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GENDERED WELL-BEING

Globalization, Women's Health and Economic Justice: Reflections Post-September 11

Rosalind P. Petchesky

I. Introduction

Let me start with the question we cannot avoid: Can war — and especially a globalized state of permanent war and ubiquitous police surveillance — ever be compatible with the goal of assuring equity and justice in access to health care and a healthy life for all? From both an ethical and an economic standpoint, will *retribution* devour the potential for *redistribution*, like the mythic god devouring his children?

I wrote much of what follows during the quiet summer months, the months of insularity and contemplation before September 11, 2001 and its aftermath transformed our world. Then it seemed not only possible but indeed imperative to critique global health care policies and their gender, class, and racial inequities, and to imagine the more hopeful alternatives that seemed to lie within their apparent contradictions. But the new "war against terrorism" asks us to put all our imaginings for a better world on hold — and to call this patriotism. As the United States and the United Kingdom showered bombs on an Afghanistan already pummeled into dust—so dismal, repressed, and impoverished that it isn't even listed in the World Bank and United Nations Development Program (UNDP) development indices — and as President Bush challenged all the countries of the world to join a timeless and borderless war on terrorism or else be counted as "against civilization," I had to wonder if what I had to say as recently as August remains of relevance. More than anything, I fear that the efforts of transnational women's health movements and social movements mobilized around HIV/AIDS are destined to become part of this war's unseen "collateral

damage." So what I want to do here is to reexamine some of my earlier and, relatively speaking, more hopeful assumptions in the light—or dark—of our current situation.

To summarize briefly, my "innocent" manuscript expressed both critical concern about the constraints that a global capitalist, market-driven economy places on equity in health care, particularly gender equity; and cautious hope that a renewed emphasis on human rights principles and health as a human right was gaining ground. Such gains for a human rights perspective I attributed both to transnational feminist movements (of which I have been a part) that advocate a broad definition of reproductive and sexual health/rights, and to movements seeking equity in treatment and prevention of HIV/AIDS. A two-pronged ethical framework informed my thinking: feminist values about women's empowerment and bodily self-determination, and a social justice approach to health rights. I was cautiously optimistic that recent pressures in opposition to globalization might bring us closer to a transnational consensus in favor of policies and institutional mechanisms that would realize those values.[1] Let me review some of my basic propositions and interrogate them from the new and grimmer global political and economic landscape.

II. Before September 11

A. Proposition 1: Globalization, or the global hegemony of neoliberal capitalism, creates conditions that directly undermine health, particularly for women and girls.

I join many other writers in associating global capitalism with a number of features that, if not new individually, are new in their interconnectedness and massive scale. These include: hypermobility of capital across borders; integration of capitalist markets; liberalization of trade; use of electronic communications technology to accelerate cross-border financial, cultural, and informational flows; opening of national and regional boundaries to people, products, and pollutants; weakening of the modern nation-state in favor of transnational corporate and financial actors; a politically and militarily unipolar world, with the U.S. as the lone superpower; and centrality of *privatization*—whereby the state abdicates its social welfare functions to the private sector and becomes a conduit (or occasionally a cop) to expedite the traffic in capital and goods.[2]

Numerous analysts and U.N. reports have documented the meanness and inequality brought in the wake of these trends. National governments in both developing and developed countries, fearing capital flight and anxious to lure investors, succumb to pressure to enact structural adjustments, deregulate business, cut taxes as well as social spending, stabilize local currencies, and clamp down on trade unions. The results, compounded by huge burdens of national debt,[3] are (1) the reduction of public sector programs, especially in health and education, upon which working people and people in poverty depend; (2) rising unemployment, as the anticipated economic growth fails to "trickle down" or keep pace with the loss of public sector jobs, and local small producers (many of them women) become displaced by export production and foreign goods; and (3) the inability of the state to provide "safety nets" any longer, due to the shrinkage of public revenues from the lowering of tariffs on imports and taxes on capital.

Under such conditions, world poverty and the gap between rich and poor, both within and among countries, continue to increase. The presumed benefits of global market integration and liberalization accrue disproportionately to the most powerful countries and people. As the *Human Development Report* for 2000 bluntly states: "…the super-rich get richer" — and, I could add, they also get healthier and live longer, relative to the super-poor and even the not-so-poor.[4] It may seem obvious that poverty exacerbates ill health, as Paul Farmer[5] and others have demonstrated, but it is also true that privatization directly exacerbates poverty: "In India, the increased cost of medical care is the second most common cause of rural indebtedness."[6] Privatization, in turn, means commodification—of even the most basic elements of life. The World Commission on Water for the 21st Century reports that "the poorest people in the world are paying many times more than their richer compatriots for the water they need to live, and are getting more than their share of deadly diseases because supplies are dangerously contaminated."[7]

Researchers and international agencies are only beginning to collect hard evidence of the deleterious—and racist, sexist—health impacts of global capitalism. In an interview with National Public Radio in 2000, World Health Organization Director Gro Harlem Brundtland expressed dismay that the average life span in some of the world's poorest countries today is the same as that in Europe 250 years ago. Life expectancy has fallen since 1970 in a number of sub-Saharan African countries while infant mortality has increased. In considerable

part, this is due to both the AIDS epidemic and civil wars, but it is also due to development policies that stress growth and exports over human well-being, and foreign direct investment and loan policies that virtually red-line much of Africa (policies some call "global apartheid").[8] In Zimbabwe, the imposition of user fees for public health services has been linked to the doubling of maternal mortality, while structural adjustments have entailed layoffs of thousands of nurses and doctors.[9] Severe shortages of public sector health workers and supplies and facilities contribute, in turn, to higher rates of death from infectious diseases (including those that are completely curable, such as tuberculosis and malaria) as well as to rising infant mortality and maternal mortality and morbidity.[10] To complete the vicious circle, unaffordable charges for health care also result in greater malnutrition, hence worse health, especially under conditions of gender subordination for women and girls.

