# HC Rd. 1

#### I value morality with a criterion of preventing structural violence.

**Structural violence is hidden and embedded, causing it to produce as much damage as direct violence**

**Winter & Leighton 99** [Deborah DuNann Winter and Dana C. Leighton, Winter is a Professor at Whitman College and Leighton is a Professor at Texas A&M University, “Peace, Conflict, and Violence: Peace Psychology for the 21st Century” 1999, http://sites.saumag.edu/danaleighton/wp-content/uploads/sites/11/2015/09/SVintro-2.pdf Direct violence is horrific, but its brutality usually gets our attention: we notice it, and often respond to it. **Structural violence**, however, **is almost always invisible, embedded in** ubiquitous **social structures, normalized by** stable **institutions and regular experience. Structural violence occurs whenever people are disadvantaged by political, legal, [and] economic or cultural traditions.** Because they are longstanding, **structural inequities usually seem ordinary, the way things are and always have been.** The chapters in this section teach us about some important but invisible forms of structural violence, and alert us to the powerful cultural mechanisms that create and maintain them over generations. **Structured inequities produce suffering and death as often as direct violence does, though the damage is slower, more subtle, more common, and more difficult to repair.** Globally, poverty is correlated with infant mortality, infectious disease, and shortened lifespans.Whenever people are denied access to society’s resources, physical and psychological violence exists.

Structural violence occurs when people are systematically excluded and harmed for arbitrary factors.

Opotow 01 [Susan Opotow, Opotow is a social psychologist and researcher at the City University of New York (CUNY). Additionally, Opotow has written/edited for *Peace & Conflict: Journal of Peace Psychology* and Past President of the Society for the Psychological Study of Social Issues, Peace, Conflict, and Violence: Peace Psychology for the 21st Centuryl Englewood Cliffs, New Jersey: Prentice-Hall, 2001, https://cpb-us-w2.wpmucdn.com/u.osu.edu/dist/b/7538/files/2014/10/Chapter-8-Social-Injustice-Opotow-1jaya7m.pdf

Both structural and direct violence result from moral justifications and rationalizations. Morals are the norms, rights, entitlements, obligations, responsibilities, and duties that shape our sense of justice and guide our behavior with others (Deutsch, 1985). Morals operationalize our sense of justice by identifying what we owe to whom, whose needs, views, and well-being count, and whose do not. **Our morals apply to people we value, which define who is inside our scope of justice** (or “moral community”), such as family members, friends, compatriots, and coreligionists (Deutsch, 1974, 1985; Opotow, 1990; Staub, 1989). **We extend considerations of fairness to them, share community resources with them, and make sacrifices for them that foster their well- being** (Opotow, 1987, 1993). **We see other kinds of people such as enemies or strangers outside our scope of justice; they are morally excluded. Gender, ethnicity, religious identity, age, mental capacity, sexual orientation, and political affiliation are some criteria used to define moral exclusion.** **Excluded people can be hated** and viewed as “vermin” or “plague” **or they can be seen as expendable non-entities.** In either case, disadvantage, hardship, and **exploitation inflicted on them seems normal, acceptable, and just—as “the way things are” or the way they “ought to be.”** Fairness and deserving seem irrelevant when applied to them and harm befalling them elicits neither remorse, outrage, nor demands for restitution; instead, harm inflicted on them can inspire celebration. Many social issues and controversies, such as aid to school drop-outs, illegal immigrants, “welfare moms,” people who are homeless, substance abusers, and those infected with HIV are essentially moral debates about who deserves public resources, and thus, ultimately, about moral inclusion. When we see other people’s circumstances to be a result of their moral failings, moral exclusion seems warranted. But **when we see others’ circumstances as a result of structural violence, moral exclusion seems unwarranted and unjust.** While it is psychologically more comfortable to perceive harm-doers to be evil or demented, we each have boundaries for justice. **Our moral obligations are stronger toward those close to us and weaker toward those who are distant**. When the media reports suffering and death in Cambodia, El Salvador, Nicaragua, the former Yugoslavia, and Rwanda, we often fail—as a nation, as com- munities, and as individuals—to protest or to provide aid. Rationalizations include insufficient knowledge of the political dynamics, the futility of doing much of use, and not knowing where to begin. Our tendency to exclude people is fostered by a number of normal perceptual tendencies: 1. Social categorization. Our tendency to group and classify objects, including social categories, is ordinarily innocuous, facilitating acquisition of information and memory (Tajfel & Wilkes, 1963). **Social categorizations can become invidious, however, when they serve as a basis for rationalizing structural inequality and social injustice.** For example, race is a neutral physical characteristic, but it often becomes a value-loaded label, which generates unequal treatment and outcomes (Archer, 1985; Tajfel, 1978). 2. Evaluative judgments. Our tendency to make simple, evaluative, dichotomous judgments (e.g., good and bad, like and dislike) is a fundamental feature of human perception. Evaluative judgments have cognitive, affective, and moral components. From a behavioral, evolutionary, and social learning perspective, evaluative judgments have positive adaptive value because they provide feedback that protects our well-being (Edwards & von Hippel, 1995; Osgood, Suci, & Tannenbaum, 1957). **Evaluative judgments can support structural violence and exclusionary thinking, however, when they lend a negative slant to perceived difference**. In-group-out-group and we-them thinking can result from social comparisons made on dimensions that maximize a positive social identity for oneself or one’s group at the expense of others (Tajfel, 1982).

