## 1AC – Nano Nagle

### Framework

#### the standard is maximizing expected wellbeing

#### 1] Extinction o/ws – [a] trillions of people in future generations means the future holds a lot of value which extinction destroys – outweighs their offense under any framework, regardless of whether they are deontic or aretaic [b] Gateway issue - we need to be alive to assign value and debate competing moral theories- extinction literally ends the debate on “ought”. Use EM – Evaluate the framework debate as a sliding scale not true/false – weigh probability of framework being true times contention offense – framework serves to prioritize not preclude certain impacts, so only EM is logical – eg util agrees freedom matters, but wellbeing outweighs.

### Advantage

#### Plan: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines deemed essential during public health emergencies of international concern.

#### 1] The intellectual property system is fundamentally mismatched with emergency pandemic conditions – creating a broad precedent that weakens restrictions lays the groundwork for future pandemics that are inevitable. Ensuring we are ready for next time is vital

Lindsey 21 [Brink Lindsey has written on a wide range of topics including trade policy, globalization, American social and cultural history, and the nature of human capital. His current research focuses on economic growth and the policy barriers that impede it. "Why intellectual property and pandemics don’t mix." https://www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/]

Although focusing on these immediate constraints is vital, we cannot confine our attention to the short term. First of all, the COVID-19 pandemic is far from over. Although Americans can now see the light at the end of the tunnel thanks to the rapid rollout of vaccines, most of the world isn’t so lucky. The virus is currently raging in India and throughout South America, overwhelming health care systems and inflicting suffering and loss on a horrific scale. And consider the fact that Australia, which has been successful in suppressing the virus, recently announced it was sticking to plans to keep its borders closed until mid-2022. Criticisms of the TRIPS waiver that focus only on the next few months are therefore short-sighted: this pandemic could well drag on long enough for elimination of patent restrictions to enable new vaccine producers to make a positive difference.

Furthermore, and probably even more important, this is almost certainly not the last pandemic we will face. Urbanization, the spread of factory-farming methods, and globalization all combine to increase the odds that a new virus will make the jump from animals to humans and then spread rapidly around the world. Prior to the current pandemic, the 21st century already saw outbreaks of SARS, H1N1, MERS, and Ebola. Everything we do and learn in the current crisis should be viewed from the perspective of getting ready for next time.

THE NATURE OF THE PATENT BARGAIN

When we take the longer view, we can see a fundamental mismatch between the policy design of intellectual property protection and the policy requirements of effective pandemic response. Although patent law, properly restrained, constitutes one important element of a well-designed national innovation system, the way it goes about encouraging technological progress is singularly ill-suited to the emergency conditions of a pandemic or other public health crisis. Securing a TRIPS waiver for COVID-19 vaccines and treatments would thus establish a salutary precedent that, in emergencies of this kind, governments should employ other, more direct means to incentivize the development of new drugs.

#### 2] COVID highlights just how vulnerable we are to both natural pandemics and human-made biological weapons – the deciding factor in effective response is ensuring people can be vaccinated as fast as possible

Lyon 21 [Regan F Lyon, 7-1-2021, "COVID-19 Response Has Uncovered and Increased Our Vulnerability to Biological Warfare," OUP Academic, https://academic.oup.com/milmed/article/186/7-8/193/6135020]

The 2018 National Biodefense Strategy (NBS) articulated a collaborative plan to prevent, detect, and respond to biological threats to the USA.1 The NBS highlights recent, isolated outbreaks of Systemic Acute Respiratory Syndrome (SARS), Ebola, and Zika viruses as warnings to nation states and justification for enhanced biological threat responses. Although these events are not considered deliberate threats, clandestine bioweapon programs and terrorist groups seeking such programs are known to exist and capitalize on such natural outbreaks.1 The NBS’s emphasis on prevention and response drives the requirement to enhance biological weapon deterrence and defense strategies to avert the employment of biological weapons on U.S. civilians or military personnel.1 The public health crisis that ensued with SARS-associated coronavirus-2 (SARS-CoV-2) has highlighted our nation’s bioweapon vulnerabilities on the international stage and has the potential for disastrous effects on national security. Previous questions regarding how the USA would respond to a large biological outbreak (or biological weapon) have now been answered for potential adversaries across the world. The ambiguity of both our capabilities and weaknesses, which provided deterrence to adversarial employment of biological weapons before the pandemic, no longer exists. This article will provide an overview on biological weapons and the concepts of deterrence and defense in the context of bioterrorism. Then, it will analyze how the national personal protective equipment (PPE) shortage, public resistance to public health measures, the anti-vaccination movement, and USNS (United States Navy Ship) Comfort deployment to New York City have increased our vulnerability to bioterror attack by impacting our deterrence and defense measures. Finally, it will offer recommendations to restore our bioterrorism security after the detrimental effects from the events unfolding in the USA. BIOLOGICAL WEAPONS REGULATIONS, DETERRENCE, AND DEFENSE Even though biological warfare is considered a “weapon of mass destruction” and is prohibited by a treaty drafted by the 1972 United Nations Biological Weapons Convention (BWC), not all adversaries adhere to these standards. Terrorist groups and covert operations have utilized biological weapons for small operations because the actors, by nature, are either non-eligible to ratify the treaty or would not do so if they could. Although there have been no intentional large-scale attacks, especially by adversarial nation states, this is not guaranteed to be the case in the future.2 The BWC does not prohibit ratified nations from having pathogens or toxins for peaceful purposes, such as the development of vaccines. After the natural outbreak of smallpox and its subsequent eradication accomplished by the World Health Organization in 1980, less virulent poxviruses have continued to be used in a variety of laboratories for research and development of vaccines for a variety of diseases.3 The original, more deadly strain of smallpox has been retained at two facilities in Russia and Atlanta.4 Because smallpox’s virology makes it an ideal biological weapon, the samples in Atlanta and Russia offer defense through researching countermeasures should an attack occur and simultaneously provide a repository from which a biological weapon can be acquired. “Deterrence” and “defense” are two concepts which are typically described in terms of nuclear warfare, but they can also be applied to national security from a biological attack.5 Deterrence is the ability to prevent an adversary from taking some action during peacetime.5 For biological warfare deterrence, vaccines and preventative medicine measures prevent susceptibility to a microbe. For a largely vaccinated and/or health-conscious population, the costs of production, storage, and dissemination of a bioweapon greatly outweighs the rare chance of the target contracting the disease. New Zealand’s robust public health measures, citizen compliance, and continued efforts to sustain a caseload under 20 since April is a strong deterrent for biological attack.6 Defense mechanisms decrease the effectiveness of the attack, putting a high cost-to-benefit burden on the adversary.5 A defense measure for bioterrorism would be an adequate medical treatment response to casualties of the bioweapon, decreasing mortality and the overall effectiveness of the weapon. COVID-19 PANDEMIC ANALYSIS The novel SARS-CoV-2 has several characteristics of an ideal biological weapon, including high transmission rate, long incubation period, airborne transmission, and significant morbidity/mortality.7 In fact, early in the pandemic, suspicion was cast that the virus was being developed as a biological weapon by a laboratory in Wuhan, China.8 Although these allegations have been deemed conspiracy theories as a result of misinformation operations, the resulting pandemic and the panicked public share similarities to a bioterror attack. The events occurring within the USA during the coronavirus disease 2019 (COVID-19) pandemic create a global narrative on how we respond to a biological crisis. The 2018 NBS emphasized the continued threat of biological weapons to national security and identified the need to deter and defend against bioterrorism acts.1 This section will analyze events in the USA during the pandemic, how they bolstered or negated our current bioterrorism deterrence or defense strategies, and offer areas for improvement to restore our bioterror security.

