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## Adv – Covid

#### Covid surge has spelt economic disparity where India’s instability is escalating tensions and sparking standoffs which explode due to deteriorating relations with China sparking worry, miscalculation and escalation

CFR 21

Council on Foreign Relations. “The Strategic Consequences of India's COVID-19 Crisis.” Council on Foreign Relations, Council on Foreign Relations, 28 Apr. 2021, [www.cfr.org/blog/strategic-consequences-indias-covid-19-crisis. //](http://www.cfr.org/blog/strategic-consequences-indias-covid-19-crisis.%20//) JoshDrills

Last week, as the magnitude of the second wave of India’s coronavirus surge became increasingly clear to the world, U.S. policymakers soon began to appreciate the strategic implications of India’s national trauma. Over the weekend, President Joe Biden and his top officials [publicly pledged](https://twitter.com/POTUS/status/1386401947729633280?s=20) their commitments to send medical supplies, including oxygen, vaccine materials, and therapeutics to India, while seeking additional ways to address India’s crisis. **COVID-19** already inflicted a **crushing blow to India’s economy** last year. A national lockdown instituted by Prime Minister Narendra Modi at the early stages of the global pandemic was intended to relieve the stresses on Indian’s inadequate healthcare system, but it also delivered a [24 percent contraction in the economy](https://www.nytimes.com/2020/08/31/world/asia/india-economy-gdp.html) and led millions of migrant day laborers to flee India’s cities for lack of work. Through the late fall and winter, it seemed that somehow India would escape the worst of the pandemic, but that hope has now been dashed by a **devastating** combination of **new viral strains** and inadequate public health preparations**. India** now **faces** this wave of the virus exhausted and depleted. The Biden administration clearly [appreciates](https://timesofindia.indiatimes.com/india/covid-19-india-is-going-through-very-terrible-situation-says-dr-anthony-fauci/articleshow/82229075.cms) that the magnitude of India’s crisis turns it into a **global crisis**. With over **1.3 billion people**, India alone counts for one-sixth of humanity. And India’s crisis will not be contained within its borders. New viral strains out of India could worsen the **health threat** to all. Other second-order economic consequences will follow; at the very least, India’s lost economic productivity will **hurt global trade** and investment. Yet the geopolitical implicationsof India’s tragedy must also be keenly felt by the new Biden administration. After his election, the president’s top national security officials quickly established the aim of closer partnership with New Delhi as a cornerstone in the U.S. strategy for competition with Beijing. India’s role was highlighted by President Biden’s decision to host a virtual “[leaders’ summit](https://www.nbcnews.com/news/world/biden-set-first-summit-quad-leaders-u-s-steps-efforts-n1260721)” of the Quad in March, and by U.S. Secretary of Defense Lloyd Austin’s three-day [visit](https://thediplomat.com/2021/03/us-defense-secretary-austins-visit-to-india-a-sign-of-closer-india-us-security-ties/) to India shortly thereafter. **Hav**ing made a **strategic bet** on **India as** an important Asian **counterweight to China**, U.S. concerns about Indian health, economic growth, and **political stability** are not purely altruistic or humanitarian. As a number of prominent Indian foreign policy [analysts](https://carnegieindia.org/2021/04/23/to-friends-in-united-states-facilitate-global-vaccine-manufacturing-pub-84392) observed in the days before the Biden administration announced its plans to assist India, the promise of U.S. partnership would be severely **undermined** from India's perspective if Washington were to fall short in such a time of need. In the midst of **immense suffering**, it is tempting to assume that India’s situation could not get worse. However, the reality is that India was already facing an entirely different, daunting threat to its national security prior to this new viral wave: [a year of **heightened tensions**](https://www.bbc.com/news/world-asia-53062484) and unusual levels of violence along its contested border with China. Many of the causes of **deteriorating relations** between India and China remain unaddressed. The two sides have taken some initial steps to disengage **from** their **border conflict** in the Himalayas in early 2021, but in recent weeks their bilateral military dialogues have [stalled](https://www.financialexpress.com/defence/china-refuses-to-vacate-four-friction-points-in-ladakh-heres-everything-you-need-to-know-about-gogra-and-hot-springs/2236611/) without progress. If **Beijing** were **to seek** a **territorial advantage from India’s** ongoing **health emergency**, the compounding of multiple **crises** would **complicate New Delhi’s decision-making and** would **increas**e the **potential for** policy **miscalculation**s **and** otherwise **avoidable** **armed escalation**. The Biden administration should help India here too. As I argue in an [update of an earlier CFR Contingency Planning Memorandum](https://www.cfr.org/report/preparing-heightened-tensions-between-china-and-india) on the **risk of armed conflict** between China and India, the United States has a strong interest in preventing military escalation along their border. Through carefully calibrated defensive assistance to India, the United States can help it deter China without taking steps that make conflict more likely. Other diplomatic and economic measures can improve India’s defenses and resilience in the face of Chinese aggression, lessen regional tensions, and prepare U.S. policymakers in the event of another Himalayan standoff this year.

#### Nuke war causes extinction AND outweighs other existential risks

PND 16. internally citing Zbigniew Brzezinski, Council of Foreign Relations and former national security adviser to President Carter, Toon and Robock’s 2012 study on nuclear winter in the Bulletin of Atomic Scientists, Gareth Evans’ International Commission on Nuclear Non-proliferation and Disarmament Report, Congressional EMP studies, studies on nuclear winter by Seth Baum of the Global Catastrophic Risk Institute and Martin Hellman of Stanford University, and U.S. and Russian former Defense Secretaries and former heads of nuclear missile forces, brief submitted to the United Nations General Assembly, Open-Ended Working Group on nuclear risks. A/AC.286/NGO/13. 05-03-2016. http://www.reachingcriticalwill.org/images/documents/Disarmament-fora/OEWG/2016/Documents/NGO13.pdf

Consequences human survival 12. Even if the 'other' side does NOT launch in response the smoke from 'their' burning cities (incinerated by 'us') will still make 'our' country (and the rest of the world) uninhabitable, potentially inducing global famine lasting up to decades. Toon and Robock note in ‘Self Assured Destruction’, in the Bulletin of Atomic Scientists 68/5, 2012, that: 13. “A nuclear war between Russia and the United States, even after the arsenal reductions planned under New START, could produce a nuclear winter. Hence, an attack by either side could be suicidal, resulting in self assured destruction. Even a 'small' nuclear war between India and Pakistan, with each country detonating 50 Hiroshima-size atom bombs--only about 0.03 percent of the global nuclear arsenal's explosive power--as air bursts in urban areas, could produce so much smoke that temperatures would fall below those of the Little Ice Age of the fourteenth to nineteenth centuries, shortening the growing season around the world and threatening the global food supply. Furthermore, there would be massive ozone depletion, allowing more ultraviolet radiation to reach Earth's surface. Recent studies predict that agricultural production in parts of the United States and China would decline by about 20 percent for four years, and by 10 percent for a decade.” 14. A conflagration involving USA/NATO forces and those of Russian federation would most likely cause the deaths of most/nearly all/all humans (and severely impact/extinguish other species)

## Adv – Zoonotic

#### Locking preparatory research and techniques behind patents hinder global innovation and access to Zoonotic disease treatments

Thomas 21 Patented technologies in zoonotic vaccines: Are they truly serving as bridge or barrier to human healthcare? - Linkedin post. Preprint · February 2021 Patented technologies in zoonotic vaccines: Are they truly serving as bridge or barrier to human healthcare? Ansu Thomas <https://www.researchgate.net/publication/349029311_Patented_technologies_in_zoonotic_vaccines_Are_they_truly_serving_as_bridge_or_barrier_to_human_healthcare_-_Linkedin_post> //avery

World Organization for Animal Health (OIE) stated that 60% of global infectious diseases are zoonotic and 75% of emerging global infectious diseases have animal origin. World Health Organization-identified 200 diseases have been found to be zoonotic. Infectious, zoonotic disease frequency rises up with human encroachment into the wilderness, new millennial climate change, across-the-seas travel and or trade. How does one own a patent for a zoonotic vaccine when the origination root source of clinical data was empirically derived through vaccine application on scores of this humanity pool segment? The vaccine on reaching the state of perfection, vaccine program investor starts owning the knowledge on that vaccine wherein the instrumental knowledge-provider (tested base population) disowns their right to use that knowledge (now locked as patent) and or vaccine for free. Let us read and ponder verbatim the egalitarian wordings on Elsevier website: “Since January 2020 Elsevier created a COVID-19 resource centre (hosted on Elsevier Connect) as free information on novel coronavirus COVID- 19. Elsevier hereby grants FREE permission to make all its COVID19-related research available on COVID-19 resource centre - immediately available in PubMed Central and other publicly funded repositories, such as WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of original source”. Likewise, patentability upon a pandemic disease vaccine must be globally declared null and void by a UN treaty amongst all member nations. Just the endemic diseasevaccines however could be regionally exempted from this Universal nullifying authority for patentability. Life-saving vaccine manufacture involves three phases: procuring biological raw material, preparatory techniques and quality success rating. The raw material (as causative organism) is sourced from diseased and suffering humanity. Quality success rating is determined after years of trialed testing. Where is the question of patent ownership rights when only the preparatory techniques alone stand ethically guarded by Intellectual Property System and not the other entities? Deprivation of rights on other peer manufacturers as new entrants to vaccine manufacture is unethical, illogical and contravention of human rights-to-healthy living, quashing even inter-generational equity on utilization of vaccines. In this new millennial age of a series of pandemics, an international access to Intellectual property must be granted to interested manufacturers or government or state-owned enterprises bodies for the protection of public community health at the outset. Tailored collaborative licensing builds zone-specific research as well as a region-specific vaccine development through a sustained freedom to operate. A nominal price Royalty margin values upon the sale of every unit of vaccine sale could also sensibly protect the earnings of pandemic vaccine patent holder (specifically on the preparatory techniques). Knowledge production and knowledge sharing of zoonotic vaccine research observations and results and equally protecting the patent and its applications is suggested. Inaccessibility to the preparatory techniques prevents innovations and access on a global perspective. A one-earth and one-health thinking, approach and strategy can save the human population much faster from future pandemics awaiting on timeline.

#### Zoonotic Diseases will be used by terrorists

Lin 15 Impacts on Human Health Caused by Zoonoses 10 Chao-Nan Lin C.-N. Lin (\*) Department of Veterinary Medicine, National Pingtung University of Science and Technology, Pingtung, Taiwan, Republic of China <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7124013/> //avery

Zoonosis is an infectious disease that is transmitted between animals and humans. Zoonosis comes from the Greek words “zoon” and “osis,” which represent “animal” and “ill,” respectively. In a systematic review of 1,415 species of pathogens known to infect humans, 868 (61 %) were zoonotic. Unfortunately, the majority of emerging infectious diseases over the last three decades have been zoonotic (Taylor et al. 2001). Most zoonoses are often previously unrecognized diseases or have increased virulence in populations lacking immunity, such as henipavirus (Marsh and Wang 2012), severe acute respiratory syndrome (SARS), and influenza virus (swine-origin H1N1 or avian influenza H5N1) (Tseng 2007). The major factor influencing the appearance of novel zoonotic diseases in the human population is increased contact between humans and wildlife, such as (i) encroachment of human activity into wilderness areas and (ii) movement of wild animals into areas of human activity (Daszak et al. 2001). Zoonoses are potential bioterrorism agents (Ryan 2008). Terrorist attacks using conventional weapons cause fear, havoc, illness, and death. Bioterrorism agents include bacteria, viruses, fungal, rickettsial or chlamydial organisms, and toxins, i.e., they can be transmitted between animals and humans (Spencer 2007). The potential for a bioterrorist attack is no longer a debate of “if” but “when” one will occur. It is impossible to predict when, where, or how bioterrorism will occur (Ippolito et al. 2006). Therefore, the control and prevention of these diseases in animals can also be accomplished to reduce disease transmission between humans and other animals. This chapter documents the history, agents, routes of exposure, detection, monitoring, and prevention of zoonotic pathogens. Zoonoses Likely to Be Used in Bioterrorism Bioterrorism aimed at a society, government, and/or its citizens is meant to cause destabilization, fear, anxiety, illness, and death in people, animals, or plants (BalaliMood et al. 2013). According to the US Centers for Disease Control and Prevention (CDC), a bioterrorism attack is the intentional release of biological agents such as viruses, bacteria, fungi, rickettsial or chlamydial organisms, toxins, or other harmful agents that cause illness or death in people, animals, or plants (Balali-Mood et al. 2013). These biological agents can be spread through the air, water, or food. The intended use of biological agents might target humans directly or might be used to disrupt an economy. The disease caused by anthrax was directed at animal populations as early as World War I. Glanders, a virulent disease in horses and mules, was used in the 1910s. Typhoid was reported in a water supply in the 1970s. 212 C.-N. Lin In September and October 2001, several cases of anthrax occurred in the United States. Letters laced with infectious anthrax were concurrently delivered to the US Congress and news media offices (Spencer 2007). Zoonotic Pathogens The US CDC categorizes biological toxins and bioterrorism agents as A, B, and C. Category A includes high-priority agents that pose a risk to national security because they (i) can be easily transmitted and disseminated from person to person, (ii) cause high mortality and have potentially major public health impacts, (iii) may cause public panic and social disruption, and (iv) require special action for public health preparedness. Category A agents include anthrax, plague, tularemia, botulism, filovirus, and smallpox. Category B, the second highest priority agents, includes pathogens that (i) are moderately easy to disseminate, (ii) cause moderate morbidity and low mortality rates, and (iii) require specific enhancements to the CDC’s diagnostic capacity and disease surveillance ability. Category B agents include brucellosis, epsilon toxin, glanders, melioidosis, psittacosis, Q fever, ricin toxin, food safety threats, staphylococcal enterotoxin B, typhus fever, viral encephalitis, and water safety threats. Category C, the third highest priority agents, includes emerging pathogens that may be engineered for mass dissemination in the future because of (i) their availability, (ii) ease of production and dissemination, and (iii) potential for high morbidity and mortality rates and ability to cause major health effects. Category C agents include Nipah virus and hantavirus. Other zoonotic pathogens, such as rabies, West Nile virus, and Streptococcus suis type II, will also be discussed briefly. Table 1 summarizes the organisms and their classification by the US CDC.

#### Bioterrorism causes Extinction – overcomes any conventional defense.

Walsh 19, Bryan. End Times: A Brief Guide to the End of the World. Hachette Books, 2019. (Future Correspondent for Axios, Editor of the Science and Technology Publication OneZero, Former Senior and International Editor at Time Magazine, BA from Princeton University)//Elmer

I’ve lived through disease outbreaks, and in the previous chapter I showed just how unprepared we are to face a widespread pandemic of flu or another new pathogen like SARS. But a deliberate outbreak caused by an engineered pathogen would be far worse. We would face the same agonizing decisions that must be made during a natural pandemic: whether to ban travel from affected regions, how to keep overburdened hospitals working as the rolls of the sick grew, how to accelerate the development and distribution of vaccines and drugs. To that dire list add the terror that would spread once it became clear that the death and disease in our midst was not the random work of nature, but a deliberate act of malice. We’re scared of disease outbreaks and we’re scared of terrorism—put them together and you have a formula for chaos. As deadly and as disruptive as a conventional bioterror incident would be, an attack that employed existing pathogens could only spread so far, limited by the same laws of evolution that circumscribe natural disease outbreaks. But a virus engineered in a lab to break those laws could spread faster and kill quicker than anything that would emerge out of nature. It can be designed to evade medical countermeasures, frustrating doctors’ attempts to diagnose cases and treat patients. If health officials manage to stamp out the outbreak, it could be reintroduced into the public again and again. It could, with the right mix of genetic traits, even wipe us off the planet, making engineered viruses a genuine existential threat. And such an attack may not even be that difficult to carry out. Thanks to advances in biotechnology that have rapidly reduced the skill level and funding needed to perform gene editing and engineering, what might have once required the work of an army of virologists employed by a nation-state could soon be done by a handful of talented and trained individuals. Or maybe just one. When Melinda Gates was asked at the South by Southwest conference in 2018 to identify what she saw as the biggest threat facing the world over the next decade, she didn’t hesitate: “A bioterrorism event. Definitely.”2 She’s far from alone. In 2016, President Obama’s director of national intelligence James Clapper identified CRISPR as a “weapon of mass destruction,” a category usually reserved for known nightmares like nuclear bombs and chemical weapons. A 2018 report from the National Academies of Sciences concluded that biotechnology had rewritten what was possible in creating new weapons, while also increasing the range of people capable of carrying out such attacks.3 That’s a fatal combination, one that plausibly threatens the future of humanity like nothing else. “The existential threat that would be most available for someone, if they felt like doing something, would be a bioweapon,” said Eric Klien, founder of the Lifeboat Foundation, a nonprofit dedicated to helping humanity survive existential risks. “It would not be hard for a small group of people, maybe even just two or three people, to kill a hundred million people using a bioweapon. There are probably a million people currently on the planet who would have the technical knowledge to pull this off. It’s actually surprising that it hasn’t happened yet.”

