### 1AC---Plan

#### The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.

#### Enforcement is done through waiving TRIPS protections and modifying relevant domestic law to ensure patent protections are reduced---spec is delineated in the card.

Jones et al. 21, Mike Jones, J.D., cum laude, Brooklyn Law School, 2014. Sean McConnell, University of Pittsburgh School of Law, J.D., 2002. Lauren Giambalvo, University of Georgia School of Law, J.D., magna cum laude, Order of the Coif, 2019; Georgia Law Review. Emily Harmon, Villanova University Charles Widger School of Law, J.D., 2020. Ipwatchdog, August 9, 2021. “What is a ‘Patent Waiver’ Anyway? Zooming Out on the TRIPS COVID IP Waiver Debate” <https://www.ipwatchdog.com/2021/08/09/patent-waiver-anyway-zooming-trips-covid-ipwaiver-debate/id=136381/> brett

Scientists, engineers, and everyday people have developed solutions for testing, preventing, and treating the COVID-19 disease. Ordinarily, we wouldn’t think twice about granting patents on these inventions. But, today, when COVID-19 is spreading all over the world and killing millions of people, some world leaders are questioning whether we should be granting the exclusionary rights of patent protection on inventions that help respond to the pandemic. Included in that group is the Biden-Harris Administration, which, in May, announced their support of an “IP waiver” on COVID 19 vaccines.

Patent Waiver

The “patent waiver” is a proposal to waive certain provisions of the Trade-Related Aspects of Intellectual Property (TRIPS) Agreement for three years. The TRIPS Agreement requires certain member countries (“Members”), including the United States, to have certain minimum intellectual property protections. While this proposal is often referred to as a “patent waiver,” the proposal would also waive sections associated with copyright, industrial designs, and undisclosed information.

The proposal seeks to waive Part II, Section 5 Patents of the TRIPS Agreement and the associated enforcement sections only with respect to “health products and technologies including diagnostics, therapeutics, vaccines, medical devices, personal protective equipment, their materials or components, and their methods and means of manufacture for the prevention, treatment or containment of COVID-19” for a period of three years. Article 27 of Section 5 requires that certain Members issue patents to inventions that “are new, involve an inventive step and are capable of industrial application.” However, Members have the option to refuse to grant patents to certain categories of inventions, including, “diagnostic, therapeutic and surgical methods for the treatment of humans or animals.” Article 28 explains that an owner of a patent can prevent others from “making, using, offering for sale, selling, or importing” (“infringing”) the patented inventions. Finally, Part III of the TRIPS Agreement explains the potential consequences of infringing a patent. Among other things, the infringer can be liable for money damages and the judicial authority of the Member may order injunctions.

Therefore, as the TRIPS Agreement currently stands, each Member must have patent laws that give patents to inventions that meet certain requirements, and each must provide avenues for patent holders to enforce its patent rights. As applied to the current situation, Members are required to grant patents to qualifying inventions related to “the prevention, containment and treatment of COVID-19” (with exceptions for pharmaceuticals if the Member does not allow pharmaceutical patents). Infringers could be liable for money damages and the judicial authority of the Member may order injunctions.

If provisions in Part II, Section 5 and the associated enforcement sections are waived, Members would no longer be required to issue patents or provide avenues for patent holders to enforce patent rights. The proposal does not, however, require Members to waive their own domestic patent rights. In other words, the proposal to waive certain provisions of the TRIPS Agreement, the “patent waiver,” does not directly waive any patent protections. Rather, the patent waiver grants to Members permission to waive their own domestic patent protections.

Patent laws are geographically limited; they only protect an invention in the country that issued the patent. For example, one cannot make, use, offer to sell, sell, or import an invention protected only by a U.S. patent in the U.S; however, one may do those things in another country where corresponding patent protection does not exist. Therefore, in order to waive patent protections worldwide, each Member subject the TRIPS Agreement’s requirement to have certain minimum intellectual property protection would have to waive its own domestic patent protections.

The United States patent laws are codified in Title 35 to the U.S. Code. It provides that inventors may obtain patents for their new and useful inventions and infringers are liable for making, using, offering to sell, selling, or importing into the U.S. patented inventions without the patent holders consent. Because the power to enact patent laws lies with Congress, Congress would likely have to waive these laws. If Congress chooses not to waive the U.S.’s patent laws, patent holders will continue to be able to enforce their U.S. patent rights in the U.S.

### 1AC---Advantage

#### COVID-19 causes extinction.

RECNA et al. 21, Research Center for Nuclear Weapons Abolition, Nagasaki University (RECNA), Asia Pacific Leadership Network (APLN), and the Nautilus Institute. Journal for Peace and Nuclear Disarmament Volume 4, 2021. “Pandemic Futures and Nuclear Weapon Risks: The Nagasaki 75th Anniversary pandemic-nuclear nexus scenarios final report” <https://www.tandfonline.com/doi/full/10.1080/25751654.2021.1890867> brett

The relationship between pandemics and war is as long as human history. Past pandemics have set the scene for wars by weakening societies, undermining resilience, and exacerbating civil and inter-state conflict. Other disease outbreaks have erupted during wars, in part due to the appalling public health and battlefield conditions resulting from war, in turn sowing the seeds for new conflicts. In the post-Cold War era, pandemics have spread with unprecedented speed due to increased mobility created by globalization, especially between urbanized areas. Although there are positive signs that scientific advances and rapid innovation can help us manage pandemics, it is likely that deadly infectious viruses will be a challenge for years to come.

The COVID-19 is the most demonic pandemic threat in modern history. It has erupted at a juncture of other existential global threats, most importantly, accelerating climate change and resurgent nuclear threat-making. The most important issue, therefore, is how the coronavirus (and future pandemics) will increase or decrease the risks associated with these twin threats, climate change effects, and the next use of nuclear weapons in war.5

Today, the nine nuclear weapons arsenals not only can annihilate hundreds of cities, but also cause nuclear winter and mass starvation of a billion or more people, if not the entire human species. Concurrently, climate change is enveloping the planet with more frequent and intense storms, accelerating sea level rise, and advancing rapid ecological change, expressed in unprecedented forest fires across the world. Already stretched to a breaking point in many countries, the current pandemic may overcome resilience to the point of near or actual collapse of social, economic, and political order.

In this extraordinary moment, it is timely to reflect on the existence and possible uses of weapons of mass destruction under pandemic conditions – most importantly, nuclear weapons, but also chemical and biological weapons. Moments of extreme crisis and vulnerability can prompt aggressive and counterintuitive actions that in turn may destabilize already precariously balanced threat systems, underpinned by conventional and nuclear weapons, as well as the threat of weaponized chemical and biological technologies. Consequently, the risk of the use of weapons of mass destruction (WMD), especially nuclear weapons, increases at such times, possibly sharply.

The COVID-19 pandemic is clearly driving massive, rapid, and unpredictable changes that will redefine every aspect of the human condition, including WMD – just as the world wars of the first half of the 20th century led to a revolution in international affairs and entirely new ways of organizing societies, economies, and international relations, in part based on nuclear weapons and their threatened use. In a world reshaped by pandemics, nuclear weapons – as well as correlated non-nuclear WMD, nuclear alliances, “deterrence” doctrines, operational and declaratory policies, nuclear extended deterrence, organizational practices, and the existential risks posed by retaining these capabilities – are all up for redefinition.

A pandemic has potential to destabilize a nuclear-prone conflict by incapacitating the supreme nuclear commander or commanders who have to issue nuclear strike orders, creating uncertainty as to who is in charge, how to handle nuclear mistakes (such as errors, accidents, technological failures, and entanglement with conventional operations gone awry), and opening a brief opportunity for a first strike at a time when the COVID-infected state may not be able to retaliate efficiently – or at all – due to leadership confusion. In some nuclear-laden conflicts, a state might use a pandemic as a cover for political or military provocations in the belief that the adversary is distracted and partly disabled by the pandemic, increasing the risk of war in a nuclear-prone conflict. At the same time, a pandemic may lead nuclear armed states to increase the isolation and sanctions against a nuclear adversary, making it even harder to stop the spread of the disease, in turn creating a pandemic reservoir and transmission risk back to the nuclear armed state or its allies.

In principle, the common threat of the pandemic might induce nuclear-armed states to reduce the tension in a nuclear-prone conflict and thereby the risk of nuclear war. It may cause nuclear adversaries or their umbrella states to seek to resolve conflicts in a cooperative and collaborative manner by creating habits of communication, engagement, and mutual learning that come into play in the nuclear-military sphere. For example, militaries may cooperate to control pandemic transmission, including by working together against criminal-terrorist non-state actors that are trafficking people or by joining forces to ensure that a new pathogen is not developed as a bioweapon.

