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## Letter from the Chair

Dear delegates,

My name is Angie Cui, I'm a junior at Dalton, and it is my pleasure to welcome you to the 3rd session of Dalton Model United Nations! I'm incredibly excited to be your chair on the World Health Organization, set in the year 2020, as we attempt to combat some of the world's newest biological threats. As an Under Secretary-General of Dalton's team, I can attest that Model UN has become a huge and integral part of my high school experience since I attended my first conference in freshman year (and I can assure you, that love has only grown).

Outside of Model UN, I enjoy watching Netflix and eating my way around New York City. My love for politics extends beyond Model UN to Student Government, where I serve as High School Vice President. I'm also the Design Director of our school newspaper, The Daltonian, and will be choreographing a piece for our annual Spring Dance Concert, Dance Theater Workshop.

Our moderator, Aryav Pal, is a sophomore who shares the same interest in Model UN as I. Outside of school, his interests include soccer, playing the saxophone and wasting too much time watching netflix.

I hope that the futuristic element of our committee will make it a unique and dynamic experience. We chose these topics because they have deep historical precedence and also highlight some of the worst tensions facing the international community today. Aryav and I had a great time coming up with these hypothetical scenarios that are hopefully plausible enough to imagine five years down the line, but while we will still be referencing past action to come up with solutions, feel free to take a bit of creative license when it comes to shaping your country's specific policy on the issues at hand.

Aryav and I can't wait to meet you all this April, and we look forward to a day of intense debate over 2020's most pressing issues. As always, feel free to email me with any questions or concerns!

Yours,

Angie Cui

Chair, WHO 2020

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## Topic Area A: Ebola Epidemic, 2020

### Overview of the Problem

A new strain of Ebola hemorrhagic fever, colloquially known as simply Ebola, surfaced in January of this year. A World Health Organization health worker in Mosopa, a relatively large village in Botswana, was diagnosed post-mortem on January 3rd. Scientific analysis concluded that the cause of the health worker was a terrifying new strain of Ebola, dubbed *Mosopa Ebolavirus* due to its village of origin.

*Mosopa Ebolavirus* is far deadlier than the Ebola virus disease outbreak that devastated West Africa in 2014; *Mosopa* is airborne, or able to be transmitted relatively easily through airborne respiratory droplets. In addition to being able to be transmitted by direct contact with blood or other body fluids of an infected human or other animal, as with all previous Ebola strains, *Mosopa*'s contagiousness is extremely heightened due to its airborne nature. The fatality rate of this strain is also much higher, given that the symptoms are not apparent until considerably later than previous strains and develop extremely quickly. Humans are also infectious in the latter part of the incubation period of this virus before symptoms arise, rendering the virus difficult to contain.

