weather. **State-sponsored programs often needed years of testing and experimentation to understand how their weapons could be used.** Though not impossible, **it is unlikely that terrorist groups possess the resources, stable environment, and patience to do likewise.**

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Pandemic Negative (2NC / 1NR)

2NC Deterrence DA (Impact – Turns Case)

Disadvantage turns the case. War makes disease outbreaks more likely

The Lancet 2022

(War And Infectious Diseases: Brothers In Arms. The Lancet, Editorial. Volume 22, Issue 5, P563. May 01, 2022. https://doi.org/10.1016/S1473-3099(22)00235-3)

On Feb 24, 2022, Russia invaded Ukraine. The invasion has resulted in death, injury, and the displacement of people. Even if ongoing peace talks bring a cessation to hostilities, Ukraine will likely continue to suffer for years to come. **War is always accompanied by infectious disease outbreaks**, and Ukraine will likely be no exception. The Russian invasion has severely damaged Ukraine's health-care infrastructure, with WHO confirming at least 70 Russian attacks on health-care facilities across Ukraine. Such **attacks,** combined with the destruction of roads, bridges, and public transportation networks, **prevent citizens from receiving medical help**, **increasing the risk of long-term injury and infection**. And, **once the fighting has stopped, reduced access to healthcare will hamper a population trying to rebuild**. Specialist services have also been disrupted. Russian military assaults have forced the closure of the AIDS Healthcare Foundation's HIV clinics in Kharkiv and Mariupol, raising the risk of treatment interruption in people with HIV in these cities. Interruption is associated with an increased risk of developing drug-resistant HIV, narrowing treatment options and increasing transmission. Tuberculosis control efforts have been similarly impacted. **Those suffering from tuberculosis**, who have been fleeing conflict zones to reach safer regions of Ukraine**, risk discontinuity of treatment, increasing risk of death, transmission, and emergence of drug resistance**. **SARS-CoV-2 will also spread** as physical distancing is made difficult in underground shelters and vaccination efforts are disrupted by the war. Vaccination efforts were already low before the invasion, with only 35% of Ukraine residents fully vaccinated against SARS-CoV-2. This low vaccination rate is just one of the health concerns that countries welcoming fleeing Ukrainians need to consider. Ukrainian refugees are also likely to be more vulnerable to infection given their living conditions during their escape. These are current infectious disease concerns, and **we can, sadly, look to other conflicts to identify possible long-term consequences. Syria has been gripped by civil war since 2011.** In 2016, during the 6-month Siege of Aleppo, pro-government forces cut supply lines and attacked medical facilities, leaving a city of 250 000 short of medicine and food. **One of the outcomes of the civil war and the siege has been, in 2017 and 2018, a measles outbreak** across northern Syria, including Aleppo, **after the disease had been absent in the country since 1999**. A similar story could play out in Ukraine. In October 2021, Ukraine reported a case of paralytic polio prompting the government to begin vaccinating 100 000 unprotected children, a rollout halted by the invasion. The war in Ukraine hopefully will not become a protracted conflict. As with Syria, the longer a conflict goes on, the more resources are diverted from health towards warfare. **In Afghanistan, after 20 years of US (and their allies) military presence in the country,** 2 million children are malnourished. Lack of food weakens the immune system and is part of the reason **Afghanistan is currently trying to rapidly vaccinate its population to halt their own measles outbreak**. **Yemen, suffering from a civil war since 2014, has also seen a** similar redistribution of resources. 4 million Yemenis have been internally displaced with reduced access to suitable water and sanitation services, increasing the risk of diarrhoeal diseases. In 2017, **a cholera outbreak with a suspected 2·5 million cases** was responsible for 3868 deaths. Before the war, cholera had been absent from Yemen.

