Global Health and Post-9/11 Human Rights

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Did 9/11 change everything? In the context of global health and human rights, are human rights (specifically the field of “health and human rights”) still relevant after September 11, 2001? The most recent incarnation of responses to the broader question are echoed in the decidedly mixed reviews of Don DeLillo’s disturbing 9/11 novel, Falling Man. The novel (like human rights?) has been described by reviewers as “frustratingly disjointed,” “masterly polyphonic fizzling,” “a terrible disappointment,” “setting the standard,” and “a display of cumulative brilliance.” My own view is that the post-World War II human rights movement in general, and its much more recent health and human rights application to global health, sets the “standard” and even represents “a display of cumulative brilliance.”

Before I make this case, it is worth using DeLillo a bit more. The human rights movement was historically shattered into two by the cold war: civil and political rights, and economic, social and cultural rights. Both strands were contained in the 1948 Universal Declaration of Human Rights (UDHR), but separated into two treaties, the 1966 International Covenant on Civil and Political Rights, and the 1966 International Covenant on Economic, Social and Cultural Rights, an artificial division reflecting priorities of two competing political philosophies. DeLillo’s last great novel, his 1997 Underworld, depicted the cold war and its fallout as well as anything in fiction or nonfiction. Its cover, surely not meant to be purposely prophetic, pictures the twin towers on both the front and back (one a photo positive, the other a negative) with a church steeple and cross in front of them and a bird of prey flying in their direction. The
cover of *Falling Man* is self- consciously derivative. The front cover is illustrated by a blue sky as seen from above cloud cover; the back cover contains the same cloudscape with the twin towers breaking through. Both books are about fear, confusion, death and decay which we cover up—with more or less success—with consumption and massive monuments to ourselves. But *Falling Man* has more bite; no doubt because of the fall of the towers. It is filled, as we are, with loss and self-destruction. Memory loss primarily, but also with assorted ways and reasons to commit suicide in the midst of plenty. The main character of *Falling Man*, a survivor from the first tower, almost universally described by reviewers as a shallow, middle-aged businessman (the typical American?), describes his plight and ours at the end of the novel (which ends where it begins, with him escaping from the tower, and observing what is happening): “He could not find himself in the things he saw and heard.”

Human rights advocates usually don’t have a hard time finding themselves, and their general quest is to change the things they see and hear. But they may see more clear blue sky than threatening clouds on the horizon, and may or may not have faded memories of the horrors of World War II that paradoxically gave birth to modern human rights. Nonetheless, 9/11 changed the international human rights movement as well. Harold Koh, for example, has perceptively identified four eras of human rights: (1) the *Era of Universalism* (1941-56), beginning with Roosevelt’s Four Freedoms speech (freedom of speech and religion, freedom from want and fear) and containing the founding of the UN and the articulation of the UDHR; (2) the *Era of Institutionalization* (1965-76) when the international structures of human rights were formed, mostly at the UN; (3) the *Era of Operationalization* (1976-89) with the formation of national and regional human rights regimes, constitutional law applications, special reporters, and specialized NGOs; and finally (4) the *Era of Globalization* (1989-present). Koh divides the globalization of human rights into two periods: (1989-2001) the age of optimism, from the fall of the Berlin Wall to 9/11; and dates the age of pessimism from September 11 to today.¹

There is reason for pessimism. The US has used 9/11 as an rationale to abandon not only its rhetorical role of global leader in human rights (always contested by some), but to abandon human rights itself as a professed guide to its own actions, adopting methods the US has consistently condemned since World War II, including preemptive war, torture, cruel and humiliating treatment, indefinite detention, disappearances, and grave breaches of the Geneva Conventions. The US has become a human rights outlaw, and can no longer provide moral, or even rhetorical, leadership in this arena.²

This is disheartening. But does it mean that it is also time to abandon the growing health and human rights movement as a fundamental underpinning for global health? I think not. And in spite of its disgraceful and illegal behavior in the human rights arena that has historically been labeled “civil and political rights,” in the health portion of “economic, social, and cultural rights,” as Benatar and Fox have argued, “the United States is the country with the most potential for favorably influencing global health trends.”³
Health and Human Rights