#### 3] Reducing IP restrictions on medicine is essential for expanding access – especially in developing countries, where lack of capital and domestic industry makes the same people who are most vulnerable to diseases the least likely to have access to expensive brand-name drugs

Baird 13 [Sean, Boston College of Law. Magic and Hope: Relaxing Trips-Plus Provisions to Promote Access to Affordable Pharmaceuticals. Boston College Journal of Law & Social Justice, 33(1), 107-145, 2013, http://lawdigitalcommons.bc.edu/jlsj/vol33/iss1/4, accessed 7-31-21]

TRIPS-Plus provisions in U.S. FTAs impede access to pharmaceuticals for indigent populations.42 The similarities between U.S. patent law and the TRIPS Agreement demonstrate the United States's influence in establishing global intellectual property standards.43 Despite the suc- cess of the United States in shaping global intellectual property stan- dards, the TRIPS Agreement maintains several flexibilities, namely data exclusivity and compulsory licensing, which were affirmed by the Doha Declaration.44 The United States's dissatisfaction with the level of intellectual property protection afforded by the TRIPS Agreement prompted the proliferation of TRIPS-Plus provisions in U.S. FTAs.45

A. Values and Ideals in U.S. Patent Law

The preeminence of patents in the United States is evidenced by the fact that patents are constitutionally protected to promote innova- tion and discovery.46 A patent is a grant of property issued by a gov- ernment that provides limited rights to the patent owner.47 A patent owner in the United States is granted monopolistic control over his or her invention for twenty years, during which time no one may make, sell, or use the patented product, absent permission from the patent holder.48 This exclusive right promotes innovation by enabling the pat- ent owner to avoid pricing competition when selling the patented product.49 In return for monopolistic power to exclude, a patent owner must disclose the technological processes and data behind the prod- uct.50 Other producers use this information, saving on the cost of re- search and development while also expediting the regulatory process, in order to offer competitive pricing when the patent terminates.51

Patents are particularly valuable to the drug industry given the plethora of research and development required to produce pharma- ceuticals.52 When a drug is no longer under patent, pharmaceutical companies must compete with generic producers who provide medi- cines at much lower prices.53 Pharmaceutical companies assert that re- search and development challenges require a rigid patent system to recover investment, turn profit, and promote continued innovation.54

In the context of international trade, pharmaceutical companies have much at stake as LMICs produce generic versions of patented drugs and sell these medications around the world, undercutting brand- name profitability.55 Although the pharmaceutical industry ranks as one of the most profitable industries in the United States, these patent con- cerns have led to the development of powerful special interest groups that the United States relies on when considering trade agreements, in- cluding the TRIPS Agreement.56

B. Global Expansion of U.S. Patent Ideals Through the TRIPS Agreement

The combination of special interests and traditional value placed on patent protection has encouraged the United States to enforce its patent ideals globally by linking patent protection and international trade through the TRIPS Agreement.57 Touted as "unquestionably the most important development in international intellectual property law [in a century]," the TRIPS Agreement "attempts to strike a balance be- tween the long term social objective of providing incentives for future inventions and creation, and the short term objective of allowing peo- ple to use existing inventions and creations."58 To accomplish this, the agreement requires all WTO signatories to implement minimum stan- dards of intellectual property law.59

The United States's influence is acutely evident throughout the TRIPS Agreement's patent provisions, which practically mirror U.S. patent law.60 For example, like U.S. patent law, the TRIPS Agreement grants patent owners exclusive rights to prevent others from making, using, selling, or importing the patented product for twenty years.61 Moreover, neither the TRIPS Agreement nor U.S. patent law permits exceptions for patenting pharmaceuticals or pharmaceutical proc- esses.62 Both the United States and the TRIPS Agreement prohibit the use of compulsory licensing for products not developed locally.63 Lastly, both the United States and the TRIPS Agreement stipulate that in ex- change for a period of monopolistic control, the patent owner must disclose the invention "in a manner sufficiently clear and complete for the invention to be carried out by a person skilled in the art . . . ."64

Although the United States was largely successful in expanding its patent ideals through the TRIPS Agreement, LMICs maintained considerable flexibility to promote access to drugs.65 This success is highlighted by the TRIPS Agreement's treatment of data exclusivity and compulsory licensing.66

1. Data Exclusivity

The TRIPS Agreement requires patent holders to disclose relevant information regarding the development of the patented product, in- cluding clinical data.67 Pharmaceutical companies invest a significant amount of time and money to develop the clinical data required to patent new drugs.68 Generic drug companies rely on the clinical data collected by brand-name drug companies in order to demonstrate that the generic drug is pharmacologically equivalent to the brand-name pharmaceutical.69 In doing so, generic producers avoid the inordinate time and expense required to generate this data, enabling expeditious regulatory approval and delivery of affordable medicines upon the ex- piration of brand-name patents.70 The TRIPS Agreement requires pro- tection of such data but affords signatories broad discretion to utilize clinical data to protect the public and promote public health, as long as steps are taken to prevent unfair commercial use.71 Moreover, scholars contend that in light of the TRIPS Agreement's purpose and objectives, the agreement does not require a period of data exclusivity, contrary to U.S. patent law.72

