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#### Medicinal IP protections institutionalize access disparities between western and nonwestern countries- reinforcing neocolonialist structures

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This brings us to the present and how this dysfunction continues to be normalised in the current pandemic. Moderna, for example, has filed [over 100 patents](https://www.nature.com/articles/d41573-020-00119-8) for the mRNA technology used in its vaccine, despite receiving funds from the [US government](https://www.forbes.com/sites/judystone/2020/12/03/the-peoples-vaccine-modernas-coronavirus-vaccine-was-largely-funded-by-taxpayer-dollars/?sh=1363197b6303) with its IP partly owned by the US [National Institutes of Health](https://www.axios.com/moderna-nih-coronavirus-vaccine-%25252520ownership-agreements-22051c42-2dee-4b19-938d-099afd71f6a0.html). [Pfizer/BioNTech](https://www.citizen.org/article/biontech-and-pfizers-bnt162-vaccine-patent-landscape/) have also filed multiple patents on not only their COVID-19 vaccine product, but also on the manufacturing process, method of use and related technologies even though BioNtech was given [$450 million by the German government](https://www.reuters.com/article/health-coronavirus-germany-vaccine-idUKL8N2GC2J0) to speed up vaccine work and expand production capacity in Germany. It has become increasingly plain that IP makes private rights out of public funds while benefitting particular corporate interests. In fact, [report](https://www.defense.gov/Explore/Spotlight/Coronavirus/Operation-Warp-Speed/)s show the US government under Operation Warp Speed led by the US Department of Health also funded other vaccines developed in 2020 by several pharmaceutical corporations including Johnson and Johnson, Regeneron, Novavax, Sanofi and GlaxoSmithKline, AstraZeneca, and others. In spite of this boost from public funds, and with many governments wholly taking on the risks for potential vaccine side effects, drug manufacturers fully own the patents and related IP rights and so can decide how and where the vaccines get manufactured and how much they cost. As a result, taxpayers are paying twice for the same shot: first for its development, then again for the finished product. Meanwhile, a [New York Times](https://www.nytimes.com/2021/01/28/world/europe/vaccine-secret-contracts-prices.html) report has revealed that in some of the agreements between pharmaceutical companies and states, governments are prohibited from donating or reselling doses. This prohibition helps explain the [price disparity](https://www.npr.org/sections/goatsandsoda/2021/02/19/969529969/price-check-nations-pay-wildly-different-prices-for-vaccines?t=1614153425644&t=1614181324128) in vaccine purchases among countries where poor countries are paying more. For example, Uganda is paying USD 8.50 per dose of the AstraZeneca vaccine while the EU is paying only USD 3.50 per dose. By prioritizing monopoly rights of a few western corporations, IP dysfunction not only continues to reproduce old inequities and inequality in health access, but helps frame our understanding about the creation and [management of knowledge](http://www.thecornerhouse.org.uk/resource/who-owns-knowledge-economy). And perhaps we begin to see the refusal of drug makers to share knowledge needed to boost global vaccine supplyfor what it truly **is:** an extension in capitalist bifurcationof who is imagined as a legitimate intellectual property owner and who isenvisioned asa threat to the (intellectual) propertied order. Supporters and opponents of a TRIPS waiver for the COVID-19 vaccines (February 2021) Despite calls to make COVID-19 vaccines and related technologies a [global public good](https://peoplesvaccine.org/), western pharmaceutical companies have declined to loosen or temporarily suspend IP protections and transfer technology to generic manufacturers. Such transfer would enable the scale-up of production and supply of lifesaving COVID-19 medical tools across the world. Furthermore, these countries are also blocking the TRIPS [waiver proposal](https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/IP/C/W669.pdf&Open=True) put forward by South Africa and India at the WTO despite being supported by 57 mostly developing countries. The waiver proposal seeks to temporarily postpone certain provisions of the TRIPS Agreement for treating, containing and preventing the coronavirus, but only until widespread vaccination and immunity are achieved. This means that countries will not be required to provide any form of IP protection on all COVID-19 related therapeutics, diagnostics and other technologies for the duration of the pandemic. It is important to reiterate the waiver proposal is time-limited and is different from TRIPS flexibilities, which are safeguards within the Agreement to mitigate the negative impact of patents such as high price of patented medicines. These safeguards include [compulsory license](https://www.southcentre.int/wp-content/uploads/2019/04/RP85_Access-to-Medicines-Experiences-with-Compulsory-Licenses-and-Government-Use-The-Case-of-Hepatitis-C_EN.pdf)s and [parallel importation](https://journals.sagepub.com/doi/abs/10.1177/14680181020020030201). However, because of the onerous process of initiating these flexibilities as well as the threat of possible trade penalties by the US through the [United States Trade Representative (USTR) “Special 301” Report](http://www.unsgaccessmeds.org/final-report) targeting countries even in the absence of illegality, many developing countries are reluctant to invoke TRIPS flexibilities for public health purposes. For example, in the past, countries such as [Colombia](https://www.keionline.org/22864#:~:text=However%25252C%252520in%252520a%252520letter%252520of,a%252520compulsory%252520license%25255Bii%25255D.&text=By%252520sending%252520this%252520letter%25252C%252520the,needs%252520of%252520the%252520Colombian%252520population), [India](https://msfaccess.org/sites/default/files/2018-10/IP_Timeline_US%252520pressure%252520on%252520India_Sep%2525202014_0.pdf), [Thailand](https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001154) and recently [Malaysia](https://www.ip-watch.org/2019/02/13/malaysia-still-pressure-make-hepatitis-c-medicine-expensive/) have all featured in the Special 301 Report for using compulsory licenses to increase access to cancer medications. It is these challenges that the TRIPS waiver seeks to alleviate and, if approved, would also provide countries the space, without fear of retaliation from developed countries, to collaborate with competent developers in the R&D, manufacturing, scaling-up, and supply of COVID-19 tools. However, because this waiver is being [opposed](https://www.politico.com/newsletters/global-pulse/2020/12/10/patent-fight-pits-rich-against-poor-in-vaccine-race-491105) by a group of developed countries, we are grappling with the problem of artificially-created vaccine scarcity. The effect of this scarcity will further prolong and deepen the financial impact of this pandemic currently estimated to cost [USD 9.2 trillion](https://iccwbo.org/media-wall/news-speeches/study-shows-vaccine-nationalism-could-cost-rich-countries-us4-5-trillion/?utm_campaign=covid19&utm_medium=email&utm_source=email), half of which will be borne by advanced economies. Thus, in opposing the TRIPS waiver with the hopes of reaping huge financial rewards, developed countries are worsening pandemic woes in the long term. Perhaps it is time to reorient our sight and call the ongoing practices of buying up global supply of vaccine what it truly is – vaccine imperialism. Another kind of scarcity caused by [vaccine nationalism](https://www.foreignaffairs.com/articles/united-states/2020-07-27/vaccine-nationalism-pandemic) has also reduced equitable access. Vaccine nationalism is a phenomenon where rich countries buy up global supply of vaccines through advance purchase agreements (APA) with pharmaceutical companies for their own populations at the expense of other countries. But perhaps it is time to reorient our sight and call the ongoing practices of buying up global supply of vaccine what it truly is – vaccine imperialism. If we take seriously the argument put forward by [Antony Anghie](https://www.jstor.org/stable/pdf/4017775.pdf?refreqid=excelsior%25253A05f55d67e4790ef5059f2e57482f608e) on the colonial origins of international law, particularly how these origins create a set of structures that continually repeat themselves at various stages, we will begin to see COVID-19 vaccine accumulation not only as political, but also as imperial continuities manifesting in the present. Take, for instance, the report released by the Duke Global Health Innovation Center that shows that high-income countries have already purchased [nearly 3.8 billion COVID-19 vaccine doses](https://dukeghic.org/wp-content/uploads/sites/20/2020/11/COVID19-Vax-Press-Release__28Oct2020-1.pdf). Specifically, the [United States](https://www.nytimes.com/2021/01/28/world/europe/vaccine-secret-contracts-prices.html) has secured 400 million doses of the Pfizer-BioNTech and Moderna vaccines, and has APAs for more than 1 billion doses from four other companies yet to secure US regulatory approval. The European Union has similarly negotiated nearly 2.3 billion doses under contract and is negotiating for about 300 million more. With these purchases, these countries will be able to vaccinate their populations twice over, while many developing states, especially in Africa, are left behind. In hoarding vaccines whilst protecting the IP interests of their pharmaceutical multinational corporations, the afterlife of imperialism is playing out in this pandemic. Moreover, these bilateral deals are hampering initiatives such as the COVID-19 Vaccine Global Access Facility ([COVAX](https://www.who.int/news/item/18-12-2020-covax-announces-additional-deals-to-access-promising-covid-19-vaccine-candidates-plans-global-rollout-starting-q1-2021)) – a pooled procurement mechanism for COVID-19 vaccine – aimed at equitable and science-led global vaccine distribution. By engaging in bilateral deals, wealthy countries impede the possibility of effective mass-inoculation campaigns. While the usefulness of the COVAX initiative cannot be denied, it is not enough. It will cover only the [most vulnerable 20](https://www.who.int/news/item/15-07-2020-more-than-150-countries-engaged-in-covid-19-vaccine-global-access-facility) per cent of a country’s population, it is [severely underfunded](https://www.devex.com/news/with-scarce-funding-for-act-a-everything-moves-slower-who-s-bruce-aylward-99195) and there are lingering questions regarding the contractual obligations of pharmaceutical companies involved in the initiative. For instance, it is not clear whether the COVAX contract includes IP-related clauses such as [sharing of technological know-how](https://www.devex.com/news/is-covax-part-of-the-problem-or-the-solution-99334). Still, even with all its faults, without a global ramping-up of production, distribution and vaccination campaigns via COVAX, the world will not be able to combat the COVID-19 pandemic and its growing variants. Health inequity and inequalities in vaccine access are not unfortunate outcomes of the global IP regime; they are part of its central architecture. The system is functioning exactly as it is set up to do. These events – the corporate capture of the global pharmaceutical IP regime, state complicity and vaccine imperialism – are not new. Recall [Article 7 of TRIPS](https://www.wto.org/english/docs_e/legal_e/27-trips_01_e.htm), which states that the objective of the Agreement is the ‘protection and enforcement of intellectual property rights [to] contribute to the promotion of technological innovation and to the transfer and dissemination of technology’. In similar vein, Article 66(2) of TRIPS further calls on developed countries to ‘provide incentives to enterprises and institutions within their territories to promote and encourage technology transfer to least-developed country’. While the language of ‘transfer of technology’ might seem beneficial or benign, in actuality it is not. As I discussed in [my book](https://www.bloomsburyprofessional.com/uk/patent-games-in-the-global-south-9781509927401/), and as [Carmen Gonzalez](https://digitalcommons.law.seattleu.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1631&context=faculty) has also shown, when development objectives are incorporated into international legal instruments and institutions, they become embedded in structures that may constrain their transformative potential and reproduce North-South power imbalances. This is because these development objectives are circumscribed by capitalist imperialist structures, adapted to justify colonial practices and mobilized through racial differences. These structures are the essence of international law and its institutions even in the twenty-first century. They continue to animate broader socio-economic engagement with the global economy even in the present as well as in the legal and regulatory codes that support them. Thus, it is not surprising that even in current global health crisis, calls for this same transfer of technology in the form of a TRIPS waiver to scale up global vaccine production is being thwarted by the hegemony of developed states inevitably influenced by their respective pharmaceutical companies. The ‘emancipatory potential’ of TRIPS cannot be achieved if it was not created to be emancipatory in the first place. It also makes obvious the ways internationalIP law isnot onlyunsuited to promote structural reform to enable theself-sufficiency and self-determinationof thecountries in theglobal south, but also produces asymmetries that perpetuate inequalities. What this pandemic makes clear is that the development discourse often touted by developed nations to help countries in the Global South ‘catch up’ is empty when the essential medicines needed to stay alive are deliberately denied and [weaponised](https://www.thebureauinvestigates.com/stories/2021-02-23/held-to-ransom-pfizer-demands-governments-gamble-with-state-assets-to-secure-vaccine-deal). Like the free-market reforms designed to produce ‘development’, IP deployed to incentivise innovation is yet another tool in the service of private profits. As this pandemic has shown, the reality of contemporary capitalism – including the IP regime that underpins it – is competition among corporate giants driven by profit and not by human need. The needs of the poor weigh much less than the profits of big business and their home states. However, it is not all doom and gloom. Countries such as India, China and Russia have stepped up in the distribution of vaccines or what many call ‘[vaccine diplomacy](https://www.theguardian.com/world/2021/feb/19/coronavirus-vaccine-diplomacy-west-falling-behind-russia-china-race-influence).’ Further, Cuba’s vaccine candidate [Soberana 02](https://www.cnbc.com/2021/02/23/soberana-02-cubas-covid-vaccine-could-be-made-eligible-for-tourists.html), which is currently in final clinical trial stages and does not require extra refrigeration, promises to be a suitable option for many countries in the global South with infrastructural and logistical challenges. Importantly, Cuba’s history of medical diplomacy in other global South countries raises hope that the country will be willing to share the know-how with other manufactures in various non-western countries, which could help address artificial supply problems and control over distribution. In sum, this pandemic provides an opportune moment to overhaul this dysfunctional global IP system. We need not wait for the next crisis to learn the lessons from this crisis.

#### These systems of hierarchies reinforce dependence on developed countries– that’s key to legitimizing structural violence in the Global South

Sekalala et al 21(Professor in law school at the university in Warwick. “Decolonizing human rights: how intellectual property laws result in unequal access to the COVID-19 vaccine”, BMJ Global Health, July 2021,  [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8277484//](http://monthlyreview.org/2015/07/01/imperialisms-health-component/))