Jonathan Mann is rightly identified as the father of the health and human rights movement. As he first noted, it is neither health nor human rights alone that provide the prospect of motivating a global public health movement, but the combination of “health and human rights.” Not only do negatives in one area exacerbate negatives in the other, positives in both amplify each other.⁴

World War II, arguably the first truly global war, led to a global acknowledgment of the universality of human rights and the responsibility of governments to promote them. Jonathan Mann also perceptively noted that the AIDS epidemic can be viewed as the first global epidemic because it is taking place at a time when all countries are linked both electronically and by easy transportation. Like World War II, this worldwide epidemic requires us to think in new ways and to develop effective methods to treat and prevent disease on a global level. Globalization is a mercantile and ecological fact; it is also becoming a healthcare reality. The challenge facing medicine and health care, both before and after 9/11, is to develop a global language and a global strategy that can help to improve the health of all of the world’s citizens. In dealing with the AIDS pandemic it has become necessary to deal directly with a wide range of human rights issues, including discrimination, rights of women, privacy and informed consent, as well as education and access to health care. Although it is easy to recognize that population-based prevention is required to effectively address the AIDS epidemic on a global level (as well as, for example, tuberculosis, malaria, and tobacco-related illness), it has been much harder to articulate a global public health ethic, and public health itself has had an extraordinarily difficult time developing its own ethical language. Because of its universality and its emphasis on equality and human dignity, the language of human rights is well suited for public health.

Similarly, Paul Farmer has asked, “What can a focus on health bring to the struggle for human rights?” and answered, “A ‘health angle’ can promote a broader human rights agenda in unique ways.” Using the example of TB in the Russian prisons, he notes that he and his colleagues would not have been invited in if they were seen as human rights workers – but as physicians with expertise in TB treatment, they were welcomed in the spirit of “pragmatic solidarity” which, Farmer notes, “may in the end lead to penal reform as well.”⁵

As Gruskin and Tarantola have made clear, the health and human rights movement is based on the human rights movement itself, and the corpus of human rights law articulated in international human rights documents. As such, primary obligations to respect, protect and fulfill human rights, including the right to health, fall on the states that have signed these instruments and have adopted domestic law to operationalize them. Most fundamentally, human rights law is itself founded on the principle of nondiscrimination, i.e. that all people everywhere should be treated equally.⁶ Women and children are subjects of special protection under the right to health, and their rights are also reinforced by specific treaties, the Convention on the Elimination of Discrimination
against Women (CEDAW), and the Convention on the Rights of the Child (CRC).

Elsewhere Gruskin insists that human rights obligations are legal obligations that bind states, distinguishing the “health and human rights” field from the more aspirational field of social justice.⁷

Gruskin is quite correct. Nonetheless, as an action-oriented public health advocate, my colleague and co-editor would likely agree that spending time mining for differences, rather than seeking commonalities that can lead to public health action, is counterproductive. The drafters of the UDHR felt the same. Founded on the concept of human dignity, the drafters nonetheless reached consensus on not specifying a foundation for human rights, since universal agreement on the foundation could not be obtained. More important for them was to agree on goals. Human rights is action and advocacy-oriented, another characteristic that makes commends it for global public health.

**Equity and Human Rights**

About ten years ago I was asked to review a conference-generated book entitled *Ethics, Equity and Health for All*, a joint WHO-CIOMS project. The 1997 conference was intended to develop an action plan to promote equity in health, and was based on four principles for action: (1) take an inclusive approach to the governance of ethics and human rights in health; (2) give priority to the involvement of countries and groups that are underrepresented in ethics and human rights deliberations; (3) combine shorter- and longer-term efforts to incorporate ethical practice and respect for human rights in the applications of science and technology to health policy and practice; and (4) give priority to the development of human and institutional capacity to ensure sustainability of effort. While the principles seem reasonable, the ultimate action plan suggested by the participants, perhaps unsurprisingly, did not. It called primarily for more work to “prepare working definitions of such key terms as ethics, equity, solidarity, [and] human rights, to take account of international intersectoral and cultural diversity.”

