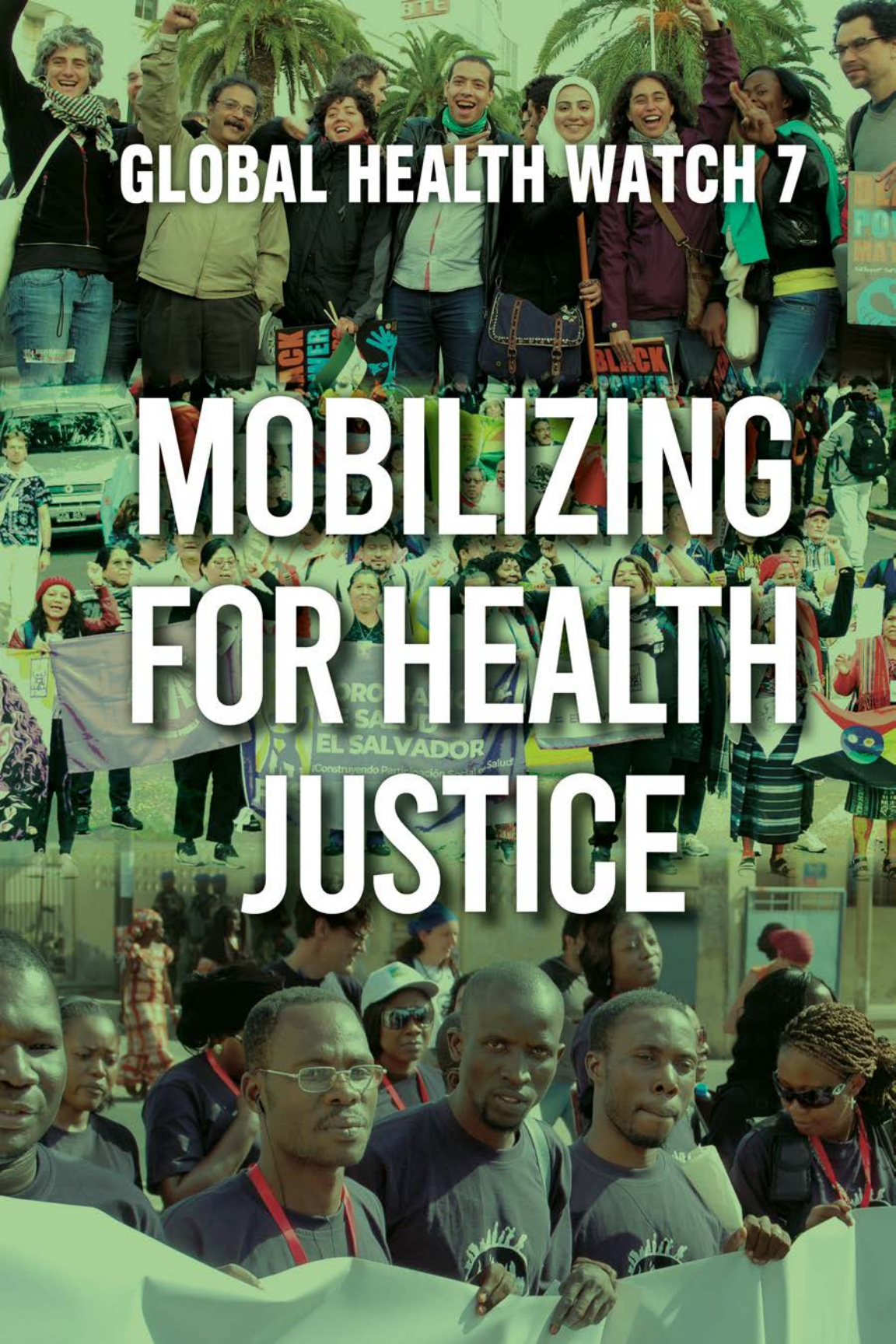

GLOBAL HEALTH WATCH 7

MOBILIZING FOR HEALTH JUSTICE

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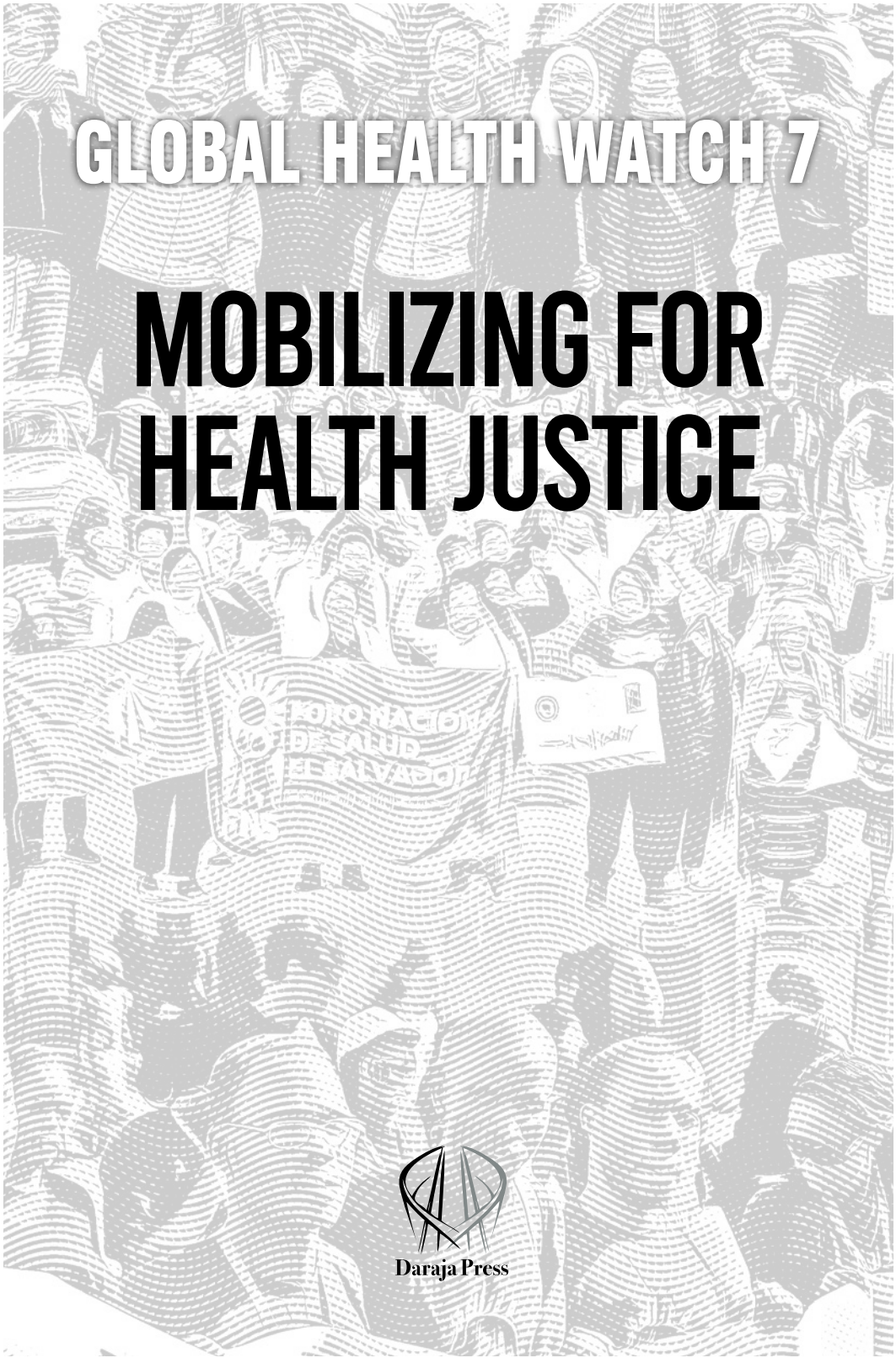

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Editorial committee members: Ron Labonté (Canada; PHM, coeditor of GHW7), Chiara Bodini (Italy; PHM, coeditor of GHW7), Rene Loewenson (Zimbabwe; TARSC, Equinet), Dave McCoy (Malaysia; UN university international institute for global health), Dian Blandina (Indonesia; PHM global health governance group), Devaki Nambiar (India; George institute for global health and PHM India), Matheus Falcão (Brazil; Brazilian Centre for Health Studies – Cebes and PHM Brazil), Lauren Paremoer (South Africa; PHM global health governance group), Penelope Milsom (UK; Medact), Ravi Ram (PHM Kenya), Hani Serag (PHM, Co-chair of Global Steering Council)

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We dedicate this edition of Global Health Watch *to the Palestinian people who have lost their lives in Gaza and the West Bank; the women, men and children; the journalists, volunteers, and health care workers. We also dedicate this edition to the activists, students, and professors in other lands who protest, often at personal cost, the ongoing genocide in Gaza.*

That this genocide persists reveals the failure of multilateral institutions to safeguard civilians and to hold the Israeli occupying force accountable for its illegal and expanding occupation and destruction.

The People's Health Movement (PHM) has long supported the Palestinian-led global movement calling for boycotts of Israeli products, divestment from companies profiting from the occupation, and sanctions against the Israeli occupying force. PHM joins with many other voices calling for an immediate and permanent ceasefire and a return to UN administered aid in Gaza.

The genocide in Gaza concerns us all, as it sets a new frightening moral standard of what is acceptable to inflict on a civilian population, before the eyes of the world. That's why we need to stand up for the Palestinians and make their struggle for life and self-determination our priority in the struggle for health for all.

Chiara Bodini (right) brings a copy of *Global Health Watch 4*
to health activists in Gaza during a PHM solidarity mission in 2015

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Acronym List

AANES: Autonomous Administration of North and East Syria
ACs: Assessed contributions
ACT UP: AIDS Coalition to Unleash Power
ADES: Economic and Social Development Association of Santa Marta (*El Salvador*)
AI: Artificial intelligence
AMC: Advance market commitment
APHA: American Public Health Association
ARPA: Advanced Research Projects Agency
ATL: Anti-Terror Law (*Philippines*)
BMGF: Bill and Melinda Gates Foundation
BOP: Balance of payments
BRP: Bergman and Ross and Partners Inc.
CAHOOTS: Crisis Assistance Helping out on the Streets
CDoH: Commercial determinants of health
CDSS: Clinical decision support systems
CEPI: Coalition for Epidemic Preparedness Innovations
CFM: Coordinating Financing Mechanism
CHWs: Community health workers
CIA: Central Intelligence Agency (*United States of America*)
CONAIE: National Confederation of Indigenous Nationalities of Ecuador
CoP: Conference of Parties
CPK: Council of K'iche's Peoples
CPP: Communist Party of the Philippines
CSO: Civil society organizations
CSR: Corporate social responsibility
DAH: Development assistance for health
DEI: Diversity, equity and inclusion
DFIs: Development Finance Institutions
DOGE: Department of Government Efficiency (*United States of America*)
DSA: Digital Services Act (*United States of America*)
DSSI: Debt Service Suspension Initiative
EB: Executive Board
ECMO: Extracorporeal Membrane Oxygenation
EDSA: Epifanio Delos Santos Avenue (*Philippines*)
EFF: Extended Fund Facility
EHR: Electronic health records
EO: Executive order (*United States of America*)
EU: European Union
EY: Ernst & Young
e-health: Electronic health

FENAMI: National Front for Migrant Health
G2H2: Geneva Global Health Hub
G7: Group of 7
G20: Group of 20
GAFAM: Google, Amazon, Facebook, Apple and Microsoft
GBV: Gender-based violence
GenAI: Generative AI
GDP: Gross Domestic Product
GDPR: General Data Protection Regulation (*European Union*)
GFATM: Global Fund to Fight AIDS, Tuberculosis and Malaria
GRCs: Grievance redressal cells
GS: Global South
HICs: High-income countries
HIS: Health information systems
HLIP: High Level Independent Panel
HRFT: Human Rights Foundation Turkey
HRUM: Health Revolutionary Unity Movement
ICESCR: International Covenant on Economic, Social and Cultural Rights
ICJ: International Court of Justice
ICTs: Information and communication technologies
IDA: International Development Association
IFC: International Finance Corporation
IFFIm: International Financial Facility for Immunization
IHC: International Holding Company
IHR: International Health Regulations
ILO: International Labor Organization
IMDRF: International Medical Device Regulators Forum
IMF: International Monetary Fund
IMSS: Instituto Mexicano del Seguro Social
INB: Intergovernmental Negotiating Body
INGUAT: Guatemalan Institute of Tourism
IOM: International Organization for Migration (IOM)
IoT: Internet of Things
IP: Intellectual property
ISDS: Investor-state dispute settlements
ISI: Inter-Service Intelligence (*Pakistan*)
ITUC: International Trade Union Confederation
JSA: Jan Swasthya Abhiyan (*India*)
LES: Statutory Health Law (*Colombia*)
LGBTQI+: Lesbian, Gay, Bisexual, Transgender and Intersex
LICs: Low-income countries
LLMs: Large Language Models

LMICs: Low- and middle-income countries
MAT: Movement for Water and Territories *(Chile)*
MENA: Middle East and North Africa
mHealth: Mobile health
MIDH: Mouvement Ivoirien des Droits Humains *(Ivory Coast)*
ML: Machine learning
NATO: North Atlantic Treaty Organization
NIEO: New International Economic Order
NGOs: Non-government organizations
NHI: National Health Insurance
NHIF: National Hospital Insurance Fund (*Kenya*)
NHS: National Health Service (*United Kingdom*)
NSAs: Non-state actors
NTFELCAC: National Task Force to End Local Communist Armed Conflict (*Philippines*)
ODA: Official development assistance
OECD: Organization for Economic Co-operation and Development
PA: Pandemic Accord
PABS: Pathogen Access and Benefit Sharing
PACS: Picture archiving and communication systems
PE: Private equity
PEF: Pandemic Emergency Financing Facility
PEPFAR: United States President's Emergency Plan for AIDs Relief
PF: Pandemic Fund
PHA5: 5th People's Health Assembly
PHC: Primary health care
PHEIC: Public Health Emergency of International Concern
PHM: People's Health Movement
PHM-LA: People's Health Movement Latin America
PHM SA: People's Health Movement South Africa
PIC: Prison-industrial complex
PIL: Public interest litigation
PKK: Kurdish Workers' Party
PNMRA: Policy on Migration, Refuge, and Statelessness (*Brazil*)
PPE: Personal protective equipment
PPPs: Public-private partnerships
PPPR: Pandemic prevention, preparedness and response
PRC: Professional Regulation Commission (*Philippines*)
PRGT: Poverty Reduction and Growth Trust
PSI: Public Services International
PwC: PricewaterhouseCoopers
R&D: Research and development
RNDS: National Health Data Network (*Brazil)*

RSF: Rapid Support Forces (*Sudan*)
RSF: Resilience and Sustainability Facility
RST: Resilience and Sustainability Trust
RTH Act: Rajasthan Right to Health Act-2022 (*India*)
SAF: Sudanese Armed Forces
SaMD: Software as a Medical Device
SAPs: Structural adjustment programs
SBA: Stand-by arrangement
SDRs: Special drawing rights
SERI: Socio-Economic Rights Institute of South Africa
SHA: Social Health Authority (*Kenya*)
SHIF: Social Health Insurance Fund Act (*Kenya*)
SIMM: Society of Migration Medicine
SLAPP: Strategic Lawsuit against Public Participation
SRH: Sexual and reproductive health
SRHR: Sexual and reproductive rights
SSN: National Health Service *(Italy*)
SUS: Unified Health System (*Brazil*)
TAP: Technical Advisory Panel
TMA: Turkish Medical Association
TNCs: Transnational Corporations
TRIPS: Trade-Related Aspects of Intellectual Property Rights
UAE: United Arab Emirates
UHC: Universal health coverage
UN: United Nations
UNCTAD: United Nations Conference on Trade and Development
UNFPA: United Nations Population Fund
UNHCR: United Nations Commissioner for Refugees
UNRWA: United Nations Relief and Works Agency for Palestine Refugees in the Near East
US: United States
USA: United States of America
VCs: Voluntary contributions
VEM: Vukani Environmental Movement
WEF: World Economic Forum
WHA: World Health Assembly
WHA77: 77th World Health Assembly
WHO: World Health Organization

Mobilizing for Health Justice

As the first chapter in *Global Health Watch 7* notes, the previous edition was "caught in the shadow of the COVID-19 pandemic." This edition is being released under a different and more ominous shadow, that of Donald Trump's return to the US presidency. We are in the midst of a massively disruptive transition in which the former US-dominated (neo)liberal world order is being transformed into a form not yet clear. The new Trump administration is driving this change, leaving global health churning in its chaotic wake. But as Chapter A1 reminds us, global health was not in very good shape before Trump's re-election.

We are facing a deepening existential health 'polycrisis' (a syndemic of multiple crises) that include rising inequalities, worsening environments and the mass movement of peoples within and across borders fleeing or being displaced by poverty, drought, violence and conflict. A fourth element has since emerged: the rise in autocratic states, the number of which outstripped democracies in 2024 for the first time in over two decades. Three quarters of the global population now live under autocratic rule characterized by restrictions on free expression and independent media, partisan capture of the judiciary and military and an ideological assault on government workers, universities and institutions that express views contrary to rulers' dictates. Civil society organizations are being shuttered, defunded, harassed, impugned or actively and violently repressed (as noted in Chapter E3).[1]

The majority of these autocracies are categorized as 'electoral autocracies,' meaning they were initially voted into existence. Unless there is mass civil society opposition (as we've seen in Turkey after the arrest of the political leader threatening Erdogan's rule) or a restraining 'lawfare' on executive power (which is being attempted in the USA), such electoral autocracies risk becoming closed single-party or military-rule states, a direction in which Trump 2.0 is rapidly heading. The good news is that whether closed or electoral, autocracies can be and have been reversed.[2] The bad news is uncertainty over whether this democracy/autocracy pendulum can swing back in a more equitable direction before our existential health polycrisis reaches its final tipping points.

By now, many GHW7 readers are likely aware of the multiple 'executive orders' issued by the US dictator-in-waiting that are having (or certainly will have) almost universally health negative impacts, a few key ones of which are summarized below:

- US withdrawal from the World Health Organization (WHO) and the resulting significant budgetary shortfall will put many funded health

Figure 1: Donald Trump's impact on climate change

Kriti Shukla

programs at short-term risk.[3] But abandoning the Paris Agreement on Climate Change, deregulating environmental protection, fast-tracking new fossil fuel projects and eliminating emission standards will be more health-devastating in the medium-term, especially as the US decisions here are incentivizing many other countries and corporations to weaken or abandon recent efforts and commitments to net-zero carbon emissions by 2050.

- The abrupt suspension and commitment to end most foreign aid will kill tens of thousands of people in the poorest countries suddenly lacking access to treatments and care. A key concern here is the potential evisceration or elimination of the PEPFAR program (President's Emergency Plan for AIDS Relief) introduced by earlier US Republican administrations and the major international source of financing for HIV prevention

and antiretrovirals. This should be considered a form of mass murder, since modeling suggests that without its fully funded return or carefully managed multi-year sunsetting, an estimated 4.2 million new HIV deaths will occur by 2029.[4] The most recent study estimates that US foreign aid cuts, as of May 23, have already led to over 92,000 adult and 190,000 child deaths.[5] These numbers are estimated to rise to over 14 million all-age deaths, including around 4.5 million child deaths, by 2030.[6] Dramatic foreign assistance cuts by other donor nations under Trumpian pressure to increase their defense spending is adding to the trauma, regardless of how much such assistance still reeks of neocolonialism and the dominating influence of rich countries' 'soft power'.

- By heading the US health portfolio with an anti-vaxx conspiracy theorist (Robert F. Kennedy Jr.), slashing its workforce, cutting research funding and withdrawing from global health networks and from treaties such as the International Health Regulations and the (new) Pandemic Treaty, the USA and much of the world is being placed in worse shape for the next pandemic than when COVID-19 first wrecked global havoc.[7]

Two other actions by Trump's new administration merit singling out.

First, there is the US imposition of tariffs and Trump's escalation of a global trade war. Chapter A1, written before the up/down and unpredictable tariff mayhem, warned that global trade rules were being fundamentally recrafted via a flurry of new bilateral and regional trade agreements with Trump's pending protectionism. The bizarrely devised tariffs, ridiculed by economists across the political spectrum, are partly to raise revenue as Trump prepares to extend tax cuts privileging the corporate and the rich amidst concerns over America's ballooning debt. But they are primarily weapons to bully other countries into adopting economic and domestic policies that favor Trump's idea of an 'America First' agenda: countries should import more American products, their industries (even if US-owned multinationals) should relocate to the USA and their US dollar assets (held in Treasury Bills) should be converted to low yielding 'century' bonds, thereby reducing the value of the US dollar while allowing it to remain the singular reserve currency. The economic intent is (supposedly) to reduce the US trade deficit and increase the country's ability to function as an autarky in which its economy becomes almost fully self-sufficient. This economic agenda extends to a renewed and more bald-faced US imperialism, witnessed in Trump's multiple threats to take over Canada and Greenland (for their natural resources) and Panama (to control its shipping canal). As Chapter A1 argues, these economic policies have one essential end-goal: to reduce the rise of China as a global hegemonic competitor. It also has a secondary goal: personally enrich Trump's companies.

Second, and arguably the more invidious, is the Trump administration's 'anti-woke' attack on 'diversity, equity and inclusion' (DEI), opposing any policy aimed

at promoting or including the rights of women, people of color, ethnic minorities, persons with disabilities and members of LGBTQIA+* communities. The anti-woke invective reached one of its many nadirs when the USA refused to attend the 2025 G20 meeting held in and chaired by South Africa, complaining that it was promoting "very bad things...solidarity, equality and sustainability", which it claimed was simply DEI repackaged.[8] Trump also ejected the South African ambassador after his country brought a genocide case against Israel at the International Court of Justice and, while denying entry to tens of thousands of successfully screened refugee claimants (from non-white nations), began to fully fund and fast-track refugee admission of white South African farmers, which Trump falsely claims are victims of a racist genocide. The daily genocide of Palestinians goes unnoticed while its critics are labeled de facto antisemitic and liable to forced deportation.[9]

As part of the anti-woke ideology, public and non-right-wing media are being defunded or harassed; universities are seeing massive withdrawals of their previously approved federal funding unless they surrender to Trump's demands over their curricula and hiring; researchers in other countries collaborating with American researchers or with (some) American research support are interrogated to ensure there is no DEI in any of their work; climate change research is wholly defunded with the term expunged from US government websites. The USA is not the only 'electoral autocracy' undertaking such repressive measures, but it is doing so with a force and at a pace that is as fiercely anti-intellectual as the infamous US McCarthy anti-communist witch hunts of the 1950s. Empathy and rationality are being replaced by viciousness and vindictiveness, and patently false statements are no longer 'fact-checked' but instead instantly amplified on social media by becoming the scripts scraped by Artificial Intelligence (AI) in its algorithmic projection of reality.

We are confronted by a new era of the 'Big Lie', a political strategy that is often attributed to Nazi propagandists' belief that if you tell a lie big enough and keep repeating it, people will eventually come to believe it. In Trump's first presidency, when his aides questioned the false statements that he ordered them to broadcast and repeat, he would reply: "...as long as you keep repeating something, it doesn't matter what you say."[10] Hannah Arendt, one of the most influential political theorists of the 20th century who wrote evocatively of the 'banality of evil' with reference to the Nazis, noted that the power of the Big Lie "is not that you believe the lies, but rather that nobody believes anything anymore", which is what "makes it possible for a totalitarian or any other dictatorship to rule."[11]

*The LGBTQIA+ acronym stands for Lesbian, Gay, Bisexual, Transgender, Intersex and Asex. It represents a diverse group of people who identify as outside of traditional gender and sexual orientations. The LGBTQIA+ community also includes individuals who may identify as queer, questioning, and other gender and sexual orientations. The + recognizes that there may exist other sexual/gender identities.

Chapter overviews

Other actions by the new Trump administration figure in several GHW7 chapters, and it is to summaries of these that this Introduction now turns. As with all previous GHW editions, we begin with a section on 'big picture' issues in the global political economy, with this edition featuring new chapters on ecofeminisms and ancestral health knowledge systems. The second section delves into the state of play across health systems, opening with an update on privatization, financialization and corporatization challenges alongside public health alternatives. It continues with new material on the pros and cons of the growth of AI use in health systems, proposals for equitable health systems from an intersectional gender perspective, an analysis of 'abolition medicine' which draws important connections between the social organization of prisons and health care systems, and a commentary on the importance of decolonizing global health.

The third section focuses on 'beyond health care' issues of critical importance, beginning with the rise in conflicts globally (with a focus on Gaza) and the role of capitalism's 'military-industrial complex' in sustaining conflict for purposes of profit and geopolitical power. It continues with an analysis of the drivers of migration and displacement, which are the highest ever recorded, before examining some of the core dynamics linking work, employment and health in the context of neoliberal capitalism. It then turns its attention to the importance of tax justice and progressive tax reforms at national and global scales, before ending with a chapter on the commercial/corporate determinants of health which includes critiques of the consultancy/accountancy transnationals (the 'Big Four' firms) that increasingly dominate global health policy making.

The fourth 'watching' section looks at what is new in global governance for health. It begins, as have all previous GHW editions, with an analysis of the health of the WHO, with this edition noting its declining leadership worsened by the US withdrawal of funding, albeit with the potential uptick of having reached agreement on a new Pandemic Treaty. The next chapter focuses on this Pandemic Treaty (referred to as a Pandemic Accord) weighing its strengths and weaknesses, notably the still-to-be-negotiated annexes covering improved access to pandemic tools for the Global South and global financing for pandemic prevention, preparedness and response. Some of these issues are explored in greater detail in the following chapter that focuses on future pandemic financing models.

The book concludes with a final suite of chapters that document health activism at different scales, celebrating acts of resistance (some successful, others not) and describing new activist modalities for healthful change. Its closing chapter draws from the 5th People's Health Assembly held in Mar del Plata, Argentina, in April 2024, and its declaration calling on activists worldwide to continue advancing the struggle for liberation and against capitalism.

What is new with this edition

There are three innovations with *Global Health Watch 7*. **First**, unlike earlier editions, almost all of the chapters that follow involved writing groups and contributions representing the geographic breadth of People's Health Movement (PHM). In striving to have this edition be an exercise in 'movement building' and not simply an analytical synopsis of global health issues, writing groups were encouraged to use their chapters as opportunities to discuss and engage across these geographies, allowing activists to learn with each other. **Second**, we chose to publish with a solidarity publisher (Daraja Press) where each chapter could be posted for free download and distribution as soon as it was completed. With all chapters completed, they are re-formatted with new front and end material as a single book, downloadable as a PDF or available in an on-demand print version. **Third**, we were able to publish individual chapters and the full book in both English and Spanish, partly an acknowledgement of the contribution of Latin American PHM activists in convening the 2024 5th People's Health Assembly in Argentina.

Section A: The Big Picture

A1: From a Political Economy of Disease to a Political Economy for Wellbeing

Chapter A1 continues the tradition of GHW's opening chapter offering a 'big picture' overview of the political economy of health. This edition's chapter explicitly critiques capitalism as the root cause of our global health polycrisis, highlighting the particularly damaging role played by several decades of neoliberal and financialized capitalism that concentrated wealth amongst a few while burdening the majority with austerity measures. Building on themes first discussed in GHW6, the text explores alternative economic paradigms such as degrowth (or postgrowth) which advocates reducing excessive consumption in wealthy nations, and the wellbeing economy, which prioritizes equitable resource distribution within planetary limits. It also discusses efforts to create an updated version of the 1974 United Nations Declaration of a New International Economic Order (NIEO) as a framework for building Global South solidarity and promoting a decoupling of economic dependency on countries of the Global North. The chapter revisits other themes from earlier editions, including calls for progressive taxation, strengthened labor rights and commitment to ecosocialist economics as tools to assist in dismantling capitalism's environmentally exploitative extractivism. Emphasizing activism and radical policy shifts, the chapter concludes with a Gramscian reflection on our present struggle to birth a new, equitable world amidst the economic and political chaos provoked by the second Trump administration.

A2: Life at the Center: Ecofeminisms and Ecoterritorial Feminisms in the Dispute for Life

Adding a new dimension to the global political economy of health, this chapter explores ecofeminist and ecoterritorial feminist perspectives, emphasizing the interconnected crises of ecological collapse, capitalism and patriarchy. It critiques extractivism—large-scale resource extraction—as a form of colonial and patriarchal violence that disproportionately harms Indigenous, peasant and marginalized communities, especially women and 'dissidences,' a term that describes identities, cultural practices and social movements that question heterosexuality as a hegemonic social norm. The text highlights how extractivism exacerbates environmental degradation, displaces communities and reinforces gendered and racialized inequalities. Ecofeminisms advocate for placing life at the center, integrating care for ecosystems and human communities, and challenging anthropocentric and capitalist logics. Ecoterritorial feminisms in Latin America (Abya Yala) emphasize the "body-territory" concept, linking personal and environmental struggles and promoting restorative justice, ancestral knowledge and communal resistance. The chapter also discusses grassroots movements defending water, land and food sovereignty, while calling for an ethics of collective care and, like Chapter A3 that follows, a politics based on *Buen Vivir* (living well). These frameworks offer transformative alternatives to systemic violence, centering Indigenous and feminist worldviews in the fight for health and ecological justice.

A3: Ancestral and Popular Knowledge for Buen Vivir

Building on themes in the previous chapter, A3 focuses on *Buen Vivir* (Living Well), a holistic, biocentric paradigm rooted in Indigenous and ancestral knowledge that offers an alternative to capitalist and colonial systems. *Buen Vivir* (sometimes also translated as 'good living') was the theme of the 5th People's Health Assembly convened in Argentina in April 2024, which brought together large numbers of traditional healers from across Latin America. Emphasizing interdepence with nature, collective well-being, and health as a communal right, *Buen Vivir* is just one of a number of ancestral cosmovisions that are part of emancipatory projects to "make possible the construction of biocentric policies." The chapter highlights the role of women as custodians of ancestral practices and agroecology as a sustainable production model, noting the resilience of Indigenous communities against dispossession and war. It calls for intercultural health systems that integrate traditional and modern medicine, and that recognizes the wisdom of healers and midwives. Challenges include decolonizing minds (freeing us from the dominance of biomedical reductionism), advancing rights for nature and (a theme across all GHW7 chapters) fostering global solidarity. Rich with Indigenous accounts, the chapter emphasizes *Buen Vivir* as a transformative political project, offering pathways to health justice and ecological balance.

Section B: Health Systems

B1: Privatization and Financialization of Health Systems: Challenges and Public Alternatives

As with previous GHW editions the first chapter in the section on health systems focuses on financialization and privatization risks to equitable health care access. This edition, while continuing to update and explore these two themes, introduces a new one: the corporatization of health systems. Privatization shifts healthcare from public to private control, often through active measures like outsourcing or passive underfunding of public systems that forces reliance on costly private care. Financialization transforms healthcare into profit-driven assets, prioritizing investor returns over patient outcomes, as seen in International Finance Corporation (IFC) investments that exacerbate inequalities.* Corporatization introduces profit-maximizing practices that lead to over-medicalization, neglect of primary care and erosion of medical professionalism. Case studies from India, Ivory Coast, the USA and Canada illustrate how these processes inflate costs, reduce accessibility and undermine public health systems. Examples of activist campaigns in South Africa and India support the chapter's calls for stronger regulation, tax justice and grassroots mobilization to reclaim healthcare as a public good, emphasizing human rights frameworks to ensure equitable, quality care for all. Resistance movements and policy reforms to counter corporate dominance in healthcare are gaining momentum in many countries.

B2: Artificial Intelligence, Digital Technologies and Health

GHW6 was the first edition to begin looking at the impacts of artificial intelligence (AI) on health systems. Chapter B2 delves much deeper into this topic, exploring the role of AI and digital technologies in global health and emphasizing both their potential benefits and risks. While AI can enhance diagnostics, drug discovery and healthcare accessibility, it raises many concerns about data privacy, algorithmic bias, corporate dominance and environmental impact. Key issues include:

1. *Data exploitation:* Big Tech firms monopolize health data, undermining public control and privacy.
2. *AI bias:* Skewed datasets perpetuate racial, gender and socioeconomic disparities in healthcare.
3. *Labor impacts:* "Uberization" of healthcare work erodes job security for health workers, and could lead to mass unemployment across a range of health-related economic sectors.
4. *Environmental costs:* Energy-intensive AI infrastructure will quickly become the single largest consumer of fossil-fueled energy pushing us way beyond climate change limits.
5. *Corporate power:* Tech giants shape regulations, prioritizing profit over equitable health outcomes.

*The World Bank's IFC's role in health system privatization has been a recurring GHW topic, notably in editions 2, 4, and 6.

The chapter also critiques data colonialism, where Global North corporations extract and control data from the Global South, and calls for stronger public governance, digital sovereignty and rights-based regulations. This is more urgent as the pace of growth and power concentration within AI in a context of the new Trump administration's extreme deregulatory environment is placing AI near the top of our existential syndemic crises.

B3: Building Equitable Health Systems: A Transformative Proposal from an Intersectional Gender Perspective

Gender equity has long been a concern in previous GHW editions, from the struggle for sexual and reproductive health rights (in GHW1) to the gendered health impacts of COVID-19 (in GHW6). Chapter B3 in this edition deepens our understanding of these issues in its advocacy for gender-transformative health systems that challenge structural inequalities and power dynamics perpetuating gender-based discrimination. It analyzes case studies from Nigeria, India and Paraguay, highlighting systemic gaps in addressing gender-based violence (GBV) and reproductive health needs, actions in defense of which are now particularly important given the US withdrawal of funding and support for reproductive health rights globally. Key findings are that underfunded health systems, patriarchal norms and disconnects between policy and practice often exacerbate GBV victimization. The chapter distinguishes between gender-blind, gender-sensitive and gender-transformative policies, emphasizing the latter's role in dismantling oppressive structures by promoting women's autonomy, equitable access to sexual and reproductive health services, and inter-institutional alliances. It underscores the importance of social movements, continuous health worker training and intersectional approaches to ensure empathetic, rights-based care as an enforceable right and a collective ethical obligation.

B4: Abolition Medicine as a Tool for Health Justice

Chapter B4 opens with a series of challenging questions: How similar is a policeman to a doctor? A prison to a hospital? Or a mental health nurse to a 'correction officer'? In answering these questions it explores the novel concept of "abolition medicine" as a framework for understanding health justice, arguing that, under capitalism, healthcare and criminal justice systems share intertwined histories of coercion and racialized control. The chapter critiques how biomedicine and policing have enforced racial hierarchies and disciplined labor, perpetuating carceral (prison-like) logics within healthcare, such as punitive treatment of marginalized groups (e.g., racialized women, people with addictions). Abolition medicine rejects these practices, advocating for no police in healthcare spaces, harm reduction approaches to substance abuse and community autonomy in the organization and delivery of health care. Case studies illustrate what an abolition medicine approach might look like: Rojava's decentralized, communal healthcare system in Kurdistan and Brazil's Care Clinic, which address collective

trauma from displacement through political, non-medicalized care. The chapter concludes by calling for solidarity between health justice and prison abolition movements, centering care over coercion and democratizing health systems. Ultimately, abolition medicine envisions healthcare as anti-capitalist, autonomous and rooted in transformative justice.

Chapter B5: Decolonizing Global Health

Global health as a term/concept/practice has emerged in recent years and grown rapidly within public health institutions and universities and, with it, critiques of global health's neocolonial legacies. This chapter examines the intersection of colonialism and global health and highlights how historical and contemporary colonial practices perpetuate inequities. It introduces a three-part framework for its analysis:

1. Colonialism *within* global health, addressing power imbalances between Global North and South institutions, such as parachute research and marginalization of Indigenous knowledge.
2. Colonization *of* global health, where governance systems are dominated by research funding from the Global North, primarily benefiting its own researchers and institutions, and by entities like the Bill & Melinda Gates Foundation which prioritize private technocratic solutions.
3. Colonialism *through* global health, where healthcare systems enable wealth extraction, exemplified by pharmaceutical profiteering during COVID-19.

The chapter's critique of neocolonialism emphasizes how financialized capitalism worsens global inequities and discusses the toxicity of its underlying logic of extractivism and capital accumulation. It calls for democratizing global health governance, challenging exploitative practices and centering grassroots voices; and advances a goal of aligning global health practice with justice, equity and anti-colonial resistance that moves beyond Western-centric models and towards pluralistic, inclusive approaches. The Trump administration's withdrawal from much global health development and research, while wrenching in the short-term, could actually strengthen such efforts via other countries' social movement struggles to confront more effectively these legacies of "coloniality".