This prompts the obvious question: How is it that existing legal mechanisms, or at least the prevailing interpretations and understandings of them, have permitted and even enabled this inequity? International IP law embedded in international trade agreements allows pharmaceutical companies time-limited rights to prevent others from making, using or selling their patented invention without permission. Under the 1995 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which was included in the Uruguay Round of multilateral trade negotiation, pharmaceutical companies have at least 20 years from filing a patent to profit from their investments in developing, testing and upscaling pharmaceutical products throughout the world.[27](https://gh.bmj.com/content/6/7/e006169#ref-27) This protection is given to pharmaceutical companies to incentivise them to engage in greater research and development for new drugs. However, there is evidence that challenges previous assumptions about the linkages between Research and Development spending and innovation for essential medicines.[28](https://gh.bmj.com/content/6/7/e006169#ref-28) The current COVID-19 crisis has brought this into sharp focus, with projections that the global public sector had spent at least €93 billion on the development of COVID-19 vaccines and therapeutics—€85.6 billion of this on vaccines.[29](https://gh.bmj.com/content/6/7/e006169#ref-29) Global IP rights, whether adopted in accordance with TRIPS, or subsequent bilateral and multilateral agreements, are part of a wider legal system which facilitates global neocolonialism. For instance, powerful actors such as the European Union (EU) and the USA have included TRIPS-plus provisions in bilateral and multilateral agreements. These agreements often force countries of the Global South to concede to more stringent patent protections in order to gain trade advantages and also to escape trade sanctions.[30](https://gh.bmj.com/content/6/7/e006169#ref-30) In so doing, IP law commodifies medicines that are essential to human survival and well-being, and sacrifices the lives and health of the poor and otherwise marginalised on the altar of corporate profitability.[31](https://gh.bmj.com/content/6/7/e006169#ref-31) Common interpretations and understandings of the international IP system are that healthcare goods and services derive their value from their tradability.[14](https://gh.bmj.com/content/6/7/e006169#ref-14) (‘We use the term “public good” as it is used in global health to mean a good that should be available universally because of its critical importance to health, and not as the term is used in economics to mean a good that is both non-excludable and non-rivalrous.’)[14 32](https://gh.bmj.com/content/6/7/e006169#ref-14) However, many, including critical Global South scholars, have questioned the prioritisation of property rights (including IP rights) over other rights (especially the rights to health, life and equal benefit from scientific progress) in a manner that is inconsistent with international human rights law.[31](https://gh.bmj.com/content/6/7/e006169#ref-31) Many low-income countries have long been active in resisting the IP system as an unjust extension of a colonial trade system. At the height of the HIV pandemic, in which millions of people in the Global South were denied life-saving medicines, civil society treatment access campaigns galvanised states within the World Trade Organization (WTO) into agreeing to the Doha Declaration on TRIPS and Public Health.[33](https://gh.bmj.com/content/6/7/e006169#ref-33) This WTO Declaration recognises human rights and allows states to use all of the ‘flexibilities’ within the TRIPS regime to protect public health, acknowledging the need for access to medicines in a public health emergency.[34](https://gh.bmj.com/content/6/7/e006169#ref-34) However, this international consensus on IP has always been strongly contested by pharmaceutical companies and their host governments, predominantly in the Global North. This remarkably strong resistance to employing TRIPS flexibilities has continued in the current COVID-19 crisis, as the attempts of countries largely from the Global South to try to obtain a TRIPS waiver to increase their supply of vaccines for COVID-19 have been unsuccessful. Although the USA has recently supported a watered-down version of a TRIPS waiver, it remains far from certain whether other states in the Global North will support this prioritisation of health over IP rights, or whether this would be sufficient, as we discuss in the section on flexibilities below. Rather than allowing for equitable vaccine access as a human right for all people everywhere, states have instead turned to a charitable donation and market purchase scheme through the COVAX initiative. This type of model, which focuses on charity and not rights, is consistent with exactly the kind of understandings of human rights and public health that are in need of decolonisation. While there have been public consensus statements issued by the Human Rights Council, in which states have agreed that all states have the right to access vaccines and the right to use TRIPS flexibilities, this statement reflects a disappointing failure to acknowledge any corresponding state obligations to employ such flexibilities.[35](https://gh.bmj.com/content/6/7/e006169#ref-35) This has allowed countries from the Global North, and their few Global South allies, to agree to this statement and support the right to vaccine access rhetorically, and in principle within the Human Rights Council, while resisting any calls for a TRIPS waiver within the WTO, and thus consolidating a denial of their obligations to employ TRIPS flexibilities. Although countries from the Global South have the option of engaging TRIPS flexibilities in the absence of a general waiver, they often do not do so because the process of using these flexibilities is often stacked against them, reproducing neocolonial dynamics. For instance, TRIPS allows states with limited manufacturing capacity to waive a patent for a limited duration so as to import essential medicines through a compulsory licence. However, in practice, this process is lengthy and complex, as it relies on ensuring that both the importing and exporting countries have enacted local laws that permit them to use TRIPS flexibilities. Further, the importing country needs to negotiate with the pharmaceutical company in order to establish a fair price, which is always tricky, but made significantly more difficult in a crisis. To date, this process has been used only once, when Rwanda obtained access to generic antiretrovirals through an importation agreement with the Canadian company Apotex. However, even in that context, although Rwanda notified the WTO Council of its intention to use the mechanism in July 2007, it took 15 months before it could import its first batch of antiretrovirals. Despite its strong support, the manufacturer Apotex felt that the process was too cumbersome to use again.[36](https://gh.bmj.com/content/6/7/e006169#ref-36) This complexity has been heightened during the COVID-19 crisis due to the speed at which vaccines were manufactured, which has created a lack of transparency around the patent process.[37](https://gh.bmj.com/content/6/7/e006169#ref-37) Thus, the Bolivian government, which is seeking to use TRIPS flexibilities through compulsory licences, recognises in their application that there is a lack of clarity around the exact extent of product and process patents for any of the existing COVID-19 vaccines due to inadequate information about manufacturing or regulatory processes in different countries.[38](https://gh.bmj.com/content/6/7/e006169#ref-38) Additionally, many countries that have manufacturing capacity, such as those in the EU, have not sought to support countries in the Global South that want to use these flexibilities. In sum, cumbersome rules, political and economic pressures and a lack of transparency conspire to enable the Intellectual Property Regime (IPR) system to sustain and deepen global health inequities. 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](https://gh.bmj.com/content/6/7/e006169#ref-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](https://gh.bmj.com/content/6/7/e006169#ref-40) These programmes may increase debt and undermine development in ways that limit the realisation of the right to health.[41](https://gh.bmj.com/content/6/7/e006169#ref-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](https://gh.bmj.com/content/6/7/e006169#ref-42) poorer nations, instead of servicing already depleted health systems, are forced to divert additional funds to servicing debt.

#### Any approach that doesn’t reject these structures legitimizes them, new understandings are key

Waitzkin & Jasso-Aguilar 15 (Howard, distinguished professor emeritus of sociology at the University of New Mexico and adjunct professor of Internal Medicine at the University of Illinois, and Rebecca, instructor of sociology at the University of New Mexico. “Imperialism’s Health Component”, Monthly Review, Volume 67, Issue 3, July-August 2015, <http://monthlyreview.org/2015/07/01/imperialisms-health-component/>) // IS

The Report emphasized its central theme at the beginning: “Improving the health and longevity of the poor is, in one sense, an end in itself, a fundamental goal of economic development. But it is also a means to achieving the other development goals relating to poverty reduction.”26 Therefore the goal of improving health conditions of the poor became a key element of economic development strategies. From this viewpoint, reducing the burden of the endemic infections that plagued the poorest countries—AIDS, tuberculosis, and malaria—would increase workforce productivity and facilitate investment. A policy emphasis on “investing in health” (the Report‘s subtitle) echoed the influential and controversial World Development Report, Investing in Health, published in 1993 by the World Bank.27 The terminology of the title conveyed a double meaning—investing in health to improve health and productivity; and investing capital as a route to private profit in the health sector. These two meanings of investment, complementary but distinct, pervaded the macroeconomic Report. As Jeffrey Sachs, the Commission’s chair (an economist previously known for “shock therapy” in the implementation of neoliberal policies of public-sector cutbacks in Bolivia and Poland), stated in an address about the Report‘s public health implications at the American Public Health Association’s annual meeting in 2001, “What investor would invest his capital in a malarial country?”28 The Ebola epidemic epitomizes the failures of WHO’s leadership and the vertically oriented policies of the past. From its underfunded circumstances and dependency on the World Bank and Gates Foundation, WHO mounted a delayed and hopelessly inadequate response to the epidemic. As usual, a race for the magic bullet emerged, with predictable financial bonanzas for the pharmaceutical industry. But because no effective vaccine or treatment of Ebola yet exists, an infrastructure of clinics and hospitals must provide supportive services like hydration and blood products, as well as educational efforts and simple supplies such as adequate gloves and materials to block transmission of the virus. Such an infrastructure, nonexistent in West Africa largely due to failure of past public health policies, would prove feasible if the powers that be would recognize the practical benefits of a horizontal approach to the development of public health infrastructure. But that approach contradicts a long tradition of top-down vertical policies that have nurtured the political and economic foundations of empire. But that age is ending. Conditions during the twenty-first century have changed to such an extent that a vision of a world without imperialism has become part of an imaginable future. In struggles throughout the world, especially in Latin America, a new consciousness rejects the inevitability of imperial power. This new consciousness also fosters a vision of medicine and public health constructed around principles of justice, not capital accumulation. Such scenarios convey a picture very different from that of the historical relation between imperialism and health—a picture that shows a diminishing tolerance among the world’s peoples for the public health policies of imperialism and a growing demand for public health systems grounded in solidarity rather than profitability and commodification.

#### Thus the plan: The member nations of the World Trade Organization ought to eliminate enforcement of patent protections for medicines in every nation except the United States, the United Kingdom, Belgium, The Netherlands, Germany, Switzerland, Italy, France, Spain, China, Japan

## Advantage One is Access

#### The removal of patents would give people better access to some of the same privileges as western countries and reduce the effects of neocolonialism

Oxfam 21, Organization working to end the injustice of poverty. Intellectual property and access to medicine. Oxfam.com, Summer 2021 < https://www.oxfamamerica.org/explore/issues/economic-well-being/intellectual-property-and-access-to-medicine/> KK

Today, more than two billion people across the developing world lack access to affordable medicines, including many patients in countries negotiating in the Trans-Pacific Partnership (TPP) free trade agreement. Two critical factors limit access to treatment: the high prices of new medicines, particularly those that are patent-protected, and the lack of medicines and vaccines to treat neglected diseases, a consequence of lack of R&D. Intellectual property (IP) has different forms; in the case of access to medicines, we are talking about patents. Patents are a public policy instrument aimed at stimulating innovation. By providing a monopoly through a patent—which gives inventors an economic advantage—governments seek to provide an incentive for R&D. At the same time, the public benefits from technological advancement. This trade-off underpins patent systems everywhere. Governments need to maintain an appropriate balance between incentivizing innovation, on the one hand, and, on the other, ensuring that new products are widely available. High levels of IP protection in developing countries exacerbate, rather than help solve, the problem of access to affordable medicines. Extensive patent protection for new medicines delays the onset of generic competition. And because generic competition is the only proven method of reducing medicine prices in a sustainable way, such high levels of IP protection are extremely damaging to public health outcomes. A word on background: The 1994 TRIPS Agreement represented the single greatest expansion of IP protection in history, but it also includes a range of public health safeguards and flexibilities, which were reinforced by the 2001 Doha Declaration on the TRIPS Agreement and Public Health. Yet US trade agreements over the past decade have sought to redefine and even undermine the Doha Declaration, as FTAs have included provisions that curb governments’ ability to use the health safeguards in TRIPS and have mandated higher levels of IP protection. These provisions block or delay the onset of generic competition, keeping medicine prices high. Higher treatment costs are devastating to poor people, and they undermine the sustainability of public health programs—particularly in low- and middle-income countries, where public finance for health care is limited and most patients pay for medicines out of pocket. The agreement reached between Congressional leadership and the Bush administration on May 10, 2007, broke this trend of imposing increasingly stricter IP protections in trade agreements by scaling back so-called TRIPS-plus rules in the FTAs with Peru, Panama, and Colombia. This agreement was very significant—not only did it confirm the importance of the Doha Declaration on the TRIPS Agreement and Public Health, but it also recognized that higher levels of IP protection can in fact run counter to public health interests and US trade and development goals. Under this agreement, which has become known as the May 10 Agreement, three key TRIPS-plus provisions that Oxfam believes have been most harmful in delaying generic competition were rolled back: namely, patent linkage and patent-term extensions were made voluntary, and important flexibilities were included in the data exclusivity (DE) provisions to speed up the introduction of generic medicines. Patent linkage prohibits a country’s drug regulatory authority from approving a medicine if there is any patent—even a frivolous one—in effect. It requires regulatory officials to police patents in addition to their core work of evaluating the safety and efficacy of medicines. Patent extension provisions allow companies to seek extensions of the 20-year patent term to compensate for administrative delays by patent offices and drug regulatory authorities. (Such delays are inevitable in developing countries, where these offices are chronically underfunded and are facing increasing numbers of patent applications.) [Data exclusivity](https://policy-practice.oxfamamerica.org/work/trade/data-exclusivity) creates a monopoly that is separate from patents by prohibiting a country’s drug regulatory authority from approving a generic medicine based on the clinical trial data provided by the originator company. Although the May 10 Agreement did not eliminate all TRIPS-plus rules, Oxfam considered it to be a step in the right direction—after a long time going the wrong way. It reflected a meaningful effort to ensure that US trade policy more appropriately balances IP protection with public health considerations in developing countries. Oxfam fully expected this new approach in US trade policy to continue. But the Office of the US Trade Representative (USTR) effectively abandoned the May 10 Agreement in TPP negotiations and added new provisions that would further constrain generic competition—for example, by expanding the scope of what can receive monopoly protection—and Oxfam’s concerns with the USTR TPP proposal relate not only to the IP chapter, but also to a proposed chapter on “transparency” in pharmaceutical reimbursement, which would hinder government efforts to control the cost of reimbursing medicines through public health care programs. The reality is that fragile gains in health in developing country TPP partners are at risk from the USTR proposal. For example, Peru is a low- to middle-income country with high levels of poverty and inequality and with a high burden of chronic and noncommunicable diseases that require medicines over the long term. Prices for patented medicines to treat cancer, for example, are unaffordable for households and have exhausted most of the government’s resources available to pay for treatments under the public health system. A 2010 study by a Peruvian government entity (the Director General of Medicines, Supply and Drugs, or DIGEMID) revealed this stark reality: the monthly cost of one key patented medicine needed to treat head and neck cancer is equivalent to 880 times the daily minimum wage in Peru, an amount that would take a worker more than two years to earn, without a single day off. The TPP would not only undermine the efforts of other countries to protect public health, but would also undermine US efforts to improve access to health care around the world. Thanks to the cost savings from use of generics, PEPFAR (the President’s Emergency Plan for AIDS Relief) has successfully initiated treatment for more than three million people worldwide, and saved $380 million in 2010 alone. In Vietnam, where more than half the population lives in poverty, 97 percent of antiretroviral medicines purchased under PEPFAR ($323 million in 2004–2009) are generics. If Vietnam had to adopt what USTR is proposing in the TPP trade agreement, it would undermine the sustainability of HIV and AIDS treatment under PEPFAR, and also undermine broader efforts by the Vietnamese government to ensure access to affordable medicines. Not surprisingly, the USTR IP proposal has generated stiff resistance from TPP negotiating partners. It’s been hard to sell greater monopoly rights and less competition as facilitating access to medicines. What’s more, the USTR proposal will not enhance pharmaceutical innovation. It’s important to challenge the argument that stricter IP rules and high prices are essential to promote innovation. This logic is flawed in rich countries and simply does not apply in most developing countries. Additional IP protection in developing countries does not alter the calculus that multinational pharmaceutical companies employ when deciding where to invest limited R&D resources. Even accounting for recent economic growth, developing countries still only represent in total about 1 percent of global pharmaceutical demand. Stricter patent rules in a few countries may generate greater profits for drug companies, but won’t lead to additional innovation that would meet the public health needs of those countries. And such rules could undermine patients’ access to new treatments. In order to generate greater innovation, changes need to be made within the pharmaceutical industry itself. This is not something that a trade agreement can achieve. The problem of access to affordable medicines cannot be solved through trade agreements, but it can be exacerbated. That will be the outcome if USTR succeeds in its insistence that TPP partners institute far-reaching IP rules that upset the important balance between access and innovation, thereby rewarding multinational companies with excessive monopolies at the expense of the public interest.

#### Studies prove- Relaxing patents means reduced prices

Crook 05[Jamie Crook- director of litigation for the Center for Gender and Refugee Studies, 2005, “Balancing Intellectual Property Protection with the Human Right to Health,” *Berkeley Journal of International Law 23*(3), 524-550, [https://lawcat.berkeley.edu/record/1119803?ln=en]/](https://lawcat.berkeley.edu/record/1119803?ln=en%5d/) Triumph Debate

They also cast AIDS as a strictly social condition rather than an infectious disease, a notion not unique to pharmaceutical conglomerates. South African President, Thabo Mbeki, for example, misguidedly asserted that "extreme poverty" is the4rimary culprit of sub-Saharan Africa's public health ravages, not the HIV virus. The circular "poverty, not patents" argument assumes that high prices are a given and that poverty is synonymous with an inability to afford medication. But high prices are not a given; based on the examples of India and Brazil, relaxing patent standards for developing countries by condoning generic manufacture and parallel imports4 3 dramatically lowers prices and increases access to anti-retroviral treatment. 44 Instead of poverty, the true barrier to access is unaffordability. This idea should empower those who are truly concerned with combating the AIDS epidemic because, while poverty is a multidimensional problem with no immediate solution, current technology already allows for the manufacture of affordable generic treatment. Yet patent protections presently suppress the production of effective generic antiretrovirals, to the detriment of the world's poorest HIV/AIDS patients.