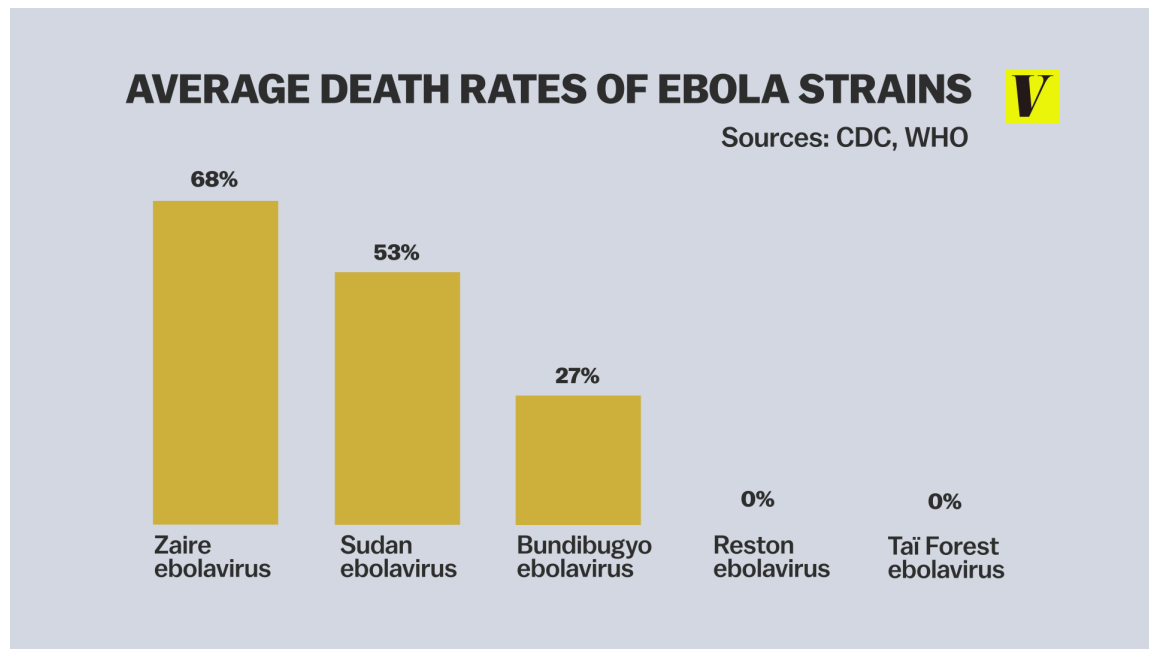
*Mosopa Ebolavirus* has already appeared in four different continents, creating panic among the international community (more detail regarding the initial outbreak is provided in the "Current Situation" section). Having already caused over 5,000 deaths, WHO high-level personnel are considering issuing a global pandemic alert, an incredibly loaded message to the international community.

Because responding quickly is of utmost importance, delegates are expected to find a comprehensive solution that will address the full scope of the situation before it gets out of control. Keep in mind that the situation as it is may change as new information arises, and that quick thinking is highly important. Ensuring that panic is reduced, the virus is contained, and citizens are protected are essential facets of any solution.

### History of the Problem

The ebola virus disease first emerged in 1976 with two simultaneous outbreaks. One outbreak occurred in Nzara, Sudan while the other occurred in Yambuku, Democratic Republic of the Congo. The ebola virus takes its name from the latter outbreak, which was in a village near the Ebola River. There are five species of ebola virus that have been identified. Four out of the five are known to be contagious. The names of the strains are Zaire, Bundibugyo, Sudan, Reston and Taï Forest, Reston being the specie that does not affect humans and Zaire

being the specie that is causing the 2014 ebola outbreak.<sup>1, 2</sup>



*Death rates acquired by adding up all records of known cases in history. Information may vary.*

The 2014 ebola outbreak is the largest in previous history. The death toll was around 6000 as compared to all previous outbreaks where the death toll was about 20. There were also around 17000 reported cases by November 2014.<sup>3</sup> The Zaire strain of Ebola was classified as extremely infectious, yet not contagious. This was due to the fact that a minute amount of the ebola virus, some report only one virus may be able to infect humans and still manifest in serious consequences. Yet contagion was fairly limited because the virus only transmitted itself through bodily fluids. Butchery of infected animals could also facilitate the contraction of the virus.<sup>4</sup>

These methods of transmission have proved to be a problem with health workers being infected readily. Many safety precautions have to be put in place before health workers can be sent in, and these health workers have to operate with an amount of care that may not be conducive to the environment they are placed in. Furthermore, funeral rituals involving close contact with bodies have proved an immense difficulty when dealing with ebola. In many of these cultures, the ritual is so ingrained that they refuse to comply with regulations regarding