Section C: Beyond Health Care

Chapter C1: War, Conflict and Displacement

This chapter begins its discussion of the health and broader human costs of conflicts and displacements by examining the geopolitical context of war: why do conflicts arise, whose interests are served and which 'great power' (imperialist) countries are the most militarily belligerent? It argues that conflicts are often deliberately fostered by the world's leading global and regional powers to maintain or establish their influence over other states, using the Arab Spring to illustrate its points. From direct military engagement to selective support of authoritarian regimes, imperial-

ist powers attempt to control global resources to their own national and corporate benefit, while often claiming that their aim is to bring democracy to these states which almost invariably fails. The chapter identifies the economic interests that drive conflict: the highly profitable arms industry, transnational corporations that gain access to new resources and industries involved in the 'business of destruction and construction.' It then turns to the human costs of war, conflict and the massive increase in internal population displacements and outward migration (returned to in the chapter that follows), and large numbers of military and civilian death and injury. The chapter describes some of these health impacts in four countries in the Middle East and North Africa region (Libya, Yemen, Sudan and Palestine) identifying acts of genocide and drawing attention to the increased and deliberate targeting of health facilities and health workers. It concludes with the importance of challenging the consumptive logic of neoliberal capitalism that continues to incentivize war and conflict.

Chapter C2: People on the Move

Building on analyses in other GHW7 chapters (e.g. A1, C1) this chapter highlights the rise in irregular migration and displacement due to conflict, environmental degradation and economic inequality. It examines global migration through an intersectional lens, emphasizing the health and human rights challenges faced by migrants. After distinguishing between categories of migrants (e.g., refugees, undocumented workers) and outlining the systemic barriers they face (such as limited healthcare access and exploitation) it returns to the main drivers of migration: economic disparities, violence and climate change. The chapter offers pertinent examples such as the experiences of Syrian refugees and Inuit communities displaced by environmental shifts. As with Chapter B5, it locates global migration within the structural roots of colonialism and neocolonial economic policies which, by perpetuating global inequalities, are forcing migration from the Global South to the Global North. The chapter then explores the healthcare barriers migrants face, exacerbated by crises like COVID-19, while providing case studies from Brazil (migrant-led health advocacy) and Italy (health worker protests) that illustrate grassroots efforts to address these care gaps. It also includes a long interview on the health crises facing migrant and displaced Palestinians, before concluding with the familiar advocacy call for universal health systems and migrant-centered policies that address structural inequities that undermine health justice.

Chapter C3: Putting the Right to Health to Work

Earlier editions of GHW have emphasized different aspects of how work/employment is affected by our political economies and, in turn, influences health outcomes.* Chapter C3 in this edition takes a step back by first describing how

*For example, editions 1, 3 and 5 critiqued 'labour market flexibilization' in a context of trade liberalization treaties, edition 4 focused the challenge of managing health worker migration ('brain drain'), while edition 6 critiqued neoliberalism's evisceration of labor incomes and organizing rights.

employment conditions act as a social determinant of health, and highlighting how the COVID-19 pandemic dramatically exposed disparities in workplace safety, particularly for essential and informal workers. The chapter next underscores the importance of decent work, unionization and social dialogue, and examines how capitalism exacerbates health risks through precarious employment, exploitation and poor working conditions, with examples from industries like meatpacking, healthcare and domestic work. It also discusses successful struggles, such as those by Kenyan health workers and Colombian domestic workers, which have secured labour and health rights and improved working conditions. What the chapter could not anticipate was Trump's post-inauguration sudden dismissal of up to 15 per cent of the federal government workforce,[12] the damaging unemployment-related health effects of which will trickle down to affect many more families and communities.

Chapter C4: Tax Justice: A Pathway to Better Health

A recurrent concern in most GHW editions has been tax justice: ensuring that the fruits of global economic activity are shared fairly with public revenues invested in public goods that promote health equity within and between countries. This chapter explores in more detail how tax justice can significantly improve global health by redressing inequalities in wealth and income, and in funding public services. Taxes, described as society's "superpower," play a critical role in revenue generation, wealth redistribution and discouraging the production and consumption of health-damaging products. However, current tax systems are undermined by corporate tax avoidance, regressive policies and international tax havens, disproportionately affecting low-income countries. The amount of global economic product that remains untaxed has skyrocketed under neoliberal capitalism, with states and UN agencies struggling to finance their programs and increasingly appealing to the extreme wealth of the 1 per cent that perpetuates a charity, rather than rights-based, model of global fairness. The chapter highlights the 5Rs of tax justice—Revenue, Redistribution, Repricing, Representation and Reparations—as key principles for reform. It critiques the OECD-dominated tax architecture and advocates for the UN-led Framework Convention on Tax to ensure fairness. Examples from Africa and Latin America illustrate the health positive impacts of tax reforms on health and climate resilience. The chapter concludes by emphasizing the need for progressive taxation and global solidarity to achieve health justice.

Chapter C5: Commercial/Corporate Determination of Health

The commercial determinants of health have been topics in earlier editions. GHW4 focused on how "big business" was hijacking efforts to control non-communicable diseases, further explored in GHW6's focus on "unhealthy commodities". Chapter C5 in this edition builds on these analyses in its critique of how transnational corporations (TNCs) and neoliberal policies routinely prioritize profit over

public health. Key harmful practices include aggressive marketing of unhealthy products (e.g., ultra-processed foods*, fossil fuels), tax avoidance, lobbying to weaken regulations and spreading health misinformation. Corporations exploit legal frameworks like intellectual property rights and investor-state dispute settlements (ISDS) to evade accountability, while voluntary codes (e.g., UN Global Compact) fail to enforce ethical standards. The chapter also interrogates the role of the 'Big Four' accounting/consultancy firms in dominating global health policy, a concern first critiqued in GHW5. The chapter proposes several solutions to the continued dominance (and oligopolization†) of TNCs. include binding international treaties, progressive taxation, breaking up monopolies and reversing privatization to reclaim public services. It concludes with a call for systemic change—shifting from neoliberal capitalism to models like degrowth, circular economies and worker cooperatives—that prioritize health and equity.

Section D: Watching (Global Governance)

Chapter D1: WHO's Compromised Role in Global Health Leadership

Concerns with the status of the WHO as the world's paramount global health agency have been voiced in each of our past GHW editions. This chapter continues by examining the declining leadership of the WHO in global health governance and questioning the extent to which the organization is actually shaping global health policy, highlighting how geopolitical tensions, ideological divides and funding constraints have compromised WHO's ability to fulfill its mandate. Key issues include the politicization of the World Health Assembly (WHA), where debates on gender and sexual health are often derailed by conservative governments, and the financial reliance on volatile voluntary contributions which skews priorities toward donor interests. The chapter also critiques the shrinking space for civil society participation in WHO processes, contrasting it with the growing influence of private stakeholders and multistakeholder initiatives. Trump's announced withdrawal from the WHO is threatening the organization's financial stability, although some headway against its current fiscal crisis was made at the 2025 WHA, where member states agreed to a 20 per cent increase in their assessed contributions. China at the same time announced additional donor financing over the next five years, moving into the lead funder position previously occupied by the USA. The chapter concludes by calling for ongoing reforms to democratize WHO and to strengthen its capacity to address politically charged health determinants, such as conflict and reproductive rights, and to restore its role as a leader in global health justice.

*There is progress in this area, with the WHO now recognizing nine countries with having eliminated transfats from their food supplies (https://bit.ly/44cQdOv) with many more countries in the process of doing so.

†Oligopolization refers to when a small number of firms dominate and exert enormous influence over an entire industry.

Chapter D2: Unpacking our Pandemic Failures for Future Pandemic Prevention, Preparedness and Response

This chapter examines the failures in global pandemic response during COVID-19 and efforts to reform future pandemic prevention, preparedness and response (PPPR) systems. While vaccine development was a biomedical success, inequitable distribution—termed "vaccine apartheid"—highlighted systemic flaws, particularly intellectual property (IP) barriers that restricted Global South access. Post-pandemic revisions to the International Health Regulations (IHR) introduced important equity principles but, as the chapter recounts, the proposed Pandemic Accord (PA) (or Pandemic Treaty) struggled unsuccessfully to fully address structural issues like IP monopolies, compulsory technology transfer and health system strengthening. Treaty negotiations revealed long-standing geopolitical tensions, with Global North countries resisting binding equity measures, with countries in the Global South insistent of having timely and equitable access to new pandemic tools.* Despite their recognition of inequities, IHR and PA reforms lack binding or enforceable commitments to ensure such access or to address gendered burdens of care, leaving future pandemic responses vulnerable to similar failures experienced with COVID-19. Although the big news coming out of WHA 2025 was the uncontested passage of a Pandemic Treaty, the two most contentious issues (agreements on pathogen access and benefits-sharing, and PPR financing systems) are left to a Conference of the Parties (CoP) for continued negotiation.†

Chapter D3: Financing Pandemic Recovery, Prevention, Preparedness and Response

This chapter begins by assuming the PA/Pandemic Treaty would be approved by the WHA in May 2025 (it was) but argues that the US withdrawal from the Treaty weakens its potential implementation, and severely constrains the financing needed to accomplish its aims. It joins several GHW7 chapters in critiquing the financialization of global health, specifically the financial architecture of pandemic prevention, preparedness and response (PPPR), which is dominated by securitized, commodified and market-driven approaches that exacerbate inequities. These approaches are legacies of the historical role of Bretton Woods institutions in shaping global health financing through neoliberal policies, such as structural adjustment programs, and the growing influence of powerful private actors like the Bill & Melinda Gates Foundation. The chapter pays particular attention to the shortcomings of mechanisms like the World Bank's Pandemic Fund and other 'innovative' financing tools (such as pandemic or other social impact bonds), which prioritize profit over equity. It sees shortcomings in the competition between institutions over which will hold

*The adopted treaty does commit 'participating manufacturers' to make available to WHO for distribution a target of 20 per cent of their new pandemic tools (vaccines, therapeutics and diagnostics), half as donation and half at affordable prices.

†As Third World Network (TWN), one of GHW7's co-producing organizations, expressed it: "WHO Pandemic Agreement: A Win for Multilateralism, A Missed Opportunity for Public Health?" (https://bit.ly/44cQctV)

pandemic funds: the World Bank (favored to run the financing for the IHRs and PA, but whose Pandemic Fund initiative is falling short) or the International Financial Facility for Immunization (which issues bonds back-stopped by donor governments to front-load its financing). Structural reforms, including debt relief, tax justice and equitable governance, are needed to ensure PPPR financing aligns with public health needs rather than corporate interests.

Section E: Resistance, Activism and Change

Chapter E1: National Struggles for the Right to Health

Chapter E1 returns to concerns with the privatization and corporatization of public heath systems critiqued in chapter B1, but with a difference. The focus in this chapter is on the more upbeat experiences in many countries to instantiate the right to health within enforceable health legislation. While many countries do offer some right to health protection in their constitutions, it is often narrowly interpreted (medical care) and rarely extended to the social determinants (determination) of health. Case studies from six countries examine social movement efforts to advance a broader understanding of the right to health and the importance of advocacy work to promote and expand interpretation of legal health rights provisions. In several instance, the power of corporate health interests continues to be a barrier to full implementation of citizens' health rights, while in other cases sustained advocacy has worked to bring about important legal health rights reforms. The chapter notes that progressive legislations are invariably a result of social struggles, underscoring the need for sustained mobilization "to move from a right on paper to a right that is fulfilled for all citizens."

Chapter E2: Taking Extractives to Court

Every GHW edition has included chapters on the threats to health and survival posed by climate change and the fossil fuel industries. Since GHW4, more emphasis has been placed on the nature of extractive industries and extractivist capitalism. GHW6 in particular described the many activist efforts to hold these industries and their enabling governments to account, often at the risk of activists' own lives. This edition optimistically tracks the rise of activist climate litigation as a tool to enforce environmental protection. Highlighting cases like the Swiss elders' victory against their government's failure to stop climate change and the Netherlands' Friends of the Earth court verdict requiring massive reduction in Shell's emissions, it showcases how courts are increasingly recognizing the right to a healthy environment in suits that are often initiated by youth and Indigenous groups. Examples from Panama, Ecuador, El Salvador and South Africa illustrate both successes and setbacks in grassroots environmental legal battles. The chapter cautions that legal victories can be contested, as seen in Shell's successful appeal in the Netherlands' case, and there are other legal challenges to environmental protection corporations can initiate, such as investor-state dispute settlements (ISDS), which corporations use to sue governments

over environmental regulations, and lawsuits aimed at silencing activists. The chapter concludes by emphasizing strategic litigation as part of broader advocacy efforts, including people's tribunals that amplify marginalized voices. While court rulings alone won't solve the climate crisis, they can play a crucial role in advancing justice, especially for Indigenous and frontline communities disproportionately affected by environmental degradation.

Chapter E3: Fear and Hope in 'Speaking Truth to Power': Struggles for Health in Times of Repression and Shrinking Spaces

Drawing from cases in Turkey, Kenya, the Philippines and South Africa, this chapter describes how authoritarian regimes, securitization and neoliberal policies combine to shrink civic spaces and target dissent. Protest and advocacy continue but in a context of increasing rise repression against health activists in their struggles for health justice. In Turkey, the Turkish Medical Association faced criminalization for advocating health rights but continues to engage in active resistance. Kenya's health activists, while still engaged, often have to endure police brutality and systemic corruption in their campaigns for health fairness. The Philippine government's "red-tagging" practice (in which activists are labelled communist or terrorist) have led to violence against health workers (including assassinations), while South Africa's xenophobia undermines migrant access to healthcare. Despite repression, resistance persists through legal battles, international solidarity and grassroots mobilization. The chapter underscores the need for broader alliances, political strategies and community rebuilding to reclaim health as a collective right and counter systemic oppression. It also calls for global health movements (such as People's Health Movement) to bridge gaps between professional discourse and on-the-ground realities – which is one of the reasons for the Global Health Watch series.

Chapter E4: 5th People's Health Assembly: Advancing in the Struggle for Liberation and Against Capitalism

This final chapter documents the Fifth People's Health Assembly (PHA5) held in Mar del Plata, Argentina, in 2024. Organized by the People's Health Movement (PHM), the Assembly brought together global health activists from different parts of the world to share experiences of their efforts to challenge the systemic health threats associated with capitalism, imperialism, and ecological crises. The Assembly intentionally framed its work around the Latin American concept of *Buen Vivir* (living well), focusing on the traditional knowledge systems and organizing efforts of Indigenous communities. Five thematic axes were used to advance strategic analyses and activist planning for the coming years: transforming health systems, gender justice, ecosystem health, resistance to forced migration and war, and the preservation of ancestral knowledge. Despite challenges, including the exclusion of a Palestinian delegation due to geopolitical barriers, PHA5 emphasized solidarity and collective action. The resulting Call to Action

advocated for a just, equitable world free from corporate control, highlighting the interconnected struggles for health, liberation, and environmental sustainability. The Assembly underscored the power of grassroots movements in challenging oppressive systems and advancing global health justice, the more urgent now in the shadow of a second Trump US presidency.

A Post-Trump Postscript

As we complete the final pages of this edition, the madness of the new Trump administration continues. Tariffs go up or down with no logic apart from exacting business deals for his personal enrichmentii or forcing trade deals to benefit the USA. Bullying of anything or anyone that Trump dislikes worsen with each passing day. Tax changes will add 4 per cent to the wealth of the richest 0.1 per cent (roughly $380,000 annually), while reducing the income of the poorest by $1,000,[15] many of whom elected Trump on the promise to 'make (their) America great again'. Civil and constitutional rights of Americans continue deteriorating as the USA rapidly descends into a fascism long predicted by critical political scientists, novelists, artists and reporters. A 1944 article in the New York Times by then vice-president, Henry Wallace, warning about the possibility of American fascism, was eerily prescient of our present times:

> A fascist is one whose lust for money or power is combined with such an intensity of intolerance toward those of other races, parties, classes, religions, cultures, regions or nations as to make him ruthless in his use of deceit or violence to attain his ends. The supreme god of a fascist, to which his ends are directed, may be money or power; may be a race or a class; may be a military, clique or an economic group; or may be a culture, religion or a political party.[15]*

It may be too early to declare Trump a fascist or the USA a fascist state. It is an illiberal state, and is rapidly sliding from being a flawed democracy to outright authoritarianism.[16] The slight Trump majority in the US Congress that passed his budget bill on May 22 (215 to 214) contains a clause that could prevent American courts from enforcing decisions that find Trump in contempt of a ruling.[17] This 'sleeper clause' in the budget bill will almost certainly provoke a constitutional crisis, the outcome of which is uncertain, but which could entrench Trump as a fascist dictator, especially given the right-wing majority of the US Supreme Court where three of the nine judges were appointed by Trump.

*A short and readable account of the warnings against American fascism from the 1930s onwards can be found in this article in The Guardian, published just after Trump's first presidency (https://bit.ly/3IcmNHE)

†Technofeudalism is a term coined by the Greek economist, Yanis Varoufakis, to describe how classical capitalism is being replaced by a digital form of feudalism, in which Big Tech companies control the digital commons and exact 'rents' on every access we make to it, while transforming us into 'data serfs' feeding their power (http://bit.ly/4kjvgWQ).

In terms of geopolitics, there is as yet no agreement on what our emerging illiberal global order might be called. Autocratic neomercantilism seems a good fit. Other contenders include oligarchic capitalism, technofeudalism† and, in the case of Trump, simply mafia capitalism. It is also not clear what might be the political projects (apart from business deals) favored by Trump and his fellow autocrats. An emergent consensus suggests a return to the late 19th century 'spheres of influence' or 'great power politics', in which the world's most powerful nations tacitly agreed to carve up parts of the planet into orbits of their direct or indirect control. At least they did so until economic competition, trade wars and overlapping orbits of interest brought us two world wars. Great power politics today is no longer strictly confined to planetary boundaries, with the tech oligarchs (primarily the American ones) now competing to move into and to 'own' space, or in the case of Elon Musk, the planet Mars.

Two astute political writers, Naomi Klein and Astra Taylor, believe that the USA is entering an "end times fascism" in which "the governing ideology of the far right has become a monstrous, supremacist survivalism."[18] The 'end times' refers to the role played by religious fundamentalists (evangelical extremists) who support Trump and who see his regime, and that of Netanyahu's attempted expulsion of Palestinians from Gaza and the West Bank, as heralding 'Rapture' when the Messiah will return and transport the faithful to their celestial kingdom. The secular equivalents of the evangelicals are the extreme (and extremely wealthy) libertarians who are creating their own celestial boltholes for the coming end times, on personal islands, out-of-the-way safe countries or the colonies they want to build in space.

Echoing several of the themes in this edition of GHW, Klein and Taylor argue the need for alternative narratives, not of end-times fascism but of better-times wellbeing. Such narratives would draw from the ecosocialist and wellbeing economies described in Chapter A1, the eco-feminist political economy for health discussed in Chapter A2 and the Indigenous cosmologies that form much of the content of Chapter A3.

Other strategies for pushing back against Trump have also been suggested. Countries and peoples caught in his chaotic and repressive wake need to unite and refute the false narratives so straight-facedly emanating from Trump's White House, or similar other Big Lies broadcasts from the administrative agencies of other of the world's autocrats. With independent media and academia under threat and a deregulated social media dominating the representation of what is 'reality,' this will be difficult and increasingly dangerous. Whether or not successful, it is nonetheless an essential act of resistance. As well, countries, peoples and institutions should not beg or try to placate the world's biggest bully; doing so only enhances Trump's egotistical narcissism. Rather, US isolationism should be embraced, ring-fenced and amplified to the extent possible, especially given that, although the USA is still the world's largest economy, the combined economies

of the EU, UK, Norway, Switzerland, Canada, Mexico, Japan, South Korea and Australia are 25 percent larger.[19] Other countries' national courts could be used to challenge US rejection of international law, while US multinationals operating within other countries' territories could be taxed as heavily as possible, creating more domestic capitalist class opposition to the Trump administration. Trump may be the 'poster boy' of the world's swing to autocratic and lawless rule; but it is neoliberal capitalism and the racism and misogyny it engenders that created the context for his (and others' potential) rise to dictatorship.

Whether we are in end days or moving forward to better days, few of us have seen days like this before. For readers of Global Health Watch past and present, we know the many things that must be done. And we also know the importance of the care we must give each other as we attempt to do so.

Reference List

1 Nord M, Altman D, Angiolilo F, Fernandes T, God A, Lindberg S. 25 Years of Autocratization – Democracy Trumped? University of Gothenburg: V-Dem Institute; 2025. Available from: http://bit.ly/4lFsSej

2 Nord M, Angiolillo F, Lundstedt M, Wiebrecht F, Lindberg SI. When autocratization is reversed: episodes of U-Turns since 1900. Democratization. 2025 Jul 4;32(5):1136–59. Available from: https://doi.org/10.1080/13510347.2024.2448742

3 People's Health Movement. PHM calls for urgent action to preserve, protect, and enhance the work of the World Health Organization. People's Health Movement; 2025 May. Available from: http://bit.ly/46sKJR9

4 UNAIDS. Estimating the potential impact of HIV response disruptions. UNAIDS; 2025 Apr. Available from: http://bit.ly/3GuQm6N

5 Impact Counter. Impact Metrics Dashboard. Impact Counter. Available from: http://bit.ly/4kp7tou

6 Cavalcanti DM, De Oliveira Ferreira De Sales L, Da Silva AF, Basterra EL, Pena D, Monti C, et al. Evaluating the impact of two decades of USAID interventions and projecting the effects of defunding on mortality up to 2030: a retrospective impact evaluation and forecasting analysis. The Lancet. 2025 Jun;S0140673625011869. Available from: https://doi.org/10.1016/S0140-6736(25)01186-9

7 Woolf SH, Galea S, Williams DR. The potential impact of the Trump administration policies on health research in the USA. The Lancet. 2025 Jun;405(10495):2114–6. Available from: https://doi.org/10.1016/S0140-6736(25)01016-5

8 RCI. U.S. to boycott next G20 meeting in South Africa. CBC News. 2025 Feb 7; Available from: http://bit.ly/4kk67v2

9 Baker K. The group behind Project 2025 has a plan to crush the Pro-Palestinian movement. The New York Times. 2025 May 18; Available from: http://bit.ly/46s21xH

10 Baker P. Trump uses lies to lay the groundwork for radical change. New York Times. 2025 Feb 23; Available from: http://bit.ly/4nOvzfx

11 Berkowitz R. On Fake Hannah Arendt Quotations. The Hannah Arendt Center for Politics and Humanities: Bard College; 2024. Available from: http://bit.ly/3Gt0uwO

12 Reinstein J. Here are all the federal agencies where workers are being fired. abc News. 2025 Feb 24; Available from: http://bit.ly/4lBFBhN

13 Baker P. As Trumps monetize presidency, profits outstrip protests. New York Times. 2025 May 25; Available from: http://bit.ly/4lbK1fJ

14 Stein C. The new Trump-led tax bill promises an American 'golden age' – that conveniently ends with his presidency. The Guardian. 2025 May 22; Available from: http://bit.ly/4eu2H7O

15 Wallace H. The Danger of American Fascism (1944). Central Bucks School District. Available from: http://bit.ly/3TmWRvj

16 Langfitt F. Hundreds of scholars say U.S. is swiftly heading toward authoritarianism. NPR. 2025 Apr 22; Available from: http://bit.ly/3I8P9Tb

17 Murphy R. Has Trump killed US democracy? Funding the Future. 2025. Available from: http://bit.ly/4kriDJx

18 Klein N, Taylor A. The rise of end times fascism. The Guardian. 2025 Apr 13; Available from: http://bit.ly/3TUabrb

19 Slaughter AM. How the World Can Push Back: The Playbook to Counter Trump's Second Term. Social Europe. 2025 Mar 28; Available from: http://bit.ly/3I8PiGd

SECTION A

The global political and economic architecture

From a political economy of disease to a political economy for wellbeing

Global Health Watch 6 (2022) was caught in the shadow of the COVID-19 pandemic. Donald Trump had lost the 2020 election and fomented a near coup d'état to overturn his loss. This edition of *Global Health Watch*, titled *Mobilizing for Health Justice*, is being released in the shadow of Donald Trump returning to the US presidency, ending the neoliberal era, and replacing it with an extreme mercantilist capitalism that some worry has hallmarks of fascism.* The world is in for perilous times in the near coming years.

The world was already in a sickly state before the results of the disunited states' November election sent shockwaves around the planet. As GHW6 noted, 40 years of neoliberal capitalism led to three interrelated crises: rampaging inequalities (income, wealth, resources), environmental collapse (climate chaos, biodiversity loss, species extinctions, environmental degradation), and mass population movements (with increasing numbers of people in the Global South seeking refuge from the first two). Despite some of the post-pandemic recovery reforms discussed in GHW6 (chapters A1 and A3), things have grown much worse.

Inequality: Elon Musk is poised to become the world's first trillionaire in 2027, whose wealth and social media will be harnessed to Trump's agenda. His trillionaire status will soon be followed by others as the cohort of billionaire oligarchs continues to grow wealthier, even as a billion of us still live in extreme hunger and near extreme poverty.

Environment: We have now crossed the 1.5-degree global warming 'red line' and are transgressing 6 of the world's 9 planetary life systems, while the fossil fuel industries and their half-century of lying and dissembling, with the collusion of enabling governments, expand current production and explore more fragile sites to exploit. Trump's promise to 'drill, baby, drill' will make that much easier, incentivizing other oil oligarchs to do the same. The UN COPs (Committee of the Parties) of the UN Framework Convention on Climate Change (UNFCCC) have drifted from reiterating unkept promises to near-capture by the fossil fuel industry, with COP 29 held in the petrostate of Azerbaijan (November 2024), and attended by over 1,773 fossil fuel lobbyists, producing 'a travesty of justice.'

Mass movement: In 2023, the number of people fleeing poverty, environmental catastrophe, violence, or all three is close to half a billion – the highest number

* Mercantilism is a nationalist economic policy and an early form of capitalism in which countries used tariffs and foreign trading monopolies to extract wealth from their colonies to increase its prosperity and power.

ever recorded (see Chapter C2). Many of these are internally displaced due to internationalized conflicts, a term for proxy wars between the world's multipolar powers. The USA is not the only country to militarize its borders, but Trump's stated intent to deport millions of undocumented migrants will strengthen alt-right politics fueled by anti-migrant anger. We can add to this list the legitimation of autocratic rule, the parlous state of multilateralism, and the century old risk of trade wars becoming world wars.

Capitalism as polycrisis

There is one thread that links these frightening trends into the modern catchphrase of 'polycrisis': capitalism, the system of market-based economic exchange that first overtook Western feudalism 400 years ago. Capitalism has long been an adaptive shape shifter, from its early days of new legislation that privatized the commons (akin to today's intellectual property rights' inclosure of knowledge), to the mercantilist contract between states and the merchant class that accelerated the colonial plunder of weaker states, to 19th century industrialization that entrenched capitalism's class system while revealing the violence of the gilded wealthy to keep their capital accumulating unabated in the face of citizen and workers' opposition.

The early 20th century imperialist competition between nations saw trade wars become world wars, not once but twice. World War Two's destructive aftermath led to a more equalizing 'New Deal' capitalism in developed market economies, characterized by strong unionization, progressive taxation, new health and social protection programs, and a slow decline in income inequality. This 'social contract' between state, market, and civil society was, in part if not primarily, Cold War policies to counter a perceived socialist threat. This global ideological arm-wrestling was also the context in which the Non-Aligned Movement of "developing countries" advanced a 1974 UN Declaration on a New International Economic Order (NIEO) to right some of the historic and disequalizing wrongs of past colonial practices (see Box A1.1).

This post-war era was also marked by an obsession with economic growth and its Gross Domestic Product (GDP) metric which, as a 1955 marketing consultant stated with almost gleeful honesty, "demands that we make consumption our way of life" such that things are "consumed, burned up, worn out, replaced, and discarded at an ever-increasing pace." Our past four decades of neoliberalism is essentially a globalized, exaggerated, and more predatory version of what much of the world has lived with for the past four centuries - an economic system with one essential feature: the drive to make a profit, to accumulate capital, and to exercise the controlling power that comes from such wealth. The International Monetary Fund (IMF) on which we will hear more throughout GHW7, and as we have stated in several of the previous editions, is quite up front about this. It identifies capitalism's 'founding pillars' as private property, self-interest, competition, market mechanisms, free choice (to consume, produce, invest), and limited government before emphasizing that capitalism's "essential feature…is the motive to make a profit."

Box A1.1: A New International Economic Order

In 1974 the UN General Assembly (UNGASS) adopted the Declaration on a New International Economic Order (NIEO). The idea of creating a NIEO was first proposed at the 4th International Conference of Heads of State or Government of Non-Aligned Countries, held in Algiers in September 1973. Post-independence, these countries remained locked into unfair terms of trade with former colonial powers. Dependent on primary commodity exports and with limited access to financing for development, they struggled to accumulate sufficient capital to industrialize their economies while being reliant on the import of costly manufactured goods. The NIEO was an attempt to reform the prevailing institutions, norms, forces, and practices of the prevailing regime of global economic governance to one that was more just and compensatory for past colonial exploitation.

The original NIEO Programme of Action emphasized using multilateral institutions (e.g. UN Trade and Development – UNCTAD) and south-south cooperation (including through the establishment of commodity cartels) to expand the economic sovereignty of "developing countries" in relation to "developed countries" and private capital. The Alma Ata Declaration (1978) recognized the importance of the NIEO Programme in achieving "health for all by the year 2000", stating that "Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries."

The vision set out in the Declaration was never implemented. Instead, Global South (GS) states' economic policy space has become more constrained since 1974 due to structural adjustment policies, the establishment of the World Trade Organization, and the embrace of neoliberal economic orthodoxies by most GS governments. These dynamics led GS governments away from experiments in prioritizing national development needs by strategically "delinking" from the global economy.

Since 2022 the Progressive International (PI) has revisited the vision of the NIEO. In 2024 it launched a "comprehensive Program of Action on the Construction of a New International Economic Order: a handbook for an insurgent South in the 21st century". This program focuses on addressing the same structural injustices identified in the 1974 NIEO. However, it has a more pointed focus on addressing the climate crisis and equitable participation in the knowledge economy than the original NIEO. It also acknowledges ecofeminist thinking more explicitly than the original NIEO, e.g. in drawing on much of the work emerging from this approach in relation to advocating for food sovereignty rather than food security.

Like the 1974 Programme it emphasizes the importance of strategic collective action between GS states. In particular, the new NIEO encourages the GS to work as a coordinated block across a range of issues to develop policies, institutions, processes,

Continues on next page

Box A1.1 continued

and concessions that favor the block as a whole and prevent retaliation against countries seen to be challenging the status quo. However, it does not necessarily acknowledge the geopolitical rivalries and challenges that complicate this proposal. The proposal is underpinned by the assumption that states will act in a way that benefit the peoples within their borders. In the current context of rising ethnonationalism, authoritarianism and a pushback against recognizing the rights of women and LGBTIQ+ communities globally – including in the GS – this assumption may not always be warranted.

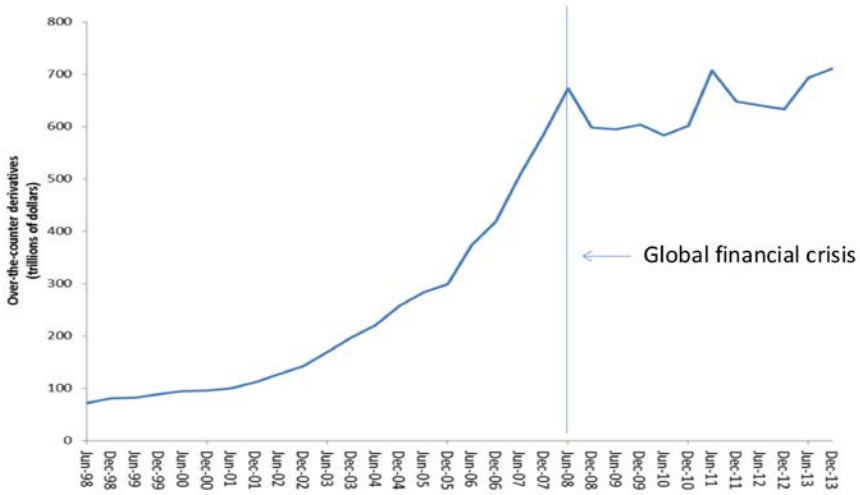
The 2024 NIEO recognizes the importance of small-scale and "slow" approaches to production, such as family farming and agro-ecology methods. Nonetheless, many of the structural reforms it proposes echo the 1974 NIEO in thinking about how to incorporate the GS in "big" industrial processes on more equal terms (e.g. developing minimum southern content requirements to promote and protect industrial capacity in the GS and coordinating industrial policy through regional value chain coordination in strategic sectors and critical technologies).

In terms of curtailing market power, the document acknowledges the importance of trying to decommodify essential and strategic goods and services to some extent (e.g. by creating a multilateral commodity buffer stock system to stabilize prices of essential commodities). It also recommends measures that try to rebuild the power of organized labor within the context of globalized labor migration flow (e.g. by recommending the establishment of a Southern Labour Commission that can act as a forum for the development of common GS labor policy and allow for a form of collective bargaining in contexts where traditional labor unions have been weakened or cannot easily function).

In terms of building a more accountable and just international order, the 2024 NIEO explicitly tackles issues of international law (e.g. it recommends coordinating legal interventions and capacities throughout the GS aimed at upholding and transforming international law), and in this sense goes beyond the 1974 NIEO's somewhat narrower focus on economic justice. That said, it echoes the older document's emphasis on the historical injustices of colonialism and imperialism and tries to think about approaches to international law that can unlock access to financing for climate adaption and mitigation (e.g. taking coordinated action to declare a global ecological emergency to unlock sufficient resources for mitigation and adaptation).

The new NIEO strategy might be summarized as state-centric and aimed at increasing GS governments' policy space and bargaining power, and in this sense is an important counterbalance to the denigration of public and popular power that characterized neoliberal globalization.

Figure 1: Rise of derivatives (trillions of $) 1998–2013



Source: Bank for International Settlements Derivatives Statistics, updated 14 Sept 2014. Available at: https://bit.ly/3XYbOXz

Neoliberal capitalism, its best-known recent shape-shift, did provide an outsourced uplift for many in parts of the world, where cheap labor and poor environmental standards lowered the costs and increased the profits of doing global business. But this uplift out of extreme poverty was not large, came at the cost of middle-class workers in the industrialized developed world, and fed the extreme wealth of a fractional 1 per cent based in the world's safe havens of capital. Much of China's stunning growth to become America's economic challenger was initially financed by US-based corporations and their investors outsourcing their production to the 'factory for the world'. In 1991 this foreign investment accounted for 6 per cent of the value of China's GDP, though this dropped to less than 1 per cent in 2023. The average contribution of foreign capital to the GDPs for all upper-middle-income countries in 2023, however, was over 4 per cent, while for South America it is almost 6 per cent.

Which is to say: billionaire investors in the world's wealthiest nations are still growing immorally wealthier even if some of that growth is now spread around the globe.

Financialized capitalism

There is one fundamental shape-shift that neoliberal capitalism solidified: a transition from accumulation based on the 'real economy' of production and consumption to one driven largely by finance, or what David Harvey describes as 'accumulation through dispossession'. We are now firmly in a world of financialized capitalism, one in which the financial sector becomes the driving force of economies worldwide (see Chapter D3), driven by asset speculation, corporate

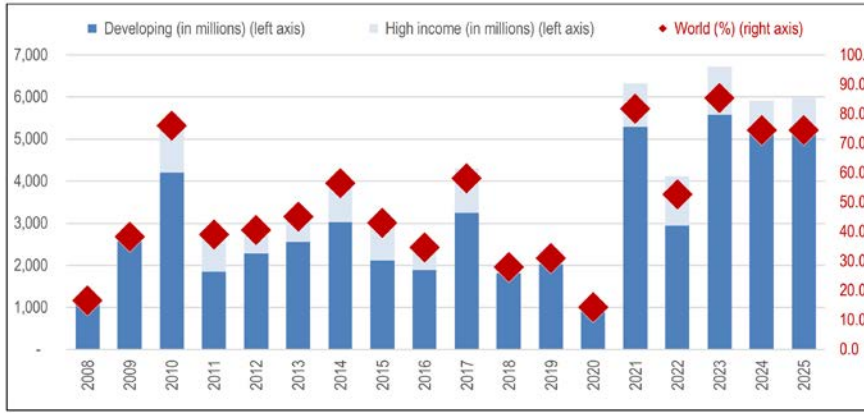
monopolistic rent-seeking (such as fees for technology mediated services), and debt bondage (today, modern slavery where a person's services are used as collateral to repay a debt). It is manifest in those with moneyed assets pursuing short-term and often speculative returns through a vast array of largely unregulated platforms, an increasing number of which are privately held and publicly unaccountable. In 2024, BlackRock, the world's largest private equity firm, managed over $11 trillion in assets, more than the combined government spending of the world's 10 wealthiest nations. Those of us with some form of retirement pension (about 64 per cent of the world's population) are implicated in this latest shape-shifted capitalism by dent of our public and private pension funds, the institutional investors that keep private equity and hedge funds humming along. Two thirds of BlackRock's assets are pension funds.