To date, however, the COVID-19 pandemic has increased the isolation of some nuclear-armed states and provided a textbook case of the failure of states to cooperate to overcome the pandemic. Borders have slammed shut, trade shut down, and budgets blown out, creating enormous pressure to focus on immediate domestic priorities. Foreign policies have become markedly more nationalistic. Dependence on nuclear weapons may increase as states seek to buttress a global re-spatialization6 of all dimensions of human interaction at all levels to manage pandemics. The effect of nuclear threats on leaders may make it less likely – or even impossible – to achieve the kind of concert at a global level needed to respond to and administer an effective vaccine, making it harder and even impossible to revert to pre-pandemic international relations. The result is that some states may proliferate their own nuclear weapons, further reinforcing the spiral of conflicts contained by nuclear threat, with cascading effects on the risk of nuclear war.

#### But, the impact is not just universal---COVID reproduces injustices

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In the context of COVID-19, the pandemic has caused the largest recession in history, with up to a half of the global population at one time being placed on lockdown. Supply shortages have occurred in a number of sectors due to panic buying, increased use of goods to fight the pandemic, and disruption to factories. There have been widespread reports of shortages of pharmaceuticals and the technology industry, in particular, has been warning about delays to shipments of electronic goods. Possible instability generated by an outbreak and associated behavioural changes could result in price spikes, and disruption to markets. Such price rises would be felt most by vulnerable populations who depend on markets for their food as well as those already depending on humanitarian assistance to maintain their livelihoods and food access.

Gender, social and political impacts

When crises strike, women and girls are harder hit by economic impacts than men. Around the world, women generally earn less and save less, are the majority of single-parent households and disproportionately hold more insecure jobs in the informal economy or service sector with less access to social protections. This leaves them less able to absorb the economic shocks than men. For many families, school closures and social distancing measures have increased the unpaid care and domestic load of women at home, making them less able to take on, or balance, paid work. The situation is worse in developing economies, where a larger share of people are employed in the informal economy in which there are far fewer social protections for health insurance, paid sick leave and more. Although globally informal employment is a greater source of employment for men (63%) than for women (58%), in low and lower-middle income countries a higher proportion of women are in informal employment than men. In Sub-Saharan Africa, for example, around 92% of employed women are in informal employment compared to 86% of men.

In the context of COVID-19 it is likely that the pandemic could result in a prolonged fall in women’s incomes and labour force participation. The ILO estimates global unemployment will rise to between 5.3 million (“low” scenario) and 24.7 million (“high” scenario) from a base level of 188 million in 2019 as a result of COVID-19’s impact on global GDP growth. In the U.S.A. men’s unemployment went up from 3.55 million in February to 11 million in April in 2020 while women’s unemployment – which was lower than men before the crisis – went up from 2.7 million to 11.5 million over the same period. The picture is even bleaker for young women and men aged 16–19 in the U.S.A., whose unemployment rate jumped from 11.5 per cent in February to 32.2 per cent in April 2020.

Evidence suggests that pandemics can have significant social and political consequences leading to clashes between states and citizens, driving population displacement and heightening social tensions and discrimination. HIV rates went up in Cambodia and E Timor after UN Peacekeepers went in and the 1990s and early 2000s saw extremely high HIV/AIDS prevalence rates among African militaries, leading to increased absenteeism and decreased military capacity and readiness.

Large scale outbreaks of infectious disease have direct and consequential impacts. For example, widespread public panic during disease outbreaks can lead to rapid population migration and migrants face increased health risks arising from poor sanitation, poor nutrition and other stressors. Migration also increases the risk of further spreading an outbreak.

Outbreaks of infectious diseases can cause already vulnerable social groups, such as ethnic minorities, to be stigmatised and blamed for the disease and its consequences. Discrimination against Asians during COVID -19 has been well documented in the USA, Canada, Australia and UK. Migrants in Singapore bore the biggest brunt of COVID-19, and more recently in HK. But in these instances, insecure employment is the main problem, and not ethnicity per se.

#### Neocolonial dynamics limit COVID vaccines to the Global North---that results in debt imperialism and undermines the right to health.

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The current global distribution of COVID-19 vaccines is largely dictated by power disparities and inequities in financial and other resources, with predominantly high-income countries contracting bilaterally with individual pharmaceutical companies (many in their own countries) for specific vaccines, leaving countries from the Global South facing inequitable vaccine access. Bilateral deals between states and pharmaceutical companies, whether completed by Global North or Global South states, significantly compromise the effectiveness and equity of the COVAX initiative, limited as it already is by the coercive influence, vested interests and participation of pharmaceutical companies and their host nations. The African Union, for example, endorsed the TRIPS waiver to relax WTO rules so that LMICs could create their own COVID-19 vaccines, but this collective effort across African countries faced resistance from Global North countries and pharmaceutical companies.

The IP system appears to have pushed countries in the Global South that may prefer not to be dependent on the charitable model of the COVAX scheme to join high-income countries in engaging directly with manufacturers to purchase COVID-19 vaccines. This has included African countries, despite the African Union’s criticism of the inequities resulting from IP law protections. This process has reproduced colonially entrenched power dynamics, in which poorer countries lack the bargaining power to obtain competitive rates and, consequently, typically end up paying far more than the wealthier, developed countries. More broadly, countries in the Global South are pressured into participating in global systems of trade that result in the exploitation of their own populations by unjust global economic systems and IP laws.39 The high cost of vaccines for countries from the Global South constitutes a large proportion of their health expenditure, and this comes at the expense of other health priorities.

In many cases, the only way in which Global South countries can purchase vaccines is to move themselves further into debt. Given the detrimental neocolonial implications of debt, with a long history of loan conditionalities through structural adjustment programmes, increasing debt to service health needs contributes to the worsening of inequalities between the Global North and Global South.40 These programmes may increase debt and undermine development in ways that limit the realisation of the right to health.41 The World Bank has set aside US$12 billion and has already disbursed loans of US$500 million for vaccines in low-income and middle-income nations;42 poorer nations, instead of servicing already depleted health systems, are forced to divert additional funds to servicing debt.

#### The time to expand vaccination on a global level is now---highly contagious mutations facilitate continued spread.

Kumar 7-12 Rajeesh Kumar, Rajeesh Kumar is Associate Fellow at Manohar Parrikar Institute for Defence Studies and Analyses, New Delhi., 7-12-2021, "WTO TRIPS Waiver and COVID-19 Vaccine Equity," Manohar Paprikar Institute for Defence Studies and Analyses, <https://idsa.in/issuebrief/wto-trips-waiver-covid-vaccine-rkumar-120721>, EH and brett

Two significant factors rekindled the debate on TRIPS waiver for essential medical products—first, vaccine inequity, and second, the insufficiency of existing waiver provisions in fighting the COVID-19 pandemic. COVID-19 is an exceptional circumstance, and equitable global access to the vaccine is necessary to bring the pandemic under control. However, the world is witnessing quite the reverse, i.e., vaccine nationalism. Vaccine nationalism is “my nation first” approach to securing and stockpiling vaccines before making them available in other countries. A TRIPS waiver would be instrumental in addressing the growing inequality in the production, distribution, and pricing of the COVID-19 vaccines.

Vaccine Inequity

According to Duke Global Health Innovation Center, which monitors COVID-19 vaccine purchases, rich nations representing just 14 per cent of the world population have bought up to 53 per cent of the most promising vaccines so far. As of 4 July 2021, the high-income countries (HICs) purchased more than half (6.16 billion) vaccine doses sold globally. At the same time, the low-income countries (LICs) received only 0.3 per cent of the vaccines produced. The low and middle-income countries (LMICs), which account for 81 per cent of the global adult population, purchased 33 per cent, and COVAX (COVID-19 Vaccines Global Access) has received 13 per cent.10 Many HICs bought enough doses to vaccinate their populations several times over. For instance, Canada procured 10.45 doses per person, while the UK, EU and the US procured 8.18, 6.89, and 4.60 doses per inhabitant, respectively.11

Source:“Tracking COVID-19 Vaccine Purchases Across the Globe”, Duke Global Health Innovation Center, Updated 9 July 2021.

Consequently, there is a significant disparity between HICs and LICs in vaccine administration as well. As of 8 July 2021, 3.32 billion vaccine doses had been administered globally.12 Nonetheless, only one per cent of people in LICs have been given at least one dose. While in HICs almost one in four people have received the vaccine, in LICs, it is one in more than 500. The World Health Organization (WHO) notes that about 90 per cent of African countries will miss the September target to vaccinate at least 10 per cent of their populations as a third wave looms on the continent.13 South Africa, the most affected African country, for instance, has vaccinated less than two per cent of its population of about 59 million. This is in contrast with the US where almost 47.5 per cent of the population of more than 330 million has been fully vaccinated. In Sub-Saharan Africa, vaccine rollout remains the slowest in the world. According to the International Monetary Fund (IMF), at current rates, by the end of 2021, a massive global inequity will continue to exist, with Africa still experiencing meagre vaccination rates while other parts of the world move much closer to complete vaccination.14

This vaccine inequity is not only morally indefensible but also clinically counter-productive. If this situation prevails, LICs could be waiting until 2025 for vaccinating half of their people. Allowing most of the world’s population to go unvaccinated will also spawn new virus mutations, more contagious viruses leading to a steep rise in COVID-19 cases. Such a scenario could cause twice as many deaths as against distributing them globally, on a priority basis. Preventing this humanitarian catastrophe requires removing all barriers to the production and distribution of vaccines. TRIPS is one such barrier that prevents vaccine production in LMICs and hence its equitable distribution.