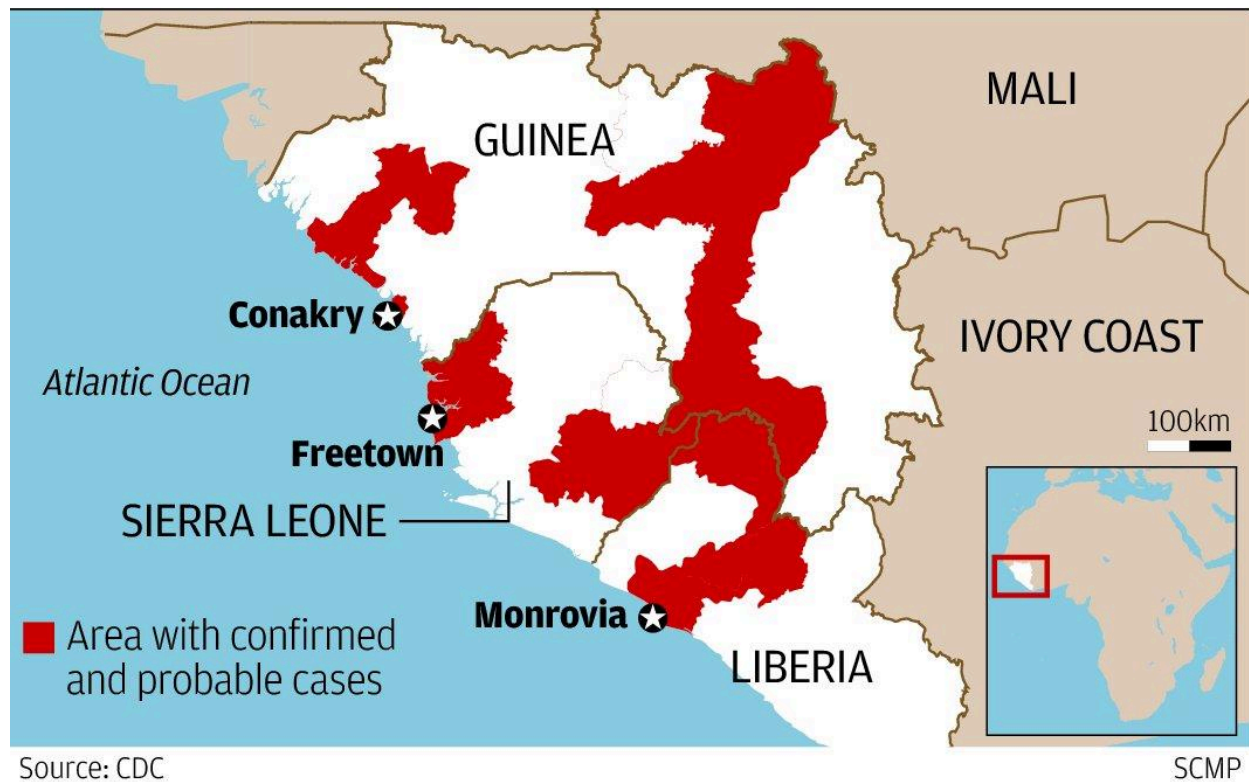
<sup>1</sup> "Ebola Virus Disease." WHO. N.p., n.d. Web. 02 Dec. 2014.

<sup>2</sup> "Ebola Fast Facts." CNN. Cable News Network, 26 Nov. 2014. Web. 02 Dec. 2014.

<sup>3</sup> "2014 Ebola Outbreak in West Africa - Case Counts." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 02 Dec. 2014. Web. 02 Dec. 2014.

<sup>4</sup> "Ebola Fast Facts." CNN. Cable News Network, 26 Nov. 2014. Web. 02 Dec. 2014.

bodies of ebola victims.<sup>5</sup>



*Graphic could be subject to change as the situation constantly evolves. Graphic is not 100 percent accurate as other representations display more areas as affected.*

Liberia, Guinea and Sierra Leone were the worst countries to be hit by this epidemic. The way this strain of Ebola was treated was unsophisticated to say the least. They attempted to maintain stability in the patient's body to ensure the best chance for the immune system to respond to ebola. Doctors provided intravenous fluids, balanced electrolytes, maintained oxygen and blood pressure, and treated other infections if or as they occurred. Recovery from this kind of ebola necessitated excellent supportive care. This kind of treatment is feasible in developed nations, with infrastructure to support it; however, trying to implement these methods in the undeveloped areas where ebola is most rampant is next to impossible.<sup>6</sup> Vaccines were developed, however those that were approved were never effective. A situation like the 2014 ebola epidemic cannot be allowed to happen again.

### Current Situation

Since patient zero was identified in Mosopa, Botswana, on January 3rd, the new strain of Ebolavirus spread rapidly throughout Botswana. 328 patients have been officially diagnosed, and 295 have died, although actual numbers are probably higher as some cases were not reported.