The uneven impact of global capitalism's harsher side is thus not only geographical but also racialized and gendered. Those who languish in the shadows outside the glitter of the global shopping mall (or the closed down hospital) are overwhelmingly Africans and dark-skinned and indigenous peoples in Asia, Latin America, and the urban ghettos of the North. Moreover, as so many feminist critics of mainstream models of development have noted, women "make up 70 percent of the world's 1.3 billion absolute poor."[11] Women are also those whose care-taking burdens multiply when public health and other social services are cut. Because they are more likely than men to be employed in the state sector, women suffer higher unemployment rates due to privatization and are also most vulnerable to prostitution, sexual trafficking, and STDs as a consequence.[12] A recent UNICEF report on 27 countries in Eastern Europe and the former Soviet Union found that free markets have an adverse impact on gender equality, leaving women and girls worse off than they were before. Rising female unemployment and loss of income bring reduced life expectancy due to "increased smoking, alcohol consumption, drug abuse and unsafe sexual activity," and consequently high rates of HIV/AIDS.[13]

Women pay for the cumulative social deficits of global capitalism and privatization in another way as well, insofar as these trends subvert the very international instruments that were designed to promote gender equality. Legally binding instruments, such as the Convention for the Elimination of All Forms of Discrimination against Women

(Women's Convention) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), contain provisions for better protection through social security programs, health and safety regulations, child care centers, and accessible health care.[14] Likewise, the nonbinding but morally compelling documents produced at the U.N. conferences in Cairo, Copenhagen, and Beijing in the 1990s call upon governments to take positive actions to implement gender equality, women's empowerment, the eradication of poverty, and access to health care, including comprehensive reproductive and sexual health services. Above all, they define "enjoyment of the highest attainable standard of health" (including reproductive and sexual health) as a fundamental human right. But implementation of this right assumes the model of a strong interventionist state, based on principles of social rights and the common good — a model that, not only in its socialist but in its democratic welfare state version (Europe and Canada), is rapidly becoming extinct.

Even in the less gloomy days of summer, I had to conclude that global economic trends, with their regimes of privatization, debt service, and trade-conquers-all, were on a collision course with international agreements and social movements to implement health as a human right. In the era before the September 11 attacks and the War to End All Peace, I had written that "the ubiquitous reach of neoliberalism and the globalization of economies have come *to replace military security* as the 'comprehensive norm' of global governance since the end of the Cold War."[15] I saw evidence for the hegemony of this econocentric norm within the United Nations and the World Trade Organization (WTO), where most national governments, including those of developing countries, were scrambling for inclusion in the global economy and Secretary-General Kofi Annan was busy courting transnational corporate "partners" to join the U.N.'s Global Compact (a scheme to give corporations a kind of honorary membership in the U.N.).[16] I saw it, too, in the prominence of financial institutions like the WTO, the International Monetary Fund (IMF), and the World Bank — which lack any democratic accountability — in influencing the direction of global health policies. Finally, I saw it in the priorities of those policies themselves and the largely quantitative, efficiency-oriented methodologies used to arrive at them. Now, let me digress for just a moment to summarize where my thinking lay by mid-summer on the matter of *health sector reform*.

"Health sector reform" is an umbrella rubric that refers to a whole range of economies aimed at making national health ministries more effective, and investments in health and health delivery systems more efficient. Most analysts trace its origins — at least in its most recent incarnation — to the World Bank's 1993 World Development Report, *Investing in Health*. The Bank has become the most powerful institution setting global and, in many cases, national policy agendas in regard to health care, having surpassed the World Health Organization in this role.[17] By its own estimate:

> The World Bank is the largest single source of external funding in developing countries for human development—which includes health, nutrition and population (HNP), education, and social protection. These sectors are also the fastest growing areas of Bank lending, accounting for 20 percent of lending for the last three fiscal years, as compared with 3 percent a decade ago.[18]

In theory, health sector reforms have two main purposes: (1) restructuring state systems of health finance and delivery to facilitate private investment, greater efficiency, and access; and (2) providing health care resources in areas where "market incentives" are absent, that is, where the private sector sees no profits. On their face, these purposes appear reasonable in terms of both better health outcomes and achieving gender/race/class equality and human rights. Inefficient and wasteful health systems can hardly be socially just. In practice, however, what we know so far about the implementation of health sector reforms is not encouraging. Neoliberal economists at the World Bank and the WHO now seem to be determining health priorities using narrow calculations of the "global burden of disease" (GBD) based on aggregate formulae for computing loss of healthy life years. Intrinsic to these methods is a bias favoring utility and cost effectiveness over prevention and social inclusion.

It is not possible in the scope of this essay to present a detailed critique of the DALYs (Disability Adjusted Life Years) methodology or the problems of so-called "sector-wide approaches" (SWAPS) but only to summarize my main concerns—the concerns I was so preoccupied with in the summer and that now seem rather trivial and far away.[19] First, as any recent WHO report immediately reveals, this economistic regime is expressly aimed at replacing the broad emphasis on primary health care, universal access, and multisectoral programs embraced in

the famous 1978 Alma Ata Declaration.[20] In fact, health sector reforms and SWAPs move us *backward* to the vertical, disease-oriented focus that prevailed in the 1950s and 1960s; to a reduced concept of "public health" as immunization campaigns and limited expenditures on a narrowly defined "package of services" for the poorest; and to a major emphasis on privatized care, private financing for all but "catastrophic" illnesses, and user fees to contain social costs.[21]

Second, reflecting the fallacy in its claims to objectivity and neutrality, the "DALYs/GBD" approach to setting priorities contains an inherent gender bias. This is not to deny that its methods have yielded policies that can benefit women and children as well as men. For example, since the methods compute disability as well as deaths, they give priority to addressing both maternal mortality and maternal morbidity, often ignored in the past. Further, they have resulted in aggressive campaigns by international agencies and private donors to wipe out such deadly but curable diseases as river blindness, malaria, and tuberculosis, and potentially to find a cure for AIDS. On the other hand, the focus on not only diseases but "catastrophic" diseases — those presumed to take the greatest toll on *productive* life — completely ignores conditions that cause so many women, especially poor women, the most endemic pain and suffering and that have been the focus of women's health movement advocacy for years. Chronic conditions such as menstrual disorders, reproductive and urinary tract infections, genital mutilation, obstetric fistulae, domestic violence — to say nothing of the lack of sanitation and clean water, or harassment or abuse by doctors and family planning clinic workers — are completely absent from the health economist's radar screen.[22]

The reason why the quantitative, narrow methods being used by global health economists to determine health policies is problematic at its core is because of the underlying assumptions about what matters for a "healthy" life. Those assumptions rest entirely on a capitalist patriarchal ideology that privileges *productivity* above all else. This means that their framework ignores the kinds of daily suffering and ill health that women, especially the poorest and most vulnerable women, often see as the inevitable pains of life, to be endured without stopping their normal work and domestic tasks. It also provides no way to evaluate the quality of health care services as women experience them. Yet that experience may have a direct bearing on the "burden of disease," since we know that practices such as disrespectful or abusive treatment, lack of confidentiality, and cultural insensitivity

discourage many women from returning to clinics and, therefore, function as de facto barriers to access.[23]