Derivatives are financial investment instruments that 'derive' their value from an underlying asset, such as a stock, bond, commodity, or index. Derivatives have little or no direct relation to the 'real economy' of production and consumption, and are often used by investors to hedge, speculate, or leverage their financial position to grow their 'moneyed' wealth. The World Bank no longer publishes annual total derivative values as it did when Figure 1 was developed, and the nominal value of derivatives did decline slightly after the global financial crisis. By 2023, however, the value exceeded $714 trillion.

Financialized capitalism first created, and then survived, the 2008 global financial crisis. Wealthy nations used their central banks and the power of their reserve currencies to 'quantitatively ease' the global economy with huge infusions of new money to cover the costs of reckless bank investing, incurring massive public debts before imposing domestic austerity. As many as 4 of every 5 countries are in fiscal retreat, shrinking their public expenditures as a percentage of their

Figure 2: Who pays the austerity price?

Millions of persons in countries affected by public expenditure contraction 2008-2025



Source: *Ortiz and Cummins, End Austerity, A Global Report on Budget Cuts and Harmful Social Reforms in 2022-25* [17] [18]

already shrinking GDP – even as third and fourth pandemic waves continue to buffet peoples' lives and livelihoods.

Instead of banks using this new capital to lend to new industries and employment, as governments had hoped, most of it went right back into (still largely unregulated) financial speculation.

The same thing happened with the new public money created to cover the costs of COVID's livelihood disruptions and the many post-pandemic 'build back better' initiatives. The wealth of a handful of billionaire investors kept swelling, much of it emanating from new realms of privatization in previously public sectors including education, health, housing, government services, even global development financing (see Chapter B1). Private equity in the US (one of the most financialized capitalist states in the world, and certainly its health system) now owns one quarter of all hospitals (see Chapter B1).

The looming post-pandemic debt crisis

Meanwhile the world's developing countries that lacked the same reserve currencies of the rich nations were left borrowing to survive the pandemic on costly and post-pandemic inflationary rates of market borrowing, placing many of them on the verge of collapse. Developing country debt servicing in 2023 was over $380 billion, much of it just maintaining interest payments without reducing the amount of the original loan. By one estimate, debt servicing consumes almost half of overall government spending in over 100 LMICs, with 53 countries considered to be in debt distress. Most of this debt is owed to private creditors unwilling to participate in debt restructuring initiatives. So-called 'vulture funds' pose another risk. Such funds purchase 'distressed debt' from countries on the edge of default at a bargain price and then use legal means to force these countries to pay off these debts and interest at full value. Despite efforts to ban such practices, our current 'worst developing world debt crisis ever' could still see countries face such extortionate practices.

In response to the rising global debt burden, the IMF is again prescribing austerity while dismissing the alternative of raising income or corporate taxes as 'politically unfeasible'. Of the total global debt of $315 trillion (as of early 2024), government debt (mostly HICs) was $91 trillion; private debt (personal, household, mostly in HICs) stood at $59 trillion; while corporate debt was more than both other sectors combined, at $165 trillion. All the austerity fuss is about public (government) debt with very little attention paid to corporate debt except, of course, when that corporate debt triggers economic crises (as it did in 2008) with the public absorbing such debt to avoid the financialized house of cards completely collapsing.

There are alternatives to austerity, including a return to progressive tax justice (see Chapter C4). The struggle for tax justice is ongoing, but in the shorter term there are options that could be pursued, specifically use of the IMF's Special Drawing Rights (SDRs), its low-interest, conditionality-free reserve asset. In 2021

Box A1.2: Financialized capitalism meets climate collapse

It could be argued that making money from money rather than from investing in a real economy reliant on unsustainable levels of material throughput might be good for planetary health. Until one realizes that financial speculation is still based upon some level of material production, consumption, and profit; and that the extreme capital accumulation of the uber-rich eventually gets expended on excess material consumption ranging from mega-yachts and multiple monster homes to private jets, scores of luxury autos, and even personal rockets, producing more climate changing emissions than most of the rest of humankind combined.

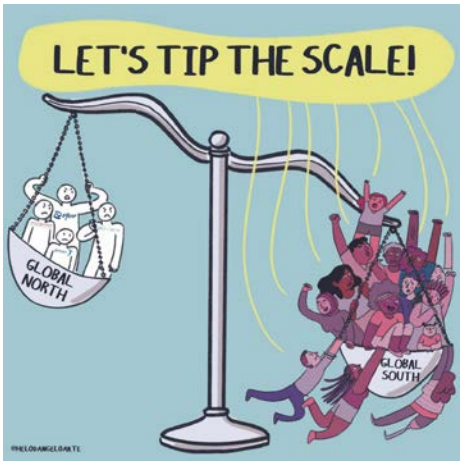
By one estimate, the capital-accumulating investments of the 125 global billionaires emit one million times more CO2 than the bottom 90 per cent of humanity. And with cryptocurrency 'mining' and artificial intelligence (both requiring massive amounts of electricity, estimated by 2026 to be as much as the whole country of Germany) Big Tech CEOs are busily purchasing or building private nuclear reactors. Nuclear may be preferable to fossil fuels, but this Big Tech atomic strategy is unfolding with no public debate about health and safety issues and with complacent governments giving it little for afraid of losing a competitive AI edge in their pursuit of growth.

Which is to say: Perverse levels of wealth inequality and climate chaos are simply flip sides of the same capitalist coin.

the IMF released $650 billion of its SDRs to help countries cope with the economic fallout of the pandemic. The only problem: as per IMF rules most of it went to the rich countries. There are calls for the IMF to release at least $1 trillion SDRs a year, with most of it going to LMICs that need it most, but without any structural adjustment strings attached.

Global trade in transition

Global trade has been a focus of health critique and civil society advocacy for decades, as the enforceable rules for such trade were crafted largely to the advantage of developed high-income countries. Trade negotiations and disputes since the birth of the WTO in 1995 have been fraught with tension and disagreements primarily pitting poorer (and trade dependent) countries in the Global South against the power of richer nations in the Global North. By the time the pandemic arrived, the WTO was already moribund. The US under the first Trump administration refused to appoint new members of the trade dispute oversight committee (the Appellate Body), undermining the WTO's enforcement powers. Wealthier member nations began negotiating side agreements (plurilateral agreements) on issues opposed by many developing country member states, and most new trade deals were bilateral (between two countries) or regional (between a small number of countries, often regionally based). COVID messed things up even more, upheaving global trade in nationalist efforts to control supply chains, from vaccines and medical supplies (see Chapter D2) to rare earth metals and fossil fuels.



Source: Development Alternatives with Women for a New Era (DAWN) and Third World Network (TWN); Feminists for a People's Vaccine Campaign

Trade has since transformed, with more emphasis on reshoring, friendshoring, and securitizing fragile supply chains. Growth in trade has slowed, but trade has neither stopped nor collapsed. New clubs of trading nations outside the global WTO regime are emerging, fracturing the notion of an international rules-based economy, regardless of how disequalizing many of those rules might be (and which still remain in force). The pivot to protectionism, particularly in the US, may herald another major shift in global trade, or in the neoliberally inspired treaties that govern it. Steep tariff hikes on Chinese EVs and across-the-board tariffs on other products, as promised by the new Trump administration and other high-income country governments, may be marketed as an effort to rebuild an industrial working class hollowed out by the off-shore profit-chasing of transnational corporations during the 1990s, the effect of which was to fuel the far-right drift to authoritarianism in many countries. But tariff walls of protectionism are fundamentally about nativist nationalism and geopolitical power. In a period of economic insecurity and high inequality that gives rise to authoritarian politics, the risk of trade wars once more becoming 'hot wars' (with all the health and destructive consequences) is very real.

While some global trade will be needed to ensure health-essential resources are available in countries that may lack the materials or technologies to produce them, retaining open trade under existing rules as envisioned by free market adherents inevitably crashes into the limits of growth so resoundingly critiqued by the Club of Rome over 50 years ago in their landmark study, The Limits to Growth. Global trade accounts for 20 to 30 per cent of climate change emissions, despite efforts to make its transport a little greener. And while rich country attempts to tax imports based on their carbon-content would reduce overall carbon emissions, it would also disadvantage poorer countries lacking state-of-the-art carbon-control technology, increasing the cost of their exports while returning some production to rich countries able to subsidize the 'greening' of their industries. Developing

countries, while supporting reductions in carbon emissions, oppose any unilateral trade measures based on climate or environment that would lead to increased global economic inequalities.

Exiting our health existential polycrisis

It is much easier to critique capitalism than it is to imagine it morphing into something fit to see us through our existential polycrisis. Imagining such a transition is particularly challenging in an era of geopolitical complexity, in which the stable bipolar Cold War has become a complex and unstable multipolar world (see Box A1.3), where geopolitical power struggles are giving rise to internationalized conflicts and the largest number of conflict-related deaths since the 1994 Rwandan genocide (see Chapter C1).

So: what is to be done? Are there pathways out of an economic paradigm that is slowly but with increasing rapidity killing us?

Many of us thought the 2008 financial crisis would offer us an opening, but post-crisis reforms merely tinkered on the margins. Many more of us thought the pandemic would usher in a much more robust response to economic transformation. As the previous edition of Global Health Watch Chapter A1 argued, there were some movements in that direction in the various 'build back better' or 'green deal' pandemic recovery packages proposed by the US, the EU, and other advanced economies. The problem then, and now, is the post-pandemic genuflection to the growth imperative. Not that growth is a bad word, but the growth that governments obsess over is the one still beholden to the GDP system of national accounts, notorious for ticking up every time there is a human or environmental catastrophe. Most of the world's governments have gone to great lengths to prime the economic growth machine, whether the old-style consumptogenic real economy of production and consumption, the new style financialized economy of investment gambling, or the trillions of dollars they offer in direct or indirect public subsidies to industries that destroy the environment (e.g. some $7 trillion annually to fossil fuels production and remediation, and $2.6 trillion in overfishing, petrol consumption, synthetic fertilizers, and monoculture crop production).

Ironically, many of the world's wealthier nations are already well past 'peak growth,' including even China. Chasing GDP-style growth is becoming a fool's errand. And, as Global Watch 6 Chapter A3 pointed out, green growth, that epitome of forward capitalist thinking, is important and much of what is included under that umbrella should be supported, but it remains too buttressed by a voodoo optimism that new scientific discovery alone will save us. Fundamentally, green growth still bumps up against capitalism's need for consumptive growth to avoid collapsing under its own contradictions.

Enter degrowth

Another growth term also matured in the post-pandemic push for reform: degrowth, sometimes also referred to as postgrowth. Degrowth was explored in

Box A1.3: Health and the Geopolitics of a Multipolar World

Geopolitics describes how geography, economics, and demography influence the politics and foreign policies of states. To grasp how changing geopolitics is affecting global health, and why understanding its impact is important in considering health policy and planning in the current epoch, it is first useful to recap recent geopolitical eras.

For several decades following World War Two, geopolitics was dominated by bi-polar competition between the centralized state-planned economy of the Soviet Union (USSR) and the liberal-democratic capitalism of the West anchored by the United States. This Cold War era gave rise to hybrid forms of state/market economic experiments in many of the de-colonizing new nations, primarily in Africa in the 1960s. This eventually led to a UN agreement to create a 'New International Economic Order' (see Box A1.1) that the neoliberal policies of the 1980s quickly undermined. The fall of the Berlin Wall in 1989 led to the dissolution of the USSR and the formal end of the bipolar era.

Following the collapse of the Soviet Union there was a brief 'unipolar moment' dominated by the United States and its projected 'liberal international order' in which trade liberalization and financial market deregulation shaped domestic and global economic policies in much of the world. The unipolar moment faded quickly in the face of the 2008 global financial crisis and the COVID-19 pandemic in 2020, coupled with the economic rise of China over the same period, which has created the prevailing multipolar world. If the EU is considered a single economic and political entity, most geopolitical scenarios describe an emerging global tri-polar order, with India potentially becoming a fourth regional anchor; although all remain within the global Western neoliberal order.

Despite its diminished geopolitical role, Russia continues to exert influence, indirectly through interference in other countries' elections (though it is not the only nation to do so), and more directly with its invasion of Ukraine, a response to the progressive eastward expansion of NATO deliberately seeking to isolate Russia, The Ukraine conflict is now widely seen as a proxy war between Russia and the liberal capitalist NATO nations led by the US. Whether this new Cold War becomes a 'hot war', or leads to some negotiated settlement, remains unknown, particularly given president-elect Trump's public displays of admiration for Russia's president Putin. As they did during the earlier Cold War, many developing countries are avoiding taking sides.

Even more striking has been the rise of the BRICS countries (Brazil, Russia, India, China and South Africa), recently expanded to include Saudi Arabia, Qatar, Iran, Ethiopia, Indonesia, and Egypt to become BRICS+. Nearly 50 more countries indicate an interest to join. The current 11-nation club comprises 45 per cent of the world's population and almost 35 per cent of global economic product. It is also attempting

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to de-dollarize its trade, especially amongst its members, emphasizing trade using its own currencies rather than the US dollar, and is considering creation of a BRICS+ currency. President-elect Trump has threatened them with his default '100 per cent tariffs' on all their exports if they do develop their own currency.

On the one hand, there is consensus that multilateralism is breaking down, abetted by the former Trump administration and likely to worsen in the second Trump administration. The militarized chaos in the Middle East, and the devastating loss in lives, livelihoods, and infrastructure, especially in Gaza, further impugn the ineffectiveness of our present multilateral governance systems (such as the UN Security Council). On the other hand, this new global multi-polarity and rearranging of country alignments may lead to new efforts by the world's largest and middle-power states to reach some agreement on health governance in a new global order. One thing is certain: The 'American Century' is over, and the US, despite its still overwhelming military strength, is no longer the global hegemon.

some depth in Global Health Watch 6, with its emphasis on the importance of a deliberate and regulated reduction in excess consumption in high-emitting sectors and countries, a redirection of investment into specific goods and services necessary for improving health and protecting the environment, and redistribution of wealth from rich people and countries to poorer people and nations. The concept has been criticized for being unrealistic, but what is more unrealistic is to assume that a capitalist economy can resolve the very crises it creates.

Breaking the ad-incentivized world of mass consumption, retail therapy, fast fashion, tech upgrades, and now AI will not be easy. But governments could start by ending all subsidies for environmentally damaging goods not essential for health, restricting advertising (especially for unhealthy commodities), and using progressive tax measures to reduce aggregate consumption. They could also mandate the right to repair and enforce compliance with a circular economy.

Degrowth has also been critiqued for being rich world-centric, minimizing the importance of economic growth for the world's poorer majority. Although this is a fair criticism of some presentations of degrowth, most degrowth economists emphasize the importance of scaling back rich world consumption to make more space available for sustainable and non-destructive growth in the low-income world. Doing so would also mean delinking the capital-dependency of economies in the under-consuming Global South on the extraction of resource wealth by transnational corporations based in the excess-consuming Global North. Degrowth is intrinsically anti-imperialist.

Fundamentally, we need to reverse the gross wealth and power inequalities that unfettered capitalism inevitably creates. Historically only two things have buffered markets disequalizing impacts: strong labor rights and organizing

that reduces premarket inequalities; and post-market progressive corporate and income taxation that redistributes economic wealth through public spending and income transfers. We may be experiencing a resurgence in labor activism, though how much of that will be captured by a radical right rather than a progressive left remains an open question in many advanced economies. Globally, unionization rates remain lower now than they did before the 2008 global financial crisis.

Then there is the matter of taxes, where we have seen a steady erosion in the amount of global economic product that states have harvested for public good purposes. Much of this slide in progressive taxation began with the rise of neoliberal capitalism in the 1980s. But since 2002 (the first year that global level data were available) the amount of untaxed income was $29.8 trillion. By 2022 it was $90.2 trillion. The growing gap between private wealth and public revenue goes a long way in illustrating why governments (with their military spending, toxic subsidies, and, yes, also their health and social protection costs) are so reliant on borrowing and debt to keep afloat; and why UN agencies, the WHO, and everyone else is after investors, private equity firms, and the spare change of the .001 per cent. The enormity of this gap also explains, in part, the public's electoral drift in liberal democratic states (notably in North America and Europe) towards right-wing authoritarian leaders. This is a well-known historical phenomenon dating back to the age of empires. More recently, as inequality and economic uncertainty/insecurity continue to rise (which has been the case in many countries over the course of neoliberalism's forty-plus years of dominance) the failure of mainstream politics to uphold the tacit social contract between workers and elites to buffer inequalities creates space for the emergence of autocratic demagogues.

To put this into health perspective; An income of $10/day (in purchase power parity) – considered to be the minimum needed to acquire the resources for a healthy life – would require $7 trillion a year in new or redistributed wealth going to the world's poorer 70 per cent. This amount is equal to annual governments' fossil fuel subsidies, or about 7 per cent of the world's global economic product. The bottom line: Our recent financialized capitalism has done a fabulous job of creating an enormous amount of wealth, but an existentially terrifying job in where that wealth has gone. Progressive taxes are one foundationally important way to remedy this. As the Tax Justice Network puts it: taxes are society's superpower (see Chapter C4).

There is momentum on this, beyond the insufficient 15 per cent minimum corporate tax rate that most of the world's countries agreed to in 2021 but which the US has yet to implement, the more so under a second Trump administration. In October 2023, UN Secretary General Antonio Guterres issued a draft resolution calling for formal negotiation of a legally binding UN Tax Convention, a motion first raised by the African Group of nations. It was adopted by the UN General Assembly on November 22, 2023, with formal negotiations for a draft convention now underway. Eight countries opposed the resolution: Australia, Canada, Israel,

Japan, New Zealand, Republic of Korea, UK, and USA, later joined by the far-right Milei government of Argentina.

Can a wellbeing economy save us?

There is one final quibble about degrowth in terms of its (in)ability to mobilize the masses: it is perceived as too negative, since for many people growth (outside of cancer, zoonoses, antimicrobial resistance or, in this instance, capitalist economics) is seen as a life-affirming positive. Yet another term has been added to the global economic reset list: the wellbeing economy. In simplest terms, a wellbeing economy is one that pursues an equitable global allocation of the resources people need for a healthy life while staying within the ecological limits of our planet. Like transforming capitalism, this is easier said than done, especially when some extend this to minimizing the impacts of human activities on all other living species, rewilding our natural surroundings, and upending the current human-generated sixth mass extinction.

The WHO threw some of its weight behind the wellbeing economy idea when it established an all-female Council on the Economics of Health for All in 2020, comprised of some of the world's most outspoken heterodox and feminist economists. Over its 2-year term the Council issued a number of well-researched policy briefs culminating in a number of high-level recommendations intended to "transform economic systems and co-create an economic policy design guide to shift societal success beyond GDP growth and instead deliver shared wellbeing." None of the Council's recommendations would be foreign to public health activists, many of which have long argued for tax and environmental justice, economic fairness, gender equity, collective human rights, food security, and properly financed governments protecting and expanding the space for public engagement in policy making.

In 2022, the Club of Rome collaboration released its Earth4All Report, echoing much of the WHO Council's recommendations. It identified 5 great turnarounds (eliminate poverty, reduce inequality, empower women, transform food systems, transform energy systems) – there is little disagreement with these high-level aspirations – and 17 specific policy directives to achieve these. Following the modeling the Club of Rome did 50 years earlier in its Limit to Growth study, Earth4All projects two scenarios. The first scenario (called 'Too Little Too Late') shows the potential consequences of continuing world development along the same dynamics as 1980 to 2020 where political leaders and industry pay lip service to reducing emissions while obsessing about growth. Labor participation rates and trust in government decline, there is a steady increase in the ecological footprint, and rising loss in biodiversity. Persistent poverty remains in most of the world, with destabilizing inequality in the rich world and a dramatic increase in the Social Tension Index. By 2100 the world temperature rises above 2.5°C passing most critical ecosystem thresholds. The second scenario (the 'Great Leap') assumes governments begin to adopt the Report's 17 policy reforms, leading to

a more optimistic 2100 outcome with poverty virtually eliminated, inequality declining, global warming flat-lining below the 2.0°C level, and a 'wellbeing index' continuing upwards.

But are states likely to embrace the challenge a wellbeing economy presents to capitalism's consumptogenic and predatory practices? Probably not. Despite some countries showing some interest in the concept, the existence of a Wellbeing Economy Alliance with over 200 member organizations, and some UN agencies (including the WHO) promoting it, there is too much historical evidence of states colluding with, rather than forcibly challenging, the short-term interests of capital apart from tossing a few mildly redistributive policy crumbs in the direction of the marginalized. The modern state that arose following the 1648 Treaty of Westphalia that ended Europe's religious wars emerged at the same time as capitalism; state and market have been conjoined ever since. The thirty-year post-war period that compressed the obscene inequalities of the pre-war 'Gilded Age' is seen by many heterodox economists as a capitalist anomaly, unlikely to be repeated. And, recall, this post-war period was also the dawn of mass, excessive, planet-destroying consumption.

Few wellbeing economy initiatives explicitly call out capitalism (including the WHO's Council on the Economics of Health for All, although the Earth4All collaboration comes close) or adopt fiscally challenging policies. There is also the risk of performativity, that governments will come up with some new indicators while the planet cooks, neoliberal capitalism transforms into authoritarian, radical mercantilist or oligarchic capitalism, and the Doomsday Clock of the Bulletin of the Atomic Scientists' advisory board moves to 90 seconds to midnight, the closest it has ever been. Over 80 per cent of the world's countries are 'building back worse', not better, with health and social spending in decline, taxes becoming regressive, and labor policy and income going in the wrong direction – with women bearing the brunt of the shocks associated with these dynamics.

At the same time, wellbeing economies' positive language of abundance, wellness, and conviviality resonates with what polling tells us many of the world's peoples want: an economy organized around wellbeing, rather than around growth and capital accumulation. With a strong emphasis on living in harmony with nature, a wellbeing economy has global resonance, from the Latin-American buen vivir to the South African ubuntu, the Swedish lagom, and values associated with Buddhism and Confucianism.

Fundamentally, as PHM's People's Health Assembly 5 Mar del Plata Call to Action emphasized:

> Capitalism is infinite in its pursuit of profit and consumption, but the world we live in is absolutely finite, and its physical limits are being attacked and exceeded. **Only a radical change that replaces the mode of production, consumption and life generated by capitalism can reverse this destructive trend.**

Central to engendering this change, and to reversing our downwards spiral of environmental degradation and social injustice, is embracing the politics of ecosocialism, in which the tenets of socialist economics entwine with the agro-ecological feminism of buen vivir and other Indigenous knowledge systems. Many of ecosocialism's demands overlap those put forward by proponents of wellbeing economies, but ecosocialism explicitly seeks to overturn (and not merely reform) the foundational elements of capitalism.

> In synthesizing the basic tenets of ecology and the Marxist critique of political economy, ecosocialism offers a radical alternative to an unsustainable status quo. Rejecting a capitalist definition of "progress" based on market growth and quantitative expansion…it advocates policies founded on non-monetary criteria, such as social needs, individual well-being, and ecological equilibrium.

Strategically, many ecosocialist movements argue the importance of prefigurative action, combining a loud and continuous discrediting critique of the prevailing capitalist ideology (as found in this, and past editions, of Global Health Watch) with immediately 'doable' creation of and support for localized forms of non-commodified (non-capitalist) economic systems (e.g. local or non-currency systems of exchange, various forms of cooperatives, environmental sustainability projects). Such initiatives 'prefigure' what a transformed economic system might look like, if achieved by revolution, evolution, or ecological necessity at political scale.

Over the near term, however, our global political economy has yet to break free in any substantive way from the depredations of a capitalism in flux. The years coming will be difficult ones. The world has been here before. The Italian philosopher and activist, Antonio Gramsci, in his Prison Notebooks, written when the 1929 stock market collapse led to the Depression of the 1930s in the aftermath of a brutal world war from which the warring countries had yet to recover, noted that:

> The old world is dying and the new world struggles to be born.
> Now is the time of monsters.

Although often cited, it is a slight mis-quote or popularized version of what Gramsci actually wrote:

> The old is dying and the new cannot be born: in this interregnum the most varied morbid phenomena occur.

The morbid phenomena to which Gramsci refers include fascism arising from a crisis in capitalism (and later Nazism in Germany), but also in his time a shift to an ultra-left Communist position that legitimated Stalin's rise to authoritarian power. However phrased, and whether right or left authoritarianism, the take-home message is that it was (then) 'a time of monsters' and is (now) one in which

we again find ourselves.

But Gramsci also wrote of the activism needed for the new world in its struggle to be born, and that he was:

> A pessimist because of intellect, but an optimist because of will.

And the only thing that sustains that will is the support of others willing and able to speak truthfully, despite the new risks this might entail.

It is important to acknowledge the efforts so many have made, and still make, to birth a new world of wellbeing or ecosocialist economies and the ethos and practices of *buen vivir*.

In the many chapters of this new edition that follow we have tried to shed light on activist efforts, successful or otherwise, in the ongoing struggle for health and planetary survival.

Reference List

1 Vargas, Elon Musk on pace to become world's first trillionaire by 2027, report says, The Guardian, September 8, 2024, https://bit.ly/41JhbMq

2 Richardson et al., Earth beyond six of nine planetary boundaries, 2023, Science Advances, 9(37), doi 10.1126/sciadv.adh2458, https://bit.ly/4hYOFeM

3 Center for Climate Integrity, Deception Documents, (nd), https://bit.ly/3QPxQaP

4 International Institute for Sustainable Development, Carbon Minefields Oil and Gas Exploration Monitor, October 24 2024, https://bit.ly/4hGYi1f

5 Noor & Carrington, Cop29 climate finance deal criticized as 'travesty of justice' and 'stage-managed', The Guardian, November 24, 2024, https://bit.ly/4ca1CB9

6 Vince, The century of climate migration: why we need to plan for the great upheaval, The Guardian, August 18, 2022, https://bit.ly/3FCA6jw

7 World Health Organization: Regional Office for Europe, Declaration of Alma-Ata, 1978, World Health Organization. Regional Office for Europe, WHO/EURO:1978-3938-43697-61471, https://bit.ly/4j5j3F9

8 Amin, A note on the concept of delinking, Review (Fernaud Braudel Center) 10(3), 435-44,1987, https://bit.ly/4iTKCRS

9 Adler, Gandikota-Nellutla & Galant, Comprehensive Program of Action on the Construction of a New International Economic Order: a handbook for an insurgent South in the 21st century, Progressive International, September 22, 2024, https://bit.ly/3FJaqla

10 Lebow, Price Competition in 1955, Journal of Retailing, 31(1)

11 Jahan & Mahmud, What is Capitalism? International Monetary Fund, (nd), https://bit.ly/42iYNdt

12 Global Economy, China: Foreign Direct Investment, percent of GDP, 2024, https://bit.ly/3DUxOvq

13 Global Economy, Foreign Direct Investment, percent of GDP – Country rankings, 2023, https://bit.ly/4i856pb

14 Harvey, The New Imperialism, Oxford: Oxford University Press, 2003

15 Watts, BlackRock accused of contributing to climate and human rights abuses, The Guardian, November 20, 2024, https://bit.ly/42iaTDz

16 Mercer, Mercer CFA Institute Global Pension Index 2022 calls for super mindset shift, October 11, 2022, https://bit.ly/3QQAWeH

17 International Swaps and Derivatives Association, Key trends in the size and composition of OTC derivative markets in the first half of 2023, December 2023, https://bit.ly/3E3W7XO

18 Ortiz & Cummins, Austerity: The new normal – A renewed Washington consensus 2010-24, SSRN, October 1, 2019, https://bit.ly/4jqU2ob

19 Ortiz & Cummins, End Austerity, A Global Report on Budget Cuts and Harmful Social Reforms in 2022-25, ActionAid (et al), September 2022 https://bit.ly/4iMeYWC

20 Armine Yalnizyan, The care economy is the foundation of the economy, CCPA Monitor, Fall 2024, https://bit.ly/4j8RF9m

21 Harvey, Vulture funds prey on developing countries, ROAR News, February 27, 2023, https://bit.ly/3FI2ssC

22 International Monetary Fund, World Economic Outlook: Policy Pivot, Rising Threats, October 2024, https://bit.ly/443aVR9

23 Zhu, Charted: $315 trillion in global debt, by sector, Visual Capitalist, September 9, 2024, https://bit.ly/42l3dR6

24 Ghosh, SDRs are the great untapped source of climate finance, Project Syndicate, December 12, 2023, https://bit.ly/3XBMnea

25 Oxfam International, A billionaire emits a million times more greenhouse gases than the average person, Oxfam International, November 7, 2022, https://bit.ly/41KUmYO

26 Castelvecchi, Will AI's huge energy demands spur a nuclear renaissance? Nature 635, 19-20, October 25, 2024, https://bit.ly/3QQq4xy

27 World Trade Organization, Goods barometer rises above trend, signaling upturn in trade volume, WTO Trade Barometer, September 4, 2024, https://bit.ly/41KfIWa

28 Ekbladh, No, the world isn't heading toward a new Cold War – it's closer to the grinding world order collapse of the 1930s, The Conversation, August 23, 2024, https://bit.ly/4hQuMGG

29 Meadows, Meadows, Randers, & Behrens, The Limits to Growth: A Report for the Club of Rome's Project on the Predicament of Mankind. Hanover, Dartmouth College: Dartmouth Libraries; 1972

30 Kyriakopoulou, Kyriacou & Pearson, How does trade contribute to climate change and how can it advance climate action? Grantham Research Institute on Climate Change and the Environment, June 12, 2023, https://bit.ly/3QQd8HT

31 Kanth, Trade: BRICS rejects CBAMS, UNCTAD embraces carbon pricing policies, Third World Network Info Service on Climate Change, October 28, 2024, https://bit.ly/4j3lDv9

32 Rustad, Siri Aas, Conflict Trends: A Global Overview, 1946–2023. PRIO Paper. Oslo: PRIO 2024, https://bit.ly/3DJEzAl

33 Labonté R, Martin G, Storeng K. Editorial: Whither globalization and health in an era of geopolitical uncertainty? Globalization and Health 2022;18(87), https://bit.ly/4i88hND

34 Ball, 12 predictions for global geopolitics for 2019 through 2025-and beyond, Global Security Review, 2019, https://bit.ly/42jU2jR

35 Tennis, Russia ramps up global elections interference: Lessons for the United States, Center for Strategic and International Studies, July 20, 2020, https://bit.ly/3DSkUOG

36 The Globalist, BRICS vs, the G7, The Globalist, October 23, 2024, https://bit.ly/42bTAD9

37 Dolgin & Turner, De-dollarisation: More BRICS in the wall, ING Think, October 23, 2024, https://bit.ly/3QR5j4M

38 Associated Press, Trump threatens BRICS nations with 100% tariff if they replace US dollar, AP Press, November 30, 2024, https://bit.ly/3Y5w5u1

39 Black, Liu, Parry & Vernon-Lin, IMF fossil fuel subsidies data: 2023 update, IMF Working Papers, August 24, 2023, https://bit.ly/42b9jT3

40 Greenfield, Global spending on subsidies that harm environment rises to $2.6tn, report says, The Guardian, September 18, 2024, https://bit.ly/4239sHV

41 QERY, Trade Unions Worldwide, April 2024, https://bit.ly/3FLxtMf

42 World Bank datasets. The dataset for untaxed income may be retrieved from https://bit.ly/3RlktiK. The dataset for global GDP may be retrieved from ttps://bit.ly/3QOgpHR. Access November 24, 2024

43 Turchin, The deep historical forces that explain Trump's win, The Guardian, November 30, 2024, https://bit.ly/3XB0HUd

44 Garay, Towards a WISE – Wellbeing in Sustainable Equity – New Paradigm for Humanity, Policies for Equitable Access to Health (blog), December 13, 2023, https://bit.ly/3FJSaIn

45 Tax Justice Network, United Nations General Assembly votes overwhelmingly to begin historic, global tax overhaul, November 27, 2024, https://bit.ly/3FLxVKr/

46 Dixson-Decleve & McLeod, 21st century wellbeing economics: The road to recovery, renewal & resilience, The Club of Rome Economic Recovery, Renewal & Resilience Series (volume 1), February 2021, https://bit.ly/43Z1xhh

47 WHO Council on the Economics of Health for All. Health for All – Transforming Economies to Deliver What Matters: Final Report of the WHO Council on the Economics of Health for All. Geneva: World Health Organization; 2023. https://bit.ly/4cbVwA6

48 Club of Rome, Earth4All Report: September 2022-September 2023, 2023, https://bit.ly/3XZ0x7h

49 Meadows, Meadows, Randers & Behrens III, The Limits to Growth, A report for the Club of Rome, 1972, https://bit.ly/3E4JM5F

50 Kamande, Walker, Martin & Lawson, The commitment to reducing inequality index 2024, Oxfam Report, October 2024, https://bit.ly/4l110ln

51 People's Health Movement, PHA5 Mar del Plata 2024 Call to Action, 2024, https://bit.ly/42l6O1y

52 Lowy, Why ecosocialism: For a red-green future, Great Transition Initiative, December 2018, https://bit.ly/43Mmc8z

53 Achcar, Morbid symptoms: What did Gramsci really mean? Notebooks: The Journal for Studies on Power, 1(2), 379-387, February 14, 2022, https://bit.ly/4c38RKO

Life at the center: ecofeminisms and ecoterritorial feminisms in the dispute for life

Introduction

The world is experiencing a deepening of extreme events related to a generalized ecological and climatic crisis. Floods, fires, water and energy crises, droughts and loss of biodiversity are more frequent. All these catastrophes were already being experienced by communities, peoples and territories in areas where extractivisms (such as intensive agriculture and livestock farming, mega-mining, fracking and other types of predatory extractivisms), as well as false solutions (such as wind and photovoltaic complexes), are present. Warnings about the consequences of the climate crisis – which in recent years has become more visible to all sectors of society– have always been present, but the invisibility and sometimes denial of the experiences and opinions of Indigenous groups, peasants and affected communities did not allow the full extent of the crisis to be understood.

The current crisis has several dimensions. It could be said that we are living an "integral crisis", this means that we cannot think only of an environmental crisis, it is necessary to understand the crisis in its integrality in order to understand how we reached this state of collapse of the world's functioning systems. In this sense, the economic and political crisis cannot be separated from the environmental crisis, nor can we fail to think about the ethical crisis that affects us as a civilization.

This ethical crisis is intimately related to the lack of care for the environment, the separation between human beings and Nature, and, above all, to the place given to care work within the capitalist system. It is not by chance that care systems and reproductive work, that is, work that is not directly related to the production of goods and services, occupy a secondary place in societies.

The lack of recognition of the need for care makes the central cause of the problems that affect human and non-human beings, and the environment in which they live, invisible. Recognition of the need for care is the ethic that can be found in communities that are more closely linked to the natural environment and that have an intimate relationship with the territories, as is the case of native and peasant communities (see Chapter A3). Likewise, for several decades, territorial, popular, community and peasant feminisms have been questioning the productivist logic that puts life and its sustainability in second place, and that delegates the tasks of care to women and feminized bodies.

From this shared ethic of placing life at the center of the debate, ecofeminisms propose a different approach from those that only demand economic, political, social and reproductive rights. Ecofeminisms understand the care of human life and ecosystems as inseparable entities, and propose that it is necessary to redefine the logic of civilization, understanding that human beings are part of Nature.

Such understanding is only possible if the relationship exists, that is, if we conceive of ourselves as humanity that is not alien to Nature, a link that has historically been lost in modern societies, in which Nature has been reified. Similarly, it is in colonized territories where this relationship is much clearer and is maintained, which is why the need to decolonize the imaginary is fundamental for ecofeminisms. This process of decolonization has a strong anti-racist component, since it is understood that the processes of colonization were carried out through the genocide of native peoples and afro-descendants, operating in turn as ecocide, as destruction of ecosystems.

The colonization process not only dominated peoples and territories, but also placed colonized populations and territories in a subordinate position. It is a process that is still present, and ecofeminisms understand that extractivism is one of the faces of this continuity. The enormous inequalities present in these regions of the world, as is the case in Latin America and Africa, is a consequence of this colonialist logic that condemns these populations to poverty and to live in inhuman conditions.

In this sense, intersectional feminisms, which understand the intersection between gender, class and race, are fundamental for the construction of an integral and just feminist struggle that embraces all the existing realities in the world. The cross-border dimension of feminisms, which challenges the capitalist logics of global division, is a powerful tool against what the Movement of Indigenous Women and Diversities for the Buen Vivir calls "terricide".

Terricide is the constant assassination of territories, ways of life and imaginaries that propose a full, healthy life in harmony with Nature. For ecofeminisms, this political, communitarian and affective practice is an insistence on survival, a proposal to live in a world in crisis, and from where to think and inhabit possible ways out.