#### Zoonotic bioweapons cause mass biodiversity destruction

Dudley and Woodford 02 Bioweapons, Biodiversity, and Ecocide: Potential Effects of Biological Weapons on Biological Diversity: Bioweapon disease outbreaks could cause the extinction of endangered wildlife species, the erosion of genetic diversity in domesticated plants and animals, the destruction of traditional human livelihoods, and the extirpation of indigenous cultures Joseph P. Dudley, Michael H. Woodford Author Notes BioScience, Volume 52, Issue 7, July 2002, Pages 583–592, [https://doi.org/10.1641/0006-3568(2002)052[0583:BBAEPE]2.0.CO;2](https://doi.org/10.1641/0006-3568(2002)052%5b0583:BBAEPE%5d2.0.CO;2) Published: 01 July 2002 //avery

Efforts to control human disease epidemics resulting from plague and tularemia bioweapon attacks will need to take into account the eradication of potential animal reservoirs and insect vectors once initial outbreaks among human populations have been contained ([Alibek and Handelman 2000](javascript:;)). As potential disease reservoirs, rare or endangered species populations within affected areas may be subject to eradication as well. Thus, endangered species now restricted to a few relict and isolated populations within highly urbanized landscapes (e.g., Stephen's Kangagroo Rat, Dipodomys stephensi) could be at high risk for extinction under such circumstances. It is worth noting in this context that an extraordinarily high number of endangered and threatened species (including D. stephensi) are now largely or entirely restricted to habitats located in and around US military installations and military training ranges, which could be potential targets of bioweapons attacks; more than 220 federally listed threatened or endangered species have been confirmed as residents or migrants on US military lands. Although military lands represent only about 3% of all US federal lands, they contain disproportionately high percentages of habitat for endangered species of plants and animals ([Leslie et al. 1996](javascript:;)).

Wild plant and animal species that are naturally rare and species that have been severely depleted in numbers from overharvesting or habitat degradation are particularly susceptible to extinction by introduced diseases ([Dobson and May 1986](javascript:;)). Diseases to which humans and human commensals have developed immunity or high levels of resistance may cause catastrophic mortality in naive and susceptible wildlife populations. Small absolute population sizes, inbreeding depression, and exposure to exotic disease organisms are a potential recipe for the extinction of endangered and threatened wildlife species ([Singer et al. 2001](javascript:;)). There needs to be much wider recognition by scientists and the public of the danger that diseases of domesticated animals and humans pose for wildlife and endangered species populations, and of the pivotal role of human interventions in fostering the introduction and establishment of exotic diseases of plants and animals to new areas ([Dudley 1993](javascript:;), [Daszak et al. 2000](javascript:;)). Bioweapon applications are only the most extreme example of the larger invasive species problems associated with the introductions of exotic diseases and organisms to new areas as the result of deliberate or inadvertent human activities.

The potentially devastating harm of even localized disease outbreaks on endangered species is illustrated by the effects of canine distemper on the North American black-footed ferret (Mustela nigripes), the Caspian seal (Phoca caspica), and the African wild dog (Lycaon pictus). Canine distemper is a common viral disease of domesticated dogs that can spill over into wildlife populations, with appalling results on susceptible species of wild carnivores. Disturbingly, canine distemper is also a disease that has been cultured and tested in bioweapon laboratories ([Kortepeter et al. 2001](javascript:;)). During the past decade, canine distemper outbreaks resulted in the extinction of the last known wild population of the North American black-footed ferret and the African wild dog population of the Serengeti National Park in Tanzania ([Daszak et al. 2000](javascript:;)). Habitat loss and persecution, exacerbated by the effects of canine distemper on ferrets and sylvatic plague on prey populations (prairie dogs), caused the decline and ultimate extinction of black-footed ferrets from their formerly vast range within the Great Plains region of North America. Similarly, persecution and predator-control operations have reduced the once widely distributed African wild dog to a few small and scattered populations that are now gravely threatened by spillover infections of canine distemper and rabies from domestic dog populations ([Ginsberg et al. 1995](javascript:;)). An outbreak of distemper in the Serengeti region of Tanzania during the early 1990s caused the extirpation of the resident wild dog population and the death of approximately one-third of the Serengeti's resident lion population. The small resident population of endangered cheetah (Acinonyx jubatus) could have been driven to the verge of extinction in the Serengeti had they experienced rates of distemper morbidity and mortality comparable to that observed among African wild dogs and lions at this site ([Kelly 2001](javascript:;)).

Livestock breed conservation is important for the retention of the genetic raw material for morphological and physiological adaptations that may provide enhanced resistance to insects, parasites, and disease and to the effects of climate, altitude, solar radiation, and other key environmental factors. Worldwide, there are approximately 4000 recognized breeds and local breed varieties of the principal domesticated livestock species (ass, cattle, water buffalo, pig, horse, sheep, goats). This once great array of local and endemic livestock breeds has been drastically eroded over the past century ([Ruane 2000](javascript:;)). At least 700 of the surviving local and traditional breeds of these seven livestock species, including 350 breeds in Europe alone, are in imminent danger of disappearance because of the global emphasis on a few highly cosmopolitan commercial breeds. Most remaining local livestock breeds have critically small population sizes and highly localized distributions, restricted in some instances to only one or two farms located within a single village or township ([Ruane 2000](javascript:;)). Local breeds often consist of highly inbred lines that may be susceptible to extinction as the result of even an extremely localized disease outbreak ([Ruane 2000](javascript:;), [Toro et al. 2000](javascript:;)). News reports in March 2001 indicated that at least one of England's relict endemic sheep breeds had been condemned to extinction through sanitary slaughter as a consequence of the recent FMD outbreak. In view of the potential effects of sanitary slaughter on the maintenance of genetic diversity within rare livestock breeds, the European Union and British government have now established policies for exempting rare breeds from prohibitions on disease vaccination and precautionary sanitary slaughter under certain circumstances ([DEFRA 2002](javascript:;)).

Some diseases that cause high rates of morbidity and mortality in humans or domesticated animals may occur in wildlife species without manifesting clinical signs of disease infection (e.g., hantaviruses, Trypanosma spp.). Control measures for zoonotic diseases may result in concerted efforts to eradicate any and all wildlife species that may be potential reservoirs, intermediate hosts, or vectors for disease transmission to humans or domesticated animals. Containment of plague and tularemia disease outbreaks resulting from bioweapon attacks will necessitate the control or eradication of rodent populations within affected areas to prevent the subsequent transmission of the disease from infected rodents to humans ([Alibek and Handelman 2000](javascript:;)). Populations of many wildlife species are already routinely subject to stringent control or local extirpation in many areas to control the transmission of endemic diseases to domesticated animals, in some instances without any supporting evidence to validate the clinical efficacy of such efforts.

In the United States, programs to control brucellosis in cattle populations have resulted in the culling or attempted eradication of populations of bison (Bison bison), elk (Cervus canadensis), and whitetail deer (Odocoileus virginiana). Other examples of such control programs include the routine culling of wild boar (Sus scrofa) populations in several European countries to control the transmission of classical swine fever to domesticated swine. Rabies control programs target populations of red fox (Vulpes vulpes) in Europe and North America, jackals (Canis mesomelas) in eastern and southern Africa, raccoons (Procyon lotor) in southern and eastern North America. In Central and South America, vampire bats (Desmodus rotundus) and other bat species are killed in large numbers to reduce rabies infections among humans and livestock. Veterinary quarantine and control programs for wild animals have been successfully constrained or curtailed in some areas by strong public opposition, however. For example, efforts currently under way to reduce the incidence of Lyme disease among humans by the large-scale culling of whitetail deer populations in the eastern United States have been blocked in many localities as the result of political lobbying and legal challenges by animal rights organizations (e.g., [Animal Protection Institute 1997](javascript:;)).

#### Biod loss Triggers planetary extinction

Hance 18 Jeremy Hance, 1-16-2018, "Could biodiversity destruction lead to a global tipping point?," Guardian, [eremy Hance is a wildlife blogger and journalist focusing on forests, indigenous people and climate change. He is the author of Life is Good: Conservation in an Age of Mass Extinction], https://www.theguardian.com/environment/radical-conservation/2018/jan/16/biodiversity-extinction-tipping-point-planetary-boundary, SJBE

Rockström agrees that there is no evidence of a planetary tipping point when it comes to biodiversity. According to Rockström, biodiversity decline does not have a hard planetary boundary like, say, climate change. Instead he describes biodiversity as a variable that operates “under the hood of the planetary system” because it influences the stability of our climate, ozone layer and oceans – all of which Rockström contends have very clear planetary boundaries. “We have never suggested a planetary scale biodiversity tipping point...” Rockström said. “Instead, the rational for biodiversity as a planetary boundary is that the composition of trees, plants, microbes in soils, phytoplankton in oceans, top predators in ecosystems…together constitute a fundamental core contributor to regulating the state of the planet.” According to Rockström, biodiversity is one of the pillars supporting our planet – and if too much biodiversity is lost we risk “triggering a tipping point” in our climate or oceans, which in turn could risk pushing the planet into a new state. “Without biodiversity, no ecosystems. No ecosystems, no biomes. No biomes, no living regulator of all the cycles of carbon, nitrogen, oxygen, carbon dioxide and water,” he added. Rockström says biodiversity loss could risk the “safe operating space” for humans, leaving us in an alien world increasingly hostile to our own survival. For example, life would still survive under apocalyptic climate change – but we may not. While ecosystems may not fully collapse, scientists have found that some ecosystems can undergo what they are called “regime shifts.” Coral reefs, overheated by climate change, will shift to a much less productive, much less biodiverse algae-based ecosystem. [Climate change](https://www.theguardian.com/environment/climate-change), or alternatively humans with chainsaws and fire, can shift forest ecosystems to grasslands. While none of these ecosystems may wholly collapse, they will look nothing like they did after the shift occurs. Montoya admits that such regime shifts “do actually happen” and is “well established” for some ecosystems – like forests, coral reefs and Arctic sea ice – though “unclear” if it happens in all ecosystems or only a few. And he adds, perhaps most importantly, that “the mechanisms [of regime shifts] have nothing to do with biodiversity loss.” Instead, they have been driven by climate change or human actions – such as clear-cutting. Debating definitions It may be that unclear or shifting definitions are at the root of the dispute. “Fatally, the boundaries framework lacks clear definitions, or it has too many conflicting definitions, does not specify units, and fails to define terms operationally, thus prohibiting application by those who set policy,” Montoya, Donohut and Pimm write in the paper. But Rockström contends that when understood correctly the planetary boundary framework holds up to scientific scrutiny. He says planetary boundaries do not mean that humanity can just destroy and upend all the way up to a red line without consequences. “This is of course just nonsense,” he noted, arguing that the planetary boundary for biosphere integrity is magnitudes more ambitious than the Aichi Targets from the Convention on Biological Diversity, an international agreement set on preserving biodiversity – though already several goals have not been met. “If the world is able to reduce biodiversity loss below the planetary boundary this would not only require major conservation efforts across the world,” he said, adding that “once inside the safe operating space, we would of course have to continue on a sustainable pathway.” Rockström said that he believes the disputing researchers have much more in common than their infighting would imply. “We are [all] working to safeguard biodiversity for sustainable development. We are [all] in the same camp. Complementing each other, they at the ecosystem level, us at the planetary level.” But Montoya and his group stand by their criticism and are working on a second paper responding to Rockström and his team. While Montoya’s paper does not critique the other eight planetary boundaries in their paper, Montoya told me that each of the boundaries – even the physical ones – have faced “a lot of controversy.” “They all suffer from the tipping-point problem,” he said, “which we argue promotes a business-as-usual ethos and distracts us from taking the action that is urgently needed.” In many ways one could argue that the planetary boundary is an easy and simple way to explain environmental impacts to world leaders – few of whom have any education on ecology or the environment – and the public. But Montoya argues that the planetary boundaries concept is doing more harm than good. “Poor or ill-founded science ultimately brings about ineffectual policies at best – and potentially highly damaging ones – and erodes trust in scientists,” he said. And this can have real world impacts: Montoya and colleagues point to forest policy in Europe as one example. “The assumption that there is a critical biodiversity level below which forest functioning will collapse prompted managers [to] plant resilient tree species to climate change, pests, and disease,” Montoya explained, adding, “this was recommended to avoid reaching a tipping point in forest service provisioning, primarily timber production.” But the recommendations have resulted in endangered old growth forests and native species, according to Montoya. While the on-going debate over planetary boundaries is deeply academic and wonky, it is not without importance to the public. How we communicate environmental crises – and the accuracy of the science that underpins that communication – proves more important with every passing year, as the world walks into climate and ecological uncertainty. Yes, life itself survived the Permian-Triassic mass extinction event – but most species did not. Believe me, humans probably wouldn’t have survived the tens-of-millions of years that followed the Great Dying: oxygen levels were dangerously low, food would have been scarce, and the world would have looked largely barren and wasted even as some species and ecosystems managed to survive. Outside the moral dilemma of extinction, there is no question that if humans push more-and-more species into oblivion there will be impacts on our society – and they could become catastrophic. Humans evolved 248 million years later in an Earth that was far more biodiverse and rich, a kind of Eden of abundance and diversity. But our current actions risk all that – and perhaps ourselves.

## Adv – India – Vaccine Nationalism

#### IPR fuels Vaccine Nationalism – Western pharmaceutical companies refuse to give up IPR

Vanni 21 Dr. Amaka Vanni’s research interests lie at the intersection of international economic law (IEL), law and development, global political economy and global governance. Dr. Vanni’s research adopts critical analysis, empirical methods and sociolegal approach in her examination and study of IEL, particularly intellectual property. As a result, her work focuses on the constitutive power of international economic law, norms and practices to affect social relations and everyday life, especially in the developing world where this impact is felt more starkly. Her work is also attentive to how various actors (both state and non-state) and local culture interact with IEL. Dr. Vanni’s award winning book ‘Patent Games in the Global South: Pharmaceutical Patent Law-Making in Brazil, India and Nigeria’ (Hart, 2020) provides fresh theoretical insights into global intellectual property regimes with focus on the role of history, social networks and how relationships between a variety of actors shape the framing of, and subsequently the responses to, national implementation of international patent law. Further publications focus on pharmaceutical patent and access to medicines, philanthro-capitlism and the growing influence of global donor organisations, IP and technology start-ups in emerging markets. Dr. Vanni obtained her PhD and LLM degrees in International Economic Law from the University of Warwick, where her doctoral thesis was awarded the 2018 SIEL–Hart Prize in International Economic Law. She has BA(Hons) in International Relations and Politics from Keele University, where was awarded the Vice-Chancellor Partial Scholarship (2004-2007). Dr. Vanni joined the University of Leeds Law School in September 2020 and currently teaches the undergraduate and postgraduate modules in intellectual property law. She is the current President of the African International Economic Law Network (AfIELN), and also a contributing editor of Afronomicslaw.org, the leading blog on the International Economic Law landscape as it relates to Africa and the Global South. MARCH 23, 2021 TWAILR: REFLECTIONS On Intellectual Property Rights, Access to Medicines and Vaccine Imperialism <https://twailr.com/on-intellectual-property-rights-access-to-medicines-and-vaccine-imperialism/> //avery

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 for the mRNA technology used in its vaccine, despite receiving funds from the US government with its IP partly owned by the US National Institutes of Health. Pfizer/BioNTech 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 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, reports 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 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 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. And perhaps we begin to see the refusal of drug makers to share knowledge needed to boost global vaccine supply for what it truly is: an extension in capitalist bifurcation of who is imagined as a legitimate intellectual property owner and who is envisioned as a 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, 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 put forward by South Africa and India at the WTO despite being supported by 57 mostly [global south] 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 licenses and parallel importation. 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 targeting countries even in the absence of illegality, many [global south]countries are reluctant to invoke TRIPS flexibilities for public health purposes. For example, in the past, countries such as Colombia, India, Thailand and recently Malaysia 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 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, 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 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 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. Specifically, the United States 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) – 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 per cent of a country’s population, it is severely underfunded 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. 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.