**Thus, the value criterion (or standard) is mitigating structural violence. Moral inclusion is a necessary precondition to all other ethical theories as we can’t form those moral theories until all those who are affected are included in it.**

#### You should prioritize everyday violence for two reasons- A) social bias underrepresents its effects B) its effects are exponential, not linear which means even if the only causes a small amount of structural violence, its terminal impacts are huge

**Nixon ’11** (Rob, Rachel Carson Professor of English, University of Wisconsin-Madison, Slow Violence and the Environmentalism of the Poor, pgs. 2-3)

**Three primary concerns animate this book, chief among them my conviction that we urgently need to rethink-politically, imaginatively, and theoretically-what I call "slow violence." By slow violence I mean a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all. Violence is customarily conceived as an event or action that is immediate in time, explosive and spectacular in space, and as erupting into instant sensational visibility. We need, I believe, to engage a different kind of violence, a violence that is neither spectacular nor instantaneous, but rather incremental and accretive, its** calamitous **repercussions playing out across a range of temporal scales. In so doing, we also need to engage the representational, narrative, and strategic challenges posed by the relative invisibility of slow violence. Climate change,** the thawing cryosphere, **toxic drift, biomagnification, deforestation, the radioactive aftermaths of wars, acidifying oceans, and a host of other slowly unfolding environmental catastrophes present formidable representational obstacles that can hinder our efforts to mobilize and act decisively. The long dyings-the staggered and staggeringly discounted casualties, both human and ecological that result from war's toxic aftermaths or climate change-are underrepresented in strategic planning as well as in human memory. Had Summers advocated invading Africa with weapons of mass destruction, his proposal would have fallen under conventional definitions of violence and been perceived as a military or even an imperial invasion. Advocating invading countries with mass forms of slow-motion toxicity, however, requires rethinking our accepted assumptions of violence to include slow violence. Such a rethinking requires that we complicate conventional assumptions about violence as a highly visible act that is newsworthy because it is event focused, time bound, and body bound. We need to account for how the temporal dispersion of slow violence affects the way we perceive and respond to a variety of social afflictions-from domestic abuse to posttraumatic stress and, in particular, environmental calamities. A major challenge is representational: how to devise arresting stories, images, and symbols adequate to the pervasive but elusive violence of delayed effects. Crucially, slow violence is often not just attritional but also exponential, operating as a major threat multiplier; it can fuel long-term, proliferating conflicts in situations where the conditions for sustaining life become increasingly but gradually degraded.**

## Advantage

#### HIV prevention and treatment are exploited by pharmaceutical companies – patent protections allow high costs and massive profits while decreasing access to life-saving medicine

**Morgan 20** [Richard Morgan. “HIV prevention drugs illustrate just how bad pharmaceutical patents are for our health.” NBC News. December 1, 2020. https://www.nbcnews.com/think/opinion/hiv-prevention-drugs-illustrate-just-how-bad-pharmaceutical-patents-are-ncna1249428]