<sup>5</sup> "Blog Posts." *Ebola Virus Disease*. N.p., n.d. Web. 03 Dec. 2014.

<sup>6</sup> "Treatment." *Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 05 Nov. 2014. Web. 08 Dec. 2014.

Throughout January and February, *Mosopa* began to make its way to other countries, particularly Zimbabwe and Mozambique. *Mosopa* has wreaked considerable damage in Zimbabwe especially, which has currently reported 4,932 cases and 3,788 deaths since January. Lack of access to clean water and inefficacy on the part of the international community when it came to providing medical aid and personnel to contain the virus further exacerbated *Mosopa*'s effect in Zimbabwe.

An outbreak in March in Johannesburg, the capital of South Africa, also caused significant panic internationally. Although on 23 cases were reported, this marked the first instance of *Mosopa* manifesting in a well-developed city.

The second continent on which *Mosopa* has taken hold and begun to spread is Asia. The first case of *Mosopa* in Asia was diagnosed in Jaipur, India on February 22nd. Thought to have been brought to Asia by a schoolteacher traveling from Zimbabwe to Jaipur, *Mosopa* has since caused over 100 reported cases in southern Asia. Clusters of cases have since been diagnosed in Nepal and Bhutan. The first two cases in China appeared on April 13th in a rural southern province. Since then, Chinese governmental officials have raised international awareness and discussion surrounding possible governmental intervention in terms of containment, as multiple Chinese diplomatic representatives have called for quarantine measures and travel bans. Most recently, the Chinese Foreign Minister called for an air travel ban to and from Zimbabwe, Mozambique and Botswana in order to prevent further exposure and movement of infected individuals, a statement which has incited significant controversy internationally.

Although most of *Mosopa*'s cases have been concentrated in Africa and Asia, isolated cases have also been diagnosed in France, Germany and Poland. These cases are also thought to be caused by apparently symptom-free but infected individuals flying into those countries from African nations. Although all of these patients have since been treated, the European countries and their neighbors are newly worried about the possible spread of *Mosopa* to the region.

On April 23rd, the first case of *Mosopa* were diagnosed in the United States. A doctor flying back from Namibia was diagnosed in Florida and treated shortly thereafter. This also marks the first case of *Mosopa* in North America. The United States' and other North American countries' stances on how to tackle *Mosopa* are yet to be determined, although if more cases were diagnosed in those countries, it logically follows that more radical containment measures would be utilized.

## **Possible Solutions**

### *Travel Restrictions*

One possible solution to consider is travel and border restrictions. If transmission of *Mosopa* cannot be interrupted at the source, then it must be limited geographically. However, it is unclear whether a travel restriction could be effective in limiting the spread of *Mosopa* once it has begun as it crosses international borders.

A common travel restriction that some countries are considering is that of controlling air traffic, by controlling enclosed aircrafts and decreasing the possibility of infected individuals contaminating flights.

However, the solution is considered harmful by many experts as it essentially cuts off aid to affected areas and can wreak economic havoc on the affected region.

Regarding ground travel, border control and security could be tightened to stop further spreading of the disease, but a similar issue is encountered as healthy citizens could be barred exit from their countries during outbreaks and could lead to supply shortages.

There are major benefits that accompany this solution, yet there are drawbacks that are equal if not bigger than the benefits.

### *International Aid*

The flipside of the quarantine measure is supplying the most afflicted regions with increased aid. The aid should include sanitation supplies, medical personnel and treatment provisions. This would dampen the impact of the *Ebolavirus* within highly afflicted areas, but there is always the danger of spreading the virus to other countries as well because of the increased traffic in and out of these countries.

### *Treatment Methods and Further Research*

Treatment methods for *Mosopa Ebolavirus* are similar to those of its sister strains, but methods also greatly differ between countries depending on available economic funds and medical infrastructure. Iatrogenic transmission is a popular form of treatment in developing countries, where hospital sanitation standards are less thorough. Iatrogenic transmission can happen through blood transfusions, transplantations, or drug and intravenous (IV) injections.