#### India attempts to fill in the void – ushering its own form of Vaccine Nationalism.

Chatterjee et al 21 Niladri Chatterjee, Zaad Mahmood & Eleonor Marcussen (2021) Politics of Vaccine Nationalism in India: Global and Domestic Implications, Forum for Development Studies, 48:2, 357-369, DOI: 10.1080/08039410.2021.1918238 <https://www.tandfonline.com/doi/citedby/10.1080/08039410.2021.1918238?scroll=top&needAccess=true> //avery

World Health Organization officials have voiced concerns at ‘vaccine nationalism’, which could increase the risk of the coronavirus mutating further, after a week-long row over a shortfall in EU supplies of Covid-19 vaccines. The WHO has asked wealthy countries to stop hoarding the Covid-19 vaccines through advance purchase agreements. While developed countries are struggling to inoculate all of their own people, most [global south]countries are yet to begin inoculation for lack of vaccines. To cite one instance, at the WHO press conference on 29 January, a nurse from Pakistan and a midwife from Uganda pleaded for vaccine supplies. ‘They are right at the end of the queue’, said Michael Ryan, WHO executive director. ‘They see people at the top of the queue fighting about where they are in the line. It looks like fighting over the cake – when they don’t even have access to the crumbs’, he said, commenting on the vaccine row in Europe. “We all need to ask ourselves, ‘would I have the vaccine if I thought it meant a health worker in the south wouldn’t get that vaccine today?’ We all need to examine our own consciences, then tell our leaders what we want them to do.” (Michael Ryan, in Eaton, 2021) The WHO has explicitly stated that such vaccine nationalism, without due regard to the intensity and spread of the contagion, will not only prolong the pandemic but also constitutes a moral failure (Farge, 2021). In addition, it is epidemiologically self-defeating and clinically counterproductive. Allowing the majority of the world’s population to go unvaccinated will not only perpetuate needless illness and deaths and the pain of ongoing lockdowns but also spawn new virus mutations as Covid-19 continues to spread among unprotected populations. What is more disconcerting is that new mutants may lead to vaccine resistance. As of 21 February 2021, out of the 128 million vaccine doses administered, more than three quarters were in just 10 countries that together account for 60 per cent of global GDP. As of today, almost 130 countries, with 2.5 billion people, are yet to administer a single dose (Kretchmer, 2021). In short, as UNICEF Executive Director Henrietta Fore and WHO Director-General Dr Tedros Adhanom Ghebreyesus in a joint statement pointed out, ‘in the Covid-19 vaccine race, we either win together or lose together … Covid-19 has shown that our fates are inextricably linked. Whether we win or lose, we will do so together’ (Fore and Ghebreyesus, 2021). ‘Vaccine nationalism’ is not a new phenomenon. In fact, the WHO director referred to the 2009 H1N1 pandemic, where wealthy countries reserved huge numbers of vaccine doses, leaving developing economies to rely on donations that arrived much later. It was only when the H1N1 pandemic began to recede that developed countries offered to donate vaccine doses to poorer economies. Consequently, as one of the studies shows, an estimated range of deaths from between 151,700 and 575,400 people perished worldwide from 2009 H1N1 virus infection during the first year the virus circulated (Centers for Disease Control and Prevention [CDC], 2012). We are currently witnessing a repetition of the past phenomenon, whereby although the high-income countries have pledged to donate the excess vaccines to low and medium-income countries, that might happen only after carrying out vaccination of their own population (Furlong, 2021), similar to what happened during the H1N1 pandemic. India’s global and regional vaccine diplomacy As the world’s largest producer of vaccines, alternatively, the ‘Pharmacy of the World’ as popularized by External Affairs Minister Subrahmanyam Jaishankar (Das, 2021), India’s vaccine nationalism has taken a different turn. The scientific ability to innovate vaccines has been used as a marker of pre-eminence and for the construction of national identity. Indian pharmaceutical companies are major manufacturers of vaccines distributed worldwide, particularly those for low-income countries, supplying more than 60 per cent of vaccines to the developing world. Despite the strong manufacturing base and early access to Covid-19 vaccines, Indian companies are struggling to produce enough doses to sufficiently manage the pandemic. One of the main pharmaceutical companies involved, the Serum Institute of India (SII) – arguably the largest vaccine manufacturer of the world, and at present engaged with the manufacturing of Covishield, a local name for the Oxford-AstraZeneca vaccine – has explicitly stated that most of its vaccine would go to Indians before it goes abroad. And yet the reality seems to be moving in a different direction altogether. India has adopted a disarming vaccine policy. The Indian Prime Minister has stated that India’s vaccine production will be used for the benefit of all humanity to fight the Covid-19 pandemic. India has announced assistance of vaccines to neighbouring countries and supplied Bhutan, Maldives, Nepal and Bangladesh as ‘gifts’ or grants in line with New Delhi’s ‘Neighbourhood First’ policy (Hindustan Times, 2021; Srivastava and Kay, 2021). Consignments of Covishield vaccine doses have also been delivered to Seychelles, Mauritius and Myanmar and plans have been made to supply vaccines to Sri Lanka and Afghanistan after regulatory clearances. India is also providing contractual supplies to Saudi Arabia, South Africa, Brazil, Morocco, Bangladesh and Myanmar. Such action has been applauded by the United States as that of a ‘true friend’ (Business Today, 2021). The Covid-19 vaccine, the latest and the most sought-after commodity in international diplomacy, provides India some leverage with neighbours otherwise enamoured by Chinese investments. India has faced stiff competition from China for influence in its South Asian neighbourhood with China’s increasingly visible footprint in Sri Lanka, Maldives, Bangladesh, Nepal, African countries and elsewhere. Lacking the kind of economic resources that China commands, India’s efforts to match that influence have been largely ineffective thus far. From the point of view of international diplomacy, one cannot, therefore, blame India to take advantage of her resources and extend her geo-political diplomacy, even if that comes at a time of global health crises. It is undeniable that India’s vaccine gifts will serve to polish its global image and earn her goodwill, especially in South Asia where it is often criticized for its ‘big brother’ behaviour. It must also be noted that India’s vaccine diplomacy has not been without a challenge from China. From the very outset of the pandemic, China tried to influence, or maybe to change the Covid-19 narrative that (still) blames China for the pandemic, by providing Personal Protective Equipment, testing kits, medical aids and equipment, and even financial aids to South and South-East Asian countries (So, 2020). However, China’s initial leverage has since then been cut short (at the time of this writing), because of their lack of transparency and information in what mattered the most, the vaccine. Two of China’s pharmaceutical companies, Sinovac and Sinopharm have mainly been involved in manufacturing the Covid-19 vaccine. Researchers have published some data from phase 1 and 2 trials of the Sinovac vaccine. There has been conflicting information about its efficacy (Reuters, 2020), with researchers in Brazil reporting 50.4 per cent versus those in Turkey claiming 91.25 per cent. Similarly, Sinopharm has undergone phase 3 trials and has claimed 78 per cent efficacy, while a study in UAE puts it at 86 per cent. The international medical research community does not yet have fixed numbers to work with (Joshi, 2021). Although several South-East Asian, Middle Eastern and Latin American countries have signed deals with Sinovac, many have also expressed doubts and hesitancy. In the Philippines, lawmakers have criticized the government’s decision to buy a Chinese vaccine. Officials in Malaysia and Singapore, which both ordered doses from Sinovac, have had to reassure their citizens that they will approve a vaccine only if proved safe and effective. In addition, delays in shipping the vaccines, as well as China’s own recent history of vaccine scandals (Wee, 2020) and vaccine hesitancy have not helped (Minter, 2021; Yang et al., 2020). This is where India has scored cookie points against her Chinese counterparts. The numerous Covid-19 vaccines developed in India underline the global collaborative networks of capital and resources. The SII is in the process of developing four other Covid-19 vaccines, apart from the Covishield. Two of these in-house initiatives are developed in collaboration with Novovax and Codagenix in the US. Indian medical companies like Biologicals E have partnered to manufacture vaccine in collaboration with Janssen Pharmaceuticals in Belgium, and Baylor College of Medicine in the US (Vaidyanathan, 2020). The list is long and expanding: Indian Immunologicals in Hyderabad is working with Griffith University in Australia, to test and manufacture the university’s vaccine; Dr Reddy’s lab Gamaleya National Centre in Russia are developing Sputnik V; Gennova Biopharmaceuticals in Pune; and HDT Biotech Corporation in the US are working on yet another vaccine. Such collaborative manufacturing capacity impacts India’s position in international politics. Independent of international collaboration Indian companies – Bharat Biotech and Zydus Cadila are also developing vaccines that are currently in various stages of clinical trials (Banerjea, 2021).

#### Causes the BJP to drum up nationalism in India.

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Attitudes of vaccine nationalism within India, moreover, have potential for political ramifications if it has consequences for adequate domestic supply. Here, the domestic politics of vaccine supply may assume importance particularly when the ruling Bhartiya Janata Party (BJP) had promised free vaccines to all in its Bihar Election Manifesto and in Madhya Pradesh; the government of Tamil Nadu has made a similar promise ahead of elections in the state (Hebbar, 2020). The promise of free vaccines by the central government for political outcomes will potentially create tensions by singling out particular states in a federal framework. In India, economic liberalization transformed the federal structure from cooperative federalism to competitive federalism as states vied for private capital (Saez, 2002). In the current health crisis, the central state and the local state government agreed on a plan regarding who should receive it on a priority basis and how much. Yet politics creeped into the public discourse as a free vaccine became an election promise. Many see this as the first indication that the central government will procure the vaccine – or vaccines – at rates it negotiates, and state governments may then be asked to purchase their own stocks. This will put pressure on other states to follow the same route. For the central state to assure free vaccine across the nation, it may have to be brought under the flagship Universal Immunization Programme, part of the National Health Mission, but the financial provisions for such a programme are quite inadequate. The politics around the regulatory approval for vaccines has had the effect of undermining India’s leverage. India has given emergency approval to two vaccines so far, the Covishield and Covaxin. The former is the vaccine by AstraZeneca and Oxford University while the latter is the indigenous vaccine developed by Bharat Biotech. Critics found in such haste a political desire of the government to be one-up that is amateurish, if not unprofessional and unethical (National Herald, 2021). The speed of approval has been driven by nationalistic political forces pushing for a ‘swadeshi’ – or locally made – shot, along with the firm’s own ambitions to be a frontrunner (Kay, 2021). The plan of the government was shelved after serious concerns were raised by scientists about the need for proper trials. The emergency approval to the two vaccines by the Drugs Controller General of India that states ‘approval granted for restricted use in the emergency situation, in the public interest as an abundant precaution, in clinical trial mode, to have more options for vaccinations, especially in case of infection by mutant strains’ (Government of India. Ministry of Health and Family Welfare, 2021). Such a convoluted statement is suggestive that the approval was granted not under ideal conditions with trial results and some have suggested that the regulator gave approval under duress (National Herald, 2021). To make things worse for public faith in the vaccines are concerns raised by the companies producing the vaccines about each other’s vaccine efficacy. Bharat Biotech founder Krishna Ella claimed that Covishield had reported more adverse side effects while Adar Poonawalla of SII made the snide comment that Covaxin was as safe as water (The Quint, 2021). In the middle of the controversy are important questions about the credibility of India’s regulatory regime, reinforced by the lack of transparency and absence of vaccine trial data. It is important to remember that the success of vaccine is not only based on the medical efficacy (both the vaccines have been found to effective) but also perceptions. China and Russia claim to have developed coronavirus vaccines several months ago, but the lack of data raises concerns and prevented international acceptance. India could have handled the situation better. The impact is visible in the mandatory recorded telephonic message that people in India hear every time they make a phone call, insisting they should have faith in the effectiveness of the vaccine and not give in to rumours. Although India has vaccinated more than 5 million frontline and medical workers, news reports suggest opposition to certain vaccines. The vaccine rollout has fallen flat with little over half the targeted number of people coming forward for shots – hesitation that is largely being blamed on the hasty approval of Bharat Biotech’s shot which is still deep in Phase III trials (Kay, 2021). The government has retorted to nationalism and likens objections to the rollout of the vaccines before phase three trials to questioning ‘the valour of our soldiers’ (Scroll, 2021). Of course, there is an aspect to this debate that is tied to larger epistemic questions. Critics have highlighted how structures and incentives prioritize concerns of the developed country and scale back the achievements and concerns of [global south] countries (Muraskin, 2017). The owners of Bharat Biotech expressed a similar sentiment when they argued that Indian companies are unfairly targeted. However, such an argument cannot undermine the need for trial-based evidence. The lack of trial data on vaccine efficacy has created vaccine hesitancy and doubt in India and internationally. The stance of the Indian government to approve vaccine before completion of stage III trials has drawn comparison to how China and Russia approved vaccines early and without releasing efficacy data. These moves did not provide either country any gain in public health. India as a major producer has much to lose by acting on an impulse to show-case an indigenous vaccine on the victory stand while undermining the scientific regulatory process. Potentially, India can now be bracketed with Russia and China into an arbitrary BRICS-like category of regulatory laxity reflected by indigenous vaccine approvals without efficacy data (Kurian, 2021).

#### BJP gains more support to use cyber violence escalating nuclear tensions with Pakistan and miscalculation due to hybrid warfare, causes nuke war

Ali 21

Ali, Syed Muhammad. “Rise of Religious Parties: Blind Love or Hybrid War?” Global Village Space, 20 Apr. 2021, www.globalvillagespace.com/rise-of-religious-parties-blind-love-or-hybrid-war/. // JoshDrills

