## Framing

#### Resisting oppression is a prerequisite to any conception of justice due to moral exclusion

Winter and Leighton 99 [Deborah DuNann Winter, Psychologist that specializes in Social Psych, Counseling Psych, Historical and Contemporary Issues, Peace Psychology. Dana C. Leighton, PhD graduate student in the Psychology Department at the University of Arkansas. Knowledgable in the fields of social psychology, peace psychology, and justice and intergroup responses to transgressions of justice] “Peace, conflict, and violence: Peace psychology in the 21st century.” Pg 4-5

Finally, to recognize the operation of structural violence forces us to ask questions about how and why we tolerate it, questions which often have painful answers for the privileged e lite who unconsciously support it. A final question of this section is how and why we allow ourselves to be so oblivious to structural violence. Susan Opotow offers an intriguing set of answers, in her article Social Injustice. She argues that our normal perceptual cognitive processes divide people into in-groups and out-groups. Those outside our group lie outside our scope of justice, injustice that would be instantaneously confronted if it occurred to someone we love or know is barely noticed if it occurs to strangers or those who are invisible or irrelevant. We do not seem to be able to open our minds and our hearts to everyone, so we draw conceptual lines between those who are in and out of our moral circle. Those who fall outside are morally excluded, and become either invisible, or demeaned in some way so that we do not have to acknowledge the injustice they suffer. Moral exclusion is a human failing, but Opotow argues convincingly that it is an outcome of everyday social cognition. To reduce its nefarious effects, we must be vigilant in noticing and listening to the oppressed, invisible, outsiders. Inclusionary thinking can be fostered by relationships, communication, and appreciation of diversity. Like Opotow, all the authors in this section point out that structural violence is not inevitable if we become aware of its operation, and build systematic ways to mitigate its effects. Learning about structural violence may be discouraging, overwhelming, or maddening, but these papers encourage us to step beyond guilt and anger, and begin to think about how to reduce structural violence. All the authors in this section note that the same structures (such as global communication and normal social cognition) which feed structural violence, can also be used to empower citizens to reduce it. In the long run, reducing structural violence by reclaiming neighborhoods, demanding social justice and living wages, providing prenatal care, [and] alleviating sexism, and celebrating local cultures, will be our most surefooted path to building lasting peace.

#### Focusing on “big picture” issues like security and economic development push gendered advocacies to the backburner—this retrenches injustices.

**Cynthia Enloe, 05-16-2014** (Research Professor in the Department of International Development, Community, and Environment, affiliations with Women’s and Gender Studies and Political Science, all at Clark University in Worcester, Massachusetts, “Bananas, Beaches, and Bases: Making Feminist Sense of International Politics,” *University of California Press,*<https://ebookcentral-proquest-com.proxy.lib.umich.edu/lib/umichigan/reader.action?docID=1687669&query=&ppg=2>)

Why do most of us not hear the names of these organizations regularly on the nightly news or on the main Internet news sites? Editors, mainstream experts, and some academic scholars employ several strategies to dismiss the analytical (that is, explanatory) value of these groups’ insights and impacts. One common rationale for ignoring *the work of these transnational*feminist networks is to dismiss them as representing only a “special interest*.”* By contrast**,** the international expert is**, so** he **(occasionally she)** claims, interested in “the Big Picture.” That is, the common assumption is that one-half of the world’s population is equivalent to, say, logging companies or soccer clubs; thus, the thinking goes, their actions do not shed light on the world but simply are intended to advance their own limited self-interests**.** A second rationale for not taking seriously the ideas and actions of these contemporary globalized women’s advocacy groups — ideas and actions that should be thoughtfully weighed, not automatically accepted—is that the arenas of politics that these feminist activists do expose are presumably merely domestic or private, as opposed to, for instance, the allegedly “significant” public arenas of military security or government debt. In other words**,** the conventional failure to take seriously the thinking behind transnational women’s advocacy isitselfrooted in unrealistically narrow understandings of “security,” “stability,” “crisis,” and “development.” **All** four concepts are of utmost concern to those worried about the international Big Picture. Each of these four concerns—security, stability, crisis, and development—is routinely imagined to be divorced from (unaffected by) women’s unpaid and underpaid labor, women’s rights within marriage, the denial of girls’ education, women’s reproductive health, and sexualized and other forms of male violence against women, as well as the masculinization of militaries, police forces, and political parties. The conventional Big Picture**, it would appear,** is being painted on a shrunken canvas. Third, these feminist transnational groups’ **analyses and actions** can be ignored**—their** reports never cited**, their** staff members never invited to speak as experts**, their** leaders or activists never turned to for interviews**—** on the questionable grounds that their campaigns are lost causes**.** Behind this justification is the notion that challenging entrenched masculinized privileges and practices in today’s international affairs is hopeless, therefore naive, therefore not worthy of serious attention.Further underpinning thisfinalargument are thestunninglyahistorical assertions that **(a**) any advancements that women have gained have come not as a result of women’s political theorizing and organizing but because women have been given these advancements by enlightened men in power,and(b) we collectively have “always” understood such useful political concepts as “reproductive rights,” “sexual harassment,” “systematic wartime rape,” and “the glass ceiling.” This latter assertion overlooks the fact that each of these revelatory concepts was hammered out and offered to the rest of us by particular activists at particular moments in recent political history. All three of these spoken or unspoken rationales, and the assumptions they rely upon, are themselves integral to how international politics operates today. All three assertions that deny the significance and analytical value of transnational feminist organizing are the very stuff of international politics. The very rarity of professional international political commentators taking seriously either women’s experiences of international politics or women’s gender analyses of international politics is, therefore, itself a political phenomenon that needs to be taken seriously**.** What so many feminist-informed international commentators ignore has been explored by the burgeoning academic field of gender and international relations. That is, paying close attention to—and explaining the causes and consequences of—what is so frequently ignored can be fruitful indeed.9