NATO defense spending is on the brink. COVID-19 has limited resources for new investment

Bergmann and Cicarelli 2021 — Researchers at the Center for American Progress

(Max & Siena, Researchers At The Center For American Progress. NATO's Financing Gap: Why NATO Should Create Its Own Bank. Center For American Progress. January 13, 2021. https://www.americanprogress.org/article/natos-financing-gap/)

Since the summit, some progress has been made in strengthening the alliance. **NATO members have increased defense spending,** deployed forces in Central and Eastern Europe, and begun investing in needed capabilities. **In 2019, almost all NATO allies increased their defense spending, with nine countries hitting the 2 percent goal**.2 Most allies have put plans in place to substantially increase defense spending by 2024.3 **The alliance is stronger and better prepared to deter Russia than it was six years ago**, despite the divisive approach of President Donald Trump, **but significant gaps remain.** Marginal spending increases by various NATO members were inherently fragmented and often yielded few new major capabilities or failed to address some of NATO's serious shortfalls. Meanwhile, many member states still have yet to adequately invest in their forces, leading to very low states of readiness and operational strain. Lack of progress toward the 2 percent benchmark has also caused major diplomatic tension within the alliance between the countries meeting their commitments and those that are not.4 **Now, with the COVID-19 crisis hammering the balance sheets of all NATO members, the prospect for European defense spending looks bleak**.5 **It seems unlikely that there will be significant new investment** to address some of NATO's critical capability gaps. **Indeed, the European Union**—which had planned to increase funding to upgrade the dual-use infrastructure critical to moving NATO forces—**has reduced its planned allocations in its recent budget**.6 **NATO members seeking to keep their economies alive are unlikely to prioritize defense**. **This is a serious problem for the alliance**, and NATO needs to think more creatively about how to support continued alliance investment in the wake of the massive economic contraction caused by COVID-19. Simply demanding that countries spend more on defense, which was not very effective prepandemic, will certainly not work now. What has become apparent is that NATO's default focus on individual nation-state spending commitments was doing little to address alliancewide issues. **Collectively, European NATO members spend as much on defense as Russia**, yet the disaggregated and loosely coordinated spending by individual states means that the alliance's combat strength is well short of what it could be and has left critical gaps in its capabilities. **NATO, since its founding, has lacked the resources to fill gaps and make investments.** The alliance has overlooked one of its potentially most powerful assets—the collective economic and financial clout of its members. NATO has not leveraged its collective financial stature and the position of its many wealthy members to shore up the alliance. In the wake of the COVID-19 crisis, this must change through the creation of its own bank.

Yes tradeoff. Pandemic response takes limited resources away from deterrence

Lasconjarias 2022 — Researcher at the NATO Defense College

(Guillaume, Researcher At The NATO Defense College. Working Group Report: Military Instrument of Power and Pandemics: A Long-Term Perspective. Pandemics And International Security: The Outlook For NATO. P. 102 - 112. February 14, 2022. https://www.iai.it/en/pubblicazioni/pandemics-and-international-security-outlook-nato)

This only highlights the continuity in the full spectrum of **armed forces'** roles. Whilst their primary task is to protect their country and, if necessary, to go into combat in a full-scale war, they **have** the **unique flexibility to respond to almost whatever sort of crisis may emerge,** on national soil or abroad as an instrument of last resort. Therefore, the military instrument has become – if it has not always been – a mean for attaining foreign policy objectives as well as to protect the national interests also domestically. **When** the **Covid-19 turned into a global crisis**, worldwide, **military forces were among the first to respond** because a variety of reasons: they represent a significant pool of trained, disciplined men and women that can be quickly called upon; they are resourceful, mobile and flexible; they know how to operate even in dire situations; because in many cases they are innovative and responsive, and for sure know how to make the best use of their equipment. In spite of these exceptional measures, and whilst taking part in the global response to the pandemic, armed forces remained at the same moment focused on maintaining their ability to deliver credible and effective deterrence (Mesterhazy, 2020: 3). **This** ability to operate "full spectrum" is deeply engrained in the military's DNA if not in their means of action, yet it **raises a lot of additional concerns**. **First** of all, it seems that **the military is tasked to perform more and more "civilian" actions in a world which has become more and more complex, raising the problem of being able to act decisively** – and not just timely. **Second, the military might be considered as a "Swiss army knife" that ends up responding to any given mission, yet without having the associated means. Tasks have been multiplied and resources have shrunk, creating some "bonsai armies". How can militaries perform with the same level of efficiency in a large array of missions, from crisis management at home to high intensity conflict,** if nobody seriously defines what are the priorities**?** How could and should these armed forces be reorganized and restructured to cope with these new requirements? **In an era of renewed great power competition**, where both the socio-economic context and the international security environment have never looked as uncertain as they do today, **there seem to be only hard choices to be made and states have to weigh defense concerns against other** (social, economic) **pressing problems**.