2. Compulsory Licensing

A compulsory license is a government authorized license to a third party for the purpose of manufacturing and producing a patented in- novation without consent from the patent owner.73 Article 31 governs compulsory licenses under the TRIPS Agreement, granting a govern- ment broad discretion in issuing these licenses.74 The following re- quirements must be met in order to obtain a compulsory license: (1) the country must ensure that the third party seeking the license at- tempts to obtain authorization from the patent holder on reasonable commercial grounds; (2) the scope and duration of the compulsory license must be limited to the purpose for which the license was author- ized; (3) the compulsory license must be predominately used "for the supply of the domestic market of the Member authorizing such use;" and finally (4) the country must provide the patent holder with "ade- quate remuneration . . . taking into account the economic value of the authorization."75 Article 31 may be waived in cases of extreme urgency, national emergency, or public non-commercial use.76

Although HICs and LMICs reached a compromise on compulsory licensing, the issue became increasingly contentious upon implementa- tion.77 HICs were dismayed with the lack of clarity surrounding terms like "adequate remuneration" and "national emergency."78 LMICs were frustrated with Article 31(f) which stipulates that compulsory licenses must be predominately used for distribution within the domestic mar- ket.79 Because many low-income countries lack manufacturing capacity, compulsory licensing under Article 31 does not provide a viable method of obtaining pharmaceuticals at a competitive price.80 At the same time, alarm over HIV/AIDS, malaria, and tuberculosis grew as developing countries struggled to contain and treat infectious disease epidemics.81 These concerns led to the signing of the Doha Declaration at the WTO Ministerial Conference in 2001.82

C. A Blow to U.S. Interests: The Doha Declaration and Article 31bis

As WTO signatories began implementing the TRIPS Agreement, the scourge of HIV/AIDS proliferated and infections increased by ten percent from 2000 to 2001.83 At that time, the World Health Organization estimated that less than four percent of those in need of HAART had access.84 It is in this context that the Doha Declaration "recog- nize[d] the gravity of the public health problems afflicting many [LMICs], especially those resulting from HIV/AIDS, tuberculosis, ma- laria and other epidemics."85 WTO delegates agreed that signatories should interpret and implement the TRIPS Agreement in a way that promotes public health and access to medicines for all.86

Intellectual property flexibilities promoted by the TRIPS Agree- ment were reaffirmed in the Doha Declaration.87 Specifically, the Doha Declaration implicitly affirmed the TRIPS Agreement's deferential data exclusivity provisions and explicitly confirmed the use of compulsory licenses.88 The Doha Declaration granted broad discretion with regard to compulsory licensing, asserting that WTO signatories have "the right to grant compulsory licences [sic] and the freedom to determine the grounds upon which such licences [sic] can be granted."89 Perhaps most importantly, the Doha Declaration recognized the ineffectiveness of compulsory licensing for countries with limited or no manufacturing capacity.90 To address this weakness, WTO signatories amended the TRIPS Agreement with Article 31bis, which enables countries with lim- ited or no manufacturing capacity to import generic drugs from other countries, thereby promoting access to more affordable medicines.91

Despite the Doha Declaration's affirmance of deferential data exclusivity and compulsory licensing as valuable mechanisms to promote access to medicine, the United States dominated the TRIPS Agreement negotiations.92 A World Bank study concluded that low-income countries stand to lose twenty billion dollars from transfers of technology, including pharmaceuticals, if the TRIPS Agreement is fully imple- mented.93 Still, the United States had to accept compromises during the negotiations and has remained discontent with the level of protection afforded to pharmaceutical patents by the TRIPS Agreement.94 This dissatisfaction spurred the proliferation of TRIPS-Plus provisions in bilateral U.S. FTAs.95

D. The Proliferation of TRIPS-Plus Provisions in U.S. FTAs

The TRIPS Agreement creates a regulatory "floor," consisting of minimum levels of protection that must be afforded to intellectual property by all WTO signatories.96 Countries are therefore permitted to seek higher levels of protection in FTAs, and the United States has done so in negotiating bilateral FTAs with numerous countries.97 These trade agreements are commonly called TRIPS-Plus U.S. FTAs because they incorporate more stringent intellectual property protection provisions than the TRIPS Agreement, while also limiting the freedoms and flexibilities provided by the TRIPS Agreement.98

Beginning with the Bush administration and continuing through the Obama administration, the U.S. has sought to "ensur[e] that the provisions of any multilateral or bilateral trade agreement governing intellectual property rights that is entered into by the United States re- flect a standard of protection similar to that found in United States law."99 Pressure from the pharmaceutical industry led to the implementation of several TRIPS-Plus provisions, including rigid data exclusivity policies and limitations on compulsory licensing, thereby impeding access to affordable medicines for indigent populations in desperate need.100

1. TRIPS-Plus Impact on Data Exclusivity Provisions

TRIPS-Plus data exclusivity provisions in U.S. FTAs constrict the flexibilities afforded by the TRIPS Agreement.101 Whereas the TRIPS Agreement applies a deferential approach towards data exclusivity, U.S. FTAs apply the same level of protection afforded under U.S. patent law.102 In U.S. FTAs, competing manufacturers are prohibited from relying on clinical data for five to fifteen years after the date of a pharmaceutical's initial regulatory approval.103 Brand-name pharmaceutical companies favor data exclusivity provisions because they enable drug companies to exploit profits by suspending competition.104

Clinical data is costly and time consuming, and data exclusivity provisions may prohibit generic producers from introducing more affordable medication immediately following a patent's expiration by prohibiting access to data previously gathered by the patent holder.105 To compete, generic producers may be forced to conduct their own costly research and development, negating their ability to provide affordable drugs.106 Alternatively, generic companies would have to delay regulatory approval and production of generic drugs.107 Thus, TRIPS- Plus data exclusivity provisions in U.S. FTAs effectively empower patent holders to extend monopolistic control of pharmaceuticals by obstructing generic competition, consequently diminishing access to medicines for indigent populations.108