#### We have an ethical responsibility to reject patriarchy—it leads to unjust domination. Thus the role of the ballot is to vote for the debater who best performatively and methodologically breaks down the patriarchy

Jhyette **Nhanenge, 2007**  (developmental Africa worker), 2007, Retrieved May 30, 2015 from http://uir.unisa.ac.za/bitstream/handle/10500/570/dissertation.pdf?sequence=1

The two characteristics, which benefit in a racist and/or patriarchal society are white and male. Since both are received by birth, the benefits are not based on merit, ability, need, or effort. The benefits are institutionally created, maintained and sanctioned. Such systems perpetuate unjustified domination. Thus, the problem lays in institutional structures of power and privilege but also in the actual social context. Different groups have different degrees of power and privilege in different cultural contexts. Those should be recognized, but so should commonalities where they exist. However, although Ups cannot help but to receiving the institutional power and privileges it is important to add that they are accountable for perpetuating unjustified domination through their behaviours, language and thought worlds. That is why ecofeminism is about both theory and practice. It does not only try to understand and analyze, it also finds it important to take action against domination. (Warren 2000: 64-65).¶ Patriarchy is an unhealthy social system. Unhealthy social systems tend to be rigid and closed. Roles and rules are non-negotiable and determined by those at the top of the hierarchy. High value is placed on control and exaggerated concepts of rationality, even though, paradoxically, the system can only survive on irrational ideologies.

## Contention One

#### The patent industry is male-dominated – women’s health is completely overlooked

**Koning 21** Koning, Rem. “Too Few Women Get to Invent – That's a Problem for Women's Health.” *The Conversation*, 29 July 2021, theconversation.com/too-few-women-get-to-invent-thats-a-problem-for-womens-health-162576. // FC

Griffith’s research and inventions have the potential to improve women’s health dramatically. The problem for women is that she stands out for another reason: She’s female. In 2020, [only 12.8% of U.S. inventors](https://www.uspto.gov/ip-policy/economic-research/publications/reports/progress-potential) receiving patents were women, and historically male researchers have ignored conditions like endometriosis.

Male researchers have tended to downplay or even outright overlook the medical needs of women. The result is that innovation has focused mainly on what men choose to research. My colleagues [John-Paul Ferguson](https://scholar.google.com/citations?user=ZboIq6YAAAAJ&hl=en), [Sampsa Samila](https://scholar.google.com/citations?user=GXbzIdkAAAAJ&hl=en) and [I](https://scholar.google.com/citations?user=sChrXHUAAAAJ&hl=en) show in a newly published study that patented biomedical inventions in the U.S. created by women are [35% more likely to benefit women’s health](https://doi.org/10.1126/science.aba6990) than biomedical inventions created by men.

To determine which inventions are female-focused, male-focused or neutral, we analyzed the title, abstract and start of the summary text from 441,504 medical patents using the National Library of Medicine’s [Medical Text Indexer](https://ii.nlm.nih.gov/MTI/). The indexer uses machine learning to categorize the subject of a text document, including whether it has a female or male focus.