Coincidence or careful **strategic** planning? The timing of these **violent protests** was interesting as these took place in the wake of six major regional and national developments which need to be analyzed together to understand the big picture. First, the US announcement of its troop’s departure from Afghanistan. Second, the improving security cooperation between Arab countries and Israel. Third, the recent South Asian visit of Russian Foreign Minister in which Indian Prime Minister did not meet him while the Russian leader reportedly offered Pakistan all possible cooperation. Fourth, Pakistan’s return to seeking IMF program. Fifth, the forthcoming Federal Budget, and sixth the FATF review. If these **geopolitical**, geoeconomics **and geostrategic developments** can be pieced together then it seems that this **crisis was built** up at a time **when** the **US needed Pakistan’s** good **offices** in the talks with the Afghan Taliban and **to help** facilitate a peaceful **US military departure**, the Russian interest in improving relations with Islamabad is greater than ever since the 1970s, while the Chinese commitment towards Pakistan and recently interest in Iran is also on the rise. This **indicates** a possible **Indian motive**, which does not favorably view Pakistan’s growing positive relevance with important global and regional powers. Amidst this geostrategic environment, the **revival of religious violence**, in the context of the **growing Indian clout** over the US and FATF, should be seen as providing the ideal instrument **to shape Pakistan’s** domestic **environment** in a manner that can help build a case that why Pakistan does not deserve easy terms for the IMF bailout, a FATF good grade, international trust, and significant foreign investment. Moreover, it also shakes the public confidence in the present government and **revitalizes** the **political opposition**. In addition, according to former Foreign Secretary Jalil Abbas Jilani, who has also served in Brussels, France along with Germany, virtually enjoy veto power over the decision of the European Union regarding awarding GSP Plus status to any country. Therefore, demanding Pakistan to expel the French Ambassador will badly damage good relations with the European Union and sabotage whatever goodwill Islamabad has earned through its economic diplomacy to develop France as a growing export market. Moreover, social unrest harms the national economic activity which will further reduce the government’s ability to meet the direct and indirect tax revenue targets before the upcoming Federal budget and will increase Pakistan’s reliance on external borrowing, which does not come freely or cheaply. Simply put, **social chaos harms** the **national economy**, hurts investor confidence, and makes the country more vulnerable to external economic coercion. Indian support? Furthermore, notwithstanding **the violent protestors** on the rampage **on** the streets of **Lahore**, what was most interesting was the extraordinary international support that they received from more than 380 Indian WhatsApp groups in the cyber world. An initial analysis of **400,000 hostile tweets** related to the TLP protests revealed that more than 70 percent of these were generated from fake accounts. Now let us unemotionally look at the main narrative of these 400,000 tweets. The meta narrative of most of these tweets had nothing to do with the love of religion or the last Prophet (PBUH), who according to the Holy Quran was sent as divine mercy for the entire universe, but aimed **to maximize** the **social chaos** through terms such as ‘Civil War in Pakistan’ etc. This indicates that those supporting the street protestors in the cyber world were neither merely local ragtag sympathizers, illiterate madrassa students nor religiously motivated individuals but a large force of dedicated cyber professionals who had carefully planned and intended **to strategically exploit** the environment shaped on the ground in Lahore and internationally present **Pakistan as** an **unstable country**. Earlier, some very irresponsible remarks about **Pakistan’s** missile and **nuclear program** were also made at similar rallies. Such statements from any person, particularly those **seen in** the **religious context** by the general public, also help those who intend to internationally shape a perception that **Pakistan’s nuclear arsenal** is not safe and could fall **in**to **irresponsible hands**. Lessons **from** the **crisis** and the way forward The government and the relevant national security institutions must carefully evaluate all the dimensions of this crisis and its specific dynamics **in** each **domain of national interest**. In the political domain, the government should interpret national security in a comprehensive manner and transcend beyond a silo-based approach towards foreign policy, national security policy, internal security, external security, economic security, human security, and national defense. National security should be conceptualized on the basis of 21st-century environment and national interests rather than the structures or institutions that evolved during the 20th Century and individually pursue these interests. For example, in order to deal with a situation like this, our Law Enforcement Agencies (LEA) should develop modern crisis management capabilities and regularly wargame emerging and likely internal security scenarios that should include learning how to negotiate during delicate hostage situations. It should not merely be left to the political leadership to negotiate with such situations unless they are professionally trained for it. Secondly, our institutions must develop professional capacity and skills to timely and tactically defuse a local law and order situation beyond the traditional options of buying time, offering compensation, or arresting them, before it escalates into a national crisis that forces the national leadership to take the nation into confidence. The kinetic response should always be the last resort after all options have been evaluated, tried and exhausted, because it is always politically costly for the government, weakens the public trust, and erodes investor confidence. A country that aims to become a trading nation by offering a viable and secure regional CPEC corridor cannot afford its bureaucracy and law enforcement agencies not to be public service-oriented and maintain its colonial culture. Tackling the **hybrid warfare** Our several relevant institutions regularly monitor the cyber and media trends but these also need to be comprehensively seen in the context of their co-relation and implications for other geo-economic, geo-strategic and regional geopolitical trends as well. In hybrid warfare, the physical **battleground** might be a small local neighborhood, but similar **to** the **air** and artillery support in case of a conventional land war, the psychological, media, and cyber reinforcement and support usually come from **across** the **borders**. This helps maximize, magnify and export the tactical and limited physical impact of a local incident way beyond the streets of a city, in order to psychologically disturb the entire nation, financially **disrupt** the national **economy**, **and** **shake** the **confidence** of all those around the world who have an interest or goodwill **towards Pakistan**. In short, this street protest’s somewhat crude, tactical, and local action received well-planned, extensive, and highly sophisticated international support that aimed to create the strategic impact of nationally **destabilizing and** globally **isolating Pakistan**.

#### Nuke war causes extinction apply pnd 16 down here

### Resolved: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines through IP/C/W/669 also called the TRIPS waiver proposalAdv – Covid

#### Trips waiver is Normal Means and solves medical infastructres answering vaccines writ large

Gupta, June 2021

Gupta, Shailly. “EU, UK, Switzerland, Norway Must Stop Blocking Negotiations on Landmark Pandemic Monopoly Waiver - World.” ReliefWeb, OCHA, 7 June 2021, reliefweb.int/report/world/eu-uk-switzerland-norway-must-stop-blocking-negotiations-landmark-pandemic-monopoly.

Geneva, 7 June 2021-- Ahead of the next **World Trade Organization** (WTO) meeting **on** the landmark pandemic **monopoly waiver proposal** --- the 'TRIPS waiver' --- the international humanitarian organisation Médecins Sans Frontières/Doctors Without Borders (**MSF**) **denounced the** European Union (**EU**) and countries **including** the **UK**, **Switzerland and Norway for** employing **delay tactics** instead of agreeing to start formal negotiations **on** this **critical waiver** at a time when COVID-19 has already killed more than 3.5 million people across the globe and there are stark inequities in access to COVID-19 medical tools. One month ago, the US signaled its support for the waiver in a groundbreaking move. On 4 June, the **EU** published a **counter-proposal** focusing on 'compulsory licensing', which brings nothing significantly new to the table and instead **is** merely **a maneuver to stall** the waiver negotiation process. If adopted, **the waiver would provide countries with** a **critical policy space to address intellectual property** (IP) barriers **to increase** **collaboration in** **r**esearch **and d**evelopment, manufacturing, scale-up, and supply of COVID-19 medicines, vaccines and other health technologies. Waiving monopolies would help level the playing field in this pandemic and ensure access to critically important COVID-19 medical tools for everyone who needs them, regardless of where they live. "In the last few months, we all helplessly witnessed how healthcare workers in countries like **India**, Peru and Brazil **struggle**d **to provide** **care** for people with COVID-19," said Dr Maria Guevara, MSF's International Medical Secretary. "Their **healthcare systems** were **on** the **verge of collapsing** and it was very challenging to provide any supportive therapies to critically ill COVID-19 patients in hospitals, as the oxygen concentrators, ventilators and medicines remain in short supply. In addition to vaccines, the world urgently needs access to newer therapeutics and diagnostics to reduce the number of hospitalisations and deaths in this pandemic. Governments must do everything in their power to make sure that every country has the best chance to save as many lives as possible throughout this pandemic." The governments co-sponsoring the waiver proposal recently submitted [a revised proposal](https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/IP/C/W669R1.pdf&Open=True%22%20%5C)to **the WTO** outlining its scope and duration, with the **objective** of progressing to formal text-based negotiations. An increasing number of countries (**63 [countries]** as of today) are **co-sponsoring the waiver** and more than 100 nations, and more recently the BRICS bloc, have come out in support and welcome the waiver overall. Brazil, however, remains reluctant to declare full support for the waiver proposal, defining its position as "open for discussion," but at the same time pushing for a longer negotiation timeline. Following the 5 May US announcement supporting the proposal and expressing willingness to engage in formal text-based negotiations, many more countries have shown an interest in moving forward with the discussions. However, **the EU has** so far **refused to engage** in productive discussions **on the proposal** and continues **to instead** **rally for voluntary measures** by pharmaceutical corporations, **which** so far **have** shown **limited success**. The EU has also been insisting that countries resort to using an existing public health measure --- 'compulsory licensing' to override patents product by product --- to facilitate production of individual COVID-19 medical tools, rather than a waiver that addresses all IP barriers up front. While MSF has long advocated for the use of compulsory licensing as needed to ensure countries benefit from the price-lowering effect of competition among generic producers to increase access to essential medicines, this route is not efficient during pandemic conditions: legal obstacles, pressure from pharmaceutical corporations and red tape make it too cumbersome, slow and complicated to address pandemic-level challenges. **The** proposed **TRIPS waiver would provide countries with an effective** and expeditious **way to remove key IP barriers in advance, rather than wait** for barriers to hit and then scramble into action. "The EU's continued insistence on the use of compulsory licensing in its counter-proposal as an excuse for opposing the original 'TRIPS waiver' is disingenuous and endangers public health globally," said DimitriEynikel,EU Policy Advisor for MSF's Access Campaign. "By focusing just on compulsory licensing, the EU is promoting a safeguard that can only bypass patents but not all IP barriers, thereby making it less effective than the proposed waiver. In this raging pandemic, countries need to have all options at their disposal to encourage the manufacturing of COVID-19 medical tools across the world. The EU and other nations opposing this waiver need to stop blocking other countries' efforts to protect their populations in a public health emergency." Meanwhile, many members of the European Parliament are making efforts to garner support for the waiver proposal. Last month, the **European** Parliament adopted a resolution on ending the HIV/AIDS epidemic by 2030, wherein a clear call was made to support the TRIPS waiver proposal. The European Parliament is expected to vote on a specific resolution in support of the waiver proposal between 7 and 10 June. A number of **countries** that continue to resist the waiver proposal are also part of the Group of 7 (G-7), whose heads of state are meeting at a summit next week. G-7 leaders should, at this critical moment in a pandemic, take concrete steps to **show global solidarity and support** this important waiver from **monopolies** to facilitate access to COVID-19 medical tools.

## Solvency

#### solves bioweapon response

Oriola 07 Taiwo A. Oriola, Against the Plague: Exemption of Pharmaceutical Patent Rights as a Biosecurity Strategy, 2007 U. Ill. J.L. Tech Cardiff Law School, and the ESRC Centre for Business Relationships, Accountability, Sustainability, & Society, University of Cardiff, United Kingdom <http://illinoisjltp.com/journal/wp-content/uploads/2013/10/05-05-08_Oriola_AHW_Formatted_FINAL.pdf> //avery

A critical countermeasure to bioterror attacks is a responsive and viable public health system, an integral element of which is an adequate and timely supply of essential vaccines and drugs. The 2001 anthrax attacks in the United States, which nearly precipitated a run on Bayer’s antibiotic ciprofloxacin,50 demonstrated that the public health care system could fall short of critical medicines to either the infected or stem the spread of infectious pathogens such as smallpox, anthrax and the plague. This is especially so since experts in the United States have said that pre-exposure medical countermeasures—that is, inoculation—for civilian populations is unlikely,51 despite dissenting views that immunizations should ideally be given prior to an attack.5 Time is of the essence in getting crucial drugs to victims of bioterrorism attacks to save as many lives as possible, and authorities should be able to mass-produce crucial drugs with minimal delay. Drug stockpiling is of limited practical value since most drugs and vaccines have limited shelf-life,53 and no one knows for sure when terrorists would strike. Moreover, drug stockpiling is not a feasible bioterrorism policy option for resource-poor countries that, unlike the United States and other wealthy nations,54 are already overwhelmed by HIV/AIDS, and lack functional public health infrastructures and the resources to stockpile bioterrorism-specific drugs for their populations.55 Nevertheless, securing crucial drugs in the shortest time possible for those infected in a bioterrorism attack is no less important than other public health preparedness measures. It would undoubtedly minimize loss of life and effectively contain further spread of diseases and mass hysteria.56 However, the high propensity for intellectual property rights wrangling—as exemplified by the skirmishes over Bayer’s ciprofloxacin in the wake of the September 11, 2001 anthrax attacks in the United States57 —could stymie authorities’ efforts to mass produce or parallel import crucial patented drugs within the shortest time possible, especially in resource-poor countries of Africa, Asia, and Latin America. This makes an effective bioterrorism-specific pharmaceutical patent appropriation clause in international and national patent laws bereft of the bureaucratic trappings of the contemporary patent regime, and the TRIPS access to medicines paradigms. There is a plethora of literature on public health preparedness in gene health law is not clearly defined, it has been sugg ral,58 and public health legal preparedness in particular, fostering holistic discourses on counterterrorism and natural disaster countermeasures.59 Public health legal preparedness has been described as a subtext of public health preparedness.60 Its rising profile in legal scholarship since the late 1990s has been attributed to the recognition of the integral role of law in securing and enforcing public health preparedness strategies.61 While the scope of public ested that it could be “any law that has significant consequences for the health of a defined population,”62 and that “the term may encompass such nominally foreign domains as economic development laws, tax law, and international trade law.”63 It is axiomatic that public health law encompasses intellectual property rights, especially patents and allied rights that directly regulate ownership of, and access to, critical medicines for public health needs,, particularly with regard to bioterrorism-induced diseases.64 Not the least of which because a lack of access to crucial drugs could have “significant consequences for the health of a defined population.”65 This is an ongoing, albeit unpleasant, reality for millions in resource-poor countries, arguably due, in part, to stronger pharmaceutical patents protection under the aegis of the World Trade Organization’s (“WTO”) TRIPS Agreement.67 The arrangement has effectively rooted international intellectual property rights governance in international trade rules. Despite the strong link between pharmaceutical patents and public health, most of the scholarship and regulatory regimes concerning public-health legal preparedness largely glosses over intellectual property law and access to medicines interface discourses, and instead focus mainly on the legal status of voluntary rescuers, public health employees, control of biological agents, civil liberties, and legal liability implications of compulsory quarantine and inoculation.69 While acknowledging the possible dearth of vaccines and drugs as a potentially critical logistic snag in the bioterror defense strategy, even the few articles that have explored potential patent obstacles sought solutions only within the traditional remit and the familiar ambit of the TRIPS Agreement, as well as national patent law and access to medicine paradigms, whose core is the compulsory licensing regime70 as circumscribed by the “consistency test.”7 this solution is arguably vulnerable to bureaucratic trappings and wrangling over the adequacy of royalties payable to the patentees.72 At the very least, the process is both incongruous and anachronistic in the context of time-sensitive bioterrorism countermeasures.73 Time is clearly of the essence in bioterrorism attacks, and the need for swift action is the defining element of the thesis for pharmaceutical patent appropriation clause in the bioterrorism context as proposed in this Article. This Article argues that the access to medicines package, as provided by TRIPS74 is unsuited to the need for mass production of critical drugs in bioterrorism-induced public health crises. A case will be made for a legal framework that allows pharmaceutical patents to be overridden with adequate compensation in bioterrorism-induced public health crises. This argument is predicated on ethical grounds, overriding public interests, and the dictates of the fundamental right to health and life. Part II of this Article explains bioterrorism and its attendant extraordinary public health emergency crises. Part III discusses the dynamics of pharmaceutical research and development and the relevance of pharmaceutical patents to drugs access. Part IV analyzes the inherent limitations of the TRIPS Article 30 limited exception to patent exclusivity, the TRIPS Article 31 on compulsory licensing, and the TRIPS-Doha Declaration on public health. Part V spells out the grounds for a bioterrorism-specific exception to pharmaceutical patent exclusivity. Part VI sums up the discourse and concludes the article.