2. TRIPS-Plus Impact on Compulsory Licensing

Although to the TRIPS Agreement enables WTO signatories to es- tablish their own national compulsory licensing scheme, TRIPS-Plus provisions in U.S. FTAs significantly limit compulsory licensing.109 Under U.S. FTAs, parties may typically only grant compulsory licenses in emergency situations, as an anti-trust remedy, or for public non- commercial use.110 Notably, U.S. FTAs do not define "emergency situa- tions" or "public non-commercial use."111 Some TRIPS-Plus provisions require "reasonable and entire" remuneration for patent owners as op- posed to "adequate remuneration" required by the TRIPS Agree- ment.112 Finally, U.S. FTAs permit challenges to compulsory licenses on the grounds that a license was not warranted under the specific circum- stances.113 By confining a government's ability to issue compulsory licenses and providing an opportunity for the patent holder to challenge the issuance of compulsory licenses, TRIPS-Plus compulsory licensing provisions diminish a generic producer's ability to compete and enable the patent holder to manipulate drug pricing.114 The net result is diminished access to medicines for Hope Tukahirwa and millions like her.115

II. Why TRIPS-Plus Provisions are Problematic: Rigid Data Exclusivity Provisions and Compulsory Licensing Provisions Obstruct Access to Medicine

TRIPS-Plus provisions promote unyielding data exclusivity and limit compulsory licensing to the detriment of indigent populations lacking access to affordable pharmaceuticals.116 Data exclusivity provisions in U.S. FTAs with Guatemala and Vietnam, two countries struggling with staggering poverty, have led to increased pharmaceutical prices by delaying generic competition.117 Moreover, the exclusion of compulsory licensing from FTAs or proposed FTAs with the Dominican Republic, Thailand, and the Southern African Customs Union (SACU) could lead to overwhelming public health challenges as generic competition is strangled from the market while patent holders maintain monopolistic control over pharmaceutical prices.118

#### 4] Expansion enables domestic manufacturing and innovation that decentralizes pharma supply chains

HRW 6/3 — (Human Rights Watch, “Seven Reasons the EU is Wrong to Oppose the TRIPS Waiver“, 6-3-2021, Available Online at https://www.hrw.org/news/2021/06/03/seven-reasons-eu-wrong-oppose-trips-waiver, accessed 10-5-2021, HKR-AR)

The European Commission claims that intellectual property (IP) is not a barrier to scaling up the manufacturing of vaccines or other health products needed for the Covid-19 response, suggesting that sharing IP would not immediately speed up manufacturing. Right now, there are manufacturers with capacity to produce additional Covid-19 vaccines and other health products at factories in Bangladesh, Canada, Denmark, India, and Israel, but they are unable to contribute because they do not yet have the right licenses. So, **IP is a barrier to them.** The TRIPS waiver proposal sponsors and experts at the leading science journal Nature, Médecins Sans Frontières (MSF) Access Campaign, the Third World Network, and others have presented many other concrete examples of how enforcement of IP rules blocked, delayed, or limited production of chemical reagents for Covid-19 tests, ventilator valves, Covid-19 treatments, and elements of Covid-19 vaccines. IP constraints have not only led to vaccine shortages but have also led to shortages of key raw materials like bioreactor bags and filters.

Rather than manufacturers being held back by an inherent lack of manufacturing and technological capability, studies have shown that transnational claims to IP impede new manufacturers from entering and competing in the market. The same dynamics are playing out today with Covid-19.

Even though a waiver will not automatically expand production overnight, it paves the way for speedy technology transfers and manufacturing.

The waiver by itself will not automatically result in widespread and diversified manufacturing, but it will ease complex global rules governing IP and exports and give governments freedom to collaborate on technology transfers and exports **without fearing trade-based retaliation.** It will help reduce the dependence on any one country or region for medical products and mitigate the risks of export restrictions. With new variants emerging and some evidence that repeat vaccine boosters may be needed, the waiver will enable governments around the world to be prepared for a long-term response to Covid-19.

Experts have mapped out plans for how the manufacturing of mRNA and other vaccines, could be dramatically expanded in a relatively short period of time. Waiving certain IP rules in the TRIPS agreement over the next three years could help create diverse regional manufacturing hubs and protect the EU and the rest of the world from future pandemics, supply chain disruptions, and resulting economic disaster.

Concerns that widening the universe of producers may lower or compromise quality standards are unfounded because stringent regulatory authorities and the World Health Organization (WHO) would continue to play their existing role as arbiters of quality and safety for vaccines, which have a very stringent process for approval.

Dose-sharing and COVAX will not be enough to deliver universal and equitable vaccine access.

The European Commission points to its participation in COVAX to suggest that it is effectively leading efforts to promote equitable access to vaccines. Individual member states have begun to use COVAX to share some of the doses they prebooked with countries in need.

However, COVAX currently only aims to provide vaccines for 20 percent of participants’ populations, far from the coverage needed to end the pandemic. Vaccine supply shortages have already hampered COVAX’s ability to reach that target. The facility began delivering vaccine doses in late February, but has only been able to deliver 71 million vaccine doses to over 100 countries as of May 25, 2021 barely enough to cover 1 percent of the combined populations of those countries.

Further, COVAX is heavily dependent on AstraZeneca’s vaccines manufactured at the Serum Institute of India. Because of the huge surge in Covid-19 in India, the Indian government has currently restricted export of vaccines, and COVAX is facing a shortfall of 190 million vaccine doses. Serum Institute of India recently announced that it expects to resume supplying COVAX only by the end of 2021.

Finally, COVAX only applies to procurement and allocation of vaccines. India and South Africa’s proposal would cover a broader range of health products and technologies needed for the Covid-19 response including tests, treatments, personal protective equipment, and more. The devastating recent surge in infections and deaths in India, Brazil, and Nepal shows that we need more than vaccines to save lives.

Temporarily waiving patent monopolies will not end all future innovation to develop vaccines and drugs.

Pharmaceutical companies and their lobbying groups claim that patent monopolies to commercialize their inventions spur innovation and that waiving such monopoly rights during a devastating global pandemic, “would jeopardize future medical innovation, making us more vulnerable to other diseases.”

The UN Committee on Economic, Social and Cultural Rights stated in April 2020 that “[P]andemics are a crucial example of the need for scientific international cooperation to face transnational threats … [i]f a pandemic develops, sharing the best scientific knowledge and its applications, especially in the medical field, becomes crucial to mitigate the impact of the disease and to expedite the discovery of effective treatments and vaccines…. The Committee reiterates that ultimately, intellectual property is a social product and has a social function and consequently, States parties have a duty to prevent unreasonably high costs for access to essential medicines.”

It is a disservice to humanity to claim scientists and researchers would have no interest in developing lifesaving vaccines and drugs without the promise of patent monopolies. Jonas Salk, the inventor of the polio vaccine, did not claim any monopoly over it and gave it away for free. When he was asked who owned the patent for his vaccine, he reportedly said, “Well, the people, I would say. There is no patent. Could you patent the sun?”