Extractivism as the coloniality of Nature and terricide

The coloniality of Nature[1,2], understood as the imposition of a modern imaginary where Nature is perceived as the bearer of raw materials and natural resources, reifying it, also responds to a gender coloniality[3], where women have been conceived as Nature, inhabiting the wild, the irrational, the liminal, and thereby underpinning the control and disciplining of the feminized bodies of native peoples, afrodescendants, migrants, peasants and popular urban sectors. Thus, extractivism, understood as the unlimited and intensive extraction of natural elements for the generation of profits through their export and circulation in global

markets[4], not only reflects patriarchal dynamics but also reinforces patriarchy, in that its effects are intensified in the face of precarious lives and crossed by various axes of structural violence.[5] This is why we speak of repatriarcalization of territories.

Extractivism corresponds to the way in which capitalism operated and continues to operate in continents such as the American continent, Abya Yala, the name given by the native Kuna communities of Panama to refer to this territoriality, and which allows what authors will call the original accumulation, which is sustained through an accumulation of lands and subjects, by dispossession[6], through the exploitation of enslaved and precarious labor and Nature itself. Thus, the ideology of development and the consolidation of central economies of the Global North have been at the cost of coloniality and the dispossession of bodies, peoples and territories of the Global South. As Brand and Wissen (2021) said, the imperial way of life of modern societies is based on the exploitation and degradation of the so-called "others" where, in order to sustain their standards of living, people in modern societies need to perpetuate the structural precariousness of sacrificial peoples, who were conceived as Third World.[7]

Extractivism has generated diverse processes of deterritorialization, displacement and migration in a current context of deepening ecocide, putting at risk the very existence of humanity, of diverse species and of Nature. This is why, as pointed out in the introduction, the Indigenous Women's Movement for Buen Vivir of Puelmapu (Mapuche territory in Argentina) has chosen to speak of terricide.

Terricide refers to the murder not only of tangible ecosystems and the people who inhabit them, but also to the murder of all the forces that regulate life on earth, what we call the perceptible ecosystem. We understand that terricide is a consequence of the dominant civilizational model, which is putting our future on the planet at risk and which today manifests itself through climate change and its consequences.[8]

Ecoterritorial feminisms in Abya Yala

In the last decade, ecofeminist perspectives have been positioning themselves as ecoterritorial feminisms[9] from the territorial defense and the organization, resistance and collective imagination of women, 'dissidences'* and feminisms, around diverse socio-environmental conflicts, and (re)creating alternatives to extractivism from experiences of community water management, food and energy sovereignty and self-determination in both urban and rural territories, as well as through the consolidation of short circuits of territorial economies.[10]

Thus, we find experiences such as the Assembly of Women and Dissidences of the Movement for Water and Territories in Chile (MAT), Women and the Sixth

*Identities, cultural practices, social and political movements that question heterosexuality as a hegemonic social norm.

in Mexico, which have developed proposals for community water management, considering basin and sub-basin management, integrating ancestral knowledge, where women play roles and their work is publicly recognized, both in the administration and care of the various bodies of water.

We speak of feminist and environmentalist political experiences in different parts of Latin America, also called Abya Yala, in the context of an ecological and climate crisis that call into question our own existence, from the growing process of feminization and decolonization of the struggles in the continent around the defense of bodies, land and territory, the struggle against the matrix of colonial oppression of race, sex, class.

Eco-territorial feminisms are positioned from other worldviews that are not anthropocentric, in which the mountain, the river, the animals are part of a network of relationships, of the fabric of life, contrary to the logic of capitalist dispossession.[11]

One of the points to highlight in these feminisms is the vindication of a restorative justice (see Chapters B4 and E2), both of ecosystems and of a justice for and from the peoples, from the experience of ethical, popular and feminist judgments, in view of the need for another justice, feminist, communitarian, plurinational, in defense of women, dissidences, Nature, from anti-racist and anti-extractivist practices that demonstrate the plots of injustices.[12]

Extractivism is also patriarchy

Ecoterritorial feminisms seek to make visible the link between extractivism and patriarchy, making visible the structural violence associated with the exploitation and degradation of territories and its impact on the bodies that inhabit them, where, for example, women have been the most affected by ecological and climatic violence. This is why we can say that socio-environmental problems are also structural gender violence.[13] For example, the impacts of the situation of water scarcity and water contamination are more severe on women, children and dissidences, since they are the ones who most fulfill roles associated with the cultivation and care of crops. Women are the ones who carry out the most irrigation work, and the ones most closely linked to the land and the productivity of its various cycles, and likewise those who play the role of water reproduction. For the same reason, they see crop monoculture as a direct threat to their bodies, due to the application of agro-toxins and pesticides, as well as environmental degradation.

Extractivist activities impact women's lives, territories and their own self-care dynamics. When talking about water scarcity, women who are menstruating, those who are breastfeeding and those who need water all the time as a way of managing their care and that of other people, in addition to the farm and animals, are made invisible, relegated to care and domestic work due to the intensification of the precariousness of their lives generated by the installation and perpetuation of extractivism.[14]

Negotiations and resolution of socio-environmental conflicts are also captured by patriarchal logics. When extractive companies enter, if they inform about their activities, it is mostly men from the affected localities or territories who are notified. The same happens when negotiations are held to stop a project or reduce its socio-environmental impacts. Women are reduced to the private sphere and to permanent disinformation, while the men in their organizations are the ones who negotiate. In the same way, several mobilized women in Abya Yala point out that, in their own mixed organizations, their presence is made invisible, with the majority being men who impose decisions, courses of action and times, without considering other ways of organizing life. For this reason, today there is not only a dispute over exiting from extractivist projects, but also over the importance of recognizing the work of women in territorial defense.

Placing life at the center of the body/territory

One of the emblematic slogans of feminisms in Abya Yala has been to place life at the center, which also includes the consideration of non-human lives, such as plants, animals, spirits and the dead, who are considered part of the web of life, as Lolita Chávez, member of the Council of K'iche's Peoples for the Defense of Life, Mother Nature, Land and Territory (CPK) pointed out.

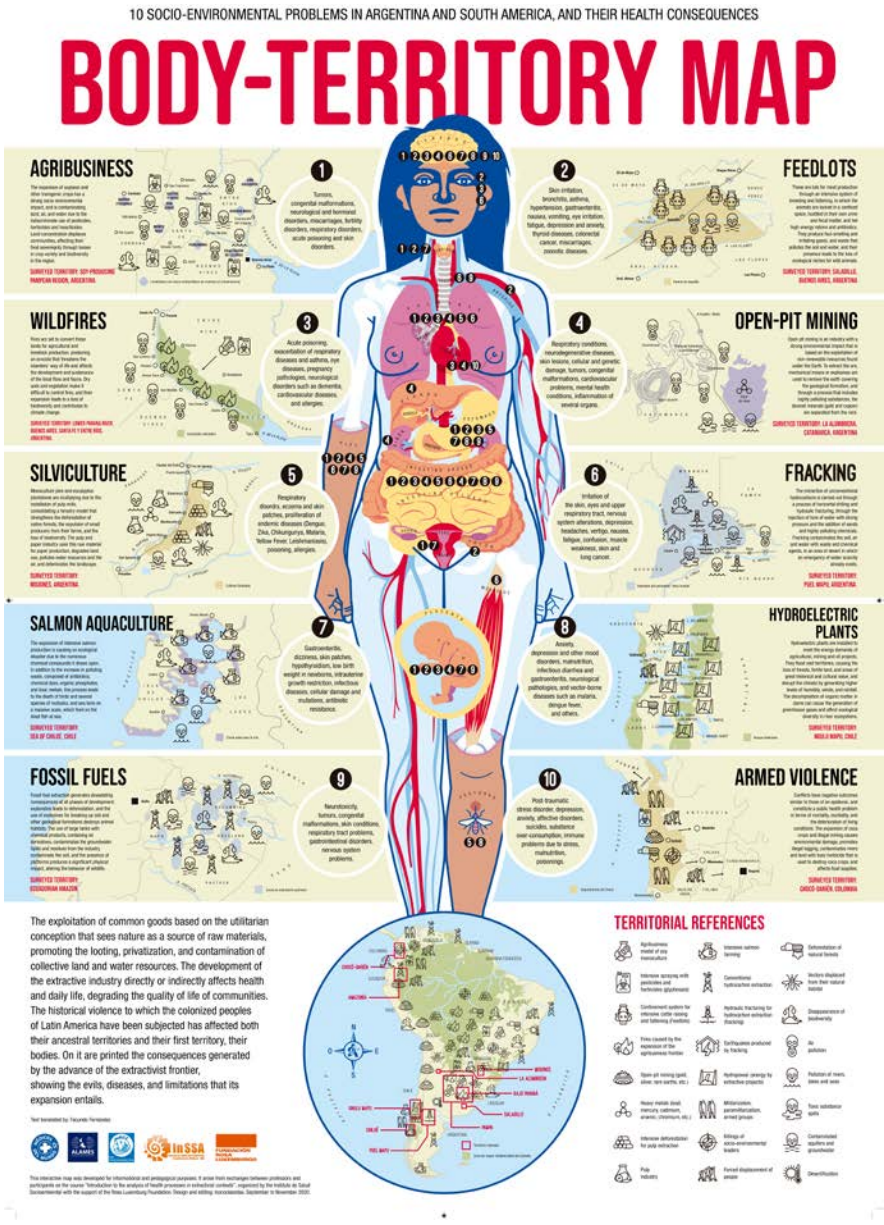
It is within this framework of existence that women, who have historically been linked to the care and reproduction of life, will be the first to experience the effects of extractivism, this being the starting point of Latin American eco-territorial feminisms, "the defense of living conditions against the threat of pollution and/or the denunciation of impacts on health, air and the environment".[15]

Women and dissidences from different peoples and territories will be interwoven around community networks[16], as a space of care and solidarity, to face the conditions of precariousness and structural violence brought about by extractivist activities, being at the same time the first to protest and organize themselves in the face of the installation and expansion of these projects. These community networks not only give account of a collective subjectivity but also make possible the material and symbolic reproduction of collective life and their own conditions of existence over time.

The community becomes the political force from which resistance and organization for life are built, through the conformation of a body that transcends the order of the individual, becoming a community body[17], constituted by collective knowledge and tasks, which is also political, which has been named and constructed from discourses that have justified its oppression, exploitation and alienation. Today the bodies of women, girls and dissidences become bodies/territories with history, memory and knowledge to inhabit by intertwining the emotional, spiritual and rational dimensions.[18]

One of the greatest contributions to think about the defense of waters and territories comes from an epistemological turn given from community feminisms in

Figure 1: Body-territory map



Institute of Socio-environmental Health, National University of Rosario (Argentina)

Download the Body-Territory Poster (in Spanish): https://bit.ly/445DT2o

Bolivia and Guatemala, incorporating the notion of body-territory, and also the triad body-land-territory, being one of the major referents Lorena Cabnal, part of the Ancestral Network of Healers of Community Feminism, Tzk'at.[19]

For Cabnal (2010), the notion of the body-territory allows the conscious recovery of "our first body territory", as an emancipatory political act and in feminist coherence with "the personal is political", "what is not named does not exist".[20] The body has been a territory in dispute by patriarchy, colonialism, racism and capitalism, to exercise its dominion from and over the bodies of women, girls and dissidences, and therefore the need to subvert this mandate.

The transgressive, transformative and creative power of the dispute over bodies and territories has given rise to a possible collective healing through the spiritual recovery and the ancestral knowledge of grandmothers[21], facilitating processes of reconnection not only with one's own corporeality but also with Nature. On the other hand, to speak of territory-land is to recognize and situate in a given space the experience, the inhabiting and the very life of the bodies, which constitute a community body, territory-land historically crossed by extractivism and today the false solutions, degrading, dispossessing and contaminating the body-territory, in addition to perpetuating structural violence.

In view of the above, we have claimed not only as a methodological tool, but also as a political tool, the realization of body mappings from which to identify the ailments and consequences of extractivism in the bodies of women and dissidences in territories in socio-environmental conflicts due to extractivist activities and false solutions – such as those that propose solutions through the financialization of Nature and other ecocapitalist and polluting projects – to then map from the same body the possibilities of building alternatives and *buen vivir* (see Chapter A3).

Many of these mappings begin with the drawing of a silhouette of a participant, where each person then places words, drawings or icons at some point on the body where they experience or express physical and mental ailments resulting from the extractive activity that afflicts them.

Towards an ethics and politics of care

Eco-territorial feminisms have been outlining an ethics and politics of care based on buen vivir, focusing on self-care for the defense of territories, but also mentioning how women defenders take care of ourselves, the need to think of care as collective, communal and as part of the defense of Nature.

To sustain the defense of waters and territories requires self-care of physical, mental, spiritual and nutritional health, promoting the use and care of gardens in the countryside and in the city, knowing the plants and herbs that heal and caring for animal lives, which is related to food sovereignty and self-determination, considering both the production, distribution and consumption of food, and the care of seeds.[22]

Another essential element is care in a joint way, assuming the organizational work in a collective manner, seeking spaces for healing and community containment from the different forms of buen vivir of the peoples, promoting a tasty living -vivir sabroso- with our traditions and environment, assuming a joyful rebellion (Zapatista principle) from the organization, vindicating the practices of care of the diverse peoples that inhabit and converge in this struggle, in addition to consolidating networks and short circuits of territorial economies for the production and reproduction of life beyond the practices of neoliberal capitalism, and today of green capitalism.

The care of the body-land-territory implies the deployment of traditional-ancestral knowledge and practices, such as talking with the grandmothers of the territories, ceremonies with and for the waters, and the sharing of experiences of sowing water as a mechanism to favor the reproduction of water and the life of ecosystems. But it also requires the encouragement of an equal management and management of water from a territorial, popular, peasant and indigenous feminist perspective.

This is why it becomes urgent to dispute the common meanings for the generation of processes of reexistence, from the creation of the conditions of existence of peoples and species through community (re)territorialization.

Reference List

1 Albán A, Rosero J. Colonialidad de la naturaleza: ¿imposición tecnológica y usurpación epistémica? Interculturalidad, desarrollo y re-existencia. Nómadas. 2016;45:27–41. Available from: https://bit.ly/3Hl3R93

2 Nogales H. Colonialidad de la naturaleza y de la mujer frente a un planeta que se agota. Ecología Política – Cuadernos de debate Internacional. 2018;54:8–11. Available from: https://bit.ly/4duoBaH

3 Lugones M. Colonialidad y género. Tábula Rasa. 2008;9:73–101. Available from: https://bit.ly/3SdSylz

4 Gudynas E. Extractivismos. Ecología, economía y política de un modo de entender el desarrollo y la Naturaleza. Cochabamba: Centro de Documentación e Información Bolivia (CEDIB); 2015. Available from: http://bit.ly/43apT7b

5 Fernández F. Extractivismo y patriarcado: la defensa de los territorios como defensa de la soberanía de los cuerpos. Red Chilena Contra La Violencia Hacia Las Mujeres; 2019 p. 29–37. (Violencia estructural y feminismo).

6 Harvey D. The new imperialism. Oxford: Oxford University Press; 2004.

7 Brand U, Wissen M, Jungwirth B. Modo de vida imperial: Vida cotidiana y crisis ecológica del capitalismo. Buenos Aires: Tinta Limón; 2021. 230 p.

8 Movimiento de Mujeres Indígenas por el Buen Vivir. Campamento climático. CLASCO. 2020. Available from: https://bit.ly/3FeDAJ9

9 Svampa M. Feminismos ecoterritoriales en América Latina Entre la violencia patriarcal y extractivista y la interconexión con la naturaleza. Madrid: Fundación Carolina; 2021. Report No.: 59 (2a época). Available from: https://bit.ly/3SQcXgA

10 Fernández F, Puente F. Trazar horizontes de futuro: herramientas para una ecología política feminista y popular. En: Fernández y Puente (Coords) Feminismos ecoterritoriales en América Latina. Buenos Aires: Fundación Rosa Luxemburgo; 2024. p. 3–8.

11 Ibid.

12 Korol C. Los feminismos en el debate sobre la "justicia". La experiencia sobre los juicios éticos, populares y feministas. En: Fernández y Puente (Coords) Feminismos ecoterritoriales en América Latina. Buenos Aires: Fundación Rosa Luxemburgo; 2024. p. 103–22.

13 Fernández F. La defensa de las aguas en el Chile neoliberal: de la hidropolítica del despojo a la gestión comunitaria de las aguas. PAPELES de relaciones ecosociales y cambio global. 2023;163:115–24.

14 Fernández F. La lucha por la desprivatización del agua y su gestión comunitaria desde un feminismo ecoterritorial. Reflexiones desde la experiencia de la Asamblea de Mujeres y Disidencias del MAT. En: Fernández y Puente (Coords) Feminismos ecoterritoriales en América Latina. Buenos Aires: Fundación Rosa Luxemburgo; 2024. p. 189–204.

15 Svampa M. Feminismos ecoterritoriales en América Latina Entre la violencia patriarcal y extractivista y la interconexión con la naturaleza. Madrid: Fundación Carolina; 2021. Report No.: 59 (2a época). Available from: https://bit.ly/3SQcXgA

16 Gutiérrez R. Producir lo común. Entramados comunitarios y formas de lo político. Re-visiones. 2020;10. Available from: https://bit.ly/3H4Rk9K

17 Guzmán A. ¿Qué es feminismo para las feministas comunitarias? Cuadernillo de formación: Aguaceros. 2020 Sep;3:5–8. Available from: https://bit.ly/4dt8kTr

18 Gómez D. Mi cuerpo es un territorio político. Brecha Lésbica; 2012. (Voces descolonizadoras). Report No.: Cuaderno 1. Available from: https://bit.ly/3ST5ddG

19 Svampa M. Feminismos ecoterritoriales en América Latina Entre la violencia patriarcal y extractivista y la interconexión con la naturaleza. Madrid: Fundación Carolina; 2021. Report No.: 59 (2a época). Available from: https://bit.ly/3SQcXgA

20 Cabnal L. Acercamiento a la construcción de la propuesta de pensamiento epistémico de las mujeres indígenas feministas comunitarias de Abya Yala. ACSUR-Las Segovias; 2010 p. 22. (Feminismos diversos: el feminismo comunitario). Available from: https://bit.ly/4k83lKj

21 Cabnal L. Acercamiento a la construcción de la propuesta de pensamiento epistémico de las mujeres indígenas feministas comunitarias de Abya Yala. ACSUR-Las Segovias; 2010 p. 10–25. (Feminismos diversos: el feminismo comunitario). Available from: https://bit.ly/4k83lKj

22 Fernández F. La lucha por la desprivatización del agua y su gestión comunitaria desde un feminismo ecoterritorial. Reflexiones desde la experiencia de la Asamblea de Mujeres y Disidencias del MAT. En: Fernández y Puente (Coords) Feminismos ecoterritoriales en América Latina. Buenos Aires: Fundación Rosa Luxemburgo; 2024. p. 189–204.

Ancestral and Popular Knowledge for *Buen Vivir*

As members of the People's Health Movement Latin America (PHM-LA) we are convinced that the *Buen Vivir* – Living Well – is the way out of the predatory system that attacks our planet. The ways of living that generate these political projects are present in the wisdom of the original peoples* of all continents. It is possible and urgent to recognize and strengthen ancestral memories and creatively regenerate more harmonious, cooperative and dignified models of coexistence for communities.

The civilizational crisis we are going through as humanity urgently requires deep changes that are being inspired, driven and summoned by these ways of living, present in the daily life of the native peoples, in their practices, in their languages and in their ways of fighting and resisting.[1]

The ancestral wisdom that takes care of life exists in all the territories of our planet. In Latin America, as well as in other regions, there are strong processes of vindication and recognition of the practices that express them. By understanding in depth the cosmovision of the peoples who have always inhabited our planet, we recognize that there are other ways of looking and living, which arise from feeling that we belong to a force greater than ourselves that at the same time constitutes us, that is, from knowing that we are nature.

As an expression of their wisdoms, our native peoples keep, in their practices, a diversity of ways of conceiving health, which have in common the understanding of health as the evolution of collective wellbeing. From these wisdoms, health is life. These ways of *thinking about* health†, to which we adhere as members of the PHM-LA, overcome the mechanistic, individualistic, medicalized and commercialized vision of the hegemonic conceptions.

From these conceptions of health, it is clear that the right to health is not only the right to medical care, and that health is not the same as medicine, since health refers to Good Living, "Tasty Living", *Küme Monguen, Lekil Kujlejal, Tinemi Yek, Teko porá* in the *Yvy Mara'ey* and other expressions of the peoples throughout our *Casa Grande*, Mother Earth. Ways of feeling and thinking about health that imply the recognition of one's own capacities that every person and community has to organize themselves in health, to enforce their rights, to take care of nature and to remain in well-being.

Considering that community organizational processes have based their work

*In this paper we choose to refer to "native peoples", taking into account that in our regions it is a term under discussion, as well as "native peoples" and "Indigenous peoples", and with this we refer to the peoples born in the place they inhabit before invasion and colonization processes.

†Action of thinking and feeling at the same time.

and struggles in different territorial and sectoral scenarios, defending their own and ancestral knowledge as the foundation of their development as peoples, it is possible and necessary to advance in the intersectoral and plurinational understanding of the defense of the right to health from the territory, articulated with the vindication of the knowledge and experiences of the peoples. Ancestral cosmovisions that entail reciprocity and harmonious coexistence among all beings require the recognition and defense of the Rights of Mother Earth.

The diversity of health conceptions present in our territories demands the creation of broad and permanent spaces for the dialogue of knowledge, which make possible the construction of biocentric policies based on the feeling of belonging to Mother Earth.

There is hope in the millenary *Buen Vivir*. The original emancipatory cosmovisions are revitalized, reconstituted and can be the basis of the political projects of the peoples, after more than 520 years of resistance. On the road to free self-determination and autonomy of the peoples, from our movement we seek, incorporating these practices, to contribute to build health sovereignty in our territories.

Buen Vivir is a political project of life, a cosmovision; it is the process of satisfaction and collective well-being to enhance life in balance with Mother Earth and the Cosmos, to achieve harmony and continuity between nature and society. *Buen Vivir* is another way of conceiving life and living it. This collective and ancestral way of facing life is profoundly ecological, spiritual, political and economic. It is nothing new, it is not a fad, and it is much more than an intellectual model and an academic-political proposal. Its strength lies in the fact that it is a life practice that implies the possibility of learning from realities, experiences, practices and values present since time immemorial in every corner of the planet, slipping triumphantly through the cracks of this capitalist civilization.[2]

Life as the center of feeling, thinking and doing of our peoples, which constitutes the so-called biocentric paradigm[3], is the path that, from their struggles, knowledge and daily practices, is making possible the cultural change that we require as a fabric of life, to achieve the *Buen Vivir* for all. The global struggle for health and life is rooted in ancestral and popular visions; the possibility of a new world lies in understanding these roots that conceive life as a whole, generating healthier and more harmonious relationships.

The feeling of belonging to Mother Earth is expressed in initiatives and scenarios, such as:

- Pedagogical proposals towards cultural change such as: The 7 A's of ALEGREMIA*[4] (love, air, shelter, food, art, water, learning) and AMISTOSOPHY†[5]

*"Joy that circulates through the blood"

†"Wisdom from friendship"

- Popular education in health as a public policy and a way of doing that preserves and dialogues with popular and ancestral wisdom and with the development of a pedagogy of care that promotes greater respect for nature, autonomy and commitment to a popular health project.
- Networks and solidarity among peoples.
- Territorial organizations and ancestral and popular knowledge articulated with decent sciences.
- Experiences of Community Health and Health in the hands of the Community that from popular participation build biocentric policies for a harmonious encounter with Mother Earth.

> *We share a thought, beyond our doctrines, religions, beliefs. We are clear about what we want and what is the meaning of the philosophy of* Buen Vivir, *which is expressed in the sacred chakana*, it is the cultural diversity, of life and of all peoples... With the historical responsibility to defend the territory and the sovereignty of the peoples, as one more link in the chain of life, of what we call pacha madre, pachamama... space and time. Space that we must occupy in the time we have to live. The* Buen Vivir *does not belong to an individual, it does not belong to a single people, it refers to all the elements of life.* – Marcos Pastrana is from the Council of Elders of the Diaguita People of Tafí del Valle, Tucumán, Argentina.[6]

Figure 1: Chakana

Source: https://bit.ly/44SEwNt

*The chakana or Andean cross, a word of Quechua origin, means "stairway to the highest". The symbol is a four-sided ladder, representing a means of union between the human world and what is higher or greater. The four main arms of the chakana represent the 4 cardinal points, the 4 elements (earth, water, air and fire), but also the four seasons.

With the purpose of continuing to contribute to the transformation of reality and the care of life from the recognition of ancestral wisdoms, we propose the following scenarios for collective reflection, which arise from the process of construction and experience of the fifth World Assembly for the People's Health: "Intercultural health systems and own health systems", "Women custodians of ancestral and popular wisdoms", "From production and consumption to reciprocity and sustainability" and "War and migrations, dispossession and resistance of ancestral wisdoms and practices".

Intercultural health systems and own health systems

Rooted in the ancestral knowledge of our peoples, we are collectively promoting the construction of a new paradigm that we call biocentric. From this perspective, we have the possibility to create, to think with hope and to experience that there are answers to the crisis of existence.

Transformations are urgent for these conceptions to occupy a central place in current health systems, which promotes profound changes in the systems themselves. Precisely, the concept of dialogue of knowledge raises the need for mutual transformation of views and forms of organization, and not only the sum of conceptions.

Ancestral and popular knowledge is based on the feeling of belonging to Mother Earth, which is expressed in models of production and consumption based on solidarity, respect for biodiversity, mutual support, reciprocity, participation and horizontality. This knowledge is expressed in a multiplicity of health practices, which are defended and strengthened in the struggles of the peoples in their territories. These health practices are often invisibilized and excluded in most health systems, although they are fundamental to sustain the life and dignity of our peoples.[7]

The ancestral and Indigenous knowledge that needs to be recognized and strengthened goes beyond the hegemonic concept of health based on disease, fragmentation, homogenization and expropriation of bodies and territories, which is functional to pharmaceutical corporations and the prevailing global economic order.[8]

The right to health is a fundamental human right, it is the right to live fully. From the Good Living, from this biocentric paradigm, we build new concepts of health that have to do with the 'health of the ecosystems'[9], the 'health in the hands of the community', the 'integral health'. Health as a vital process, integrating our being with the Whole.[10]

This new approach requires rethinking and transforming the concept of health and public health, conceived as the health of the people. It is essential to establish a transdisciplinary dialogue that incorporates diverse knowledge and practices, promoting the use of the different ancestral forms of healing of each people. We must encourage healthy practices that include natural medicine, the use of plants,

Figure 2: Opening ceremony of the fifth People's Health Assembly (PHA5); Mar del Plata, Argentina, April 2024

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seeds, flowers, healthy eating, massages and rituals, respecting each people's way of healing. These practices remind us that the body-territory has the capacity to self-organize and heal itself, and that health should not depend exclusively on a system or on certain people (doctors, nurses, etc.), but is, above all, a personal and community responsibility.

It is necessary to warn that there are millenary practices used by the neoliberal system, a framework from which millenary ancestral knowledge is pirated in order to commercialize it. It is necessary to stop this barbarism and put in its place the millenary practices for the Good Living of the peoples.

In addition to integrating these millenary practices with those from other medicines so that they complement each other for the benefit of people and their environments, the aim is to transform all systems of society, including health systems, in the light of the biocentric paradigm.

How do we interweave ancestral and popular wisdom in complementarity with medical knowledge and the official health system? Our peoples keep in their practices, integral conceptions of health that overcome the mechanistic, individualistic, medicalized and mercantilized vision of the hegemonic conceptions. Transformations are urgently needed to allow the protagonism of these conceptions in the current health systems.

From the recognition of our cultural diversity, who are the health workers? *Sabedores, Sabedoras*, (wise men and women), Midwives, Traditional Doctors, and many more, are the protagonists of the health of our communities. The transmission of knowledge, wisdom and practices to future generations is fundamental for the continuity of human life. We need to care for those who care and train health personnel in interculturality.

Rethinking the conceptions and practices of health systems implies overcoming the disease-centered approach and situating health as an integral process, learning from native cultures. It is essential to remove the power that health systems and their workers have over life and death, returning to the recognition that health is in the hands of people and communities. It is imperative to reconfigure health as a collective and counter-hegemonic phenomenon.

Health systems must deepen the conception of health in the hands of the community and design strategies that prioritize primary care as the primary care, not only for individuals, but for all forms of life.

Discussing the uniqueness of health systems in a framework of cultural diversity is key. We need inclusive systems that consider people with disabilities, the LGTBIQ+ population and that recognize cultural diversity, including so-called alternative and complementary medicines. This also encompasses mental health from different intercultural perspectives.

Women custodians of ancestral and popular knowledge

Integral conceptions of health recognize the importance of community care practices, which are deeply rooted in the cosmovisions and traditions of native peoples. In this context, the role of women is fundamental, as they are the ones who preserve and transmit from generation to generation the ancestral knowledge that promotes the integral wellbeing of their communities. These practices are not only limited to physical health care, but also encompass spiritual, emotional and social dimensions, offering an integral holistic approach that goes beyond conventional medicine.

Women, as custodians of this knowledge, historically played a central role as machis (shamans), healers, herbalists and midwives. These often-invisible figures are pillars of ancestral and popular health systems. Their work is not limited to childbirth care or the administration of medicinal plants, but represents a deep commitment to the life, culture and spirituality of their communities. Most of them are spiritual leaders who connect the present with the forces of nature and the ancestors.[11]

During the COVID-19 pandemic, their work took on special significance. Many of these women became guardians of life in the midst of isolation and health crisis, silently and, in many cases, anonymously caring for their communities. From emotional accompaniment to the creation of syrups, tinctures and treatments based on their knowledge, their work was an example of resilience, solidarity and community creativity.

Nevertheless, there are still challenges for the recognition and dignity of these women. The vindication of their rights and the valuation of their knowledge implies opening spaces for dialogue and exchange, where their voices and experiences are heard and respected. It is urgent to make visible their struggle to preserve health and life from an integral and sustained perspective, in a world where their efforts have been historically underestimated.[12]

To recognize women as defenders of life and promoters of struggles is also to embrace the diversity of knowledge and perspectives that enrich our societies. Their work embodies the sustainability of life and must be dignified, not only symbolically, but also through public policies, community initiatives and the strengthening of their capacities and leadership. In this way, their legacy can be recognized, respected and passed on to future generations.

> *Well, I was telling you that the community is organized by authorities and one of the authorities that represents the community is the philosophical* lonko *[head, authority], he is the maximum authority – let's say – of the community, who organizes the ceremonies, the* willipun. *Here in the community in April every year the* willipun *is organized, the* rogativa *we call it. In the* rewe *is where the culture is strengthened, where the Mapuche* kimün *[knowledge] is strengthened, where it is related, – what we say – the cosmovision that we have with the world, with the* wallmapu *[Mapuche ancestral territory], we say. So the* lonko *is the one who carries out the* willipun *with the* pillañküshe *[wise old woman and guardian of the collective memory],* calfu malen, calfu wentru *are all authorities that in this ceremony represent us and accompany us in this cultural strengthening that we have. It is done once a year. And well, in all the territories ceremonies are held precisely to ask and thank the* wallmapu, *the world,* itrofil mongen, *we say, biodiversity for everything it gives us, for each* lawen *[remedy or medicinal plant] it gives us, for each food it gives us. So that is what the ceremony is for. We believe in nature, we believe in the relationship we have with it. We are strengthened thanks to Mapuzugun, to our language, to* che zugun *[Mapuche language] and that is our cosmovision. That is how we see the world: that the birds give us a sign, the rivers give us a sign and each element has its* gnen *[spirit], a* newen*. *We have to strengthen that* newen, *and we have to take care of that* gnen. *So in this territory where we have diverse lives, diverse forces, we are practically related to all of them.* Clara González has been a great referent of the Mapuche community of Paraje Payla Menuco, province of Neuquén, Argentina.
>
> – Kimeltufe, teacher of Mapuche language and culture.

*Newen means strength, but it is a word that transcends what it specifically denotes. It is a deep energy that presents itself as the spirits that protect the mountains and the ancestral knowledge.

From production and consumption to reciprocity and sustainability

Since its origins, agriculture, the way of production respecting natural cycles and seeds, was protected by ancestral cultures. From the wisdom and hands of grandmothers and grandfathers, from generation to generation, they bequeathed agriculture to us as an inheritance, they taught us to care for and preserve seeds, and to continue life on our planet.

More than 10,000 years ago, possibly a woman decided to save a seed of a wild fruit and plant it near her home to have it at her disposal. From then on, in different parts of the world, men and women farmers developed different varieties of crops that provided food sustenance to their communities. These practices, which multiplied from the care of each seed, the elaboration of each food and the sharing of farming families, were carried out in harmony with nature, making it possible not only to feed the people but also to recreate socio-environmental health conditions and strengthen food sovereignty. In this event of saving, exchanging and multiplying the seed, which seems very simple, the memory and all the associated ancestral wisdom of thousands of years is preserved.[13]

However, the disappearance of biodiverse agriculture has led to the loss of peasant knowledge. People working with monocultures are often trapped in a single mindset that limits their connection to nature and agroecological practices. In a context where large corporations seek to privatize seeds and control food systems, it is crucial to remember that "seeds are the heritage of the people, at the service of the community and not the commodity of corporations".

Before being turned into merchandise, seeds have been the fundamental axis of sustenance, sovereignty and autonomy of peoples; they were part of the enormous community and cultural heritage of peasant and Indigenous peoples around the world, the fruit of collective work accumulated from generation to generation. The peasants and especially the peasant women have not let their seeds disappear, sowing even in the most unfavorable contexts their own seeds either for special uses (festivities) or for self-consumption.[14]

Thinking about production from the perspective of the *Buen Vivir* proposal means going deeper into the concepts of agroecology, since it preserves the elemental natural assets of food production, such as soil, water and biodiversity. These actions are based on respect for rural communities (who provide the genetic material best adapted to local conditions) and on ethical and humane principles in carrying out these activities. Agroecology reincorporates agriculture into communities, values and dignifies peasant work and recovers the diversity of ways of experiencing the community. It proposes non-dependence on external inputs, eliminating the use of pesticides, protects and saves native and creole seeds so that in the future the use of transgenic products can be avoided. Agroecology guarantees adequate food/nutrition and thus favors the integral health of the communities.

Agroecology is a renewed science under construction, a paradigm whose principles and epistemological foundations give rise to the conviction that it

is possible to reorient the altered course of processes of use and management of natural resources in order to broaden social inclusion, reduce environmental damage and strengthen food sovereignty. Agroecology recovers and enhances ancestral knowledge on production.

Integral health encompasses much more than physical well-being; it implies connection with the earth, balance with nature, and recognition of the ancestral and popular knowledge that has sustained community life for generations. In this context, practices such as healthy markets, community and educational agroecological gardens, and popular economy reflect a model of self-management that promotes a holistic approach to health, based on solidarity, mutual respect and food sovereignty. These initiatives not only provide access to food and natural medicines, but also generate spaces for meeting and collective learning, strengthening the social fabric and safeguarding ancestral memory. These are practices that are multiplying in our territories and that generate hope.[15]

Plants occupy a central place in ancestral cosmovisions and in this new paradigm. Plants are considered allies, they are "sister plants" that are offered as food and remedy, companions that accompany people, families and communities in the processes of health-disease, where they also indicate the climate, the state of the soil, what is to come in a new cycle, etc. Therefore, they are not depredated

Figure 3: Opening ceremony of the fifth People's Health Assembly (PHA5); Mar del Plata, Argentina, April 2024

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but respected like other forms of life. The relationship with plants, based on a deep ancestral knowledge, has been transmitted from generation to generation, being a fundamental pillar of community health self-management. In times of crisis, as evidenced by the pandemic, the benefits offered by plants for medicinal purposes were reaffirmed as an accessible and powerful alternative to the limitations of the conventional medical system.[16]

Spirituality, as Leonardo Boff puts it, "is the human attitude that leads us to place life at the center of our existence" and constitutes a central dimension in the worldview of *Buen Vivir*. This approach is profoundly political, economic, ecological and, above all, spiritual, as it seeks to restore balance and place life at the center of our practices and relationships. The biocentric paradigm, which places life in all its forms as a priority, is modeled and recreated from this perspective.[17]

Agroecology, in itself, is an expression of this spirituality. Although it encompasses social, economic and environmental dimensions, its essence lies in the search for a harmonious and respectful relationship with all forms of life. It promotes a sense of plenitude and transcendence based on integration with nature, reestablishing flows, cycles and relationships between the components of agroecosystems and the cosmos. In this sense, agroecology contributes to a dynamic balance, weaving connections between society, nature and the cosmos in a process of mutual enrichment.