My invitation to participate in this workshop brought the WHO-CIOMS conference to mind, as well as my thoughts about it: “…the conference wound up calling for more conferences. Perhaps this is inevitable given that CIOMS is primarily devoted to bringing its members together to discuss various topics in a conference format. Academic conferences have an important place in health and human rights work, but do we really need more conferences to define ‘equity, ethics, and human rights’ in our world? Aren’t the inequalities gross enough and obvious enough to warrant direct attention to actions to deal with the problem itself, rather than to refine the ‘ethics’ of approaching it? Moreover, strong theoretical works already exist that provide astute analyses of the relationships between equity (and ethics) and development. Of special note are two books by Amartya Sen, *On Ethics and Economics*, and *Inequality Reexamined.*⁸

Do we really need more conferences to define equity, ethics and human rights before engaging in advocacy and direct health action? I’m skeptical. I think we can conference ourselves and the would-be beneficiaries of direct action to death.
Nonetheless, I’m here and recognize that, for example, Anand and Peter have suggested in their *Public Health, Ethics, and Equity* that “the commitment of public health to social justice and to health equity raises a series of ethical issues which, until recently, have received insufficient attention.” Their work, co-edited with Sen, nonetheless, has not satisfied everyone. Powers and Faden, for example, argue that “the foundational moral justification for the social institution of public health is social justice,” and that “[c]ommentary on ethics and public health is, at best, thin.” Nor is their view idiosyncratic. As Jennifer Ruger argues, although “global health inequalities are wide and growing…[and] pose ethical challenges for the global health community…we lack a moral framework for dealing with them,” and would also pursue equality from a theory of justice. Elsewhere Ruger has contended that on the narrower question of the human right to health, “One would be hard pressed to find a more controversial or nebulous human right than the ‘right to health.’ (although she has also suggested that a philosophical justification for this right can be provided). Others have argued that the human rights approach to health disparities and inequality is more rhetoric than reality, akin to singing Kumbaya.

It is easy to be cynical about or disenchanted with human rights. David Kennedy has catalogued the major critiques of human rights, noting that human rights can be legitimately critiqued for driving out other emancipatory possibilities, for framing problems and solutions too narrowly, for over-generalizing and being unduly abstract, and for expressing a Western, 18th to 20th Century liberalism. Kennedy’s list continues: human rights promises more than it can deliver, the human rights bureaucracy is itself part of the problem, it can strengthen bad government, and it can be bad politics in particular contexts. In his words, “The generation that built the human rights movement focused its attention on the ways in which evil people in evil societies could be identified and restrained. More acute now is how good people, well-intentioned people in good societies, can go wrong, can entrench, support, the very things they have learned to denounce. Answering this question requires a pragmatic reassessment of our most sacred humanitarian commitments, tactics and tools.”

There is a measure of truth in all these observations, and effective action does require specifically-defined goals and specific actions to reach them. But as Joseph Kunz noted almost 60 years ago in regard the Universal Declaration of Human Rights, “In the field of human rights…it is necessary to avoid the Scylla of a pessimistic cynicism and the Charybdis of mere wishful thinking and superficial optimism.” No other language other than rights language seems suitable for global health advocacy. All people have human rights by definition, and people with rights can demand change, not just beg for it. And rights matter—and will matter even more as judicial structures to enforce them, like the International Criminal Court, continue to be established and nourished. Values of course underlie rights, but it would be incomprehensible to enunciate a “Bill of Values” instead of a “Bill of Rights” to protect people.

In the language of contemporary human rights, governments don’t simply have the obligation to act or not to act; but rather have obligations regarding all rights to respect rights themselves, to protect citizens in the exercise of rights, and to promote and
fulfill rights. Of course, not all governments can fulfill economic rights immediately because of financial constraints, and international law suggests that governments must work toward the “progressive realization” of these rights within the limits of their resources. Some governments are so limited in their resources that they require assistance from the world community, and the novel but powerful “right to development” speaks to the obligations of the world community to provide that assistance, as do the goals in the UN’s Millennium Declaration.