Economists Mariana Mazzucato and Jayati Ghosh, and public health activist Els Torreele, argue that IP rights were never designed to be used during pandemics. “Patents erect barriers against competitors when what is needed is technological co-operation, harnessing our global scientific and technological capabilities to fight the virus together,” they explain. The 1994 Marrakesh Agreement, which established the WTO allows for waivers in exceptional circumstances. What could be a more exceptional circumstance than a global pandemic that has claimed the lives of 3.5 million people? Dr. Tedros Adhanom Ghebreyesus, the director-general of the WHO, supported the waiver, asking poignantly: “If not now, when?”

The argument that we need market-based incentives like patents to spur innovation also ignores the fact that billions of Euros of public money have funded research, development, and delivery of Covid-19 vaccines and other health technologies. For example, a recent study found that public money from government and philanthropic sources accounted for 97.1 to 99 percent of the funding toward research and development of the Oxford-AstraZeneca vaccine. Johnson & Johnson received an estimated US$1 billion (€820 million) in funding from the US government for development of its Covid-19 vaccine; Moderna’s vaccine was also significantly funded by public money from the US government. Even where public money was not directly given for research and development, experts say that governments’ advance market commitments significantly de-risked the investments of pharmaceutical companies, by providing them a guaranteed market even before their vaccines were proven to be safe and effective.

#### 5] Building domestic productive capacity is key to future pandemic resilience after COVID

UNCTAD 20 [The United Nations Conference on Trade and Development was established in 1964 as an intergovernmental organization intended to promote the interests of developing states in world trade. UNCTAD is the part of the United Nations Secretariat dealing with trade, investment, and development issues. "COVID-19 heightens need for pharmaceutical production in poor countries." https://unctad.org/news/covid-19-heightens-need-pharmaceutical-production-poor-countries]

With more than 100 projects to develop a COVID-19 vaccine underway around the globe – eight of which have entered the clinical stage – hope is growing for a miracle breakthrough. But so is concern over who would and would not have access to the shot, if and when one is approved. “Once a vaccine for COVID-19 is available, the massive demand is likely to outstrip supply quickly,” said James Zhan, UNCTAD’s director of investment and enterprise. “If the pharmaceutical industry cannot keep up with demand, populations in poor countries will be the ones left behind,” he said while opening a webinar organized with the World Health Organization (WHO). Lack of access to essential medicines is a tragic reality for many families in developing nations. For example, nearly half a million children in sub-Saharan Africa die each year from vaccine-preventable diseases, according to the WHO. Back in the spotlight COVID-19 has thrust the issue back in the spotlight. Fears that access would be based on some sort of pecking order peaked on 13 May when French pharmaceutical giant Sanofi Pasteur said the first doses of their vaccine, if approved, would go to the United States because its government had invested first in the required research and development. The following day, more than 140 world leaders and public figures signed an open letter calling for global public health interests to be given priority over nationalism and corporate profits. The call for a “people’s vaccine” followed a European Union-led event that a week earlier had secured nearly $8 billion from governments within and outside the bloc to help ensure universal and affordable access to COVID-19 medication. And on 19 May, the World Health Assembly adopted a historic resolution co-sponsored by more than 130 countries calling for equitable access to vaccines and treatments against the virus. Untapped local production While the resolution and funds will help, they provide a temporary solution. And with discussions focused on the issue of patents and profits, a fundamental issue is being overlooked: the lack of productive capacity in developing countries. Vaccine production is currently concentrated in a few developed countries, in the hands of a few major players. According to the WHO, nearly one third (32%) of vaccines have fewer than four suppliers, while nearly two thirds (63%) have two or fewer prequalified products. “COVID-19 has shown just how vulnerable medical product supply chains are when relying on a small number of manufacturers for raw materials and final products,” said Emer Cooke, director of the WHO’s regulation and prequalification department. According to UNCTAD and the WHO, many developing countries need help to build their capacity to produce essential medical products, whether they are vaccines, antibiotics or personal protective equipment. Those that have so far succeeded in establishing a local pharmaceutical industry capable of complying with international quality standards are mostly middle-income and low middle-income countries in Asia, such as India and Thailand. Productive capacity has remained largely untapped in Africa, where the majority of the least developed countries are located. 25 million doses Of the 40 vaccine manufacturers in 14 nations that are part of The Developing Countries Vaccine Manufactures Network, only one is African: the Biovac Institute based in Cape Town, South Africa, which currently delivers over 25 million doses of vaccines each year for illness such as measles, polio and tuberculosis. Biovac’s chief executive officer, Morena Makhoana, said Africa’s public health security requires ramped-up local production. Otherwise, the continent’s 1.2 billion people remain vulnerable to shocks in global supply chains and foreign governments’ trade policies. Since the pandemic began, nearly 80 countries have imposed some form of restriction on the **export of medical supplies**. “African governments should look at domestic capacity as an insurance for the next pandemic,” Mr. Makhoana said. “We cannot continue to rely on external sources.”

#### 6] Counterfeiting, innovation, donation, and manufacturing arguments are all wrong—strong domestic manufacturing is essential to pandemic containment

Gostin 9/27 — (Lawrence O Gostin, Lawrence O. Gostin is professor of global health law, Georgetown University, and directs the World Health Organization Center on Global Health Law. His book "Global Health Security: A Blueprint for the Future"will be published in Oct. 2021, “Biden’s plan to vaccinate the world won’t work. Here’s a better one. “, Washington Post, 9-27-2021, Available Online at https://www.washingtonpost.com/outlook/2021/09/27/biden-vaccines-globe-inequity-donations/, accessed 10-5-2021, HKR-AR)

Ramped up charitable donations are urgently needed but they will never be enough to meet global need. That’s why vastly increased manufacturing of vaccines abroad makes more sense than a donations-only approach. Donations — whether of personal protective equipment (PPE), oxygen or vaccines — always seem to come late and in insufficient quantities. Empowering regional hubs to manufacture their own vaccines, in contrast, would amplify supplies globally and enable countries to serve their own needs and that of their regions — whether Africa, Latin America or Asia.