Our data reveal that inventions by research teams that are primarily or completely composed of men are significantly more likely to focus on the medical needs of men. In 34 of the 35 years from 1976 to 2010, male-majority teams produced hundreds more inventions focused on the needs of men than those focused on the needs of women. These male inventors were more likely to generate patents that addressed topics like “erectile” or “prostate” than “menopause” or “cervix.” Male inventors also tended to target diseases and conditions like Parkinson’s and sleep apnea that disproportionately affect men.

Conversely, inventions patented by research teams that are primarily or completely composed of women were more likely to be focused on the needs of women in all 35 years of our data. These patents are more likely to address conditions like breast cancer and [postpartum preeclampsia](https://www.mayoclinic.org/diseases-conditions/postpartum-preeclampsia/symptoms-causes/syc-20376646) and diseases that disproportionately affect women like [fibromyalgia](https://www.mayoclinic.org/diseases-conditions/fibromyalgia/symptoms-causes/syc-20354780) and lupus. However, in 1976 only 6.3% of patents were invented by teams with as many women as men. By 2010 that figure had risen to only 16.2%. As a result, while inventions by women were more likely to be female-focused, such patents were uncommon because so few inventors were women.

We found that across inventor teams of all gender mixes, biomedical invention from 1976 to 2010 focused more on the needs of men than women. Our calculations suggest that had male and female inventors been equally represented over this period, there would have been an additional 6,500 more female-focused inventions. In percentage terms, equal representation would have led to 12% more female-focused inventions.

There are also more subtle benefits when more women invent. Female inventors are more likely to identify how existing treatments for non-sex-specific diseases like heart attacks, diabetes and stroke can be improved and adapted for the needs of women. Indeed, women are more likely to test whether their ideas and inventions [affect men and women differently](https://doi.org/10.1038/s41562-017-0235-x): for example, if a drug has more adverse side effects in women than in men.

#### IPP and the TRIPS agreement has led to millions of unsafe abortions and preventable deaths of women

**Mike 20** Mike, Jennifer H. M. “Access to Essential Medicines to Guarantee Women's Rights to Health: The Pharmaceutical Patents Connection.” *Wiley Online Library*, John Wiley & Sons, Ltd, 29 June 2020, onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161. // FC

Particularly, contraceptives are essential medicines as they are necessary to curtail early and unwanted childbearing, and prevent unplanned pregnancies. This is especially where the pregnancy is damaging to the health, welfare and human development of the woman (WHO, [2017](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0224)). Significantly, access to appropriate drugs and contraceptives, including emergency contraception, could prevent and control unsafe sex and even reduce vertical HIV transmission (Nanda et al., [2017](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0124); Perehudoff, Pizzarossa, & Stekelenburg, [2018](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0142); WHO, [2004](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0219), p. 14).[13](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0013) Accessing contraceptives can also prevent the termination of unwanted pregnancies and the option of unsafe abortion (MSF, [2019](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0112)). Data reveals that unsafe abortion kills about 68,000 women every year, representing 13% of all pregnancy-related deaths (Grimes et al., [2006](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0366); WHO, [2002](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0215); WHO, [2004](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0219), p. 14). It is further estimated that 25 million unsafe abortions take place worldwide each year, majorly in developing countries (WHO, [2019](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0225)). Following unsafe abortions, women may be vulnerable to a range of harms that affect their quality of life and well-being; they may suffer reproductive and genital tract infection and experience other health complications (WHO, [2004](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0219), p. 14). Some of these infections are fatal and serious, leading to infertility, disability and worse, death (Perehudoff et al., [2018](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0142); WHO, [2004](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0219), p. 14). This is in addition to the social and financial costs to women, their families, the community at large and health care systems. There is therefore a need to improve access to contraceptives. A survey, however, estimated that many women who are at risk of unplanned or unintended pregnancy and would choose birth control using effective modern contraceptives are unable to do so (ICPD, [1995](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0084); Logez et al., [2011](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0103); WHO, [2004](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0216), [2017](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0224)).