#### The Plan saves millions of lives every year

Pheage 16[Tefo Pheage- journalist for African Renewal, December 2016, “Dying from lack of medicines,” United Nations Africa Renewal, [https://www.un.org/africarenewal/magazine/december-2016-march-2017/dying-lack-medicines]/](https://www.un.org/africarenewal/magazine/december-2016-march-2017/dying-lack-medicines%5d/) Triumph Debate

Approximately 1.6 million Africans died of malaria, tuberculosis and HIV-related illnesses in 2015. These diseases can be prevented or treated with timely access to appropriate and affordable medicines, vaccines and other health services. But less than 2% of drugs consumed in Africa are produced on the continent, meaning that many sick patients do not have access to locally produced drugs and may not afford to buy the imported ones. Without access to medicines, Africans are susceptible to the three big killer diseases on the continent: malaria, tuberculosis and HIV/AIDS. Globally, 50% of children under five who die of pneumonia, diarrhoea, measles, HIV, tuberculosis and malaria are in Africa, according to the World Health Organisation (WHO). The organisation defines having access to medicine as having medicines continuously available and affordable at health facilities that are within one hour’s walk of the population. In some parts of Zimbabwe, for example, some nurses give painkillers to sick patients as a “treat-all drug,” says Charles Ndlovu, a Zimbabwean living in Botswana. Some of his family members have been treated in hospitals in Zimbabwe. With most medicines unavailable, the nurses have little choice. Dave Puo, from Mpumalanga in South Africa, says that in his country, “when you seek medical attention, you are often informed that there is no medication and advised to go to the big hospitals,” which the majority of the poor cannot afford. “The system does not care about your [empty] pockets.” Inhibiting factors

## Advantage Two is Contraception

#### IP allows for misogynistic power structures to replicate through denial of access to contraception

Allen 1: Allen, Scott A. [Indiana University Maurer School of Law] “Patents Fettering Reproductive Rights” *Indiana Law Journal,* 2012. <https://www.repository.law.indiana.edu/cgi/viewcontent.cgi?article=3004&context=ilj> JP.

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

#### Studies prove it- TRIPS prevents access to reproductive health products

Jennifer, Mike., 20, Access to essential medicines to guarantee women's rights to health: The pharmaceutical patents connection, Wiley Online Library, 6-29-2020, DOA: 9-17-2021, https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161, r0w@n. Bracketed for gendered language

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

#### Millions of unsafe abortions happen because of a lack of access to contraceptives due to TRIPS.

Mike 1: Mike, Jennifer H. [School of Law, American University of Nigeria, Yola, Nigeria, Nigeria] “Access to essential medicines to guarantee women's rights to health: The pharmaceutical patents connection” *Wiley Online Library,* 2020. <https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161> JP Bracketed for gendered language

Particularly, contraceptives are essential medicines as they are necessary to curtail early and unwanted childbearing, and prevent unplanned pregnancies. This is especially where the pregnancy is damaging to the health, welfare and human development of the woman (WHO, 2017). Significantly, access to appropriate drugs and contraceptives, including emergency contraception, could prevent and control unsafe sex and even reduce vertical HIV transmission (Nanda et al., 2017; Perehudoff, Pizzarossa, & Stekelenburg, 2018; WHO, 2004, p. 14).13 Accessing contraceptives can also prevent the termination of unwanted pregnancies and the option of unsafe abortion (MSF, 2019). Data reveals that unsafe abortion kills about 68,000 women every year, representing 13% of all pregnancy-related deaths (Grimes et al., 2006; WHO, 2002; WHO, 2004, p. 14). It is further estimated that 25 million unsafe abortions take place worldwide each year, majorly in developing countries (WHO, 2019). Following unsafe abortions, women may be vulnerable to a range of harms that affect their quality of life and well-being; they may suffer reproductive and genital tract infection and experience other health complications (WHO, 2004, p. 14). Some of these infections are fatal and serious, leading to infertility, disability and worse, death (Perehudoff et al., 2018; WHO, 2004, p. 14). This is in addition to the social and financial costs to women, their families, the community at large and health care systems. There is therefore a need to improve access to contraceptives. A survey, however, estimated that many women who are at risk of unplanned or unintended pregnancy and would choose birth control using effective modern contraceptives are unable to do so (ICPD, 1995; Logez et al., 2011; WHO, 2004, 2017). Furthermore, reproductive and sexual health problems such as maternal, perinatal mortality and gynaecological health-related complications are said to be a significant disease burden for women of reproductive age (WHO, 2017, p. 11). Sexual and reproductive ill-health can lead to sexual dysfunction and other gynaecological conditions such as severe menstrual problems, urinary and faecal incontinence due to obstetric fistulae, uterine prolapse and pregnancy loss (Filippi et al., 2016, p. 6; Timilsina, 2018, pp. 18–19). This, in turn, leads to maternal and perinatal mortality. Women will, therefore, need access to medical interventions to prevent these avoidable health situations or treat theirrr conditions. For example, maternal health complications such as postpartum haemorrhage (PPH), pre-eclampsia and eclampsia, can be prevented or treated by the appropriate use of essential medicines such as oxytocin and ergometrine injections; magnesium sulfate (MgSO4) injection for the prevention and treatment of severe pre-eclampsia and eclampsia; ampicillin, gentamicin and metronidazole injections for the treatment of maternal sepsis; procaine benzylpenicillin, and ceftriaxone for neonatal sepsis (Tran & Bero, 2015). Access to the high quality, therapeutic medications in developing countries may not be adequate, resulting in a high number of preventable maternal deaths (Torloni et al., 2016, p. 645). Lack of access to Oxytocin in some sub-Saharan African countries and Tanzania has also been traced to institutional, socioeconomic, financial, cultural and political barriers (Torloni et al., 2016, p. 645). 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#### This saves thousands every year and is key to global poverty reduction efforts

*(*Hocker 17*) Kaitlin Hocker, 3 REASONS WHY CONTRACEPTION REDUCES POVERTY, The Borgen Project, 8/3/17, DOA: 7/27/20,* [*https://borgenproject.org/contraception-reduces-poverty/*](https://borgenproject.org/contraception-reduces-poverty/)*, RG* Bracketed for gendered language

Here are three facts about the relationship between contraception and poverty reduction: If [people] who currently lack the means to sexual health information, as well as proper contraception, were allowed access to these reproductive tools, an estimated 35 million abortions and 76,000 maternal deaths would be prevented each year. Given that abortions far exceed the price of standard birth control, these women could instead spend this money to provide for their families and improve their quality of life. Saving [people] from premature death from unwanted pregnancy due to a lack of reproductive education and resources is not only beneficial in regard to humanitarian measures, but it also strengthens the economic security of the household. More people being integrated into the workforce, followed by a decrease in the number of dependents, provides a boost to economies worldwide. Populations dense with working-age individuals often live in more developed countries given the surplus of people contributing to the respective economy. Contraception reduces poverty in this sector because adults who either choose not to have children or delay the rate at which they have children have more time and resources to earn better-living potentials when compared to those who must use their income to provide for their families. While education and international aid offer clear benefits in the fight against poverty, the growth of an excessive population counters these measures. Given the current population’s exponential growth, the economies and civil services of developing countries already lack the capacity or resources to provide for the influx of people to come. The ways in which global poverty is combatted today may no longer be effective in the future if contraception is not accessible. Family planning means more than just preventing unwanted pregnancies. According to the former executive director of the UN Population Fund, the late Babtunde Osotimehin, “It is a most significant investment to promote human capital development, combat poverty and harness a demographic dividend, thus contributing to equitable and sustainable economic development.” Funding family programming can ensure that contraception reduces poverty, and it will remain effective for generations to come. Additionally, it will help the planet utilize its limited resources more effectively.

#### Contraception provides a direct rupture to cyclical poverty

(Bailey 14*) Martha J. Bailey et. al, DO FAMILY PLANNING PROGRAMS DECREASE POVERTY? EVIDENCE FROM PUBLIC CENSUS DATA, The National Institute of Health, 10/22/14, DOA: 7/27/20,* [*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206087/*](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206087/)*, RG*

Our research design compares the poverty rates of individuals born in the years leading up to and just after federally funded family planning programs began. We draw upon several public-use datasets that measure individuals’ ages and place of residence: the 1980 US decennial census observes the potentially affected cohorts as children and the 2000 census and 2005–2011 American Community Survey (ACS) observes the same cohorts as adults. Our results show that federally funded family planning programs are associated with significant reductions in child poverty rates and, later, poverty rates in adulthood.3 Individuals born one to six years after program funding were 4.2 percent less likely to live in poverty in childhood and 2.4 percent less likely to live in poverty in adulthood. Although both white and non-white children born after family planning programs began experienced large reductions in childhood poverty, white children experienced greater relative reductions in poverty rates in adulthood. Whites born after family planning programs began were 4.1 percent less likely to live in poverty in childhood and 6.1 percent less likely to live in poverty in adulthood. Non-whites born after family planning programs began were 8.2 percent less likely to live in poverty in childhood, but 2 percent less likely to live in poverty in adulthood. In short, family planning programs may help break the cycle of poverty. Our results suggest that family planning programs reduce poverty among children and, ultimately, in adulthood. These findings complement a growing body of research that suggests that investments in children can have sizable effects on children’s longer-term educational attainment, health, and labor market productivity (Cunha and Heckman 2007, Almond and Currie 2011).

# Framing Proper

#### The standard is reducing structural violence.

CU Online, 17, Recognizing and Addressing Structural Violence, 6-30-2017, DOA: 9-11-2021, https://online.campbellsville.edu/social-work/structural-violence/, r0w@n

Because direct, physical violence is easy to see and recognize, it gets significant attention from both law enforcement and the news media. A violent crime, such as an assault or murder, is a discrete event that can be handled in a number of ways. Structural violence, on the other hand, is often invisible and challenging to respond to. Addressing structural violence typically requires large structural changes in society, and such changes happen slowly in part because it’s difficult to recognize structural violence as violence. What Is Structural Violence? Chronic undernourishment affected one in nine people worldwide from 2014 to 2016, according to the United Nations. The Economist reports that an estimated 1.49 million people in the United States used homeless shelters in 2014, and around another 500,000 went without shelter; those numbers are likely to be conservative estimates at best. Hunger and homelessness may not seem to fit the definition of violence, but they’re clear examples of structural violence. “Structural violence occurs whenever people are disadvantaged by political, legal, economic or cultural traditions. Because they are longstanding, structural inequities usually seem ordinary, the way things are and always have been,” according to D.D. Winter and D.C. Leighton. Rather than being focused on direct, brutal acts, structural violence is the result of societal systems, such as social stratification, that have been in place for years — systems that create situations where people don’t have access to the things required to fulfill their basic human needs. “Structural violence is problematic in and of itself,” continue Winter and Leighton, “but it is also dangerous because it frequently leads to direct violence. Those who are chronically oppressed are often, for logical reasons, those who resort to direct violence.” This, in turn, usually leads to direct violence from law enforcement and the military that is directed at the oppressed community to re-exert the dominance of the status quo. Perhaps the most challenging aspect of addressing structural violence is how difficult it can be to bring attention to it. “When social inequities are noticed, attempts are made to rationalize and understand them,” Winter and Leighton say. “Unfortunately, one outcome of this process is to assume that victims must in some way deserve their plight.” Because the constant presence of structural violence is desensitizing, the structures that maintain the violence become normalized and seen as “the way things are.” Because of this, it can be difficult to convince those with the ability to create change that there is a problem or that it can be addressed. How Structural Violence Perpetuates Poverty In 2015, 13.5 percent of the U.S. population — around 43 million people — fell below the federal poverty line of $24,250 for a family of four. When broken down into specific populations, it becomes easy to see that some populations have higher poverty rates. Poverty among whites was 9.1 percent during that time, compared to 24.1 percent among African-Americans; African-Americans have a long history of being the victims of structural violence in America. Structural violence usually has, at its root, some political or economic structure that disenfranchises a group of people. For example, children in inner cities typically lack access to adequate schools, which limits their access to jobs with good salaries when they get older. This, in turn, limits their access to healthcare, legal protections, political power, safe housing and other important resources. This cycle of poverty perpetuates itself, creating entire communities subject to regular structural violence. Access to resources like education, healthcare and purchasing power are all vital to breaking the cycle of poverty. Individuals without adequate access to healthcare are not only more likely to have shorter life spans, but also to spend a significant portion of their income treating illnesses and other health issues, or simply enduring them and reducing their ability to work and earn money. Without adequate education, access to good jobs and influence within society is limited. An inability to buy necessities like food and shelter leads to worse healthcare outcomes, less money spent on educating the next generation and so forth. Effects on Individual and Public Health Lack of proper maternal care is a significant source of structural violence directed against women. About 350,000 women die every year due to pregnancy-related causes, and nearly 99 percent of those deaths occur in poor countries with limited access to good maternal care.

#### Prefer:

#### Policymaking- specifically with orientations toward minimizing structural violence- teaches the language of power to enable internal resistance strategies

Coverstone 05

Alan Coverstone (masters in communication from Wake Forest, longtime debate coach) “Acting on Activism: Realizing the Vision of Debate with Pro-social Impact” Paper presented at the National Communication Association Annual Conference November 17th 2005 <https://www.natcom.org/> -CAT

An important concern emerges when Mitchell describes reflexive fiat as a contest strategy capable of “eschewing the power to directly control external actors” (1998b, p. 20). Describing debates about what our government should do as attempts to control outside actors is debilitating and disempowering. Control of the US government is exactly what an active, participatory citizenry is supposed to be all about. After all, if democracy means anything, it means that citizens not only have the right, they also bear the obligation to discuss and debate what the government should be doing. Absent that discussion and debate, much of the motivation for personal political activism is also lost. Those who have co-opted Mitchell’s argument for individual advocacy often quickly respond that nothing we do in a debate round can actually change government policy, and unfortunately, an entire generation of debaters has now swallowed this assertion as an article of faith. The best most will muster is, “Of course not, but you don’t either!” The assertion that nothing we do in debate has any impact on government policy is one that carries the potential to undermine Mitchell’s entire project. If there is nothing we can do in a debate round to change government policy, then we are left with precious little in the way of pro-social options for addressing problems we face. At best, we can pursue some Pilot-like hand washing that can purify us as individuals through quixotic activism but offer little to society as a whole. It is very important to note that Mitchell (1998b) tries carefully to limit and bound his notion of reflexive fiat by maintaining that because it “views fiat as a concrete course of action, it is bounded by the limits of pragmatism” (p. 20). Pursued properly, the debates that Mitchell would like to see are those in which the relative efficacy of concrete political strategies for pro-social change is debated. In a few noteworthy examples, this approach has been employed successfully, and I must say that I have thoroughly enjoyed judging and coaching those debates. The students in my program have learned to stretch their understanding of their role in the political process because of the experience. Therefore, those who say I am opposed to Mitchell’s goals here should take care at such a blanket assertion. However, contest debate teaches students to combine personal experience with the language of political power. Powerful personal narratives unconnected to political power are regularly co-opted by those who do learn the language of power. One need look no further than the annual state of the Union Address where personal story after personal story is used to support the political agenda of those in power. The so-called role-playing that public policy contest debates encourage promotes active learning of the vocabulary and levers of power in America. Imagining the ability to use our own arguments to influence government action is one of the great virtues of academic debate. Gerald Graff (2003) analyzed the decline of argumentation in academic discourse and found a source of student antipathy to public argument in an interesting place. I’m up against…their aversion to the role of public spokesperson that formal writing presupposes. It’s as if such students can’t imagine any rewards for being a public actor or even imagining themselves in such a role. This lack of interest in the public sphere may in turn reflect a loss of confidence in the possibility that the arguments we make in public will have an effect on the world. Today’s students’ lack of faith in the power of persuasion reflects the waning of the ideal of civic participation that led educators for centuries to place rhetorical and argumentative training at the center of the school and college curriculum. (Graff, 2003, p. 57) The power to imagine public advocacy that actually makes a difference is one of the great virtues of the traditional notion of fiat that critics deride as mere simulation. Simulation of success in the public realm is far more empowering to students than completely abandoning all notions of personal power in the face of governmental hegemony by teaching students that “nothing they can do in a contest debate can ever make any difference in public policy.” Contest debating is well suited to rewarding public activism if it stops accepting as an article of faith that personal agency is somehow undermined by the so-called role playing in debate. Debate is role-playing whether we imagine government action or imagine individual action. Imagining myself starting a socialist revolution in America is no less of a fantasy than imagining myself making a difference on Capitol Hill. Furthermore, both fantasies influenced my personal and political development virtually ensuring a life of active, pro-social, political participation. Neither fantasy reduced the likelihood that I would spend my life trying to make the difference I imagined. One fantasy actually does make a greater difference: the one that speaks the language of political power. The other fantasy disables action by making one a laughingstock to those who wield the language of power. Fantasy motivates and role-playing trains through visualization. Until we can imagine it, we cannot really do it. Role-playing without question teaches students to be comfortable with the language of power, and that language paves the way for genuine and effective political activism. Debates over the relative efficacy of political strategies for pro-social change must confront governmental power at some point. There is a fallacy in arguing that movements represent a better political strategy than voting and person-to-person advocacy. Sure, a full-scale movement would be better than the limited voice I have as a participating citizen going from door to door in a campaign, but so would full-scale government action. Unfortunately, the gap between my individual decision to pursue movement politics and the emergence of a full-scale movement is at least as great as the gap between my vote and democratic change.