The most likely vaccine candidates for regional production also happen to be the most technologically advanced. That’s because mRNA vaccines can be manufactured more rapidly, and at larger scale, more easily than traditional vaccine technologies, such as that used in the Johnson & Johnson vaccine. (MRNA vaccines are produced by small chemical reactions and don’t need living components, like the weakened or inactivated viruses used in traditional vaccines). They are also more easily adapted to target emerging variants, because it’s possible to replace one sequence of mRNA in the vaccine for another in a matter of weeks. But Pfizer-BioNTech and Moderna have thus far kept their intellectual property and trade secrets close to the chest. (Moderna has said it will not enforce its patents related to its coronavirus vaccine, but that doesn’t mean it will share its patented information with others, let alone its manufacturing know-how.)

The vaccines were hardly developed purely by the private sector: Moderna received $2.5 billion from Operation Warp Speed, both Moderna and Pfizer benefited from over a decade of National Institutes of Health basic research funding for mRNA technologies, and NIH holds several key mRNA patents.

That strengthens the case for forcing the companies — in the name of national defense — to share their technologies. Under the DPA, the government would compensate the companies both for the costs of any additional production and for the technology-sharing arrangements. The government would determine “reasonable” compensation, and the drug companies could challenge the sum in courts, but there is nothing outrageous about this: The Fifth Amendment to the Constitution requires “just compensation” for a “taking,” which is simply the fair market value for the property, including intellectual property.

Some observers might worry that sharing our cutting-edge technologies in this way would lead to its being co-opted by other countries, especially adversaries such as China or Russia. We could hedge against that threat by requiring that foreign producers keep innovative technologies confidential and secure. And these producers would have to pledge to exclusively serve low-income markets, and not usurp richer markets in the United States and Europe. We’ve used that model before to empower foreign manufacturers to make antiretroviral medications for HIV.

Many have argued that foreign manufacturers don’t have the technical competence to produce cutting-edge vaccines. But countries including India, Brazil and Vietnam have a proven track record in vaccine production. And South Africa is already establishing a major mRNA vaccine technology transfer hub, with the support of the World Health Organization. (All it’s waiting for is cooperation from the innovator drug companies.) Countries such as Australia, Singapore and South Korea have invested in advanced vaccine technology but they, too, require cooperation from Pfizer and Moderna.

#### 7] Only 0.9% of the developing world has the vaccine – capacity to produce it exists, but intellectual property restrictions are preventing production. Expanding access is key – it stops mutations and variants that take us back to square one on COVID

Erfani et al 21 [Parsa Erfani MD Candidate at Harvard Medical School. "Intellectual property waiver for covid-19 vaccines will advance global health equity." https://www.bmj.com/content/374/bmj.n1837]

By late June 2021, 46% of people in high income countries had received at least one dose of the covid-19 vaccine compared with 20% in middle income countries and only 0.9% in low income countries.1 This inequity has been driven by a global political economy that has permitted some countries to purchase more vaccine than they require while others have very limited supplies. Canada, for example, with a gross domestic product (GDP) of $46 000 (£32 000; €39 000) per head has vaccines for 434% of its population, whereas Jordan, which has twice the incidence of covid-19 and a GDP of $4400 per head, has secured doses for only 6% of its people.2 As covid-19 variants are already showing some ability to evade the current vaccines, it is evident that without global vaccine equity and immunity, our efforts against covid-19 are in jeopardy.

Equitable vaccine distribution to the world’s highest risk populations requires a multipronged approach that includes vaccine development and approval; scaling manufacturing; streamlining shipment, storage, and distribution; and building vaccine confidence. International collaborations have helped tackle several of these fundamentals. However, the global community remains deeply divided on how to overcome the scarcity of supply. Pharmaceutical trade associations claim that supply is not a problem as manufacturers can supposedly provide 10 billion doses by the end of 2021.3 But as suppliers consistently fall short in achieving manufacturing targets, production is clearly a bottleneck to global vaccination.3 Indeed, at the current global vaccination rate, it will take years to achieve the needed level of global immunity.4

The barrier to adequate vaccine supply today is not lack of vaccine options, nor even theoretical production capacity; the problem is the intellectual property (IP) protection governing production and access to vaccines—and ultimately, the political and moral will to waive these protections in a time of global crisis. Without such liberty, there will not be enough vaccine fast enough to prevent the spread of variants, the avoidable deaths, and the continued choking of low and middle income countries (LMICs) through poor health.

#### 8] Resistance causes extinction---microbiome collapse and superbugs.

Garrett 16. (Laurie Garrett is a Pulitzer prize-winning science journalist and writer of two bestselling books. She was awarded the Pulitzer Prize for Explanatory Journalism in 1996 for a series of works published in Newsday, chronicling the Ebola virus outbreak in Zaire. Antibiotic-Resistant Bacteria and the World's Peril. September 19, 2016. https://blogs.scientificamerican.com/guest-blog/antibiotic-resistant-bacteria-and-the-world-s-peril/)

Welcome to the Anthropocene, the era in which one species—human beings—so utterly dominates the planet that all of the driving forces of climate, oceans, geology, air and every other life form on Earth are controlled by the activities of humanity. Most of the damage is thoughtless. Humans don’t decide to pollute, they just do so. People don’t make a choice to lower the numbers of oxygen-producing trees on the planet, they just chop them down without thinking about it. Among the most dangerous of these thoughtless actions executed by our species is wild misuse of antibiotics. On September 21, the United Nations General Assembly is convening a special session to look at ways to curb use of precious medicinal drugs that are swiftly being outwitted by drug-resistant bacteria, making everything from a scraped knee to a bout of pneumonia far more dangerous and difficult to treat. But that focus, important as it is, remains limited to human use of chemicals and concern about their misuse to our species’ health. Genuine governance and stewardship in the Anthropocene requires a far broader look at what our activities mean for the planet, writ large. At the most basic levels of life every single system on Earth is controlled, or influenced, by microbes—microscopic creatures ranging from nano-sized viruses to enormous colonies of bacteria; from populations of microbes in the depths of the oceans to the inside of the human gut. A human being is made up of about 30 trillion cells and 39 trillion microbes, most of which are indispensable to our mental and physical health. If all the viruses and parasites swarming inside and on the skin of a human being are tallied the microbe-to-cell ratio is about ten-to-one. The microbes—collectively known as the Human Microbiome—digest our food, help us do battle with invading pathogens, clean our skin and provide us fuel. Life without microbes is no life at all. Antibiotics kill bacteria, and as anybody who has been on a long course of the drugs to treat an ailment knows, the medicine is indiscriminate, knocking off not only invaders like the bugs that cause pneumonia and ear infections, but also those that prevent stomach aches and constipation in response to ingestion of food. Human overuse or misuse of antibiotics has bred the emergence of Superbugs that are not only resistant to the drugs, but may be able to surge in numbers within a person’s gut, for example, leading to dangerous imbalances in bacterial populations that then cause diabetes, some types of heart disease, depression and an enormous range of common diseases. The Earth has its own microbiome, representing about a third of the weight of all biological material and life forms on the planet. And it is every bit as indispensable to the planet as your microbiome is to your personal health. Microbes living on the surface of the oceans, for example, aerosolize and end up in the atmosphere, where water droplets collect on their surfaces, forming clouds . Eliminating those microbes would directly affect rainfall. More oxygen that humans breathe is made by microbes than plants. And even the plants rely upon the microbiome of soil to transfer nutrients into their roots, allowing trees and forests to make more oxygen for humans to breathe. So it should be with some considerable alarm that we consider the killing potential manmade antibiotics have for Earth’s microbiome.

