

Introduction

Origins

The *Global Health Watch* comes out of one of the largest ever civil society mobilisations in health – the first People’s Health Assembly, held in Savar, Bangladesh, in December 2000. Some 1,500 people from 75 nations attended and collectively drew up and endorsed a People’s Health Charter. The Charter is a call for action on the root causes of ill-health and the lack of access to essential health care. It set the agenda for the People’s Health Movement (PHM) (www.phmovement.org).

The first *Global Health Watch* (*GHW1*) took up the Charter’s call for action and brought together health activists, health professionals and academics from around the world to contribute to an alternative world health report. *GHW1* and the Observatorio Latinoamericano de Salud (Latin American Health Watch) were launched at the second People’s Health Assembly in Cuenca, Ecuador, in July 2005. Approximately 1,500 people from 83 countries attended this Assembly. In addition, the Assembly saw the birth of the International People’s Health University and the global Right to Health Campaign.

Global Health Watch 2 (*GHW2*) has brought together another collection of activists, scientists and practitioners, and applies evidence, intellect and passion to critique both the state of global health and the inadequate global response to poor health and widening disparities. As with *GHW1*, it sets out an explicitly political understanding of the current state of health around the world, highlights poverty as the biggest epidemic the global public health community faces, and emphasises the importance of economic policy as a health issue. And, as before, it notes the impending and potentially cataclysmic effects of climate change. *GHW2* addresses several other underlying

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determinants of health: access to sanitation facilities, water and food; war and conflict; and the state of primary education.

GHW2 emphasises not just the health needs of poor and vulnerable people, but also their relationship with rich people and the powerful. Improving the situation of the world's poor cannot be achieved through aid or charity alone; profoundly unequal power relationships need to be tackled.

One tool for enabling progressive shifts in the imbalances of power and agency are declarations of human rights that include a right to household food security, essential health care and other provisions necessary for the requirements of human dignity. In today's world it is not just governments that have obligations and duties to fulfil; and neither are obligations and duties limited to fulfilling the rights of people living within national boundaries. Governments, multinational corporations and citizens have duties and obligations to people within and across national boundaries to achieve the universal attainment of human rights.

In light of the evidence that social, political and economic arrangements are failing to reduce adequately the current state of ill-health, poverty and inequity, a stronger mobilisation of civil society committed to the fulfilment of human rights is needed.

What we cover in *GHW2*

GHW2 has five sections. Section A, 'An Alternative Paradigm for Development', builds on *GHW1*'s analysis of the globalised political economy and its impact on poverty and ill health. It outlines in brief how the current paradigm for development is fatally flawed and ineffective – it does not deliver on poverty reduction; it does not deliver on reducing greenhouse gas emissions; and it does not deliver on health. On the contrary, it is rigged in many ways to do the opposite. But what is significant about Section A is that it puts forward an alternative model of development that combines the twin aims of promoting development where it is needed whilst also addressing climate change, and thinks outside the parameters of mainstream economics.

Section B deals with health sector themes. As with *GHW1*, there is a strong emphasis on health systems. Chapter B1, 'Health Systems Advocacy', summarises the major arguments about health systems strengthening that were put forward in *GHW1*, and proposes a nine-point health systems strengthening agenda. The following chapter, B2, covers the limitations and deficiencies of Western models of mental health care, particularly when applied to Southern communities and in humanitarian emergencies where a

lack of understanding of the prevailing social mores can result in external assistance being counterproductive and harmful.

Given the increasingly porous nature of national boundaries and the growing number of refugees and asylum-seekers arising from the effects of globalisation, war and climate change, the health of migrants is a critical public health issue. Chapter B₃, on migrant health, documents the difficulties and secondary victimisation that migrants and displaced people experience in accessing quality health care, with a focus on their experiences within high-income countries.

Chapter B₄ describes the state of health care for prisoners worldwide, and notes the scandalously high proportion of children and people with mental illnesses who have been misdirected to prison. Despite a plethora of international laws and agreements and standards about the treatment of prisoners, wide-scale human rights abuses occur across the globe. The chapter calls for an urgent need to incorporate prison health into public health policy and for the right to health to be recognised in prisons.

The final chapter in this section discusses new mechanisms for financing and incentivising pharmaceutical research and development (R&D). It describes how prize funds offer an alternative method for financing and rewarding the development of effective and affordable medicines, especially for neglected diseases. In addition, the chapter highlights the growing threat of antibiotic resistance. Initiatives to prevent and contain antibiotic resistance must be reframed in a more comprehensive way, and involve the realignment of incentives, the pooling of risks, resources and responses, and a re-engineering of the value chain of R&D.

None of the chapters in Section B deals specifically with HIV/AIDS, nor with TB, malaria or any other disease. Although the mortality and morbidity caused specifically by diseases are significant, the aim of *GHW2* is to examine the underlying determinants of disease, as well as the preconditions required by societies to protect themselves from diseases, and to be treated and cared for when they fall ill. Furthermore, disease-based analyses of global health problems are common and can reinforce the neglect of the social, political and economic solutions to poor health relative to biomedical and technological solutions.