Furthermore, reproductive and sexual health problems such as maternal, perinatal mortality and gynaecological health-related complications are said to be a significant disease burden for women of reproductive age (WHO, [2017](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0224), p. 11). Sexual and reproductive ill-health can lead to sexual dysfunction and other gynaecological conditions such as severe menstrual problems, urinary and faecal incontinence due to obstetric fistulae, uterine prolapse and pregnancy loss (Filippi et al., [2016](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0055), p. 6; Timilsina, [2018](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0181), pp. 18–19). This, in turn, leads to maternal and perinatal mortality. Women will, therefore, need access to medical interventions to prevent these avoidable health situations or treat theirrr conditions. For example, maternal health complications such as postpartum haemorrhage (PPH), pre-eclampsia and eclampsia, can be prevented or treated by the appropriate use of essential medicines such as oxytocin and ergometrine injections; magnesium sulfate (MgSO4) injection for the prevention and treatment of severe pre-eclampsia and eclampsia; ampicillin, gentamicin and metronidazole injections for the treatment of maternal sepsis; procaine benzylpenicillin, and ceftriaxone for neonatal sepsis (Tran & Bero, [2015](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0184)). Access to the high quality, therapeutic medications in developing countries may not be adequate, resulting in a high number of preventable maternal deaths (Torloni et al., [2016](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0183), p. 645). Lack of access to Oxytocin in some sub-Saharan African countries and Tanzania has also been traced to institutional, socioeconomic, financial, cultural and political barriers (Torloni et al., [2016](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0183), p. 645). In 2019, a heat-stable carbetocin for the prevention of PPH was added to the WHO Essential Medicines List (EML; WHO, [2019a](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0226)). This new formulation has similar effects to oxytocin, the current standard therapy, but offers a significant advantage for tropical countries as it does not require refrigeration for storage. Raltegravir is another medicine on the WHO's EML that is particularly important for pregnant women, as well as other contraceptives such as; levonorgestrel, an oral hormonal contraceptive, medroxyprogesterone acetate, an injectable hormonal contraceptive, progesterone vaginal ring, an intravaginal contraceptive and many others (WHO, [2019b](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0227)). Injectable contraceptives are often preferred by women as they can be used discretely and conveniently to circumvent the factors aforementioned in Section [1.1.1](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-sec-0040). Studies, however, indicate that poor reproductive health and sexual health problems, including complications arising from early childbearing, HIV infection and STIs are significant disease burdens in developing countries and also, essential medicines and contraceptives for reproductive health are often not available to the majority of women who need them (Hall, [2005](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0068); The World Bank, [2001](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0180)). In this respect, Hall ([2005](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0068), pp. 32–34), made the observation that Mifepristone, a useful medicine for safe abortion, which can be self-administered to induce a discrete and noninvasive medical abortion up to 2 weeks of gestation is still prohibitive to most women wanting to access the drug. Some of these essential contraceptives, their compositions or methods may be impacted by patent-right restrictions as data indicates that contraceptives such as raltegravir, levonorgestrel, medroxyprogesterone acetate, process of extracting ergometrine, progesterone and the composition of carbetocin are more widely patented (Drug Patent Watch; European Patent Office; Medicines Patent Pool, [2013](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0114), p. 11). This may be due in part to changes in national patent laws in many countries following the entry into force of the TRIPS Agreement, or the patenting practices of applicants (Medicines Patent Pool, [2013](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0114), p. 11). Invariably, the inability to access better and high quality therapeutic treatments may mean that majority of women, particularly in developing countries, may be restricted to a limited choice of contraceptives.

#### Those opposed to reproductive rights use IPP to prohibit women’s access to them

**Allen 12** Allen, Scott A. “Patents Fettering Reproductive Rights.” *Indiana Law Journal*, 2012, doi:https://www.repository.law.indiana.edu/cgi/viewcontent.cgi?article=3004&context=ilj#:~:text=The%20Supreme%20Court%20has%20established,right%20to%20terminate%20a%20pregnancy.&text=Conceivably%2C%20private%20actors%20could%20use,reproductive%20technology%20from%20the%20public. // FC