Ancestral peoples have imbued their ceremonies related to agrarian cycles with deep spiritual meaning. These practices, carried out collectively, express gratitude, renew energies and strengthen community ties. Through rituals and celebrations, communities maintain their connection with the earth, water, stars and cosmos, always seeking balance and harmony. For example, the Guarani culture celebrates key moments related to the cycles of the year. The *"ara pyau"* or "new time", which coincides with the southern spring, marks the end of frost and is a crucial time for the corn peoples. It is followed by the *"ara mbyte"* or "middle time" during the summer, and the *"ara yma"* or "old time" in autumn and winter. At the time of the first corn harvests, the Guaraní community performs the ceremony of presenting the fruits and seeds to be blessed, known as *Ñemongarai de mbojape,* along with the ceremony of assigning names to boys and girls, *Mitá ery*. These traditions reinforce the spiritual and ecological connection with their environment, preserving knowledge that transcends generations and continues to shape community life in harmony with nature.[18]

War and migration, dispossession and resistance of ancestral knowledge and practices

With *Buen Vivir* as a horizon, our peoples have lived health as a force of anti-colonial resistance against the imperialist model that generates wars, destruction and death on our planet.

As a testimony of this reality, we present the following text that addresses the denunciations of repression and the struggles for freedom faced by healers and leaders from different territories, who defend ancestral knowledge in contexts of conflict, migration and forced exile. It expresses how war impacts on health, the community fabric and the cosmovision of the peoples, generating displacements, losses and profound transformations. Through the analysis of processes such as the Peace Agreements in Guatemala, it examines the non-fulfillment of commitments assumed for the recognition of Indigenous rights and the perpetuation of structures of inequality. Finally, it highlights the resistance and resilience of Indigenous peoples who, in the face of centuries of oppression, continue to rebuild their identity, their cultural practices and their vision of life in harmony with the land.

> *The impact of the war in the villages primarily affects health, due to the fear that is imposed, the concern for displacement, the abandonment of houses and cultivation plots, the separation of family members, the loss of relatives, the lack of food and the minimum to survive. In addition, the abandonment of elements of identity is suffered, the forced abandonment of practices of the cosmovision that in previous times were carried out even in a discreet way, by the pressure of the imposed religion, by the insecurity where one arrives as a place of refuge. Everything is coming together, fear, anguish, insecurity and suffering from nervousness and other alterations that make us sick, years of living in uncertainty, in distrust, in the change of environment, of climate. It is necessary to initiate a process to know how to adapt.*
>
> *In the case of Guatemala, after 36 years of armed conflict, national and international pressure led to the preparation of peace agreements. The issues of demobilization of the warring parties, the rights of the civilian population, including the rights of Indigenous peoples, which are:*
>
> 1. *Identity of Indigenous peoples*
> 2. *Fight against discrimination that addresses the rights of Indigenous women*
> 3. *Cultural rights*
> 4. *Civil, political, social and economic rights*
> 5. *Joint committees*
> 6. *Resources*
>
> *Before the conflict there was a practice of cosmovision in the territory attending hundreds of active ceremonial centers, attended by guides who came from the ancestral heritage, but also from the resistance, as it is demonstrated that several guides without*

knowing the Popol Vuj in physical form, handled it by the transmission of oral capacity. This fortress suffered the impact of the war because many grandparents were eliminated cutting the oral transmission, it is not easy to quantify the loss; let us also remember that the tentacles of the counterinsurgency came through the civil self-defense patrols, members of the communities that manipulated them to control the insurgent organization, because their objective was to "take the water from the fish". But there were also people who did not betray their communities, here we see another manifestation of resistance in the midst of repression. Today what is being recovered is really with great effort, which helps us to rebuild and reconstitute ourselves.*

Hardly steps were taken for the reconstitution, because in 2010 the Mayan organizations were preparing for the commemoration of the oxlajuj baqtun*, a period of thirteen times four hundred, giving the total of 5,200 years of the long count†. This helped to remember the millenary periods of the Maya people, but the government along with INGUAT (Guatemalan Institute of Tourism) saw it as an opportunity to folklorize the event and proposed to hold folkloric events in various historical ceremonial centers. But the Quiché people did not allow the historic center of Kumarkaj to be used, they rejected the proposal, demonstrating that there are places of resistance where folklorization and neo-colonization are not allowed.*

What five hundred years ago the Castilians destroyed with blood and fire, later there have been places where the cosmovision of resistance was reestablished and later confronted the imposition of evangelization. Today the heirs of the Castilians, by means of folklorization continue exploiting the peoples, let us not forget the onslaught provoked by the Neo-Pentecostals, which adds to the "supposed pacification", that dehumanization only allows them to see the peoples and their historical assets as resources. What they did not expect is that the peoples, in spite of all the oppression, resurface, revive, re-exist and reconstitute themselves with the proposal of the Good Living."

Leopoldo Méndez Martínez "Tata Polo", grandfather and healer of the Kaqchikel people of Guatemala, facilitator, promoter and defender of life, Mayan cosmovision and *Buen Vivir*, in academic, community and political spheres.

*Popol Vuj: sacred book of the Mayan people.

† Long count is the name of a non-repetitive Mesoamerican vigesimal calendar used by several Mesoamerican cultures.

Challenges[19]

The great challenge we face is, without a doubt, to find a development model that does not generate natural or social imbalances and that at the same time respects our health, that of Mother Earth and of all forms of life, a challenge that we urgently need to solve considering that there are more and more human beings on the planet and that the levels of pollution, disease, social differences and destruction are increasing exponentially.

Another crucial challenge is to deepen a process of transformation that is decolonizing and depatriarchalizing. This implies emphasizing intellectual decolonization, as a necessary step to decolonize the economy, politics, education and society as a whole[20] (see Chapter B5).

It is also necessary to make the rights of nature a reality, which means politically encouraging their passage from object to subject, as part of a centuries-old process of broadening the subjects of law. The core of the rights of nature is to rescue the right to existence of human beings themselves. The rights of nature need, and at the same time originate, another type of definition of citizenship, which must be built in the social but also in the environmental sphere. The original concept of citizenship proposes the individual as independent and isolated from his or her social context. The individual freedoms with which the patriarchal-capitalist-mercantile system seduces us deny the human social fabric, the need we have for each other, our collective being, the "we" instead of the "I".

We propose to deepen the concept of citizenship[21] which defends and cares for life collectively, creating social bonds inspired by matristics, leaving aside that of citizenship, as obsolete and individualistic. Matristics is a culture where the center is cooperation, participation, care, attention, joy.[22] In this sense, the construction of the *Buen Vivir* is an essential path to find global answers to the challenges that humanity has to face.

The *Buen Vivir* or living well as a culture of life in fullness, with different names and varieties, has been known and practiced in different periods in different regions of Mother Earth. This concept is not only historically rooted in the Indigenous world; it can also be based on other philosophical principles: ecological, feminist, cooperativist, Marxist, humanist. Therefore, it is necessary to take on the challenge of building this utopia in other parts of the planet, including industrialized countries.

It is important to strengthen local spaces, and to support those groups that have long sustained different ways of relating to the environment, so that they become stronger and stronger. At the same time, it is necessary to generate global responses to dismantle institutions and practices that encourage financial speculation, and to prevent humanity from falling into a totalitarian technological nightmare. To this end, we require new levels of pluralistic organization on a global scale, from which global solutions can be clearly and profoundly proposed.

In this context, the *Buen Vivir* or good living is presented as a proposal for all of humanity: a decolonized humanity, reconstituted and liberated from the structures of domination with a cosmogonic and non-anthropocentric being.

Reference List

1 Gudynas E. Debates on development and its alternatives in Latin America: a brief heterodox guide. In: Más allá del desarrollo, grupo permanente de trabajo como alternativas al desarrollo. Fundación Rosa Luxemburgo y AbyaYala; 2011.

2 Kawsay, qamana S, K.'aslemal U, kujlejal L, Felen K, mara'ey Y. Approximations to BuenVivir, [Internet]. Peoples Health Movement; 2017. Available from: https://bit.ly/4lZQhI5

3 Payan S. Dimensions and scenarios of paradigms. Alta Alegremia [Internet]. 2009; Available from: https://bit.ly/4iQn3ZE

4 Monsalvo J. 1. ¿Que es la alegremia? Alta Alegremia [Internet]. 2009; Available from: https://bit.ly/4iQn3ZE

5 Weinstein L. Cuadernos de la internacional de la esperanza [Internet]. Available from: https://bit.ly/3ShUskS

6 Memoirs of the Popular Health Meetings Laicrimpo Salud.

7 Yala A. Conclusiones Generales de las Mesas de Trabajo de la III Cumbre Continental De Pueblos y Nacionalidades Indígenas de AbyaYala. Cumbre Continental de Pueblos y Organizaciones Indigenas. 2007 Mar; Available from: https://bit.ly/4lYZeBx

8 Bobatto M, Orlando F, Segovia G, Viudes S. Ecosystem Health, a counter hegemonic vision. Rosa Luxemburgo Foundation; 2022.

9 Monsalvo J. Ecosystem health: an articulating thought. Alta Alegremia. 2013 Aug 5; Available from: https://bit.ly/4lWWC78

10 Bobatto M. Emancipatory Practices of the Good Living: 30 years of the National and Latin American Health Movement. Rosa Luxemburgo Foundation; 2020.

11 International Forum of Indigenous Women. Indigenous women in the front line of defense of individual and collective rights. International Forum of Indigenous Women; 2023. Available from: https://bit.ly/4jGZcwK

12 Fuks A. Mujeres rurales: que defender el territorio no cueste vida. LATFEM. Available from: https://bit.ly/4jJ3O5q

13 Lizarraga P, Kostlin L, Reyes L, Sergovia G, Frank F, Ortt E, et al. Sowing life, memory and community for the people from the territories. Buenos Aires: Rosa Luxemburgo Foundation; 2024 Jun.

14 Segovia G. Sustainability and agroecology. Posadas Argentina: UNAM Facultad de Humanidades y Cs. Sociales; 2007.

15 Sarandón S, Marasas ME. Brief history of agroecology in Argentina: origins, evolution, and future prospects. Agroecology and Sustainable Food Systems. 2017 Apr 21;41(3–4):238–55.

16 Marin S, Marcus A. Fundamental principles of the Jarilla Network of Healthy Plants of Patagonia. Buenos Aires: Ediciones de la Bruja; 2011.

17 Boff L. Cry of the earth, cry of the poor. Maryknoll, NY: Orbis Books; 1997. 1 p.

18 Lizarraga P, Kostlin L, Reyes L, Sergovia G, Frank F, Ortt E, et al. Sowing life, memory and community for the people from the territories. Buenos Aires: Rosa Luxemburgo Foundation; 2024 Jun.

19 Bobatto M, Segovia G, Marin S. El Buen Vivir, PHM's way to another alternative to development. Saude Debate Rio de Janeiro Magazine. 2020 Jan;44:24–36.

20 Acosta A. Only by imagining other worlds, this one will be changed. Reflections on the *buen vivir*. UNAD; 2010 p. 10–7. Report No.: 2(1). Available from: https://bit.ly/4d1UQ0E

21 Isabel A. Transformar la ciudadania en cuidadania [Internet]. Naciendo en casa. 2020. Available from: https://bit.ly/3Sht8TY

22 Maturana HR, Pörksen B, Maturana HR. From being to doing: the origins of the biology of cognition. Heidelberg: Carl-Auer-Systeme-Verl; 2004. 208 p.

SECTION B

Health systems

Privatization and financialization of health systems: challenges and public alternatives

Introduction

Why do we continue to see massive and growing inequities in people's access to healthcare across the world? Why, on the one hand, are public health services in most countries under-resourced, understaffed and often insufficient, while on the other hand for-profit private hospitals and healthcare industries continue to expand, even though their services and products are beyond reach for a majority of the population? To answer these questions, we need to understand the underlying transformations in the healthcare sector which have been underway for over three decades, and which have accelerated in recent years. At the core of these transformations are processes of privatization of healthcare, and associated financialization and corporatization of the healthcare sector.

Privatization of healthcare: a brief recap

Privatization refers to the transfer of ownership, management, or provision of healthcare services from public to private entities. It is a process through which private actors are more involved in the provision and financing of healthcare services.*

Active privatization may involve full handover of public healthcare assets such as public hospitals, clinics or other healthcare infrastructure that are sold or leased outright to private entities; outsourcing services like diagnostics or ambulance services which are contracted to private providers; and Public-Private Partnerships (PPPs) where private healthcare companies build, finance and operate healthcare infrastructure or services under long-term contracts with governments. Passive privatization occurs less visibly but is equally damaging, resulting from political neglect, underfunding and other deleterious policies which diminish the capacity and reach of the public healthcare system. Over time, this underfunding of public healthcare forces patients to seek care from the private sector. This is often linked with erosion of public trust due to perceived decline in the quality of underfunded public healthcare, long waiting periods, lack of resources in public facilities and increasing out-of-pocket payments. These payments may be associated with imposition of formal user fees, or arise from the need to purchase medicines, investigations and specialized services from private providers due to insufficient availability in the public system.

*See GHW6 - Chapter B3, *Healthcare and COVID-19: Privatization by stealth* for a detailed description and analysis of variants of privatization.

Passive privatization and its effects are often used as justification for active privatization, with governments claiming that private sector involvement is necessary to fill gaps in the under-functioning public health system. Privatization invariably leads to growing inequalities in access to healthcare, and deprivation of care especially for poorer and marginalized sections of the population.

Global policy shifts since the 1980s and 1990s, mostly promoted by international institutions such as the World Bank and International Monetary Fund (IMF), have created the ground for large scale and continuing privatization of healthcare and social services across the world. Structural adjustment programs (SAPs) imposed by the IMF and the World Bank in response to the 1980s/1990s developing country debt crises, supported by the World Bank's influential *Investing in Health* report (1993), played a key role in shaping such processes. Under pressure from these powerful influences, public health budgets have been constrained and downsized, and the commercial private healthcare sector has been promoted as being more 'efficient' and positioned as a solution to the problems of public healthcare. This has led to massive expansion of private hospitals, clinics and diagnostic centers in most low- and middle-income countries (LMICs).[1]

Established in 1948,[2] the British National Health Service (NHS) was one of the first public healthcare systems in the world providing medical care to the entire population. Publicly funded through general taxation, the NHS is also characterized by public healthcare provision. However, since the 1990s, the role of private actors in publicly funded healthcare provision (outsourcing) has gradually increased, as it has in several other high-income countries.[3] The proportion of NHS budgets spent on private providers rose from 3.9 per cent in 2008/09 to 7.3 per cent in 2018/19.[4] A recent study suggests that this is an underestimate and that, when looking at spending at local levels, the NHS budget spent on private providers is at least 18 per cent.[5]

However, Goodair and Reeves find that the outsourcing of healthcare provision in the English NHS is associated with a decrease in healthcare quality.[6] Combined with excessive waiting lists for treatment, privatizing healthcare may also reduce its accessibility.[7] During the COVID-19 pandemic, one in four patients had to pay to access treatment. Between 2019 and 2022 the number of paid knee surgeries rose from 13 per cent to 23 per cent.[8]

Privatization of healthcare forms a continuum with processes of financialization and corporatization by increasingly transferring healthcare from public to private control expanding markets for healthcare. This policy framework has constricted public health services, while promoting global capital flows which have massively expanded investments in the private healthcare sector.

Figure 1: Protest against the privatization of the NHS, 2023

We Own It

Accelerated financialization of healthcare

Financialization of healthcare refers to the increasing role of financial markets, investment firms and speculative capital in the healthcare sector. While expanded financial investments have accompanied healthcare privatization since the 1980s, they began to accelerate in many LMICs in the early 2000s. Financialization transforms the manner in which the healthcare sector is managed and organized, shifting the focus from service provisioning to providers becoming a class of financial assets, linked with overwhelming focus on maximizing returns for financial investors. This involves –

> ... transformation of healthcare into saleable and tradeable assets for global investors. ... Healthcare financialization represents a new phase of capital formation that builds on, but is distinct from, previous rounds of privatization and neoliberal health care reform ....[9]

Financialization of healthcare is fueled by a range of powerful financial actors including global private equity firms, transnational corporations and venture capitalists, as well as being strongly promoted by Development Finance Institutions (DFIs) such as the International Finance Corporation (IFC), financial intermediaries and regional and domestic financial institutions.

Financialization of healthcare leads to an emphasis on maximizing short-term profits for investors, rather than strengthening health systems or improving long-term patient outcomes. International investors acquire hospitals, pharmaceutical companies and health-tech startups for the opportunity these represent

for maximizing returns, and often extract value (by decreasing services, firing staff, increasing patient costs and taking on loans for other investment purposes) before selling the (often now indebted) asset after a few years. For example, according to a 2025 report, French private speculators in the market for real estate have purchased buildings and land from public and private healthcare facilities (e.g. hospitals, clinics and elderly care homes), forcing these institutions to pay substantial rental fees to their new landlords for many years. The report estimates that "private elderly care homes, hospitals and clinics across France in 2023 may have paid around €2.5 billion to private property investors: equivalent to annual salaries for more than 82,000 nurses."[10]

Financialization of the healthcare sector has major negative impacts also for the healthcare workforce, public health systems and society. To understand these processes further, it is insightful to examine the operations and impacts of one of the largest such financial investors in healthcare in LMICs – the International Finance Corporation (IFC).

International Finance Corporation investments in the private healthcare sector

The International Finance Corporation (IFC), part of the World Bank Group, is the largest and most influential development finance institute that, through its private sector loans and investments, is reshaping healthcare policies in LMICs. IFC investments are closely aligned to the World Bank Group's strategy for promoting private sector healthcare in the name of increasing and improving access to affordable, quality health services. Over the past 25 years the IFC has invested over $9 billion in the private healthcare sector, with a current committed portfolio of $3.6 billion.[11]

IFC has made a wide range of healthcare investments in Africa, such as Lenmed Hospital Group, radiology provider Bergman and Ross and Partners Inc. (BRP) in South Africa; Quest Medical Imaging and Accra Medical Centre in Ghana; and a $12.7 million loan to the Avenue Group in Kenya. Several IFC ventures in Africa involve Indian healthcare companies as partners, such as ISO Health Kenya, Life Healthcare Ltd in South Africa (the second largest healthcare company in South Africa) and CIEL Healthcare in Mauritius. In Latin America, IFC investments include loans of US$25 million to Grupo Conclina in Ecuador and US$27 million to CienoGroup in Colombia - a business conglomerate oriented to health care. IFC has made investments in Rede D'Or in Brazil and Hospitaria Tenedoria in Mexico, and has recently invested $20 million in Grupo Farmanova Intermed, a pharmaceutical company in Central America. The wide range of serious problems associated with IFC investments in healthcare are exemplified by their numerous projects in India, which have been extensively analyzed by Oxfam in its report 'First, do no harm' (see Box B1.1).

Box B1.1: IFC investments in private healthcare in India: doing more harm than good?[12]

Since the 1990s, IFC has made 18 direct investments to private healthcare providers in India with their hospital and clinic investment portfolio for India now totaling $523 million. In addition, IFC has made at least 22 investments in the Indian healthcare sector through Private Equity (PE) funds acting as intermediaries (unlike banks and other investment institutions, PE funds are privately managed with little public regulation or accountability). IFC has also provided advisory support for 14 Public-Private Partnership (PPP) projects in the healthcare sector in India.

Several serious issues have been identified in IFC-supported Indian healthcare projects. Many PPP projects have completed their contractual periods without any disclosed results, preventing effective accountability. Numerous PPPs have also experienced significant delays and cost overruns. IFC supported PPPs often tie governments into long-term agreements with private entities which fail to adapt to changing health needs and often cause unsustainable fiscal burdens.

IFC relies heavily on financial intermediaries, but their lack of transparency, particularly involving PE funds, remains a major problem. Many PE funds do not fully disclose details of their investments, making it difficult to assess the true impact of projects or monitor compliance with environmental and social standards. Another major concern is the extensive use by intermediaries of tax havens (like Mauritius and the Cayman Islands) which are involved in 68 per cent of the IFC's healthcare PE funds in India. These funds raise major concerns about tax financial loss due to massive tax avoidance, with India losing over $10 billion annually which could have funded critical public health services.

The IFC has also invested directly in private healthcare in India, but these investments reveal a major lack of transparency. Only a few projects explicitly aim to improve healthcare for underserved populations. There is minimal information on job creation or the developmental impacts of these investments, particularly in terms of improving healthcare access or affordability for vulnerable groups. Most IFC invested hospitals are located in large cities, with only 4.2 per cent in smaller habitations. IFC's investments prioritize profitability over addressing gaps in access to healthcare.

Private hospitals which have been fueled by IFC investments are found to display major violations of patients' rights with significant complaints about overcharging, medical negligence and unethical practices. Despite IFC's focus on improving patient safety and rights, numerous violations have been reported, including over 60 officially upheld complaints against Apollo, Max, and Fortis hospitals in India, which are repeat IFC investees. These complaints largely pertain to price rigging, refusal to treat patients during the COVID-19 pandemic and overbilling for medical services and supplies.

Continues on next page

Box B1.1 continued

IFC's approach to healthcare investments appears to be doing much more harm than good, first by promoting private healthcare giants in a dangerously unregulated context, and then by failing to design and uphold adequate impact and accountability mechanisms. The investments accentuate healthcare inequalities in India by continuing to prioritize larger urban areas (particularly million-plus cities) and focusing on rich patients at a time when rural areas and the poor are in dire need of improved health services. The IFC fails to acknowledge or address the impact of its support for major expansion of the private healthcare sector on the viability of the public health system. IFC has facilitated the expansion of chains of corporate hospitals despite extensive case law and widespread coverage in the mainstream Indian media of overbilling, price rigging, refusing to treat patients and multiple failures of corporate governance by these hospital chains, including fraud and medical negligence.

Similar dynamics can be observed in the case of significant investment in private healthcare by the German DEG, the third-largest DFI globally in 2021. Over two decades, DEG has channeled substantial funds into private hospitals, yet evidence on its impact remains limited. A study by SATHI examined DEG-supported hospital investments in India, focusing on transparency and patient impact, revealing opacity in DEG's operations that are heavily reliant on financial intermediaries.[13] DEG lacks a robust disclosure policy and does not publish comprehensive details of supported projects. Ranked 11th among DFIs in the 2023 Transparency Index with a score of 27.7/100, DEG demonstrates a pressing need for improved transparency.[14]

Numerous complaints have been filed by patients to the state's Clinical Establishment regulatory body regarding a DEG-invested hospital.[15] Of 36 such complaints filed between 2017 and 2022, 11 were related to overcharging, 13 to medical negligence and the remaining 12 to private insurance claims, state health insurance schemes and treatment protocols. The hospital faced allegations of involvement in a 2014-15 kidney transplantation racket, consequently, the state suspended its license for kidney transplant procedures.[16] During the second wave of the COVID-19 pandemic, the hospital purchased many ECMO (Extracorporeal Membrane Oxygenation) machines with large scale assistance from DEG for COVID patients. However, the hospital reportedly used these sophisticated machines for profit with critically ill patients charged up to INR60,000 (€668) daily in the Intensive Critical Care Unit. These findings contrast the DEG claims of ensuring equitable and affordable access to healthcare through such investments.[17] Instead, they suggest that DEG's support to private hospitals is fueling the growing commercialization and corporatization of India's healthcare system.

Corporatization of private healthcare

Corporatization of healthcare refers to restructuring healthcare systems or organizations to adopt corporate principles, focusing on revenue generation and profit maximization. Corporatization can involve both public and private healthcare providers; here we will focus on private healthcare.

Corporatization of private healthcare is closely associated with processes of financialization and refers to the transformation of private healthcare institutions through adoption of corporate practices and operation as profit-driven businesses. This process involves major changes compared to earlier healthcare provisioning by individual physicians, family-run clinics, nursing homes, smaller independent hospitals and not-for-profit or charitable bodies which traditionally have played a significant role in providing healthcare in many countries.

Box B1.2: Pay before being treated: the impact of private sector providers in Ivory Coast[18]

In Francophone West African countries, little research has been done on the privatization and commercialization of healthcare. To address this gap, GI-ESCR, in collaboration with *Mouvement Ivoirien des Droits Humains* (MIDH), conducted mapping research examining the impacts of privatization and commercialization of healthcare in Ivory Coast, applying a human right lens. The findings from the report on the city of Bouaké (the second largest city) and suburbs of Cocody and Yopougon in the district of Abidjan (the largest city) highlighted significant challenges.

Ivory Coast has over 3,000 private healthcare providers, with 92 per cent operating illegally without proper authorization from the Ministry of Health. This raises serious concerns about the safety and quality of care provided. Furthermore, 64.7 per cent of private healthcare centers are inaccessible to persons with disabilities. Worryingly, patients have to pay before being treated, which is contrary to medical ethics under the 2021 Ivorian Medical Association Act. This trend was also experienced in public hospitals where some facilities refuse to treat patients in emergencies if they lack financial resources.

Underfunding of the public healthcare system exacerbates these issues. Ivory Coast allocates only 6.66 per cent of its national budget to health, far below the 15 per cent Abuja Declaration recommendations. This has resulted in reliance on foreign aid for specific health programs and substantial out-of-pocket payments for citizens. Furthermore, while a national healthcare insurance scheme (Couverture Maladie Universelle) was introduced in 2019, and made mandatory in 2022, the scheme has not yet been implemented. 87 per cent of respondents reported that healthcare providers do not accept the health insurance card under the national insurance as a payment.

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Box B1.2 continued

Some findings and challenges in Ivory Coast mirror those in Kenya and Nigeria. In all three countries, weak regulation and monitoring have allowed numerous private healthcare facilities to operate illegally or with unqualified staff, delivering substandard care. Furthermore, all three states have failed to meet the Abuja Declaration commitment. This chronic underfunding, coupled with government policies, has intensified the issues caused by the unregulated growth of private actors, disproportionately impacting marginalized populations, particularly those form lower socio-economic backgrounds. For example, the Kenya Health Policy 2014-2030 strengthens the role of the private sector as a financier and a provider, including through tax exemptions that incentivize private health care expansion. Nigeria's 2016 National Health Policy and the National Health Development Plan (2018-2022) emphasize public-private partnerships in healthcare, further enabling private sector dominance without sufficient oversight.

To address these issues, states must invest in sustainable public healthcare financing to ensure universal access to quality public healthcare services. This includes increasing domestic revenue through fair taxation and allocating at least 5-6 per cent of GDP to public healthcare. Additionally, governments must strengthen the regulation and monitoring of private healthcare providers to ensure compliance with safety, quality and ethical standards. By investing in public healthcare and enforcing strict oversight of private actors, Ivory Coast, Kenya and Nigeria can move closer to realizing the right to health for all citizens.

As a consequence of the GI-ESCR report in Ivory Coast, the Ministry of Health ordered the closure of 1,022 illegal private health facilities on 6 December 2023 (while the Ministerial plan published at the beginning of 2023 was to legalize only 500 unauthorized private health facilities).

It involves adopting practices that are typical of for-profit businesses, such as hierarchical management, major emphasis on revenue generation, aggressive marketing and market-oriented strategies, imposing clinical targets and restricting decision making by physicians involved in clinical care, while subordinating them to professional managers – all driven by a strong emphasis on profitability. Corporatization of healthcare tends to have an influence much wider than just the expansion and operation of corporate hospitals; this process, driven by finance capital, tends to reshape the entire healthcare landscape including other private providers, prevailing management practices and the culture of the entire healthcare sector. Corporatization of healthcare is a visible manifestation of deeper transformations, linked with change in the basic institutional framework of the healthcare sector which is associated with financialization.

Corrosive impacts of financialization and corporatization in the healthcare sector

The deeply intertwined processes of financialization and corporatization of healthcare are now expanding in the context of ongoing privatization of healthcare. Many of the following trends, which emerged as manifestations of privatization, are now being further exacerbated:

1. Commercialization and over-medicalization: Corporate hospitals, driven by profit motives, often engage in unnecessary procedures, diagnostics and treatments, leading to over-medicalization. The cost of treatment in corporate hospitals is generally much higher than in public or smaller private hospitals. The growth of the corporatized private sector drives inflation in healthcare prices, further widening health inequities.

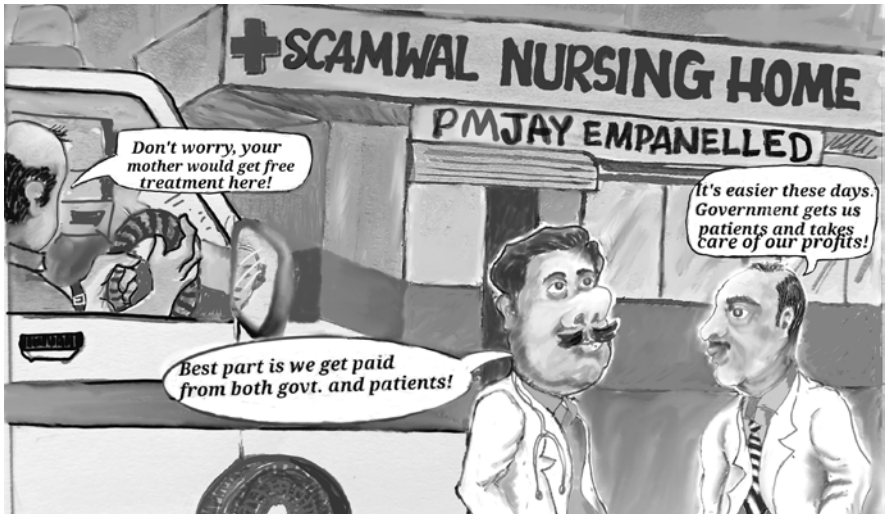
2. Neglect of primary health care, negative impacts on other healthcare providers: Corporatized healthcare systems tend to focus on high-cost tertiary care rather than preventive, primary and community-based healthcare. This generally leads to neglect of primary health care, and conversion of frontline providers into 'agents' for referring cases to private hospitals. There is also generally a negative impact on not-for-profit hospitals, which might be forced due to changing market dynamics to adopt corporate-type practices or acquired by corporate hospital chains. Smaller, rural and not-for-profit hospitals may face the scenario of closure or downsizing with the changing nature of a corporatized healthcare market.

3. Erosion of autonomy of medical professionals in corporate hospitals and raised mistrust: Doctors practicing in corporate hospitals may experience performance 'targets', with pressure from management to admit more patients, or perform a higher number of procedures or investigations to maximize revenue. These compulsions often override the patient's actual clinical condition, and the doctor's scientific judgement which might recommend more prudent treatment. Increasing constraints are placed on professional autonomy of healthcare professionals, accompanied by trends in cost inflation, medical malpractice and growing distrust in doctor-patient relationships.[19]

4. Growth of commercial health insurance, rising out-of-pocket expenditure: Commercial health insurance is expanded based on infusions of finance capital, and the focus on profit making leads to high premiums, exclusions and complex claim processes, making healthcare increasingly unaffordable. Publicly funded health insurance schemes are also often promoted as a way of encouraging private sector growth while offering some 'coverage' especially for the poor. However significant portions of the population may remain uninsured or under-insured, where the coverage offered is inadequate and out-of-pocket expenditures remain high.

5. Continued shift from public to private healthcare, and the rise of PPPs: The shift towards private healthcare is accompanied by decline in investment for the public healthcare system. Various PPPs prioritize profit over patient care, impacting affordability and equitable access to quality services. The dominant discourse and practices of 'Universal Health Coverage' project the PPP logic to the entire healthcare system. Universal health coverage is effectively projected as a giant conglomeration of private providers, which would be supported by public funds and corporate-oriented management.

Figure 2: Under government-funded health insurance schemes it is claimed that people would get free care, however they end up incurring high out-of-pocket expenses, while the private sectors gets paid from government and charges patients as well.



Sketch by Indranil for GHW7

6. Impact on medical education and workforce: Commercialization of medical education and the rise of private medical colleges make medical education unaffordable for the majority of aspirants, since private seats are 'reserved' for those who can pay huge fees. This leads to change in the profile of emerging doctors, while promoting profit-making over patient care and affecting the ethos of the healthcare workforce. The powerful pull of corporate hospitals may lead to reduced availability of skilled healthcare personnel (particularly specialist doctors) for public and charitable hospitals, which might find themselves understaffed since they are in position to offer relatively modest payments.

Box B1.3: Fragmented and privatized health insurance: a barrier to care in the USA

The US spends far more on health care than any other nation, yet its outcomes, such as life expectancy and access to medical care, trail those of other wealthy nations. Profit-driven distortions of care drive the exorbitant costs and undermine care. Paradoxically, although private insurers and providers dominate US healthcare, government expenditures account for more than two-thirds of total health spending,[20] and for much of the enormous profits generated from the system. In effect, the US health care system is publicly funded but privately controlled.

Health coverage in the US is fragmented and insecure. Twenty-six million people are uninsured at any point in time and must pay for care themselves or rely on charity, and tens of millions with insurance are saddled with unaffordable medical bills that their insurance does not cover. About 70 million people are covered by the publicly-funded Medicaid program for the poor, with a similar number having coverage from the public Medicare program for the elderly. But even the publicly-funded insurance programs are being rapidly privatized, with the government now paying premiums to private insurers, who in turn are responsible for paying for services. This influx of government funding has fueled profits for private insurers, which now derive up to 90 per cent of their profits from Medicare and Medicaid.[21] In Medicare, private insurers' overhead (including profit) averaged $2,257 per enrollee in 2020,[22] vs. overhead of only $245 per enrollee under the remaining publicly-administered segment of Medicare. Privatization of public insurance raised Medicare's costs by an estimated $78 billion in 2023 alone over the costs of a fully public program.[23]

Corporate interest also increasingly dominates care delivery. As one example: UnitedHealthcare, the nation's largest insurer covering 50 million Americans (and with profits of $32.4 billion in 2023)[24] now employs or "affiliates" with 90,000 physicians,[25] and owns a home care chain with 527 locations.[26] Recently, even more pernicious actors have entered health care markets – private equity (PE) firms. These firms spent more than half a trillion dollars buying up hospitals and other health care resources in the US between 2018 and 2023.[27] PE firms have sold off the real estate and buildings of hundreds of the hospitals and nursing homes they've purchased, saddling the hospitals and homes with burdensome rent payments for facilities they once owned, and spiraling them into bankruptcy.

While major progress on de-commercializing health care in the US seems unlikely in the next four years, even the financial power of health care firms cannot long hold off demands for change in the context of powerful and deepening dissatisfaction with the health care status quo.

Box B1.4: Public funds financing private providers: the expansion of PPPs in Canada

In Canada, general political consensus over the last six decades has created a model of a single public payer (public insurance) health system financing, managed by each province individually. Medically necessary services are free of charge to legal residents, funded through the general tax pool. Bypassing the public system for medically necessary care through private payment has historically been strictly regulated on equity grounds, and consequentially is almost non-existent. While much of the health workforce may be employed by ministries of health, doctors (through professional power) largely remain independent contractors, negotiating contracts with individual institutions, and bill the public health insurance plan for their services. Hospitals have historically emerged out of the colonial history of church-based care, later evolving into more secular institutions.

This status quo has been maintained despite significant resistance and pressure, often from actors within the health system itself, such as physician lobby groups. Government austerity policies driven by neoliberal dogma from the 1990s onwards systematically underfunded the health system to points close to collapse across time and place. In previous cycles of crisis, entities seeking to profit from the health sector have consistently offered private capital as the solution to the health system's woes.

However, like elsewhere in the world, the crisis in labor supply of health services in Canada has become particularly acute in the wake of the COVID-19 pandemic. As public opinion has traditionally resisted a "two-tier" system that would allow the wealthy to bypass a public waiting list through private payment (although this consensus is eroding rapidly particularly in provinces like Quebec), entities have now become adept in pursuing a political strategy of offering their services to the public system and marketing themselves as public-private partnerships. These companies are often paid by health ministries to provide services to the public at a cost to the government's health budget.

Private equity firms have leaped at this opportunity to actively siphon profit from public coffers, by investing in companies that provide diagnostics in laboratory or radiology services for a fee in outpatient clinics. But now, private surgical centers have become a primary focus of investment from these firms, in a bid to reduce waiting lists for surgeries that have ballooned recently. While these centers existed prior to the COVID-19 pandemic, they were small, catering to privately-paid surgeries that managed to circumvent regulations created to limit bypassing any public wait through wealth. They have now pivoted under the Canadian legislative framework, marketing themselves as partners in the public system to help surgeries happen more efficiently. But there is considerable evidence that these partnerships do not result in improved wait times, given several previous experiments across Canada. While

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Box B1.4 continued

private clinics often discuss their impact on the "demand" side for health services by "relieving" the public waitlist, they do not address the "supply" side. Health care labor is a scarce resource, and in pulling clinician hours away from the public system, they exacerbate shortages of care in the public system, causing a decline in healthcare quality to the general public.