#### Waiving IP protections is essential to expand manufacturing and global exports. A litany of countries possess capacity but lack know-how -- the plan is key.

Kumar 7-12 Rajeesh Kumar, Rajeesh Kumar is Associate Fellow at Manohar Parrikar Institute for Defence Studies and Analyses, New Delhi., 7-12-2021, "WTO TRIPS Waiver and COVID-19 Vaccine Equity," Manohar Paprikar Institute for Defence Studies and Analyses, <https://idsa.in/issuebrief/wto-trips-waiver-covid-vaccine-rkumar-120721>, brett

Another argument against the proposed TRIPS waiver is that a waiver would not increase the manufacturing of COVID-19 vaccines. Indeed, one of the significant factors contributing to vaccine inequity is the lack of manufacturing capacity in the global south. Further, a TRIPS waiver will not automatically translate into improved manufacturing capacity. However, a waiver would be the first but essential step to increase manufacturing capacity worldwide. For instance, to export COVID-19 vaccine-related products, countries need to ensure that there are no IP restrictions at both ends – exporting and importing. The market for vaccine materials includes consumables, single-use reactors bags, filters, culture media, and vaccine ingredients. Export blockages on raw materials, equipment and finished products harm the overall output of the vaccine supply chain. If there is no TRIPS restriction, more governments and companies will invest in repurposing their facilities.

Similarly, the arguments such as that no other manufacturers can carry out the complex manufacturing process of COVID-19 vaccines and generic manufacturing as that would jeopardise quality, have also been proven wrong in the past. For instance, in the early 1990s, when Indian company Shantha Biotechnics approached a Western firm for a technology transfer of Hepatitis B vaccine, the firm responded that “India cannot afford such high technology vaccines… And even if you can afford to buy the technology, your scientists cannot understand recombinant technology in the least.”25 Later, Shantha Biotechnics developed its own vaccine at $1 per dose, and the UNICEF (United Nations Children’s Emergency Fund) mass inoculation programme uses this vaccine against Hepatitis B. In 2009, Shantha sold over 120 million doses of vaccines globally.

India also produces high-quality generic drugs for HIV/AIDS and cancer treatment and markets them across the globe. Now, a couple of Indian companies are in the last stage of producing mRNA (Messenger RNA) vaccines.26 Similarly, Bangladesh and Indonesia claimed that they could manufacture millions of COVID-19 vaccine doses a year if pharmaceutical companies share the know-how.27 Recently, Vietnam also said that the country could satisfy COVID-19 vaccine production requirements once it obtains vaccine patents.28 Countries like the United Arab Emirates (UAE), Turkey, Cuba, Brazil, Argentina and South Korea have the capacity to produce high-quality vaccines but lack technologies and know-how. However, Africa, Egypt, Morocco, Senegal, South Africa and Tunisia have limited manufacturing capacities, which could also produce COVID-19 vaccines after repurposing.

Moreover, COVID-19 vaccine IPR runs across the entire value chain – vaccine development, production, use, etc. A mere patent waiver may not be enough to address the issues related to its production and distribution. What is more important here is to share the technical know-how and information such as trade secrets. Therefore, the existing TRIPS flexibilities, such as compulsory and voluntary licensing, are insufficient to address this crisis. Further, compulsory licensing and the domestic legal procedures it requires is cumbersome and not expedient in a public health crisis like the COVID-19 pandemic.

#### Boosting manufacturing capacity is critical to a timely response to COVID AND ensures preparedness for future pandemics.

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Since consequentialist justifications treat the value of IP as purely instrumental, they are also vulnerable to counterarguments showing that a sought-after goal is not the sole or most important end. During the COVID-19 pandemic, we submit that the vaccinating the world is an overriding goal. With existing IP protections intact, the world has fallen well short of this goal. Current forecasts show that at the current pace, there will not be enough vaccines to cover the world’s population until 2023 or 2024.15 IP protections further frustrate the goal of universal access to vaccines by limiting who can manufacturer them. The WHO reports that 80% of global sales for COVID-19 vaccines come from five large multinational corporations.16 Increasing the number of manufacturers globally would not only increase supply, but reduce prices, making vaccines more affordable to LMICs. It would stabilise supply, minimising disruptions of the kind that occurred when India halted vaccine exports amidst a surge of COVID-19 cases.

It might be objected that waiving IP protections will not increase supply, because it takes years to establish manufacturing capacity. However, since the pandemic began, we have learnt it takes less time. Repurposing facilities and vetting them for safety and quality can often happen in 6 or 7 months, about half the time previously thought.17 Since COVID-19 will not be the last pandemic humanity faces, expanding manufacturing capacity is also necessary preparation for future pandemics. Nkengasong, Director of the African Centres for Disease Control and Prevention, put the point bluntly, ‘Can a continent of 1.2 billion people—projected to be 2.4 billion in 30 years, where one in four people in the world will be African—continue to import 99% of its vaccine?’18

#### Linking advocacy in spaces like debate to state reductions of IP protections spills up.

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Under the ICESCR and IHR, states have a duty to cooperate with other states in progressively realising the right to health, including ensuring provision of minimum levels of health services, facilities and goods on a non-discriminatory basis.54 55 The CESCR has clarified that, in the context of COVID-19, this duty should include: ‘sharing of research, medical equipment and supplies, and best practices in combating the virus; coordinated action to reduce the economic and social impacts of the crisis; and joint endeavours by all States to ensure an effective, equitable economic recovery’.56 Additionally, it affirmed that ‘the needs of vulnerable and disadvantaged groups as well as fragile countries, including least developed countries, countries in conflict and post-conflict situations, should be at the centre of such international endeavours’.56

Many statements from various UN treaty bodies have acknowledged that ensuring universal access to essential medicines is central to the realisation of the right to health, and that IP considerations should never over-ride human rights obligations for universal and equitable access to the COVID-19 vaccine.57–62 These statements have been achieved through a global movement of solidarity, encompassing states, civil society organisations and individuals, and reflect a reassessment of human rights values from below. For instance, the Special Rapporteur on the right to health has argued that solidarity needs to be part of a wider effort to redistribute health resources. However, these statements need to go further and call for explicit reparations in global health, which is the only way to redistribute health resources globally.4 63

Increased financing could fund public research and development through either WHO’s existing efforts for a complementary research and development treaty,64 or through mechanisms such as the proposed Pandemic Financing Facility. The latter proposes to mobilise long-term contributions of approximately US$5–US$10 billion per annum to finance preparedness, but should also focus on funding research and development on pathogens so as to restructure patents as a global public good.65 For those states unable to fund their own access to COVID-19 vaccines, there is an international human rights duty on other states to ensure that such states are not harmed through the actions of multilateral institutions that leave them with devastating debt (The Maastricht Principles (see note 57), Principles 3, 4 and 9).66

In meeting these international obligations immediately to ensure access to COVID-19 vaccines, only a few countries are capable of manufacturing the vaccine at the scale needed.67 This inequity in vaccine production capacity requires countries from the Global North to support countries in the Global South to increase their production capacity, including through non-exclusive licensing and the WHO’s COVID-19 Technology Access Pool.68 Sharing technology and building manufacturing capacity will be critical to ensuring that countries can solve problems of access to essential medicines in the long term, setting a precedent that will be necessary in addressing environmental justice, antimicrobial resistance prevention and other global public goods.