Because these patentable reproductive inventions have enabled reproductive choice and are often catalysts for reproductive rights, opposition to reproductive autonomy has translated into opposition to specific technologies. In turn, opposition has slowly begun to find its way into the patent laws that provide limited monopolies on reproductive inventions. Unlike inventions of antiquity, the advanced technology that now constitutes patent-eligible subject matter has the potential to tread on deeply moral, religious, and political ideologies. One commentator has noted that “[a]s human existence becomes increasingly embedded in technology, the impact of traditionally patentable subject matter upon the exercise of individual liberties grows.”9 There is no area more fundamental to human existence than that of reproduction—an area that has recently experienced extraordinary technological advances. For example, in the last several decades, patents have been issued on technologies ranging from abortive methods,10 pharmaceuticals,11 and instruments,12 to in vitro fertilization (IVF),13 cloning (e.g., Dolly),14 and in vitro pre-implantation genetic diagnostic (PGD) procedures.15 Reproductive knowledge and capabilities have expanded in exponential ways, promising that the future holds even more technological advancements. Much of that practical knowledge is owned, or has the potential to be owned, as intellectual property. These “twenty-first century” technological developments, and the new perceived reproductive liberties that may accompany their growth,16 pose new challenges to a constitutionally empowered system of “promot[ing] the Progress of Science and useful Arts”17 with eighteenth-century origins. Whether or not the Framers contemplated the vast universe of procreative and reproductive developments as within the scope of traditionally patentable subject matter,18 the fact remains that as section 101 of the Patent Act19 currently stands, inventions related to human reproduction will routinely fall within its broad scope. It is likely, however, that the Framers did contemplate a patent system that would continue to provide broad and robust incentives to invent—a set of incentives that has helped establish the United States as a technological superpower and that many feel may be best left untouched. As currently configured, the patent system is susceptible to use by those opposed to reproductive rights—those who desire to prohibit access to reproductive and procreative technologies that directly bear on reproductive rights. Taken to its extreme, those who want to limit individuals’ ability to exercise their currently constitutionally protected rights or future constitutional rights, or desire to deny access to technologies on other moral bases, could obtain patent rights (by application, assignment, or license) on reproductive technologies and then enforce those governmentally granted property rights against any infringer. In other words, the same government that affords the rights to reproductive choices as found in the Constitution could be forced to grant limitations on the access to a private patentee’s reproductive technologies or inventions—regardless of societal value. Because a private patentee is a private actor, as opposed to a state actor, the application of the Bill of Rights and the Fourteenth Amendment has traditionally been thought to be inapplicable in this context.2

#### Unintended births perpetuate a patriarchal hierarchy that draws from socioeconomic status – access to contraceptives is key to reduce this gap

**Venator and Reeves 15** Venator, Joanna, and Richard V. Reeves. “The Implications of Inequalities in Contraception and Abortion.” *Brookings*, Brookings, 29 July 2015, www.brookings.edu/blog/social-mobility-memos/2015/02/26/the-implications-of-inequalities-in-contraception-and-abortion/. // FC

A poor woman is about five times as likely as an affluent woman to have an unintended birth, which further deepens the divides in [income](https://www.brookings.edu/research/opinions/2014/05/06-family-structure-poverty-sawhill), [family stability](https://www.brookings.edu/research/reports2/2014/09/generation-unbound), and [child outcomes](https://www.brookings.edu/research/papers/2014/09/12-impact-unintended-childbearing-future-sawhill). But what is behind the gap? That is the question we address in our new paper, [Sex, contraception, or abortion? Explaining class gaps in unintended childbearing](https://www.brookings.edu/research/sex-contraception-or-abortion-explaining-class-gaps-in-unintended-childbearing/), and [accompanying data interactive](https://www.brookings.edu/interactives/sex-contraception-or-abortion-class-gaps-in-unintended-childbearing/).

Among single women who are not trying to get pregnant, we find no income gaps in the chances of being sexually active in the previous year (our data is from the latest National Survey of Family Growth). This suggests that use of contraception and/or abortion may explain variations in unintended birth rates. This is, in fact, what we find: We also simulate two ‘what-if’ scenarios, exploring how equalizing contraceptive use and abortion rates across income groups would affect birth rates. By our estimates, if all single women adopted the same rates of contraception use as high-income single women, the ratio of unintended births between affluent and poor women would be cut in half. If all single women had the same abortion rates as high-income single women, the ratio would be reduced by one-third.

Our paper concludes: “Control of fertility varies widely between income groups. Most unmarried women are sexually active, regardless of income. But women with higher incomes are much more successful at ensuring that sex does not lead to an accidental baby. This almost certainly reflects their brighter economic and labor market prospects: simply put, they have more to lose from an unintended birth. Improving the economic and educational prospects of poorer women is therefore an important part of any strategy to reduce unintended birth rates. But there are more immediate solutions, too. Affluent women use contraception more frequently and more effectively, and there is a clear case for policies to help close this income gap, including increasing access to long-acting reversible contraceptives (LARCs). But access to affordable abortion also matters, and this is currently limited for many low-income women. There are of course strongly-held views on abortion, but it should be hard for anyone to accept such inequalities by income, especially when they are likely to reverberate across two or more generations. Abortion is a difficult choice, but it is not one that should influenced by financial status.”