The United States is the only major economy on the planet where health care is a for-profit industry instead of a free public service; it's also the only place where the government allows health care not just to be run as an industry, but allows that industry to be run as a cartel. What this means in practice is that pharmacology — **the** study and **development of pharmaceuticals** — **has become more a branch of industry than of science, and it is therefore controlled by lobbying interests rather than either science or the public good.** The only better example of this than the infamous price gouging of insulin in America is how the **drug companies have a captive audience for their many still-patented products not only in HIV-positive Americans but also in the nation’s millions of LGBT people who are encouraged to take the sole HIV-prevention drug, Truvada, to avoid HIV infection. Last year, for the first time, it was announced that a generic version of Truvada — the pill used since 2004 to fight HIV infection and since 2012 as pre-exposure prophylaxis (PrEP) for HIV — would finally be available in the U.S. Generic versions are already sold elsewhere in the world and, usually, when drugs go generic in America, it’s an open field, which dramatically lowers prices. Truvada’s patent holder, Gilead, however, granted rights to produce a generic U.S. alternative to just one company — the Israeli firm Teva — for a six-month period, as the result of a settlement. Truvada currently costs American users roughly $1,700 a month; Teva’s generic, which debuted in October, is marketed for around $1,455 per month.** Of course, few people pay the full price of a medicine out-of-pocket. Insurance, for those who have it, helps lower out-of-pocket costs in many cases, though private insurers aren't required to do so until 2021. Gilead provides some patients a coupon for $7,200 worth of purchasing assistance per year, with no monthly limit (which means some months it might be free and others it might be full price). Teva's patient discounts are also $7,200 per year, but they’re limited to $600 per month — knocking its monthly cost down to around $855. Unfortunately, California and Massachusetts both forbid the use of pharmacological coupons that made Truvada somewhat accessible if a generic alternative exists; patients who relied on those discounts must now apply for access to other programs or pay out of pocket for the medications they couldn't afford. Meanwhile, **generic versions of Truvada** — Ricovir, Tavin-EM, or Tenof-EM — **elsewhere in the world cost $210 to $720 per year. Ironically, Gilead put little of its own money into the research that developed Truvada, which is a combination of two medicines,** tenofovir disoproxil and emtricitabine (though the company says otherwise). The former input was, in fairness, developed as an oral medication by Gilead (heavily based on a drug first developed by a Czech scientist, after a collaboration with scientists at the University of California-San Francisco showed it was effective in treating HIV), but its patent expired in 2018. **Emtricitabine, the second drug in Truvada and its generic equivalents, was developed at Emory University with NIH grants; Emory then entered into an agreement with a company Gilead eventually acquired to give it control of the drug in exchange for a sliver of the profits.** (**Until Teva’s generic debuted, Gilead owned 100 percent of the Truvada market in the U.S, pulling in roughly $3 billion a year.**) But **the basic research, animal trials and human trials for the combination of the two as preventative drug were all publicly financed by the National Institutes of Health and the Centers for Disease Control and Prevention.** The 1980 Bayh-Dole Act, though, allows private grabs of public science; the government can claw patents back under certain circumstances, but Sen. Birch Bayh, D-Ind., and Robert Dole, R-Kan., argued in 2002 that pricing was deliberately not conceived as one such circumstance. So the only Truvada-related patent Gilead now owns — until September 2021 — is for emtricitabine; its all-but-proprietary access to sell Truvada is the equivalent of Hershey’s controlling who has access to chocolate milk. **Still, last year, the FDA also approved Descovy, Gilead’s newest, pricier rival to Truvada; although Descovy results in some improved kidney function versus Truvada because it uses a newer type of tenofovir** (tenofovir alafenamide instead of tenofovir disoproxil) **patented by Gilead, a Harvard study found an “absence of any clinically meaningful changes in renal or bone markers” between the two. In January, Gilead still hoped to switch 40 to 45 percent of Truvada users to Descovy before the former goes fully generic at the end of 2020, preserving their profits.** It doesn't have to be this way, as advocacy groups like PrEP4All have been arguing for years. Empowered with the intellectual property equivalent of eminent domain, the federal government has the ability to compel broad generic production of Truvada virtually overnight and has refused to act on its ability — whether in the Obama administration or the Trump administration. (There are few indications that the Biden administration will be any different.) **The problem with patents thus persists because toxic agents in soulless systems have created a ruthless market for its ostensible solutions. Unaffected politicians and policymakers** — including lobbyists and Big Pharma C-suite cynics — **instead cast unsustainable, unaffordable drug prices as a result of tough decisions, difficult circumstances or unavoidable economic realities. But they are wholly avoidable. Such anguish is not a necessary evil of market forces or political gridlock; every other industrialized nation manages to recognize how unnecessary profit-driven health care is.** The most bitter pill in all of human health is the one we prescribe the least: the truth, without a spoonful of sugar. And the truth is that we are fighting late-stage, metastasized cowardice here, a societal immunodeficiency in which we are unable to defend people over profits, or dignity over dollars. Sadly, as far as we’ve come in our understanding of immunology — a knowledge built almost entirely on the bones and blood of the world’s 32.7 million AIDS deaths and 75.7 million HIV infections — such cowardice is wholly incurable because it is more dictum than dysfunction. **As Americans and the world have witnessed the planet’s greatest economy suffer some of the planet’s poorest Covid-19 health care, it is increasingly clear to everyone that government has all the legal and political power it needs to improve the lives of millions with a snap of its fingers, but none of the willpower.** When America’s founders committed — and condemned — us to a government ruled by values of life, liberty and the pursuit of happiness, they unfortunately allowed no checks or balances against how much happiness the powerful can find in their fellow Americans’ misery.