Vectors, organisms that carry disease without becoming infected, can infect humans through contact. For this reason, delegates should also research the role of vector control in the containment of *Mosopa*.



*Graphic released in 2014. Communicates vital yet simple information regarding the disease in an easily comprehensible manner.*

### *Sanitation Improvement*

Sanitation is an obvious candidate for improvement. Given the nature of the Ebolavirus family, sanitation is one of the key factors in ensuring contagion is limited. Delegates should research how good sanitation can be achieved in crisis burdened areas. This is especially applicable to developing nations wherein bodies and waste matter are not properly disposed of. Furthermore, ensuring that infected animals are not butchered is highly important. Dissemination of basic information regarding how to address these methods is a quick, short term solution.

### *Standardizing Human Surveillance*

Finding methods to identify possible vectors for the disease, as well as infected people is key. In attempting to slow down the progression of this contagion, finding it in it's early stages in humans is highly important. To achieve this, ensuring that we observe more closely certain high-risk areas is one of the most important aspects of any resolution.



## Bloc Positions

### *Africa*

The African continent is where *Mosopa* originated and has had its worst impact. Most African nations with a high number of diagnosed cases and fatalities are looking towards international aid and support in regards to provision of medical supplies and personnel. An additional concern is that many African nations suffering the most under *Mosopa Ebolavirus* lack basic sanitation supplies and measures that are required in the treatment and containment of the disease, such as running water and sanitary health facilities. Given the respiratory nature of this new strain, adequate water, sanitation and hygienic supplies are absolutely essential in order to properly combat this disease. Therefore, finding ways to either import or locally develop sanitation technologies will be of the utmost importance. Furthermore, recently, rural protests due to distrust of medical facilities following high fatality rates and low recovery rates have broken out in many African nations currently afflicted with the disease.

African nations who do not yet currently have patients diagnosed with *Mosopa Ebolavirus* are rapidly developing contingency plans in case the virus does spread. In doing research, delegates should consider the country's past action in previous outbreaks of Ebola and similar epidemics, and the geographical proximity of the country to the infected region.

### *Asia*

Many Asian countries, especially Southeastern ones, are calling for radical and immediate action to contain the disease. This effort is being spearheaded by China, which has outspokenly called for a number of containment measures including travel bans and strict quarantine. Drawing upon suppression methods utilized in previous epidemics such as SARS, most Asian nations are calling on the international community to sanction immediate travel bans. Additionally, nations are also recommending the quarantining of infected patients that would be implemented by national governments and regulatory structures.

These assertions have been met by significant backlash from other nations, particularly in Europe and North America, claiming that outside aid would not be possible if travel to and from the region were banned and that quarantine is not the best way to deal with containment of the issue. However, most Asian countries still insist that these measures are necessary at this time to stop the spread of *Mosopa Ebolavirus*.

### *Europe*

Many officials of European nations have critiqued the suggestions of Asian officials regarding containment. Europe, on a whole, has also been providing the largest amount of aid to the region in the forms of money, personnel and supplies. In addition to a number of governmentally-sponsored groups, many non-governmental organizations based in Europe have greatly aided infected African nations in treating and containing the disease.

The attitude of most European nations has been to provide aid but also develop national contingency plans in the case of transmission. The compiling of these plans has been disorganized and fractured amongst European nations, and as a result, many have been calling for a European Union sponsored prevention plan as opposed to a nation-by-nation one.

### *North and South America*

Similarly to European countries, North and South American countries have also been desperately attempting to put together prevention plans. Especially in the United States and other North American nations following the diagnosis of the first two cases of *Mosopa* in the US just two days ago, paranoia and fear surrounding the spread of *Mosopa* has increased dramatically within the populus. In addition to containing and treating the disease on a practical level if *Mosopa* were to take hold in North and South America, the contingency plan as of now also has to deal with widespread hysteria surrounding the disease, primarily because of the general population's lack of understanding of the symptoms and transmission of this new strain.