#### and key to cause a global surge of covid 19 vaccines

Thrasher 21

Thrasher, Rachel. “How Will Everyone Benefit If WTO Members Sign the TRIPS COVID-19 Waiver?” Open Access Government, 15 Feb. 2021, [www.openaccessgovernment.org/trips-covid-19-waiver/103738/](http://www.openaccessgovernment.org/trips-covid-19-waiver/103738/). [researcher with the Boston University Global Development Policy Center. She works on policy issues related to trade and investment agreements, trade law and development, economic relations between [global south] countries, and multilateral environmental agreements. She is the author of Constraining Development: The Shrinking of Policy Space in the International Trade Regime (Anthem, forthcoming, July 2021).] // JoshDrills

\*Brackets in original article

At the informal meeting of the Council for the Agreement of Trade-Related Aspects of Intellectual Property (TRIPS) on February 4, the United States, together with the European Union, United Kingdom, Japan and Australia continued to block the **initiative to waive** certain World Trade Organization (**WTO**) **provisions** that potentially constrain manufacture and disbursal of COVID-19 medicines, diagnostics, medical equipment, and vaccines. What is the TRIPS COVID-19 waiver? This narrow waiver, **proposed** initially **by** **South Africa and India**, would temporarily **waive patent rights** over these products to facilitate increased production volume and more widespread manufacturing worldwide. Nevertheless, while the US and the EU push for more discussion about the facts of the current situation, South Africa, India, and others are seeking to negotiate the text of the proposed waiver. At the moment, the talks are at an impasse. At the moment, the talks are at an impasse. But evidence is mounting that signing the **TRIPS waiver** would not only be **good for** the current supporters of the initiative, but for the **whole world**, and maybe especially for the developed countries who are currently opposed to it. The financial costs to all countries during the pandemic goes far beyond paying for the research and development, treatments and vaccines **to manage COVID-19** cases. Economic impacts will be felt across the global economy through supply chain disruptions rooted in growing inequality within and between countries, likely costing around $9.2 trillion dollars, half of which would be borne by a handful of developed economies. **Economic impacts** […] likely costing **around $9.2 trillion dollars** The projected timeline for vaccinations exacerbates the financial costs. Initial predictions for vaccine rollout all over the world have proven optimistic at best and current projections suggest that many will have to wait at least three, and up to seven, years for substantial global immunity through vaccines, leaving low-income countries hopelessly behind. The **lack of manufacturing** capacity **by drugmakers** One of the main reasons the vaccines have not become **as** widely available as initially hoped is the lack of production capacity by key firms. For obvious reasons, a **small handful of corporations cannot produce enough** vaccines for the whole world population. Producing enough will depend heavily on licensing and transferring technology to more manufacturers. This reality is highlighted by a recent case in which a vaccine innovator company (Inovio) sued its own contracted biologics manufacturer (VGXI) because they refused to release their own trade secrets to other potential producers in order to ramp up capacity. These same supply capacity issues afflict other more well-known companies as well – including Novavax and Moderna. Pharmaceutical companies would prefer to rely on **voluntary licensing agreements** (VLAs) to increase production. These VLAs allow the patent holder to control who is producing their patented good and where they are able to sell the product. Gilead’s VLA to produce remdesivir is the most widely known example of such a process. While initially applauded for increasing access and to a potentially life-saving treatment for COVID-19 at affordable prices, further research showed that the agreement excluded 70 countries who would have to purchase the drug at the monopoly price. Given that cautionary tale, it is **unlikely** that VLAs would be enough **to ensure** widespread **access**. The rigid reality of the TRIPS Agreement Many countries who push back against a **TRIPS waiver** suggest that the TRIPS Agreement is already flexible in its allowance of compulsory licensing to facilitate generic manufacture of patented vaccines. The agreement allows member states to **authorise compulsory licenses** (CLs) under their own domestic law **in** cases of **extreme urgency**, as long as the scope and duration of the license is narrowly circumscribed. In ordinary circumstances, countries can impose a CL if they are unable to negotiate a voluntary license within a reasonable period of time. In both cases, the innovator is due “adequate remuneration” (Art. 31). Certainly, there has never been a case of extreme urgency like this one, and WTO members theoretically may have recourse to this provision. However, previous CLs issued by member states have met with both public and private opposition. The United States has repeatedly put pressure on India for its CL on an expensive cancer drug, claiming that India is “diluting” intellectual property rights and violating the TRIPS Agreement. Private pharmaceutical companies and U.S. lawmakers have even taken action to threaten sanctions against India through its Special 301 Report, a trade watch-list of sorts. Colombia faced similar backlash when they took the first steps toward issuing a CL for a leukemia treatment – Glivec. Both the Swiss government and Novartis, the patent holder, argued forcefully that CLs are “tantamount to expropriation” – code for exercising a sort of eminent domain through regulation. More recently, Malaysia attempted to use a CL to increase affordability of a Hepatitis C medication and once more the United States, together with its pharmaceutical industry, threatened to wield the power of sanctions through a Special 301 Report. As a result of these and other instances, countries have, understandably, been reluctant to develop more flexible domestic CL policies and are certainly out of practice in using them. A TRIPS COVID-19 waiver opens up global production Given the challenges of imposing compulsory licenses and the limits of voluntary ones, the TRIPS waiver offers another way for vaccine producers around the world to ramp up global production without the risks of contending with domestic and international IP disputes. the TRIPS **waiver offers** another way for vaccine producers around the world **to ramp up global production** In the first place, they argue, intellectual property protection is [what made these vaccines possible](https://insidetrade.com/daily-news/us-others-defend-ip-rights-waiver-backers-push-text-based-talks) to begin with – undermining those rights, then could undercut the potential for future lifesaving products. The protection of intellectual property is [certainly aimed at increasing innovation](https://www.journals.uchicago.edu/doi/full/10.1086/669706?casa_token=rONrWfPIP7EAAAAA%3AY7UnTSWbe2rI79fnx2KlCZ2CxOcuy9zeKeh9cPdCjfMyhoSC1g1NC-eL9KUTCKRmsZTknURuOP8&), and some studies have shown that [innovation does increase with greater protection](https://journals.sagepub.com/doi/pdf/10.1177/0976399616686860?casa_token=LEX4uDS6wnAAAAAA:CHAWXha9-HMEVK8xeAMM1Gy39L6QscB22M4TfpvxKHstG9LIKXexoUfAO6C7w8ebS_wCAvZFkSXG). At the same time, other research suggests that strong IP protection could [actually discourage subsequent innovation](https://www.journals.uchicago.edu/doi/full/10.1086/669706?casa_token=rONrWfPIP7EAAAAA%3AY7UnTSWbe2rI79fnx2KlCZ2CxOcuy9zeKeh9cPdCjfMyhoSC1g1NC-eL9KUTCKRmsZTknURuOP8&). Even without disregarding the valuable role of intellectual property protection, however, the TRIPS waiver would not dismantle our current system of innovation incentives. Rather it is a narrow, time-limited waiver aimed only at facilitating global access to COVID-19 related products. Most of the vaccine developers have already received [ample](https://grants.nih.gov/policy/natural-disasters/corona-virus.htm) [government](https://ec.europa.eu/info/live-work-travel-eu/coronavirus-response/public-health/coronavirus-vaccines-strategy_en) [support](https://www.fiercepharma.com/pharma/after-nearly-1b-research-funding-moderna-takes-1-5b-coronavirus-vaccine-order-from-u-s) for the research and development stage – diminishing the need for patent monopolies (which are supposed to make up for large up-front capital expenditure). The second argument put forward by opponents of the TRIPS waiver points out that intellectual property rights are not the real bottleneck preventing more rapid global production, at least in the case of vaccines. Rather, the manufacturing capacity of most of the world’s countries is simply [not advanced enough](https://insidetrade.com/daily-news/us-others-defend-ip-rights-waiver-backers-push-text-based-talks) to make these types of vaccines. But this argument seems to run up against the vein of the previous contention – if intellectual property rights are not the issue, if no vaccine manufacturers are going to be able to ramp up production to make any kind of real difference in distribution, then there’s no point in being concerned about temporarily waiving those rights. The current producers will still effectively benefit from their patent monopolies. The current producers will still effectively benefit from their patent monopolies. On the other hand, there is growing evidence that perhaps qualified [producers around the world stand ready](https://www.oxfam.org/en/press-releases/monopolies-causing-artificial-rationing-covid-19-crisis-3-biggest-global-vaccine) to contribute to the production of more vaccines. Despite an unknown timeline, there is a real possibility that the TRIPS waiver may make it possible for a huge increase in vaccine production, not to mention the production of other COVID-19 treatments and equipment.

**New Global south manufacturers not being able to produce is a form of scientific racism – in reality, developing countries are more than adept at producing vaccines.**

Annalisa **Merelli 5-28**. [(Reporter at Quartz) “Big pharma wants you to think sharing vaccine patents overseas is very dangerous” https://qz.com/2013661/big-pharma-argues-poor-nations cant-be-trusted-to-make-vaccines/]

When it comes to the suspension of patents for Covid-19 vaccines, **it’s big pharma against the world**—or most of it, anyway. Earlier this month, the US government expressed its support of a waiver to the international agreements governing intellectual property rights. The waiver, proposed in November 2020 by India and South Africa, would allow poor countries to produce Covid-19 vaccines without paying pharmaceutical companies for patent rights, at least until the pandemic is over. This would help increase the global supply of vaccines at a lower price, and make progress toward the goal of vaccinating the global population by the end of the year. The proposal, to be negotiated through the World Trade Organization, gained the support of many countries, especially low- and middle-income, but found resistance among rich ones, including the EU, Switzerland, the UK, Australia, Canada and, initially, the US. However, the US lifted its opposition earlier this month to expand vaccine supply and access to bring the pandemic to a faster end. With the US government putting its weight behind the proposal, its approval is much more likely. Vaccine apartheid Waiving the Trade-Related Aspects of Intellectual Property Rights agreement (TRIPS), while also allowing the sharing of manufacturing know-how, is key to boosting the global production of Covid-19 vaccine, advocates say. Ethically speaking, it’s even more urgent now than when the proposal was introduced. The world is experiencing a two-speed pandemic, with wealthy nations moving back toward normalcy, and poor ones experiencing new outbreaks and dealing with a lack of vaccines and therapeutics. It is a situation the World Health Organization (WHO) has denounced as “vaccine apartheid.” But ethics aren’t the only reason to commit to expanding vaccination capacity by any means possible. As long as there are Covid-19 outbreaks, the chance that vaccine-resistant variants might emerge persists—as goes the global health community‘s mantra “Covid anywhere is Covid everywhere.” Yet the pharmaceutical industry isn’t exactly on board with missing out on patent profits. The International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) has expressed disappointment at the US’s stand, claiming the patent waiver won’t help produce more doses, and calling instead for a lowering of trade barriers that would make it easier for western manufacturers to sell vaccines to poorer countries. “The TRIPS waiver […] could spur a spate of confusing, mutually inconsistent, and heavy-handed “compulsory” demands by governments all over the world for supply and technology transfer,” warned Michelle McMurry-Heath, the president of the Biotechnology Innovation Organization, in a statement. **A false risk narrative** The Pharmaceutical Research and Manufacturers of America (PhRMA), the trade organization representing the biggest US drug companies, has published polling results that shows a majority of Americans oppose the waiver. But the framing of their questions betrays the not-so-subtle suggestion that suspending patents would create safety concerns—for those who would receive the vaccines. In one survey, responders were asked whether poorer countries should be allowed to manufacture the vaccines even though they may be less safe. In another, they were asked whether they were concerned about the fact that other countries might not have the same quality standards as the US, or that the risk of getting counterfeit vaccines might be higher if production was expanded to poor countries. Unsurprisingly, a majority of people found these scenarios concerning. The myth that making vaccines in poor countries might be dangerous is very dear to pharmaceutical companies. “Entities with little or no experience in manufacturing vaccines are likely to chase the very raw materials we require to scale our production, putting the safety and security of all at risk,” wrote Pfizer CEO Albert Bourla in a statement. A narrative as old as AIDS “**The history behind this particular tactic of questioning the safety of manufacturers in other parts of the world has been played out on various** occasions,” says Tahir Amin, the co-founder of I-MAK, a US-based organization working to increase global access to medicines Perhaps the most egregious precedent is the dispute between big pharma and poor countries over the making of antiretroviral drugs for AIDS, which cost about $10,000 per person per year before the introduction of generics that brought the price down to $300 per person per year. A famous episode of that battle culminated in court in 1998, when a coalition of multinational drugmakers and the South African Pharmaceutical Manufacturers Association sued the Nelson Mandela-led South African government for its attempts to encourage the local, patent-free production of more affordable AIDS medications, although eventually the charges were dropped. At the time, western pharmaceutical companies claimed drugs made in developing countries didn’t meet the necessary quality standards, **though** research **repeatedly found that there was no reason to think so.** “Had it not been for generics manufacturers in the global south, we wouldn’t have gotten more people treated with antiretrovirals, **and we’ve** seen that generics are very much safe and the quality is not questioned,” says Amin. A matter of prejudice Granted, vaccines are more difficult than oral drugs to produce, but big vaccine makers in developing countries including India—the biggest vaccine producer in the world—have long been used by UNICEF and other global development agencies to produce their vaccines, **with constant scrutiny of their quality.** In fact, poor countries have even been able to develop their own vaccines, as is the case of the hepatitis B vaccine developed by Shanta Biotechnics in India. The price of the vaccine made by western countries ($23 per dose in the 1980s) was prohibitive, so a local pharmaceutical company set out to develop its own formulation, at a cost of $1 per dose. This

led to a mass inoculation against the virus, with over 120 million doses distributed worldwide to poor countries. **“There is this ‘scientific racism’ that exists in the west**, that we are still living in colonial times where science was only done by the rich global north,” says Amin. The prejudice that vaccines and drugs made by poorer countries won’t meet the standards of wealthy countries doesn’t just extend to the manufacturing capacity, but to the quality assurance provided by the governing bodies of those countries. Effectively, the US pharma industry is claiming greater expertise at verifying the quality of pharmaceutical products than the national and international bodies working with producers outside the western world. “Nobody wants to see poor quality vaccines, but in this spotlight, I think everyone that is coming up with a version of the vaccine is going to really check their manufacturing practices,” says Amin. What makes the skepticism toward vaccines made in poor countries even more contradictory is that often the actual ingredients bought by western manufacturers to produce their drugs are produced in India or China. **So the very same companies** that are **raising doubts about** the **quality of products made by** manufacturers in **poor countries trust them for their raw materials.**

### Framing

#### The standard is maximizing expected well-being. Prefer:

#### 1] Actor specificity – a) government actors don’t have knowledge as to the effects on specific individuals which means only aggregates can be used for calculation b) intrinsicness – focusing on intrinsic factors to policy such as aggregation is better for topics that aim to make a policy action

#### Extinction comes first – 3 warrants:

#### Moral uncertainty means preventing extinction should be our highest priority.

Bostrom 13 [Nick Bostrom, Professor in the Faculty of Philosophy @ University of Oxford, “Existential Risk Prevention as Global Priority,” Global Policy Vol. 4 Issue 1, February 2013]  
These reflections on **moral uncertainty suggest** an alternative, complementary way of looking at existential risk; they also suggest a new way of thinking about the ideal of sustainability. Let me elaborate.¶ **Our present understanding of axiology might** well **be confused. We may not** nowknow — at least not in concrete detail — what outcomes would count as a big win for humanity; we might not even yet **be able to imagine the best ends** of our journey. **If we are** indeedprofoundly **uncertain** about our ultimate aims,then we should recognize that **there is a great** option **value in preserving** — and ideally improving — **our ability to recognize value and** to **steer the future accordingly. Ensuring** that **there will be a future** version of **humanity** with great powers and a propensity to use them wisely **is** plausibly **the best way** available to us **to increase the probability that the future will contain** a lot of **value.** To do this, we must prevent any existential catastrophe.

#### 2] Future improvement – extinction removes possibility for future innovation or allowing development of systems or evaluation

#### 3] Bodily Security – extinction removes actors ability to act which means it’s a lexical pre-requisite as it destroys actors ability to act

## Underview

#### AFF theory – a) AFF gets it because otherwise the neg can engage in infinite abuse, making debate impossible, b) drop the debater – the 1AR is too short for theory and substance so ballot implications are key to check abuse, c) no RVIs – they can stick me with 6min of answers to a short arg and make the 2AR impossible, d) competing interps – 1AR interps aren’t bidirectional and the neg should have to defend their norm since they have more time. Aff theory first – it’s a much larger strategic loss because 1min is ¼ of the 1AR vs 1/7 of the 1NC which means there’s more abuse if I’m devoting a larger fraction of time.