Overall financialization and corporatization deepen the processes unleashed by healthcare privatization and accelerate the conversion of healthcare into a commodity rather than a social good. Compared to the earlier phases of privatization when smaller and charitable providers were more prevalent, now there is complete social disembedding of healthcare, along with a breakdown of trust and doctor-patient relationships. Impersonal corporate hospitals treat doctors and healthcare workers as 'spare parts' which can be replaced at will, while also dissolving the traditional bonds between patients and providers who used to be more trusted due to family and community ties.

The processes of financialization–corporatization are closely linked with technological transformations in healthcare, including the major growth of digital healthcare technologies (see Chapter B2). These tech sectors are treated as 'exciting opportunities' for business and capital, hence they are prime sites for financialization. These sectors draw private equity and even venture capital into healthcare, exemplifying the convergence of specific varieties of technology and finance capital.

Due to these processes which have extended their global domination in recent decades, the basic dynamics of the healthcare sector and the goal underlying healthcare provisioning have undergone major transformation, with maximizing returns for investors and shareholders exercising an overwhelming and relentless logic. Financialization of healthcare is based on major changes in the scale and patterns of flow of globalized capital during the last few decades, penetrating all sectors of the economy and increasingly permeating the healthcare sector, while overwhelming healthcare providers, governments, and all of society.

Advancing health rights, challenging privatization and commercialization

Privatization, commercialization and financialization in healthcare have important human rights implications. In particular, the right to health means that everyone is entitled to the full range of healthcare services that are necessary to live a healthy life, and that these services should be available, accessible, acceptable and of the highest possible quality.[28] This entitlement also applies when private actors are involved in healthcare.

The human rights framework is an important tool to prevent the kinds of situations described in this chapter from happening.[29] For instance, the UN Guiding Principles on Business and Human Rights detail states' duty to *respect, protect,* and *fulfil* human rights when third parties are involved in sectors such as health and social care, as well as a corporate responsibility to respect human rights.[30] Under such principles, states are obliged to strictly monitor and regulate private providers in a meaningful way. Furthermore, while international human rights law does not prohibit private involvement in healthcare, United Nations Human Rights Treaty Bodies are increasingly providing states with clear guidance in this field. These bodies are committees of experts that monitor the implementation of human rights treaties. For instance, an article analyzing state reporting procedures under some of these committees over 1990-2023 has found that private actors' involvement in healthcare, if needed, must at the very least not:

- decrease the accessibility, acceptability, availability, and quality of healthcare;
- result in discrimination of any group or higher inequalities;
- result in sub-optimal use of maximum available resources;
- decrease a healthcare system's capacity to prevent, respond and control pandemics.[31]

Current trends of outsourcing publicly funded healthcare to private providers should be reversed, with human rights always taking precedence over profits and market-based approaches to healthcare. Civil society plays a fundamental role working towards this, by monitoring and unveiling the human rights impact of any privatization plan in health and social care,* or challenging rights violations by commercial private providers.

A recent example of civil society mobilizing against these dynamics includes an open letter issued by the Africa Public Services coalition in January 2025 calling on the World Bank to exit investments in for-profit hospitals and to investigate practices at facilities financed by it.[35] Significantly, such efforts can be bolstered by critiques of international financial institutions' investment practices that come from within the UN system. For example, in December 2023 Professor Attiya Waris (Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights) and Dr. Tlaleng Mofokeng (Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health) submitted a letter critiquing the "lack of accountability and transparency of the International Finance

*For an example of such good practice in civil society, see: Just Fair, 'Evidence received to inform our 2025 report to CESCR' (2025), available from: https://bit.ly/4cP8d40

Box B1.5: Social action to challenge exploitation by commercial hospitals in India

During the COVID pandemic, a large scale movement emerged in Maharashtra state of India, enabling overcharged patients and civil society networks to demand justice through audits and refunds for excessive private hospital bills. This process has since sparked broader social action, pushing for regulatory enforcement and the implementation of patients' rights.

Claiming refunds from overcharging hospitals, campaigns for accountability of private healthcare[32]

As Maharashtra grappled with the country's highest COVID caseloads, private hospitals frequently ignored government-mandated treatment rates. To expose this situation, the civil society networks Jan Arogya Abhiyan (People's Health Movement - Maharashtra) and Corona Ekal Mahila Punarvasan Samiti (a network of widows who lost their husbands to COVID) surveyed 2,579 families, revealing that 75 per cent had been overcharged, with bills averaging three times the regulated rates. This data fueled 'Anger Assemblies,' where COVID widows and families publicly shared testimonies of financial devastation, followed by dialogue with the state health minister, who ordered unprecedented audits and refunds for overcharged patients during 2021-22. Health activists facilitated the audit process, meticulously analyzing nearly 500 complex hospital bills and identifying numerous violations. As a result, 63 patient families received refunds totaling over INR1.6 million, while many others secured informal settlements. This achievement highlighted the power of social mobilization in turning "regulation on paper" into realization of patient rights.

Following the refund efforts, civil society groups in various parts of Maharashtra have continued pushing for systemic improvements through patient rights campaigns. In Pune, Nashik and Sangli cities, workshops, hospital visits and patient assemblies have been organized to expose the widespread gaps in regulation implementation. Emerging demands include mandatory display of hospital rate charts, adherence to the Patient Rights Charter, and the formation of Grievance Redressal Cells (GRCs) for patients. Persistent follow-ups with municipal authorities have now resulted in many private hospitals displaying rates for the first time and establishing GRCs with toll-free numbers. These campaigns have reinforced the principle that healthcare regulation must be combined with accountability-driven social action to safeguard health rights.

National legal action for regulation of private healthcare

Parallel to grassroots efforts, the People's Health Movement in India (Jan Swasthya Abhiyan or JSA) filed a Public Interest Litigation (PIL) in the Supreme Court in 2021, demanding enforcement of the Clinical Establishments Act and the Patients' Rights Charter.[33] The PIL advocates for standardized hospital rates, treatment protocols and

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Box B1.5 continued

effective grievance redressal mechanisms. The Supreme Court's directive to the U nion Health Ministry in 2024 asking for a framework for rate regulation in private hospitals, is a significant outcome. While multiple private hospital associations represented by high-profile lawyers have pushed back by strongly arguing against rate regulation, JSA has widened the process for demanding regulation by submitting expert testimonies from 100 doctors supporting rate standardization.[34] Along with this, JSA has engaged with national consumer organizations, leading to filing of a supportive petition asking for implementation of consumer-oriented regulations.

These public actions demonstrate that top-down regulations might not be sufficient to ensure rights in context of largely unregulated, privatized healthcare. Dynamic movements which collectivize individual grievances, link these to systemic reform, and promote legal action can effectively overcome rights violations, while reclaiming healthcare as a social good.

Corporation's (IFC) investments in healthcare and ensuing risks for the realization of human rights."[36] The letter calls on the IFC to reconsider several financial instruments – e.g. development impact bonds, public-private partnerships and investment through IFC intermediaries – that lack accountability and transparency, and that have undermined poor and marginalized populations' access to healthcare services.

It is essential to hold governments accountable for their human rights obligations under international law, including when contracting out publicly funded healthcare services. Mobilizations to do so could include:

- Prioritizing strengthening public healthcare services for everyone.
- Widely publicizing and demanding health rights including patients' rights, to ensure that everyone enjoys the highest attainable standard of physical and mental health without discrimination based on immigration status or any other protected characteristic, in any public or private healthcare setting.
- Developing health policy and strategies which consider the interlinked nature of rights realization, and which recognize and address the impact of poverty on mental and physical health.
- Ensuring that any involvement of private actors in healthcare, in case it is considered, is compliant with the state's human rights obligations on the right to health.
- Campaigning for effective regulation of private healthcare providers, including regulation of rates, assured standards of care delivered according to appropriate protocols, and observance of various patients' rights.

- Reforming domestic and international tax laws so that for-profit corporations are required to report on all public funding they receive, including as tax waivers, payments for services rendered, subsidies or rental income from properties.

The global drive by capital for privatization, financialization and corporatization of healthcare is aggressively converting healthcare into a profit-driven industry, fueling inequities and eroding public systems. Yet, these destructive processes are being met with growing critiques and waves of resistance. From grassroots patient movements to legal challenges and public campaigns, communities and health professionals are contesting the impacts of commercialization and corporate dominance. These efforts must be strengthened and connected across the globe, forging a collective movement that demands de-commercialized, people-centered health systems which will serve society, not profit.

Reference List

1 Sriram V, Yilmaz V, Kaur S, Andres C, Cheng M, Meessen B. The role of private healthcare sector actors in health service delivery and financing policy processes in low-and middle-income countries: a scoping review. BMJ Glob Health. 2024 Feb;8(Suppl 5):e013408. Available from: https://bit.ly/3YS9fXe

2 Delamothe T. Founding principles. BMJ. 2008 May 31;336(7655):1216–8. Available from: https://bit.ly/3RIXq1L

3 Toth F. Healthcare policies over the last 20 years: Reforms and counter-reforms. Health Policy. 2010 Apr;95(1):82–9. Available from: https://bit.ly/4lO5NXH

4 Iacobucci G. Is the NHS being privatised? BMJ. 2019 Nov 5;l6376.

5 Calnan M. What are the costs of privatisation in the UK's healthcare system? Economics Observatory [Internet]. 2023 Dec 12; Available from: https://bit.ly/3EwHgFP

6 Goodair B, Reeves A. The Effect of Health- Care Privatisation on the Quality of Care. The Lancet Public Health. 2024 Mar;9(3)e199-206. Available from: https://bit.ly/4jNh1tq

7 Anandaciva S. The Darzi review of NHS performance signals why radical change is needed. The Kings Fund. 2024. Available from: https://bit.ly/3ERrlll

8 Rowland D. The COVID Inquiry is the last chance to get to the bottom of the £2 billion contract with the private hospital sector during the pandemic. Centre for Health and the Public Interest. 2024. Available from: https://bit.ly/3SbXRBP

9 Hunter, BM, Murray SF. Deconstructing the financialization of healthcare. Development and Change. 2019 Sep;50(5),1263-1287. Available from: https://bit.ly/4jQ90nz

10 CICTAR, Santé Sociaux. Property Speculation at the Heart of France's Healthcare System: The Case of Ramsay Santé. Centre for International Corporate Tax Accountability and Research (CICTAR) and Santé Sociaux; 2025 Jan. Available from: https://bit.ly/42RHKOR

11 International Finance Corporation. IFC's Work in Health. n.d. Available from: https://bit.ly/44KDfYO

12 Taneja A, Sarkar A. First, Do No Harm: Examining the impact of the IFC's support to private healthcare in India [Internet]. Oxfam International; 2023 Jun. Available from: https://bit.ly/3RIXZZr

13 Marathe S, Shukla A. Perverse Development-Examining German Development Finance Institutions' Engagement in Private Healthcare Sector in India. Development. 2024 Jun;67(1–2):100–7.

14 Publish What You Fund. DFI Transparency Index 2023. Publish What You Fund; 2023. Available from: https://bit.ly/3EQjAMw

15 Marathe S, Shukla A. Supporting patients or profits? Analysing Engagement of German Developmental Agencies in the Indian Private Healthcare Sector [Internet]. SATHI; 2023 Jun. Available from: https://bit.ly/3RClnb3

16 Marathe S, Shukla A. Supporting patients or profits? Analysing Engagement of German Developmental Agencies in the Indian Private Healthcare Sector [Internet]. SATHI; 2023 Jun. Available from: https://bit.ly/3RClnb3

17 Marathe S, Shukla A. Supporting patients or profits? Analysing Engagement of German Developmental Agencies in the Indian Private Healthcare Sector [Internet]. SATHI; 2023 Jun. Available from: https://bit.ly/3RClnb3

18 De Falco R, Douabou A. Access to Healthcare in Cote d'Ivoire: A Participatory-Action Research [Internet]. Global Initiative for Economic, Social and Cultural Rights; 2024. Available from: https://bit.ly/4jzJi7k

19 Marathe S, Hunter BM, Chakravarthi I, Shukla A, Murray SF. The impacts of corporatisation of healthcare on medical practice and professionals in Maharashtra, India. BMJ Glob Health. 2020 Feb;5(2):e002026. Available from: https://bit.ly/435v08q

20 Gaffney A, Woolhandler S, Himmelstein DU. Century-Long Trends in the Financing and Ownership of American Health Care. Milbank Quarterly. 2023 Jun;101(2):325–48.

21 National Association of Insurance Companies. U.S. Health Insurance Industry Analysis Report: 2021 Annual Results. National Association of Insurance Companies; 2022. Available from: https://bit.ly/3RFsAqH

22 Ortaliza J, Biniek J, Hinton E, Neuman T, Rudowitz R, Cox C. Health Insurer Financial Performance in 2023. KFF. 2024 Jul 2; Available from: https://bit.ly/43nbBjw

23 Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy. Washington, DC: Medicare Payment Advisory Commission; 2024 Mar. Available from: https://bit.ly/44lrjwJ

24 United States Securities and Exchange Commission. UnitedHealth Group 2023 annual report. Washington, DC: United States Securities and Exchange Commission; 2023. Available from: https://bit.ly/4iCw608

25 Wilson R. Optum now has 90,000 physicians. Becker's Hospital Review. 2023 Nov 29; Available from: https://bit.ly/4jSTTK9

26 Donlan A. $5.4 billion LHC Group-Optum deal closes. Home Health Care News. 2023 Feb 22; Available from: https://bit.ly/3Ymg2bH

27 Jain N, Murphy K, Podpolny D, Klingan FR, Kapur V, Boulton A. Healthcare Private Equity Market 2023: Year in Review and Outlook. Bain & Company; 2024 Jan. Available from: https://bit.ly/4jSgmab

28 United Nations General Assembly. International Covenant on Economic, Social and Cultural Rights [Internet]. Jan 3, 1974. Available from: https://bit.ly/3YRQAL6

29 De Falco R. The right to health in the UK. London: Just Fair; 2024 Dec. Available from: https://bit.ly/3Ylxkpl

30 Ruggie J. Protect, respect and remedy: a framework for business and human rights: report of the Special Representative of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises. Geneva: United Nations Human Rights Council; 2008. Report No.: A/HRC/8/5. Available from: https://bit.ly/3Etipmk

31 De Falco R, Hodgson TF, Mcconnell M, Kayum Ahmed A. Assessing the Human Rights Framework on Private Health Care Actors and Economic Inequality. Health Hum Rights. 2023 Dec;25(2):125–39. Available from: https://bit.ly/3ENjUM5

32 Shukla A. Regulation of private hospitals during COVID gets a 'booster' of social accountability, The Leaflet. 2022 Apr 27. Available from: https://bit.ly/42YaGor

33 Shukla A. A law blocked for a decade: Old imperatives and newer initiatives for regulation of private healthcare, The Leaflet. 2025 Jan 13. Available from: https://bit.ly/42RKyeR

34 Sharma G. Standardized Rates and Enforcement of Patients' Rights in Indian Private Hospitals, Nivarana (India's Public Health Platform). 2024 Dec 9. Available from: https://bit.ly/4iIhCMn

35 Finch G, Taggart K, Kocieniewski D. African NGOs call on World Bank to exit hospital investments. Bloomberg News. 2025 Jan 30; Available from: https://bit.ly/3Sa7fWC

36 Waris A, Mofokeng T. Letter: Mandates of the Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [Internet]. 2023. Available from: https://bit.ly/3GuqBTP

Artificial Intelligence, Digital Technologies, and Health

Introduction

Global Health Watch 6 was the first edition to devote a chapter on digital health. Although much has since changed, the foundational concerns remain similar: digital technologies, including Artificial Intelligence (AI), need to be steered by states to protect the right to health and not increase inequalities. Concerns with mass surveillance, including of political activities, remain particularly important with the rise of autocratic regimes (see Chapter A1).

Digital health is defined by the WHO as "the field of knowledge and practice associated with the development and use of digital technologies to improve health" characterized by the interactions between communication and information technologies (ICTs) and the field of health. A commonly used earlier term, 'e-health,' was amplified and renamed digital health to include new technologies, such as robotics, genetics, and AI, with raised expectations around AI leading to more work being done with this technology (Box B2.1).[1]

Box B2.1: Understanding AI

The development of artificial intelligence (AI) began in the 1950s, with British mathematician Alan Turing laying its conceptual groundwork. Early research was heavily funded by military institutions, particularly through the US-based Advanced Research Projects Agency (ARPA), which collaborated with universities like Stanford and the Massachusetts Institute of Technology (MIT). However, funding declined in the 1970s as interest shifted to emerging technologies such as personal computers and the internet. AI research persisted and saw renewed interest in the 2000s, driven by increased computational power, large datasets and advancements in machine learning (ML), a subset of AI that allows systems to improve performance through data analysis.

AI techniques are primarily categorized into Symbolic AI and Machine Learning. Symbolic AI relies on predefined rules to perform tasks and are sometimes referred as expert systems, whereas ML enables systems to learn from data and make generalizations. The effectiveness of ML-based AI depends on three critical components: computing power, datasets and algorithms. Algorithms are the coded structure of AI models, but they require vast amounts of data to recognize patterns and create inferences. Training these models involves extensive mathematical computations, necessitating powerful computational resources. Advances in microprocessor

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Box B2.1 continued

technology and data collection, especially through the internet and connected devices (technically named as Internet of Things or IoT), have significantly enhanced AI capabilities, with quantum computing expected to drive future breakthroughs.

From an infrastructure standpoint, AI relies on data centers and high-performance microprocessors. Large technology firms, often referred to as GAFAM (Google, Amazon, Facebook, Apple and Microsoft), dominate data storage and processing, while advanced microchips are produced by a few manufacturers like TSMC and NVIDIA. The recent rise of Generative AI (GenAI), which can generate text, images and other media, is largely attributed to Large Language Models (LLMs). These models use deep learning techniques involving multiple computational layers to process data and generate human-like content. However, their complexity makes them difficult to interpret, raising concerns about transparency and decision-making.

The first widely adopted LLM was ChatGPT-4, launched by OpenAI in 2022. Since then, companies like Microsoft and Meta have developed their own models. Despite growing interest from startups and research institutions, foundational models remain controlled by a few major providers who, in turn, rely on even fewer for specialized hardware. As a result, the AI ecosystem is shaped by a small number of dominant players, leading to significant technical, economic and infrastructural dependencies.

Fornazin et al (2021) conducted an extensive bibliometric analysis of the waves that led to digital health, starting in the 1960s with the medical informatics field.[2] They describe five waves of the medical informatic research field, with correspondent technologies starting with the origins of medical informatics (1961-89), followed by its consolidation in the 90s with technologies such as clinical decision support systems (CDSS), picture archiving and communication systems (PACS) and telemedicine. In the first decade of the 21st century, the WHO started to actively work with digital technologies as the field of health informatics consolidated the expansion of the technology with the rise of the use of electronic health records (EHR) and Health Information Systems (HIS).

The fourth wave would come in the next decade when the concepts of electronic health (e-health) and mobile health (mHealth) gained relevance and led to the adoption of e-health strategies across countries. The end of this period was deeply impacted by the COVID-19 pandemic that broke regulatory constraints for the use of digital technologies, especially with telemedicine, and accelerated the adoption of digital solutions. The last wave, currently happening, is the digital health one, that began with the amplification of the e-health concept to include new technologies, such as the Internet of Things (IoT) and the surge of Artificial Intelligence (AI).

Figure 1: AI generated image with the prompt "AI in the near future in health care"

ChatGPT; note the racial features of all the health professionals, which reveal the bias in ML-trained AI that relies upon skewed data sets.

Potential applications of digital health and AI in health

There is a vast literature exploring potential applications of digital health and particularly AI starting with publication of WHO guidance documents on use of the technology.[3,4] As is often the case with new technologies, innovations in digital health can have great potential if steered for the public good, but also can be badly used or be part of an exaggerated technologic euphoria that aims to resolve all the problems of health systems with technologies in the name of efficiency, without properly addressing structural underlying issues. Part of the critical work developed in this chapter is acknowledging that these technologies present a set of possibilities that can be used for good if well-regulated and steered.

AI use in digital health has some benefits: improving diagnostics, increasing access and reducing waiting times are often quoted among them. Telehealth can be used to reach distant communities, particularly in rural areas, and AI could be deployed to reproduce medical knowledge in low resource settings. These benefits can emerge in different parts of health systems: healthcare, health systems management, research and development and workforce training and education.[5]

In healthcare, AI benefits include treatments that are more personalized and the possibility to reach more people with automatization of decisions and actions. In health systems management, AI can be used to operationalize procedures and increase efficiency, and for making decisions on resource allocation. GenAI can be applied to help professionals, such as doctors, with clerical tasks, scribing what patients tell them and connecting it directly with their electronic health records, and even offering possible treatment options.[6]

AI has transformative potential in the discovery of new drugs and therapies. By analyzing vast datasets, such as electronic health records, AI systems can identify novel therapeutic applications and contribute to post-market drug surveillance. At a more foundational level, AI can predict and identify molecular structures, accelerating breakthroughs in biomedical research. A notable example is the 2024 Nobel Prize in Chemistry, which highlighted AI's role in advancing basic drug research.[7] AI also has applications in training and educating healthcare professionals. It can provide interactive, adaptive learning platforms and simulations that enhance the skills of healthcare workers, ensuring they remain equipped to meet evolving challenges.

Emerging issues of concern

Personal health information

The use of digital health technologies involves handling vast amounts of personal health information that pertains to an individual's health status. This can include information on genetics, sexual behavior, consumption habits or even geolocation data, especially when combined with other datasets. Personal health information is increasingly being viewed as an extension of an individual's body, warranting the same ethical considerations and legal protections associated with human dignity. These protections are often grounded in human rights frameworks, particularly the obligation of states to refrain from violating health rights and to safeguard individuals against third-party infringements.[8] The protection of personal health information is critical due to its sensitive nature and potential for misuse, which can lead to discrimination and harm. Davis (2020) and Sekalala (2020) explored a few examples of those issues in the context of the COVID-19 pandemic, in which governments increased surveillance and partnerships with Big Tech companies.[9] Two primary concerns in this regard are cybersecurity and undue use.

Cybersecurity involves safeguarding personal health information from breaches and unauthorized access. Data breaches can have serious consequences, particularly for vulnerable populations, such as individuals with chronic illnesses or those experiencing pregnancy. The exposure of such data can lead to stigmatization, discrimination or workplace repercussions, highlighting the critical need for robust cybersecurity measures.

Undue use refers to the intentional misuse of personal health information by governments or corporations in ways that conflict with the data subject's

interests and autonomy. Authoritarian regimes may repurpose health data for mass surveillance or repression. This aligns with the World Health Organization's (WHO) concept of "repurposing" where data is used for purposes other than those initially intended, often to the detriment of the individual.

On the corporate side, a common example is the denial of insurance coverage based on pre-existing health conditions. In some cases, AI systems are employed to score individuals based on health data, leading to increased premiums or outright denial of coverage. This concept of a "health score" is rooted in insurance industry practices but is now technically feasible with AI, raising concerns about exacerbating inequality. By undermining the principle of pooled risk—where resources are shared to support individuals equitably—such practices threaten the foundational ethics of insurance systems. In Brazil, health insurance companies tried to approve such a measure, which is currently expressly prohibited by the legislation in the country.

Health data is also valuable for other economy activities. Marketing is one of them. While receiving tailored advertisements may not seem as harmful as being denied care, it still constitutes an undue use of personal health information, as it often violates the individual's autonomy and personal interests. It can be used as well for research and development of new AI models. Those uses are called secondary use of data, and regulations are imperative to ensure proper protection. A survey in Korea, for example, expressed the disagreement of people on the secondary use of their own health data.[10]

AI bias

Bias is one of the main concerns with the use of AI and it can be potentially harmful in the context of health. ML-based AI applications basically reproduce what they infer from the datasets used as input to create generalizations. From a technical point of view, there are several types of bias that can affect an AI model.[11]

Data bias occurs when datasets are either unrepresentative or skewed. Unrepresentative datasets exclude a significant part of the population that will use the AI system, potentially rendering it less efficient to them. A good example is an application to detect skin cancer lesions trained on a population with lighter skin. At a broader level, populations in the Global North and high-resource settings have well-documented and accessible data, while rural populations, Indigenous communities and those in low-resource settings are often underrepresented.

The issue with skewed datasets refers to the reproduction of practices that are rooted on racism,[12] gender-based inequalities,[13] income discrimination and other forms of discrimination. Different inequities present in healthcare can be maximized by the deployment of AI.

External bias refers to factors beyond the AI system itself that influence its deployment and impact. One example is contextual bias,[14] which arises when an AI system is implemented in an environment for which it was not designed.

For instance, an AI system developed in a Global North hospital to assist with treatment prescriptions might perform poorly in low-resource settings where the recommended treatments are not feasible.

AI environment impact

Another relevant impact of AI is on the environment and consequently on human societies. Many publications, including this GHW, acknowledge the impacts of climate change on human health and how this crisis is one of the main challenges faced by humanity. The reliance of AI systems, especially generative AI, on data centers is the reason for this environmental concern. Data centers consume a significant amount of energy to function and fresh water to cool down. Currently, they consume together around 6 per cent of all human-produced energy. Dhanani (2024) compiled several sources to indicate the current footprint of generative AI.[15] Increasing our reliance on a new technology that intensifies the carbon imprint can be potentially a bad choice for humans, especially if this technology is being deployed on harmful or frivolous applications. Additionally, data centers can have local impacts, such as increasing local temperatures of the air and water bodies and produce sound disturbance.

Health workforce

Digital health technologies, while useful, also carry additional risks, particularly concerning labor market dynamics. A prominent concern is the "uberization" of work, where stable, long-term employment contracts are replaced with on-demand work arrangements. In this model, platforms enable healthcare institutions, such as hospitals, to hire workers—nurses, for example—on a per-shift basis, rather than maintaining consistent employment relationships. This shift can lead to increased job insecurity, reduced benefits and lower overall remuneration for healthcare workers.

The uberization of work in healthcare is closely tied to broader trends driven by the expansion of the Big Tech industry and the financialization of healthcare services (see Chapter B1) and is already well reported in the USA with nursing work.[16] Platforms offering on-demand labor are often framed as cost-saving innovations, enabling private providers to minimize salaries and maximize profits. However, this model has significant implications for workforce stability, job quality and equity, as it prioritizes financial efficiency over the well-being of healthcare professionals (see Chapter C3). Gurumurthy et al (2022) also stress how much those platforms can be used to collect and use personal data of workers without their consent.[17]

Corporate power and commercialization

The institutional practice of quantifying actions and information is not a new phenomenon. In the field of healthcare, information has been collected and quantified for decades as a fundamental tool for developing public policies in the sector and advancing health science. However, with the advancement of digital

technologies this landscape intensifies and transforms into a crucial asset for market concentration and corporate power.[18]

The debate about the exponential collection and quantification of data involves, on one hand, perspectives that argue that quantified data can solve problems previously deemed insurmountable by humanity and, therefore, should grow and become central to public policies and business model development. Others point out how this quantification is primarily an approach beneficial to corporate power that transforms such data into profitable assets.

This process, known as datafication, has advanced in the healthcare sector due to a strong belief in the potential of big data technologies in providing economic benefits, such as better pricing and cost reductions, as well as social advantages, like expanded healthcare access, reduced waiting times and predictive analyses for prevention, among others. The enthusiasm for these benefits is reflected as a central element in discussions and actions aimed at developing a global digital health ecosystem. Organizations and institutions in the sector, such as the WHO, have emphasized that the use of data-driven technologies is crucial to achieving the United Nations' Sustainable Development Goals. Since 2005, the WHO has promoted strategies to transform healthcare into a global digital ecosystem, grounded in guidelines and recommendations for implementing digital technologies in the sector, as well as encouraging the sharing of health data across various levels.

To implement these strategies, governments have turned to private companies which take on the responsibility of collecting, storing and processing health data, particularly during COVID-19 pandemic, as showed by Storeng (2021).[19] These Big Tech corporations, which are mostly based in economically powerful countries, operate in a monopolistic manner, concentrating and controlling digital infrastructures and technologies that are essential not only to healthcare but to various areas of social life. This control extends from transoceanic optical cables through which digital data flows; to data centers responsible for storing and processing this data; to Internet Service Providers which can monitor and conduct behavioral surveillance; and finally, to digital platforms which facilitate user interactions and collect large volumes of real-time data, including data used in the development of AI models. Through the extraction and analysis of information derived from the vast amounts of data they store, these corporations gain deep insights into individuals, enabling them to influence and shape behaviors using algorithmic systems to determine how users interact, with whom, and in which environments within their platforms. Alphabet, the parent company of Google, and AWS, from Amazon, are representative examples of this dominance, operating across all layers of this digital ecosystem.

In a system where data has become a crucial input for business development and profit growth, large corporations have recognized that digital platforms serve as the essential virtual space to drive their socio-economic activities. A clear example of this is social media platforms—private virtual spaces where users must

adhere to established rules, including consenting to the use of data generated by their interactions, whether public or through private messages. This data feeds into the business models of these corporations, which can range from marketing strategies to the development of AI systems and other products or services.

Some platforms also provide infrastructure for data storage and processing, a service known as cloud computing, which plays a central role in the digitization of economic, political and social spheres. Given the growing volume of digital interactions and the massive collection of digital traces, these platforms have become yet another highly profitable service in the business models of Big Tech companies. In the healthcare sector, the impact of this market is evident in both the Global North and South.

One of the main consequences of this scenario is the almost unprecedented power these companies wield, allowing them to use the collected data for their own purposes, reaching into strategic engagement with political and legislative classes in the countries where they operate and shaping regulations that often favor their corporate interests. An example of this is the intense lobbying activities of companies like Meta (the owner of Facebook and Instagram) and Alphabet (the owner of Google) in the United States and the European Union to undermine data regulation proposals, such as the Digital Services Act (DSA) and the General Data Protection Regulation (GDPR). In countries in the Global South, such as Brazil, the impact is even more pronounced, as governments often rely on these companies for technological infrastructure, which reinforces power inequalities and complicates the oversight of their practices. Most recently the role of US Big Tech in financing or promoting the 2024 election of Donald Trump is one side of this coin; the other is how Big Tech can be coopted by political leaders such as Trump to serve their personal political interests.*

In the healthcare sector, this issue is reflected in how states are becoming clients and funders of Big Tech business models, often in an uncritical manner. Instead of investing in their own public digital infrastructures and platforms, they come to rely on solutions provided by these private companies, compromising technological sovereignty and becoming vulnerable to digital monopolies. Three examples illustrate this dynamic: the digitalization of social care in Denmark, that created lock-in situations with private providers,[20] the partnership between Google Cloud and the National Health Service (NHS) in the UK and the collaboration between AWS Cloud and the Unified Health System (SUS) in Brazil.[21] In the case of the NHS in the UK, the transfer of sensitive health data to the US company Palantir raises concerns about privacy and the ethical management of data. In Brazil, the Unified Health System (SUS) uses Amazon's services to host the National Health Data Network (RNDS), the country's primary system for

*The front-row presence during the inauguration of Donald Trump's second presidency (20 January 2025) of the US 'tech bros', the CEOs of the world's largest technology corporations and the world's richest men, was a striking image of the unhealthy link between political, financial and technology power.

health data interoperability. These political choices strengthen dependence on foreign actors and can limit governments' ability to ensure the security, control and public use of this data for social rather than commercial purposes.

Figure 2: Campaigners in the UK against Palantir involvement in the NHS

Talia Woodin/Medact

With all this power, these companies not only dominate the present but also shape the future through predictive analyses often presented as infallible yet rarely questioned due to the lack of studies on potential errors and the consequences of this scenario. Furthermore, the innovation environment is strongly influenced by data-driven technologies, such as AI, which advance mainly thanks to the resources and infrastructure these companies possess. The monopoly in the field of innovation tends not only to be maintained but also to be expanded.

It is also important to understand this scenario in relation to computational power, particularly the significance of microprocessors, which represent the physical dimension of digital technological innovation. These components, mainly made of silicon, are essential for the calculations performed by computers and digital devices. The control of this production is concentrated in a small number of companies on the global stage, following the monopolistic logic of Big Techs. Other essential infrastructures, such as microchips, also follow the monopolistic logic of these corporations.

The global arena of digital health

The digital transformation of health has led to different initiatives worldwide to provide guidance and steer the adoption of digital technologies in healthcare. This section explores the main actors in the global arena, which are international organizations working with digital health, and legal trends in terms of regulation that are influencing the way jurisdictions deal with the topic.

Global actors

In terms of international organizations, the WHO in partnership with the International Telecommunications Union has been publishing guidance documents to help countries adopt technologies, especially AI. The most important document is the Global Digital Health Strategy 2020–25, recently extended to 2027. This strategy defines general principles for digital health and encourages a lot the participation with the private sector.

Another organization that has played a major role internationally is the Organization for Economic Co-operation and Development (OECD), which has led different initiatives to discuss and influence the adoption of AI in healthcare. Other initiatives aim to influence countries to implement and harmonize their regulation on digital health, for example, the Global Partnership for AI, an OECD-fostered organization to bring together countries and academics. The nature of digital health also invites activists to understand further the dimensions of internet governance.[22] New technologies have also influenced the adoption of legal frameworks that, although different at each jurisdiction, get their inspiration from international standardized frameworks, discussed below.

Legal trends

The regulation of privacy and personal data protection was the first major international regulatory response to the challenges of the digital economy. The European Union's General Data Protection Regulation (GDPR) has become a global benchmark, inspiring similar laws in various jurisdictions to promote transparency, accountability and greater individual control over personal data.* An important exception to this trend is the United States, which lacks a comprehensive federal data protection law. Its Health Insurance Portability and Accountability Act, approved in 1996, does not meet the needs of the digital economy, creating concerns about use of health data by US-based companies.

Despite the widespread adoption of data protection regulations, significant limitations persist. In some regions, efforts to enact robust data protection laws have stalled. For instance, India's attempts to pass a comprehensive data protection law, including rights for data subjects and community protections, have not succeeded, leaving a regulatory gap in one of the world's largest digital markets.

Even where such laws are enacted, enforcement remains inconsistent. Brazil's data protection legislation, for example, has faced implementation challenges due to limited resources for regulatory agencies and difficulties in ensuring compliance across sectors.

Beyond enforcement challenges, a fundamental critique of existing data protection frameworks is their predominantly individualistic approach. As Anita Gurumurthy (2024) has pointed out, this perspective often fails to account for the

*The GDPR is not without some problems. As Chapter E2 discusses, it has been used to launch court cases against environmental activist organizations (so-called 'SLAPP' injunctions, or 'strategic lawsuit against public participation').

collective dimensions of data and its broader societal implications.[23] The digital economy does not extract value from individual data points alone but rather from aggregated datasets, yet current regulations do not adequately address this reality.

While data protection laws focus on the handling of personal data, AI regulation primarily concerns the outputs of AI systems—that is, when and how they can be deployed. AI regulatory models can be classified based on their scope (general vs. sectoral) and their foundation (rights-based vs. risk-based). At the general level, there is ongoing debate about regulating AI comprehensively through broad legislative frameworks such as the EU AI Act, which was approved by the European Parliament in 2024. Several other countries are currently considering their own AI legislation.

In contrast, sector-specific regulation focuses on particular domains where AI applications have significant impact. One prominent example is the regulation of Software as a Medical Device (SaMD)—software applications used in clinical care, which must meet safety and efficacy standards similar to those governing medicines and vaccines. Since 2021, regulatory agencies have been exploring ways to oversee AI-powered SaMD, particularly those using machine learning. The challenge lies in regulating "unfixed" AI-based applications that continuously evolve as they learn from new data. For products requiring market approval, this poses difficulties, as their safety and efficacy must be reassessed over time. Moreover, sector-specific regulations have inherent limitations. In the case of medical AI, regulations primarily focus on clinical care applications, excluding other critical AI-driven areas such as public health management, research and development and administrative decision-making.

Speaking of rights-based vs risk-based regulatory approaches, while these concepts are not always strictly defined and often overlap, they represent distinct philosophies of governance. Rights-based regulation takes fundamental rights as its starting point, ensuring that AI systems do not infringe upon individual or collective rights. Under this model, companies must design AI systems in a way that respects legal and ethical principles from the outset, whereas risk-based regulation focuses on identifying and mitigating specific risks associated with AI applications. This approach assesses AI systems based on the potential harm they could cause and develops safeguards accordingly. One example is the International Medical Device Regulators Forum (IMDRF), a regulatory authority-based organization, with participation of the medical device industry in their working groups, working to create uniform standards for AI-enabled SaMD.

Political economy approach to digital health

A few new theoretical approaches have emerged in scholarship and across civil society movements to proper diagnose the emerging issues around digital health, especially to address it from a political economy point of view. One of these concerns data colonialism. Data has become a critical resource, akin to a new

form of raw material. Countries in the Global North, with greater access to data, proprietary regimes and infrastructure, are consolidating their dominance, creating a new form of colonialism, in which low-resource nations remain dependent on more powerful, technologically advanced states that are the global centers of AI technology and development. This represents an extension of economic colonialism in which the periphery keeps participating in the world economy by providing raw material, in this instance data. Khauja (2024) illustrates this process as primitive accumulation of data, in the same mode of the Marxist concept of primitive accumulation of capital.[24]

Another theoretical approach rooted on the colonial structural is digital colonialism, in which the Global North controls which technologies are being deployed and used in the South, in spite of its needs (see Chapter B5). Sekalala and Chatikobo (2024) highlight this point by addressing the colonialism in the digital health agenda, that often disregards local context and approaches technology as a magic wand.[25] This is aggravated by the increasing power of Big Tech companies over states.