#### Patents magnify gender biases and prevent women from access to life-saving medicines – reducing IPP is key

**Mike 20 (2)** Mike, Jennifer H. M. “Access to Essential Medicines to Guarantee Women's Rights to Health: The Pharmaceutical Patents Connection.” *Wiley Online Library*, John Wiley & Sons, Ltd, 29 June 2020, onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161. // FC

Deeply ingrained gender bias and stereotypes also lead to behaviours that favour men over women, especially in accessing healthcare. Gender-related limitations through cultural and traditional practices are also factors that can affect women's health and influence their access to healthcare services, facilities and medicines (Ezeah & Achonwa, [2015](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0052), p. 47; NPC & ORC Macro, [2004](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0128), pp. 39–40, 127–128). These gender-related problems are prevalent in societies that subjugate the social status of women and subject them to harsh traditional medical practices. Examples of adverse cultural practices are Female Genital Mutilation (FGM),[4](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0004) preferential treatment of male children (Lewu, [2015](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0101), p. 227). and differential access to and utilisation of healthcare facilities by men and women in many communities in of some developing countries (Mandara, [2000](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0106), pp. 97–98.) In Nigeria, for example, the practice of FGM is largely prevalent in communities that believe the act is necessary to control a female's libido and prevent promiscuity (WHOb). Apart from the psychological torture, this painful circumcision practice exposes women to infections such as human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), hepatitis B, as well as the danger of haemorrhage, shock and death (Ayanleye, [2013](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0012), p. 131). These gender inequalities can have far reaching consequences on women's health and well-being, consequently, they will need access to medicines.

Similarly, religious and cultural practices, such as the purdah system of wife seclusion are also barriers to accessing healthcare by women (Adedini et al., [2014](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0002), pp. 341–359; Wall, [1998](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0210), pp. 341–359). These practices can prevent women from seeking medical attention when necessary.

A gender-based assessment of poverty and a review of the literature on social inequalities and health further suggest that most women, especially in the rural parts of developing countries, experience limited access to health services and resources (Bennett, Dolin, & Blaser, [2014](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0015), pp. 1477–1479; O'Donnell, [2007](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0132), p. 2827; Sicchia & Maclean, [2006](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0162), p. 70). Several factors such as economic hardship, illiteracy and poverty, and so forth, create barriers to access to health treatments (Holmes et al., [2012](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0079), p. 11). The lack of economic resources to support the provision of essential health services could significantly contribute to the limited availability and access to quality healthcare and medicines by women (Ojanuga & Gilbert, [1992](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0136), p. 614).

Although the poor access to healthcare services, facilities and medicines for women is not limited to resources and low income, inaccessibility due to finances and cost of drugs makes it even less likely for women to have access to adequate patented medicines healthcare. As a result of the many factors that obstruct their access to health care, women will require specific attention in the efforts to scale up access to the necessary healthcare treatments and medicines (CESCR, [2000](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0191), para 21).[5](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0005)

Gender-based violence such as intimate partner violence, rape and sexual violence, physical battery and psychological harm also affect women's health and impinge their fundamental human rights. These violent practices, in turn, have far reaching consequences on women's physical, sexual and psychological health and wellbeing (Onigboji, Odeyemi, & Onigboji, [2015](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0139), p. 92.) The violence and abuse of women is linked with negative health outcomes including physical injuries, reproductive health disorders, HIV and sexual infections, unwanted pregnancy, emotional problems, depression and sleeping disorders (Alo, Kereem, & Olayinka, [2014](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0007), pp. 748–749; Campbell, [2002](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0022), pp. 1331–1332; Ellsberg et al., [2008](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0048), pp. 1165–1166). Consequently, the inability to access healthcare resources to alleviate their health situation mean that they are severely restricted from regaining good health to pursue other productive activities. Here, a human rights perspective would argue that women should be able to access healthcare, and specifically essential medicines because it constitutes the basic minimum to respect her human dignity, which every human being is entitled to.

Research studies has revealed that HIV/AIDS incidence is higher for women than it is for men in the sub-Saharan African region (Physicians for Human Rights, [2006](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0145), p. 16). Thus the specific healthcare needs of women, especially those infected with HIV/AIDS offer an additional ethical base to argue for a consideration of women's access to medicines. For various reasons relating to biological and cultural factors, lack of control over sexual interactions and economic hardship, women are more vulnerable to HIV infections (Maharaj & Roberts, [2006](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0105), p. 215; Müller, [2005](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0120), p. 27; Physicians for Human Rights, [2006](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0145), p. 16). Several factors, including physiological disposition; sexual behaviour, social attitudes to the infection, cultural norms where women are less likely to negotiate condom use, domestic violence and rape, and so on, work to women's disadvantage with regard to the infection.[6](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0006) In many parts of the developing world, the increasing spread of the virus among younger and pregnant women is attributable to social and cultural practices that encourage older men to have sex with younger women, or more women and restrict women's freedom in negotiating sexual practices (Sampath, [2004](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0155), pp. 251–291).[7](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0007)