### Method Underview

#### **The role of the ballot is to endorse the best policy position:**

#### 2] Refuse to categorize biomedicine as completely bad – medicine and disease are not stable categories.

Parens 13, Erik. "On good and bad forms of medicalization." Bioethics 27.1 (2013): 28-35. (Senior Research Scholar at The Hastings Center)//Elmer

It can be appropriate to use medical means to prevent suffering and enhance well-being even if the source of the problem is not a disease. Laura Purdy2 For the last thirty or forty years, sociologists have used the term medicalization to refer to the process by which ‘non-medical’ (or ‘life’ or ‘human’) problems become understood and treated as ‘medical’ problems.3 Of course social scientists typically understand themselves to be describing – not evaluating – social processes. Indeed, one of the fathers of medicalization theory, the sociologist Peter Conrad, has stated more than once that the term medicalization is value neutral. In his recent book he writes: ‘While medicalization describes a social process, like globalization or secularization, it does not imply that a change is good or bad.’4 That assertion notwithstanding, when sociologists use the term medicalization, they have traditionally assumed that the process it names is bad. In this paper, I will suggest that we in **bioethics should not make** that **simplifying assumption**, but should instead do the complex work of attempting to **distinguish between good and bad** forms of **medicalization**. That suggestion might sound radical at first, but it isn’t. In fact, into both the sociological and bioethical literatures there has already begun to creep a distinction which does roughly the same work as the distinction I’m getting at with the difference between ‘bad’ and ‘good’ forms of medicalization. I am referring to the distinction between ‘over-medicalization’ (which is assumed to be bad) and ‘medicalization’ (which is assumed to be not bad). In an attempt to deflect the criticism that the term medicalization entails but does not acknowledge the assumption that the process is bad, Conrad writes: ‘While ‘medicalize’ literally means ‘to make medical,’ and the analytical emphasis has been on over-medicalization and its consequences, assumptions of over-medicalization are not a given in the perspective.’5 That is, in the course of attempting to deflect the charge that the sociological analysis takes the badness of medicalization to be ‘a given,’ Conrad tacitly distinguishes between overmedicalization, which is bad, and medicalization, which apparently is not. One can find the same tacit distinction in the bioethics literature. In their argument for distinguishing between using memory-attenuating drugs to respond to Post Traumatic Stress Disorder (which they approve of) and using the same drugs to achieve non-medical purposes (which they do not approve of), Michael Henry and colleagues write: ‘If memory-attenuating drugs prove effective, we argue that the most immediate social concern is the over-medicalization of bad memories and its subsequent exploitation by the pharmaceutical industry.’6 Like Conrad, Henry et al. tacitly distinguish between medicalization and over-medicalization. They approve of the sort of ‘medicalization’ that occurred when we applied the PTSD diagnosis to the once-familiar human problem of shell shock, but disapprove of the sort of ‘over-medicalization’ that a pharmaceutical company might initiate with the creation of a new diagnosis like Bad Memories Syndrome. I am merely suggesting that we should become explicit about what we’re already trying to do: get over **the traditional assumption that medicalization is bad per se**, and try to articulate the difference between good and bad forms of it. In preparation for explicating how such an attempt has actually begun in the context of the debates about using pharmaceuticals to shape our experience of love, I want first to rehearse what I take to be the great insights as well as the blind spots built into the term medicalization. I. THE MEDICALIZATION CHARGE HAS TRADITIONALLY ILLUMINATED AND OBFUSCATED What’s wrong with medicalization? First, construing non-medical (or life or human) problems as medical problems, construing normal human variations as pathological, commits a category mistake. Sadness is a problem that human beings experience when, for example, someone they love dies. Shyness can be an unpleasant state that many people experience upon meeting new people. Short stature can occasion unpleasant feelings in some short individuals. And so on. But, the critic of medicalization observes, neither sadness7 nor shyness8 nor short stature9 is a medical problem. Sadness is a normal, perhaps even essential part of a full human life. The feelings that can go with being sad or shy or short may be difficult, but they are not symptoms of disease; only disease-mongers suggest otherwise. To treat human problems as medical problems, according to the critique, is to make a mistake about the nature of the world. Seeing clearly and living well require us to avoid such a mistake. More specifically, living well requires that we learn to let some sorts of problems be. It requires that we learn to affirm, rather than try to erase, variations in our moods, behaviors, and appearances. In addition to entailing a category mistake, medicalization can have bad consequences. Perhaps the easiest to see is that, insofar as medicalization expands the category of what warrants medical treatment, the cost of medical treatment grows exponentially. While this may be to the advantage of gluttonous purveyors of medical products and services, it makes it ever harder for any government to pay for medical care for all.10 On top of the astronomical direct costs of such interventions are the indirect costs of their side-effects. A second bad consequence is that, insofar as the institution of medicine focuses on human beings as objects (i.e. as bodies), the medicalization process potentially undermines seeing ourselves as subjects; it potentially undermines our ‘subjectivity.’ When we argue, say, against the medicalization of badness – e.g., against treating criminal behavior as the symptom of a psychiatric disorder – we are arguing against the view of ourselves as objects at the mercy of forces beyond ourselves, and for the view of ourselves as subjects who can choose. Similarly, when, for example, we argue against using medical means such as drugs to treat sadness, we are often arguing against the view of ourselves as objects that can be fixed and for the view of ourselves as subjects who can be influenced by reasons.11 The critic of medicalization can accept that we need both ways of understanding ourselves, but worry that the medical way is crowding out the other. This is at least one thing critics are getting at when they suggest that we should use means like psychotherapy before or instead of using drugs. A third bad consequence of medicalization is that, insofar as medicine focuses on changing individuals’ bodies to reduce suffering, its increasing influence steals attention and resources away from changing the social structures and expectations that can produce such suffering in the first place. The idea is that, for example, rather than changing the bodies of shy people with drugs, we could change our expectations of how people behave in novel situations; again, doing so, would exemplify the virtue of learning to affirm natural variation. Further, changing social expectations would be fairer to individuals, who, instead of changing their bodies to better fit dominant norms, could, again, be affirmed in their normchallenging variation.12 Whether critics argue that we are making a category mistake, or are creating a putative need that no government can afford to fulfill, or are undermining understanding ourselves as subjects, or are obscuring understanding the social sources of suffering, the basic idea is that it is bad when the institution of medicine oversteps its proper limits. As someone who is by nature-nurture a critic of medicalization, I think that the preceding worries are insightful and important. But I also want to call attention to what the critique can obfuscate. Specifically, I want to call attention to some of the problematic assumptions that the critique inadvertently entails – where by ‘problematic’ I mean assumptions that contradict or at least are in tension with other assumptions that critics like me tend to embrace. Problematic assumptions built into the notion of medicalization First, the idea of medicalization **depends upon the notion that medicine has ‘proper’ goals,** which are visible to those with knowledge of the essence of medicine. More specifically, while it’s true that broad conceptions of the goals of medicine (such as the World Health Organization’s) 13 are indeed available, one needs a narrow conception of those goals to get traction for the medicalization critique. Without a narrow conception, one can’t restrict the range of the targets that medicine ‘properly’ aims at. **Those** of us **attuned to how** institutional **goals change** over time with the coming and going of more and less savory political interests, however, **will be wary of** an **analysis that assumes knowledge of** a given institution’s ‘proper’ or ‘essential’ or **‘real’ goals**. Peter Conrad fully anticipates such wariness. Indeed, he begins his recent summary of his thinking on medicalization by saying that he will ‘bracket’ the question of whether the conditions he says are medicalized are ‘real’ medical problems.14 To justify setting aside the question of how he knows what a real medical problem is or what the proper goals of medicine are, he makes a distinction. He says that ‘it is the viability of the designation rather than the validity of the diagnosis that is grist for the sociological mill’ (emphasis added).15 He is asserting that when he uses the term medicalization, he does not mean to assume that he knows the difference between valid (or real) medical diagnoses and invalid (or fake) ones; he means only to assume that the new, expanded conceptions of medical problems are ‘viable’. But that distinction does not so much resolve as reintroduce the original concern about essentialism. How does the sociologist know which ‘viable’ diagnoses to investigate as examples of medicalization? To pick them she has to assume that she knows the difference between viable diagnoses that are valid and viable diagnoses that are not; otherwise she would have to investigate all viable medical diagnoses as instances of medicalization – and that is clearly not what is happening. All of which is to say that, the valid/viable distinction seems to depend on the same assumption – about knowing the difference between real and fake medical conditions – that Conrad recognizes is problematic. The specter of inadvertent essentialism remains. The medicalization critique’s narrow conception of the goals of medicine harbors other problematic assumptions as well. For one thing, it usually if not always entails the dualistic notion that the proper target of medical intervention is the disordered body, as distinct from the troubled mind. One familiar variation on this theme suggests that medicine should deal with disorders of the body, not disorders of the mind; or that it should treat disorders that are ‘organic,’ not ones that are context-dependent. For example, in a recent essay Jonah Lehrer recounts the tale of a psychiatrist who was taken aback to notice that, in his enthusiasm for prescribing antidepressants, he had failed to distinguish between suffering rooted in his patients’ dysfunctional bodies and suffering rooted in their minds or social contexts. The psychiatrist’s epiphany came when he asked one of his patients whether her antidepressants were working. She answered, ‘Yes, they’re working great . . . I feel so much better. But I’m still married to the same alcoholic son of a bitch. It’s just now he’s tolerable.’16 Lehrer and the psychiatrist’s point of course is that, because the woman’s problem was rooted in her relationship with her alcoholic husband rather than in her dysfunctional body, it was a mistake to treat her. That line of criticism’s great virtue is that it can be used to shelter some dimensions of human life from the raging storm of medical intervention. But it is important to beware of the lurking mind-body dualism. In the case Lehrer describes, the alternatives seem to be that the source of the woman’s suffering is either her body or her mind (and relationships). If we successfully jettisoned mind-body dualism, however, we would be wary of that disjunction. We might wonder, for example, about the role her embodied mind played in her entering into such a relationship in the first place. Such a question would not aim to blame the victim (!), but to remind us of how staggeringly complex mind-body (-world) interactions are. It would remind us to be on the lookout for an assumption that we would normally reject. Yet another problem with the critics’ narrow conception of the goals of medicine is that it usually entails – whether explicitly or inexplicitly – some notion of normal or species-typical functioning.17 The idea is that that we can look out into nature, discern the line between species typical and atypical functioning (or between behaviors inside and outside of the normal range), and thereby know whether to intervene. If the individual exhibits species-atypical (or ab-normal) functioning, she occupies a disease category and we should intervene, and if her functioning is typical (or normal), she doesn’t occupy a disease category and we shouldn’t intervene. It would be lovely if we could look to nature and discern the line between species-atypical and species-typical functioning, between the categories of disease and health. That way it wouldn’t be our ethical responsibility to decide, based on our understanding of the facts and our values, whether to intervene. We’d just point to nature. Alas, one would be hard pressed today to find a natural scientist who studies the etiology and diagnosis of disease and believes that those lines and categories are there for us to discover. Geneticists, neuroscientists, and others increasingly abandon the species-typicality model, which seeks to discover typical functioning, to embrace an individual-differences model, which seeks to understand why it is that, within populations, there is almost always continuous variation with respect to any trait or cluster of traits. On the individual differences view, what we call disorders are almost always ‘dimensional,’ not ‘categorical.’ As the psychiatric geneticists Ian Craig and Robert Plomin put it: Whereas the species typicality model . . . assumes that mental illness is a broken brain, . . . the individual differences model considers variation as normal. . . . Common mental illness is thought to be the quantitative extreme of the normal distribution.18 According to the individual-differences model (and the dimensional view that goes with it), there is no value-free, readily visible line between behaviors and traits that really are – and really aren’t – disordered. This is unfortunate in at least two very different ways. First, it means that purveyors of cures have ever more grounds to assert that even if we aren’t floridly ill, we’re still ill enough to purchase their cure; they can – and do – argue that we are within in the penumbra of illness.19 Second, it means that the ethical responsibility for deciding whether or not to intervene falls to us and our valueladen interpretations of nature; we can’t rely on the hoped-for, value-free guidance from nature. II. THE PHARMACOLOGICAL CALVINISM CHARGE HAS TRADITIONALLY ILLUMINATED AND OBFUSCATED In principle, the medicalization charge can be used to criticize the use of any means to achieve what is construed to be a non-medical purpose. But in our current context, with the avalanche of ever more pharmaceuticals, the medicalization charge often refers to the use of pharmacological means to deal with some normal human problem. When enthusiasts about self-shaping hear the medicalization charge, they sometimes exasperatedly counter that the critics suffer from ‘pharmacological Calvinism.’ Gerald Klerman first used that now-famous phrase in the early 1970s, in an article in the Hastings Center Report.20 According to Klerman, pharmacological Calvinists think that ‘if a drug makes you feel good, it not only represents a secondary form of salvation but somehow it is morally wrong and the user is likely to suffer retribution with either dependence, liver damage, . . . ,or some other form of medical-theological damnation.’ Klerman continues, ‘Implicit in the theory of therapeutic change is the philosophy of personal growth, basically a secular view of salvation through good works.’21 As Klerman was a psychiatrist, not a theologian, we can set aside his unconventional understanding of Calvinism and try to understand the insight at work in his charge. A less snarky version might read: ‘If pharmacological and psychotherapeutic means can both achieve the same end – improving how one experiences herself and the world – then it is irrational and perhaps inhumane to prefer the more strenuous and expensive means. It’s irrational not to take a shortcut when improving human well-being is the destination.Weshould be slower to imagine that suffering leads to growth and understanding, and quicker to remember that sometimes it just crushes human souls.’ Even if the chances of finding a ‘pharmacological Calvinist’ in the USA today are about as good as spotting a bald eagle in Manhattan, Klerman was surely right to observe that we come from long and particular traditions (originating in both Jerusalem and Athens), which have taught that with suffering comes understanding. Those traditions have valorized the suffering that goes with large and small normal human problems.22 Insofar as those traditions celebrated suffering for which there were no medical remedies, Klerman must be right that at least to some extent those traditions made a virtue of necessity. But he must be wrong to the extent that his charge invites us to ignore the respect in which suffering can be a crucial element in a good human life. To take but one example, which I mentioned above: even the staunchest self-shaping enthusiasts acknowledge the respect in which suffering from the loss of someone we love is ‘proper’ – and as such should be endured rather than erased. (Yes, I did suggest above that the notion of ‘the proper’ can obfuscate and here I amsuggesting that it can illuminate.) Moreover, the charge of pharmacological Calvinism must be wrong to the extent that it ignores how the means we use to reduce the suffering associated with normal problems can matter morally. As critics of medicalization argue, using medical means to solve normal human problems can lure us into thinking that the individual rather than her social context is the source of the problem. It can lure us into attending only to the respect in which we are objects – and ultimately to forgetting that we are also subjects, who can remedy some problems by giving and taking reasons to change our minds and contexts. Klerman’s charge can also obfuscate the fact that different means can emphasize different values in an even more obvious sense. Insofar as means like medications can be cheaper or work more quickly than, say, means like words, they can emphasize the value of efficiency. Insofar as means like words require the giving and taking of reasons between persons, they can emphasize the value of engagement. So, like the medicalization charge, the ‘pharmacological Calvinism’ charge can both help us to think and give us an excuse to stop thinking. If that’s right, we are saddled with a daunting ethical responsibility. By ‘we’ I mean those who think it is important to respond to the suffering of individuals and that it is important to attend to the social roots of that suffering; those who think it is important to consider ourselves as subjects and that we should be grateful for the ways in which considering ourselves as objects can help us to diminish human suffering; and those who worry that medicalization can be bad and believe that choosing for or against ‘medicalization’ full stop could be lazy or unhelpful. By ‘ethical responsibility’ I refer to the responsibility to attempt to distinguish between good and bad forms of medicalization. III. TOWARD A CONVERSATION ABOUT THE DIFFERENCE BETWEEN GOOD AND BAD FORMS OF MEDICALIZATION To start, it helps to remember the respect in which we already do embrace some forms of medicalization. When for example Dostoyevsky wrote The Idiot, the cluster of traits that today we call **epilepsy was called a divine gift**. In the beginning of the 20th century, that cluster of traits was construed as a ‘psychological’ disorder, and today we are **confident that ‘it’ is a proper medical disorder**. None of us criticizes the process whereby that particular constellation of traits was transformed from a divine gift into a medical problem. Nor does any of us criticize the process whereby what today we call **Alzheimer’s** disease **went from** being interpreted as the **moral** problem of ‘senility’ **to** being interpreted as a **medical** [disorder] ~~problem~~. One could counter that these aren’t examples of ‘good’ medicalization. Rather, they are only examples of us overcoming past mistakes: calling epilepsy a disease instead of a divine gift is just an example of aligning our everyday practice with our deeper scientific or medical knowledge. Mistaking epilepsy for a divine gift, goes this argument, is no more interesting than mistaking whales for fish. Fair enough. But this brings us to straightforward, harder-to-dismiss examples to support my suggestion that we should be skeptical about assuming that medicalization is bad, full stop. Many feminists and fellow travelers have in the past, with good reason, lamented the medicalization of everything from childbirth, to menstruation, to menopause.23 More recently, the institution of medicine has brought within its purview ‘labia-plasty,’ which its practitioners say can be used to treat ‘emotional problems such as embarrassment, anxiety, and loss of self-esteem’24 related to the shape of one’s labia minora. The profound, amplysupported concern is that, by bringing ever more normal features of women’s bodies and lives within the purview of medicine, disease mongers diminish women’s power to control their own bodies and, more generally, diminish their ability to flourish. While there may be no better arena than what gets called ‘women’s health’ to witness dis-empowering forms of medicalization, there may also be no better place to see empowering forms. As feminist philosopher Laura Purdy has argued in this journal25 – and others have argued elsewhere26 – a blanket condemnation of medicalizing ‘normal facets’ of women’s (and men’s) lives fails to acknowledge the respect in which women (and men) use medical technologies to gain control over their lives to promote their own flourishing.27 Consider for example the normal human capacity of producing eggs (or sperm), or the normal capacity of bringing a fertilized egg to term. Given that those capacities can’t be construed as symptoms of disease, and given that becoming pregnant when one doesn’t want to is a perennial human problem, we must grant that **using medical technologies** to control those capacities (**from birth control** pills**, to vasectomies**, to IUDs) **are forms of medicalization** – forms of medicalization **that seem good** to many of us. Even many of us who are in general deeply, wholeheartedly critical of the idea that more control is always better, embrace technologies that allow women to determine if and when they will become pregnant. We embrace those technologies not only **because** we believe that **women have a right to self-determination**, but because we know that women who cannot control if and when they become pregnant are at significantly increased risk of living (along with their children) lives blighted by poverty. For this observer, **fertility control counts as a good form of medicalization**. Of course, ‘many of us’ isn’t all of us. Who, though, objects to the process whereby what once was considered chronic pain associated with normal aging came to receive labels like Complex Regional Pain Syndrome (CRPS)?28 Before we could do anything to treat such pain, we construed it as a normal, if difficult part of the aging process. But once it’s technically feasible for healthcare professionals to reduce such pain, the door swings wide open to new diagnostic labels and ‘treatments’. What was once a problem of everyday living becomes a medical problem. It is a classic example of the medicalization process – but, I am suggesting, an example of ‘good’ medicalization. IV. THE MEDICALIZATION OF LOVE In the conclusion of a forthcoming essay, ‘Bioethics and Medicalization,’ the sociologist John Evans, writes: Most scholars of medicalization seem to have reached the normative conclusion that they do not want to live in a world where increasing swaths of human experience are under the logic of medicine. There are, or should be, experiences that use an older logic, which are under the jurisdiction of another profession or under no jurisdiction at all. We can all fear the medicalization of love (emphasis added).29 At work in Evans’s claim, is the at-first seemingly obvious assumption that medicalizing love is bad, full stop. But I want to suggest that even in the case of love, we need to try to distinguish between good and bad forms of medicalization. Indeed, I want to suggest that in the bioethics literature we can already begin to glimpse progress toward making such a distinction. Even mortal academic foes can sometimes agree on the difference between good and bad forms of medicalization In its characteristically heterocentric and fuddy-duddy tone, in Beyond Therapy the President’s Council on Bioethics offers a scenario that makes a deeply important point. They invite us to imagine a young man at a party who is under the influence of Ecstasy and begins a conversation with a woman he has never met before. He tells her that he loves her and wants to marry her. The Council invites us to imagine that the man means what he says ‘insofar as the feeling he now has is indistinguishable from what he might one day feel when he truly falls in love with a woman.’30 Then the Council asks, ‘Should the fact that this man’s feelings are produced by the drug, rather than inspired by the woman, matter?’ The Council argues that it should matter to the woman and to the man. It should matter to her because she wants to be seen as she truly is, not as the drug makes her seem. She wants recognition. And it should matter to him, too, insofar as he should want his love to be real. As the Council puts it, ‘The young man’s drug induced ‘love’ is not just incomplete – an emotion unconnected with knowledge of and care for the beloved. It is also unfounded, not based on anything – not even visible beauty – from which such emotions normally grow.’ Even we post postmodernists are here thrown back on some version of the distinction between the true and false, authentic and inauthentic. Even we have to accept the inescapability of such a distinction in the context of thinking about the sort of love we want for ourselves and for those we love. We want our feelings of love to grow out of knowledge of and care for the other. We want them to grow out of engaging in activities with the person we love. We want the other’s love for us to be chosen freely. We, even we post postmodernists, don’t want to settle for the feelings that grow out of a drug alone. No one familiar with the bioethics literature will be surprised to find this sort of argument in a report by the President’s Council, which is known both for its critique of self-shaping in general and medicalization in particular. It may be more surprising, however, to find a similar argument being made by enthusiasts about technological self-shaping. In a recent paper, Julian Savulescu and Anders Sandberg define a good marital relationship as ‘one which both parties desire and which gives each pleasure, and allows or facilitates each to lead lives which are objectively valuable.’31 To advance their argument, they make a distinction, which reveals an important value commitment they share with their academic foes, The President’s Council. Savulescu and Sandberg distinguish between using a drug to maintain a loving attachment and using a drug to create such an attachment. Specifically, they endorse using technology to maintain a relationship that is founded on shared perceptions of the goodness of the other, and the shared experiences that grow out of such perceptions, but they reject using technology to create the feelings normally associated with such perceptions and experiences. As the President’s Council might put it, we don’t want the illusion of love, we want the real thing. To make their point, Savulescu and Sandberg even use the language of authenticity, which is as unusual for them as it is usual for the Council. They write, ‘The use of drugs to instill a new love is more likely to create inauthentic love, since the causal reasons for the love may lie in the drug . . . , rather than the particular person loved.’ So at least we can say that, insofar as being without love is a normal, human, non-medical problem, and insofar as both sides would oppose using a technology to remedy that problem by creating a love out of whole cloth (i.e. in the absence of the feelings and experiences normally associated with love), it is fair to say that both sides agree that using a technology to create love out of whole cloth would be a bad form of medicalization. The problem is normal but the medical-technological solution is bad. But can both sides agree on a good form of medicalization? Well, Savulescu and Sandberg say that marriage counseling is a perfectly fine way to maintain a love relationship. The President’s Council doesn’t speak directly to this issue, but I see no evidence that they would disagree. Insofar as relationship difficulties are a normal human problem, and insofar as marriage counseling is sometimes done by people with medical degrees, it seems fair to say that both sides could in principle agree that relationship counseling to maintain a marriage relationship could be a good form of medicalization. While both sides might agree that using words (as in counseling) to treat relationship problems is a good form of medicalization – or at least is not a form of ‘overmedicalization’ – things might become more contested if someone proposed using drugs to remedy those problems. For example, would both sides agree that it is a good form of medicalization for marriage counselors to use Ecstasy to facilitate marriage counseling? (This is not hypothetical; Ecstasy has been used for this purpose.)32 30 President’s Council on Bioethics. 2003. Beyond Therapy: Bioetechnology and the Pursuit of Happiness New York, NY, Regan Books: 253. This is of course a variation on Robert Nozick’s famous ‘experience machine’ thought experiment in Anarchy, State, and Utopia. 31 J. Savulescu & A. Sandberg. Neuroenhancement of Love and Marriage: The Chemicals between Us. Neuroethics 2008; 1: 33–44. 32 S. Braun. 2001. Seeking Insight by Prescription. Cerebrum. 1 April. Available at: http://www.dana.org/news/cerebrum/detail.aspx?id=3046 [accessed 20 Jan 2011]. On Good and Bad Forms of Medicalization 34 © 2011 Blackwell Publishing Ltd. We can imagine that whereas the President’s Council might object, Savulescu and Sandberg would not. Indeed, even if Savulescu and Sandberg would oppose the creation of relationships with drugs, their conception of the appropriate use of drugs to maintain a relationship is far more expansive than the Council’s. Indeed, they invite their readers to imagine a woman who takes herself to be in a good and loving relationship with a man who happens to be promiscuous, and then invite us to accept that, in an effort to maintain her relationship, this woman might autonomously choose to take a drug that allowed her to tolerate her husband’s promiscuity. It strikes me that, for Savulescu and Sandberg to be consistent, they should reject the promiscuity-toleration pill on the same grounds that they rejected a pill that created the feelings of love out of whole cloth. In both cases, rather than facilitating engagement with the world as it really is, the pill distances the relevant parties from the world as it is. Again, however, their published article indicates that they could condone a drug that made the promiscuity of one partner tolerable for the other. But even if Savulescu and Sandberg agreed that, to be consistent, they should reject the promiscuity-toleration drug, I am surely not suggesting that they and the President’s Council agree on precisely how to articulate the difference between good and bad forms of medicalization – or between ‘medicalization’ and ‘over-medicalization.’ I am only suggesting that self-shaping critics and selfshaping enthusiasts do agree – at least implicitly – that we should attempt to articulate that difference. Insofar as some forms of medicalization can maintain or facilitate, as opposed to create or thwart, human relationships and experience, both sides – no matter how different their tones – need some version of that distinction. CODA Early on in this paper, I mentioned Jonah Lehrer’s example of the unhappy woman who was married to an alcoholic man. Following Lehrer, I suggested that construing her normal human unhappiness as depression would be a distressingly bad form of medicalization. No matter how much the medication might attenuate her suffering, that could not justify her becoming complicit in cutting herself off from an important feature of her life as it truly was. In that case, however, ‘the alcoholic husband’ was a sort of prop (not unlike ‘the promiscuous husband’ was for Savulescu and Sandberg). Lehrer and I were using the alcoholic husband to try to understand what we thought of the woman using an antidepressant to manage her unhappiness. But now we can ask, What should our attitude be toward her husband? Would it be bad to construe his alcoholism – and his accompanying unhappiness – as a medical disorder? Would it be bad to medicalize his bad behavior? I don’t think it would. Above I rehearsed some of the ever-present, very real social and philosophical dangers associated with medicalizing such behavior. I think, however, that if we remain vigilant about the ever-present dangers associated with the process of medicalization, and if the medical model of alcoholism can help someone to remedy the common human problem of excessive drinking, then medicalizing the alcoholic husband’s bad behavior might be good. To the extent that construing his bad behavior as a ‘medical’ problem can help him to take responsibility for his life and to start engaging in the sorts of meaningful relationships and activities that human beings seem to need and want, this seems to be a good form of medicalization This may make me a prime exhibit for (the sociologist) John Evans’s case that ‘bioethics’ has itself become an ‘engine’ of medicalization.33 And perhaps beginning to say out loud that some medicalization can be good puts us at still greater risk of creating exactly what Goethe feared: a world turned into one huge hospital, where everyone is everybody else’s humane nurse. I don’t dismiss or minimize either of those concerns. On the contrary, they trouble me deeply. But if we are committed to ‘ambiguity and complexity’ (as Evans says sociologists are, and I would say we all should be), if we are committed to helping flesh-and-blood human beings to engage in meaningful activities and relationships, then we might have to try to distinguish between good and bad forms of medicalization. That would take time and energy, and would delay the rest we all desire, but it might also be what we owe each other if flourishing for all is what we’re really after.