A third theoretical concept developed to address this complexity from the perspective of states is that of "platformization", which describes the process of digitizing public services inspired by practices common in the private sector. In this context, new forms of mediation are introduced that connect the different stages of service provision, as well as the transfer of parts of their implementation to private companies, often through contracts established with public authorities. This phenomenon is based on the large-scale collection of population data, the transformation of citizens into consumers and the privatization of state infrastructures as a means of generating financial revenue. The adoption of business-oriented methods by the state is not a recent process and traces back to initiatives driven by the logic of the managerial state. However, platformization incorporates innovations from private digital platforms, reflecting a new stage in this process of imitating corporate practices.[26,27]

Another interesting approach is the claiming of digital sovereignty. The word sovereignty can be polysemic, especially as it is used more frequently in the public debate. Rikap et al (2024) in their manifesto reclaiming digital sovereignty enunciated a few actions that could help to protect people from corporate power.[28]

Gurumurthy and Chami[29,30] propose a feminist and critical approach to understanding the implications of menstrual apps and data collection. Their research highlights how existing legal frameworks for personal data protection, which are rooted in an individualistic perspective, fail to adequately address the expansive reach of digital capitalism. This critique aligns with political economy theories of the digital economy, particularly Shoshana Zuboff's concept of surveillance capitalism which emphasizes the extraction and commodification of behavioral data to generate predictive inferences.[31] Additionally, it resonates with Cecilia Rikap's (2021) more recent analysis of data-driven intellectual monopolies, which

explores how dominant tech corporations leverage data control to consolidate intellectual and economic power.[32] Together, these perspectives underscore the limitations of current data governance models and the need for alternative collective approaches to data regulation.

Opportunities

Beyond theoretical perspectives for diagnosing the current landscape, it is essential to explore concrete actions that can drive change in the political governance of digital health. One key avenue for intervention is leveraging legal frameworks to shape the regulatory environment, in both lawmaking processes and through court and administrative litigation.

With the rapid advancement of AI there is an ongoing and intense debate over its regulation, reminiscent of the discussions that took place a few years ago around personal data protection laws. Similarly, digital health is now at the center of regulatory discussions, particularly regarding the development of digital health platforms, data infrastructures and governance models. This presents a critical opportunity to engage with these policy debates and advocate for equitable, transparent and rights-based digital health regulations.

At the same time, existing legal frameworks, such as those designed to protect privacy and personal data, remain relatively new and underutilized by civil society organizations. These frameworks offer opportunities for public interest litigation, strategic advocacy and legal interventions to ensure greater accountability and fairness in digital health governance. Furthermore, legal mechanisms that are not explicitly designed for digital health—such as benefit-sharing agreements—can be creatively repurposed to promote more equitable outcomes.

The benefit-sharing approach, established under the Nagoya Protocol and effectively implemented in the Pandemic Influenza Preparedness Framework (see Chapter D2), could serve as a model for data governance and innovation in digital health. Applying benefit-sharing principles to the processing and use of health data could help redistribute the economic and technological gains derived from digital health assets, ensuring that communities and stakeholders—rather than just private corporations—benefit from innovation.

Finally, an important recommendation for social movements and governments, particularly at the local level, is to invest in digital literacy and information technology capacity-building. Much of the corporate dominance in digital health stems from states losing their technological and regulatory capacity to private companies. Strengthening public-sector expertise in data governance, AI and digital infrastructure management is essential for reclaiming agency and ensuring that digital health ecosystems serve the public interest rather than being driven solely by commercial imperatives.

Reference List

1 World Health Assembly. WHA 71.7 Digital health. Geneva: World Health Organization; 2018 [cited 2024 Dec 15]. Available from: https://bit.ly/3TeMucL

2 Fornazin M, Penteado BE, de Castro LC, de Castro Silva SL. From Medical Informatics to Digital Health: A Bibliometric Analysis of the Research Field. In AMCIS 2021 Aug (pp. 18-18).

3 World Health Organization. Global strategy on digital health 2020-2025. Geneva: World Health Organization; 2021. License: CC BY-NC-SA 3.0 IGO; World Health Organization. Ethics and governance of artificial intelligence for health: WHO guidance. [S.l.]: WHO; 2021 [cited 2024 Dec 15]. Available from: https://bit.ly/3RGwaRC

4 World Health Organization. Ethics and governance of artificial intelligence for health: Guidance on large multi-modal models. [S.l.]: WHO; 2024 [cited 2024 Dec 15]. Available from: https://bit.ly/44ckw8t

5 World Health Organization. Ethics and governance of artificial intelligence for health: WHO guidance. [S.l.]: WHO; 2021 [cited 2024 Dec 15]. Available from: https://bit.ly/3HzHGw7.

6 World Health Organization. Ethics and governance of artificial intelligence for health: WHO guidance. [S.l.]: WHO; 2021 [cited 2024 Dec 15]. Available from: https://bit.ly/3HtKo6x.

7 Abriata LA. The Nobel Prize in Chemistry: past, present, and future of AI in biology. Commun Bio. 2024 Oct 29;7(1):1409. Available from: https://bit.ly/4jMTJ6O

8 Mofokeng T. Digital innovation, technologies and the right to health. United Nations Human Rights Council; 2023 Apr 21 [cited 2025 Mar 8]. Report No.: A/HRC/53/65. Available from: https://bit.ly/45gyCWU

9 Davis SL. The trojan horse: Digital health, human rights, and global health governance. Health Hum Rights. 2020 Dec;22(2):41; Sekalala S, Dagron S, Forman L, Meier BM. Analyzing the human rights impact of increased digital public health surveillance during the COVID-19 crisis. Health Hum Rights. 2020 Dec;22(2):7.

10 Jung J, Kim H, Lee SH, Park J. Survey of Public Attitudes Toward the Secondary Use of Public Healthcare Data in Korea. Healthc Inform Res. 2023 Oct 31; 29(4):377-85. Available from: https://bit.ly/3Fw7JUv

11 Obermeyer Z, Nissan R, Stern M, Eaneff S, Bembeneck EJ, Mullainathan S. Algorithmic bias playbook. Center for Applied AI at Chicago Booth; 2021 Jun. Available from: https://bit.ly/43YP7ER

12 Hussain SA, Bresnahan M, Zhuang J. The bias algorithm: how AI in healthcare exacerbates ethnic and racial disparities–a scoping review. Ethnicity & Health. 2025 Feb 17;30(2):197-214. Available from: https://bit.ly/3TgQmtS

13 Lau PL. AI gender biases in women's healthcare: Perspectives from the United Kingdom and the European legal space. In: Gill-Pedro E, Moberg A, editors. YSEC Yearbook of Socio-Economic Constitutions 2023. Cham: Springer Nature Switzerland; 2024. P.247-74. Available from: https://bit.ly/4kzo6yA

14 Price II, N. Medical AI and contextual bias. Harv. JL & Tech. 2019;33(1):65-116.

15 Dhanani R. Environmental impact of generative AI – 20 stats & facts [Internet]. The Sustainable Agency; 2024 Sep 27. Available from: https://bit.ly/4jMauiz

16 Wells KJ, Spilda FU. Uber for nursing: how an AI-powered gig model is threatening health care. Roosevelt Institute; 2024 Dec 17 [cited 2025 Mar 8]. Available from: https://bit.ly/3SJpjHp

17 Gurumurthy A, Chami N, Chatterjee S, Shah S. Workers' data rights in the platformized workplace: a new frontier for the labor agenda. IT for Change; 2022 Jun [cited 2025 Mar 8]. Available from: https://bit.ly/43XPcIQ

18 Viljoen S. A relational theory of data governance. The Yale Law Journal. 2021 Nov; 131(2): 370-81. Available from: https://bit.ly/4mVpHjX

19 Storeng KT, de Bengy Puyvallée A. The Smartphone Pandemic: How Big Tech and public health authorities partner in the digital response to Covid-19. Global Public Health. 2021 Sep 2;16(8-9):1482-98. Available from: https://bit.ly/3ZkeC1S

20 Collington R. Disrupting the welfare state? Digitalisation and the retrenchment of public sector capacity. New Political Economy. 2022 Mar 4;27(2):312-28. Available from: https://bit.ly/4kzgrjZ

21 Rachid R, Fornazin M, Castro L, Gonçalves LH, Penteado BE. Digital health and the platformization of the Brazilian Government. Science & Collective Health. 2023 Jul;28(7):2143-53. Available from: https://bit.ly/43A2uw7.

22 Kurbalija J. An introduction to internet governance. Geneva, Switzerland. DiploFoundation; 2016 Nov 8.

23 Gurumurthy A. Towards Feminist Futures in the Platform Economy: Four Stories from India. Epistemic Rights in the Era of Digital Disruption. 2024 [cited 2025 Mar 10]. P.113-26.; Available from: https://bit.ly/4dSs1nD

24 Khauaja P. Dependência e Soberania nas Tecnologias de Inteligência Artificial: uma análise a partir dos conceitos de acumulação primitiva de dados e Data Processing Inequality. Liinc Rev. 2024 Dec 3;20(2). Available from: https://bit.ly/3HygGNG

25 Sekalala S, Chatikobo T. Colonialism in the new digital health agenda. BMJ global health. 2024 Feb 1;9(2):e014131. Available from: https://bit.ly/4dSs2rH

26 Rachid R, Fornazin M. From the UK to Brazil: digital health and the platformization of public health systems [Internet]. Society for Social Studies of Science; 2024 Feb 19 [cited 2025 Mar 9]. Available from: https://bit.ly/4jUVb7q

27 Rachid, R; Fornazin, M.; Castro, L.; Gonçalves, L.; Penteado, B.. Digital health and the platformization of the Brazilian Government. Science & Collective Health. 2023 Jul;28(7):2143-53. Available from: https://bit.ly/42BNo8Q

28 Rikap C, Durand C, Paraná E, Gerbaudo P, Marx P. Reclaiming Digital Sovereignty: A roadmap to build a digital stack for people and the planet. 2024 Dec 3. Available from: https://bit.ly/4e1lwiI

29 Gurumurthy A, Chami N. Beyond data bodies: New directions for a feminist theory of data sovereignty. SSRN Journal [Internet]. 2023 [cited 2025 Mar 28]; Available from: https://bit.ly/43ClYQT

30 Gurumurthy A. Towards Feminist Futures in the Platform Economy: Four Stories from India. Epistemic Rights in the Era of Digital Disruption. 2024 [cited 2025 Mar 10]. P.113-26. Available from: https://bit.ly/3GLWyqE

31 Zuboff S. Surveillance capitalism and the challenge of collective action. New Labor Forum. 2019 Jan;28(1):10-29. Available from: https://doi.org/10.1177/1095796018819461

32 Rikap C. Capitalism, Power and Innovation: Intellectual Monopoly Capitalism Uncovered. London: Routledge; 2021. 295 p.

Building equitable health systems: a transformative proposal from an intersectional gender perspective

Introduction

Gender transformative approaches refer to practices, interventions or policies that aim not only to address gender inequalities but to actively challenge and change the underlying structures, norms and power relations that perpetuate gender-based discrimination. Such an approach goes beyond simply providing equal opportunities or improving access to resources and services for all individuals. It involves reshaping societal structures and behaviors that create or sustain inequities rooted in power dynamics and social norms. In that sense, gender-transformative public services refer to services that are intentionally designed and delivered to challenge and transform unequal norms, roles and power dynamics rooted in societal structure.

The idea of gender transformative health services was developed in response to the recognition that health systems and services often perpetuate inequalities, particularly in areas such as reproductive health, sexual rights and maternal care; and that this must change. Although the gender transformative concept has been adopted by mainstream development institutions that do not necessarily promote strengthening of public services, such as the World Bank and UN Women, its roots lie in feminist theory, gender equality and intersectionality frameworks that aim to challenge power relations in society.

Adopting a gender transformative approach to assess the social impacts of health systems with a more holistic gender lens, this chapter presents three case studies from the Global South, one each from Africa (Nigeria), Asia (India) and Latin America (Paraguay). The case studies focus on the health system response to gender-based violence and reproductive health needs with a critical eye on the power relations at play. The extended case studies were originally published in 2023 by Public Services International a global federation that joins under its umbrella unions of healthcare workers, as part of an effort to understand how the concept of gender transformative health services can help in advocating for stronger quality public healthcare.[1]

This chapter aims to continue this effort by looking jointly at the three cases and extracting lessons and proposals for strengthening public health services.*

*The case studies primarily concerned affected cisgender women in health systems. However, the focus of this chapter understands exclusions and discrimination to be intersectional in nature. Therefore, the conclusions on gender transformative health systems consider women in all their diversity: cisgender, transgender and non-binary, as well as recognizing that exclusions also affect (in a similar way and with their particularities) LGTBQIA+ populations.

Figure 1: Rally supporting abortion rights at the 5th People's Health Assembly (Mar del Plata, Argentina, 2024)

People's Health Movement

Evidence from the Global South

Health system response to survivors of violence in Paraguay

Paraguay is a small, South American country with a population of approximately 6.3 million inhabitants and a democratic political system that has faced significant challenges in terms of stability and governance. These challenges have resulted in a fragile institutional framework and an inefficient bureaucracy. The population suffers the consequences of public institutions with little capacity to meet the needs of the population, lack of resources, corruption and political clientelism.

The national budget has historically reflected these difficulties, since governments (except for the 2008-2012 government of President Fernando Lugo, who was deposed by a coup d'état) have limited social spending and give priority to macroeconomic conditions favoring the entry of transnational capital and the accumulation of capital by national companies in export sectors, mainly livestock and soybean. The tax system has been sustained at the lowest rate in the entire region, affecting the ability of the governments in office to ensure quality public services.

In the area of health, Paraguay faces serious problems of access and quality. Although the health budget has increased in recent years, reaching an average public investment of 4 per cent of GDP, it is still insufficient to meet the needs of a dispersed and sometimes remotely located population, and is lower than WHO / PAHO recommendations for a minimum of 6 per cent of GDP.[2] Health

Box B3.1: What does a gender transformative approach to health systems mean?

Definitions of gender policies and gender mainstreaming vary between countries, but the possible goal is the same: to eliminate gender inequality. It is useful to develop definitions of what a gender approach to health systems means, such as distinction between policies that are gender blind, gender sensitive and gender transformative, as this creates a gradual continuum, a possible pathway for health systems to achieve a gender transformative approach.

- "Gender blind" health policies are those that do not consider gender-based inequalities and their effects on health. Gender blind policies forget or ignore the gender norms at play. Therefore, they fail to see and address gendered power relations and their effects on health.
- "Gender sensitive" health policies recognize the role of gender norms in their relationship to health, but do not question or challenge the power structures that underpin them. They fail to incorporate actions that address the deeper connections between gendered social norms, inequalities and health.
- "Gender transformative" health policies challenge the hierarchy of power that underpins gender inequalities, the consequences of which affect women's access to and maintenance of comprehensive health, and discrimination that negatively impacts their health status and outcomes. They involve the creation of systemic actions which address patriarchal structures within health systems, public policies and society at large. In addition, gender transformative health policies promote accountability of the relationship between individuals and public institutions, with the aim of providing comprehensive and equitable health services that challenge the legislative and cultural norms that sustain inequality, rather than conforming to and confirming them.

system underfunding forces people to pay for their health with an out-of-pocket expenditure of around 38 per cent of the total investment in health, which places Paraguay as one of the countries with the highest out-of-pocket expenditure per capita in the region.[3] Disparities in health infrastructure between urban and rural areas are notorious. The Primary Health Care (PHC) strategy, with a population coverage of less than 30 per cent, is concentrated in rural areas with health facilities that do not have sufficient conditions to solve the health problems of the population, while the best equipped hospitals and health centers are mainly located in the capital, Asuncion, and in a few other nearby cities. The lack of medical specialists, combined with the low responsiveness of referral and referral systems, imposes significant barriers to health care access. In addition, the availability and cost of medicines are a constant challenge, disproportionately affecting the most vulnerable sectors of the population, particularly women, who require greater access due to conditions related to their sexual and reproductive health.

In this context, Paraguay has implemented an inter-institutional policy of prevention and care for women affected by gender-based violence (GBV), where the public health system, through sexual and reproductive health services, plays a fundamental role as a gateway. According to the last national survey conducted in 2021, eight out of ten Paraguayan women have suffered some type of violence throughout their lives, and 60.9 per cent have been victims of sexual violence, with 77 per cent of them being young women between 18 and 29 years of age.

The mandate of public health services includes comprehensive protection of sexual and reproductive rights (SRHR), based on international treaties ratified by the country. Within this international human rights framework and other national regulations such as the law against all forms of violence against women (No. 5777/2016), the sexual and reproductive health policy established a protocol for health system care of victims of sexual violence. The protocol defines key concepts such as gender, violence and types of violence; and identifies a wide range of conditions, risk factors and mandatory guidelines that health professionals must follow in the care process. It also explicitly points out the processes and actions within the health services themselves that can victimize and re-victimize women, so that the necessary measures are taken to guarantee the protection of their rights during bio-psycho-social interventions and to ensure the organic, coherent and effective functioning of the system.

A case study conducted by PSI published in 2023 detailing the therapeutic journey of a woman victim of violence who had suffered a sexual assault, revealed that GBV policies, even when designed with a gender sensitive approach, can still have pernicious effects on women.[4] When a woman victim of GBV arrives at public health services at the first level of care, this level is unable to provide an adequate approach and is limited to referring victims to hospitals at higher levels that are usually located at a greater distance. When women arrive at these hospitals, the quality of care is seriously affected by the lack of adequate resources, such as the lack of prophylactic drugs or mental health professionals. This is compounded by insufficient training and sensitization of medical professionals and other hospital staff. Despite the existence of regulations and training processes, many of these professionals do not adjust their attention to the specific needs of the victims or to their vulnerable conditions (such as impoverishment, lack of knowledge or lack of family support). In addition, they reproduce patriarchal stereotypes that re-victimize women, subjecting them to comments that hold them responsible for the aggressions they have received or cast doubt on their stories when they are reluctant to file a formal complaint. This sometimes leads to the victims not having timely access to the necessary medical care to prevent sexually transmitted infections and unwanted pregnancies, and they are not properly referred to other social support institutions that can accompany them.

The intervention of feminist organizations in the health system has been, in many cases, crucial for the victims to receive the necessary care. However, this

care does not always follow established protocols and does not always guarantee comprehensive protection against GBV. Barriers, both visible and invisible, in public health services create a notable disconnect between gender sensitive sexual and reproductive health normative policies and their effective implementation.

Health system response to survivors of gender-based violence in India

The women's movement in India has played a significant role in highlighting the issues of gender-based violence (GBV) and discrimination. This has led to increased awareness and advocacy, resulting in greater mobilization and legal reforms. Despite the global prevalence of GBV, the issue is often overlooked in public health discussions and systemic responses. There is a need to address this gap to improve reporting, intervention mechanisms, and multi-sectoral coordination within healthcare systems. A gender transformative approach is necessary to address the systemic gaps and ensure comprehensive healthcare for women, girls, and gender non-binary individuals.

Despite clear policies in India mandating the health system's role in addressing GBV, there are challenges in implementation and gaps in the systemic response. An analysis employing a gender-intersectionality framework has highlighted these challenges and identified existing gaps for our understanding. While there have been efforts to examine how factors such as race, caste, class, religion, sexuality, disability, age and work intersect to exacerbate vulnerabilities to violence, the healthcare system has yet to fully integrate these insights. It is crucial to emphasize that, despite this understanding, barriers persist for survivors seeking healthcare and justice, underscoring the need for further implementation of intersectional analyses, particularly within health policies and systems. The existing legal and policy frameworks in India, along with national guidelines and protocols, highlight the role of healthcare providers in responding to sexual violence and domestic violence. However, there is a need for better implementation and adherence to these guidelines to ensure effective support for survivors of GBV.

The health system in India currently prioritizes "medico-legal compliance" over comprehensive care for survivors of GBV. While there are some improvements in select health facilities, overall policies and practices lack the necessary comprehensiveness. For instance, certain forms of violence, such as marital rape, are often overlooked because they do not fit neatly within legal definitions. Even without a criminal charge or acknowledgment of an offence, the healthcare needs and traumas faced by survivors remain significant. Just because a survivor of sexual assault within a marital relationship cannot pursue a criminal case against their perpetrator (husband), it does not mean they should be denied care and support to address the health impacts of that assault. Although the Supreme Court of India has recognized the healthcare needs of marital rape survivors, the health system continues to demonstrate bias and ignorance in its practices.[5] This oversight leads to significant gaps in healthcare for survivors.

Moreover, the focus on medico-legal aspects places disproportionate emphasis on identifying physical injuries and collecting forensic evidence. This is problematic as it neglects other critical dimensions of violence, including emotional, psychological and economic abuse. Additionally, the realities faced by survivors—such as delayed reporting due to societal stigma, victim-blaming and a general lack of awareness about available systems and provisions—are often overlooked. The current discourse on GBV responses tends to overly rely on criminalization and medicalization as primary solutions. Consequently, survivors encounter systemic gaps during their interactions with the health system impacting their health and human rights. There is a pressing need for strengthened public health services that are sensitive to the complexities of GBV and can address the significant challenges faced by women, girls and gender non-binary individuals, as a first step towards gender transformative services.

It is important to emphasize that the health system is ideally positioned to take on a much larger role in addressing stigma and the normalization of violence. This can be achieved through a proactive approach aimed at adopting gender transformative public health services that not only respond to the needs of individual survivors, but that also contribute to building public awareness that challenges stigma and the normalization of violence. By doing so, the health system can establish a violence prevention response as a fundamental aspect of primary healthcare.

The recent incident of sexual violence and killing of a young woman doctor in the Indian city of Kolkata* has reiterated discussions about the 2013 POSH Act—Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal). The incident raises an important question: why, after nearly a decade, do we still need to demand that this law be effectively implemented in the healthcare sector across the country? While the current protests have primarily focused on demanding punishment for the offenders, many young women doctors and others are also calling for a re-examination of the system itself while demanding justice and better security and facilities at medical campuses and hospitals.[6]

The COVID-19 pandemic related lockdown in India was also a significant testament to these ground realities. The lockdown exacerbated challenges for GBV survivors, as many had become isolated with their abusers. With limited access to support services, transportation and social spaces, individuals seeking help faced significant barriers. This situation had reportedly led to an increase in violence and adverse health impacts requiring comprehensive healthcare services, including emergency care, medico-legal assistance, psychological counseling and sexual and reproductive health services, all of which were disrupted during the lockdown.[7]

An intersectional understanding of GBV and health system responses underscores the need for a comprehensive approach to women's health. Normalizing GBV can lead to underreporting and silencing, thus advocating for a zero-

*The incident took place in August 2024 at the hospital where the trainee doctor worked.

tolerance approach becomes essential. This still prevalent silence often aligns with societal norms of stigmas and patriarchal control surrounding women's sexuality and reproduction. GBV is strongly associated with adverse sexual and reproductive health (SRH) outcomes. While emphasizing reproductive choices and autonomy, it is crucial to recognize that a woman's reproductive and sexual health is shaped not only by individual and notional choices, but also by various factors within her life-cycle experiences, family and community. The debilitating impact of violence and the empowering influence of health should be considered together. The focus should be on providing opportunities through health education, supportive laws and guaranteed access to quality healthcare for everyone. In essence, GBV interventions should not be limited to addressing violence alone, but should also aim to enhance knowledge, capacities and equal opportunities for marginalized identities to improve their SRH and overall health outcomes.

Adopting a gender-transformative approach in public health allows for the examination of long-standing and historically significant issues that are often overlooked in public health and rights analysis and advocacy.

Reproductive health services in Nigeria

Nigeria is the most populous African nation with, as of 2023, a population of close to 228 million people. In 2024, it ranked 125th out of 146 countries on the Global Gender Gap Index published by the World Economic Forum (WEF).[8] This low ranking reflects widespread barriers to women's rights, gender stereotypes and socio-cultural norms that negatively impact women in many areas, including in the provision of, access to, and uptake of quality care, especially maternal and reproductive healthcare services such as family planning, antenatal care and contraceptive use.

Women in Nigeria face serious health impacts from a lack of access to adequate reproductive health services. While nearly 100 per cent of global maternal deaths occur in countries of the Global South, more than half of these deaths occur in sub-Saharan Africa with Nigeria accounting for nearly 20 per cent of all global maternal deaths. Nigeria's maternal mortality rate is among the highest in the world.[9] Unsafe abortion has been shown to be a leading cause of maternal mortality, to which unmet needs for contraception contribute.[10] Access to modern contraceptives among women of reproductive age is low, estimated to be between 12 per cent and 20 per cent and there is a high prevalence of unintended pregnancies.[11]

Compared with countries with similar income, the country's health outcomes are poor, with drastic differences between wealthy and poor, urban and rural populations and different regions.[12] The system is grossly underfunded and relies heavily on out-of-pocket expenditure, leaving the population with the ever-present risk of catastrophic expenditures.* Primary health care constitutes 88 per cent of health facilities in the country[13] but are worse affected by this underfunding

* In 2021, Nigeria's health expenditure was 4% of its GDP, much below the recommended 15%, out of which out-of-pocket health expenditure accounts for about 77%.

due to the decentralization of their management to local government authorities, the weakest governing structures in the country.[14] These limitations play out in accessing reproductive healthcare services too.

Despite laws, policies and legal frameworks to promote women's health and reproductive rights, gaps in implementation add to the weakness of the health system and combined with gender inequalities and low levels of reliable health care data, lead to poor access to reproductive health services.[15] Regressive laws, such as restrictive abortion laws, present an additional barrier to accessing reproductive health services. According to Nigerian law abortion is illegal except when pregnancy threatens the life of the mother, though some states, such as Ogun State, permit abortion for victims of rape and incest. The penalization of the health practitioner's role in performing abortion is a strong deterrent.

Public services are social equalizers as they play a fundamental role in power and resource redistribution. In applying the core principles of equality and equity they can significantly contribute to social transformative change. The design of key sexual and reproductive healthcare programs in Lagos State has the potential to progress towards gender transformative approaches. In the face of restrictive abortion laws, prohibitive costs, poor access to safe health services and intense social stigma that prevent women from accessing safe and legal abortion, efforts towards reforms that liberalize abortion clubbed with progressive health policies provide steps towards improving reproductive health services. The Lagos State House of Assembly amendment of its Criminal Code to the Criminal Law of Lagos State 2011 expanded the lawful grounds for which abortion can be carried out: preservation of a mother's life and preservation of a woman's physical health (Section 201). To this, Guidelines were added in 2022 that provide a guide to standardize and build capacity for medical practitioners to save lives of women whose pregnancy continuation is a danger to their lives and physical health. Both are the result of concerted efforts by women's rights advocates.*

However, the strong social stigma that women's rights face manifested in religious groups pressuring the Lagos State government to revoke the guidelines, which were suspended just a month after they were unveiled. A strong social movement led to actions such as petitions and press conferences expressing concerns over the suspension of the abortion guideline. On 23 August 2023, over 800 people marched to the Government House to pressure the Governor of Lagos State, Babajide Sanwo-Olu, to lift the suspension on the guidelines.[16] More than two years later, intense pressure is still on to reinstate them.†

The path towards gender transformative health systems also requires strengthening the health system itself, in quality, accessibility and universality. Approximately 60 to 70 per cent of women in Nigeria are financially dependent[17]

* Such as Women Advocates Research and Documentation Centre (WARDC) – https://bit.ly/3GwqVRY

† On 8 March 2024, 150 organizations urged the government of Lagos to reinstate the suspended guidelines on safe termination of pregnancy. See https://bit.ly/3Sb21K9

which means that women's ability to exercise autonomy in making decisions about their maternal and reproductive health is dependent on the approval and financial support from their family before accessing care. Prioritizing maternal healthcare is also made difficult due to the system of power imbalance that allows men to control women's mobility. Availability of geographically accessible and free services are important elements too.

Finally, in Nigeria and across the world, deep seated gender inequalities and restrictive norms were exacerbated because of the pandemic, leading to a surge in GBV[18] intimate partner violence and disruption to healthcare services, widening the gap in access to health services and resources among women.[19]

Key findings from country experiences

Definitions of gender policies and gender mainstreaming vary between countries, but the possible goal is the same: to eliminate gender inequality. It is useful to develop definitions of what a what a gender approach to health systems means, such as distinguishing between policies that are gender blind, gender sensitive or gender transformative (see Box B3.1), as this creates a gradual continuum, a possible pathway for health systems to achieve a gender transformative approach. This can be a useful tool for assessing public policies and thinking about the steps to take to reach our goal.

The public health system as women's entry point to the protection system. The public health system is the main gateway for women to access institutional responses to sexual and reproductive health and gender-based violence. However, the underfunding of public health services in all three case study countries means that all have gaps in their capacity to respond to these needs. Health professionals have a social responsibility to their communities, but they may also bring their own biases into the health system. This is where policies and guidelines become crucial to ensure that service delivery is based on the principles of human rights and equality. Conversely, the lack of adequate response and denial of services by the health system leads to further victimization of victims, as demonstrated in all three countries.

Changing laws is not enough, but it is a first step. There are systematic gaps between written (normative) guidelines and their implementation in practice, reflecting the invisible barriers created by the social constructions of patriarchy and other hierarchies. The role of social movements, especially the women's movement and community movements, becomes central in changing the status quo based on exclusion and inequality. These interventions have led to changes at different levels, from shifting the focus from one step to another (India) to improving access to services at the local level (Paraguay) or even to holding public institutions accountable (Nigeria).

Proposals towards gender transformative health services

What can public health services do to become gender transformative?

Based on the case studies and research and experiences from many other countries, there are several goals to which gender-transformative health policies and practices must aspire:

1. Promote women's autonomy and decision-making capacity

According to UNFPA data, only 55 per cent of women can make decisions about their sexual and reproductive health. Gender transformative public health services are those that create the conditions for women to be able to make autonomous decisions about their lives and their bodies, without patriarchal or sexist barriers. The goal is for 100 per cent of women to have access to quality sexual and reproductive health services.

2. Prevention and elimination of GBV

The UN Global Data Base on Violence against Women estimates that over 30 per cent of women worldwide suffer physical or sexual violence at least once in their life.[20] Gender transformative health services identify the different forms of violence that affect women, take care of their health when they enter the services, guarantee good treatment and avoid re-victimization. They take a leading role in primary prevention, care and rehabilitation. They guarantee effective measures and reduce the statistics of violence through effective prevention measures and victim support.

3. Equitable access to sexual and reproductive health resources and services

Sexual health problems account for 20 per cent of the global burden of women's ill health. A transformative health policy ensures equitable access to contraceptive methods and reproductive health services. Regardless of intersectionality of gender, class, ethnicity or place of residence, access is universal and territorialized. Services are tailored to local needs, and barriers to access are removed.

4. Reconceptualizing quality of care as an enforceable right

The protection of women's rights is still a global debt. Significant differences exist within countries, but also between countries. Gender transformative policies need to redefine the quality of health services as an enforceable right, ensuring that they are technically adequate, humanized and empathetic.

5. Contributing to empowerment and emancipation

Patriarchy, macho relations and a state that reproduces power relations based on gender inequality perpetuate processes of tutelary empowerment, where women have access to certain rights as long as they do not undermine the patriarchal system. A transformative gender health policy contributes to non-protected empowerment. It creates conditions for the emancipation of women, recognizing them as full and equal citizens, capable of defining their life projects and their own relations with the state.

How can health services become gender transformers?

There are several ways in which health services can contribute to addressing gender inequalities, within their own care provisions but also more generally across public and private institutions.

1. Build a social alliance

In a stable alliance between the public health system, women, social movements and organizations are and must become promoters of social change for a gender-equal structure.

2. Strengthen the primary health care strategy

It is necessary to build health systems with solid structures in the territories, based on strengthened primary health care (PHC) and aligned with the Alma Ata principles, emphasizing the importance of integrated health care. These systems must be transformative, since in contexts where inequality, violence and life projects truncated by gender injustices persist, it is not possible to achieve integrated health.

The infrastructure available to PHC health systems is insufficient and, in many systems, do not have the conditions to attend to women, much less to generate spaces for collective health promotion, which is why it is essential to provide the system with the necessary infrastructure.

On this path, health teams within PHC play a fundamental role due to the trust they have gained within the community and can promote and lead meeting spaces with organized women and/or contribute to their organization, accompanying the processes of women's empowerment over their bodies and territories. Similarly, the creation of spaces made up of men will contribute to the empowerment of their bodies and the deconstruction of violent masculinities, as well as to knowledge about women's bodies, their rights and respect for their autonomy.

3. Reconceptualize the quality of health systems with social participation

The reconceptualization of the concept of quality in public health systems and their policies requires the active participation of women and people of diversity. States are called upon to design mechanisms for effective participation, where quality translates into enforceable rights, helping to reduce inequality and ensuring that the needs and experiences of this population are considered for continuous improvement.

4. Systematically apply an intersectional approach to policy design, implementation and evaluation

Health policies can only achieve their objectives if they are implemented from an intersectional approach. Women are diverse and policies need to recognize this rich diversity of experiences and needs, and take into account factors such as class, ethnicity, sexual orientation and territory in order to provide appropriate and differentiated health responses.

5. Provide ongoing training for health workers

Eliminating patriarchal structures and building systems that transform gender inequality implies a major effort that includes the re-education of health professionals in quality care, respect for women's rights and gender equality, as well as the development of internal policies that sanction machista practices that reproduce violence within the systems, along with policies that promote and reinforce these changes. Staff training policies must be continuous, not sporadic or intermittent, to avoid the loss of skills in the systems due to turnover and mobility of health personnel.

6. Proactively promote inter-institutional alliances from the health system.

Health systems must be proactive in generating inter-institutional and intersectoral alliances, although the leadership of the actions can often be other institutions, as in the case of the interaction of the public health system with the educational sector. This intersectoral alliance aims to strengthen education in equality and human rights, with special emphasis on integral sexual education that can contribute to improved erotic, sexual-affective and family relationships, and to the construction of less violent societies.

Likewise, social organizations and the health system know the territories and their problems, while institutions such as the police, public prosecutor's office, ministries of women, family, social affairs, etc. have the conditions to contribute to the prevention and guarantee of justice in the face of gender violence. The design of intersectoral and inter-institutional policies led and / or promoted by transformative health systems, respectful of women's rights and diversity, accompanied in the territory by social organizations, can positively influence the work of other institutions. These synergies can contribute to removing the machista structures of these institutions and undermine the patriarchal structures of the state, sowing the seeds for institutions to design and promote gender-transformative policies.

Conclusion

Gender transformative public health services represent a historic opportunity to reshape social structures that perpetuate inequality and discrimination. Through these case studies from Nigeria, India and Paraguay, it is evident that although health systems face structural challenges, such as lack of funding, persistent patriarchal norms and the gap between policy and implementation, there are significant advances that demonstrate the viability of this approach. Gender transformation in health is not just about ensuring equitable access to services; it involves dismantling the power dynamics that marginalize women and other non-binary identities, and reframing quality of care as an enforceable right.

One of the central conclusions is that women's autonomy in making decisions about their sexual and reproductive health must be a fundamental pillar of any transformative policy. However, this cannot be achieved without a strong alliance

between health systems, social movements and communities. The active participation of these actors is crucial to ensure that policies are not only gender-sensitive but also challenge the social norms that perpetuate violence and exclusion and become gender transformative.

In addition, ongoing training of health workers in intersectional approaches and human rights is essential to avoid re-victimization and to ensure empathetic and quality care. The cases analyzed show that, even in resource-limited contexts, training and sensitization can make a significant difference to the experience of people affected by intersectional discrimination.

Gender transformative health systems cannot therefore operate in isolation. They require inter-agency and inter-sectoral partnerships that address multiple dimensions of inequality, from education to justice. The experience of Nigeria, where social mobilization achieved progress in liberalizing abortion, and Paraguay, where feminist organizations have been key in caring for victims of violence, underline the importance of civil society as a driver of change.

Finally, gender transformation in the health system is not only a possible goal, but an ethical and political obligation. States have the responsibility to lead this process, but its success will depend on their ability to integrate all social actors in a collective effort to build health systems that not only heal but also empower and emancipate. The road ahead is complex, but the progress made in various contexts shows that, with political will and social commitment, it is possible to move towards truly transformative public health.