#### Structural violence is the largest proximate cause of suffering- creates priming that psychologically structures escalation

Scheper-Hughes and Bourgois ‘4

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(Nancy and Philippe, Introduction: Making Sense of Violence, in Violence in War and Peace, pg. 19-22)

This large and at first sight “messy” Part VII is central to this anthology’s thesis. It encompasses everything from the routinized, bureaucratized, and utterly banal violence of children dying of hunger and maternal despair in Northeast Brazil (Scheper-Hughes, Chapter 33) to elderly African Americans dying of heat stroke in Mayor Daly’s version of US apartheid in Chicago’s South Side (Klinenberg, Chapter 38) to the racialized class hatred expressed by British Victorians in their olfactory disgust of the “smelly” working classes (Orwell, Chapter 36). In these readings violence is located in the symbolic and social structures that overdetermine and allow the criminalized drug addictions, interpersonal bloodshed, and racially patterned incarcerations that characterize the US “inner city” to be normalized (Bourgois, Chapter 37 and Wacquant, Chapter 39). Violence also takes the form of class, racial, political self-hatred and adolescent self-destruction (Quesada, Chapter 35), as well as of useless (i.e.  preventable), rawly embodied physical suffering, and death (Farmer, Chapter 34).  Absolutely central to our approach is a blurring of categories and distinctions between wartime and peacetime violence. Close attention to the “little” violences produced in the structures, habituses, and mentalites of everyday life shifts our attention to pathologies of class, race, and gender inequalities. More important, it interrupts the voyeuristic tendencies of “violence studies” that risk publicly humiliating the powerless who are often forced into complicity with social and individual pathologies of power because suffering is often a solvent of human integrity and dignity. Thus, in this anthology we are positing a violence continuum comprised of a multitude of “small wars and invisible genocides” (see also Scheper- Hughes 1996; 1997; 2000b) conducted in the normative social spaces of public schools, clinics, emergency rooms, hospital wards, nursing homes, courtrooms, public registry offices, prisons, detention centers, and public morgues. The violence continuum also refers to the ease with which humans are capable of reducing the socially vulnerable into expendable nonpersons and assuming the license - even the duty - to kill, maim, or soul-murder. We realize that in referring to a violence and a genocide continuum we are flying in the face of a tradition of genocide studies that argues for the absolute uniqueness of the Jewish Holocaust and for vigilance with respect to restricted purist use of the term genocide itself (see Kuper 1985; Chaulk 1999; Fein 1990; Chorbajian 1999). But we hold an opposing and alternative view that, to the contrary, it is absolutely necessary to make just such existential leaps in purposefully linking violent acts in normal times to those of abnormal times. Hence the title of our volume: Violence in War and in Peace. If (as we concede) there is a moral risk in overextending the concept of “genocide” into spaces and corners of everyday life where we might not ordinarily think to find it (and there is), an even greater risk lies in failing to sensitize ourselves, in misrecognizing protogenocidal practices and sentiments daily enacted as normative behavior by “ordinary” good-enough citizens. Peacetime crimes, such as prison construction sold as economic development to impoverished communities in the mountains and deserts of California, or the evolution of the criminal industrial complex into the latest peculiar institution for managing race relations in the United States (Waquant, Chapter 39), constitute the “small wars and invisible genocides” to which we refer. This applies to African American and Latino youth mortality statistics in Oakland, California, Baltimore, Washington DC, and New York City. These are “invisible” genocides not because they are secreted away or hidden from view, but quite the opposite.  As Wittgenstein observed, the things that are hardest to perceive are those which are right before our eyes and therefore taken for granted. In this regard, Bourdieu’s partial and unfinished theory of violence (see Chapters 32 and 42) as well as his concept of misrecognition is crucial to our task. By including the normative everyday forms of violence hidden in the minutiae of “normal” social practices - in the architecture of homes, in gender relations, in communal work, in the exchange of gifts, and so forth - Bourdieu forces us to reconsider the broader meanings and status of violence, especially the links between the violence of everyday life and explicit political terror and state repression, Similarly, Basaglia’s notion of “peacetime crimes” - crimini di pace - imagines a direct relationship between wartime and peacetime violence. Peacetime crimes suggests the possibility that war crimes are merely ordinary, everyday crimes of public consent applied systematically and dramatically in the extreme context of war. Consider the parallel uses of rape during peacetime and wartime, or the family resemblances between the legalized violence of US immigration and naturalization border raids on “illegal aliens” versus the US government- engineered genocide in 1938, known as the Cherokee “Trail of Tears.” Peacetime crimes suggests that everyday forms of state violence make a certain kind of domestic peace possible.  Internal “stability” is purchased with the currency of peacetime crimes, many of which take the form of professionally applied “strangle-holds.” Everyday forms of state violence during peacetime make a certain kind of domestic “peace” possible. It is an easy-to-identify peacetime crime that is usually maintained as a public secret by the government and by a scared or apathetic populace. Most subtly, but no less politically or structurally, the phenomenal growth in the United States of a new military, postindustrial prison industrial complex has taken place in the absence of broad-based opposition, let alone collective acts of civil disobedience. The public consensus is based primarily on a new mobilization of an old fear of the mob, the mugger, the rapist, the Black man, the undeserving poor. How many public executions of mentally deficient prisoners in the United States are needed to make life feel more secure for the affluent? What can it possibly mean when incarceration becomes the “normative” socializing experience for ethnic minority youth in a society, i.e., over 33 percent of young African American men (Prison Watch 2002).  In the end it is essential that we recognize the existence of a genocidal capacity among otherwise good-enough humans and that we need to exercise a defensive hypervigilance to the less dramatic, permitted, and even rewarded everyday acts of violence that render participation in genocidal acts and policies possible (under adverse political or economic conditions), perhaps more easily than we would like to recognize. Under the violence continuum we include, therefore, all expressions of radical social exclusion, dehumanization, depersonal- ization, pseudospeciation, and reification which normalize atrocious behavior and violence toward others. A constant self-mobilization for alarm, a state of constant hyperarousal is, perhaps, a reasonable response to Benjamin’s view of late modern history as a chronic “state of emergency” (Taussig, Chapter 31). We are trying to recover here the classic anagogic thinking that enabled Erving Goffman, Jules Henry, C. Wright Mills, and Franco Basaglia among other mid-twentieth-century radically critical thinkers, to perceive the symbolic and structural relations, i.e., between inmates and patients, between concentration camps, prisons, mental hospitals, nursing homes, and other “total institutions.” Making that decisive move to recognize the continuum of violence allows us to see the capacity and the willingness - if not enthusiasm - of ordinary people, the practical technicians of the social consensus, to enforce genocidal-like crimes against categories of rubbish people. There is no primary impulse out of which mass violence and genocide are born, it is ingrained in the common sense of everyday social life.  The mad, the differently abled, the mentally vulnerable have often fallen into this category of the unworthy living, as have the very old and infirm, the sick-poor, and, of course, the despised racial, religious, sexual, and ethnic groups of the moment. Erik Erikson referred to “pseudo- speciation” as the human tendency to classify some individuals or social groups as less than fully human - a prerequisite to genocide and one that is carefully honed during the unremark- able peacetimes that precede the sudden, “seemingly unintelligible” outbreaks of mass violence. Collective denial and misrecognition are prerequisites for mass violence and genocide. But so are formal bureaucratic structures and professional roles. The practical technicians of everyday violence in the backlands of Northeast Brazil (Scheper-Hughes, Chapter 33), for example, include the clinic doctors who prescribe powerful tranquilizers to fretful and frightfully hungry babies, the Catholic priests who celebrate the death of “angel-babies,” and the municipal bureaucrats who dispense free baby coffins but no food to hungry families.  Everyday violence encompasses the implicit, legitimate, and routinized forms of violence inherent in particular social, economic, and political formations. It is close to what Bourdieu (1977, 1996) means by “symbolic violence,” the violence that is often “nus-recognized” for something else, usually something good. Everyday violence is similar to what Taussig (1989) calls “terror as usual.” All these terms are meant to reveal a public secret - the hidden links between violence in war and violence in peace, and between war crimes and “peace-time crimes.” Bourdieu (1977) finds domination and violence in the least likely places - in courtship and marriage, in the exchange of gifts, in systems of classification, in style, art, and culinary taste- the various uses of culture. Violence, Bourdieu insists, is everywhere in social practice. It is misrecognized because its very everydayness and its familiarity render it invisible. Lacan identifies “rneconnaissance” as the prerequisite of the social. The exploitation of bachelor sons, robbing them of autonomy, independence, and progeny, within the structures of family farming in the European countryside that Bourdieu escaped is a case in point (Bourdieu, Chapter 42; see also Scheper-Hughes, 2000b; Favret-Saada, 1989).  Following Gramsci, Foucault, Sartre, Arendt, and other modern theorists of power-vio- lence, Bourdieu treats direct aggression and physical violence as a crude, uneconomical mode of domination; it is less efficient and, according to Arendt (1969), it is certainly less legitimate.  While power and symbolic domination are not to be equated with violence - and Arendt argues persuasively that violence is to be understood as a failure of power - violence, as we are presenting it here, is more than simply the expression of illegitimate physical force against a person or group of persons. Rather, we need to understand violence as encompassing all forms of “controlling processes” (Nader 1997b) that assault basic human freedoms and individual or collective survival. Our task is to recognize these gray zones of violence which are, by definition, not obvious. Once again, the point of bringing into the discourses on genocide everyday, normative experiences of reification, depersonalization, institutional confinement, and acceptable death is to help answer the question: What makes mass violence and genocide possible? In this volume we are suggesting that mass violence is part of a continuum, and that it is socially incremental and often experienced by perpetrators, collaborators, bystanders - and even by victims themselves - as expected, routine, even justified. The preparations for mass killing can be found in social sentiments and institutions from the family, to schools, churches, hospitals, and the military. They harbor the early “warning signs” (Charney 1991), the “priming” (as Hinton, ed., 2002 calls it), or the “genocidal continuum” (as we call it) that push social consensus toward devaluing certain forms of human life and lifeways from the refusal of social support and humane care to vulnerable “social parasites” (the nursing home elderly, “welfare queens,” undocumented immigrants, drug addicts) to the militarization of everyday life (super-maximum-security prisons, capital punishment; the technologies of heightened personal security, including the house gun and gated communities; and reversed feelings of victimization).

#### Structural violence has no intervening actors- it’s definitionally supported by the system- means outside actors like debate fiat are key to solving

#### Waiting for reform is the elite telling you to not change the system- productive reformations of those systems collapses their calculus

Olson 2015 [Elizabeth Olson, professor of geography at UNC Chapel Hill, ‘Geography and Ethics I: Waiting and Urgency,’ *Progress in Human Geography*, vol. 39 no. 4, pp. 517-526] //CJC