Finally, the main problem with neoliberal economists determining global health policies is philosophical. It has to do with their underlying concept of justice as the distributive outcome of free markets, and their unquestioning belief that markets, while imperfect, can solve most of the problems of curative health care.[24] As the World Bank put it in proposing that the state abandon the business of operating public hospitals and clinics, "if government does not foot the bill, all but the poorest will find ways to pay for care themselves."[25] The end result of this approach is that vast areas of the social sector are now opened up for private investment and profit, a good part of which comes from public revenues through subcontracting. Public hospitals are defunded, privatized, or shut down. The market becomes the source of most services for most people, and those who cannot afford to pay ("the most vulnerable") are left to be protected by (often nonexistent) "safety nets." In other words, as the U.S. system with its millions of uninsured and uncared-for so shamefully illustrates, health care becomes a two-tiered system — a commodity for many ("health consumers") and a form of public assistance, or an unattainable luxury, for the rest.[26]

Why is this so bad? By putting so much social need into the hands of the private sector — "marketizing" the state's social welfare functions — it obviates any systematic, democratic mechanisms of *accountability* regarding standards of quality and access. The market is an ethically closed, or self-regulating, system. It measures value only by supply and demand. In practice, then, *ability to pay for services* becomes the ethic governing distribution, rather than principles of human rights and social inclusion. A human rights approach differs fundamentally from a market-oriented model because it provides (a) a normative ground on which people can feel entitled to make social justice claims; (b) standards for evaluating programs and services from the standpoint of the needs and well-being of those whom they are designed to benefit; and (c) mechanisms of accountability for enforcing those standards. It relies on a community consensus, arrived at through democratic processes, for determining health needs and priorities,[27] rather than on marketing surveys or letting individual consumers simply "shop around." And it does not accept the neoliberal economist's model of scarcity, so obscene in the face of exorbitant wealth, budget surpluses, and massive military spending ($1 billion a month and

expected to grow geometrically for the "war against terrorism" alone).[28]

Now let me back up and ask what was wrong with this picture? From the vantage point of the "new war" front, I see at least four challenges to my earlier critique of the politics of global health. First, as globalization furiously goes military, it becomes all too obvious that militarism as a "comprehensive norm" is alive and well and quite ready to displace economic rationality. We are reminded that no country, least of all the U.S., ever seriously contemplated demilitarizing after the Cold War ended. "Terrorism" was always standing in reserve as the incarnation of evil—an empire without borders—to replace the supposed threat of communism. "National security," now escalated into "global security," trumps all the other logics of power and, in the name of sheer survival, silences all the demands for a decent and healthy life.

Second, my cursory review of the health deficits wrought by global capitalism was much too focused on middle and low-income countries, neglecting the deterioration of health systems here at home. In the face of bioterrorism and several deaths from anthrax, officials admit that the U.S. itself suffers from "inadequacy of our public health infrastructure" (due, of course, to two decades of privatization and cutbacks in public funding); and that "many of the nation's hospitals lack necessary equipment—in some cases even simple tools like fax machines—to receive or report information in an emergency."[29] (One wonders how public hospitals have coped with many other kinds of emergencies until now.) In short, the harsher health impacts of global capitalism are perhaps more evenly spread than I had imagined. Will the prescribed antidote be the militarization of hospitals and clinics?

Third, the current scenario calls into question the analysis of the state as weakened, much less in decline. Just as the U.S. has been the global model of commodification and markets, it is also likely to set the parameters of the permanent security state and the globalization of militarism. For now, it appears that this means not only the federalization of airports but also the expansion and centralization of state agencies for policing and intelligence-gathering (the so-called "Department of Homeland Defense"); the presence of uniformed and armed state agents in many public venues (as is currently the case in Brazil, Israel, and Egypt); the continual surveillance of communication and transportation networks of all kinds; and the restraint of civil liberties and mobility for all citizens, but particularly for immigrants. The "U.S.A.

Patriot Act," passed hastily and almost without opposition in Congress in October 2001, provides extraordinary powers to the Attorney General to conduct surveillance through floating wiretaps; to eavesdrop on communications between lawyers and their clients in federal custody; and to pick up and detain indefinitely any foreigners he has "reasonable grounds to believe" are "engaged in any activity that endangers the national security of the United States," without providing any information about their whereabouts or the charges against them.[30] In addition, President Bush ordered the establishment of a system of secret military tribunals to try "terrorists" without any of the usual due process protections or the public disclosure of proceedings that accompany criminal or even court-martial trials under U.S. law.[31] All of this is justified by the "emergency" conditions of "wartime"—in a situation where Congress (the only governmental body constitutionally authorized to do so) has never made an official declaration of war.

Clearly, there is nothing to suggest that the refurbished security state will give any priority to provision of social services, including even the minimal forms of preventive health care and "safety net" packages for the poor recommended in the pre-September 11 era by the World Bank. Quite the contrary. The security and anti-terrorist apparatus (not only in the U.S. but in all countries that join the "anti-terrorist coalition") will devour enormous public funds, while helping to reconstitute the strong centralized state—now under the lead of the very conservatives who long complained about "too much (federal) government." Further, we cannot help noticing the deafening silence of those international institutions that only months ago were recognized, or hated, as the most powerful managers of global capitalism—the WTO, the IMF and the World Bank. They have either been conscripted as auxiliaries to America's war, as in the convenient and sudden timing of the IMF's generous loan to Pakistan,[32] or relegated to inconsequentiality. No one worries that they will be targeted for terrorist attacks.

Finally, I register with some alarm what is already happening to globalization's much vaunted porous boundaries. Borders are tightening everywhere, as our security-obsessed nations — particularly in North America and Europe—increasingly perceive the flows of information, people, drugs, arms, and viruses as sources of deadly danger. As in some medieval garrison town, the policing of borders and boundaries (not the provision of social services) becomes the defining signifier of the state. Whether we are observing the fleets of police heli-

copters and military personnel who now patrol New York's ports of entry or the televised footage of throngs of starving Afghan refugees pushing up against the sealed Iranian and Pakistani borders, we seem to be staring at globalization's future. A future of segregation rather than integration, and none of it—including the packets of "humanitarian" veggies and antibiotics dropped into the barren, land mined dust — has anything to do with health. The United Nations Population Fund announced an emergency program to provide Afghan women refugees — some 10,000 of whom have high-risk pregnancies — with desperately needed reproductive health care, only not abortions.[33] Whether this was in deference to the Muslim fundamentalists in Afghanistan or the Christian ones in Washington, I do not know. Otherwise, health, including reproductive and sexual health, has almost disappeared as a public issue—unless the bioterrorist threat ironically succeeds as a wake-up call.

B. Proposition 2. Whether despite or because of the growing inequities and negative health indicators that have accompanied global capitalism, the end of the 20th century and the beginning of the 21st also brought new possibilities and new ways of thinking in international arenas about the links between poverty, health, and human rights.