#### 1] Debates surrounding health policies are good.

Shelton 17, Rachel C., Derek M. Griffith, and Michelle C. Kegler. "The promise of qualitative research to inform theory to address health equity." Health Education & Behavior 44.5 (2017): 815-819. (Assistant Professor, Sociomedical Sciences, Columbia University)//Elmer

In the 30 years since the 1985 Secretary’s Task Force Report on Black and Minority Health was released (Heckler, 1985), the 20 years since Society of Public Health Education (SOPHE) published its first research agenda (Clark & McLeroy, 1995), and the decade since the Inaugural SOPHE Summit on Eliminating Racial and Ethnic Health Disparities (Airhihenbuwa, 2006), the patterns of health and illness in the United States continue to tell a story of societal inequity. Whether implicit or explicit, theory is critical in that it serves as a lens through which we can view the contours of health issues and inequities. Given our modest progress in reducing health disparities over the past 20 years, it is possible that our current theories are not directing us to the priority determinants, which, if modified, could enable us make significant progress in achieving health equity. It is also plausible that the theory-based change strategies and interventions that researchers and practitioners typically implement fall short of what is needed to create significant changes to redress structural, social, and historical injustices that have contributed to health disparities. Qualitative methods are uniquely poised to offer insight into not just the theory of the problem but insight into the principles and theories that may be the best candidates on which to build an intervention (McLeroy et al., 1993). Yet qualitative methods (used on their own or in the context of mixed-methods research) tend to be perceived within the scientific community as less valuable and important than quantitative methods in the context of health disparities research. To understand the perspectives, context, and daily lives and experiences that shape health, qualitative research is essential. Particularly in the context of health education and health promotion, qualitative research has provided critical insights into the factors that shape modifiable determinants of health across all levels of the ecological model (McLeroy, Bibeau, Steckler, & Glanz, 1988). Previously, there has been little critical or systematic consideration of how qualitative research could be used to advance research on health disparities or health equity in our field. In this commentary, we reflect on some of the theoretical and conceptual challenges facing health disparities and health equity research and highlight how qualitative methods provide important and unique insights that inform future research and practice. Role of Theory In health education and health promotion, we discuss the theory of the problem and change theories or theories of action (Glanz, Rimer, & Viswanath, 2015). Theories of the problem are explanatory and help identify and describe determinants of a problem and identify modifiable factors that can be prioritized for change (Glanz et al., 2015). Theories of change inform how to design intervention strategies that will influence priority determinants and also help pinpoint logical short-term and intermediate outcomes for logic models and evaluation efforts (Bartholomew, Parcel, Kok, Gottlieb, & Fernandez, 2011; Crosby, Kegler, & DiClemente, 2009; Eldredge, Markham, Ruiter, Kok, & Parcel, 2016; Glanz et al., 2015). Thus, theories provide an organizing framework for our research and practice by systematically guiding us toward constructs to target with our interventions and organize our evaluation and research results. Despite growing recognition of the importance of broader organizational, community, and policy-related factors in shaping health and health disparities, our field’s tendency to use theories at the individual and interpersonal levels is well documented (Golden & Earp, 2012; Painter, Borba, Hynes, Mays, & Glanz, 2008). Even our program and intervention planning models, which allow for selection of constructs from a range of theories depending on the identified determinants (Airhihenbuwa, 1995; Bartholomew et al., 2011; Green & Kreuter, 2005; Iwelunmor, Newsome, & Airhihenbuwa, 2014), largely rely on our existing theories to shape the questions we ask and how we go about addressing the identified determinants. In the context of informing efforts to pursue health equity, however, the challenge is that few of our theories specify how constructs intersect and interact across levels, and which of these are most powerful in explaining behavior and the environmental conditions that create, maintain, or exacerbate disparities. Moreover, our theories **generally** **do not provide guidance** as to which causal pathways are most likely to specifically reduce disparities and in which populations (Diez Roux, 2012). Additionally, theories at the higher levels of the social ecology are less likely to be operationalized and measured in a manner consistent with our quantitative research methods, which may present barriers to more widespread application. Furthermore, with some rare exceptions (e.g., critical race theory/public health critical race praxis; Ford & Airhihenbuwa, 2010a, 2010b), our existing theories in health behavior and health education neither critically examine nor address the important fundamental causes of health, including the social and political determinants that may be at the root of health inequities. Given the nature of short-term grant and budget cycles (and prohibitions on lobbying with federal funds), it is not surprising that the theories most typically pursued in our field focus on proximal or short-term outcomes and what is perceived as more easily addressable determinants of health. Therefore, as a field, we do not typically recognize or attempt to address historical and ongoing societal factors that have implications for health disparities like racism and power. The Promise of Qualitative Methods In considering how qualitative research might advance theory pertinent to health equity, it is first important to recognize that experts approach the application of theory in research from a variety of perspectives. Hennink, Hutter, and Bailey (2011) describe an interplay between deductive and inductive reasoning in their approach and describe how theory is central in the design phase with a clear role in framing research questions and informing conceptual models and frameworks (Hennink et al., 2011). Depending on the goal and context of the research, the analytic process can involve developing inductive theory or applying deductive codes from the research questions, existing theory, or conceptual frameworks. Hennink et al. (2011) argue there is always a theory underlying research and making it explicit is essential, typically in the form of a conceptual framework to guide the research (e.g., categories of questions asked, coding, organization of data, and results; Hennink et al., 2011). Patton (2015) describes theory primarily within the context of sampling and analysis. For example, he describes deductive theoretical sampling for deepening or verifying theory-derived constructs, giving examples such as resilience, trauma, and respect. He also describes inductive grounded theory sampling in which the sample is constructed as the emerging theory begins to take shape and evolves from exploratory to verification. These examples highlight that there is a vast array of opportunities for theory to inform disparities-oriented research. To date, however, there has been relatively little attention paid to the use of qualitative research to advance theory in the area of health disparities and health equity. The volume of literature describing health disparities and discussing strategies to eliminate health disparities has not made strong conceptual or empirical distinctions between minority health promotion and health disparities elimination (Srinivasan & Williams, 2014). While both outcomes are important and deserve attention, it is likely that each has different determinants and intervention strategies that matter most; as such, the theoretical and conceptual frameworks used to study them may also be different. Furthermore, there are some limitations to relying predominately on a comparative approach that has become the cornerstone of health disparities research in recent years (Bediako & Griffith, 2007). In this context, qualitative methods can play an important role in how we understand and describe the problem of health inequities and their determinants. Not only can these approaches help illuminate social, cultural, and political factors that may underlie health disparities, but qualitative approaches are also uniquely positioned to document and contextualize how these factors affect health across levels of the social–ecological framework in a more nuanced and in-depth way. Qualitative methods also have the potential to illuminate new theories of change, particularly those that operate at higher levels of the social ecological framework, as well as interactions between constructs at varying levels of the framework. Providing insight into how well-accepted theoretical constructs should be operationalized or adapted for specific subpopulations (e.g., social norms, social capital, intention, or attitudes; Burke, Bird, et al., 2009; Pasick, Barker, et al., 2009; Pasick, Burke, et al., 2009) is another potential strength of a qualitative approach. By acknowledging the complex interplay of factors that influence and underlie health disparities, social ecologic approaches that have been informed by qualitative methodologies may provide a good blueprint for moving toward health equity. While qualitative methods offer these possibilities, according to Hennink et al. (2011), without theory development of some kind, qualitative research ends purely in description, which does not explain a phenomenon and neglects to answer “how” and “why” questions (Hennink et al., 2011). Similarly, Patton (2015) states that “much qualitative inquiry stops at reporting the explanations of the people studied” (p. 583) without attempting further qualitative causal analysis. He further acknowledges that asserting that qualitative analysis can yield causal explanations remains controversial, and this is undoubtedly true in health education and health promotion as well. This may relate in part to the tendency by qualitative researchers to downplay or minimize the generalizability of findings, often due to relatively small sample sizes, which is in sharp contrast to quantitative research that seeks to highlight the generalizability and reproducibility of its findings. However, we encourage our fellow qualitative researchers to go further with our studies and make a concerted (and well-documented) effort to develop, extend, or refine theory within the context of trying to figure out how to reduce health disparities, and when appropriate, to highlight any insights that are consistent with prior work and could be scaled up and tested on a broader scale. Moving Forward To make real progress in addressing health disparities and moving toward health equity will require a renewed commitment to and deeper understanding of qualitative research on the part of health disparities researchers in our field. In particular, we encourage researchers to move beyond only descriptive documentation of disparities toward thinking about mechanisms and theory building and refining, with an eye toward informing interventions, strategies, and health promotion messaging in public health and clinical contexts. Through this process, it will be important that researchers refrain from relying only on individual and interpersonal theories, and begin explicitly incorporating behavior change theories with theories at the social, organizational, community, and policy levels, and consider how factors interact synergistically across levels. While we agree that the field should be selective and parsimonious with respect to the development of new theories (Glanz et al., 2015), we also assert that with respect to promoting health equity, there is room for the development of new theories and refinement of theoretical constructs, particularly for those pertaining to the social, organizational, community, and policy levels. Building theoretical and conceptual frameworks and models that can be applied across multiple levels is highly pertinent to disparities research in several ways. First, these theories are more likely to address the larger societal and social factors that shape disparities and can help researchers identify which factors matter most across levels (e.g., what is most relevant and meaningful for a population), and should therefore be prioritized as intervention or policy targets. While most research to date has focused on using qualitative research to provide insight into the populations experiencing inequities, we recommend researchers use qualitative research to advance understanding of “behaviors in context,” and the settings and social context in which disparities arise (Burke, Joseph, Pasick, & Barker, 2009; Okechukwu, Davison, & Emmons, 2014). This includes investigating the contexts in which interventions to address disparities are implemented, with an eye toward theory building and theory refinement. Second, we encourage researchers to move beyond approaching health disparities largely as a single dimension toward considering the possible intersectionality of social dimensions that have implications for health equity (Bauer, 2014; Bowleg, 2008). Using qualitative research that is grounded in the daily experiences of people’s lives may help address the methodological challenges of thinking about social categories as additive and instead frame them as related and intersecting social structures that create and recreate social disadvantage and health inequity. There are also many opportunities for researchers to use more community-engaged, participatory, and action-oriented theories and frameworks that not only focus narrowly on health disparities but also encourage an assets-based approach that focuses on promoting health equity (Grieb, Smith, Calhoun, & Tandon, 2015; Wallerstein & Duran, 2006). This Commen-tary is consistent with Bowleg’s (2017) Perspective in Health Education & Behavior, which advocates for the wider use of critical theoretical frameworks in health equity research. In making advances in this area, it is also clear that we have much to learn from other disciplines that have rich histories in both theory and qualitative research, including anthropology, history, and sociology (Chowkwanyun, 2011; Hirsch, Wardlow, & Smith, 2009; Livingood et al., 2011; Livingood, Allegrante, & Green, 2016; Nathanson, 2007; Pasick & Burke, 2008). Of note, these fields have also incorporated a much broader range of qualitative approaches in their research (e.g., textual analysis, comparative ethnography) that we encourage researchers to explore and embrace. Finally, we recommend that in examining health disparity issues, researchers in this area be thoughtful and detailed in the social dimension and lenses through which they are grouping “disparity” populations, as there is tremendous diversity and heterogeneity within groups (e.g., documented differences among Latinos in health disparities and determinants of health by country of origin; Shelton, Jandorf, Thelemaque, King, & Erwin, 2012). This will help increase the likelihood that interventions will be developed or adapted with cultural specificity when needed (e.g., when the determinants are unique to that population) or will help identify when there are commonalities across social groups that can be addressed across disparity populations (Emmons, Barbeau, Gutheil, Stryker, & Stoddard, 2007; Goldman et al., 2003). In addition, qualitative research can be used to inform the operationalization and measurement of constructs that may be newly identified within a social context and/or are culturally specific (Airhihenbuwa, 2006; Airhihenbuwa & Liburd, 2006). In conclusion, we believe there is much work to do to make progress in both eliminating health disparities and promoting health equity. In fact, in examining qualitative research focused on promoting health equity, the majority of research, including the rich scholarship featured in this special issue, focuses on the methodological and intervention implications of their research findings. However, we also believe that there are tremendous opportunities for qualitative and health equity scholars to advance research and practice in this area through the expansion and application of rigorous, theoretically informed qualitative research. We hope researchers will recognize and seize this challenging, but critically important opportunity.