Though toileting might be thought of as a special case of bodily urgency, geographic research suggests that the body is increasingly set at odds with larger scale ethical concerns, especially *large-scale future events of forecasted suffering*. Emergency planning is a particularly good example in which the large-scale threats of future suffering can distort moral reasoning. Žižek (2006) lightly develops this point in the context of the war on terror, where in the presence of fictitious and real ticking clocks and warning systems, the urgent body must be bypassed because there are bigger scales to worry about:¶ What does this all-pervasive sense of urgency mean ethically? The pressure of events is so overbearing, the stakes are so high, that they nec           essitate a suspension of ordinary ethical concerns. After all, displaying moral qualms when the lives of millions are at stake plays into the hands of the enemy. (Žižek, 2006)¶ In the presence of large-scale future emergency, the urgency to secure the state, the citizenry, the economy, or the climate creates new scales and new temporal orders of response (see Anderson, 2010; Baldwin, 2012; Dalby, 2013; Morrissey, 2012), many of which treat the urgent body as impulsive and thus requiring management. McDonald’s (2013) analysis of three interconnected discourses of ‘climate security’ illustrates how bodily urgency in climate change is also recast as a menacing impulse that might require exclusion from moral reckoning. The logics of climate security, especially those related to national security, ‘can encourage perverse political responses that not only fail to respond effectively to climate change but may present victims of it as a threat’ (McDonald, 2013: 49). Bodies that are currently suffering cannot be urgent, because they are excluded from the potential collectivity that could be suffering everywhere in some future time. Similar bypassing of existing bodily urgency is echoed in writing about violent securitization, such as drone warfare (Shaw and Akhter, 2012), and also in *intimate scales* like the street and the school, especially in relation to race (Mitchell, 2009; Young et al., 2014).¶ As *large-scale urgent concerns are institutionalized*, the urgent body is increasingly obscured through technical planning and coordination (Anderson and Adey, 2012). The predominant characteristic of this institutionalization of large-scale emergency is a ‘built-in bias for action’ (Wuthnow, 2010: 212) *that circumvents contingencies*. The urgent body is at best an assumed eventuality, one that will likely require another state of waiting, such as *triage* (e.g. Greatbach et al., 2005). Amin (2013) cautions that in much of the West, governmental need to provide evidence of laissez-faire governing on the one hand, and assurance of strength in facing a threatening future on the other, produces ‘just-in-case preparedness’ (Amin, 2013: 151) of neoliberal risk management policies. In the US, ‘personal ingenuity’ is built into emergency response at the expense of the poor and vulnerable for whom ‘[t]he difference between abjection and bearable survival’ (Amin, 2013: 153) will not be determined by emergency planning, but in the material infrastructure of the city.¶ In short, the urgencies of the body provide justifications for social exclusion of the most marginalized based on impulse and perceived threat, while large-scale future emergencies effectively absorb the deliberative power of urgency into the institutions of preparedness and risk avoidance. Žižek references Arendt’s (2006) analysis of the banality of evil to explain the current state of ethical reasoning under the war on terror, noting that people who perform morally reprehensible actions under the conditions of urgency assume a ‘tragic-ethic grandeur’ (Žižek, 2006) by sacrificing their own morality for the good of the state. But his analysis fails to note that bodies are today so rarely legitimate sites for claiming urgency. In the context of the assumed priority of the large-scale future emergency, the urgent body becomes literally nonsense, a non sequitur within societies, states and worlds that will always be more urgent.¶ If the important ethical work of urgency has been to identify that which must not wait, then the capture of the power and persuasiveness of urgency by large-scale future emergencies has consequences for the kinds of normative arguments we can raise on behalf of urgent bodies. How, then, might waiting compare as a normative description and critique in our own urgent time? Waiting can be categorized according to its purpose or outcome (see Corbridge, 2004; Gray, 2011), but it also modifies the place of the individual in society and her importance. As Ramdas (2012: 834) writes, ‘waiting … produces hierarchies which segregate people and places into those which matter and those which do not’. The segregation of waiting might produce effects that counteract suffering, however, and Jeffery (2008: 957) explains that though the ‘politics of waiting’ can be repressive, it can also engender creative political engagement. In his research with educated unemployed Jat youth who spend days and years waiting for desired employment, Jeffery finds that ‘the temporal suffering and sense of ambivalence experienced by young men can generate cultural and political experiments that, in turn, have marked social and spatial effects’ (Jeffery, 2010: 186). Though this is not the same as claiming normative neutrality for waiting, it does suggest that waiting is more ethically ambivalent and open than urgency.¶ In other contexts, however, our descriptions of waiting indicate a strong condemnation of its effects upon the subjects of study. Waiting can demobilize radical reform, depoliticizing ‘the insurrectionary possibilities of the present by delaying the revolutionary imperative to a future moment that is forever drifting towards infinity’ (Springer, 2014: 407). Yonucu’s (2011) analysis of the self-destructive activities of disrespected working-class youth in Istanbul suggests that this sense of infinite waiting can lead not only to depoliticization, but also to a disbelief in the possibility of a future self of any value. Waiting, like urgency, can undermine the possibility of self-care two-fold, first by making people wait for essential needs, and again by reinforcing that waiting is ‘[s]omething to be ashamed of because it may be noted or taken as evidence of indolence or low status, seen as a symptom of rejection or a signal to exclude’ (Bauman, 2004: 109). This is why Auyero (2012) suggests that waiting creates an ideal state subject, providing ‘temporal processes in and through which political subordination is produced’ (Auyero, 2012: loc. 90; see also Secor, 2007). Furthermore, Auyero notes, it is not only political subordination, but the subjective effect of waiting that secures domination, as citizens and non-citizens find themselves ‘waiting hopefully and then frustratedly for others to make decisions, and in effect surrendering to the authority of others’ (Auyero, 2012: loc. 123).¶ Waiting can therefore function as a potentially important spatial technology of the elite and powerful, mobilized not only for the purpose of governing individuals, but also to retain claims over moral urgency. But there is growing resistance to the capture of claims of urgency by the elite, and it is important to note that even in cases where the material conditions of containment are currently impenetrable, arguments based on human value are at the forefront of reclaiming urgency for the body. In detention centers, clandestine prisons, state borders and refugee camps, geographers point to ongoing struggles against the ethical impossibility of bodily urgency and a rejection of states of waiting (see Conlon, 2011; Darling, 2009, 2011; Garmany, 2012; Mountz et al., 2013; Schuster, 2011). Ramakrishnan’s (2014) analysis of a Delhi resettlement colony and Shewly’s (2013) discussion of the enclave between India and Bangladesh describe people who refuse to give up their own status as legitimately urgent, even in the context of larger scale politics. Similarly, Tyler’s (2013) account of desperate female detainees stripping off their clothes to expose their humanness and suffering in the Yarl’s Wood Immigration Removal Centre in the UK suggests that demands for recognition are not just about politics, but also about the acknowledgement of humanness and the irrevocable possibility of being that which cannot wait. The continued existence of places like Yarl’s Wood and similar institutions in the USA nonetheless points to the challenge of exposing the urgent body as a moral priority when it is so easily hidden from view, and also reminds us that our research can help to explain the relationships between normative dimensions and the political and social conditions of struggle.¶ In closing, geographic depictions of waiting do seem to evocatively describe otherwise obscured suffering (e.g. Bennett, 2011), but it is striking how rarely these descriptions also use the language of urgency. Given the discussion above, what might be accomplished – and risked – by incorporating urgency more overtly and deliberately into our discussions of waiting, surplus and abandoned bodies? Urgency can clarify the implicit but understated ethical consequences and normativity associated with waiting, and encourage explicit discussion about harmful suffering. Waiting can be productive or unproductive for radical praxis, but urgency compels and requires response. Geographers could be instrumental in reclaiming the ethical work of urgency in ways that leave it open for critique, clarifying common spatial misunderstandings and representations. There is good reason to be thoughtful in this process, since moral outrage towards inhumanity can itself obscure differentiated experiences of being human, dividing up ‘those for whom we feel urgent unreasoned concern and those whose lives and deaths simply do not touch us, or do not appear as lives at all’ (Butler, 2009: 50). But when the urgent body is rendered as only waiting, both materially and discursively, it is just as easily cast as impulsive, disgusting, animalistic (see also McKittrick, 2006). Feminist theory insists that the urgent body, whose encounters of violence are ‘usually framed as private, apolitical and mundane’ (Pain, 2014: 8), are as deeply political, public, and exceptional as other forms of violence (Phillips, 2008; Pratt, 2005). Insisting that a suffering body, now, is that which cannot wait, has the ethical effect of drawing it into consideration alongside the political, public and exceptional scope of large-scale futures. It may help us insist on the body, both as a single unit and a plurality, as a legitimate scale of normative priority and social care.¶ In this report, I have explored old and new reflections on the ethical work of urgency and waiting. Geographic research suggests a contemporary popular bias towards the urgency of large-scale futures, institutionalized in ways that further obscure and discredit the urgencies of the body. This bias also justifies the production of new waiting places in our material landscape, places like the detention center and the waiting room. In some cases, waiting is normatively neutral, even providing opportunities for alternative politics. In others, the technologies of waiting serve to manage potentially problematic bodies, leading to suspended suffering and even to extermination (e.g. Wright, 2013). One of my aims has been to suggest that moral reasoning is important both because it exposes normative biases against subjugated people, and because it potentially provides routes toward struggle where claims to urgency seem to foreclose the possibilities of alleviation of suffering. Saving the world still should require a debate about whose world is being saved, when, and at what cost – and this requires a debate about what really cannot wait. My next report will extend some of these concerns by reviewing how feelings of urgency, as well as hope, fear, and other emotions, have played a role in geography and ethical reasoning.¶ I conclude, however, by pulling together past and present. In 1972, Gilbert White asked why geographers were not engaging ‘the truly urgent questions’ (1972: 101) such as racial repression, decaying cities, economic inequality, and global environmental destruction. His question highlights just how much the discipline has changed, but it is also unnerving in its echoes of our contemporary problems. Since White’s writing, our moral reasoning has been stretched to consider the future body and the more-than-human, alongside the presently urgent body – topics and concerns that I have not taken up in this review but which will provide their own new possibilities for urgent concerns. My own hope presently is drawn from an acknowledgement that the temporal characteristics of contemporary capitalism can be interrupted in creative ways (Sharma, 2014), with the possibility of squaring the urgent body with our large-scale future concerns. *Temporal alternatives already exist in ongoing and emerging revolutions* and the disruption of claims of cycles and circular political processes (e.g. Lombard, 2013; Reyes, 2012). Though calls for urgency will certainly be used to obscure evasion of responsibility (e.g. Gilmore, 2008: 56, fn 6), they may also serve as fertile ground for radical critique, a truly fierce urgency for now.

# Accessible Version

#### Medicinal IP protections institutionalize access disparities between western and nonwestern countries- reinforcing neocolonialist structures

**Vanni 21** –Lecturer in Law at University of Leeds. ("On Intellectual Property Rights, Access to Medicines and Vaccine Imperialism," 3-23-2021,<https://twailr.com/on-intellectual-property-rights-access-to-medicines-and-vaccine-imperialism/>)

the refusal of drug makers to share knowledge needed to boost global vaccine supply **is:** an extension of who is imagined as a legitimate intellectual property owner and who isa these development objectives are circumscribed by capitalist imperialist structures, adapted to justify colonial practices and mobilized through racial differencesIP law isunsuited to promote structural reform to enable theself-determinationof theglobal south,

crisis.

#### These systems of hierarchies reinforce dependence on developed countries– that’s key to legitimizing structural violence in the Global South

Sekalala et al 21(Professor in law school at the university in Warwick. “Decolonizing human rights: how intellectual property laws result in unequal access to the COVID-19 vaccine”, BMJ Global Health, July 2021,  [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8277484//](http://monthlyreview.org/2015/07/01/imperialisms-health-component/))

This prompts the obvious question: How is it that existing legal mechanisms, or at least the prevailing interpretations and understandings of them, have permitted and even enabled this inequity? International IP law embedded in international trade agreements allows pharmaceutical companies time-limited rights to prevent others from making, using or selling their patented invention without permission. Under the 1995 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which was included in the Uruguay Round of multilateral trade negotiation, pharmaceutical companies have at least 20 years from filing a patent to profit from their investments in developing, testing and upscaling pharmaceutical products throughout the world.[27](https://gh.bmj.com/content/6/7/e006169#ref-27) This protection is given to pharmaceutical companies to incentivise them to engage in greater research and development for new drugs. However, there is evidence that challenges previous assumptions about the linkages between Research and Development spending and innovation for essential medicines.[28](https://gh.bmj.com/content/6/7/e006169#ref-28) The current COVID-19 crisis has brought this into sharp focus, with projections that the global public sector had spent at least €93 billion on the development of COVID-19 vaccines and therapeutics—€85.6 billion of this on vaccines.[29](https://gh.bmj.com/content/6/7/e006169#ref-29) Global IP rights, whether adopted in accordance with TRIPS, or subsequent bilateral and multilateral agreements, are part of a wider legal system which facilitates global neocolonialism. For instance, powerful actors such as the European Union (EU) and the USA have included TRIPS-plus provisions in bilateral and multilateral agreements. These agreements often force countries of the Global South to concede to more stringent patent protections in order to gain trade advantages and also to escape trade sanctions.[30](https://gh.bmj.com/content/6/7/e006169#ref-30) In so doing, IP law commodifies medicines that are essential to human survival and well-being, and sacrifices the lives and health of the poor and otherwise marginalised on the altar of corporate profitability.[31](https://gh.bmj.com/content/6/7/e006169#ref-31) Common interpretations and understandings of the international IP system are that healthcare goods and services derive their value from their tradability.[14](https://gh.bmj.com/content/6/7/e006169#ref-14) (‘We use the term “public good” as it is used in global health to mean a good that should be available universally because of its critical importance to health, and not as the term is used in economics to mean a good that is both non-excludable and non-rivalrous.’)[14 32](https://gh.bmj.com/content/6/7/e006169#ref-14) However, many, including critical Global South scholars, have questioned the prioritisation of property rights (including IP rights) over other rights (especially the rights to health, life and equal benefit from scientific progress) in a manner that is inconsistent with international human rights law.[31](https://gh.bmj.com/content/6/7/e006169#ref-31) Many low-income countries have long been active in resisting the IP system as an unjust extension of a colonial trade system. At the height of the HIV pandemic, in which millions of people in the Global South were denied life-saving medicines, civil society treatment access campaigns galvanised states within the World Trade Organization (WTO) into agreeing to the Doha Declaration on TRIPS and Public Health.[33](https://gh.bmj.com/content/6/7/e006169#ref-33) This WTO Declaration recognises human rights and allows states to use all of the ‘flexibilities’ within the TRIPS regime to protect public health, acknowledging the need for access to medicines in a public health emergency.[34](https://gh.bmj.com/content/6/7/e006169#ref-34) However, this international consensus on IP has always been strongly contested by pharmaceutical companies and their host governments, predominantly in the Global North. This remarkably strong resistance to employing TRIPS flexibilities has continued in the current COVID-19 crisis, as the attempts of countries largely from the Global South to try to obtain a TRIPS waiver to increase their supply of vaccines for COVID-19 have been unsuccessful. Although the USA has recently supported a watered-down version of a TRIPS waiver, it remains far from certain whether other states in the Global North will support this prioritisation of health over IP rights, or whether this would be sufficient, as we discuss in the section on flexibilities below. Rather than allowing for equitable vaccine access as a human right for all people everywhere, states have instead turned to a charitable donation and market purchase scheme through the COVAX initiative. This type of model, which focuses on charity and not rights, is consistent with exactly the kind of understandings of human rights and public health that are in need of decolonisation. While there have been public consensus statements issued by the Human Rights Council, in which states have agreed that all states have the right to access vaccines and the right to use TRIPS flexibilities, this statement reflects a disappointing failure to acknowledge any corresponding state obligations to employ such flexibilities.[35](https://gh.bmj.com/content/6/7/e006169#ref-35) This has allowed countries from the Global North, and their few Global South allies, to agree to this statement and support the right to vaccine access rhetorically, and in principle within the Human Rights Council, while resisting any calls for a TRIPS waiver within the WTO, and thus consolidating a denial of their obligations to employ TRIPS flexibilities. Although countries from the Global South have the option of engaging TRIPS flexibilities in the absence of a general waiver, they often do not do so because the process of using these flexibilities is often stacked against them, reproducing neocolonial dynamics. For instance, TRIPS allows states with limited manufacturing capacity to waive a patent for a limited duration so as to import essential medicines through a compulsory licence. However, in practice, this process is lengthy and complex, as it relies on ensuring that both the importing and exporting countries have enacted local laws that permit them to use TRIPS flexibilities. Further, the importing country needs to negotiate with the pharmaceutical company in order to establish a fair price, which is always tricky, but made significantly more difficult in a crisis. To date, this process has been used only once, when Rwanda obtained access to generic antiretrovirals through an importation agreement with the Canadian company Apotex. However, even in that context, although Rwanda notified the WTO Council of its intention to use the mechanism in July 2007, it took 15 months before it could import its first batch of antiretrovirals. Despite its strong support, the manufacturer Apotex felt that the process was too cumbersome to use again.[36](https://gh.bmj.com/content/6/7/e006169#ref-36) This complexity has been heightened during the COVID-19 crisis due to the speed at which vaccines were manufactured, which has created a lack of transparency around the patent process.[37](https://gh.bmj.com/content/6/7/e006169#ref-37) Thus, the Bolivian government, which is seeking to use TRIPS flexibilities through compulsory licences, recognises in their application that there is a lack of clarity around the exact extent of product and process patents for any of the existing COVID-19 vaccines due to inadequate information about manufacturing or regulatory processes in different countries.[38](https://gh.bmj.com/content/6/7/e006169#ref-38) Additionally, many countries that have manufacturing capacity, such as those in the EU, have not sought to support countries in the Global South that want to use these flexibilities. In sum, cumbersome rules, political and economic pressures and a lack of transparency conspire to enable the Intellectual Property Regime (IPR) system to sustain and deepen global health inequities. 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](https://gh.bmj.com/content/6/7/e006169#ref-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](https://gh.bmj.com/content/6/7/e006169#ref-40) These programmes may increase debt and undermine development in ways that limit the realisation of the right to health.[41](https://gh.bmj.com/content/6/7/e006169#ref-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](https://gh.bmj.com/content/6/7/e006169#ref-42) poorer nations, instead of servicing already depleted health systems, are forced to divert additional funds to servicing debt.