#### 9] New diseases cause extinction – uniquely probable due to environmental changes.

Mooney 21 — (Tom Mooney, Senior Communications & Advocacy Manager for the Coalition for Epidemic Preparedness Innovations, “Preparing for the next “Disease X””, CEPI, 2-1-21, Available Online at <https://cepi.net/news_cepi/preparing-for-the-next-disease-x/>, accessed 9-10-21, HKR-AM)

Disease X represents the knowledge that a serious international pandemic could be caused by a pathogen currently unknown to cause human disease. It was first included in the WHO’s list of priority pathogens in 2018. COVID-19 represents the first occurrence of Disease X since its designation was established, emerging much sooner than anticipated.

While the world battles to control COVID-19, we know that future outbreaks of Disease X are **inevitable**. Our interconnected world has made us more vulnerable than ever to the rapid spread of new emerging infectious diseases. Rapid urbanisation, deforestation, intensive agriculture, livestock rearing practices, climate change and globalisation are increasing opportunities for animal-to-human contacts and for human-to-human transmission of disease on a global scale. **The threat of Disease X infecting the human population, and spreading quickly around the world, is greater than ever before.**

COVID-19: CEPI’s first Disease X

When CEPI was established in 2017 we classed Disease X as a serious risk to global health security, for which the world needed to prepare. Prior to the COVID-19 pandemic, CEPI had initiated a rapid response programme—including mRNA vaccines—against novel pathogens. Our goal was to be able to start safety testing of vaccines within months of a new pathogen being genetically sequenced.

In January 2020—within 2 weeks of the publication of the genome sequence of the COVID-19 virus, and with just 141 confirmed cases of COVID-19 globally—CEPI began work on developing vaccine candidates against the virus. CEPI was able to move with such agility because it had already identified coronaviruses as serious threats and invested over $140 million in the development of vaccines against MERS. Within a few weeks of the COVID-19 outbreak, most of CEPI’s MERS vaccine development partners had pivoted to work on the new virus.

Just one year later, two CEPI-supported vaccine candidates are amongst the first in the world to be approved by regulatory authorities and deployed to protect people from the virus; and potentially over one billion doses of vaccine enabled by CEPI investment will be available to the COVAX Facility in 2021.

The speed of the scientific progress has been astounding, compressing vaccine development—which typically takes a decade into the space of 12 months—yet over 2 million lives have been lost to COVID-19 already and economies the world over have been devastated.

So, could we move even faster next time?

What next for Disease X?

We don’t know where or when the next Disease X will emerge, only that it will. As COVID-19 has demonstrated, diseases do not respect borders so we need to be prepared on a global scale to respond to future outbreaks of Disease X, and we need to do it fast.

In many ways COVID-19 is a proof of concept for rapidly developing a vaccine against a new viral threat. Scientists were already working on vaccines against MERS and SARS—pathogens from the same virus family as COVID-19—which gave us a crucial head start this time around.

25 viral families are known to infect humans, and over 1.6 million yet-to-be-discovered viral species from these viral families are estimated to exist in mammal and bird hosts—the most important reservoirs for viral zoonoses.

We cannot develop vaccines against all potential viral threats, but we could produce a library of prototype vaccines and other biological interventions against representative pathogens from each of these 25 viral families. Having such a library of prototype vaccines, which could be ‘pulled off the shelf’, and advanced into clinical testing as soon as a related threat emerges would dramatically accelerate the development of vaccines.

We also know that beta coronaviruses that cause SARS and MERS are associated with case fatality rates of 10-35% (25-88 times worse than COVID-19) and that coronaviruses circulate widely in animal reservoirs. The emergence of a coronavirus variant combining the transmissibility of COVID-19 with the lethality of SARS or MERS would be utterly devastating. We must minimise this threat as a matter of urgency. One way to do this in the long-term would be to develop a vaccine that provides broad protection against coronaviruses in general.

If we can produce vaccines against Disease X in a matter of months instead of a year or more, we could revolutionise the world’s ability to respond to epidemic and pandemic diseases. **Disease X and other emerging infectious diseases pose an existential threat to humanity**. But for the first time in history, with the right level of financial commitment and political will, we could credibly aim to eliminate the risk of epidemics and pandemics.

#### 10] Pandemics increase the risk of regional and dyadic conflict—best case studies from COVID prove. Independently, negative examples are cherrypicked and solely analyze the beginnings of pandemics, continued transmission lays the groundwork for eventual instability and conflict

Ide 12/14 — (Tobias Ide, Tobias Ide’s research broadly focuses on the intersections of environmental change and environmental politics with peace, conflict, and security. In my current research, I assess the impact of disasters on conflict dynamics, the security implications of climate change, and environmental peacebuilding processes. Further academic interests of me include climate politics, peace and conflict studies, international politics, and the critical geopolitics of education. I employ various quantitative and qualitative research methods, including qualitative comparative analysis (QCA) and field research. My teaching is guided by three principles: (1) introduce the core theoretical foundations of a field, (2) explore their usefulness in the context of real word developments and practical examples, and (3) utilise interactive methods to increase learning success. I hold an MA in Political Science (Leipzig, 2012), a PhD in Earth Sciences (Hamburg, 2015) and an advanced PhD (Habilitation) in Political Science (Braunschweig, 2019). Previously, I worked at the Georg Eckert Institute and the University of Melbourne, and held visiting positions at the Hebrew University of Jerusalem and the American University in Washington DC. My research has attracted funding by various external bodies (see Awards and grants). I published in leading disciplinary and interdisciplinary journals, including Global Environmental Change, International Affairs, International Studies Review, Journal of Peace Research, Nature Climate Change, and World Development (see Publications). Furthermore, I am a director of the Environmental Peacebuilding Association (EnPAx) and have consulted several decision makers (see Professional and community service)., “COVID-19 and armed conflict“,Available Online at https://www.sciencedirect.com/science/article/abs/pii/S0305750X20304836?via%3Dihub, accessed 10-6-2021, HKR-AR)