Social Justice and Human Rights

The values contained in concepts of social justice underlie a number of specific human rights—but, as I have argued, the language of human rights seems much more powerful in the real world, and any distinction seems unnecessary, and perhaps even counterproductive at least in the world of global health. In their discussion of social justice and public health, for example, Powers and Faden describe what they characterize as “[o]ne of the most compelling recent examples of work in public health on behalf of an oppressed group…” The example involves documentation of the rights of women by Physicians for Human Rights (PHR) during Taliban rule. The authors write, “Research conducted by the group Physicians for Human Rights provides powerful evidence that the denial of basic rights to women resulted not only in horrible injustices with regard to respect, affiliation, and personal security, but also with regard to health.” Of course this research project by PHR can be characterized as “public health research,” and it can even be said to be directed at documenting a major injustice to women. But neither accurately describes what PHR itself thought it was doing. PHR’s name could not be more descriptive of their membership and their goals: physicians for human rights.

Nor could the subtitle of their report be any more explicit: The Taliban’s War on Women: A Health and Human Rights Crisis in Afghanistan. Nor is the first sentence of their report ambiguous: “This report documents the results of a three-month study of women’s health and human rights concerns and conditions in Afghanistan by Physicians for Human Rights.” The report continues: “Taliban policies of systematic discrimination against women seriously undermine the health and well-being of Afghan women. Such discrimination and the suffering it causes constitute an affront to the dignity and worth of Afghan women, and humanity as a whole.” PHR’s report is extremely powerful, and merits the praise it has received. Nonetheless, it is a report by a physician group, not a public health group, and it is a group dedicated to doing “health and human rights” work, here especially founded on the International Covenant on Civil and Political Rights and CEDAW. Although primarily focused on health, the report also noted that “The Taliban’s edicts restricting women’s rights have had a disastrous impact on Afghan women and girls’ access to education, as well as health care. One of the first edicts issued by the regime when it rose to power was to prohibit girls and women from attending school.”

Since the beginning of the ongoing post-9/11 war in Afghanistan, conditions for women have improved, but much remains to be done. Leadership in human rights is in the hands of a physician, Sima Samar, who is chair of the Afghan Independent Human
Rights Commission. This is the first human rights commission in Afghanistan’s history, and has a wide-ranging mandate, including the promotion of health and human rights, especially the health and human rights of women. When this Commission speaks of justice, it means bringing the perpetrators of war crimes in Afghanistan to justice. And when it speaks of health, it does so in the language of human rights, for example it in May 2006 report on “Economic and Social Rights in Afghanistan.” Of special note is the Commission’s recommendation regarding women and children’s health: “The Government should prioritize reproductive (pre-natal and post-natal) and child health care, according to their obligations under international treaties to which Afghanistan is a party. Afghan women should have universal access to reproductive health care.”

It is easy for Americans to criticize the marginalization of human rights and health of women in other countries. But when the health of women in the US is directly undermined by our government, silence seems the preferred response. Thus when the U.S. Supreme Court ruled that it is constitutionally acceptable for Congress to make it a crime for a physician to use a specific medical procedure which the physician believes in his or own best medical judgment is the best to protect his female patient’s health, most commentary focused on abortion politics, rather than the health of women. Few noted that American physicians have never before been prohibited from using a recognized medical procedure, or that prohibiting it only affected the health of women. The Taliban must be smiling. As Rebecca Cook has noted in the broader context of abortion availability globally, “Whether it is discriminatory and socially unconscionable to criminalize a medical procedure that only women need is a question that usually goes not simply unanswered but unasked.”