Mother-to-child transmission (MTCT) of HIV from an infected mother to child either during pregnancy, or delivery, or through breastfeeding is another challenging issue of concern to women and their children (Agboghoroma, Sagay, & Ikechebelu, [2013](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0005), pp. 1–7). Joint United Nations Programme on HIV/AIDS (UNIADS) indicate that many children living with HIV had been directly infected by their mothers, primarily in utero, during labour or while breastfeeding (Skinner-Thompson, [2015](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0164), pp. 1–34; UNAIDS, [2010](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0087), p. 63). Crucially, access to antiretroviral medicines can significantly reduce the risk of MTCT (McIntyre, 2015; Sampath, [2004](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0155), p. 265; UNAIDS, [2010](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0087), pp. 9–10; UNAIDS, [2013](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0088), pp. 38–39; WHOc.)[8](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0008) However, UNAIDS reports that many pregnant women living with HIV have insufficient access to essential antiretroviral treatments (UNAIDS, [2013](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0088), p. 40; UNAIDS, [2014](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0089), pp. 232–233).[9](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0009) Without adequate medications, their babies' chances of surviving to adulthood are reduced, thus access to and use of antiretroviral drugs to prevent transmission and safeguard children is paramount (Siegfried et al., [2011](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0163)). For this reason and others, the UN general Assembly Special Session on HIV/AIDS made a case for a response to issues of HIV prevention and treatment in a multisectoral and gender-sensitive manner (Article 14, Declaration of Commitment on HIV/AIDS: United Nations General Assembly Special Session on HIV/AIDS, [2001](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0037)).

More recently, the spread of the Zika virus, which is passed from mother and child during pregnancy, has drawn global attention and heightened the need to find a more sustainable and effective treatments for reproductive health, vector-borne and neglected infectious diseases that predominantly affect women (Nour, [2010](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0130), pp. 31–32; WHO, [2016](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0221)).

Asides the difficulty posed by HIV/AIDS, studies have also demonstrated that women are more prone to the risk of sexually transmitted diseases (STDs) such as chlamydia and gonorrhoea because of their anatomy (Berman & Kamb, [2007](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0016), p. 75). Poorer women may also be more susceptible to other diseases that affect their immune systems such as malaria or TB due to problems caused by anaemia and malnutrition (Katona & Katona-Apte, [2008](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-bib-0091), pp. 1584–1585).

In the face of these challenges and many others, it is argued that women should have access to essential medicines. Through a human rights approach, special attention is drawn to women, particularly the marginalised and disadvantaged, who require access to medicines, in addition to other necessary responses to their health situations and circumstances.

Although patent right is not an underlying cause, it is a factor that can further exacerbate the issue of accessibility to medicines. The point being made here is that for women already confronted with these limiting factors, any additional constraint on access to essential medicines will typically impose a greater challenge to their health outcomes.[10](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0010) This argument does not lose sight of the fact that the most logical thing to do is address the sociocultural and economic root cause of these problems and health concerns. Nonetheless, the problems associated with accessing drugs within the context of a patent right and the effect on their rights to health cannot be underestimated, hence the focus in this article.[11](https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161#jwip12161-note-0011)

## Solvency

#### Thus, I affirm: Resolved: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines concerning women’s health.

I’ll clarify any more in CX – it checks – otherwise I’d spend 6 minutes speccing tiny parts of the plan and never get to substance – guts clash

#### Eliminating patent barriers is key to women’s increased access to contraceptives and life-saving medicines – the current system is broken

**Chaskalson 21** Chaskalson, Julia. “Opinion: WTO Waiver Is Important, but so Is Fixing Sa's Outdated Patent Laws.” *Spotlight*, 10 Mar. 2021, www.spotlightnsp.co.za/2021/03/10/opinion-wto-waver-is-important-but-so-is-fixing-sas-outdated-patent-laws/. // FC

The [history of the battle for antiretrovirals to treat HIV](https://standingupforourlives.section27.org.za/) has shown that patent regimes can either be crucial in realising the right to access healthcare and health products, or act as barriers to equitable, affordable access to medicines. [As it stands](https://www.fixthepatentlaws.org/wp-content/uploads/2020/05/Fix-The-Patent-Laws-Activist-Guide-2014-ENGLISH.pdf), our patent system does not examine patent applications to determine whether they meet strong patentability criteria, and simply grant patents on application. This has resulted in many patents being unwarranted: some drugs under patent here are not patented anywhere else in the world. Our patent system allows ‘patent evergreening’ – where the period of patent protection is extended and keeps the prices of medicines artificially high for extended periods of time, which has limited access to life-saving medicines. Activists are adamant that government must reform our patent system.