Regarding quarantine and travel bans, recent rumors have spread that the United States is considering travel bans following the diagnosis of the first two cases, although White House officials have neither confirmed nor denied that statement. On the whole, North and South American governments have taken a more conservative stance on radical containment measures than those of Asian countries. In doing research, delegates are also encouraged to look into previous actions of one's country in similar outbreaks such as the 2014 Ebola outbreak and the 2002-2004 SARS epidemic.

### **Questions to Consider:**

Are quarantine measures and/or travel bans containment methods that your country is willing to use?

To what extent should your country and the larger international community provide external aid to the regions most heavily impacted by *Mosopa Ebolavirus*?

How can funds and manpower be effectively channeled to develop rapid and effective new treatment methods, contingency plans and pan-national prevention strategies?

Should countries focus on eliminating *Mosopa Ebolavirus* in the region it was originally found, or should WHO consolidate its resources and fight the disease as it arises elsewhere?

## **Topic Area B: The Threat of Biological Warfare**

### **Overview of the problem**

Biological warfare is the use of biological toxins or microorganisms, such as viruses and bacteria, to deliberately inflict disease or harm upon people, animals or agriculture. It is distinct from nuclear and chemical warfare, which together make up NBC (nuclear, biological and chemical warfare or weapons), all of which are considered weapons of mass destruction (WMDs) due to the level of their destruction potential.<sup>7</sup> Biological weapons are dangerous

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<sup>7</sup> "Introduction to Biological Weapons" *Federation of American Scientists*. Carnegie Corporation of New York and the Ellison Medical Foundation, 2007. Web. 12 Dec. 2014.  
<http://www.fas.org/biosecurity/resource/bioweapons.htm>

because of their many forms and long-term effects: attacking agents can infect humans, contaminate food or water, or destroy agriculture, and the effects of a biological weapons attack are also not immediately detectable. While international action has prohibited most biological warfare research and development, recent advances in biotechnology have made it easier than ever to develop dangerous viruses, bacteria and toxins with fewer resources, increasing the likelihood that groups may resort to bioterrorism in times of conflict.



*All are hazard symbols, although the symbol in the center is internationally recognized as a hazard symbol.*

In 2019, a terrifyingly powerful clandestine terror organization arose called the Liberty Initiative. The Liberty Initiative was not officially affiliated with any national government or organization, leaving the international community paranoid and confused after the attacks. The Liberty Initiative's members hail from mostly developed nations across all continents, and its mission was to "revive the world through biological cleansing".

In May and June of 2019, the Liberty Initiative launched two devastating bioterrorism attacks on Tokyo and London, respectively. The attacks involved the dissemination of the bacterium *Bacillus anthracis*, which causes the lethal acute disease Anthrax, across the major cities. Luckily, the bioweapon was contained relatively quickly after being deployed and because the nations targeted were able to provide effective antibiotic treatment and vaccines, the bioweapons only managed to kill an estimated 100 people as compared to the hundreds, if not thousands it could have killed if allowed to spread. Another reason containment was relatively easy was that Liberty Initiative had not yet developed an effective dispersal method, meaning that the anthrax strain that Liberty Initiative used could not spread to more than 10-15 people in each site where it was used before officials became aware of the problem.

However, it is very possible that before the Initiative was destroyed, it shared or sold this technology with other terrorist organizations or even national governments. It will be the job of this committee to update traditional bioterrorism protocols and prevention procedures and locate the holder of this new technology.

## History of the problem

Biological warfare goes as far back as, in recorded history, as 400 BC, when Scythian archers infected their arrows by dipping them in decomposing bodies or into blood mixed with manure. Roman, Persian and Greek literature from 300 BC show examples of dead animals dropped in wells and other bodies of water to contaminate them. Hannibal won a naval victory, in 190 BC, over King Eumenes II by firing jars of venomous snakes into enemy ships. Other incidences involving transmission of smallpox were used during the French and Indian war and the Civil War.

By the turn of the 18th century, advances in germ theory and bacteriology allowed biological weaponry to be developed with increasing levels of sophistication because isolation and production of stocks of specific pathogens was now possible. During World War I, the Germans developed anthrax, glanders, cholera and wheat fungus specifically for use as biological weapons, even though a biased subcommittee of the Temporary Mixed Commission of the League of Nations at the time found no hard evidence of biological warfare.