Disadvantage turns the case. Military pandemic response risks backlash that critically undermines civilian public health programs

Gibson-Fall 2021 — Lecturer in Global Health at King's College London

(Fawzia, PhD Researcher / Lecturer In Global Health At King's College London. Military Responses To COVID-19, Emerging Trends In Global Civil-Military Engagements. Review of International Studies (2021), 42:2, 155-170.)

Resistance to military involvements in health relates to specific areas of **concerns.** These partake to the adverse effects of politicising health interventions37 (for example, the manipulation of health goals for strategic outcomes) deemed unethical and counterproductive.38 The lack of respect of the Geneva conventions by militaries (growing civilian casualties, targeting of civilian institutions)39 and the adoption of health-related 'hearts and minds' type tactics has led to cognitive dissonance in international-level civil-military relations. **Public health goals and humanitarian principles** (for example, neutrality, impartiality, and independence) **are often hard to reconcile with military mandates**40 **and institutional cultures**.41 **The conflation between civil and military roles is often deemed detrimental to delivery outcomes. Military health programmes (in disease surveillance, for instance) are** thought more likely to be **subject to geopolitical tensions and community suspicion**.42 **This distrust in turn risks having a knock-on effect on wider civilian health structures**.43 Critics fear **military involvement can be detrimental to advocacy initiatives, undermine primary care efforts or deter attention from the systemic root causes of ill health**.44 Another apprehension lies in the potential slow takeover of civilian issues and institutions by militaristic culture and processes.45 The ensuing angst lies in military and intelligence organisations using their health mandates and authority to impede on civil liberties.46 These risks have led to the idea that **civilians simply do better than the armed forces in global health emergency contexts.**47 Here, military comparative advantage is relegated to limited technical activities (for example infrastructure, airlifts, airports, transport helicopters).48 If states have turned to their militaries for assistance in COVID-19, they also lack understanding of what that assistance can or should look like to establish parameters and limits of involvement.

Military relief efforts like the plan are too expensive and don't work

De Waal 2014 — Executive Director of the World Peace Foundation

(Alex, Executive Director of the World Peace Foundation At Tufts University. Militarizing Global Health. Boston Review. November 11, 2014. https://bostonreview.net/articles/alex-de-waal-militarizing-global-health-ebola/)

The Military Has Limited Value in Humanitarian Response Ebola is not merely an epidemic, but a humanitarian crisis. The weak health services in Guinea, Liberia, and Sierra Leone are overwhelmed, people are frightened, and everyday activities such as bringing food to market are affected by fear of infection. Emergency humanitarian operations to stabilize food prices and maintain essential services are needed. **The army** can carry out some useful tasks—but it **must know its place**, and that is not in charge. As the United Nations geared up to declare that Ebola was a threat to international peace and security, Obama announced "Operation United Assistance," and dispatched the 101st Airborne Division to Liberia. He said: "Our forces are going to bring their expertise in command and control, in logistics, in engineering. And our Department of Defense is better at that, our Armed Forces are better at that, than any organization on Earth. We're going to create an air bridge to get health workers and medical supplies into West Africa faster." His words are surely true—after all, $650 billion a year should buy some impressive logistics—but **a military-led response is still cost-inefficient and ineffective**. **When Air Force planes carry out airdrops** of emergency relief, **they are invariably much more expensive and less effective than their humanitarian counterparts. Army engineers have the equipment** to construct flood defenses or temporary accommodation for people displaced by fire or water, **but there is invariably much wastage and learning on the job (by definition, too late). Experienced relief professionals can list many of the downsides of bringing in the military: they utilize vast amounts of oversized equipment, clogging up scarce airport facilities, docks and roads; their heavy machinery damages local infrastructure; they use more equipment and personnel in building their own bases and protecting themselves than in doing the job; their militarized attitudes offend local sensibilities and generate resentment; and they override the decision-making of people who actually know what they are doing**. In the days after the Haitian earthquake in January 2010, the U.S. Army was efficient at clearing debris, setting up an air traffic control system, and getting Haiti's ports and airport functional. One third of the emergency spending in Haiti was costs incurred by the military. (The costing includes only additional or marginal costs for the deployment.) When the army moved into other relief activities, such as general health and relief programs, even those marginal costs were disproportionately high. Trained for battlefield injuries, army surgeons weren't skilled at treating the crush injuries common in an earthquake zone. In West Africa today, militaries are providing an important air bridge, given that commercial airlines have stopped flying. But the United Nations could do the job more cheaply and efficiently—if it had the resources. **Invariably, military commanders want to be the ones giving orders. In a humanitarian crisis, relief operations are best run by civilians who understand relief.** Some humanitarian workers actually refuse to be seen with soldiers—even peacekeepers—who are ostensibly there to support their activities. The army can carry out some useful humanitarian tasks—but it must know its place.