#### The epidemic is not over – funding has been negatively affected by the false belief that HIV is a thing of the past

**Bhardwaj et al 20** [Kajal Bhardwaj; Matteo Cassolato; Revanta Dharmarajah; Othoman Mellouk; Morgane Ahmar; Sergey Kondratyuk. “The Problem with Patents: Access to Affordable HIV Treatment in Middle-income Countries.” Edited by Aditi Sharma, Juliet Heller, and Jenny Berg. Frontline AIDS 2020. https://frontlineaids.org/wp-content/uploads/2020/01/The-problem-with-patents\_pages\_web2.pdf]

Criticised for **years of optimistic reporting on successes in addressing** the **HIV** epidemic, in 2018 UNAIDS finally started acknowledging that progress was in fact slowing29. Unfortunately, the years of poor messaging had already **had an impact on donors**. In 2018, UNAIDS reported that **investment in the HIV responses of low- and middle-income countries decreased by $900 million in just one year.**30 **As international funding for HIV has contracted, funding agencies and bilateral donors have tightened their policies to focus their shrinking funds.** The World Bank’s country classification is key to these adjusted policies. For example, the Global Fund’s Eligibility Policy, revised in May 2018, states that upper-middle income countries must have at least a ‘high’ burden of disease to be eligible for financing.31 Another major funding agency, **Unitaid, dedicates 85% of funds specifically to commodity purchase interventions in lower middle-income countries.** In addition, **bilateral donors** (mostly developed countries) **appear to be moving away from middle- income countries and focusing largely on sub-Saharan Africa.**32 Civil society **organisations are already raising the alarm about increasing death rates and the risk that countries may need to ration HIV treatment.**33 Changes in the income status of countries seldom reflect ground realities;34 yet “graduation” to **middle-income status often results in the immediate and simultaneous withdrawal of aid.**35 **For countries like Venezuela and Argentina that have been see-sawing between middle income and high-income status for the past few years, these changes leave their health programmes in an increasingly precarious position.**3

#### Patent laws give pharma companies the means to sue governments pursuing public health – this creates even more barriers to medicine access

**Bhardwaj 2** [Kajal Bhardwaj; Matteo Cassolato; Revanta Dharmarajah; Othoman Mellouk; Morgane Ahmar; Sergey Kondratyuk. “The Problem with Patents: Access to Affordable HIV Treatment in Middle-income Countries.” Edited by Aditi Sharma, Juliet Heller, and Jenny Berg. Frontline AIDS 2020. <https://frontlineaids.org/wp-content/uploads/2020/01/The-problem-with-patents_pages_web2.pdf>]

**Besides high costs and scarce funds, middle-income countries also have to contend with pressure from high income countries and patent holders not to use TRIPS flexibilities. Patent holders often resort to lengthy, costly litigation. One of the earliest examples was in 2001, when 39 pharma companies sued South Africa for the inclusion of TRIPS flexibilities in their national medicines law. In 2006, Pfizer sued the Philippines for trying to register generic versions of medicines going off-patent.**53 In 2013, **the Indian Supreme Court upheld the strict interpretation of India’s patent law on evergreening, after an extensive seven-year battle fought by Novartis against the Indian government, cancer patients and Indian generic companies.**54 **Brazil and Argentina are currently facing litigation by multiple pharmaceutical companies on their strict patent criteria.**55 **Middle-income countries also face bilateral pressure from high-income countries. For instance, the United States Trade Representative annually lists countries it believes are not adequately protecting US intellectual property, backed by threats of sanctions and investigations.** In 2007, Thailand was elevated from the Watch List to Priority Watch List for issuing compulsory licenses.56 In 2013 and 2014, the US International Trade Commission announced investigations into India’s trade policies that included intellectual property law and policy.57 In 2018, in response to the Malaysian compulsory license on sofosbuvir, the USTR announced an out-of-cycle review of Malaysia.58 **One of the most direct approaches to preventing the use of TRIPS flexibilities is to push for ‘TRIPS-plus measures’. These require protection of intellectual property far in excess of TRIPS requirements, for instance, patent term extensions which require patents to be granted for periods much longer than the 20 years that is required under TRIPS. TRIPS-plus measures are typically pushed through bilateral or regional free trade agreements** (FTAs)59 **and several studies have found that such measures result in higher medicine prices. A 2015 study concluded “the negotiated prices of branded antiretrovirals are, on average, 57% higher in countries with FTAs than they are in other countries.**”60 UNAIDS recommends “**to retain the benefits of TRIPS Agreement flexibilities, countries, at minimum should avoid entering into FTAs that contain TRIPS plus obligations that can impact on pharmaceuticals price or availability.”**61