#### Any approach that doesn’t reject these structures legitimizes them, new understandings are key

Waitzkin & Jasso-Aguilar 15 (Howard, distinguished professor emeritus of sociology at the University of New Mexico and adjunct professor of Internal Medicine at the University of Illinois, and Rebecca, instructor of sociology at the University of New Mexico. “Imperialism’s Health Component”, Monthly Review, Volume 67, Issue 3, July-August 2015, <http://monthlyreview.org/2015/07/01/imperialisms-health-component/>) // IS

The Report emphasized its central theme at the beginning: “Improving the health and longevity of the poor is, in one sense, an end in itself, a fundamental goal of economic development. But it is also a means to achieving the other development goals relating to poverty reduction.”26 Therefore the goal of improving health conditions of the poor became a key element of economic development strategies. From this viewpoint, reducing the burden of the endemic infections that plagued the poorest countries—AIDS, tuberculosis, and malaria—would increase workforce productivity and facilitate investment. A policy emphasis on “investing in health” (the Report‘s subtitle) echoed the influential and controversial World Development Report, Investing in Health, published in 1993 by the World Bank.27 The terminology of the title conveyed a double meaning—investing in health to improve health and productivity; and investing capital as a route to private profit in the health sector. These two meanings of investment, complementary but distinct, pervaded the macroeconomic Report. As Jeffrey Sachs, the Commission’s chair (an economist previously known for “shock therapy” in the implementation of neoliberal policies of public-sector cutbacks in Bolivia and Poland), stated in an address about the Report‘s public health implications at the American Public Health Association’s annual meeting in 2001, “What investor would invest his capital in a malarial country?”28 The Ebola epidemic epitomizes the failures of WHO’s leadership and the vertically oriented policies of the past. From its underfunded circumstances and dependency on the World Bank and Gates Foundation, WHO mounted a delayed and hopelessly inadequate response to the epidemic. As usual, a race for the magic bullet emerged, with predictable financial bonanzas for the pharmaceutical industry. But because no effective vaccine or treatment of Ebola yet exists, an infrastructure of clinics and hospitals must provide supportive services like hydration and blood products, as well as educational efforts and simple supplies such as adequate gloves and materials to block transmission of the virus. Such an infrastructure, nonexistent in West Africa largely due to failure of past public health policies, would prove feasible if the powers that be would recognize the practical benefits of a horizontal approach to the development of public health infrastructure. But that approach contradicts a long tradition of top-down vertical policies that have nurtured the political and economic foundations of empire. But that age is ending. Conditions during the twenty-first century have changed to such an extent that a vision of a world without imperialism has become part of an imaginable future. In struggles throughout the world, especially in Latin America, a new consciousness rejects the inevitability of imperial power. This new consciousness also fosters a vision of medicine and public health constructed around principles of justice, not capital accumulation. Such scenarios convey a picture very different from that of the historical relation between imperialism and health—a picture that shows a diminishing tolerance among the world’s peoples for the public health policies of imperialism and a growing demand for public health systems grounded in solidarity rather than profitability and commodification.

#### Thus the plan: The member nations of the World Trade Organization ought to eliminate enforcement of patent protections for medicines in every nation except the United States, the United Kingdom, Belgium, The Netherlands, Germany, Switzerland, Italy, France, Spain, China, Japan

## Advantage One is Access

#### The removal of patents would give people better access to some of the same privileges as western countries and reduce the effects of neocolonialism

Oxfam 21, Organization working to end the injustice of poverty. Intellectual property and access to medicine. Oxfam.com, Summer 2021 < https://www.oxfamamerica.org/explore/issues/economic-well-being/intellectual-property-and-access-to-medicine/> KK

Today, more than two billion people across the developing world lack access to affordable medicines, including many patients in countries negotiating in the Trans-Pacific Partnership (TPP) free trade agreement. Two critical factors limit access to treatment: the high prices of new medicines, particularly those that are patent-protected, and the lack of medicines and vaccines to treat neglected diseases, a consequence of lack of R&D. Intellectual property (IP) has different forms; in the case of access to medicines, we are talking about patents. Patents are a public policy instrument aimed at stimulating innovation. By providing a monopoly through a patent—which gives inventors an economic advantage—governments seek to provide an incentive for R&D. At the same time, the public benefits from technological advancement. This trade-off underpins patent systems everywhere. Governments need to maintain an appropriate balance between incentivizing innovation, on the one hand, and, on the other, ensuring that new products are widely available. High levels of IP protection in developing countries exacerbate, rather than help solve, the problem of access to affordable medicines. Extensive patent protection for new medicines delays the onset of generic competition. And because generic competition is the only proven method of reducing medicine prices in a sustainable way, such high levels of IP protection are extremely damaging to public health outcomes. A word on background: The 1994 TRIPS Agreement represented the single greatest expansion of IP protection in history, but it also includes a range of public health safeguards and flexibilities, which were reinforced by the 2001 Doha Declaration on the TRIPS Agreement and Public Health. Yet US trade agreements over the past decade have sought to redefine and even undermine the Doha Declaration, as FTAs have included provisions that curb governments’ ability to use the health safeguards in TRIPS and have mandated higher levels of IP protection. These provisions block or delay the onset of generic competition, keeping medicine prices high. Higher treatment costs are devastating to poor people, and they undermine the sustainability of public health programs—particularly in low- and middle-income countries, where public finance for health care is limited and most patients pay for medicines out of pocket. The agreement reached between Congressional leadership and the Bush administration on May 10, 2007, broke this trend of imposing increasingly stricter IP protections in trade agreements by scaling back so-called TRIPS-plus rules in the FTAs with Peru, Panama, and Colombia. This agreement was very significant—not only did it confirm the importance of the Doha Declaration on the TRIPS Agreement and Public Health, but it also recognized that higher levels of IP protection can in fact run counter to public health interests and US trade and development goals. Under this agreement, which has become known as the May 10 Agreement, three key TRIPS-plus provisions that Oxfam believes have been most harmful in delaying generic competition were rolled back: namely, patent linkage and patent-term extensions were made voluntary, and important flexibilities were included in the data exclusivity (DE) provisions to speed up the introduction of generic medicines. Patent linkage prohibits a country’s drug regulatory authority from approving a medicine if there is any patent—even a frivolous one—in effect. It requires regulatory officials to police patents in addition to their core work of evaluating the safety and efficacy of medicines. Patent extension provisions allow companies to seek extensions of the 20-year patent term to compensate for administrative delays by patent offices and drug regulatory authorities. (Such delays are inevitable in developing countries, where these offices are chronically underfunded and are facing increasing numbers of patent applications.) [Data exclusivity](https://policy-practice.oxfamamerica.org/work/trade/data-exclusivity) creates a monopoly that is separate from patents by prohibiting a country’s drug regulatory authority from approving a generic medicine based on the clinical trial data provided by the originator company. Although the May 10 Agreement did not eliminate all TRIPS-plus rules, Oxfam considered it to be a step in the right direction—after a long time going the wrong way. It reflected a meaningful effort to ensure that US trade policy more appropriately balances IP protection with public health considerations in developing countries. Oxfam fully expected this new approach in US trade policy to continue. But the Office of the US Trade Representative (USTR) effectively abandoned the May 10 Agreement in TPP negotiations and added new provisions that would further constrain generic competition—for example, by expanding the scope of what can receive monopoly protection—and Oxfam’s concerns with the USTR TPP proposal relate not only to the IP chapter, but also to a proposed chapter on “transparency” in pharmaceutical reimbursement, which would hinder government efforts to control the cost of reimbursing medicines through public health care programs. The reality is that fragile gains in health in developing country TPP partners are at risk from the USTR proposal. For example, Peru is a low- to middle-income country with high levels of poverty and inequality and with a high burden of chronic and noncommunicable diseases that require medicines over the long term. Prices for patented medicines to treat cancer, for example, are unaffordable for households and have exhausted most of the government’s resources available to pay for treatments under the public health system. A 2010 study by a Peruvian government entity (the Director General of Medicines, Supply and Drugs, or DIGEMID) revealed this stark reality: the monthly cost of one key patented medicine needed to treat head and neck cancer is equivalent to 880 times the daily minimum wage in Peru, an amount that would take a worker more than two years to earn, without a single day off. The TPP would not only undermine the efforts of other countries to protect public health, but would also undermine US efforts to improve access to health care around the world. Thanks to the cost savings from use of generics, PEPFAR (the President’s Emergency Plan for AIDS Relief) has successfully initiated treatment for more than three million people worldwide, and saved $380 million in 2010 alone. In Vietnam, where more than half the population lives in poverty, 97 percent of antiretroviral medicines purchased under PEPFAR ($323 million in 2004–2009) are generics. If Vietnam had to adopt what USTR is proposing in the TPP trade agreement, it would undermine the sustainability of HIV and AIDS treatment under PEPFAR, and also undermine broader efforts by the Vietnamese government to ensure access to affordable medicines. Not surprisingly, the USTR IP proposal has generated stiff resistance from TPP negotiating partners. It’s been hard to sell greater monopoly rights and less competition as facilitating access to medicines. What’s more, the USTR proposal will not enhance pharmaceutical innovation. It’s important to challenge the argument that stricter IP rules and high prices are essential to promote innovation. This logic is flawed in rich countries and simply does not apply in most developing countries. Additional IP protection in developing countries does not alter the calculus that multinational pharmaceutical companies employ when deciding where to invest limited R&D resources. Even accounting for recent economic growth, developing countries still only represent in total about 1 percent of global pharmaceutical demand. Stricter patent rules in a few countries may generate greater profits for drug companies, but won’t lead to additional innovation that would meet the public health needs of those countries. And such rules could undermine patients’ access to new treatments. In order to generate greater innovation, changes need to be made within the pharmaceutical industry itself. This is not something that a trade agreement can achieve. The problem of access to affordable medicines cannot be solved through trade agreements, but it can be exacerbated. That will be the outcome if USTR succeeds in its insistence that TPP partners institute far-reaching IP rules that upset the important balance between access and innovation, thereby rewarding multinational companies with excessive monopolies at the expense of the public interest.

#### Studies prove- Relaxing patents means reduced prices

Crook 05[Jamie Crook- director of litigation for the Center for Gender and Refugee Studies, 2005, “Balancing Intellectual Property Protection with the Human Right to Health,” *Berkeley Journal of International Law 23*(3), 524-550, [https://lawcat.berkeley.edu/record/1119803?ln=en]/](https://lawcat.berkeley.edu/record/1119803?ln=en%5d/) Triumph Debate

They also cast AIDS as a strictly social condition rather than an infectious disease, a notion not unique to pharmaceutical conglomerates. South African President, Thabo Mbeki, for example, misguidedly asserted that "extreme poverty" is the4rimary culprit of sub-Saharan Africa's public health ravages, not the HIV virus. The circular "poverty, not patents" argument assumes that high prices are a given and that poverty is synonymous with an inability to afford medication. But high prices are not a given; based on the examples of India and Brazil, relaxing patent standards for developing countries by condoning generic manufacture and parallel imports4 3 dramatically lowers prices and increases access to anti-retroviral treatment. 44 Instead of poverty, the true barrier to access is unaffordability. This idea should empower those who are truly concerned with combating the AIDS epidemic because, while poverty is a multidimensional problem with no immediate solution, current technology already allows for the manufacture of affordable generic treatment. Yet patent protections presently suppress the production of effective generic antiretrovirals, to the detriment of the world's poorest HIV/AIDS patients.

#### The Plan saves millions of lives every year

Pheage 16[Tefo Pheage- journalist for African Renewal, December 2016, “Dying from lack of medicines,” United Nations Africa Renewal, [https://www.un.org/africarenewal/magazine/december-2016-march-2017/dying-lack-medicines]/](https://www.un.org/africarenewal/magazine/december-2016-march-2017/dying-lack-medicines%5d/) Triumph Debate

Approximately 1.6 million Africans died of malaria, tuberculosis and HIV-related illnesses in 2015. These diseases can be prevented or treated with timely access to appropriate and affordable medicines, vaccines and other health services. But less than 2% of drugs consumed in Africa are produced on the continent, meaning that many sick patients do not have access to locally produced drugs and may not afford to buy the imported ones. Without access to medicines, Africans are susceptible to the three big killer diseases on the continent: malaria, tuberculosis and HIV/AIDS. Globally, 50% of children under five who die of pneumonia, diarrhoea, measles, HIV, tuberculosis and malaria are in Africa, according to the World Health Organisation (WHO). The organisation defines having access to medicine as having medicines continuously available and affordable at health facilities that are within one hour’s walk of the population. In some parts of Zimbabwe, for example, some nurses give painkillers to sick patients as a “treat-all drug,” says Charles Ndlovu, a Zimbabwean living in Botswana. Some of his family members have been treated in hospitals in Zimbabwe. With most medicines unavailable, the nurses have little choice. Dave Puo, from Mpumalanga in South Africa, says that in his country, “when you seek medical attention, you are often informed that there is no medication and advised to go to the big hospitals,” which the majority of the poor cannot afford. “The system does not care about your [empty] pockets.” Inhibiting factors

## Advantage Two is Contraception

#### IP allows for misogynistic power structures to replicate through denial of access to contraception

Allen 1: Allen, Scott A. [Indiana University Maurer School of Law] “Patents Fettering Reproductive Rights” *Indiana Law Journal,* 2012. <https://www.repository.law.indiana.edu/cgi/viewcontent.cgi?article=3004&context=ilj> JP.

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

#### Studies prove it- TRIPS prevents access to reproductive health products

Jennifer, Mike., 20, Access to essential medicines to guarantee women's rights to health: The pharmaceutical patents connection, Wiley Online Library, 6-29-2020, DOA: 9-17-2021, https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161, r0w@n. Bracketed for gendered language

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

#### Millions of unsafe abortions happen because of a lack of access to contraceptives due to TRIPS.

Mike 1: Mike, Jennifer H. [School of Law, American University of Nigeria, Yola, Nigeria, Nigeria] “Access to essential medicines to guarantee women's rights to health: The pharmaceutical patents connection” *Wiley Online Library,* 2020. <https://onlinelibrary.wiley.com/doi/full/10.1111/jwip.12161> JP Bracketed for gendered language

Particularly, contraceptives are essential medicines as they are necessary to curtail early and unwanted childbearing, and prevent unplanned pregnancies. This is especially where the pregnancy is damaging to the health, welfare and human development of the woman (WHO, 2017). Significantly, access to appropriate drugs and contraceptives, including emergency contraception, could prevent and control unsafe sex and even reduce vertical HIV transmission (Nanda et al., 2017; Perehudoff, Pizzarossa, & Stekelenburg, 2018; WHO, 2004, p. 14).13 Accessing contraceptives can also prevent the termination of unwanted pregnancies and the option of unsafe abortion (MSF, 2019). Data reveals that unsafe abortion kills about 68,000 women every year, representing 13% of all pregnancy-related deaths (Grimes et al., 2006; WHO, 2002; WHO, 2004, p. 14). It is further estimated that 25 million unsafe abortions take place worldwide each year, majorly in developing countries (WHO, 2019). Following unsafe abortions, women may be vulnerable to a range of harms that affect their quality of life and well-being; they may suffer reproductive and genital tract infection and experience other health complications (WHO, 2004, p. 14). Some of these infections are fatal and serious, leading to infertility, disability and worse, death (Perehudoff et al., 2018; WHO, 2004, p. 14). This is in addition to the social and financial costs to women, their families, the community at large and health care systems. There is therefore a need to improve access to contraceptives. A survey, however, estimated that many women who are at risk of unplanned or unintended pregnancy and would choose birth control using effective modern contraceptives are unable to do so (ICPD, 1995; Logez et al., 2011; WHO, 2004, 2017). Furthermore, reproductive and sexual health problems such as maternal, perinatal mortality and gynaecological health-related complications are said to be a significant disease burden for women of reproductive age (WHO, 2017, p. 11). Sexual and reproductive ill-health can lead to sexual dysfunction and other gynaecological conditions such as severe menstrual problems, urinary and faecal incontinence due to obstetric fistulae, uterine prolapse and pregnancy loss (Filippi et al., 2016, p. 6; Timilsina, 2018, pp. 18–19). This, in turn, leads to maternal and perinatal mortality. Women will, therefore, need access to medical interventions to prevent these avoidable health situations or treat theirrr conditions. 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#### This saves thousands every year and is key to global poverty reduction efforts

*(*Hocker 17*) Kaitlin Hocker, 3 REASONS WHY CONTRACEPTION REDUCES POVERTY, The Borgen Project, 8/3/17, DOA: 7/27/20,* [*https://borgenproject.org/contraception-reduces-poverty/*](https://borgenproject.org/contraception-reduces-poverty/)*, RG* Bracketed for gendered language

Here are three facts about the relationship between contraception and poverty reduction: If [people] who currently lack the means to sexual health information, as well as proper contraception, were allowed access to these reproductive tools, an estimated 35 million abortions and 76,000 maternal deaths would be prevented each year. Given that abortions far exceed the price of standard birth control, these women could instead spend this money to provide for their families and improve their quality of life. Saving women from premature death from unwanted pregnancy due to a lack of reproductive education and resources is not only beneficial in regard to humanitarian measures, but it also strengthens the economic security of the household. More people being integrated into the workforce, followed by a decrease in the number of dependents, provides a boost to economies worldwide. Populations dense with working-age individuals often live in more developed countries given the surplus of people contributing to the respective economy. Contraception reduces poverty in this sector because adults who either choose not to have children or delay the rate at which they have children have more time and resources to earn better-living potentials when compared to those who must use their income to provide for their families. While education and international aid offer clear benefits in the fight against poverty, the growth of an excessive population counters these measures. Given the current population’s exponential growth, the economies and civil services of developing countries already lack the capacity or resources to provide for the influx of people to come. The ways in which global poverty is combatted today may no longer be effective in the future if contraception is not accessible. Family planning means more than just preventing unwanted pregnancies. According to the former executive director of the UN Population Fund, the late Babtunde Osotimehin, “It is a most significant investment to promote human capital development, combat poverty and harness a demographic dividend, thus contributing to equitable and sustainable economic development.” Funding family programming can ensure that contraception reduces poverty, and it will remain effective for generations to come. Additionally, it will help the planet utilize its limited resources more effectively.