#### [3] Policy education is key to advocacy – that outweighs on portable skills.

Nixon 2KMakani Themba-Nixon, Executive Director of The Praxis Project. “Changing the Rules: What Public Policy Means for Organizing.” Colorlines 3.2, 2000.

Getting It in Writing Much of the work of framing what we stand for takes place in the shaping of demands. By getting into the policy arena in a proactive manner, we can take our demands to the next level. Our demands can become law, with real consequences if the agreement is broken. After all the organizing, press work, and effort, a group should leave a decision maker with more than a handshake and his or her word. Of course, this work requires a certain amount of interaction with "the suits," as well as struggles with the bureaucracy, the technical language, and the all-too-common resistance by decision makers. Still, if it's worth demanding, it's worth having in writing-whether as law, regulation, or internal policy. From ballot initiatives on rent control to laws requiring worker protections, organizers are leveraging their power into written policies that are making a real difference in their communities. Of course, policy work is just one tool in our organizing arsenal, but it is a tool we simply can't afford to ignore. Making policy work an integral part of organizing will require a certain amount of retrofitting. We will need to develop the capacity to translate our information, data, stories that are designed to affect the public conversation [and]. Perhaps most important, we will need to move beyond fighting problems and on to framing solutions that bring us closer to our vision of how things should be. And then we must be committed to making it so.

#### [4] Pluralism is good.

**Bleiker 14** – (6/17, Roland, Professor of International Relations at the University of Queensland, “International Theory Between Reification and Self-Reflective Critique,” International Studies Review, Volume 16, Issue 2, pages 325–327)

Methodological pluralism lies at the heart of Levine's sustainable critique. He borrows from what Adorno calls a “constellation”: an attempt to juxtapose, rather than integrate, different perspectives. It is in this spirit that Levine advocates multiple methods to understand the same event or phenomena. He writes of the need to validate “multiple and mutually incompatible ways of seeing” (p. 63, see also pp. 101–102). In this model, a scholar oscillates back and forth between different methods and paradigms, trying to understand the event in question from multiple perspectives. No single method can ever adequately represent the event or should gain the upper hand. But each should, in a way, recognize and capture details or perspectives that the others cannot (p. 102). In practical terms, this means combining a range of methods even when—or, rather, precisely when—they are deemed incompatible. They can range from poststructual deconstruction to the tools pioneered and championed by positivist social sciences. The benefit of such a methodological polyphony is not just the opportunity to bring out nuances and new perspectives. Once the false hope of a smooth synthesis has been abandoned, the very incompatibility of the respective perspectives can then be used to identify the reifying tendencies in each of them. For Levine, this is how reification may be “checked at the source” and this is how a “critically reflexive moment might thus be rendered sustainable” (p. 103). It is in this sense that Levine's approach is not really post-foundational but, rather, an attempt to “balance foundationalisms against one another” (p. 14). There are strong parallels here with arguments advanced by assemblage thinking and complexity theory—links that could have been explored in more detail.

#### [3] Only the aff makes any radical movements possible – speaking the language of power redirects state policy against itself whereas their tactic fails and is coopted.

DeLeon 12 (Associate Professor & Assistant Dean for Curriculum and Programming Educational Leadership and Policy Studies @ UTSA (Abraham P, “Chapter 17: Against the Grain of the Status Quo: Anarchism behind Enemy Lines,” in Anarchist pedagogies : collective actions, theories, and critical reflections on education, edited by Robert H. Haworth, Published: Oakland, CA : PM Press, ©2012, p. 312-15)

Infiltration: a word that may evoke a host of thoughts and fantasies from soldiers operating behind enemy lines, police informants gaining access to criminal organizations, or to scenarios of radicals inserting themselves into corporations or research labs. Whatever the scenario, infiltration can be tactic that anarchists pursue when thinking about operating within current institutional realities, especially if interested in teaching in public schools. Although this claim is entangled within complex relationships of power and privilege, struggle arises wherever domination coalesces, especially within institutional structures and settings (Sharp, Routledge, Philo & Paddison, 2000). Power conjures, “the threadings, knottings and weavings” of social relationships through a intertwining of the social, political, moral, educational, and historical realities of a given society. In this way, power is “crucially and unavoidably spun out across and through the material spaces of the world” (Sharp, et al., 2000, p. 22). This chapter thus looks to situate itself and build radical pedagogy within the threads and knots of contemporary relationships of power; inbetween what Holloway (2010) has called the “cracks” of capitalism, trying to “desperately find . . . faults beneath the surface, or to create cracks by banging the walls” (p. 8). Cracks have emerged through environmental disaster, economic collapse, psychological alienation, a crisis of identity, and decades of war and imperial aggression conducted by the West. It is under these historical conditions that resistance needs to be conceptualized. Creating, finding and exploiting “cracks” within a diffused and networked capitalism demonstrates that dated narratives of revolutionary struggle are no longer viable and there is “no guarantee of a happy ending” (Holloway, 2010, p. 9). Unfortunately, although these narratives may provide comfort amid an onslaught of capitalism, war, death, terror, and alienation, they do not open up, nor allow, alternative possibilities of resistance to form outside the boundaries they construct. In some ways, these may only help to reproduce the current order we find ourselves in. This does not mean that we should resign ourselves to the throngs of nihilistic defeat, as there is indeed potential for radical hope within the cracks of Empire. The multitude, with its potential for infinite possibilities, can build a complex and dispersed resistance through the breaks, tears, and folds of our social order (Deleuze, 1992), and the tactics and pedagogies that we envision as radicals can attempt to capture this spirit. Although the manifestations of these cracks and folds is yet to be seen, I leave the reader to their own radical imaginations in devising ways to subvert a networked and diffused machine (Shukaitis, 2009). Evoking the metaphor of a “machine,” as I describe the multifaceted nature of contemporary capitalism, harkens to Trotter’s (1990) claim that colonialism operated in a very similar way, divorced from individual interactions and operating abstractly through “official” and “unofficial” discourses, forms of knowledge, ways of knowing, the morality of a given era, and the reproduction of knowledge to name a few. The analogy of a machine also challenges that human agency is solely at the center of how social system operate, because machines, “create, distribute, and organize populations and impose regimes of conduct, agency and effectivity” outside of individual actors and agency (Grossberg, 2010, p. 36). Radicals (within and outside the labor movement) had ingenious ways in which to deal with the machines of capitalism, occurring through tactics that spanned strikes, sit-ins, walking out, and subversion to even more direct forms like sabotaging machinery, bringing production to a halt. Sabotage is a tactic that anarchists need to rethink in light of how labor is now dispersed among a wide variety of institutional realities (factories, banks, corporations, and public institutions, for example), as well as the contemporary knowledge and abstract economies. The machines of capitalism that produced goods during the height of the Industrial Revolution of the nineteenth century provide us a way in which to think of societal machines and tactics that can be adapted for current conditions. How do we as anarchists, who want to teach and work with students, deal with the contradictions of being located within the same institutions that seek to discipline bodies and coerce us? How do we sabotage these machines and build a radical pedagogy from this perspective? Sabotage provides a provocative conceptual framework in which to think about building alternative forms of resistance and aligns with ways in which anarchists have historically conceptualized direct political action. This is even more interesting when we think of how this will emerge through educational practice, as teaching allows us to directly engage ideology, challenging students’ conceptions about the world around them. With this type of important, dare I say political work, why do some anarchists shun the world of public teaching and service? Education is at the “front lines” of the contemporary ideological war conducted by corporate media, official organs of the State, and influential economic institutions. Whether that emerges through corporate textbooks that omit subaltern experiences and worldviews, standardized testing that stress rote memorization, or a curriculum that reproduces Eurocentrism and Western ways of knowing, education is invested in reproducing dominant conceptions of the world. However, sabotage can take myriad forms, and this chapter will build on the conceptual idea of building politics of infiltration. It has been well established that police and other State agents have infiltrated radical political movements, especially with the rise of anarchist praxis over the past two decades (Borrum & Tilby, 2004). Anarchists should think about assuming this same tactic, using the idea of infiltration as a guiding way to think about our praxis within institutional realities and as a way to think about diffused forms of sabotage. Although anarchism is rife with identity and lifestyle politics that detests any signs of “selling out,” this has only proven to further marginalize us in the eyes of the larger society that we must work at convincing how terribly oppressive the current social arrangement is. In the end, our movement is going to have to be broadbased and span multiple identities, social locations, political affiliations, and a renewed sense of politics that seeks to look at how, “the contemporary world has been made to be what it is [and] make visible ways in which it can become something else” (Grossberg, 2010, p. 1). Stoler (2010) discusses the idea of reading and analyzing “against the grain” of archival documents to unearth new interpretations and voices. This chapter urges radicals to think of our social actions along these same lines of thought: against the grain of dominant ideologies that serve to support historically oppressive realities. In this chapter, I will attempt to propose a politics of infiltration through a peculiar anarchist lens that seeks to subvert capitalism and its accompanying institutional realities through a diffused resistance stemming from bodies; bodies immersed in oppressive institutional realities. I dance through theoretical traditions to demonstrate how infiltration can be conceptualized as not only a physical practice (such as our work in classrooms), but also can be a theoretical framework in which to situate our practice, always looking for cracks, weaknesses, and oppor- tunities to sabotage dominant conceptions of the world that demonstrates another world is possible. Although radicals may think of this action as “selling out,” I want to reframe teaching and working within institutions as a potential form of infiltration, inserting other ways of knowing and being into the academy to challenge systemically oppressive realities. Shannon (2009) reminds us that cooptation lurks around every corner and Shukaitis (2009) warns us of the recuperative nature of capitalism. Both of these realities are firmly acknowledged as risks, however, it should not immobilize us into inaction. Nor should this resign us to “ghettoizing” ourselves into intellectual enclaves where conversations are more about nodding our collective heads in agreement rather than challenging our own practices with alternative voices and tactics. Indeed, tensions can be the basis for a critical reflection about what we are actually doing in our practice and engaging a wide variety of techniques and approaches to explore these, such as writing and political organization. Communities of practice, whether in activism or through qualitative research, are an essential feature of building bridges with other like-minded activists and scholars (Rossman & Rallis, 2003). Cooptation and recuperation are indeed challenges we will face but should not stop us from doing something, keeping in mind the question that Lorde (2003) had when she struggled with the tools of the master (p. 25). This chapter will hopefully allow the conversation to continue about the role of anarchist theory in building alternative forms of praxis, pedagogy, and direct action, especially within the context of public education and the contradictions that anarchists face within hierarchical and coercive institutions.