Specifically, developing countries won't follow military pandemic response. Only civilian public health initiatives solve

De Waal 2014 — Executive Director of the World Peace Foundation

(Alex, Executive Director of the World Peace Foundation At Tufts University. Militarizing Global Health. Boston Review. November 11, 2014. https://bostonreview.net/articles/alex-de-waal-militarizing-global-health-ebola/)

The Legacy of Public Health and Colonialism **There is another, deeper problem with the militarization of public health: the legacy of colonialism** and coercive medicine. **Best practices in global health include efforts to be sensitive to national histories and cultures and to overcome the suspicions induced by outside health programs.** Medicine in khaki is not only inefficient, it is bad practice. **British, French, and American armies have a history of imposing control in the name of hygiene**, cordoning off a city or as-yet-insufficiently governed parts of the global borderlands. After the opening of the Suez Canal, the British and French regulated migration in the Muslim world in the name of controlling infectious diseases, especially cholera. For pilgrims to Mecca, the vaccination card preceded the passport. Hubert Lyautey, the French general who conquered Morocco, famously saw public health as a tool of counter-insurrection: "the physician, if he understands his role, is the most effective of our agents of penetration and pacification." Migrant laborers for South African mines were the focus of intense medical screening and control; rural populations in central Africa were forcibly relocated in the name of controlling sleeping sickness; traditional migration routes across the Sahel were strictly regulated ostensibly to stop transmission of infection. The United States imposed a similar securitized epidemiological control on Central America and the Caribbean after completing the Panama Canal. Its concerns were yellow fever and malaria. Army engineers developed skills and capacities in draining swamps and relocating communities to settlements where they, and their health status, could be monitored and controlled. The civil engineering skills were useful, but the military apparatus was problematic. **In much of Africa, public health has struggled to free itself from the way it was implicated in coercive colonial control measures**. **A foreign doctor** arriving in an African town with poor health service **is always openly welcomed, but there is also suspicion about whether he or she harbors a hidden agenda. Every time there is an epidemic that demands unpopular measures**—HIV/AIDS and Ebola are examples—**rumors spread that the infectious agent was introduced with the aim of controlling the African population. Frustrated physicians may stigmatize the local societies in which an epidemic has arisen**, coming to believe that it is local misbehavior and irrationality that allows infections to spread. **Such mutual resentment can quickly become the greatest impediment to public health, greater than the pathogen itself. Restrictive and unpopular measures may be needed to contain an epidemic, but they will only be effective if people understand why they are imposed.**

Counterplan won’t take years. A treaty is already being negotiated

Sharfstein 2022 — Doctor of Medicine

(Josh, M.D. The Movement For A Global Pandemic Treaty. John Hopkins Bloomberg School of Public Health. July 15, 2022. https://publichealth.jhu.edu/2022/an-international-pandemic-treaty-could-improve-prevention-and-response)

What is this pandemic treaty about and how is it getting organized? A lot of that actually remains up in the air. So far, we know that **this pandemic treaty is a call that's been recognized** to address these gaps and create a new convention or international treaty. **At the end of last year, at a special session of the World Health Assembly, it was recognized that this pandemic treaty should be further discussed, and that's why they created an intergovernmental negotiating body**. **This is made up of countries that are putting forth ideas of what the pandemic treaty would be, what powers it may hold**, and what it shouldn't be. **We're hoping to get** some further **clarity later this summer when the first draft should be released.**