#### Contraception provides a direct rupture to cyclical poverty

(Bailey 14*) Martha J. Bailey et. al, DO FAMILY PLANNING PROGRAMS DECREASE POVERTY? EVIDENCE FROM PUBLIC CENSUS DATA, The National Institute of Health, 10/22/14, DOA: 7/27/20,* [*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206087/*](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206087/)*, RG*

Our research design compares the poverty rates of individuals born in the years leading up to and just after federally funded family planning programs began. We draw upon several public-use datasets that measure individuals’ ages and place of residence: the 1980 US decennial census observes the potentially affected cohorts as children and the 2000 census and 2005–2011 American Community Survey (ACS) observes the same cohorts as adults. Our results show that federally funded family planning programs are associated with significant reductions in child poverty rates and, later, poverty rates in adulthood.3 Individuals born one to six years after program funding were 4.2 percent less likely to live in poverty in childhood and 2.4 percent less likely to live in poverty in adulthood. Although both white and non-white children born after family planning programs began experienced large reductions in childhood poverty, white children experienced greater relative reductions in poverty rates in adulthood. Whites born after family planning programs began were 4.1 percent less likely to live in poverty in childhood and 6.1 percent less likely to live in poverty in adulthood. Non-whites born after family planning programs began were 8.2 percent less likely to live in poverty in childhood, but 2 percent less likely to live in poverty in adulthood. In short, family planning programs may help break the cycle of poverty. Our results suggest that family planning programs reduce poverty among children and, ultimately, in adulthood. These findings complement a growing body of research that suggests that investments in children can have sizable effects on children’s longer-term educational attainment, health, and labor market productivity (Cunha and Heckman 2007, Almond and Currie 2011).

# Framing

#### The standard is reducing structural violence.

CU Online, 17, Recognizing and Addressing Structural Violence, 6-30-2017, DOA: 9-11-2021, https://online.campbellsville.edu/social-work/structural-violence/, r0w@n

Because direct, physical violence is easy to see and recognize, it gets significant attention from both law enforcement and the news media. A violent crime, such as an assault or murder, is a discrete event that can be handled in a number of ways. Structural violence, on the other hand, is often invisible and challenging to respond to. Addressing structural violence typically requires large structural changes in society, and such changes happen slowly in part because it’s difficult to recognize structural violence as violence. What Is Structural Violence? Chronic undernourishment affected one in nine people worldwide from 2014 to 2016, according to the United Nations. The Economist reports that an estimated 1.49 million people in the United States used homeless shelters in 2014, and around another 500,000 went without shelter; those numbers are likely to be conservative estimates at best. Hunger and homelessness may not seem to fit the definition of violence, but they’re clear examples of structural violence. “Structural violence occurs whenever people are disadvantaged by political, legal, economic or cultural traditions. Because they are longstanding, structural inequities usually seem ordinary, the way things are and always have been,” according to D.D. Winter and D.C. Leighton. Rather than being focused on direct, brutal acts, structural violence is the result of societal systems, such as social stratification, that have been in place for years — systems that create situations where people don’t have access to the things required to fulfill their basic human needs. “Structural violence is problematic in and of itself,” continue Winter and Leighton, “but it is also dangerous because it frequently leads to direct violence. Those who are chronically oppressed are often, for logical reasons, those who resort to direct violence.” This, in turn, usually leads to direct violence from law enforcement and the military that is directed at the oppressed community to re-exert the dominance of the status quo. Perhaps the most challenging aspect of addressing structural violence is how difficult it can be to bring attention to it. “When social inequities are noticed, attempts are made to rationalize and understand them,” Winter and Leighton say. “Unfortunately, one outcome of this process is to assume that victims must in some way deserve their plight.” Because the constant presence of structural violence is desensitizing, the structures that maintain the violence become normalized and seen as “the way things are.” Because of this, it can be difficult to convince those with the ability to create change that there is a problem or that it can be addressed. How Structural Violence Perpetuates Poverty In 2015, 13.5 percent of the U.S. population — around 43 million people — fell below the federal poverty line of $24,250 for a family of four. When broken down into specific populations, it becomes easy to see that some populations have higher poverty rates. Poverty among whites was 9.1 percent during that time, compared to 24.1 percent among African-Americans; African-Americans have a long history of being the victims of structural violence in America. Structural violence usually has, at its root, some political or economic structure that disenfranchises a group of people. For example, children in inner cities typically lack access to adequate schools, which limits their access to jobs with good salaries when they get older. This, in turn, limits their access to healthcare, legal protections, political power, safe housing and other important resources. This cycle of poverty perpetuates itself, creating entire communities subject to regular structural violence. Access to resources like education, healthcare and purchasing power are all vital to breaking the cycle of poverty. Individuals without adequate access to healthcare are not only more likely to have shorter life spans, but also to spend a significant portion of their income treating illnesses and other health issues, or simply enduring them and reducing their ability to work and earn money. Without adequate education, access to good jobs and influence within society is limited. An inability to buy necessities like food and shelter leads to worse healthcare outcomes, less money spent on educating the next generation and so forth. Effects on Individual and Public Health Lack of proper maternal care is a significant source of structural violence directed against women. About 350,000 women die every year due to pregnancy-related causes, and nearly 99 percent of those deaths occur in poor countries with limited access to good maternal care.

#### Prefer:

#### Policymaking teaches the language of power to enable internal resistance strategies

Coverstone 05

Alan Coverstone (masters in communication from Wake Forest, longtime debate coach) “Acting on Activism: Realizing the Vision of Debate with Pro-social Impact” Paper presented at the National Communication Association Annual Conference November 17th 2005 <https://www.natcom.org/> -CAT

An important concern emerges when Mitchell describes reflexive fiat as a contest strategy capable of “eschewing the power to directly control external actors” (1998b, p. 20). Describing debates about what our government should do as attempts to control outside actors is debilitating and disempowering. Control of the US government is exactly what an active, participatory citizenry is supposed to be all about. After all, if democracy means anything, it means that citizens not only have the right, they also bear the obligation to discuss and debate what the government should be doing. Absent that discussion and debate, much of the motivation for personal political activism is also lost. Those who have co-opted Mitchell’s argument for individual advocacy often quickly respond that nothing we do in a debate round can actually change government policy, and unfortunately, an entire generation of debaters has now swallowed this assertion as an article of faith. The best most will muster is, “Of course not, but you don’t either!” The assertion that nothing we do in debate has any impact on government policy is one that carries the potential to undermine Mitchell’s entire project. If there is nothing we can do in a debate round to change government policy, then we are left with precious little in the way of pro-social options for addressing problems we face. At best, we can pursue some Pilot-like hand washing that can purify us as individuals through quixotic activism but offer little to society as a whole. It is very important to note that Mitchell (1998b) tries carefully to limit and bound his notion of reflexive fiat by maintaining that because it “views fiat as a concrete course of action, it is bounded by the limits of pragmatism” (p. 20). Pursued properly, the debates that Mitchell would like to see are those in which the relative efficacy of concrete political strategies for pro-social change is debated. In a few noteworthy examples, this approach has been employed successfully, and I must say that I have thoroughly enjoyed judging and coaching those debates. The students in my program have learned to stretch their understanding of their role in the political process because of the experience. Therefore, those who say I am opposed to Mitchell’s goals here should take care at such a blanket assertion. However, contest debate teaches students to combine personal experience with the language of political power. Powerful personal narratives unconnected to political power are regularly co-opted by those who do learn the language of power. One need look no further than the annual state of the Union Address where personal story after personal story is used to support the political agenda of those in power. The so-called role-playing that public policy contest debates encourage promotes active learning of the vocabulary and levers of power in America. Imagining the ability to use our own arguments to influence government action is one of the great virtues of academic debate. Gerald Graff (2003) analyzed the decline of argumentation in academic discourse and found a source of student antipathy to public argument in an interesting place. I’m up against…their aversion to the role of public spokesperson that formal writing presupposes. It’s as if such students can’t imagine any rewards for being a public actor or even imagining themselves in such a role. This lack of interest in the public sphere may in turn reflect a loss of confidence in the possibility that the arguments we make in public will have an effect on the world. Today’s students’ lack of faith in the power of persuasion reflects the waning of the ideal of civic participation that led educators for centuries to place rhetorical and argumentative training at the center of the school and college curriculum. (Graff, 2003, p. 57) The power to imagine public advocacy that actually makes a difference is one of the great virtues of the traditional notion of fiat that critics deride as mere simulation. Simulation of success in the public realm is far more empowering to students than completely abandoning all notions of personal power in the face of governmental hegemony by teaching students that “nothing they can do in a contest debate can ever make any difference in public policy.” Contest debating is well suited to rewarding public activism if it stops accepting as an article of faith that personal agency is somehow undermined by the so-called role playing in debate. Debate is role-playing whether we imagine government action or imagine individual action. Imagining myself starting a socialist revolution in America is no less of a fantasy than imagining myself making a difference on Capitol Hill. Furthermore, both fantasies influenced my personal and political development virtually ensuring a life of active, pro-social, political participation. Neither fantasy reduced the likelihood that I would spend my life trying to make the difference I imagined. One fantasy actually does make a greater difference: the one that speaks the language of political power. The other fantasy disables action by making one a laughingstock to those who wield the language of power. Fantasy motivates and role-playing trains through visualization. Until we can imagine it, we cannot really do it. Role-playing without question teaches students to be comfortable with the language of power, and that language paves the way for genuine and effective political activism. Debates over the relative efficacy of political strategies for pro-social change must confront governmental power at some point. There is a fallacy in arguing that movements represent a better political strategy than voting and person-to-person advocacy. Sure, a full-scale movement would be better than the limited voice I have as a participating citizen going from door to door in a campaign, but so would full-scale government action. Unfortunately, the gap between my individual decision to pursue movement politics and the emergence of a full-scale movement is at least as great as the gap between my vote and democratic change.

#### Structural violence is the largest proximate cause of suffering- creates priming that psychologically structures escalation

Scheper-Hughes and Bourgois ‘4

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(Nancy and Philippe, Introduction: Making Sense of Violence, in Violence in War and Peace, pg. 19-22)

This large and at first sight “messy” Part VII is central to this anthology’s thesis. It encompasses everything from the routinized, bureaucratized, and utterly banal violence of children dying of hunger and maternal despair in Northeast Brazil (Scheper-Hughes, Chapter 33) to elderly African Americans dying of heat stroke in Mayor Daly’s version of US apartheid in Chicago’s South Side (Klinenberg, Chapter 38) to the racialized class hatred expressed by British Victorians in their olfactory disgust of the “smelly” working classes (Orwell, Chapter 36). In these readings violence is located in the symbolic and social structures that overdetermine and allow the criminalized drug addictions, interpersonal bloodshed, and racially patterned incarcerations that characterize the US “inner city” to be normalized (Bourgois, Chapter 37 and Wacquant, Chapter 39). Violence also takes the form of class, racial, political self-hatred and adolescent self-destruction (Quesada, Chapter 35), as well as of useless (i.e.  preventable), rawly embodied physical suffering, and death (Farmer, Chapter 34).  Absolutely central to our approach is a blurring of categories and distinctions between wartime and peacetime violence. Close attention to the “little” violences produced in the structures, habituses, and mentalites of everyday life shifts our attention to pathologies of class, race, and gender inequalities. More important, it interrupts the voyeuristic tendencies of “violence studies” that risk publicly humiliating the powerless who are often forced into complicity with social and individual pathologies of power because suffering is often a solvent of human integrity and dignity. Thus, in this anthology we are positing a violence continuum comprised of a multitude of “small wars and invisible genocides” (see also Scheper- Hughes 1996; 1997; 2000b) conducted in the normative social spaces of public schools, clinics, emergency rooms, hospital wards, nursing homes, courtrooms, public registry offices, prisons, detention centers, and public morgues. The violence continuum also refers to the ease with which humans are capable of reducing the socially vulnerable into expendable nonpersons and assuming the license - even the duty - to kill, maim, or soul-murder. We realize that in referring to a violence and a genocide continuum we are flying in the face of a tradition of genocide studies that argues for the absolute uniqueness of the Jewish Holocaust and for vigilance with respect to restricted purist use of the term genocide itself (see Kuper 1985; Chaulk 1999; Fein 1990; Chorbajian 1999). But we hold an opposing and alternative view that, to the contrary, it is absolutely necessary to make just such existential leaps in purposefully linking violent acts in normal times to those of abnormal times. Hence the title of our volume: Violence in War and in Peace. If (as we concede) there is a moral risk in overextending the concept of “genocide” into spaces and corners of everyday life where we might not ordinarily think to find it (and there is), an even greater risk lies in failing to sensitize ourselves, in misrecognizing protogenocidal practices and sentiments daily enacted as normative behavior by “ordinary” good-enough citizens. Peacetime crimes, such as prison construction sold as economic development to impoverished communities in the mountains and deserts of California, or the evolution of the criminal industrial complex into the latest peculiar institution for managing race relations in the United States (Waquant, Chapter 39), constitute the “small wars and invisible genocides” to which we refer. This applies to African American and Latino youth mortality statistics in Oakland, California, Baltimore, Washington DC, and New York City. These are “invisible” genocides not because they are secreted away or hidden from view, but quite the opposite.  As Wittgenstein observed, the things that are hardest to perceive are those which are right before our eyes and therefore taken for granted. In this regard, Bourdieu’s partial and unfinished theory of violence (see Chapters 32 and 42) as well as his concept of misrecognition is crucial to our task. By including the normative everyday forms of violence hidden in the minutiae of “normal” social practices - in the architecture of homes, in gender relations, in communal work, in the exchange of gifts, and so forth - Bourdieu forces us to reconsider the broader meanings and status of violence, especially the links between the violence of everyday life and explicit political terror and state repression, Similarly, Basaglia’s notion of “peacetime crimes” - crimini di pace - imagines a direct relationship between wartime and peacetime violence. Peacetime crimes suggests the possibility that war crimes are merely ordinary, everyday crimes of public consent applied systematically and dramatically in the extreme context of war. Consider the parallel uses of rape during peacetime and wartime, or the family resemblances between the legalized violence of US immigration and naturalization border raids on “illegal aliens” versus the US government- engineered genocide in 1938, known as the Cherokee “Trail of Tears.” Peacetime crimes suggests that everyday forms of state violence make a certain kind of domestic peace possible.  Internal “stability” is purchased with the currency of peacetime crimes, many of which take the form of professionally applied “strangle-holds.” Everyday forms of state violence during peacetime make a certain kind of domestic “peace” possible. It is an easy-to-identify peacetime crime that is usually maintained as a public secret by the government and by a scared or apathetic populace. Most subtly, but no less politically or structurally, the phenomenal growth in the United States of a new military, postindustrial prison industrial complex has taken place in the absence of broad-based opposition, let alone collective acts of civil disobedience. The public consensus is based primarily on a new mobilization of an old fear of the mob, the mugger, the rapist, the Black man, the undeserving poor. How many public executions of mentally deficient prisoners in the United States are needed to make life feel more secure for the affluent? What can it possibly mean when incarceration becomes the “normative” socializing experience for ethnic minority youth in a society, i.e., over 33 percent of young African American men (Prison Watch 2002).  In the end it is essential that we recognize the existence of a genocidal capacity among otherwise good-enough humans and that we need to exercise a defensive hypervigilance to the less dramatic, permitted, and even rewarded everyday acts of violence that render participation in genocidal acts and policies possible (under adverse political or economic conditions), perhaps more easily than we would like to recognize. Under the violence continuum we include, therefore, all expressions of radical social exclusion, dehumanization, depersonal- ization, pseudospeciation, and reification which normalize atrocious behavior and violence toward others. A constant self-mobilization for alarm, a state of constant hyperarousal is, perhaps, a reasonable response to Benjamin’s view of late modern history as a chronic “state of emergency” (Taussig, Chapter 31). We are trying to recover here the classic anagogic thinking that enabled Erving Goffman, Jules Henry, C. Wright Mills, and Franco Basaglia among other mid-twentieth-century radically critical thinkers, to perceive the symbolic and structural relations, i.e., between inmates and patients, between concentration camps, prisons, mental hospitals, nursing homes, and other “total institutions.” Making that decisive move to recognize the continuum of violence allows us to see the capacity and the willingness - if not enthusiasm - of ordinary people, the practical technicians of the social consensus, to enforce genocidal-like crimes against categories of rubbish people. There is no primary impulse out of which mass violence and genocide are born, it is ingrained in the common sense of everyday social life.  The mad, the differently abled, the mentally vulnerable have often fallen into this category of the unworthy living, as have the very old and infirm, the sick-poor, and, of course, the despised racial, religious, sexual, and ethnic groups of the moment. Erik Erikson referred to “pseudo- speciation” as the human tendency to classify some individuals or social groups as less than fully human - a prerequisite to genocide and one that is carefully honed during the unremark- able peacetimes that precede the sudden, “seemingly unintelligible” outbreaks of mass violence. Collective denial and misrecognition are prerequisites for mass violence and genocide. But so are formal bureaucratic structures and professional roles. The practical technicians of everyday violence in the backlands of Northeast Brazil (Scheper-Hughes, Chapter 33), for example, include the clinic doctors who prescribe powerful tranquilizers to fretful and frightfully hungry babies, the Catholic priests who celebrate the death of “angel-babies,” and the municipal bureaucrats who dispense free baby coffins but no food to hungry families.  Everyday violence encompasses the implicit, legitimate, and routinized forms of violence inherent in particular social, economic, and political formations. It is close to what Bourdieu (1977, 1996) means by “symbolic violence,” the violence that is often “nus-recognized” for something else, usually something good. Everyday violence is similar to what Taussig (1989) calls “terror as usual.” All these terms are meant to reveal a public secret - the hidden links between violence in war and violence in peace, and between war crimes and “peace-time crimes.” Bourdieu (1977) finds domination and violence in the least likely places - in courtship and marriage, in the exchange of gifts, in systems of classification, in style, art, and culinary taste- the various uses of culture. Violence, Bourdieu insists, is everywhere in social practice. It is misrecognized because its very everydayness and its familiarity render it invisible. Lacan identifies “rneconnaissance” as the prerequisite of the social. The exploitation of bachelor sons, robbing them of autonomy, independence, and progeny, within the structures of family farming in the European countryside that Bourdieu escaped is a case in point (Bourdieu, Chapter 42; see also Scheper-Hughes, 2000b; Favret-Saada, 1989).  Following Gramsci, Foucault, Sartre, Arendt, and other modern theorists of power-vio- lence, Bourdieu treats direct aggression and physical violence as a crude, uneconomical mode of domination; it is less efficient and, according to Arendt (1969), it is certainly less legitimate.  While power and symbolic domination are not to be equated with violence - and Arendt argues persuasively that violence is to be understood as a failure of power - violence, as we are presenting it here, is more than simply the expression of illegitimate physical force against a person or group of persons. Rather, we need to understand violence as encompassing all forms of “controlling processes” (Nader 1997b) that assault basic human freedoms and individual or collective survival. Our task is to recognize these gray zones of violence which are, by definition, not obvious. Once again, the point of bringing into the discourses on genocide everyday, normative experiences of reification, depersonalization, institutional confinement, and acceptable death is to help answer the question: What makes mass violence and genocide possible? In this volume we are suggesting that mass violence is part of a continuum, and that it is socially incremental and often experienced by perpetrators, collaborators, bystanders - and even by victims themselves - as expected, routine, even justified. The preparations for mass killing can be found in social sentiments and institutions from the family, to schools, churches, hospitals, and the military. They harbor the early “warning signs” (Charney 1991), the “priming” (as Hinton, ed., 2002 calls it), or the “genocidal continuum” (as we call it) that push social consensus toward devaluing certain forms of human life and lifeways from the refusal of social support and humane care to vulnerable “social parasites” (the nursing home elderly, “welfare queens,” undocumented immigrants, drug addicts) to the militarization of everyday life (super-maximum-security prisons, capital punishment; the technologies of heightened personal security, including the house gun and gated communities; and reversed feelings of victimization).