At the midsummer solstice, I saw many rays of hope shining out of the contradictions between global capitalism's promise and its realities. In almost classic dialectical fashion, these grew out of some fairly dismal shifts signifying *new configurations of global power*. By the late 1990s, serious chinks had developed in the global capitalist armor, bringing division in its inner circles and new power constellations challenging its hegemony. The failure of the "Asian tigers;" chronic economic and health crises in Russia and other "transitional" economies; and the onset of recessions and widespread layoffs, bankruptcies, and downsizing in many of the leading capitalist countries sent shock waves through the central institutions that manage the global economy. These unanticipated economic downturns, along with the mounting size and visibility of mass protests, muffled the optimism of globalization's champions and triggered a period of self-searching and ideological revision. Even the unipolar configuration of global power seemed fractured and unstable. Although the U.S. remained the world's single most powerful country economically and militarily, by 2001 and the G-

8 summit meeting in Genoa in July, it had also become the world's chief outlaw and rogue nation, refusing to comply with international legal and normative standards on just about any issue. It was isolated from its closest allies in Europe and Japan, derelict in paying its large backlog of U.N. dues, voted off the U.N. Human Rights Commission in Geneva, rudely walked out of the World Conference Against Racism in South Africa, and widely distrusted for its cowboy, go-it-alone political posture.[34]

The sequel was the revision of the neoliberal agenda. By the turn-of-the-millennium, critiques of neoliberal dogma, even from within the World Bank, and the undeniable evidence of its failures, had induced international organizations to reframe their growth-oriented policies and begin addressing issues of systemic poverty and ill health. A shift to a kind of "neo-Keynesian moment" has been particularly evident in the policies of the World Bank (thanks mainly to its former chief economic advisor, Joseph Stiglitz, who left the Bank but also won a Nobel prize). Amidst the 1998–99 global economic crises, World Bank leaders were outspoken in questioning the orthodoxy of the past decade and, to some extent, separating themselves from both the IMF and the U.S. Treasury and Federal Reserve chiefs on global economic priorities—a turn that many commentators characterized as a "breakdown in the Washington consensus."[35] Rejecting the orthodox assumption that economic growth alone will eliminate poverty or that markets can be relied on to ensure health, education and gender equality, especially for the poor, the Bank embarked on a campaign encouraging states to redistribute resources in order to create "pro-poor" public goods. In the most recent *World Development Report* (WDR), it states boldly: "Poor people have few assets in part because they live in poor countries or in poor areas within countries. They also lack assets because of stark inequalities in the distribution of wealth and the benefits of public action."[36]

Of course, this shift to an emphasis on poverty reduction and redistribution is partly a response to strong protests against Bank policies and projects in many developing countries as well as in countless anti-globalization demonstrations.[37] But the Bank's new "global welfare state" policy is not just an attempt to give capitalism a more human public face. It represents, arguably, a real change in outlook and priorities. Conceding that "markets do not work well for poor people," the Bank in 2000 began to urge redistributive policies targeted especially to health, education, and infrastructure. It praised countries that have

chosen to spend more on better rural roads, sanitation, health, and education and *less* on "debt service, subsidies to the nonpoor…and the military." Military spending and paying off foreign debt receive particularly strong censure as "regressive" and "unsustainable" fiscal policies in the Bank's revised outlook.[38] In contrast, the 2000/2001 WDR cites this glowing example: "Mauritius cut its military budget and invested heavily in health and education. Today all Mauritians have access to sanitation, 98 percent to safe water, and 97 percent of births are attended by skilled health staff."[39] Before September 11, it seemed we had come a long way from the Structural Adjustment programs of the 1980s and 90s.

There also arose new and vigorous transnational social movements and coalitions. The underside of globalization—aided by instant internet communication — brought new forms of coalition-building and new popular movements joining labor groups, farmers, students, environmentalists, social development activists, and feminists. One has only to look at the waves of mass protests at the WTO and G-8 meetings in Seattle, Prague, and Genoa; or the unprecedented gathering of 10,000 opponents of global capitalism and advocates of social democracy at the World Social Forum in Porto Alegre, Brazil; or the occasional resistance by some developing country governments (notably, Malaysia, South Africa, Brazil, and, always, Cuba) to the dictates of the North. These growing sites of opposition pointed to fissures in the global capitalist regime and the power of both popular movements and Southern states to contest it. In July, I was unaware of the full portent of my words when I wrote, "*These ruptures may have destabilizing effects, unleashing in their wake reactionary, patriarchal nationalisms*," for I was also hopeful that they could open up spaces for alternative visions and liberatory social action.

Feminists have been at the center of such alternative visions and activism. From the standpoint of transnational women's health movements seeking to empower women as reproductive, sexual, and political actors, recent economic crises and cuts in public health services have brought home that "macroeconomic issues can no longer be left off the table when sustainable development, women's rights, the environment and health are discussed."[40] Feminists have condemned the ways that multilateral donor institutions, donor countries, and developing country governments have allowed debt service, military expenditures, and free-market priorities to override the desperate need for public investment in health care and other social needs. Along with

other groups, they have called for demilitarization, debt forgiveness, transparency and accountability in the decisions of transnational corporations and international financial institutions, and international regulation of unsustainable, unhealthy economic practices through such devices as "Tobin taxes" on speculative capital flows.[41]

Women's health activists from the global South and from Eastern Europe have sounded the alarm about reproductive and other health threats from not only environmental and industrial toxins but also unfair trade practices. Two examples are the U.S. embargo on Cuba that prevents women there from receiving mammograms, and unregulated drug prices that prevent people with AIDS in Africa and Asia from receiving life-prolonging but economically unaffordable medications. Women's groups have participated in demanding a more equitable distribution of the world's wealth and resources, and have helped to create people's (and specifically women's) budgets. They have also been instrumental in forming new kinds of transnational coalitions working effectively to promote human rights, gender equality, and development principles within U.N. forums. Such coalitions have for the first time brought together women's health, human rights, and development NGOs with certain women-friendly U.N. agencies (such as UNIFEM and UNDP) as well as sympathetic governments in the "Group of 77" (G-77).[42] They have not only given voice to a powerful if still embryonic global civil society but also provided a base of strength and authority for the United Nations itself and for principles of international law.

Also generated was a broader acceptance of human rights approaches linking health, equality, and social development. All of this activity and organizing at the global level in the 1990s was based on a feminist ethical framework developed over many years by women's health activists in Latin America, Asia, and Africa as well as in North America and Europe. It was a framework that both privileged a woman's right to control her own body, fertility, and sexuality, and, in the words of DAWN, placed that right "within a comprehensive human development framework."[43] Thus, it implied a vision of human rights as inseparable from basic human needs, in accordance with the principle of indivisibility that sees personal rights, socioeconomic rights, and civil rights as completely interdependent.[44] From this perspective, even the Cairo definition of reproductive rights as the right "to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so"[45]

becomes very complex and expansive. How can a woman or girl avail herself of this right if she lacks the financial resources to pay for health services or the transportation to get to them; if she is illiterate or given no information in a language she understands; if her workplace is contaminated with pollutants that have an adverse affect on pregnancy; or if she is harassed by parents, a husband, or in-laws who abuse or beat her if they find out she uses birth control? The "means to do so" contains a universe of freedoms and capabilities out of reach for many women and girls.