Increased funding, as a form of reparations, would help finance a more equitable manufacturing base to ensure that all countries in the Global South are not totally reliant on existing manufacturers. Although we acknowledge that the manufacturing of vaccines is a complex process and that not every country is likely to manufacture medicines including vaccines at the required scale, the WHO has projected that at present, five African countries have some capacity to manufacture vaccines, and efforts to finance manufacturing capacity for countries of the Global South would go a long way towards readdressing the charity model proposed under COVAX by ensuring that African countries can rely on regional compacts for their vaccine access. Coordination and cooperation within the African Union and the Africa Centres for Disease Control and Prevention, which has already begun, could determine the strategically best, and most effective, locations and ways to scale up manufacturing on the continent to improve vaccine access.69 70

#### Debate is historically valuable as a site for anti-imperial advocacy.

**Iverson ’9** [Joel; 2009; Associate Professor of Communication at the University of Montana, Ph.D in Communication from Arizona State University Relations at the University of Sydney; Debate Central, “Can Cutting Cards Carve into Our Personal Lives: An Analysis of Debate Research on Personal Advocacy,” <https://debate.uvm.edu/dybvigiverson1000.html>] brett

Mitchell (1998) provides a thorough examination of the pedagogical implication for academic debate. Although Mitchell acknowledges that debate provides preparation for participation in democracy, limiting debate to a laboratory where students practice their skill for future participation is criticized. Mitchell contends: For students and teachers of argumentation, the heightened salience of this question should signal the danger that critical thinking and oral advocacy skills alone may not be sufficient for citizens to assert their voices in public deliberation. (p. 45) Mitchell contends that the laboratory style setting creates barriers to other spheres, creates a "sense of detachment" and causes debaters to see research from the role of spectators. Mitchell further calls for "argumentative agency [which] involves the capacity to contextualize and employ the skills and strategies of argumentative discourse in fields of social action, especially wider spheres of public deliberation" (p. 45). Although we agree with Mitchell that debate can be an even greater instrument of empowerment for students, we are more interested in examining the impact of the intermediary step of research. In each of Mitchell's examples of debaters finding creative avenues for agency, there had to be a motivation to act. It is our contention that the research conducted for competition is a major catalyst to propel their action, change their opinions, and to provide a greater depth of understanding of the issues involved. The level of research involved in debate creates an in-depth understanding of issues. The level of research conducted during a year of debate is quite extensive. Goodman (1993) references a Chronicle of Higher Education article that estimated "the level and extent of research required of the average college debater for each topic is equivalent to the amount of research required for a Master's Thesis (cited in Mitchell, 1998, p. 55). With this extensive quantity of research, debaters attain a high level of investigation and (presumably) understanding of a topic. As a result of this level of understanding, debaters become knowledgeable citizens who are further empowered to make informed opinions and energized to take action. Research helps to educate students (and coaches) about the state of the world. Without the guidance of a debate topic, how many students would do in-depth research on female genital mutilation in Africa, or United Nations sanctions on Iraq? The competitive nature of policy debate provides an impetus for students to research the topics that they are going to debate. This in turn fuels students’ awareness of issues that go beyond their front doors. Advocacy flows from this increased awareness. Reading books and articles about the suffering of people thousands of miles away or right in our own communities drives people to become involved in the community at large. Research has also focused on how debate prepares us for life in the public sphere. Issues that we discuss in debate have found their way onto the national policy stage, and training in intercollegiate debate makes us good public advocates. The public sphere is the arena in which we all must participate to be active citizens. Even after we leave debate, the skills that we have gained should help us to be better advocates and citizens. Research has looked at how debate impacts education (Matlon and Keele 1984), legal training (Parkinson, Gisler and Pelias 1983, Nobles 19850 and behavioral traits (McGlone 1974, Colbert 1994). These works illustrate the impact that public debate has on students as they prepare to enter the public sphere. The debaters who take active roles such as protesting sanctions were probably not actively engaged in the issue until their research drew them into the topic. Furthermore, the process of intense research for debate may actually change the positions debaters hold. Since debaters typically enter into a topic with only cursory (if any) knowledge of the issue, the research process provides exposure to issues that were previously unknown. Exposure to the literature on a topic can create, reinforce or alter an individual's opinions. Before learning of the School for the America's, having an opinion of the place is impossible. After hearing about the systematic training of torturers and oppressors in a debate round and reading the research, an opinion of the "school" was developed. In this manner, exposure to debate research as the person finding the evidence, hearing it as the opponent in a debate round (or as judge) acts as an initial spark of awareness on an issue. This process of discovery seems to have a similar impact to watching an investigative news report. Mitchell claimed that debate could be more than it was traditionally seen as, that it could be a catalyst to empower people to act in the social arena. We surmise that there is a step in between the debate and the action. The intermediary step where people are inspired to agency is based on the research that they do. If students are compelled to act, research is a main factor in compelling them to do so. Even if students are not compelled to take direct action, research still changes opinions and attitudes. Research often compels students to take action in the social arena. Debate topics guide students in a direction that allows them to explore what is going on in the world. Last year the college policy debate topic was, Resolved: That the United States Federal Government should adopt a policy of constructive engagement, including the immediate removal of all or nearly all economic sanctions, with the government(s) of one or more of the following nation-states: Cuba, Iran, Iraq, Syria, North Korea. This topic spurred quite a bit of activism on the college debate circuit. Many students become actively involved in protesting for the removal of sanctions from at least one of the topic countries. The college listserve was used to rally people in support ofvarious movements to remove sanctions on both Iraq and Cuba. These messages were posted after the research on the topic began. While this topic did not lend itself to activism beyond rallying the government, other topics have allowed students to take their beliefs outside of the laboratory and into action. In addition to creating awareness, the research process can also reinforce or alter opinions. By discovering new information in the research process, people can question their current assumptions and perhaps formulate a more informed opinion. One example comes from a summer debate class for children of Migrant workers in North Dakota (Iverson, 1999). The Junior High aged students chose to debate the adoption of Spanish as an official language in the U.S. Many students expressed their concern that they could not argue effectively against the proposed change because it was a "truism." They were wholly in favor of Spanish as an official language. After researching the topic throughout their six week course, many realized much more was involved in adopting an official language and that they did not "speak 'pure' Spanish or English, but speak a unique dialect and hybrid" (Iverson, p. 3). At the end of the class many students became opposed to adopting Spanish as an official language, but found other ways Spanish should be integrated into American culture. Without research, these students would have maintained their opinions and not enhanced their knowledge of the issue. The students who maintained support of Spanish as an official language were better informed and thus also more capable of articulating support for their beliefs. The examples of debate and research impacting the opinions and actions of debaters indicate the strong potential for a direct relationship between debate research and personal advocacy. However, the debate community has not created a new sea of activists immersing this planet in waves of protest and political action. The level of influence debater search has on people needs further exploration. Also, the process of research needs to be more fully explored in order to understand if and why researching for the competitive activity of debate generates more interest than research for other purposes such as classroom projects. Since parliamentary debate does not involve research into a single topic, it can provide an important reference point for examining the impact of research in other forms of debate. Based upon limited conversations with competitors and coaches as well as some direct coaching and judging experience in parliamentary debate, parliamentary forms of debate has not seen an increase in activism on the part of debaters in the United States. Although some coaches require research in order to find examples and to stay updated on current events, the basic principle of this research is to have a commonsense level of understanding(Venette, 1998). As the NPDA website explains, "the reader is encouraged to be well-read in current events, as well as history, philosophy, etc. Remember: the realm of knowledge is that of a 'well-read college student'" (NPDA Homepage,<http://www.bethel.edu/Majors/Communication/npda/faq2.html>). The focus of research is breadth, not depth. In fact, in-depth research into one topic for parliamentary debate would seem to be counterproductive. Every round has a different resolution and for APDA, at least, those resolutions are generally written so they are open to a wide array of case examples, So, developing too narrow of a focus could be competitively fatal. However, research is apparently increasing for parliamentary teams as reports of "stock cases" used by teams for numerous rounds have recently appeared. One coach did state that a perceived "stock case" by one team pushed his debaters to research the topic of AIDS in Africa in order to be equally knowledgeable in that case. Interestingly, the coach also stated that some of their research in preparation for parliamentary debate was affecting the opinions and attitudes of the debaters on the team. Not all debate research appears to generate personal advocacy and challenge peoples' assumptions. Debaters must switch sides, so they must inevitably debate against various cases. While this may seem to be inconsistent with advocacy, supporting and researching both sides of an argument actually created stronger advocates. Not only did debaters learn both sides of an argument, so that they could defend their positions against attack, they also learned the nuances of each position. Learning and the intricate nature of various policy proposals helps debaters to strengthen their own stance on issues.

#### Raising the threat level of COVID is key to motivate responses---AND, when combined with our advocacy, is decolonial