#### Structural violence has no intervening actors- it’s definitionally supported by the system- means outside actors like debate fiat are key to solving

#### Waiting for reform to prevent catastrophic events is the elite telling you to not change the system- productive reformations of those systems collapses their calculus

Olson 2015 [Elizabeth Olson, professor of geography at UNC Chapel Hill, ‘Geography and Ethics I: Waiting and Urgency,’ *Progress in Human Geography*, vol. 39 no. 4, pp. 517-526] //CJC

Though toileting might be thought of as a special case of bodily urgency, geographic research suggests that the body is increasingly set at odds with larger scale ethical concerns, especially *large-scale future events of forecasted suffering*. Emergency planning is a particularly good example in which the large-scale threats of future suffering can distort moral reasoning. Žižek (2006) lightly develops this point in the context of the war on terror, where in the presence of fictitious and real ticking clocks and warning systems, the urgent body must be bypassed because there are bigger scales to worry about:¶ What does this all-pervasive sense of urgency mean ethically? The pressure of events is so overbearing, the stakes are so high, that they nec           essitate a suspension of ordinary ethical concerns. After all, displaying moral qualms when the lives of millions are at stake plays into the hands of the enemy. (Žižek, 2006)¶ In the presence of large-scale future emergency, the urgency to secure the state, the citizenry, the economy, or the climate creates new scales and new temporal orders of response (see Anderson, 2010; Baldwin, 2012; Dalby, 2013; Morrissey, 2012), many of which treat the urgent body as impulsive and thus requiring management. McDonald’s (2013) analysis of three interconnected discourses of ‘climate security’ illustrates how bodily urgency in climate change is also recast as a menacing impulse that might require exclusion from moral reckoning. The logics of climate security, especially those related to national security, ‘can encourage perverse political responses that not only fail to respond effectively to climate change but may present victims of it as a threat’ (McDonald, 2013: 49). Bodies that are currently suffering cannot be urgent, because they are excluded from the potential collectivity that could be suffering everywhere in some future time. Similar bypassing of existing bodily urgency is echoed in writing about violent securitization, such as drone warfare (Shaw and Akhter, 2012), and also in *intimate scales* like the street and the school, especially in relation to race (Mitchell, 2009; Young et al., 2014).¶ As *large-scale urgent concerns are institutionalized*, the urgent body is increasingly obscured through technical planning and coordination (Anderson and Adey, 2012). The predominant characteristic of this institutionalization of large-scale emergency is a ‘built-in bias for action’ (Wuthnow, 2010: 212) *that circumvents contingencies*. The urgent body is at best an assumed eventuality, one that will likely require another state of waiting, such as *triage* (e.g. Greatbach et al., 2005). Amin (2013) cautions that in much of the West, governmental need to provide evidence of laissez-faire governing on the one hand, and assurance of strength in facing a threatening future on the other, produces ‘just-in-case preparedness’ (Amin, 2013: 151) of neoliberal risk management policies. In the US, ‘personal ingenuity’ is built into emergency response at the expense of the poor and vulnerable for whom ‘[t]he difference between abjection and bearable survival’ (Amin, 2013: 153) will not be determined by emergency planning, but in the material infrastructure of the city.¶ In short, the urgencies of the body provide justifications for social exclusion of the most marginalized based on impulse and perceived threat, while large-scale future emergencies effectively absorb the deliberative power of urgency into the institutions of preparedness and risk avoidance. Žižek references Arendt’s (2006) analysis of the banality of evil to explain the current state of ethical reasoning under the war on terror, noting that people who perform morally reprehensible actions under the conditions of urgency assume a ‘tragic-ethic grandeur’ (Žižek, 2006) by sacrificing their own morality for the good of the state. But his analysis fails to note that bodies are today so rarely legitimate sites for claiming urgency. In the context of the assumed priority of the large-scale future emergency, the urgent body becomes literally nonsense, a non sequitur within societies, states and worlds that will always be more urgent.¶ If the important ethical work of urgency has been to identify that which must not wait, then the capture of the power and persuasiveness of urgency by large-scale future emergencies has consequences for the kinds of normative arguments we can raise on behalf of urgent bodies. How, then, might waiting compare as a normative description and critique in our own urgent time? Waiting can be categorized according to its purpose or outcome (see Corbridge, 2004; Gray, 2011), but it also modifies the place of the individual in society and her importance. As Ramdas (2012: 834) writes, ‘waiting … produces hierarchies which segregate people and places into those which matter and those which do not’. The segregation of waiting might produce effects that counteract suffering, however, and Jeffery (2008: 957) explains that though the ‘politics of waiting’ can be repressive, it can also engender creative political engagement. In his research with educated unemployed Jat youth who spend days and years waiting for desired employment, Jeffery finds that ‘the temporal suffering and sense of ambivalence experienced by young men can generate cultural and political experiments that, in turn, have marked social and spatial effects’ (Jeffery, 2010: 186). Though this is not the same as claiming normative neutrality for waiting, it does suggest that waiting is more ethically ambivalent and open than urgency.¶ In other contexts, however, our descriptions of waiting indicate a strong condemnation of its effects upon the subjects of study. Waiting can demobilize radical reform, depoliticizing ‘the insurrectionary possibilities of the present by delaying the revolutionary imperative to a future moment that is forever drifting towards infinity’ (Springer, 2014: 407). Yonucu’s (2011) analysis of the self-destructive activities of disrespected working-class youth in Istanbul suggests that this sense of infinite waiting can lead not only to depoliticization, but also to a disbelief in the possibility of a future self of any value. Waiting, like urgency, can undermine the possibility of self-care two-fold, first by making people wait for essential needs, and again by reinforcing that waiting is ‘[s]omething to be ashamed of because it may be noted or taken as evidence of indolence or low status, seen as a symptom of rejection or a signal to exclude’ (Bauman, 2004: 109). This is why Auyero (2012) suggests that waiting creates an ideal state subject, providing ‘temporal processes in and through which political subordination is produced’ (Auyero, 2012: loc. 90; see also Secor, 2007). Furthermore, Auyero notes, it is not only political subordination, but the subjective effect of waiting that secures domination, as citizens and non-citizens find themselves ‘waiting hopefully and then frustratedly for others to make decisions, and in effect surrendering to the authority of others’ (Auyero, 2012: loc. 123).¶ Waiting can therefore function as a potentially important spatial technology of the elite and powerful, mobilized not only for the purpose of governing individuals, but also to retain claims over moral urgency. But there is growing resistance to the capture of claims of urgency by the elite, and it is important to note that even in cases where the material conditions of containment are currently impenetrable, arguments based on human value are at the forefront of reclaiming urgency for the body. In detention centers, clandestine prisons, state borders and refugee camps, geographers point to ongoing struggles against the ethical impossibility of bodily urgency and a rejection of states of waiting (see Conlon, 2011; Darling, 2009, 2011; Garmany, 2012; Mountz et al., 2013; Schuster, 2011). Ramakrishnan’s (2014) analysis of a Delhi resettlement colony and Shewly’s (2013) discussion of the enclave between India and Bangladesh describe people who refuse to give up their own status as legitimately urgent, even in the context of larger scale politics. Similarly, Tyler’s (2013) account of desperate female detainees stripping off their clothes to expose their humanness and suffering in the Yarl’s Wood Immigration Removal Centre in the UK suggests that demands for recognition are not just about politics, but also about the acknowledgement of humanness and the irrevocable possibility of being that which cannot wait. The continued existence of places like Yarl’s Wood and similar institutions in the USA nonetheless points to the challenge of exposing the urgent body as a moral priority when it is so easily hidden from view, and also reminds us that our research can help to explain the relationships between normative dimensions and the political and social conditions of struggle.¶ In closing, geographic depictions of waiting do seem to evocatively describe otherwise obscured suffering (e.g. Bennett, 2011), but it is striking how rarely these descriptions also use the language of urgency. Given the discussion above, what might be accomplished – and risked – by incorporating urgency more overtly and deliberately into our discussions of waiting, surplus and abandoned bodies? Urgency can clarify the implicit but understated ethical consequences and normativity associated with waiting, and encourage explicit discussion about harmful suffering. Waiting can be productive or unproductive for radical praxis, but urgency compels and requires response. Geographers could be instrumental in reclaiming the ethical work of urgency in ways that leave it open for critique, clarifying common spatial misunderstandings and representations. There is good reason to be thoughtful in this process, since moral outrage towards inhumanity can itself obscure differentiated experiences of being human, dividing up ‘those for whom we feel urgent unreasoned concern and those whose lives and deaths simply do not touch us, or do not appear as lives at all’ (Butler, 2009: 50). But when the urgent body is rendered as only waiting, both materially and discursively, it is just as easily cast as impulsive, disgusting, animalistic (see also McKittrick, 2006). Feminist theory insists that the urgent body, whose encounters of violence are ‘usually framed as private, apolitical and mundane’ (Pain, 2014: 8), are as deeply political, public, and exceptional as other forms of violence (Phillips, 2008; Pratt, 2005). Insisting that a suffering body, now, is that which cannot wait, has the ethical effect of drawing it into consideration alongside the political, public and exceptional scope of large-scale futures. It may help us insist on the body, both as a single unit and a plurality, as a legitimate scale of normative priority and social care.¶ In this report, I have explored old and new reflections on the ethical work of urgency and waiting. Geographic research suggests a contemporary popular bias towards the urgency of large-scale futures, institutionalized in ways that further obscure and discredit the urgencies of the body. This bias also justifies the production of new waiting places in our material landscape, places like the detention center and the waiting room. In some cases, waiting is normatively neutral, even providing opportunities for alternative politics. In others, the technologies of waiting serve to manage potentially problematic bodies, leading to suspended suffering and even to extermination (e.g. Wright, 2013). One of my aims has been to suggest that moral reasoning is important both because it exposes normative biases against subjugated people, and because it potentially provides routes toward struggle where claims to urgency seem to foreclose the possibilities of alleviation of suffering. Saving the world still should require a debate about whose world is being saved, when, and at what cost – and this requires a debate about what really cannot wait. My next report will extend some of these concerns by reviewing how feelings of urgency, as well as hope, fear, and other emotions, have played a role in geography and ethical reasoning.¶ I conclude, however, by pulling together past and present. In 1972, Gilbert White asked why geographers were not engaging ‘the truly urgent questions’ (1972: 101) such as racial repression, decaying cities, economic inequality, and global environmental destruction. His question highlights just how much the discipline has changed, but it is also unnerving in its echoes of our contemporary problems. Since White’s writing, our moral reasoning has been stretched to consider the future body and the more-than-human, alongside the presently urgent body – topics and concerns that I have not taken up in this review but which will provide their own new possibilities for urgent concerns. My own hope presently is drawn from an acknowledgement that the temporal characteristics of contemporary capitalism can be interrupted in creative ways (Sharma, 2014), with the possibility of squaring the urgent body with our large-scale future concerns. *Temporal alternatives already exist in ongoing and emerging revolutions*

and the disruption of claims of cycles and circular political processes (e.g. Lombard, 2013; Reyes, 2012). Though calls for urgency will certainly be used to obscure evasion of responsibility (e.g. Gilmore, 2008: 56, fn 6), they may also serve as fertile ground for radical critique, a truly fierce urgency for now.