**Health Law, Bioethics and Human Rights**

American bioethics has had a major positive impact on the way medicine is currently practiced in the U.S., especially in the areas of care of dying patients, including advance directives (living wills and health care proxies); and the establishment of rules governing medical research, including federal regulations to protect research subjects and institutional review boards (IRBs). It is noteworthy that these accomplishments all came by enacting specific laws related to health. American bioethics has probably exhausted what it can usefully accomplish in these limited spheres. In the only other major area it has worked in, the related fields of abortion, embryo research, and cloning, it has had no real impact in debates that have been dominated by religion. Given this, I think it is fair to conclude that bioethics is likely to have little real world future without a significant re-orientation of its focus and direction. I suggest that the most useful reformulation involves recognition and engagement with two interrelated forces reshaping the world and simultaneously provide new frameworks for ethical analysis and action, globalization and public health.

The boundaries between bioethics, health law, and human rights are permeable, and border crossings, including crossings by blind practitioners, are common. I suggest we can more effectively address the major health issues of our day if we harmonize all
three disciplines; and American bioethics can be reborn as a global force by accepting its roots in the 1946-47 Nuremberg Doctors’ Trial and actively engaging in a health and human rights agenda. That these disciplines have often viewed each other with suspicion or simple ignorance tells us only about the past. They are most constructively viewed as integral, symbiotic parts of an organic whole.

Both American bioethics and international human rights were born of World War II, the Holocaust, and the Nuremberg tribunals. While the Doctors’ Trial was only a part of Nuremberg and the new field of international human rights law, I believe it is accurate to conclude that the trial itself marked the birth of American bioethics. The International Military Tribunal at Nuremberg (which articulated the Nuremberg principles that serve as a basis for international criminal law, and in which judges from the four Allied powers presided) was followed by 12 subsequent trials, each presided over solely by American judges. The first of the “subsequent trials” was the “Doctors’ Trial,” a trial of 23 physicians and scientists for murderous and torturous experiments conducted in the Nazi concentration camps. The most infamous of these were the high altitude experiments and the freezing experiments, both of which resulted in the planned death of the research subjects, and both of which were conducted with the rationale that the results would help German pilots survive and so the experiments were necessary for the good of the survival of German society. The American judges rejected the defense that the experiments were acceptable in wartime. In their final judgment, condemning the experiments and most of the defendants, seven of whom were hanged, the court articulated what is now known as the Nuremberg Code. This ten-point code governing human experimentation was articulated by the American judges, and based on what they had heard at trial, including the arguments of American prosecutors, and the American physicians who served in the roles of consultant (Leo Alexander) and expert witness (Andrew Ivy) for the prosecution.21

Recognizing and nourishing this birth relationship will permit American bioethics to break free from its focus, if not obsession, with the doctor-patient relationship and medical technology and to cross our own border to become a global force for health and human rights – not as an imperialistic project, but to learn from and work with other cultures, countries, and activists. It may also help us answer another question Wiesel posed after learning of contemporary torture at Abu Ghraib and Guantanamo Bay, why the “shameful torture to which Muslim prisoners were subjected by American soldiers has not been condemned by legal professionals and military doctors alike?”

Entirely new entities, termed nongovernmental organizations or simply NGOs, have sprung up and become the leading forces for change in the world. A notable health-related example is Médecins sans Frontières (MSF), a humanitarian-human rights organization founded on the belief that human rights transcend national borders and thus human rights workers cannot be constrained by borders, but should cross them when necessary. As Renée Fox describes it, over the years the le droit d’ingerence (the right to interfere) has been displaced with an even more activist le devoir d’ingerence (the duty to interfere). This concept takes human rights to be universal and sees globalization as a potential force for good. MSF expands medical ethics to include physician action to
protect human rights, blending these two fields and treating the law that protects government territorial boundaries as subordinate to the requirements of protecting human rights.

Globally, boundaries are being breached by ideas, communication systems, and economics, even as the world paradoxically splinters into more and more countries. Nonetheless, as daunting and discouraging as many contemporary challenges are, especially those related to global terrorism, the international research in genetic engineering and human cloning, and provision of basic health care to everyone, the UDHR really does provide the world with an agenda and a philosophy. The centrality of the UDHR to bioethics is well recognized internationally. As put concisely in a 2003 report of the International Bioethics Committee of UNESCO: “modern bioethics is indisputably founded on the pedestal of the values enshrined in the Universal Declaration of Human Rights.” Notably, the final version of UNESCO’s attempt to develop an international bioethics framework explicitly adopts the UDHR as its basis, and had to be re-titled the “Declaration on Bioethics and Human Rights.”