Section C contains chapters related to issues that are 'Beyond Health Care', including carbon trading and climate change, war, food and globalisation, urbanisation, the sanitation and water crisis, oil extraction, humanitarian aid and education. Efforts to depoliticise climate change and restrict international action on reducing carbon emissions within a neoliberal framework are discussed in Chapter C₁. It raises questions about the ethical and human rights implications of carbon trading.

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Chapter C2, 'Terror, War and Health', notes the terrible human costs of war and conflict and describes the role of health advocates and researchers in monitoring the conduct and documenting the effects of war. It also discusses the definition of terrorism and its interface with health.

Chapter C3, 'Reflections on Globalisation, Trade, Food and Health', examines how the processes driving the integration of global food markets – specifically trade, foreign investment and the growth of transnational food companies – affect our health. It focuses on the growing phenomenon of diet-related illnesses, such as obesity and undernutrition, as well as food safety.

The rate of urbanisation over the past twenty years has been especially high in poor regions, characterised by a massive expansion of informal settlements and slum dwellings. Chapter C4 examines the associated health and environmental problems caused by rapid urbanisation.

The social and health consequences of the lack of water and sanitation, particularly for women and girls, are discussed in Chapter C5. It notes in particular the shameful neglect of sanitation as a public health issue by governments, donors and the international health community as a whole.

In many parts of the world, industry, often designed to support the consumption of the world's rich minority, has detrimental effects on the health of local people in developing countries. The extractive industries in particular have had a poor record of respecting people's rights and protecting the environment. Chapter C6, 'Oil Extraction and Health in the Niger Delta', illustrates this issue, revealing again the fundamentally political nature of development and health.

Chapter C7, 'Humanitarian Aid', considers the concepts and actors involved in humanitarian assistance, in particular the frequently underestimated role of local actors, and the role of the media. The inequalities that underlie disaster response, the commercialisation of humanitarian assistance and the co-option of humanitarian assistance for foreign policy objectives are additional issues discussed.

The final chapter in this section, C8, describes progress towards the attainment of education for all. The value of education as a 'social vaccine' against HIV/AIDS and the gendered nature of the lack of educational opportunities are also presented.

GHW2 is intended to be more than just a report on the state of global health. It is also a report on the performance of key actors related to global health. Section D, 'Holding to Account', includes an important chapter on the Gates Foundation. The Gates Foundation has arguably become *the* major player in the global health arena. The chapter attempts to stimulate a critical discussion about its work and about philanthropy

more generally. It also examines the extent of its influence and its lack of accountability.

The chapter on the Gates Foundation is one of a cluster of chapters that reflect upon the global health landscape more generally as well as on other key actors, namely the World Bank, the WHO and the Global Fund to Fight AIDS, TB and Malaria. A reading of all these chapters suggests the existence of a vast, complex and self-serving global health aid industry. It is argued that this industry requires substantial downsizing and rationalisation; that the WHO needs to provide stronger leadership; that greater public accountability is required across the board; and that there needs to be a shift from top-down to bottom-up practices, where those affected by poverty, inequity and poor health have greater say.

Too little is being done by global actors and bilateral donors to get their own houses in order. This undermines low-income countries' ability to provide effective stewardship, and to develop a coherent agenda for the comprehensive development of their health systems. The inadequate global response to the world's health challenges is also a result of poor donor performance. There is still too little development assistance; too much of it is poorly provided; and too much of it is tied to the interests of donor countries. *GHW2* questions the value and worth of bilateral donor aid, particularly in the context of a global political economy that maintains economic and political disparities between donor and recipient countries.

Chapter D2.1 describes and discusses the foreign assistance programme of the United States, particularly in relation to health. It describes a set of double standards and internal contradictions and reveals how the US aid machinery is increasingly being shaped to serve the strategic political and economic interests of the United States.

The growing common linkage of global health to global security, which is being driven by the United States and other actors, is a prominent development of the last few years. Chapter D2.3 discusses this issue in greater detail. It describes the potential advantages and disadvantages of such a linkage and calls on the health community to engage in a much more informed and rigorous debate about the issue. There are already strong signs of the HIV/AIDS sector being co-opted to serve foreign policy objectives, and of public health priorities being distorted by an overemphasis on biosecurity and infectious disease control.

It is not just global health institutions and governments that need to be watched. The corporate sector also needs to be watched, as is evident from the shameful behaviour of the oil companies. In Chapter D3.1 we discuss the history and role of commercial companies in promoting infant formula at the expense of breastfeeding. In spite of much progress having been made

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over the past few decades, the three case studies in this chapter illustrate the need to continue the struggle against unethical corporate practices that contribute to the alarmingly low rates of breastfeeding worldwide and unnecessary infant death and disease. Chapter D3.2 examines the tobacco industry and progress in implementation of the Framework Convention on Tobacco Control.

GHW2 ends with a chapter entitled ‘Postscript: Resistance’, which describes the ongoing resistance of people around the world against exploitation and subjugation. The struggle for health is a moral imperative, and, as *GHW* shows, is ultimately about unequal political and economic power. Even though it is often the most vulnerable communities that are in the forefront of this struggle, every one of us who is committed to the right to health as a basic human right can make an important contribution. We hope the issues raised and stories told in this *Global Health Watch* will be an inspiration to all those who read it.