The necessary enabling conditions to exercise one's reproductive rights go well beyond an individual's or a household's financial resources. They also involve freedom from cultural constraints and infrastructure deficiencies.[46] Even the minimal components of vertical family planning programs — contraceptives, safe abortion, and STD prevention — are often inaccessible to women and girls, especially unmarried adolescents, even if they have the means to pay, due to oppressive traditions and codes enforced by religious authorities, the media, and conservative groups as well as family members. A community's lack of clean water, sanitation, or decent, uncrowded housing compromises reproductive and sexual health and well-being for millions of women and girls. The absence of such basic infrastructure — for example, being able to use a condom or deliver a baby safely or avoid sexual abuse — puts women in untenable dilemmas. Another conundrum is faced by HIV-positive pregnant women who must choose between breastfeeding and exposing their infants to the risk of AIDS, or bottle-feeding and exposing them to deadly bacterial infection from contaminated drinking water.[47] Even the antiretroviral medications that can prevent perinatal HIV transmission are still too often unaffordable or unavailable due to a lack of political will.

Thanks to the efforts of transnational women's health and HIV/AIDS organizations, this holistic, integrative concept of the right to health has received recognition from U.N. committees and treaty bodies. In May of 2000, the Committee on Economic, Social and Cultural Rights, the treaty body responsible for interpreting and enforcing the ICESCR provisions, issued a comment clarifying "the right to the highest attainable standard of health" contained in Article 12 of that document. This right, it said, "is not confined to the right to health care ...[but] embraces a wide range of socio-economic factors...[extending] to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe

and healthy working conditions, and a healthy environment." Not only material conditions but also a wide range of civil and political rights, such as "education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement" are also "integral components of the right to health."[48] What this means in practice is that implementation of the right to health requires *multisectoral* approaches like those called for in the old Alma Ata Declaration (those that global health economists wish to shelve), and that it can only be addressed effectively through a vision of gender equality, antiracism, and human development.

I must also highlight the successful campaigns asserting the rights of health over the prerogatives of corporate patents and global trade. In 2000, during the five-year review process for the U.N.'s World Summit on Social Development (WSSD+5), a little known but groundbreaking event occurred: the achievement of historically unprecedented language linking trade-related intellectual property rights (TRIPS),[49] access to essential medicines, and the fundamental human right to health. In large part, this achievement became possible because of the new kind of alliance among transnational women's groups, development groups, and certain friendly country delegations within the U.N. The Women's Caucus had proposed the following language in regard to a paragraph on TRIPS: "*Recognize that intellectual property rights under the TRIPS Agreement must not take precedence over the fundamental human right to the highest attainable standard of health, as provided in many international human rights and other multilateral instruments, nor the ethical responsibility to provide life-saving medications at affordable cost to developing countries and people living in poverty.*" The Caucus saw this as a wedge issue that might raise the awareness of governments and development NGOs of the connections among health, human rights, and global trade. The issue also had important gender implications because of the plight of HIV-infected pregnant women in poor countries, especially sub-Saharan Africa, and the greater susceptibility of women and girls to HIV infection generally. But there was little optimism that the proposal would be accepted, especially given the staunch commitment of the U.S. and European Union governments to TRIPS and WTO authority. Thus, women's rights NGOs were both surprised and elated when the South African delegation took over their language verbatim and succeeded in winning its adoption by the entire G-77 and China.

Given the concerted opposition of Northern governments, led by the U.S., it was remarkable that the conference adopted a compromise paragraph putting the "right of everyone to the enjoyment of the highest attainable standard of . . . health" *first*, before the intellectual property rights of companies. The paragraph also recognizes "the critical importance of access to essential medicines at affordable prices," including the right of countries to bypass TRIPS through cheaper imports or local manufacture "in an unrestricted manner." The political and strategic importance of this moment for the politics of global health is unmistakable:

- For the first time in any international multilateral agreement, global trade, human rights, and health were connected — with important implications for women's health.
- A precedent was set in international norms for the principle that intellectual property is not more valuable than human life, and that access to affordable medicines is a matter not only of exceptions to patent laws and trade as usual, but also of fundamental human rights.
- For one of the few times within U.N. debates (the right to development being a notable exception), the G-77 and China adopted a human rights framework as the basis of their position.
- By taking the initiative to introduce this language, the Women's Caucus showed its concern with linking gender and health issues to macroeconomic policies and global trade.

Access to medicines is deeply embroiled in international conflicts over trade inequities and the alleged prerogatives of transnational pharmaceutical companies and their Northern government patrons to monopolize patents and markets. It lies at the heart of globalization and the ways that globalization is always already about class, race, gender, and human rights. No wonder it has been such an effective wedge issue for anti-globalization coalitions. Seizing front-page attention in the mainstream media, the sequel to the hidden story of WSSD+5 is now well known. The giant pharmaceuticals continually lowered their prices for HIV/AIDS drugs in sub-Saharan Africa, in response to international pressure (led by groups like Doctors Without Borders and Act-Up) and the competition of generic manufacturers. In addition, the drug companies finally dropped their patent case against South Africa, after angry demonstrations by AIDS organizations and trade unionists in the streets of Johannesburg and Pretoria. Following

suit, the U.S. dropped its patent case against Brazil, and the Brazilian government persisted in its exemplary HIV/AIDS policy to manufacture locally the AIDS "cocktail" of drugs and provide full treatment to everyone who needs it free of cost.[50] Most recently, the WTO ministerial meeting in Qatar, in autumn 2001, adopted a compromise declaration that, while not changing the language of TRIPS, opens the way for "promoting access to medicines for all" through allowing poor countries to manufacture or import cheap generic versions, patents notwithstanding. The language is that of public health, not human rights, but the principle now has a global mandate.[51]

By the spring of 2000, then, access to essential, life-prolonging medicines, especially in regard to the HIV/AIDS pandemic, had become the most visible example of "the human right to the highest attainable standard of health," when "attainability" is a matter of affordability and supply. Moreover, because of the greater vulnerability of women and girls to infection and the tested effectiveness of antiretroviral drugs such as AZT and Nepinephrine in preventing perinatal transmission, this issue could be seen as an integral component of reproductive and sexual rights for women. It thus illuminates the intersection of gender justice, reproductive rights, and sexual rights with issues of poverty, class, and racist and regional exclusion.