Transnationalism and Human Rights

At this ambiguous and pessimistic moment in human rights history there is both cause for concern and cause for hope. In Falling Man, DeLillo portrays people who forget who they, survivors of the towers, a writing group of early Alzheimer patients, a new breed of terrorist. After 9/11 the US as a country forgot who we are, and abandoned our human rights principles in the grip of fear, engaging in all manner of human rights abuses. An NGO I founded in 1996 with my colleague Michael Grodin, Global Lawyers and Physicians, was established primarily to continue the legacy of the Nuremberg Doctors’ Trial (physicians and lawyers working together transnationally to foster human rights in the health context) in setting and following basic human rights standards for international research trials (like the U.S. government sponsored 076 trials), and articulating consent and benefit sharing standards. Our hope was to use the agreements on benefits from research trials as an entry into more pragmatic arguments to support the broader “right to health.” We continue to want to do more in these arenas, but since September 11 we have been overwhelmed with what has been described as “hard core” human rights issues, many of which involve crimes against humanity: specifically torture and cruel and abusive treatment. Our major project has become the establishment and nourishment of the Boston Center for Refugee Health and Human Rights, where more than two thousand torture survivors and their families, from more than 60 countries have been and continue to be treated at Boston Medical Center. Related projects involve physician participation in executions, and the role of military physicians in interrogation, torture, and breaking hunger strikes, and ways for physicians and lawyers to uphold the ethics of their professions and protect their colleagues who refuse to follow unlawful orders.

Looking forward, there is an increasing recognition that many, if not most, of the 80 countries that have actually put the “right to health,” including special health rights for women and children, in their constitutions, are economically unable to make these rights
a reality, even under a “progressive realization” regime. They require the assistance of other countries to provide the basic health infrastructure, and, as Laurie Garrett has argued well, are not well served by projects that limit their assistance to one, two, or even three specific diseases. This recognition has spawned another one: transnational corporations, although not the direct target of human rights law, can be reached indirectly and are often much more capable than any other entity of providing needed resources, especially (but not exclusively) pharmaceutical agents. Corporations have historically been seen at least part of their social responsibility as providing charity to the communities in which they have a large presence, but they have been quick to argue that this is purely voluntary and that the responsibility to provide direct services rests with the government. A nascent movement to articulate the human rights obligations of transnational corporations is now underway, both in the United Nations, and voluntarily among corporations themselves.

As to the first, John Ruggie, the Special Representative of the Secretary-General on the issue of human rights and transnational corporations has recently released his report on “Business and Human Rights” which identifies five sources avenues to introduce human rights law into corporate behavior, from strongest to weakest: (1) the state’s duty to protect (its citizens against non-state actor human rights abuses); (2) corporate responsibility and accountability for international crimes (like slave labor, child soldiers, torture) under complicity theories; (3) corporate responsibility for other human rights violations under international law (e.g. under the UDHR, currently “not necessarily legal in nature”); (4) “soft law” mechanisms, like voluntary international agreements, such as the Kimberley process which seeks to avoid international trade in conflict diamonds; and (5) self-regulation, in which at least some of the 77,000 transnational corporations and their 770,000 subsidiaries adopt and follow human rights standards in their businesses. Approximately 3,000 of these corporations, including some major pharmaceutical companies, have joined the UN’s “Global Compact” and committed themselves to its principles, the first two of which are: 1) Business should support and respect the protection of internationally proclaimed human rights; and 2) Make sure that they are not complicit in human rights abuses.