#### Additionally, pharma companies use “evergreening” patents to maintain monopolies across the world

**Bhardwaj 3** [Kajal Bhardwaj; Matteo Cassolato; Revanta Dharmarajah; Othoman Mellouk; Morgane Ahmar; Sergey Kondratyuk. “The Problem with Patents: Access to Affordable HIV Treatment in Middle-income Countries.” Edited by Aditi Sharma, Juliet Heller, and Jenny Berg. Frontline AIDS 2020. https://frontlineaids.org/wp-content/uploads/2020/01/The-problem-with-patents\_pages\_web2.pdf]

**Evergreening is a tactic used by pharmaceutical companies to extend their exclusivity over a medicine by applying for and usually getting multiple, overlapping patents on a single medicine. Most medicines are covered by several patents, known as patent ‘thickets’ and are used to delay or complicate generic production. In the case of ARVs, lopinavir/ritonavir sold as Kaletra by Abbott, is an interesting example. This second-line ARV is a combination of two existing medicines both of which should be off-patent in most countries. Yet, they remain highly priced and free of generic competition in several middle- income countries thanks to evergreening patents.** The example illustrates the extent of delay that evergreening can cause to generic competition. **One study** of the patents for lopinavir/ritonavir,28 **found 108 patents, which together could delay generic competition until at least 2028 - 12 years after the patents on the drugs’ base compounds expired, and 39 years after the first patents on ritonavir were filed.**

#### HIV afflicts people living at the margins of society – race, class, and gender sexuality all contribute to risk

**Parker 02** [Richard Parker, Ph.D. “The Global HIV/AIDS Pandemic, Structural Inequalities, and the Politics of International Health.” American Journal of Public Health. March 2002. https://ajph.aphapublications.org/doi/10.2105/AJPH.92.3.343]