Counterplan solves. A pandemic treaty would be legally binding

Jecker 2022 — Professor of Bioethics and Humanities

(Nancy S., Professor of Bioethics and Humanities At The University of Washington. Achieving Global Vaccine Equity: The Case For An International Pandemic Treaty. Yale Journal of Biology and Medicine. June 2022. 95(2): 271-280. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9235252/#)

The idea of using the treaty powers of the WHO to address global vaccine equity and general pandemic preparedness was first proposed by the President of the European Council, Charles Michel, in December 2020; Michel called for a general treaty "anchored in collective mobilisation and solidarity" with the objective "to do better in all areas where we recognize it is in our interest to strengthen cooperation" [50]. **Pre-pandemic, a Lancet Commission recommended utilizing international law to promote global health justice, calling strong legal capacity "a key determinant of progress towards global health and sustainable development"** ([51], p. 1858). **The legal basis for a Pandemic Treaty exists in the UN Charter, which includes** among its purposes, "**achieving international cooperation in solving international problems of a**n economic, social, cultural, or **humanitarian character** and promoting and encouraging respect for human rights and for fundamental freedom without distinction as to race, sex, language or religion" ([52], p. 3). **In contrast to "soft rules," such as declarations and resolutions, international laws that stem from treatises are generally binding on states** [51].

Counterplan solves. Only international law can prevent pandemics in a globalized world

Jecker 2022 — Professor of Bioethics and Humanities

(Nancy S., Professor of Bioethics and Humanities At The University of Washington. Achieving Global Vaccine Equity: The Case For An International Pandemic Treaty. Yale Journal of Biology and Medicine. June 2022. 95(2): 271-280. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9235252/#)

The pragmatic argument for considering **a Pandemic Treaty** to address vaccine equity and overall pandemic readiness **is premised on the** sober **recognition**, noted previously (in Section II), **that global interconnectivity creates** not only systemic benefits, but **systemic risks. Globalization,** "a process driven by and resulting in increased cross-border flows of goods, services, money, people, information, technology, and culture" **requires collective action and international coordination to manage** ([53] p. 10). **It would be farfetched to imagine** otherwise, ie, **that threats to health like emerging infectious diseases can be managed nationally or contained over the long-term by closing national borders**. Commenting on this, Goldin and Mariathasan point out that "**Any pathogen that is carried through a major airport hub will be global within three days at the most**" and conclude that **there is an urgent need for building capacities to address this,** including rapidly developing and scaling up vaccines ([53], p. 167). **The new landscape of public health demands legally binding understandings between multiple global actors involved in global health governance.** The ethics of solidarity and cooperation affords the ethical underpinning for such action and **the WHO treatise instrument provides the legal means to operationalize it.**

2NC Kritik (Framework)

Our framework is the judge should vote for the team that best promotes racial justice. Race-neutral policies like the plan are complicit in maintaining white supremacy. Only a focus on structural racism can transform public health

Ndumbe-Eyoh 2020 — Senior Knowledge Translation Specialist

(Sume, Senior Knowledge Translation Specialist At The National Collaborating Centre For Determinants Of Health. What Would It Take For Health Promotion To Take Structural Racism Seriously?. Global Health Promotion. Volume 27, Issue 4: p. 3-5. December 17, 2020. https://journals.sagepub.com/doi/full/10.1177/1757975920972259)

The way forward **If we accept that racism is a system,** implicated in and by all other systems, **we accept that we all have a role to play** in our everyday health promotion activities. **We then have to proactively invest in ensuring that sites of** health promotion **knowledge production, education and practice advance the interests and wellbeing of Black, Indigenous and racialized communities** (8, 9). **Health promotion has to ask,** 'What is our stake in upholding White supremacy and the 'ways of White folks'? **Are we prepared to continue to create and maintain systems and practices that harm and ultimately kill or are we ready to take racism seriously?' An explicit focus on** cultural, structural, **institutional racism and Whiteness provides direction for health** promotion **education, research and practice.** Health promoters in all spheres must develop a deep race consciousness that acknowledges the centrality of race and racism in everyday life (9, 19). **This requires moving from colour-blind or race-neutral approaches to a view that racism's contemporary manifestations are not arbitrary and mysterious, but systematic and knowable.** Racial inequities then stop being seen as random but as the natural product of oppressive racist norms, values and actions. **Doing so subverts the assumptions of everyday life which work to uphold and bolster White dominance and racial inequities** (20). Anti-racist and critical race approaches must be embedded across health promotion competencies and curricula to contribute to training a new cadre of health promoters deeply implicated in addressing racism across the spectrum of the health promotion field.