In his conclusion to this report, Ruggie makes three points that have special importance to global health: (1) “human rights and the sustainability of globalization are inextricably linked”; (2) like many human rights, companies (like governments) will “get tried in ‘courts of public opinion’” for human rights violations [“name and shaming”]; and (3) “no single silver bullet can resolve the business and human rights challenge.” In our current climate, where transnational corporations seem intent on fostering primarily protection of intellectual property, why is there any room for optimism? For me it comes from two sources. The first is the recognition that transnational corporations become involved in issues of bioethics because of their desire (and need) to do clinical trials around the world—they needed to follow generally accepted notions of informed consent (and more recently benefit sharing) to conduct their trials and have the results used to certify their products. More recently the issues they are confronted with have broadened significantly, to include patenting, pricing, and access to their products in general by people who need them to survive or thrive, but who individually, or their
governments, simply cannot afford them. These are basic human rights issues that have not been addressed by bioethics; and I find it at least somewhat optimistic that the first session in the “bioethics” track of the annual international convention of BIO, the Biotechnology Industry Organization, was titled “Biotechnology’s Responsibility for Human Rights?”, although as I told the gathering here in Boston earlier this month, I would not have put a question mark at the end of the title.

DeLillo would likely think that human rights and transnational corporations make too unlikely a combination to take seriously. In *Underground*, he saw the transnationals simply taking over from the exhausted cold war governments. He pictured, for example, waste disposal done in secret by private corporations using underground nuclear explosions. One Kazakhstan company, Tchaika (meaning seagull, a “nicer name” than rat or pig), is looking for an American to recruit US customers:

They want us to supply the most dangerous waste we can find and they will destroy it for us. Depending on the degree of danger, they will charge their customers—the corporation or government or municipality—between three hundred dollars and twelve hundred dollars per kilo. Tchaika is connected to the commonwealth arms complex, to bomb-design laboratories and the shipping industry. They will pick up waste anywhere in the world, ship it to Kazakhstan, put it in the ground and vaporize it. We will get a broker’s fee.(at 788)

He may be right; but little progress is likely to be made in global health without the active engagement of the transnationals, either through private-public agreements, or though holding transnationals themselves accountable for not only respecting human rights themselves, but also protecting and fulfilling them in their spheres of business. In this regard, for example, Tchaika would be legally responsible for all the radiation-caused health consequences of its activities. The currently-contested question, of course, is whether transnationals should have obligations to help fulfill human rights as well, including the right to access to life-saving drugs whose supply they control.

**The Future**

Tony Blair entitled his thoughts on September 11 in the January 2007 issue of *Foreign Affairs*, “A Battle for Global Values.” There is much in his essay, especially about the continuing wars in Iraq and Afghanistan, that is easy to disagree with. But his basic message is sound: we are not in a war that can be won by force of arms. “This is a battle of values [and] we have to show that our values are not Western, still less American or Anglo-Saxon, but values in the common ownership of humanity, universal values that should be the right of the global citizen.” There is a name for those “universal values” that are the “right of the global citizen,” and that is “human rights.”

But Blair goes further, noting correctly, I think, that “The challenge now is to ensure that the agenda is not limited to security alone. There is a danger of a division of global politics into ‘hard’ and ‘soft,’ with the ‘hard’ efforts going after the terrorists,
whereas the ‘soft’ campaign focuses on poverty and injustice. That divide is dangerous because interdependence makes all these issues just that: interdependent. The answer to terrorism is the universal application of global values; the answer to poverty and injustice is the same. That is why the struggle for global values has to be applied not selectively but to the whole global agenda. In the sphere of global health, another way to make the same point is, as Jonathan Mann put it, “health and human rights are inextricably linked.”
References


24. For more see [www.glphr.org](http://www.glphr.org).


27. Blair T. A Battle for Global Values, *Foreign Affairs*, Jan/Feb. 2007, 79-90. It is worth noting that Telford Taylor used similar language describing the Nazi atrocities in his opening statement at the Doctors’ Trial at Nuremburg: “The perverse thoughts and distorted concepts which brought about these savageries are not dead. They cannot be killed by force of arms. They must not become a spreading cancer in the breast of humanity. They must be cut out and exposed…”