The coalition has [urged](https://www.fixthepatentlaws.org/south-africas-patent-laws-threaten-access-to-future-covid-19-medicines/) the Presidency and DTIC to publish new legislation adhering to the recommendations of the [Intellectual Property Policy Phase I](https://www.gov.za/sites/default/files/gcis_document/201808/ippolicy2018-phasei.pdf) which was adopted by Cabinet in 2018. This policy aligns with global [public health policies](https://www.who.int/medicines/areas/policy/tripshealth.pdf?ua=1) and best practice, but the DTIC seems to drag its feet when with publishing new legislation. It is critical that Bills be published for public comment and expedited into law not only to strengthen South Africa’s efforts to make sure that COVID-19 vaccines and treatments can reach all the people but importantly also to increase access to medicines generally at home.

The South African government has acknowledged, through its joint-proposal at the WTO, that special measures are needed to facilitate access to medicines, prevent deaths and relieve pressure on the health system. But COVID-19 is not the only health crisis to which these measures should apply. While the patent waiver at the WTO is a bold move from the South African government for our country and others in the Global South, the waiver would only exist for the duration of the pandemic, and only in relation to COVID-19 medicines. Real patent law reform domestically would save lives in South Africa now and for years to come.

Patent law reform could help to give [cancer patients](https://www.fixthepatentlaws.org/minister-mkhize-must-ensure-access-to-cancer-medicine-that-who-now-considers-essential/) affordable and equitable access to medicines, people living with HIV greater access to second or third line [antiretrovirals](https://www.fixthepatentlaws.org/key-medicines/), increase the supply of [contraceptive](https://www.fixthepatentlaws.org/court-case-blocks-cheaper-version-of-birth-control-pill/)s and [push down the prices](https://www.fixthepatentlaws.org/activists-demand-johnson-johnson-drop-the-price-of-vital-tb-medicine-bedaquiline/) of drugs for drug-resistant tuberculosis. Not only is this possible, but it is a constitutional imperative. Over and above promoting the rights to equality, dignity and access to healthcare and medicines, new legislation would save lives, relieve pressure on healthcare workers and ease the strain on our public health system. And it cannot wait any longer.

#### Examining foreign policy through an intersectional feminist lens is key to solving structural disparities in policy – it’s a pre-req to all other impacts

**Amhed et. al 21** Ahmed, Zara, et al. “Here's Why Sexual and Reproductive Rights Must Be the Linchpin of Feminist Foreign Policy.” *Guttmacher Institute*, 2 June 2021, www.guttmacher.org/article/2021/06/heres-why-sexual-and-reproductive-rights-must-be-linchpin-feminist-foreign-policy#. // FC

As global leaders are taking decisive steps to begin rebuilding many of the systems devastated in the first year of the COVID-19 pandemic, they have an opportunity and a responsibility to optimize this moment of reconstruction and address structural, gender-based disparities.

The combination of long-standing inequities and pandemic-exacerbated conditions has clarified that sexual and reproductive health and rights are foundational and necessary for gender equality, as well as to a full recovery from the damage caused by COVID-19.

What Is Feminist Foreign Policy?

Traditionally, foreign policy has treated issues like gender equality as separate from and peripheral to core aims, such as promoting national security and trade. But a new and growing body of evidence illustrates how improving gender equality is in fact central to those aims, [resulting in healthier and more prosperous societies](https://www.pwc.co.uk/services/economics/insights/women-in-work-index.html). For example, equalizing women’s participation in the workforce with men [could boost the global gross domestic product](https://www.cfr.org/womens-participation-in-global-economy/) by $28 trillion annually and would benefit countries at all income levels. There is also [evidence](https://blogs.worldbank.org/dev4peace/can-gender-equality-prevent-violent-conflict) that gender equality is associated with peace and stability; the larger the differences between men and women’s experiences and opportunities in a given country, the more likely that country is to be involved in violent conflict.

The first official recognition of gender equality as a global priority was in 1995 at the [United Nations Fourth World Conference on Women](https://www.un.org/womenwatch/daw/beijing/platform/index.html) in Beijing, but it is only in the past decade that countries have begun to develop and adopt feminist foreign policies. This approach has evolved from tackling gender equality as just one of the many disparate aims of foreign policy, and instead applies a gender lens to every foreign policy decision, from aid allocations to political representation. It also acknowledges how gender inequality overlaps with other forms of oppression, such as racism and classism, and takes an intersectional approach to feminism.