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For the last two decades a strategy employed by health professionals, scientists, and diplomats has been to play the ‘health security card’ to achieve particular trade, diplomatic, strategic, and development goals (Elbe 2011). The presumption has been that the securitisation of health will harness global political leadership and resources. This marriage of health issues to security logic has been met with a mix of applause, caution, and critique (Feldbaumet al. 2010; McInnes and Rushton 2013; Hanrieder and Kreuder-Sonnen 2014). But the presumption has remained that, for the most part, the marriage of health issues to security will ‘harness political leadership and resources for various international health issues’ (Elbe 2011: 220). In the last 15 years, there have been three United Nations Security Council (UNSC) resolutions that have specifically referred to health matters – S/Res/1308 (2000), S/Res/1983 (2011), both concerning HIV/AIDs, and S/Res/2177 (2014) in response to the Ebola viral disease outbreak in West Africa. In December 2012, the United Nations General Assembly (UNGA) passed resolution A/67/L.36, Global Health and Foreign Policy, the fifth resolution on global health and foreign policy resolution to pass in the UNGA since the adoption of the first resolution on Global Health and Foreign Policy in 2008 (A/63/33). The UNGA also adopted resolution A/69/1 giving support to the measures recommended by UN Secretary-General to contain the Ebola outbreak (A/69/389 2014). The decision of the UNSC to adopt three resolutions on health matters in 15 years and the UNGA sessions on global health and foreign policy have received mixed views. Some point to these events as illustration of the weakness of the global health security narrative (Youde 2014). In particular, it has been noted that the Ebola outbreak in 2014 was initially met with no international capacity outside of the World Health Organization (WHO) to respond to this crisis. The creation of the UN Mission on Ebola Emergency Response (UNMEER) in September (2014) was the first, and some argue should be the last, effort to respond to a viral outbreak (Panel of independent experts 2015). Others contend that, given that there is no procedure under the UN Charter for the General Assembly or Security Council to examine health matters – let alone develop a mission like UNMEER – broader UN engagement in health beyond the WHO could point to the success of the global health diplomacy (McInnes 2015). The question is what does successful global health diplomacy look like? Do we see in practice the securitisation of health as essential to pursue international diplomatic engagement in global health? There have been recent claims that the successful international engagement in health initiatives such as the Global Fund for AIDS, TB, and Malaria (Global Fund) and Millennium Development Goals (MDGs) have been achieved without asserting their necessity ‘primarily on security considerations’ (McInnes and Rushton 2013: 16; see also Sridhar 2012; Gagnon and Labonte 2011). However, the assumption remains that linking health issues, specifically health emergencies and infectious disease outbreaks to security discourse will create more opportunities for diplomatic cooperation and engagement (see Feldbaum et al. 2010; Hafner and Shiffman 2013). This chapter explores this argument beginning with the period where the phrase ‘global health diplomacy’ and ‘global health governance’ began to gain usage in international relations in the 1990s. In the first part of the chapter I briefly present the conceptual history of health security and its relationship to ‘global health diplomacy’. I explore the argument that the success of global health diplomacy has come from the preponderant use of security language, referents, and discourse (cf. Elbe 2011; Feldbaum et al. 2010; Kickbusch et al. 2007; McInnes and Rushton 2013). In the second part of the chapter I examine two cases, one where a type of security logic was deliberately employed to frame the ‘health emergency’ (Framework Convention on Tobacco Control or FCTC) and one where human rights logic was initially deployed when advocating for its creation (the Global Alliance for Vaccine Immunization or GAVI). I evaluate what ‘health security’ looks like in these global health initiatives and explore the presumption that ‘security discourse’ must be present in comparing these two major, successful global health initiatives. HEALTH SECURITY States have a history of formal international agreements addressing health matters and health threats, particularly infectious diseases, from the Decree of Quarantine in Ragusa-Dubrovnik in 1377 (Mackowiak and Sehdev 2002) to the International Sanitary Conference in 1851 (Fidler 2003) and the revised International Health Regulations in 2007 (Davies et al. 2015). However, the treatment of health as a ‘low politics’ priority at the international level remained the case through most of the formative years of nation-building in the nineteenth and twentieth centuries (Fidler 1999). This was in spite of its great strategic benefit for colonial era expansion, winning wars and rapid industrialisation (Diamond 1997). In contemporary politics, a range of actors – such as foreign governments, non-governmental organisations (NGOs), pharmaceutical companies, private donors, and international organisations – drive a variety of different health agendas that influence priorities within individual states and affect the resources that are available to individual health workers and opportunities for patients (Youde 2012). Likewise, the post–Second World War Bretton Woods system had a profound influence upon health-care policy and practice around the world, with key lending institutions like the World Bank promoting particular health-care systems and policies in their lending programmes (Sridhar 2012). In this period, key discourses such as ‘Health for All’, the Essential Medicines List, and Right to Health emerged in the absence of linkage to security. These discourses brought in a range of actors including international organisations,NGOs and transnational corporations with the power to shape health opportunities and outcomes within and amongst states (Gagnon and Labonté 2011). In the 1990s, however, foreign and defence ministries became increasingly interested in global health policy – particularly infectious diseases – which would be referred to as having a ‘securitising’ effect on health (McInnes and Lee 2006). 14 ADVOCATING GLOBAL HEALTH SECURITY 255 During the 1990s, key events combined with a paradigm shift in International Relations (IR) and security studies (particularly in Western developed countries with the end of the Cold War) (Paris 2001) to connect security to health (Enemark 2007; Collier and Lakoff 2008). Acute awareness was growing amongst Western states that they were not immune to health events such as infectious disease outbreaks. The outbreak and spread of HIV across developing and developed countries during the 1980s; fear of biosecurity attacks with the breakdown of security in laboratories across the former Soviet Union (Koblentz 2010); sudden outbreak of the plague in India in 1995 and the arrival of West Nile virus near New York City in 1999; and the return of ‘slow-burn’ diseases thought eradicated such as Tuberculosis (TB), measles and meningitis in the United States, United Kingdom, and Australia (Price- Smith 2002). As well, new strains of disease, such as haemorrhagic dengue fever and drug-resistant malaria were on the rise due to significant climate change impact in South Asia, Southeast Asia, and Pacific (Kim and Schneider 2013). Andrew Price-Smith argues that prior to President Clinton’s appointment of the National Science Council on Emerging and Re-Emerging Infectious Diseases in 1995, developed states had grown complacent to the fact that ‘despite their enormous technological and economic power, it is extremely unlikely that developed countries will be able to remain an island of health in a global sea of disease’ (2002: 122). Clinton’s move created a wave of interest in other developed countries, particularly the United Kingdom, Australia, and Canada, all shifting to appreciate and contextualise health threats in foreign policy terms (McInnes and Lee 2012: 32). Until then, on the rare occasion that health policy was discussed at the international level it was in relation to (mostly) infectious disease outbreaks such as plague and cholera, or large-scale efforts such as the mass immunisation programme led by WHO to eradicate smallpox. During infectious disease outbreaks, emphasis had been squarely placed on the responsibility of the host state and regardless of the capacity of its public health system to effectively respond (Fidler 1999). Meanwhile, the spread and scale of HIV/AIDS raised fears about its potential to threaten state cohesion and national economies. There was a particular focus on military forces being at risk of HIV infection, and the political insecurity these infectious could bring in societies (Singer 2002; Elbe 2006). The apparent potential for HIV/AIDS to cause state collapse or serious disruption that could ricochet throughout neighbouring states 256 S.E. DAVIES was considered a realistic scenario in sub-Saharan Africa, as well as some parts of South and East Asia and the Pacific (Shisana et al. 2003; Ramiah 2006; Price-Smith et al. 2007). It was specific reference to the threat of HIV/AIDs on peacekeepers that led to the first resolution on health, Resolution 1308, being passed in the UN Security Council in 2000 (UNSC 2000). In response to these developments, a host of analysts, including Solomon Benatar (1998, 2002), Peter W. Singer (2002), Robert Ostergard (2002), called for IR to engage with the economic, humanitarian, political, and security ramifications of the AIDS epidemic. At the same time, David Fidler and Andrew Price-Smith called for equal attention to the economic, political, and social insecurity that stems from a range of infectious diseases already prevalent in countries (Fidler 2003; Price-Smith 2002). Using quantitative analysis of the relationship between infectious diseases and state capacity, Price-Smith claimed that ‘infectious disease [already] constitutes a verifiable threat to national security and state power’ (Price-Smith 2002: 19). Health security, Price-Smith (2002: 9) argued, referred to the threat of the disease on particular populations as well as the country’s economic and political stability becoming unsustainable as a result of a pathogen wiping out the core population base. While a disease may have a different impact in different states: [I]ncreasing levels of disease correlate with a decline in state capacity. As state capacity declines and as pathogen-induced deprivation and increasing demands upon the state increase, we may see an attendant increase in the incidence of chronic sub-state violence and state failure. State failure frequently produces chaos in affected regions as neighbouring states seal their borders to prevent the massive influx of disease-infected refugee populations. Adjacent states may also seek to fill the power vacuum and may seize valued territory from the collapsing state, prompting other proximate states to do the same and so exacerbating regional security dilemmas. (Price-Smith 2002: 15) In a similar vein, David Fidler’s seminal 1999 book International Law and Infectious Diseases argued that with the increased risk of drug-resistant microbes in the twenty first century, as identified by public health officials (Institute of Medicine 1992; Heymann 1996), it will become important to ‘understand the international politics of infectious disease control, or microbialpolitik’ (Fidler 1999: 19). Microbialpolitik, argued Fidler, was ‘wrapped up not only in traditional concerns such as sovereignty and power but also in the implementation of scientifically sound infectious disease policies at the national and international levels’ (ibid.). Both Fidler and Price-Smith argued that the risk of newly emerged infectious diseases and drug-resistant infectious diseases required that all governments engage with the problem as if they were threats to national security. Likewise, Laurie Garrett argued in 2001 that ‘a sound public health system, it seems, is vital to societal stability and, conversely, may topple in the face of political or social stability or whim. Each affects the other: widespread political disorder or anti-governmentalism may weaken a public health system, and a crisis in the health of the citizens can bring down a government’ (Garrett 2001: 5). These ideas continued to influence the global politics of health into the twenty-first century (Fidler 2009; Davies 2012). In a 2010 study on the influence of global health on foreign policy, Feldbaum and his colleagues found that most discussion and policy from diplomatic engagement focused on the interplay of national interests and security, which meant that most diplomacy focus and discussion was on the containment of infectious diseases (Feldbaum et al. 2010: 87). At the time, WHO also immersed itself in the health security argument: Collaboration between Member States, especially between developed and developing countries, to ensure the availability of technical and other resources is a crucial factor not only in implementing the [International Health] Regulations, but also in building and strengthening public health capacity and the networks and systems that strengthen global public health security will. (WHO 2007: 13) Of course, health diplomacy refers to the pursuit of international health cooperation on matters of concern to states (Kickbusch et al. 2007). It is the amalgam of cooperation in areas where there is the possibility of genuine technical cooperation for a diverse range of diseases (Youde 2012: 25). However, because health diplomacy involves the interplay of national interests, power and diplomatic compromise, ‘state interests have been critical to either the success or obstruction of such agreements . . . and issues of national security remain atop the foreign-policy hierarchy’ (Feldbaum et al. 2010: 87). The counter-narrative to the health security discourse described above is that the securitisation of health promotes an instrumental pursuit of health. To capture foreign policy interest and engagement, global health discussions produce a ‘hierarchy of illnesses’ whereby some health issues receive interest and resources whilst other equally deadly health matters do not (Youde 2012: 160). Jeremy Shiffman’s (2006: 411–420) work on the peaks and troughs of investment in global health initiatives has revealed that despite disease burden to a population, some infectious diseases (i.e. HIV/AIDS) consistently attract stronger short-term investment from donor states – primarily those that are contagious or linked to the national security interests of donor states. However, it would be a mistake to assume that the threat of infectious disease alone encapsulated all diplomatic engagement with health issues at the turn of the twenty-first century. The rise of non-traditional security has also been attributed to the increased influence of the introduction of different social science methods and theories to International Security Studies (Buzan and Hansen 2009: 188). This has influenced research into the subject matter of security studies and IR. If insecurity and grievances amongst the population played a large part in the civil wars that gripped the 1990s (Fearon and Laitin 2003), engagement with health is not just a security concern for developed states but also for developing states. In other words, appreciations of health security were not one-dimensional. It was possible to advocate for a vision of health security that sought to protect individuals as much as states. Indeed, a human centred appreciation of security – coined ‘human security’ by the 1994 United Nations Development Programme (UNDP) Human Development Report (see MacFarlane and Khong 2006) – sought to redefine the ‘traditional’ security with issues and concepts under the umbrella term ‘non-traditional’ security, including health (Chalk 2006). Thus, there does appear to be a significant relationship between international health events and the direction of research and policy engagement (Davies 2012). In the last decade, events such as the United Nations Security Resolution on HIV/AIDS (S/Res/1308) and SARS create an explosion of IR engagement with global health governance, particularly in the area of health security. This ‘phenomenon’ has been witnessed again with the Ebola outbreak (Youde 2014). Amongst all these engagements, two key approaches have emerged. First, those who accept the inevitability of a ‘narrow’ approach to health and IR, focused on infectious diseases and bioterrorism as security threats (Koblentz 2012). Alternatively, there are those who articulate a broader vision related to development, state capacity, and cross-national health issues (Shiffman 2006; Nunes 2014; Rushton and Williams 2012). One of the central claims of the former approach is that health securitisation is an effective way of galvanising diplomatic engagement amongst states and other actors, resulting in the allocation of political will and material resources (Collier and Lakoff 2008; Elbe 2011; Hafner and Shiffman 2013). In the next part of the chapter I examine this core assumption. In particular, I explore whether the effectiveness of health initiatives is tied to their securitisation, focusing on the examples of two major health initiatives. I examine the Tobacco Free Initiative (TFI) and the GAVI. Interest in these two cases comes from exploring the above presumption that security and health, particularly concerning infectious diseases, drives, and delivers policy momentum. While there is debate about whether that momentum translates into ‘real’ policy progress or whether it is mere rhetoric deployed at particular crises/events with no lasting impact, there is no debate that health security has dominated global health and foreign policy discourse (Feldbaum et al. 2010; McInnes and Rushton 2013). Below, I briefly examine the dominance of health security in successful global health initiatives – one where you would expect it to be deliberately deployed (GAVI) and one where it was not (TFI). TFI and GAVI, I contend, are interesting cases precisely because they confound the issueframing conventions about the relationship between health and security. CONFOUNDING EXPECTATIONS A global health initiative is defined in this chapter as ‘an emerging and global trend in health. They are usually focused on state, international organisation and public–private partnerships. Global initiatives typically target specific diseases and are supposed to bring additional resources to health efforts’ (WHO 2015). Case Selection and Discourse Analysis This section briefly compares two international health initiatives: the TFI and GAVI. The TFI sought to reach an international agreement under international law that countries would adopt to regulate the sale and production of tobacco. This global health initiative was in aid of preventing the unchecked rise of tobacco related illnesses – non-communicable diseases – including cancer (various), emphysema, heart disease, stroke, and diabetes (to name a few). In the case of the TFI, and in light of the 260 S.E. DAVIES literature discussion concerning health security above, it would be expected that there was little to no presence of security discourse in the early days of this initiative. It was (and is) about introducing tobacco control legislation, addressing unregulated sale and distribution of tobacco to address preventable tobacco-related diseases in young populations in already over-burdened public health-care systems (Roemer et al. 2005). In contrast, the GAVI is a public and private partnership between states, international organisations, pharmaceutical companies, and philanthropic donors that sought cooperation amongst this diverse group of actors to manufacture, purchase and deliver life-saving vaccines against deadly infectious diseases in the most remote, dangerous and impoverished locations around the world. GAVI is, ostensibly, the initiative where it would be expected to see initial employment of ‘security’ rhetoric given it is addressing the health insecurity of under five children in need of vaccination from, mostly, contagious infectious diseases. In fact, the immediate previous iteration of GAVI – the Child Vaccination Initiative – used security type discourse such as ‘mission’, ‘operation’, and ‘threat’’ under the steerage of a former US defence army medic (see Muraskin 2002). These cases were also selected because they shared some important features. Both the TFI and the GAVI are concerned with one specific health concern – tobacco and immunisation; both were launched within a similar time where health security discourse was gaining policy attention; both initiatives required the involvement of multiple stakeholders, including national governments, to enjoy success. The main difference, of interest to this chapter, is that the association of security with the health issue confound the type of cases analysed to date in the IR literature on global health security. I reveal below that the non-communicable, ‘slow moving’ health threat engaged more securitised discourse than the high morbidity communicable health threat. The comparison of the two cases was organised around a common framework involving three steps. 14 ADVOCATING GLOBAL HEALTH SECURITY 261 First, understanding the rhetoric and concepts used to frame the initiative. Each initiative has produced a significant volume of material outlining its purpose, scope and mandate. For the purposes of this chapter, I focused on the ‘founding’ document for each initiative. In the case of TFI, the Framework Convention on Tobacco Control, adopted by the World Health Assembly in 2003, 8 years after the Convention was first proposed in the 1995 World Health Assembly. The Framework Convention was the outcome of the TFI and details ‘a regulatory strategy to address addictive substances; in contrast to previous drug control treaties, the WHO Framework Convention asserts the importance of demand reduction strategies as well as supply issues’ (WHO 2003). Included in the Framework Convention document analysed is an Annex 2, which details the history of drafting the Framework from 1995 to 2003. For GAVI, the document analysed is the GAVI Meeting of the Proto-Board in Seattle, July 1999. This document details GAVI’s terms of reference, mission, objectives, functions, structure, milestones, and budget priorities. An interest in the discourse used in the founding document of each initiative is informed by the premise outlined in the above literature – to what extent security frames were employed to justify, conceptualise, and operationalise these two global health initiatives which remain, successfully, in place today. Second, once accepting the premise that securitisation is deliberately engaged the two documents were analysed to identify a set of ‘benchmarks’ to guide its assessment of the extent to which a health initiative has aligned with security. Both documents were examined in detail for the presence of ‘speech acts’ (Hansen 2012) – the initiative itself or actors associated with the initiative identified an existential threat or risk and speech acts that called for the adoption of extraordinary measures. Was the initiative itself referred to as ‘security’, ‘threat’, or ‘risk’. Who was the ‘referent object’ identified – the group threatened; who was the functional actor capable of protecting the referent object from the identified threat (Buzan et al. 1998: 26–39); and what was the ‘scale’ of securitisation utitlised to emphasise the need for extraordinary measures (Buzan and Weaver 2009). Third, discourse analysis (Hansen 2012). In this case, the discourse within the two documents were analysed using NVivo Software. For the purposes of this chapter, I refer to three query searches conducted to analyse the perspectives being presented in the two documents concerning the threat the initiative is addressing, who the initiative is ‘protecting’ and 262 S.E. DAVIES who is responsible for such protection. To facilitate answering these three levels of inquiry, three query searches within NVivo of each document were conducted: (1) word frequency analysis, (2) text search of ‘security’ terms and, and (3) text search of ‘other’ normative terms (development, rights, economy). A word tree was then developed for the second and third text searches with a ‘in context’ search up to ten surrounding words (on either side) to enable understanding of the context and usage of the key words, i.e. ‘threat’ or ‘poor’ being searched in the document. The word frequency search assisted with identifying the primary actors discussed in the documents – i.e. who was identified as the referent actor intended for that initiative versus the functional actor necessary to give effect to the initiative. Findings Discourse analysis of the TFI and GAVI documents produced three key findings. The first, unexpected, find was that the TFI initiative was framed just as much in security terms as was GAVI. The number of securitisation ‘speech acts’ (Hansen 2012) searched and located in the Framework Convention was practically the same at GAVI – 0.08% and 0.07%, respectively (speech act terms: secure, threat, risk, mission, extraordinary, urgent). In both cases, the presence of security language was less than 1% of each document. What was significant was that in the search for ‘other’ normative terms (terms: responsible, rights, develop, needs, poor) – the Framework Convention was comparatively high at 1.05%, and a similar search for GAVI came at 0.4% references. However, given the Framework Convention is a legal document the presence of ‘right/rights’ partly accounts for high percentage compared to GAVI. Contextual analysis of these terms reveals further detail in how the documents framed the problem, the referent actor and the functional actor (see Table 14.1). In the Framework Convention – despite higher use of ‘other’ (nonsecurity) normative language than GAVI – there is a clear disposition towards identifying the state as the ‘functional’ actor responsible for taking measures necessary to protect the population from tobacco sale, use, and morbidity. The Convention directly refers to populations at risk (women and minors) and the need for member states to support civil society capacity to inform and educate tobacco awareness in these populations. Again, this is a legal instrument so the emphasis on member states is not surprising as they are the only signatories. However, even in ‘other normative’ references to rights, responsibilities and need – primary emphasis remains on the state as the functional actor protects the population at risk of addiction rather than alternative dominant frames such as the right to health, the right to information. The Framework Convention leans towards more ‘traditional’ security language in conceptualising the state–individual relationship concerning tobacco control: risk and risk mitigation; threat and protection. In the case of GAVI, the 0.07% security references in contrast with its 0.4% ‘other’ references hints at a different frame being brought to this initiative. However, it is not particularly clear until, again, the broader context of these terms is analysed. In the case of GAVI the focus is overwhelming on the ‘mission’ of the alliance and ensuring institutional clarity to support the primary focus – the right of the child to immunisation. This is clearly stated as seen above, particularly in the mission and responsibility statements (Table 14.1). The only time the roles of functional actors are associated with either security or other terms are in the context of securing commitment from actors (broad range of board membership from states to international organisations, pharmaceutical companies, and civil society), and development of health sector capacity. Despite GAVI addressing the containment of infectious disease, there is no threat language present. Securitised speech acts are practically absent – even when ‘security’ terms are located. The emphasis is overwhelming on rights and alleviating deprivation. Both initiatives confound the expectations prior to analysis – the infectious disease focused initiative is ‘under-securitised’ in comparison to the non-communicable focused initiative. Finally, hinted at above, the emphasis on primary actors in these two documents revealed key similarities – both focus on the institutional arrangements and the actors most closely associated with these arrangements. In the case of GAVI the board (comprised of international organisation, civil society, member states, pharmaceutical, and philanthropic members) is the primary functional actor; in the case of the TFI, the actor that looms largest is the organisation (namely, WHO) followed by signatory states to the Convention. Discussion about the population who are to benefit and arguably be empowered from these initiatives, is not discussed as much as the organisation and accordingly the implementation arrangements around the initiative itself. To some extent, given the nature of these two documents, this is not surprising. However, its presence in two documents for two very different initiatives may reveal that the pathology of organisations rather than the framing of an initiative requires further study when engaging with the comparative success and failure of global health diplomacy (Barnett and Finnemore 2003; Hanrieder 2015). 14 ADVOCATING GLOBAL HEALTH SECURITY 265 CONCLUSION What is the value of securitisation when it comes to building and sustaining global political interest in health issues? Some contend that global health security has not run its course and continues to have utility in building state interest, particularly the resources of foreign affairs and defence departments, to secure global health diplomacy objectives (Kickbusch et al. 2007; Feldbaum et al. 2010; Elbe 2011). Others contend it is a ‘smokescreen’ that captures short bursts of attention that are episodic and may have immediate impact but no essential ‘follow through’ (McInnes and Rushton 2013). In this chapter, I explored how global health initiatives securitise and what becomes of them. I deliberately chose two successful initiatives with the expectation that one had securitised a conventional health issue – vaccine preventable infectious diseases – and one had not – tobacco regulation. In examining the cases of TFI and GAVI, I looked at their core document: their mission and value statements reflected in, respectively, the Framework Convention on Tobacco Control and the first meeting documents of GAVI. Speech acts, identified as the hallmark of securitising moves, were analysed in both documents and contrasted with ‘non-securitisation’ or ‘other normative’ language. The Framework Convention engaged in more securitising language or ‘speech acts’ compared to GAVI but both contained more references to human rights and responsibilities discourse. In neither case did it appear as if actors had taken a conscious decision to securitise the issue any more than they chose to articulate the issue in terms of human rights obligations. In the case of the Framework Convention where a focus on security was expected and to a greater extent seen here was an equally strong presence of human rights and ‘sovereignty as responsibility’ language. The security discourse may have helped capture attention but it was not the only discursive tool at play and neither did it obviously displace other discourses. In the case of GAVI, the initiative identified its primary mission as fulfilling the rights of the child; whereas for TFI, emphasis was member states fulfilling their responsibility to address the threat of tobacco related illness from tobacco usage. GAVI appears to have a single referent – the right of the child to health via immunisation; while TFI related to a multitude of actors. The operationalisation of the initiative(s) and their embeddedness in global health architecture dominated the discussion far more than the framing language. Framing language constituted a relatively small part of the discourse compared to the consuming discussion of institutional design. What this comparison of two global health initiatives reveals is that whilst security discourse might help capture the attention of states, it has not necessarily overtaken other policy frames such as human rights and ‘sovereignty as responsibility language’. Indeed, the key priority seems to be not whether the international community should be engaged with these issues, but the appropriate institutional design for initiatives to achieve these health goals.