Kritik turns the case. Structural racism makes solvency impossible. The alternative is a pre-requisite to effective pandemic response

The Network For Public Health Law 2022

(The Network For Public Health Law, Legal Advocacy Organization Specializing In Public Health Law and Policy. We Need To Address Structural Racism As A Public Health Crisis. Last Updated February 18, 2022.
https://www.networkforphl.org/news-insights/we-need-to-address-structural-racism-as-a-public-health-crisis/)

We're seeing it first-hand in our communities and in decades of evidence: **racist practices perpetuated** and sanctioned **by laws and policies are at the root of the suffering endured by so many people of color**, especially Black people, in America. In the midst of a pandemic that is disproportionately affecting the Black community, the brutal killing of George Floyd is yet another example of how structural racism enables egregious harm. Laws and policies that create and maintain barriers to equal justice, power, health, and economic advancement harm people of color and negatively impact all of us. **As a country, we cannot be resilient and thrive as long as there are inequities built into our system that marginalize communities** – **the pandemic** and the current civil unrest are **[is] painfully revealing how these inequities are crushing us**. As Dr. Kesha Moore of the Legal Defense and Education Fund's Thurgood Marshall Institute wrote recently: "**Ongoing structural inequalities in nearly all aspects of life**, **from the economy to housing to health care** delivery systems, **show clear evidence of racial disparities**. **It is these inequalities**, rather than any biological or cultural differences, **that contribute most dramatically to the disparity in deadly outcomes of the current pandemic in Black communities relative to White communities." Widespread inequities create** the **conditions that stymie our ability to** fully **mitigate the** devastating health and economic **impacts of COVID-19. Negative health outcomes** and civil turmoil **are consequences of structural racism**, **and** at this moment **the two are intertwined forces that will intensify the damage from COVID-19,** damage that will continue to affect all of us in the years to come **unless we advance equitable laws and policies.**

Pandemic response is rooted in structural racism. Now is key to reimagine public health and create a health care system based on racial justice

Metzl et al. 2020 — Professor of Sociology and Psychiatry

(Jonathan, Professor of Sociology and Psychiatry At Vanderbilt University. Aletha Maybank, Chief Equity Officer Of The American Medical Association. Fernando de Maio, Assistant Professor of Sociology and Anthropology At Simon Fraser University. Responding To The COVID-19 Pandemic: The Need For A Structurally Competent Health System. Journal of the American Medical Association. 2020; 324(3):231-232. https://jamanetwork.com/journals/jama/fullarticle/2767027)

The coronavirus disease 2019 (COVID-19) **pandemic has exposed the consequences of inequality** in the US. Even though all US residents are likely equally susceptible to infection with SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), the virus that causes COVID-19 disease, the resulting illness and the distribution of deaths reinforces systems of discriminatory housing, education, employment, earnings, health care, and criminal justice.1,2 The patterns of COVID-19 illuminate centuries of support systems that the US did not build and investments it did not make. **Each stage of the pandemic**, from containment, to mitigation, to reopening, **highlights the extent to which certain populations were rendered vulnerable long before the virus arrived**. **As a result, marginalized**, minoritized, and **communities** of low wealth **have been at highest risk, with disproportionate death rates among African American, Latinx, and Native American populations** across the US.3,4 **Sociodemographic differences in COVID-19 morbidity and mortality highlight an unavoidable reality facing the** US **health care system as it strives to fulfill its mission** to promote health and well-being, and to treat disease. **At its core, the practice of medicine is based on individual-level interactions among clinicians, patients, and families. Yet the pandemic highlights the extent to which illness for many people results from larger structures, systems, and economies**.1,2 Understanding how these processes operate requires not only acknowledging the social determinants of health, but more important, moving farther upstream to address the structural drivers that generate poverty and other aspects of social disadvantage. For example, rates of adverse outcomes related to COVID-19, including deaths, can be mapped onto zip codes.2,5 COVID-19 morbidity and mortality patterns highlight ways that persons from certain groups disproportionately lack housing security or live in multifamily or multigenerational housing where physical distancing is not an option. Persons in these communities often work jobs that expose them to the virus, or earn incomes that render access to adequate medical care exceedingly difficult. **The pandemic illustrates the effects of** what Pirtle has referred to as COVID-related **racial capitalism, a system that constructs the harmful social conditions that fundamentally shape pandemic patterns**.6 Over the coming months and years, the US health care system will struggle to adapt to new, postpandemic norms. **In this moment of crisis, however, the US health care system has a generational imperative to begin to address the inequities made even more apparent by the COVID-19 crisis. The opportunity exists to reimagine and redesign the health care delivery and education systems through a lens of health equity and racial justice. By so doing, during a pandemic that highlights the extent to which no one is safe until everyone is safe, health outcomes can be improved more broadly.**