III. After September 11

There I was in midsummer, feeling relatively optimistic that health and social justice movements were winning some real victories inside the regime of global capitalism. Now all I see is the grotesque spectacle of Bush telling the Afghans that this is a "humanitarian war" and to prove it we're dropping packets of food and medicine into your rubble along with all the bombs. There is a striking resemblance between the two "phantom towers" of Jihad and Crusade, with their apocalyptic rhetoric, their masculinism, their rush to violence—even their rivalry over who works the media best.[52] One could take this further and argue that *corporate tribalism*—the allegiance to oil and gas and military hardware industries based in the southwestern and western U.S. states—bears a certain resemblance to ethnic and warlord tribalism. The Bush administration, mirroring its jihadist enemies, thrives on war, a permanent state of war. But the war it seeks is not only *against* terrorism but *for* Unocal, the Carlyle Group, Aramco, cheap crude, unlimited SUVs, and a president whose image finally looks manly.

Meanwhile, the regimes of international law and human rights and the multilateral U.N. agencies responsible for global health, such as WHO, ECOSOC, and even the World Bank, are consigned to irrelevance. Indeed, multilateralism and international cooperation seem buried beneath the wings of the phoenix superpower that issues ultimatums in return for rubber-stamp approvals. In this climate, ideas like "health security," "human security," and "social security" become shadowy relics in the face of the far more compelling realities of "national security" and "global security." The welfare state and the democratic state are ghosts in the citadel of the total security state. And what about the popular movements and coalitions of "global civil society" that were becoming such powerful advocates for social justice, gender justice, health, and human rights? They (we) have no choice now but to organize marches and teach-ins and to dig in for the very long battle to reestablish sanity and peace.

Returning to my original question: Can war—and especially a globalized state of permanent war and ubiquitous police surveillance—ever be compatible with the goal of assuring equity and justice in access to health care and a healthy life for all?[53] In the present context, the basic health care packages and SWAPs of the health economists, and the revisionist neoliberalism and poverty reduction strategies of the World Bank, don't look so bad. At least they took global health issues seriously. Beyond the destructive war, the terrorist attacks, and the anarchy and starvation threatening to replace the Taliban's brutal repression of the Afghan people, the real danger now is that all the resources that might have been marshaled toward reducing misery, eliminating maternal mortality, finding a cure for AIDS, and promoting women's equality, will be diverted into military and police projects—the waging and deflecting of violence. In November of 2001, senior administration officials anticipated that the $1 billion a month spent on war costs so far would grow "geometrically," taking into account all the costs of upgrading Central Asian airfields, paying for National Guard and reserve forces, patrolling U.S. cities, and defending the nation's borders.[54] With the Taliban apparently routed, official pronouncements from Washington increasingly used the language of "*this phase* of the war," clearly laying the groundwork for a next phase and a next (Somalia? Iraq? Airfields and pipelines in Uzbekistan?).[55] This endless war and all its ancillary security production, in the midst of a global recession, will erase the agendas and sap the budgets for health, education, and economic, racial, and gender justice for years to come.

Wouldn't it actually be easier and cheaper to end poverty and contagious disease everywhere?

During March 2002, in Mexico, another U.N. conference will take place. Called Financing for Development, its aim is to identify international and national resources to implement all the human development, health, and gender equality commitments of the past decade. What can that conference realistically do at this moment? At the General Assembly meeting on HIV/AIDS in July 2001, the U.N. pledged to raise $10 billion to provide a fund to combat AIDS in sub-Saharan Africa, but a mere fraction has been raised.[56] The same amount of money, according to a recent WHO report, could provide safe water and sanitation throughout that poorest of regions, only no one seems to know where such funds can be found. Meanwhile, the U.S. Congress managed to come up with $15 billion almost overnight to bail out the sagging airline industry and then authorized a *$200 billion* contract for the Lockheed Corporation to produce an endless supply of fighter planes.[57] In the global arena, the World Conference Against Racism ended only a few days before the September 11 attacks and revealed for the first time in history the linkages among so many different forms of racism against, for example, Romas, Dalits, indigenous peoples, Palestinians, and Africans. It now seems a distant memory, as Arabs or Muslims become the primary *Other* still visible. In this context, how can claims for racial justice, to say nothing of reparations, be heard?

Still, we have to explore whatever alternative paradigms for constructive action may be possible, beyond merely seeking an end to the useless, terrible cycle of retaliation and violence. To borrow Auden's words, can we find any "ironic points of light" in all this darkness that will "Flash out wherever the Just/Exchange their messages"?[58] First, I think it's urgent to stop the bombing and the cycle of retaliation; nothing, *nothing* can be done before we do that. Women's peace movements like Women in Black—in the Middle East, Northern Ireland, Sri Lanka, Bosnia, Sierre Leone—have understood for a very long time that violence only breeds more violence; and this is infinitely truer in the age of total annihilation. Women's movements have struggled for years against the viciousness and misogyny of fundamentalisms—in Algeria, Iran, Afghanistan before and under the Taliban, Pakistan, and right here in the U.S. I remind you that Timothy McVeigh was a homegrown American Christian; that Christian anti-abortion terrorists in this country continue to firebomb clinics, threaten bioterrorism, and target doctors and clinic workers for assassination; and that the immediate

response of the Reverends Falwell and Robertson to the September 11 attacks was to blame "the abortionists, and the feminists, and the gays and the lesbians…all of them who have tried to secularize America."[59] But women opposing fundamentalisms know well enough that we adopt their methods at our peril. As Zillah Eisenstein says, "I wish to foil each and every attempt of terrorist actions but not simply by the use of more terror."[60] Addressing the root causes of anger and violence is the only healthy weapon we have.

This brings me to a second constructive paradigm. We should perceive a common ethical failure behind both the pre-September 11 regimes of global capitalism and global apartheid, and the current regimes of fundamentalist terrorism and anti-terrorist global militarism. They all raise the question: Should some lives count more than others? Isn't health about the preservation and enhancement of life, and isn't the viewing of whole groups of people as lesser—whether as "infidels," "bad risks," or expendable "collateral damage"—basically unhealthy and anti-life?[61] Do massive violations of civil liberties and fundamental freedom from FBI harassment and punishment, without proof of crime, matter less because their targets are "foreigners"? Do they make anyone safer or rather feed the climate of danger, insecurity, and arbitrary power they are alleged to prevent?