#### Even the most extreme forms of securitization don’t result in military interventions

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Perhaps the best reason to hesitate in characterizing HIV/AIDS as a security threat is that this could portray the disease as an extreme threat requiring an extreme response. Such reasoning is behind the warning issued by Elbe and others that if HIV/AIDS is securitized this might jeopardize the rights of people living with HIV. Desperate times do not, however, always require resort to desperate measures. Furthermore, those who have been most visible in advocating recognition of HIV/AIDS as a security threat have tended to offer health- and development-oriented recommendations about how the threat should be dealt with. Examples include: increasing access to medication; preventing HIV transmission by promoting safe sex, (marital) fidelity or abstinence; vaccine development; poverty relief and capacity building; and education and awareness-raising. Virtually none of the recent high-profile advocacy for the securitization of HIV/AIDS has included suggestions that responding to the threat requires infringements of the rights of people living with HIV/AIDS, privacy violations, (military) imposition of isolation and quarantine, mandatory HIV testing, and so forth. The UN (1998), for example, has (through the Security Council) officially declared HIV/AIDS to be a security threat, and at the same time has consistently advocated (through its health and human development agencies, such as UNAIDS) that a human rights approach must be central to HIV/AIDS prevention and control. The UN is thus an important counterexample to the notion that framing an issue in security terms involves endorsement of extreme response measures. It is widely acknowledged within public health circles that a human rights approach to HIV/AIDS is necessary because more restrictive/intrusive responses would likely be ineffective or counterproductive—for example, by driving the epidemic underground and thus exacerbating the threat. From an ethical perspective, furthermore, it is widely believed that the least restrictive means should be employed in the pursuit of public health goals. An extreme threat would not justify extreme response measures if the threat could be reduced without resort to such measures. The claim of those who warn against characterizing HIV/AIDS as a security threat is that such characterization may eventually lead to extreme response measures even if that was not the intention of the initial securitizing actors (such as the UN) whose aim was to highlight an extreme threat justifying extra spending (which does not count as an extreme response measure for the purpose of this discussion). Our conclusion, however, is that such a claim is at best questionable and in need of (additional) empirical justification.

#### Extinction is the most important moral priority. Utilitarianism should be used in the context of existential pandemics---this framework avoids abuses while ensuring just outcomes at the tail end of disease risks.