Specifically, NATO lacks expertise and supplies for pandemic response

Lundquist 2021 — Retired Captain in the U.S. Navy

(Edward, Retired Captain In The U.S. Navy. NATO Learns Lessons From COVID-19 Crisis. National Defense Magazine. August 30, 2021. https://www.nationaldefensemagazine.org/articles/2021/8/30/nato-learns-lessons-from-covid-19-crisis)

While the alliance has access to military resources and expertise, **NATO**'s role in coordinating national and multinational responses to such events is under the leadership of civilian authorities with the military in a supporting role. **Officials** also **admit that the lessons of floods and earthquakes are vastly different events from the current pandemic**, **and that the airborne virus poses very different logistical challenges**. Geoană said NATO needs to engage more with civilian authorities who are primarily the first responders to better support civil disaster response efforts. "This crisis has underlined the importance of working closely and sharing information and expertise with other international organizations, such as the United Nations Office for the Coordination of Humanitarian Affairs, the World Food Program and, of course, our strategic partner — the European Union," he said. "Regular communication has meant we could avoid duplication and collaborate when appropriate." **The alliance's COVID logistics response has not been entirely successful**, however. Geoană said **NATO's 'just-in-time' approach to supply chains**, **which had been adopted to increase efficiency and reduce costs, did not work under extreme pressure.** "**When the whole world is simultaneously crying out for medical equipment and supplies, the market simply cannot cope,"** he said. "We have to be honest here. The truth is, we were not adequately prepared for a global health crisis on this scale."

No risk of biological terrorism. History proves terrorists lack the capability

Blum and Neumann 2020 — PhD in Biochemistry & Professor of Security Studies

(Marc-Michael, PhD In Biochemistry. Peter, Professor of Security Studies At King's College London. Corona and Bioterrorism: How Serious Is The Threat. War on the Rocks. June 22, 2020. https://warontherocks.com/2020/06/corona-and-bioterrorism-how-serious-is-the-threat/)

Among terrorists, however, the use **of biological weapons has been rarer,** although groups from nearly all ideological persuasions have contemplated it. **Recent examples include a plot to contaminate** Chicago's **water** supply **in the 1970s; food poisoning** by a religious cult in Oregon **in the 1980s; and the stockpiling of ricin** by members of the Minnesota Patriot Council **during the 1990s. No one died in any of these instances**. **The same is true for** the biological warfare programs of **al-Qaeda and the Islamic State** group. **Both groups have sought to buy, steal, or develop biological agents**. For al-Qaeda, this seems to have been a priority in the 1990s, when its program was overseen by (then) deputy leader Ayman al-Zawahiri, a trained physician. With the Islamic State, evidence dates back to 2014, when Iraqi forces discovered thousands of files related to biological warfare on a detainee's laptop. **Yet none of these efforts succeeded**. **The only al-Qaeda plot** in which bioterrorism featured prominently — the so-called "ricin plot" in England in 2002 — **was interrupted at such an early stage that none of the toxin had actually been produced. The Islamic State's most serious attempt, in 2017, involved a small amount of ricin, whose only fatality was the hamster on which it was tested. Of the tens of thousands of people that jihadists have murdered, not a single one has died from biological agents.**