During World War II, the Japanese developed a terrifyingly sophisticated biological warfare program, whose center was referred to as “Unit 731”. More than 10,000 prisoners are believed to have died as a result of experimental infection during the Japanese program between 1932 and 1945, many from direct effect of experimental inoculation of agents causing anthrax, cholera, dysentery or plague. In December 1949, the Soviets tried 12 Japanese prisoners of war for preparing and using biological weapons; in turn, the Japanese government accused the Soviet Union of experimentation and development of bioweapons. During that time, German officials also accused the Allies of using biological weapons, citing British experimentation with *B. anthracis* and the United States’ development of an offensive biological warfare program.

After World War II, nations including the United States, Canada, Britain, France, the Soviet Union/Russia and the United Kingdom continued their biological weapons research. A slew of allegations, especially during the Korean war, surfaced as the international community continued to search for a way to contain this terrifying branch of modern weaponry.<sup>8</sup>

## Previous International Action

In response to the initial use of chemical warfare during World War I, international efforts directed toward limiting the proliferation and use of WMDs resulted in the adoption of the “Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous or Other Gases and of Bacteriological Methods of Warfare”. More commonly referred to as the Geneva Protocol of 1925, it was signed by 108 nations and extended a multilateral ban on chemical weapons to biological weapons as well. Notably, the United States did not ratify the Protocol until 1975. The

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<sup>8</sup> Riedel, Stefan. “Biological warfare and bioterrorism: a historical review.” *Baylor University Medical Center Proceedings*, United States National Library of Medicine, National Institutes of Health. Web. 12 Dec. 2014. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1200679/>

Protocol did not include concrete verification of compliance measures, however, rendering ineffective.

After the failure of the Geneva Protocol, the 1972 “Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological and toxin Weapons and on their Destruction”, known as the BWC, was developed. The BWC prohibited the development of biological weaponry delivery mechanisms, the transfer of biowarfare technology to other countries and mandated the destruction of stockpiles, production equipment and delivery systems. The treaty was ratified in 1972 and went into effect in March 1975; review conferences to the BWC were also held in the years following. However, similarly to the 1925 Geneva Protocol, the BWC does not provide firm guidelines for inspections and compliance assurance. As a result, several of the signatory nations of the BWC have since been developing biowarfare technology outlawed by the convention. Several assassination attempts and attacks as well as non-state-sponsored terrorist attacks have been documented since the passing of the BWC, highlighting its ineffectiveness. Biological warfare has remained a terrifying aspect of modern weaponry and the international community has always been looking for ways to impede its development.<sup>9</sup>

### **Current situation**

After the Liberty Initiative’s attacks in 2019, the world was sent into a state of paranoia and chaos. It is unclear how much of the Liberty Initiative’s materials or technologies remain, and in whose hands, so the international community must both prevent the development of the Initiative’s technology and biological warfare technology as a whole.



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<sup>9</sup> "Biological Warfare: Get Facts on Examples and History." *EMedicineHealth*. N.p., n.d. Web. 12 Dec. 2014.

*Displays the internationally recognized symbol for a hazard. Can be seen over bomb shelters, terror shelters, etc.*

Nations have retained their biological weaponry development programs; in other words, those nations who were developing and researching biowarfare technology in 2015 have continued to do so throughout the past five years. A rift has developed between countries who allegedly develop biological weapons for offensive reasons and defensive reasons. Offensive biological warfare can target personnel, agriculture, livestock and water supplies, and are difficult to control because of their sporadic spread. Although several nations are accused of housing biological weapon facilities that are researching offensive biowarfare technologies, none have been proven. These allegations have heightened international tensions in the aftermath of the Liberty Initiative attacks because the terrorist organization is speculated to have ties with a national government that facilitated its development. Luckily, a strong global norm still exists that rejects development of offensive biological weapons, so nations strongly opposing the development of offensive biological weapons should catalyze on this standard.