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Public health authorities in many economically advantaged nations are bracing themselves to face future pandemics that will harm large numbers of citizens. Modern medical horrors such as Monkeypox or the much-feared future mutations of Avian Influenza (H5N1) are mentioned in the same breath as virulent strains of influenza, as a danger to our ‘way of living.’ Far beyond sickness and large numbers of death, an outbreak of one of these pandemics poses a real threat to long-term health, as well as to the social and economic well being of significant percentages of our surviving population.1 While confronting issues brought forth by a pandemic, the fundamental nature of ‘public health’ and its focus on the welfare of a population demands special attention to utilitarian considerations of promotion of the greatest good—in this case, health—as well as the limitation of illness and death in the ‘worst-case’ scenarios posed by the most lethal of pandemics. Of particular interest to this paper are questions related to the obligation of health-care workers (HCWs) to report to work in the face of heightened immunological threat and whether those same workers should have greater access to immunizations and treatments than should non-HCWs. Utilitarianism within public health ethics The fundamental feature of the ethical theory of utilitarianism states that moral behavior is that which promotes good and minimizes harm.2 In writings based on public health, utilitarianism is widely recognized as a fragment in the ethical ‘scheme’ of public health,3 but it is not afforded a stronger role for two primary reasons: first, considering its extreme position, utilitarianism is morally problematic,4 as it could literally permit anything in the name of the ‘greatest good to the greatest number,’ and second it is virtually impossible to live a moral life under the most extreme forms of utilitarianism, because the obligations are too difficult to discern (the ‘what’ of promoting the good) and impossible to execute (the ‘how’).5 Utilitarianism, in a moderate form, used in public health ethics, means that our actions and policies should be focused on increasing the total ‘net’ goodness rather than an average ‘net’ good for each person. The institutions of individual rights and the recognition of patient autonomy are not contradictory to this, but are believed to serve the overall good, as individual benefit increases the total good, and serves as a preventative measure of unjustified majoritarian actions against smaller groups. This model of utilitarianism is evident in many aspects of public healthFnot only through health-promotion projects that encourage the otherwise illness-free individuals to take up a more healthful diet and exercise regimen but also through harm-reduction programs, in which people with negative health behaviors such as abuse of drugs or dietary fats are aided to eliminate, or at least minimize the harm they cause to those around them. In everyday practice, the force of this utilitarian aspect has a supportive role along with other ethical elements of public health practice, and presents a balanced moral justification for all actions undertaken in accordance with this practice.6 However, I contend that there must be an ‘escalator clause’ in the utilitarian aspect that suggests that in the event of an extensive threat to the existence of a population, the force of this utilitarian aspect becomes the primary consideration in proportion to the threat. Therefore, the greater the threat, the greater the moral force of utilitarianism in making public health decisions. This also entails that the greater the threat, the greater the moral impetus to minimize the harm to the population. On duty, outbreaks, and distribution of resources Obligations to minimize harm and promote the goods of public health are not particularly controversial in times of relatively stable ‘good-health’ measures among the populace. The more troubling question emerges from the scenario in which promoting health and minimizing illness and death demands more from HCWsFhow can, or should, we compel HCWs to attend to their duties in the event that a highly lethal form of communicable disease should start spreading?7 Although current debates focus on questions of duty, and how much personal risk invalidates that commitment, utilitarian aspects of that obligation are not given enough weight in the debate. In many of the debates, the question of risk is posed in terms of how we do not expect a trained ‘first responder’ to recklessly endanger his or her life to save the life of another. The classic story of the lifeguard is offered as exemplar: a lifeguard is not expected to rescue a drowning swimmer if a shark is clearly present.8 Although this statement seems reasonable, it does not justify itself. By contrast, the consideration of the utilitarian aspect makes the point that in attempting to save a life, two are likely to be lost, thus propagating a greater total harm. The same holds true for the example of firefighters rushing into a house badly damaged by an active fire. Although there may be a life on that second floor to save, we do not expect any number of firefighters to sacrifice their lives for the doomed soul because the loss of many, including the original life in peril, is a maximization of harm, when harm should be minimized. When you control for the risks involved, such as using precautions to assure a level of safety for the rescuers, such as shark nets for the lifeguard, or safety gear for the firefighters, then the obligation to assist comes back into full force, as the potential for greater harm is manageable.9 It is the variable of risk, which creates variable demands on those whose duty it is to care for the population in times of crisis. We consider not only the risk to the obligated but also a question of the scope of risk to the population. In academic and public debates regarding the compulsion to attend to duty in the face of danger, one fallacy has been allowed to stand: the notion that exposure to a pandemic can be avoided if one simply does not come to his or her job as a HCW. Although it is true that working in a hospital during times of influenza outbreak puts one at a greater risk for contracting the illness,10 the more widespread the outbreak, the more people become sick, and the more likely the ‘stayat-home’ HCW will become sick even after having avoided contact in the course of his or her duties. We could reasonably state that, by virtue of staying home during a time of need for his or her service, the HCW improves the odds that he or she will contract this illness outside professional practice as part of the greater number who will be exposed. Another feature of the argument offered to defend dereliction of duty is to suggest that this risk that the HCW takes with his or her own health is a fixed variable, and thus should be considered as an exception to duty. On the contrary, it is a common feature of the infection-control literature that states that doctors and nurses are overwhelmingly neglectful toward their own basic infection-control protocols.11 Therefore, the threat is not a fixed variable, but one that is actually quite within the scope of the control of a HCW. Ethically, one cannot willfully or negligently enhance the exceptions to duty. At the same time, it is an obligation of the management to ensure that diligent HCWs are equipped to do all they can to reduce their risks. During the SARS crisis in Toronto, health-care administrators did not effectively communicate which precautions should be undertaken by HCWs to protect themselves.12 It bears mentioning that once clear direction could be given about the type and execution of masking procedures, the intrahospital transmission of SARS decreased to 0%.13 This fact speaks to the issue of risk, as the non-transmission of SARS correlated with the increased attentions of management and staff to infection-control precautions and the provision and use of proper equipment.14 When we speak in terms of risk and pandemics from the utilitarian perspective discussed herein, we recognize that it is completely nonsensible to sacrifice highly trained HCWs by rushing them ill equipped into dangerous situations. Much as with the example of firefighters and the unsafe burning house, we find it morally unacceptable to treat them as disposable, because of the singularity of their lives and their right to exist as individuals. There is also the detriment we would cause in an event such as a pandemic by losing the people trained to save us to the very threat they were trained to save us from. By that same logic, it could be argued that HCWs should have first access to available and medically accepted vaccinations by virtue of the fact that those HCWs are absolutely essential to our survival. The fear of an Avian Influenza outbreak brought with it much debate about scarce Tamiflu supplies and giving HCWs preferential access.15 However, the added value of a HCW is the fact that he or she will be facing the greater risk by virtue of faithful and responsible execution of his or her duty, and if this is trueFand we have seen from the example of SARS that it is not always the case that HCWs exercise due diligence or face unmanageable risks of infection simply by being ‘on-site’Fthen we should do more to protect them. Nevertheless, if the claim is that they can excuse themselves from duty because of risk, then we excuse ourselves from privileging their protection, through the preferential access to measures such as Tamiflu. The same should be true for access to vaccines or treatments: those who are compelled into service to defend the overall health of a society at tremendous risk should be first in line, as their opportunity for infectionFand to act as a vector for infection both within and outside their health-care facilitiesFmeans that the greater good is served by privileging their access to prophylaxis. A common objection to this comes from the perspective of social justice. The objection would point out that those who are least able to prevent their own infection, such as those from the lower socioeconomic classes, retirees and pensioners, and other vulnerable groups, would be denied access to the protections and treatments that are going to HCWs whoFto varying degreesFenjoy more comfortable socioeconomic positions. Although this question of access is valid in questions of many public health interventions, the preference of HCWs in questions of preferential access to vaccines and treatments is not unjust in these terms. Fundamentally, justice addresses unjustified imbalances in treatment. Aristotle famously mandated that equals should be treated as equals, and unequals as unequals.16 The key point of justice is that there should be a valid justification for differential treatment, and in that light, in this context, we are describing pandemics that pose a unique and credible threat to the public in a manner that could fundamentally undermine our way of life. Preferential treatment of HCWs, in this limited context, is a just and defensible practice. It is this same special status that we afford those who can save us from the most lethal and dangerous illnesses in times of public health emergency that also places greater demands on those same people. The greater the risk to society, the greater the responsibilities on those who can reduce the body count. The relationship between the duty of a HCW and the lethality of a disease is proportional—danger and obligation increase in step with each other, as opposed to other conceptions that suggest a threshold of exception as the risk of illness becomes too great. The fundamental flaw with this suggestion is that a negation of duty in such an outbreak simply allows the outbreak to pose an even greater threat to the populationFincluding that same derelict HCWFrather than confronting the illness in the relatively controlled environment of a hospital. Conclusions Utilitarianism in the form of promoting the good and diminishing the bad is a key moral belief in the realm of public health. It is one view in concert with others, all working to counterbalance each view to achieve a tenable moral equilibrium. In the extreme cases under consideration herein, such equilibrium dictates that the moral force of health promotion and harm minimization increases in relation to the threat posed to the well being of a larger society. In the case of widespread death or disability caused by a pandemic, this paper contended that an increased threat generates a heightened obligation on the part of HCWs, while also creating a reasonable expectation that those same HCWs will have preferential access to vaccines and treatments.