The growing number of armed conflict events in India was not related to the Maoist insurgency. The presence of state security forces on the ground has been reduced due to fears of infectionand the Maoists’ supply lines were negatively affected by a comprehensive lockdown. There are concerns, however, that the rebels use the lack of state presence and economic deprivation caused by a heavy lockdown to **recruit** for future offensives (Bhardwaj, 2020;Kujur, 2020). Armed confrontations in the Kashmir region contested between India and Pakistan, by contrast, **increased significantly**. Clashes between both countries’ militaries were a result of longer-standing tensions and thus unrelated to the pandemic(Staniland, 2020). There is however evidence that Pakistan’s support for pro-Pakistani insurgents increased to put additional pressure on India during the COVID-19 crisis. At the same time, the Indian army capitalised on the comprehensive restrictions and the occupation of public attention with the pandemic to launch a heavy crackdown campaign against (presumed) insurgents in Kashmir (Basu & Philip, 2020; Islam & Uzair, 2020). Communal tensions in India also rose because of disputes related to permits for and infections linked to Hindu and Muslim religious gatherings during the pandemic. So far, these tensions rarely translated into larger violent confrontations (Kapur, 2020).

In Iraq, the capabilities of the government have been severely strained by the crisis, among others because oil prices collapsed and military forces were preoccupied with COVID-19 responses(e.g., enforcing curfews). Due to the pandemic, the international coalition supporting the government has also stopped training activities and some joint missions, and pulled out troops. The Islamic State (IS) was affected financially by the crisis as well due to its involvement in oil trade and the general economic decline. Nonetheless, the group sought to exploit the current weakness of the Iraqi state to expand its territorial control, thus launching additional attacks. The rise of violence in Iraq during the first months ofthe pandemic has been modest and non-linear (perhaps due to Ramadan in late April and May), but there was a clear upward trend of IS-initiated attacks (Hanna, 2020; Sattar, 2020).

The civil war in Libya between the Government of National Accord (GNA) and the Libyan National Army (LNA) has intensified since March 2020. Both parties aimed to launch decisive strikes and received significant logistical and material support from their international patrons. Therefore, an escalation of the war would have taken place irrespective of COVID-19. But the pandemic accelerated this escalation in two minor ways: It distracted the world’s attention from the fact that both sides ignored the peace agreement concluded in January 2020. Furthermore, the GNA and the LNA believed that the other side might collapse very soon under the combined pressure of military offensives and the virus(Allahoum, 2020; Mustasilta, 2020). Conflict intensity saw a rapid decline in June 2020, but this was due to the mutual acceptance of a military stand-off and renewed peace negotiations, **rather than related to the pandemic** (Gosh, 2020).

The military of Pakistan engaged in more battles with the Indian army and local Taliban groups from April 2020 onwards. The intensification of the India-Pakistani conflict is linked to other factors than COVID-19 (Staniland, 2020). It is plausible that groups like the Taliban have attempted to exploit a situation where the state is weakened, border controls with Afghanistan get more difficult, dissatisfaction with the government’s response is widespread (especially among religious groups), and a rise in poverty makes recruitment easier (Ahmed, 2020; Guz, 2020). Concrete evidence of this is currently lacking, however. A reason for the slight bump in violent events in May and early June could be that many senior Taliban leaders and commanders became infect with SARSCoV-2 (O’Donnell & Khan, 2020).

In the Philippines, the upwards trend in armed conflict events was mostly driven by a steep rise of clashes between the military and the Communist New People’s Army (NPA). Both sides declared unilateral ceasefires when the number of infections increase drapidly in late March to facilitate responses to COVID-19. Accusing each other of continuing attacks, the government and the NPA decided not to extend their respective ceasefires in late April. There have been reports that the government utilized the distraction caused by the pandemic as well as the increased control gained during a strict lockdown for harsher measures against its opponents, including the rebels. Others claim that the NPA sought to utilize the pre-occupation of security forces with health-related tasks to launch further attacks and raid food supplies (Chavez,2020; Lalu, 2020).

Besides its immediate health and economic effects, COVID-19 can also impact armed conflict risks, with these conflicts themselves being an important obstacle in dealing with the pandemic. This article provided an assessment of the impact of COVID-19 on armed conflict based on data from the first six months of 2020. Theoretically, the pandemic could affect conflict risks through increased grievances, possibilities to demonstrate solidarity, or modified opportunity structures for armed groups.

Results show that in four of the nine countries under study, the number of armed conflict events declined after the onset of the COVID-19 crisis. These declines are mostly related to strategic decisions and less favourable opportunity structures for armed groups, such as logistical difficulties and attempts to increase popular support. They offer few prospects for health diplomacy and sustainable peacebuilding. In places like Afghanistan, where the Taliban restrained their military activities to gain local support, the initial decline might even set the stage for a later escalation of the armed conflict. Similar concerns exist regarding recruitment in Colombia and India.

In five of the nine countries analysed, armed conflict prevalence increased in the face of the pandemic. This is further evidence that health diplomacy approaches demonstrating goodwill and reducing grievances have little impact during the pandemic (Polo,2020). COVID-19 did not change the root causes or principal dynamics of the armed conflicts in any of these five countries, but it accelerated existing trends and provided strategic opportunities for armed groups to exploit. Two factors are particularly relevant here: The weakening of state institutions (providing incentives for rebels to intensify military pressure) and a lack of(international) public attention (allowing to extend military operations without backlashes).

While short-term rises in armed conflict risks related to the pandemic are mostly driven by changed opportunity structures, grievances could play a more prominent role when longer time horizons are considered. The economic repercussions associated with the current global spike in infections could exceed the coping capacities of households that did relatively well during the first COVID-19 wave. In coincidence with ethnic or religious cleavages ,this could raise discontent to a level at which **armed conflicts erupt**. However, grievances usually take time to translate into organised armed activities. Declining levels of democracy as states claim emergency powers to combat COVID-19 are also a risk factor. Countries with a medium level of democracy and highly repressive regimes are empirically much more likely to experience civil wars than consolidated democracies (Cederman & Vogt, 2017).