When we turn our gaze beyond our own borders to focus on the HIV/AIDS pandemic in the most resource-poor countries of the developing world, however, the picture is considerably worse. The Joint United Nations Program on AIDS (UNAIDS) estimates that **by the end of 2000 approximately 36.1 million people had been infected with HIV globally.**2 **Of these, approximately 34.7 million are adults—16.4 million are estimated to be women—and 1.4 million are children. Since the beginning of the epidemic, 21.8 million people are estimated to have died—17.5 million adults** (roughly 9 million women) **and 4.3 million children.** In 2000 alone, 3 million deaths were attributed to AIDS, and 5.3 million new infections are believed to have occurred—2.2 million among women and nearly 570 000 among children.2 These current estimates are enough to give us pause, but it is also important to remember that there is little likelihood that the situation will improve any time soon. On the contrary, UNAIDS and the World Bank predict that HIV, which was responsible for 8.6% of deaths from infectious disease in the developing world in 1990, will be responsible for 37.1% of such deaths among adults between the ages of 15 and 59 by 2020.4 If treatment advances and other recent scientific advances give us reason for optimism, there is equally good reason for concern, as HIV/AIDS continues to stand as one of the most significant global health problems that must be confronted in the new millennium. Beyond the sheer weight of the numbers, **what is perhaps most important about the shape of the HIV pandemic is the fact that the global distribution of infection has been anything but equal. It is estimated that approximately 920 000 people have been infected in North America, for example, with 540 000 infections in Western Europe and another 15 000 in Australia and New Zealand.2 In sub-Saharan Africa, by contrast, it is estimated that as many as 25.3 million persons have been infected by HIV. Another 5.8 million have been infected in South and Southeast Asia, and 1.4 million have been infected in Latin America.2 In short, the vast majority of HIV infections can be found in the poorest regions of the world, in developing countries already facing a wide range of other serious public health problems. This concentration of HIV infection in the countries of the developing world becomes even more worrisome if we look again at societies such as the United States, where disproportionate levels of HIV infection have been documented among racial and ethnic minority populations. Rates are especially high among gay and bisexual men in communities of color and among heterosexual women living in poverty in the inner cities.**5 Indeed, if we bring together the available data on HIV/AIDS in the developing world with the most recent trends on HIV infection in countries such as the United States, it is impossible not to be impressed by the extent to which a range of structural inequalities intersect and combine to shape the character of the HIV/AIDS epidemic everywhere, both North and South, in developed as well as developing countries. **In all societies, regardless of their degree of development or prosperity, the HIV/AIDS epidemic continues to rage—but it now affects almost exclusively the most marginalized sectors of society, people living in situations characterized by diverse forms of structural violence.6 It is in the spaces of poverty, racism, gender inequality, and sexual oppression that the HIV epidemic continues today—in large part unencumbered by formal public health and education programs, let alone by the advances in treatment that might otherwise convince us that the emergency has passed.** The context in which the HIV/AIDS epidemic continues to expand in countries around the world is one of growing polarization between the very rich and the very poor, increasing the isolation of some segments of the population at a time when others are perversely integrated into the criminal economies of international drug smuggling and the like, and increasing social inequalities that seem to be an integral part of globalization based on neoliberal economic policies.7 **These structural factors, which shape the HIV/AIDS epidemic within the contours of specific societies, even in the resource-rich industrialized countries, are the same factors that shape the global epidemic, particularly in the resource-poor and often economically dependent countries of the developing world.** Indeed, perhaps **no other major international public health problem so clearly reflects the social, political, and economic architecture of** what has been described as the new world order: **a post–Cold War international system in which**, at least until very recently, **the gravest threats to human security** seemed to **stem less from state-controlled and state-inflicted violence (such as the threat of nuclear war) than from the dismantling of previously existing health, education, and welfare systems in many of the most advanced industrial societies and from diverse forms of structural adjustment that have been imposed on many developing countries.**

### Advocacy

**Plan: The member nations of the World Trade Organization should substantially reduce intellectual property protections for HIV/AIDS treatments and preventative medicines by:**

* **Permanently codifying TRIPS flexibilities in public health laws**
* **Eliminating “evergreening” through comprehensive examination of HIV medicine patents**
* **Cooperating internationally to prevent price gouging and ceasing all future TRIPS plus measures**

#### The plan solves – global patent protections must be controlled to prevent hundreds of thousands of deaths in the near future

**Bhardwaj 4** [Kajal Bhardwaj; Matteo Cassolato; Revanta Dharmarajah; Othoman Mellouk; Morgane Ahmar; Sergey Kondratyuk. “The Problem with Patents: Access to Affordable HIV Treatment in Middle-income Countries.” Edited by Aditi Sharma, Juliet Heller, and Jenny Berg. Frontline AIDS 2020. https://frontlineaids.org/wp-content/uploads/2020/01/The-problem-with-patents\_pages\_web2.pdf]  
The recent Lancet Commission-International AIDS Society report, Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals, finds that **not only is the HIV epidemic not on track to end but that the prevailing discourse on ending AIDS has bred a dangerous complacency and may have hastened the weakening of global resolve to combat HIV.**104 It warns that **tens of millions of people will require sustained access to ARVs for decades to come.**105 As the world strives to make progress towards the 2030 goals, it is crucial to remember that **without tackling the issue of patents and high prices of medicines, the goal of healthy lives and well-being for all will remain out of reach. This is particularly true for middle income countries, which account for an estimated 70% of people living with HIV. Governments in middle-income countries must lead efforts to make full use of TRIPS flexibilities to ensure sustainable access to affordable medicines.** This will require them to work with and support CSOs, including meaningfully engaging them in negotiations on trade and investment agreements. **Governments should review their patent laws and incorporate the full range of public health safeguards**, seeking technical assistance from global health and development agencies as they review and draft intellectual property laws and policies. **They should also take proactive steps to strengthen the patent examination process, in order to prevent evergreening. Finally, they must work together against political and legal pressure, including advocating for the use of TRIPS flexibilities at international and regional forums and platforms, and rejecting any TRIPS-plus measures that may impact access to medicines.**