In this rare moment of U.S. media attention to the world outside the nation, we can discover a time of challenge and even opportunity for us as Americans. We can urge Congress to conduct a special investigation, not only into who and where are the terrorists, but also into the painful question: Why did so many people in Asia, Africa, Latin America, and the Middle East agree with the Pakistani accountant who said after September 11, "America bullies everybody; now they know what other countries suffer"? We can learn more about how others see us and begin to take responsibility for our immense power. We can demand respect for the civil and human rights of all persons within our borders, whether citizens or not. We can insist that those who commit crimes against humanity (the legal name for terrorist acts) be apprehended and tried through multilateral mechanisms and the rule of international and constitutional law, not unilateral, secret tribunals; and that the U.S. immediately ratify the Rome Statute establishing an International Criminal Court, the logical body to try such cases in the future.

But no amount of international penal action, however cooperative, can stop terrorism without addressing the conditions of misery and

injustice that nourish and aggravate terrorism. The U.S. has to undertake a serious reexamination of its values and its policies with regard not only to the Middle East and Central Asia but also to the whole world. It has to take responsibility for being in the world, including ways of sharing its wealth, resources, and technology, and democratizing decisions about global trade, finance, and security. It must assure that access to "global public goods," like health care, housing, food, education, sanitation, water, and freedom from racial and gender discrimination, is given priority in international relations. What we even mean by "security" has to encompass all these aspects of well-being, and has to be universal in its reach. The U.S. has to want less and to develop humility.

There are hopeful signs. As I finished revising this essay, the U.S. Congress authorized the Bush administration to direct some of the funds appropriated for relief of the 9/11 victims to Afghan women and children, for food and health care. After six full weeks of bombing and well over six years of transnational feminist pleas that fell on deaf ears, the politicians and media started to pay attention to the plight of Afghan women, confined like prisoners to their homes and *burqas*, banished from work and schooling, and denied basic health care. This opened a public space for American women to support the courageous Afghan women's organizations in their demand for full participation in all efforts to reconstruct their government and society.[62]

And yet, the cynicism of a First Lady and a President who suddenly discover women's rights just in time to legitimate an ever-widening war under cover of a rescue mission for Afghan women (or to garner more women's votes in the next election) is sobering.[63] Again, I quote Zillah Eisenstein's wise and cautionary words: "It is unconscionable to wrap U.S. bombs in women's rights discourse. Do not make a war against terrorism in our name when women make up the greatest numbers of the new casualties and refugees of this war."[64] Yet this discourse is happening, and maybe, just maybe, Americans will start to hear the contradictions between the rhetoric and the reality, and to demand a politics that embraces all humanity.

IV. Postscript

A last image: as U.S. bombs continue pulverizing the area in the eastern part of Afghanistan around Jalalabad, supposedly near the caves and tunnels where bin Laden and Al Qaeda are hiding, we learn that at

least three villages have been hit, "killing dozens of civilians." A man lies in a Jalalabad hospital, one of the very few (and poorly equipped) hospitals still standing in the entire country, his head almost fully bandaged. He tells reporters through a translator: "The village is no more. All my family, 12 people, were killed. I am the only one left in this family. I have lost my children, my wife. They are no more." And he weeps.[65] On CNN, I see a child, or what remains of a child, lying in the same hospital, his face shrouded in bandages, one arm and the other hand gone, only stumps dripping blood. He doesn't weep; he is silent. Health care and a healthy life for all are very far from this place, but the place seems very near, in my living room, and always before my eyes. ◉

Notes

1. See *Globalizing Bodies: Gender, Health and Human Rights* (London: Zed Books, forthcoming 2002), chapters 1 and 4, from which this essay has been adapted, for a fuller discussion.

2. Analyses of globalization are developed more thoroughly, though from diverse perspectives, in works by Appadurai 1996; Barker and Mander 1999; Bauman 1998; Bello 2001; Brecher, Costello, and Smith 2000; Eisenstein 1998; Hardt and Negri 2000; Houtart and Polet 2001; Sassen 1998; Smith 1997; and Tabb 2001.

3. "Nigeria's external debt exceeds a full year's GNP"; Tanzania spends nine times as much on debt service as on health care and Ecuador eleven times as much. (WEDO 1999a:10; UNDP 2000a, Table 5.3). It is still unclear how much of this burden will be lifted by agreements of the G-8 countries to extend debt relief to certain "heavily-indebted poor countries" (HPIC), since qualifying for such relief is in most cases linked to future economic reforms and other conditionalities. Nor can we know how much, if any, of the resources made available through debt relief will be used to finance health care.

4. UNDP 2000a: 82.

5. Farmer 1999.

6. WEDO 1999a: 11.

7. Crossette 1999: 15.

8. Epstein 2001: 35; MacKintosh 2001; Booker and Minter 2001.

9. Epstein 2001: 35, citing Gaidzanwa 1999.

10. Farmer 1999; Stillwaggon 2001.

11. WEDO 1999a: 7.

12. For further analysis of the impacts of globalization and structural adjustment policies (SAPs) on women, see Wichterich 2000; WEDO 1999a; General Assembly 1999; Eisenstein 1998; Sassen 1998; and Sparr 1994.

13. The gendered impact of global capitalism may in some settings fall more heavily on men. Field, Kotz, and Bukhman (2001) show that declining life expectancy among young

and middle-aged Russian men took a sharply worsening course in the years following imposition of neoliberal market "reforms" and was directly caused by premature deaths from alcohol abuse, murder, and infectious diseases. They persuasively link this trend to the psychosocial and behavioral impacts of the abrupt transition to capitalism, including high rates of crime, suicide, unemployment and despair. Life expectancy has declined much more sharply for men than for women (58.3 years vs. 71.7 years in 1995): "Russia is on its way to becoming a country of widows and fatherless children," they write. "At present rates, about half of all males now aged 16 will not reach the official retirement age of 60." However, in these same years, the *increase* in "loss of working potential" from suicides and alcohol-related deaths (though not from murders) has been much higher for women than for men.

14. O'Neill 1995.

15. Stienstra 1999: 269.

16. For substance and critical analysis of the Global Compact, as well as a list of companies supporting it, see TRAC 2000 (Bruno and Karliner), available at http://www.corpwatch.org/un.

17. DAWN 1999; Koivusalo and Ollila 1997; and Parker 1999.

18. World Bank/HNP 1999: 14.

19. For more detailed discussions of SWAPs, DALYs, and HSRs in general, see AbouZahr 1999; Anand and Hansen 1997; Elson and Evers 1998; Evers and Juárez 2000; Koivusalo and Ollila 1997; Murray 1994; Murray and Acharya 1997; Nanda 2000; Nygaard 2000; Paalman et al. 1998; Petchesky 2000 and 2002; Salm 2000; and Standing 1999.

20. This was the Declaration adopted by the World Conference on Primary Health Care held in Alma Ata in the former Soviet republic of Kazakhstan. For a good review of its history and substance, see Koivusalo and Ollila 1997.