A larger number of countries are known to house defensive biological weapon research and development facilities. Many of these facilities are conducting research concerning counter-measures to possible biowarfare attacks, and early means of detecting and preventing biological attacks. Additionally, in order to increase national and homeland security, these facilities aim to protect agriculture, food and water by identifying bioweapons and organizing contingency plans in the event of a biological attack. While defensive research facilities are much more accepted by the international community, standards of transparency must still be enforced by the international community.

## **Proposed solutions**

### *Increased International Transparency*

Almost all nations are calling for increased transparency as a means to improve communication regarding what biowarfare developments nations are making. Because of its huge implications on public health, the current director of the WHO has already urged nations to begin to release data regarding transactions and technological developments. Increased transparency will also be helpful in discerning whether or not countries possess the technology that the Liberty Initiative utilized and if countries are developing their own biological weapons mirrored after the Initiative's weapon. However, increased transparency and compliance is difficult to enforce, and as many of these development programs are clandestine, it is unlikely that nations will comply.

### *Civilian Preparedness*

Ensuring that civilians are prepared in the event of the worst eventuality is a primary concern of the WHO. Making sure that civilians know how they can conduct themselves if this weapon is used will increase their chances for survival. This would be a worst case scenario alternative, yet it is also necessary. Preparedness would involve coordination with the medical

community in order to improve disease surveillance and reporting, as well as early detection and prompt treatment of the disease.

#### *Limiting Availability of Materials for Creation of Bioweapons on International Markets*

This remains one of the most radical proposed solutions. It would be effective, however, for limiting terrorist organizations as well as rogue countries from developing a bioweapon to use against established world powers. Many countries claim that this would allow a monopoly of bioweapons in nations with more resources available to them, but supporters of this solution argue that it is the only way to pinpoint this issue at its source.

#### *Revising Current Legislation*

Both the Geneva Protocol and the BWC were ultimately unsuccessful in limiting the proliferation of biowarfare development. Therefore, many nations are suggesting that the international body revisit these pieces of legislation and tighten their stipulations. Redefining certain key terms, such as what a biological weapon specifically entails, and adding further enforcement provisions are among the suggestions. Another option is creating a separate document detailing the current situation of biowarfare development to present to the United Nations General Assembly.

### **Bloc positions**

#### *Nations with Probable Biological Weapons*

Nations with likely offensive capabilities, including China, Egypt and Iran, will highly oppose measures that encourage increasing transparency and the release of information concerning the state of their biowarfare technology development. Specific biowarfare agents that these countries possess differ, but these nations will likely oppose any solutions that may endanger the clandestine nature of their biowarfare programs.

Nations with known research programs, mostly defensive, including India, North Korea, Russia and Syria will most likely also oppose radical transparency measures, but to a lesser extent.

#### *European Union and North America*

These nations are, and have been, strong advocates for increased transparency and tighter control of biological weapons in order to increase international security and decrease the possibility of weapons stockpiling. The United States, United Kingdom and most of the European Union advocate for greater adherence to the Geneva Protocol and BWC. After the Liberty Initiative attack, these countries have been in a state of panic and believe that any methods that can contain these weapons should be put in place.

#### *Africa, Latin America and Southeast Asia*

Being less willing to pour funds into a problem that they don't see will impact them, these nations are not as terrified by recent developments. These nations, which have historically been relatively uninvolved and unaffected, are still concerned about controlling these weapons

because all nations have the potential to be affected; they still see the benefit of increased global transparency and also increasing preparedness among densely populated urban areas.

### **Questions to consider**

How will your country's current biological warfare program impact its views on offensive and defensive bioweaponry development?

How can the international community attempt to prevent already developed biowarfare technologies from ever being used?

What is the best way to ensure civilian preparedness in the event of a biological attack?

How should the international community address the allegations and hypotheses concerning nations that are possibly housing the Liberty Initiative's technology? Are these allegations worth taking into account, or should more attention be paid to increasing preparedness and prevention on a larger scale?

Does your nation believe it should invest funds and research personnel in containment measures, transparency measures or measures to stop a bioweapon from spreading among civilian populations?