21. Standing 1999; and Evers and Juárez 2000.

22. AbouZahr 1999.

23. Petchesky and Judd 1998.

24. Nygaard 2000.

25. World Bank 1997: 141.

26. Schrecker 1998.

27. The rudiments of this kind of democratic model can already be found in Brazil, whose universal health system (SUS) provides free coverage for many basic treatments and services, with priority going to primary care and reproductive and sexual health care, including HIV/AIDS prevention and treatment. Priority-setting and monitoring of the Brazilian system is highly decentralized, based in part on citizens' health councils at the national, state and local levels. See Corrêa 1999 and CNDP 1999.

28. Dao, *New York Times*, 2001.

29. Stolberg, *New York Times*, 2001.

30. The law restricts detention to seven days, after which charges must be filed, but does not require any public disclosure of the charges. By early November, well over 1,000 people — nearly all of them Muslims or Arabs from the Middle East — had been so

detained; after Nov. 3, 2001, however, the federal government refused to release any more numbers. (Purdy, *New York Times*, 2001): B4–5.

31. Purdy, *New York Times*, 2001.

32. Khan, *New York Times*, 2001a.

33. Apparently the UNFPA's provision of "life-saving reproductive health care services" does include emergency contraception, or the "morning-after pill," much to the discontent of the Vatican and other anti-abortion groups. See www.un/unfpa.org.

34. At this writing, the U.S. was: the only major industrialized country to refuse signing the final Kyoto Protocol on Global Climate Change, despite compromises in that document designed to meet U.S. objections; one of only a small number of countries that has failed to ratify the Women's Convention and the only country besides Somalia that has not ratified the Children's Convention; an active opponent of the pending International Criminal Court and the treaties banning land mines and germ warfare; a subverter of a new multilateral treaty to combat illegal small arms trafficking; the sole country in the world to threaten an unprecedented space-based defense system and imminent violation of the ABM treaty; and a persistent defender of protectionist policies for American farmers despite constant trumpeting of "free-trade" rhetoric by U.S. officials.

35. See Stiglitz 1998; Wolfensohn 1998; and *Business Week* 2000.

36. World Bank 2000/2001; and A. Sen 1999.

37. During the 1990s, successful NGO pressure on Bank policies resulted in its decision to pull out of several dam projects, such as the proposed Narmada Dam in India, which community and environmental groups warn will destroy local livelihoods and ecology. Likewise, a transnational coalition of development NGOs, working mainly over the Internet, defeated OECD negotiations for a Multilateral Agreement on Investment (MAI). (G. Sen 1998). Other influential transnational campaigns to influence World Bank policies are the "50 Years Is Enough" network and "Women's Eyes on the World Bank." In the case of the Narmada Dam, however, the Indian government decided — against advice from the World Commission on Dams and the Bank — to go ahead with its construction.

38. World Bank 2000/2001: 79–82.

39. World Development Report 2000/2001, p. 5, Box 2.

40. WEDO 1999a: 11.

41. See *Dawn Informs* 2000–2001; Richter 2000; and Petchesky 2000a.

42. The G-77 "is an intergovernmental group established in 1964 to represent the interests of the developing countries in the United Nations" (UNIFEM 1995). Today it consists of nearly 150 member states that differ vastly in culture, economic conditions, domestic politics, and power positions within the U.N. and in the global arena.

43. Corrêa 1994: 58.

44. Petchesky 2000a and b.

45. ICPD 1994, paragraph 7.3.

46. Corrêa and Petchesky 1994.

47. Berer 1999.

48. ECOSOC 2000.

49. The TRIPS (Trade-Related Intellectual Property Rights) Agreement was enacted as part of the Uruguay Round of GATT (General Agreement on Tariffs and Trade, the precursor to the WTO) in 1994, and is binding on all WTO members. Its purpose is to advance the inviolability of patents across national borders—that is, the globalization of property. See C.M. Corrêa 2000, World Intellectual Property Organization 1999, and WEDO 1999b.

50. For an excellent review of the politics of "Trade, AIDS, Public Health and Human Rights," see DAWN 2001; also, Crossette, *New York Times*, 2001; Rich, *New York Times*, 2001; Donnelly 2001; Peterson and Rohter, *New York Times*, 2001; and Myers, *New York Times*, 1999. Unfortunately, this victory and South Africa's leadership in it has been marred by President Mbeki's baffling denial that HIV causes AIDS and his government's distressing lag in providing antiretroviral drugs, now available at very low cost, to pregnant women. (See Swarns, *New York Times*, 2001a and b; COSATU 2001; and McNeil, *New York Times*, 2001.) Brazil, on the other hand, has "the most successful AIDS treatment program in the developing world." (Crossette, *New York Times*, 2001; Brazil Ministry of Health 1999; and Parker 1999).

51. Kahn, *New York Times*, 2001b; Dugger, *New York Times*, 2001; and Bellow and Mittal 2001.

52. Petchesky 2001.

53. A new and important collection that addresses this question on a much broader scale is Taipale et al., Physicians for Social Responsibility, 2002.

54. Dao, *New York Times*, 2001.

55. This kind of extended war language was especially prominent on the part of the National Security Advisor, Condoleeza Rice, Secretary of Defense Rumsfeld and his next-in-command, Paul Wolfowitz; others in the Bush administration, however, such as Secretary of State Colin Powell, have seemed less bellicose. (See Keller 2001).

56. For further information, go to www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html.

57. Alvarez and Labaton, *New York Times*, 2001.

58. This is a line from W. H. Auden's widely quoted poem, "September 1, 1939."

59. Niebuhr, *New York Times*, 2001.

60. Eisenstein 2001a.

61. Eisenstein 1996; and Hammad 2001.

62. Bumiller, *New York Times*, 2001; Erlanger, *New York Times*, 2001; and "Twelve Points," 2001. "Twelve Points: Stop the War, Rebuild a Just Society in Afghanistan and Support Women's Human Rights" demands, among other things, that "the United States and its allies…halt all military action in Afghanistan" and "not carry out any military attacks in other states;" that the U.N. "take the lead in peace-making, peace-keeping and peace-building in Afghanistan;" and that "the full participation of Afghan women and Afghan women's organizations in all stages of peace negotiation and post-war reconstruction," and their ability "to fully exercise their human rights" be secured. At this writing, over 1,000 individuals and organizations from around the world had signed the statement, which is posted at the website of the Women's Human Rights Network (www.whrnet.org).

63. As many critics have pointed out, this cynical turnaround is made doubly bitter by the history of U.S. support for *mujahedeen* fighters against the Soviets, including those who would become the Taliban, and the certain knowledge of the Bush administration that the Northern Alliance warlords resurrected by its bombing campaign are just as brutal and misogynist as those they now deem “the enemy.”

64. Eisenstein 2001b.

65. Weiner, *New York Times*, 2001.

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