Reference List

1 Montufar M, Aye B, Barria S. Emphasis on Gender-Transformative Approaches to Women's Health: Studies on India, Paraguay, and Nigeria. Public Services International. 2023; Available from: https://bit.ly/4jT9Gso

2 PAHO. Fiscal Space For Health in Latin America and the Caribbean. Washington, DC: Pan American Health Organization; 2020.

3 Amnesty International. Paraguay: La deuda de la salud (The health debt). Amnesty International; 2024 May. Report No.: AMR 45/7965/2024. Available from: https://bit.ly/4mzaJQE

4 Martin M. Política de salud sexual y reproductiva en la atención a víctimas de violencia. Paraguay: Public Services International; 2023 Nov. Available from: https://bit.ly/3ZshIAD

5 Mathew A. Activists hail SC judgment stressing on rights-based perspective for women to seek abortion. National Herald. 2022 Sep 29; Available from: https://bit.ly/4cSygYj

6 Bajoria J. Doctor's Rape, Murder in India Sparks Protests. Human Rights Watch. 2024 Aug 15; Available from: https://bit.ly/42zeSfq

7 Sama. People are under lockdown, gender based violence is not: Responding to the crisis of gender based violence amidst the lockdown. Sama - Resource Group for Women and Health. 2020. Available from: https://bit.ly/45pKQfM

8 Abimbola O. Nigeria moves five spots to 125th on global gender ranking. Punch. 2024 Jun 19; Available from: https://bit.ly/3Gq04qD

9 WHO. Maternal health in Nigeria: generating information for action. World Health Organization: Departmental update. 2019 Jun 25; Available from: https://bit.ly/3ZwERlz

10 Akande OW, Adenuga AT, Ejidike IC, Olufosoye AA. Unsafe abortion practices and the law in Nigeria: time for change. Sexual and Reproductive Health Matters. 2020 Jan 1;28(1):1758445. Available from: https://bit.ly/3Ykaj6e

11 Oyinlola FF, Kupoluyi JA, Adetutu OM. Changes in unmet need for family planning among married women of reproductive age in Nigeria: A multilevel analysis of a ten-year DHS wave. Bolarinwa O, editor. PLoS ONE. 2024 Aug 2;19(8):e0306768. Available from: https://bit.ly/3S9z9C3

12 Solanke BL, Adetutu OM, Rahman SA, Soladoye DA, Owoeye MO. Prevalence and determinants of unmet need for contraception among women in low and high-priority segments for family planning demand generation in Nigeria. Arch Public Health. 2022 Nov 21;80(1):239. Available from: https://bit.ly/3GwPL4c

13 Abubakar I, Dalglish SL, Angell B, Sanuade O, Abimbola S, Adamu AL, et al. The Lancet Nigeria Commission: investing in health and the future of the nation. The Lancet. 2022 Mar;399(10330):1155–200. Available from: https://bit.ly/4jTxmwU

14 Omotosho O. Socioeconomic and Policy Context of the Nigerian Health Care Financing System: A Literature Review. International Affairs and Global Strategy. 2017;53:8–16. Available from: https://bit.ly/42wXWGj

15 Ajisegiri WS, Abimbola S, Tesema AG, Odusanya OO, Peiris D, Joshi R. The organisation of primary health care service delivery for non-communicable diseases in Nigeria: A case-study analysis. Shivashankar R, editor. PLOS Glob Public Health. 2022 Jul 1;2(7):e0000566. Available from: https://bit.ly/3Gxp7bt

16 Akiyode-Afolabi A. Linking Sexual and Reproductive Health with Gender-Transformative Quality Public Services [Internet]. Public Services International; 2023 Nov. Available from: https://bit.ly/44MDe6F

17 Akiyode-Afolabi A. Linking Sexual and Reproductive Health with Gender-Transformative Quality Public Services [Internet]. Public Services International; 2023 Nov. Available from: https://bit.ly/44MDfaJ

18 World Bank. Gender data portal. Available from: https://bit.ly/42A3csS

19 Roy CM, Bukuluki P, Casey SE, Jagun MO, John NA, Mabhena N, et al. Impact of COVID-19 on Gender-Based Violence Prevention and Response Services in Kenya, Uganda, Nigeria, and South Africa: A Cross-Sectional Survey. Front Glob Womens Health. 2022 Jan 27;2:780771. Available from: https://bit.ly/435GOaM

20 Fawole OI, Okedare OO, Reed E. Home was not a safe haven: women's experiences of intimate partner violence during the COVID-19 lockdown in Nigeria. BMC Women's Health. 2021 Dec;21(1):32. Available from: https://bit.ly/3EHL7Qs

21 UN. Global database on violence against women [Internet]. Available from: https://bit.ly/4mvmoj6

Abolition medicine as a tool for health justice

Introduction

How similar is a policeman to a doctor? A prison to a hospital? Or a mental health nurse to a 'correctional officer'?

The criminal justice and healthcare systems are public services that appear at different ends of a spectrum; one purportedly deals in care and well-being, the other in crime and punishment. We suggest that they have more in common than might initially appear, and that severing their relationship can help to transform society in pursuit of liberatory visions for health and healthcare.

This chapter introduces an abolitionist approach to health, both as an analytic tool and framework for action, which is often overlooked by health justice activists. 'Abolition medicine' provides a critical lens through which to understand the current landscape of community health and its relationship to policing and incarceration. It also serves as a scaffold for the reorganization of community healthcare. The chapter spotlights two case studies in which the principles of an abolitionist approach to community health are applied.

Capital's coercion: the shared histories of biomedicine and policing

The lineages of biomedicine and policing are intertwined with the emergence of global capitalism and its modern state. To understand the importance of an abolitionist framework for liberatory healthcare, we must read them both as part of this brutal history. The lynchpin of these stories is race. Race, born of colonialism, is a necessary feature of global capitalism, rather than an incidental aberration.[1] The histories of biomedicine and policing are of integral significance for two important reasons: the **production and enforcement of racial hierarchy** and the **disciplining of a racially segmented global labor force**.

Production and enforcement of racial hierarchy

Through different strategies, both biomedicine and policing produce a deviant, *racialized* 'other', generating the hierarchical group-differentiation that is foundational to capitalism. Biomedicine underwrote a biological basis for race, heralded by the pseudoscientific study and practice of eugenics that continues to inform healthcare today, whether in our clinical algorithms or how the state treats disabled people.[2] Indeed, eugenics has been preoccupied with linking "mental defect" with "crime, prostitution [and] pauperism" since the early 1900s.[3] Practitioners of colonial medicine, particularly on the African continent, claimed a more benevolent 'civilizing' motive than their eugenicist peers, locating critical etiological

components of tropical diseases in the supposed moral, cultural and intellectual inferiority of 'Africans'.[4] The coercive technologies enforcing these were often tested in brutal circumstances before being imported back to the metropole – known as the imperial boomerang. Eugene Fischer, a colonial professor of medicine and eugenics, conducted forced sterilization experiments on Herero women in what is now modern-day Namibia, before transposing his work back to Nazi Germany to be applied directly in the concentration camps.[5] Meanwhile, policing (re)produced forms of legal and cultural categorization; the racial constitution of 'suspect communities' is evident in the colonial origins of policing, whether the first formulation of the Royal Irish Constabulary, or the refinements of policing techniques in Kenya, Algeria and the Philippines.[6,7]

Disciplining racialized labor

Policing and biomedicine have functioned as essential instruments for the disciplining of labor into a racially organized global production process. Capitalism transformed the world by both enclosing land and compelling sections of the dispossessed into industrial labor, where profits depended on maximizing output per unit time. In dialectic with the racial categorization described above, populations were marked for different biological destinies.[8] 'Free' wage, indentured and enslaved workers were all coerced into work, but the range in forms of exploitation and resistance produced different forms of policing, from slave codes and patrols to Coolie Ordinances to the Metropolitan police.[9,10] Meanwhile, those deemed bio-culturally incapable of 'proper' work faced mass death enforced by the policing of the enclosures, as with the Irish Constabulary or the Rangers and Mounties.[11,12]

Institutionalization – the mass warehousing of those deemed 'mentally ill' – developed in this context. None but the most able-bodied survived factory conditions. Simultaneously, the informal provision of care through social networks vanished as agricultural peasants became a working class with even less control of their time.[13] Within this, as Frazer-Carroll writes, the asylum – employing barbaric 'treatments' – threatened the fate of those who could not, or did not, cede to the demands of those who owned the means of production.[14] The use of medical diagnoses for labor discipline extends beyond psychiatry and the psy-disciplines; biocertification – the means by which biomedicine is used to verify claims of illness for the purpose of access to state resources such as social security payments – tightly controls people, and where possible directs them back to work. Under capitalism, illness is simply our distance from productivity.[15]

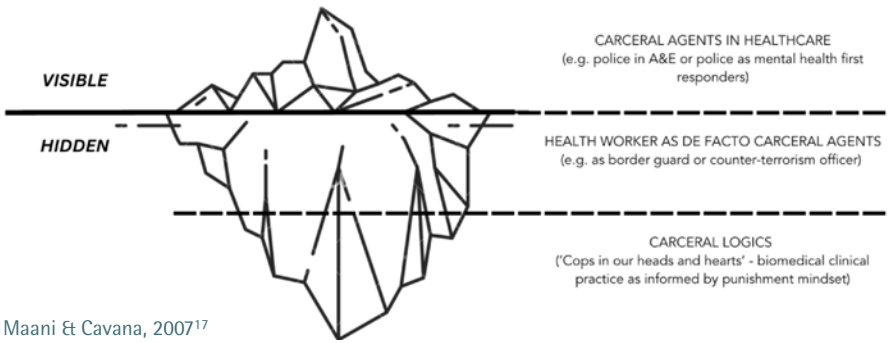
Cops as health workers – health workers as cops

These histories bring us to the present-day realities of prisons, policing and health. Most of you reading this will know how harmful policing is to health – whether in the form of direct police brutality, surveillance tactics or consequent trauma.[16] Prisons produce sickness through poor living and working conditions,

lack of access to healthcare and their profound impact on mental health. Border policing regimes kill and maim, their immigration detention practices no different from prisons and are often operated by the same multinational security conglomerates, such as G4S and Geo Group. Police and paramilitary forces have crushed Global South movements that had – or otherwise sought to – transform their public services and infrastructures, often with deadly health consequences (see Chapter B1). Chile is one striking example, where the state continues to grapple with the legacy of the US-installed Pinochet regime and his roll back of community health programs set up by his socialist predecessor, Allende.

Less attention has been afforded to the malignant invasion of policing and prisons into healthcare. This invasion makes perfect sense if we remember the functions of categorization and socio-political control that are shared by both of these arms of the state, in service of protecting capital and its accumulation. We can understand this in three layers as represented in Figure 1.

Figure 1: Visible and hidden levels of carcerality within healthcare. Adaptation of systems thinking 'iceberg model'



Maani & Cavana, 2007[17]

The militarized securitization of health is the first and most visible layer and refashions public health as a matter of national security, rather than of collective wellbeing and flourishing. Healthcare has long-standing importance in foreign policy; during the invasions of Iraq and Afghanistan, for example, it formed the basis of so-called counter-insurgency strategies.[18] More recently, the COVID-19 pandemic increased police powers around the world, such that they became arbiters of quarantine and lockdown measures, disproportionately targeting the homeless and precariously housed, sex workers and the poor, in the name of public health. Other examples include the presence of police in hospital emergency rooms, or the deployment of police as first-responders to mental health emergencies.

The second layer is within healthcare itself. The Hippocratic Oath that affirms a commitment to confidentiality and patient autonomy has been widely eroded by statutory duties that (re)cast the healthcare worker as police officer, counter-terror agent and border guard. Porous information-sharing between government agencies means that those people with insecure immigration status or who use criminalized

substances are at risk of deportation or incarceration. Surveillance technology companies that have been awarded contracts to manage public data – such as Palantir – have further dissolved firewalls that should exist between different government agencies, and between the public and private sectors (see Chapters B2 and A1).[19]

These examples understand health workers and those within policing, prisons or border enforcement agencies as colluding but otherwise distinct entities. Yet frameworks of punishment also undergird mainstream clinical practice itself – a third layer. Health workers and health systems often allocate attention and resources based on assigned 'deservingness' rather than clinical need. In many of these cases, patients are blamed for their sickness, while their symptoms are simultaneously disbelieved. Certain patients – distinguished by race, class, gender and ability – draw compassion, while others draw contempt, and are accused of malingering or feigning symptoms.

Examples are plentiful. Patients considered obese receive systematically worse healthcare, from both individual clinicians and a system that ascribes personal responsibility as the primary determinant.[20] 'Clinically' defined obesity is a poor proxy for health, and multifactorial in origin; risk factors are diverse, spanning early life trauma, air pollution and mental health conditions. Yet despite widespread acceptance of its pseudoscientific roots, body mass index continues to be used as a core clinical tool that designates access to life-changing care such as fertility treatment or joint replacements for arthritis. Racialized women are disproportionately affected across clinical specialties.[21] Other blamed and dismissed cohorts include people with addictions and those with particular mental health diagnoses such as personality disorders. In such cases, other important medical conditions are frequently misattributed to these diagnoses – termed 'diagnostic overshadowing'. The clinical consequences of such systematized negligence can be fatal.

Incorporating a critical and integrated approach that works to unpick the stitches of coercion and violence that weave together the worlds of medicine and policing is imperative for health justice activists. For this, we turn to the abolitionist tradition.

So – what is abolition then?

Initially a term born out of organized opposition to the transatlantic slave trade, the contemporary abolitionist movement refers to the dismantling of the 'prison-industrial complex' (PIC), comprising "overlapping interests of government and industry that use surveillance, policing, and imprisonment as solutions to economic, social and political problems".[22] The PIC has a central structuring logic: carcerality. Carcerality refers to the use or threat of punishment using different forms of violence to exert disciplinary control. PIC abolition seeks to break these cycles of violence and to build a society of life-affirming institutions that function to transform the root causes of criminalized behaviors: disproportionately material deprivation, secondary to racialized capitalism.[23]

There is no comprehensive 'theory' of PIC abolition. This is partly a reflection of a movement that rose from the ground up, rather than from within the academe.

However, there are several facets that commonly structure its practice, as set out in Table 1.

Table 1. Some core tenets of PIC abolition

CORE TENETS OF AN ABOLITIONIST POLITIC	
Root cause analysis	Abolitionist politics demand that we trace criminalized behaviors to the underlying conditions that both compel violence, and that understand police and prisons as the optimal response. It proposes that the process of criminalization obscures the complexity of situations, and skews lines of accountability towards individuals and away from overarching systems and structures.
Rehearsal + experimentation	Crucially, PIC abolition commits to the perpetual practice of "rehears[ing] the social order coming into being".[24] Abolition is propositional. The call to 'abolish' seeks to create space for different – sometimes new, though often not – postures, orientations and approaches to conflict.
Transformative justice (i.e. against punishment)	Our commonly socialized responses to perceived harm place blame on the individual, or their community, and punish them. This is applied most visibly by the judiciary but provides the blueprint for the dynamics of our interpersonal responses to harm and violence. Abolition imagines and practices a world without these carceral logics of punishment. Instead, it leans towards frameworks such as transformative justice, that attend to victims, perpetrators and the community around both in a bid to break cycles of violence and prevent the conditions that may produce future harm.
Critical perspectives on the state	Abolitionists are critical about the radical potential of the state. By seeing the state not as an abstract or amorphous entity distinct from society but instead understanding the two as one and the same, we can complicate how the state acts, in whose interests, and why. We can contest the idea that the state can ever be truly benevolent, or that it can do so without wanting something in return (e.g. labor).

What is the role of abolition in the struggle for health?

What, then, constitutes an abolitionist approach to health?

The worlds of abolition and health justice were only explicitly brought together in 2020. Much of the existing writing on an abolitionist approach to health – also termed abolition medicine – relates to the US context. It disproportionately focuses on racist policing, particularly in the form of direct brutality, as a threat to public health. This chapter encourages a more expansive understanding of abolition medicine.[25]

Abolition medicine most obviously involves rejecting the in-reach of the PIC into healthcare. This means demanding, for example, no police in emergency rooms or indeed anywhere in hospitals. It means no data-sharing between healthcare and immigration services or the police. It means no police as first-responders to mental health crises, and means supporting harm reduction approaches to substance use, rather than criminalization.

By recognizing deeper similarities between biomedical healthcare and the PIC, several other important elements of abolition medicine emerge. Abolition medicine takes time to understand individuals and communities in their broader context and history, and to chart the course of sickness with a political analysis, rather than reducing people to proxies of diagnoses and social categories. Support is compassionate rather than punitive.

Abolition medicine also understands the need for distributive care, where decision-making power and access to healing resources is not concentrated among a few and hands back autonomy for the organization and delivery of healthcare to communities. Abolition medicine is propositional and experimental, and fundamentally commits to a redistribution of power. It demands that healthcare workers, particularly doctors, hold less disciplining influence.

Who can we learn from?

Communities have practiced abolition medicine around the world for as long as practices of domination and exploitation have existed. Below, we draw out four key spheres of healthcare that particularly demand an abolitionist approach, along with some examples within each of these spheres that have been documented. Notably, most case studies documented in the literature focus on practices in Europe and the US.

Case Studies

However, as the preceding section suggests, the domain of abolition medicine is neither tightly defined nor prescriptive. There are many examples of abolition medicine in practice that may not define themselves as such, but which fulfil some or all of the important elements of it. Below are two such examples.

Table 2. Key domains of abolitionist approaches to health

Mental health	There is a strong tradition of critical engagement with the carcerality of psychiatry and the psy-disciplines more broadly, from within and outside the spheres of healthcare, starting from the anti-psychiatry movement of the 1960s. Although the details vary, these traditions broadly understand involuntary detention and restraint (both physical and chemical), ubiquitous in mainstream psychiatry, as clear forms of punitive incarceration, and to differing extents call for their abolition in practice. The Trieste model in Italy, represents one long-standing prototype for anti-carceral community mental healthcare, founded by one of the key figures in the anti-institutionalization movement, Dr Franco Basaglia.[26] Mobile mental health crisis response units are another example, such as Crisis Assistance Helping out on the Streets (CAHOOTS) that began in the US state of Oregon in 1989, with similar programs scaling up in much of the country and in Europe.[27]
Autonomous community healthcare	Autonomous healthcare refers to healthcare provided outside formal state structures, where decision-making is horizontal, and care is stewarded by and for the community. This is something that the Zapatistas in Chiapas have been concretely developing for several decades.[28] The People's Free Medical Clinics run by the Black Panther Party across 13 US cities in the 1960s and 1970s delivered care to Black communities that had been systematically abandoned across the country.[29] In New York, the Young Lords, a revolutionary group founded in the 1960s by radical, working-class Puerto-Rican youths, coalesced the Health Revolutionary Unity Movement (HRUM).[30] Their demands centered around an expansive and liberatory public health. All these movements understood healthcare as a critical site of material struggle which, if left to the state or to those outside specific communities, would not provide healthcare with an orientation towards greater community autonomy and freedom

Continues on next page

Table 2, continued. Key domains of abolitionist approaches to health

Access to healthcare for the criminalized	The criminalization of access to healthcare by structurally marginalized groups – e.g. sex workers, undocumented migrants or intravenous drug users – has severe health repercussions. In this vein, actions disrupting the surveillance and prosecution of these communities' access to healthcare constitute abolition medicine. This might include clinics – such as by Doctors of the World – that provide free and no-questions-asked healthcare to asylum seekers, or mobile clinics for sex workers.
Harm reduction	A portion of practices of abolition medicine fall under what is known in public health terms as 'harm reduction'. Here, we understand the term not in sterile, instrumental policy terms, but as 'liberatory harm reduction', a longstanding grassroots self-advocacy and mutual aid practice led by and for the likes of Black trans and queer people, sex workers and intravenous drug users.[31] Although these practices are usually through informal networks, there are some examples of formally organized work in South Africa such as the Community Oriented Substance Use Program and, historically, the work by the AIDS Coalition to Unleash Power (ACT UP).[32, 33]
Reproductive justice	The coercive control and violation of birthing bodies has been part of the exercise of colonial and neocolonial power and remains a live issue in most of the world. Reproductive justice is defined "as the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities".[34] Abolitionist medicine examples here include work by organizations such as Women on the Waves, that looks to expand access to abortion care, and others such as the Feminist Resource Centre in Bombay and attendees of the Encuentros Feministas Latinoamericanas y del Caribe, who organized against and resisted neocolonial population control measures through so-called 'family planning'.[35]

Case study I: healthcare in Rojava, Kurdistan

What is it?

Rojava – also known as Autonomous Administration of North and East Syria (AANES) – is a multi-ethnic de-facto autonomous territory in what is currently occupied West Kurdistan. It is governed under a structure of democratic confederalism, as pioneered by exiled revolutionary and founder of the Kurdish Workers' Party (PKK), Abdullah Öcalan.

To understand its healthcare, it is important to know a little about the politics of Rojava. The three core pillars of the 'Rojava Revolution' are direct democracy, women's liberation and social ecology. Within this is an assertion that "health care as commodified by capitalist modernity has manufactured demand for dubious services and made people dependent on them".[36]

There are three key intentions to healthcare in Rojava:[37]

1. To solve the problem of relations between health and power/the party
2. To critique and rebuild the relationship between society and doctors
3. To return ownership of health to society

Under democratic confederalism, power and decision-making are decentralized. The smallest and most important unit is that of the commune, comprising anywhere from 10 to 150 families. These function as direct democracies and receive 70% of central funding. Representatives from the commune level then feed into larger units – neighborhood, district then canton. Different committees attending to key areas of societal need exist at each level of governance. The health committee is one.

Each of these health committees organizes a health assembly or *meclîsa tendurustî*. These comprise participants across disciplines and include not just health workers (doctors, nurses, pharmacists and so on) but also journalists, cross-sectoral union representatives, municipality leaders and representatives from the war-wounded. They also draw across ethnicities, not only Kurdish, but Aramaic, Assyrian, Yazidi and Arab. Key decisions are made in these assemblies. Accountability is core – all meetings can be attended by the public, with written and video records available. Healthcare itself is delivered through a mixture of hospitals and community health centers at low cost, though no-one is turned away for lack of ability to pay.

In addition to healthcare itself, health education is a central priority, and part of the strategy that looks to devolve health knowledge. Seminars and workshops are widespread as part of popular education programs, carried out in settings ranging from people's houses (*mala gel*) to secondary schools and youth centers. These cover topics such as basic first aid in case of medical emergencies and more advanced interventions.[38]

How is it an example of abolition medicine?

Rojava constitutes one of the world's largest abolitionist polities – an estimated 4.7 million people live in the autonomous territories – on account of its structures of self-defense and conflict resolution.[39] Autonomy is perhaps the most critical structuring principle within Rojava – and threading this through its practice (and aspirations) for healthcare in the region is what animates the abolitionist element of this 'medicine'.

Healthcare is built as communal, rather than public or private, with an explicit intent to interrupt the relationship between healthcare and the power of the state. There is a clear understanding that capitalism has commodified health, shifting the focus away from prevention. The focus on health education is also powerful. Increasing levels of medical education amongst the general population both liberates knowledge from healthcare professionals and facilitates greater autonomous decision-making at every level.

What questions does this ask of us as health justice activists?

- What becomes possible when the autonomy of communities is truly centered, instead of their control?
- What happens when decisions about health and healthcare are actually made by those outside of simply healthcare?

Case study II: the care clinic – Para, Brazil

What is it?

There is a textured history of the 'psy-' disciplines in Brazil. Birthed from the womb of the military dictatorship in the second half of the 20th century – and the capitalist path to 'national development' that it espoused – these disciplines subscribed to a biological model that localized liability of emotional distress to individuals, and were mainly accessible to the wealthy, via private consultations.[40] As the power of social movements grew in the 1980s, the field quickly found itself in critical discourse with more radical traditions of both liberation and community psychology. This manifested as a distributed movement of psychotherapy that claimed no leader and was intended *for the people* – typified by one emerging practice termed 'psicanálise na rua' (literally 'psychoanalysis on the street').[41]

It is from this soil that the Care Clinic – 'clínica do cuidado' – grew on the banks of the Xingu River of the Brazilian Amazon. It came about as a specific response to the violent dispossession wrought by state and corporate interests on the *Ribeirinhos* or river-dwelling communities, in order to build the Belo Monte Hydroelectric Power Plant in the early to mid-2010s. Over 20,000 people were evicted, most relocated to urban housing well away from the riverbanks upon which most relied for cultural subsistence.

The clinic was mobile and grounded in two key principles – listening and testimony. It rejected a medicalized analysis structured around mental health diagnosis and intentionally avoided a frame that focused only on individual 'suffering'. Instead, it oriented "to favor or trigger a process of mourning, to reposition group identifications, to narrate suffering, to address them to new social resistance practices and to the new methods of treatment available, to recompose critical situations in interpersonal terms resulting from the installation and fragmentation of families and their lifestyles".[42] Crucially, the care was deeply imbued with a political analysis that understood the material and historical perspective to the mental health issues faced within the community.

How is it an example of abolition medicine?

The Care Clinic operated at sites of contestation and expropriation, working closely with local social movements. The clinic explicitly rejected the limited frame of (bio)medicalization to make sense of the experiences and impacts of dispossession, resisting the use of straightforward diagnostic categories and attendant management that characterizes mainstream mental healthcare. The referral system was informal, where existing networks of mutual aid and care provided recommendations for who might benefit from the input of the clinic. It represents experimental and responsive care that did not rely on the structure or funding of the state. Furthermore, the therapeutic approach was fundamentally structural. It was spacious enough to hold the collective experience of displacement not only alongside, but in relation to that of the individual. And clinical encounters were held within a critical perspective on relation to work, exploitation and economic dispossession.

What questions does this ask of us as health justice activists?

- What if we focused on bearing testimony and witnessing as optimal conditions for healing and transformation, rather than diagnostic criteria?
- What constitutes the spatialities of a clinic – and what becomes possible when the clinic is a collective entity, rather than focused on the individual?
- How might such approaches to mental health stoke a collective revolutionary consciousness that makes taking organized political action to transform healthcare more possible?

Conclusion

Abolition medicine calls us into orientations of counter-hegemony, demanding our rejection of norms – race, gender, 'able'-bodiedness – that structure the relations of exploitation. Tracing the intimate histories of biomedicine, policing and prisons draws our attention to their enduring interdependence, not only in our current system of healthcare, but across society as a whole. Though the

terminology is nascent, communities have been building and practicing abolitionist alternatives to coercive forms of healthcare for generations.

An abolition medicine calls into dialogue the spheres of health justice and PIC abolition set out above. It provides a cohesive political analysis across healthcare and the PIC as comparable forms of carceral state violence. This invites solidarity between spaces that may be siloed – health activists struggling for health equity (particularly racial equity in health) on one side, and anti-police/prison organizers on the other. It is an opportunity to build power across struggles and to proliferate a health justice analysis outside the traditional health worker space, while deepening health activists' analysis of violence.

At its core, as set out in the Alma Ata declaration and in successive global people's health movements, abolition medicine speaks to a political orientation that places care over coercion, where the needs of everyone in the community are heard and met. It speaks to a democratization of who controls the means and priority-setting of health and care systems for the community, away from profit-oriented providers. Crucially, its demands explicitly include the defunding and dismantling of policing and the PIC. Abolition medicine proposes a liberatory vision for health(care) that is anti-capitalist, autonomous and internationalist – and invites us to practice it now.

Reference List

1 Singh NP. On Race, Violence, and So-Called Primitive Accumulation. Soc Text. 2016 Sep 1;34(3):27–50. Available from: https://bit.ly/4ju3siW

2 Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms. N Engl J Med. 2020 Aug 27;383(9):874–82. Available from: https://bit.ly/42TCZEq

3 Lombardo PA. "Ridding the Race of His Defective Blood" — Eugenics in the Journal, 1906–1948. N Engl J Med. 2024 Mar 6;390(10):869–73. Available from: https://bit.ly/43kGnsn

4 Tilley H. Medicine, Empires, and Ethics in Colonial Africa. AMA J Ethics. 2016 Jul 1; 18(7):743-53. Available from: https://bit.ly/43dxYYw

5 Russell A. 20th Century's First Genocide: Hereros. Aegis Trust. 2015 [cited 2025 Feb 16]. Available from: https://bit.ly/3RNABKl

6 Makalintal, J. Dismantling the Imperial Boomerang: A Reckoning with Globalised Police Power. Longreads: Transnational Institute; 2021 May [cited 2025 Feb 16]. Available from: https://bit.ly/44gnKI5

7 Elliott-Cooper A. Black Resistance to British Policing. Manchester University Press; 2021. Available from: https://bit.ly/3EVS1kX

8 Wolfe P. Traces of History: Elementary Structures of Race. Verso Books; 2016. Available from: https://bit.ly/4d1SP4H

9 Storch RD, Engels F. The Plague of the Blue Locusts: Police Reform and Popular Resistance in Northern England, 1840–57. Int Rev Soc Hist. 1975 Apr;20(1):61–90.

10 Li TM. The Price of Un/Freedom: Indonesia's Colonial and Contemporary Plantation Labor Regimes. Comp Stud Soc Hist. 2017;59(2):245–76. Available from: https://bit.ly/3RJDETK

11 Bhandar B. Colonial Lives of Property: Law, Land, and Racial Regimes of Ownership. DukeUniversity Press; 2018. Available from: https://bit.ly/4lVqbpB

12 Graybill AR. Policing the Great Plains: Rangers, Mounties, and the North American Frontier, 1875-1910. Nebraska Paperback; 2007. Available from: https://bit.ly/3RKCeII

13 Oliver M. The Politics of Disablement — New Social Movements. In: The Politics of Disablement. London: Macmillan Education UK; 1990 [cited 2025 Feb 16]. p. 112–31. Available from: https://bit.ly/4k2Gb7D

14 Frazer-Carroll M. Mad World: The Politics of Mental Health. Pluto Press; 2023. Available from: https://bit.ly/42Ybn10

15 Frazer-Carroll M. Mad World: The Politics of Mental Health. Pluto Press; 2023. Available from: https://bit.ly/42Ybn10

16 Bor J, Venkataramani AS, Williams DR, Tsai AC. Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study. The Lancet. 2018 Jul 28;392(10144):302–10. Available from: https://bit.ly/44fdJeb

17 Maani KE, Cavana RY. Systems thinking, system dynamics: managing change and complexity. 2. ed., repr. Rosedale: Pearson Prentice Hall; 2010. 278 p.

18 Ricks TE. Health care in insurgency and counter-insurgency: Some lessons from others. Foreign Policy. 2015 [cited 2025 Feb 16]. Available from: https://bit.ly/3GPunHp

19 Health Workers for a Free Palestine (UK). How is your health data linked to Israeli occupation?. Shado Magazine. 2023 [cited 2025 Feb 16]. Available from: https://bit.ly/3Z0r6LE

20 McPhail D, Orsini M. Fat acceptance as social justice. CMAJ Can Med Assoc J. 2021 Sep 7;193(35):E1398–9. Available from: https://bit.ly/3GCG9ox

21 Strings S. How the Use of BMI Fetishizes White Embodiment and Racializes Fat Phobia. AMA J Ethics. 2023 Jul 1;25(7):535–9. Available from: https://bit.ly/4jWXQgO

22 Critical Resistance. Critical Resistance. 2022 [cited 2025 Feb 16]. What is the PIC? What is Abolition? Available from: https://bit.ly/3GPuz9B

23 Davis AY, Dent G, Meiners ER, Richie BE. Abolition. Feminism. Now. Vol. 2. Haymarket Books; 2022.

24 Wilson Gilmore R, Gilroy P. In conversation with Ruth Wilson Gilmore. [cited 2023 Sep 23]. Available from: https://bit.ly/4k13pLr

25 Kaner E. Abolition Medicine: Dismantling Carceral Logics in Healthcare. NSUN website. 2021 [cited 2023 Sep 17]. Available from: https://bit.ly/3RH7rwt

26 Foot J. Franco Basaglia and the radical psychiatry movement in Italy, 1961–78. Crit Radic Soc Work. 2014 Aug 1;2(2):235–49. Available from: https://bit.ly/4k2XOnW

27 Waters R. Enlisting Mental Health Workers, Not Cops, In Mobile Crisis Response. Health Aff (Millwood). 2021 Jun;40(6):864–9. Available from: https://bit.ly/4jw3IOo

28 Rebrii, A. Zapatistas: Lessons in community self-organisation in Mexico. openDemocracy. 2020 [cited 2023 Sep 17]. Available from: https://bit.ly/3YWCdFm

29 Bassett MT. Beyond Berets: The Black Panthers as Health Activists. Am J Public Health. 2016 Oct;106(10):1741–3. Available from: https://bit.ly/4ju54t0

30 Fernández J. The Young Lords' Public Health Revolution: Fifty years ago, the Young Lords occupied Lincoln Hospital in the Bronx and won concrete advances in services and patients' rights. Their legacy of radical health activism illuminates the inhumanity of for-profit medicine and the urgency of winning free healthcare for all. NACLA Rep Am. 2020;52(3):339–47. Available from: https://bit.ly/4lVAnP2

31 Hassan S. Saving our own lives: a liberatory practice of harm reduction. Haymarket Books; 2022.

32 Scheibe A, Shelly S, Hugo J, Mohale M, Lalla S, Renkin W, et al. Harm reduction in practice – The Community Oriented Substance Use Programme in Tshwane. Afr J Prim Health Care Fam Med. 2020 May 6;12(1):2285. Available from: https://bit.ly/4lSMFb7

33 Johnson S, Sue KL. Drawing on Black and Queer Communities' Harm Reduction Histories to Improve Overdose Prevention Strategies and Policies. AMA J Ethics. 2024 Jul 1;26(7):580–6. Available from: https://bit.ly/44Q8ilZ

34 Ross L. Understanding reproductive justice. In: McCann CR, Kim SK, Ergun E, editors. Feminist theory reader: local and global perspectives. New York, NY: Routledge; 2020. p. 77–82.

35 Bracke MA. Contesting 'Global Sisterhood': The Global Women's Health Movement, the United Nations and the Different Meanings of Reproductive Rights (1970s–80s). Gend Hist. 2023;35(3):811–29. Available from: https://bit.ly/42Vkr6R

36 Knapp M, Flach A, Ayboğa E, Graeber D, Abdullah A, Biehl J. Health Care. In: Revolution in Rojava. Pluto Press; 2016 [cited 2024 Dec 10]. p. 185–91. (Democratic Autonomy and Women's Liberation in Syrian Kurdistan). Available from: https://bit.ly/3YTfBpd

37 Woodbine. Fight Like Hell for the Living. 2017 [cited 2025 Feb 17]. Available from: https://bit.ly/3EQ89of

38 Knapp M, Flach A, Ayboğa E, Graeber D, Abdullah A, Biehl J. Health Care. In: Revolution in Rojava. Pluto Press; 2016 [cited 2024 Dec 10]. p. 185–91. (Democratic Autonomy and Women's Liberation in Syrian Kurdistan). Available from: https://bit.ly/3YTfBpd

39 Salih MA. Syria's Kurdish Northeast Ratifies a New Constitution. New Lines Magazine. 2024 [cited 2025 Feb 17]. Available from: https://bit.ly/3EK7pRy

40 Castro L, Guzzo RSL. Community and Politics: Decolonizing Psychology in Brazil. Community Polit Decolonizing Psychol Braz. 2024 Jan 1 [cited 2025 Feb 17]; Available from: https://bit.ly/4jXbpNp

41 Neto AC, Guimarães T. A experiência brasileira da psicanálise na rua. Teoría Crítica Psicol. 2019 Mar 19;12:290–1.

42 Katz I, Dunker CIL, Rezende R de N. Care Clinic on the Banks of the Xingu River: A Psychoanalytic Intervention with the Riverine Population Seriously Affected by Belo Monte. Rech En Psychanal. 2019;27(1):49a–58a.

Decolonizing Global Health

Introduction

The last few years have seen a rise in interest and discussion about 'colonialism' and 'coloniality' in many mainstream global health academic journals and forums.[1,2,3] Much of this recent interest within global health circles arose from broader societal conversations, including those arising from student protests on various university campuses against monuments and plaques celebrating individuals involved in European imperialism and the slave trade, as well as criticisms about the Eurocentricity of much academic literature and practice, including within the fields of medicine and public health.[4]

Running alongside this interest in the legacies of colonialism was a surge in attention and anger about racism, precipitated in part by the shocking killing of George Floyd by police in the United States in 2020. Across the world, anti-racist demonstrations helped draw attention to the existence of racialized power structures, including within the global health community.[5]

For those who work on the social determinants of illness, disease and health inequalities, this rise in interest in colonialism, coloniality, racism and inequity were welcome, drawing attention to a large body of social epidemiology that describes how the unequal distribution of social, economic, political and cultural resources across different population groups underlies structured and systemic inequities in health and access to healthcare. Importantly, the conversation also drew attention to inequities and expressions of coloniality within the structures and systems of global health itself, which in turn led to calls to decolonize global health.

However, it's worth noting that the focus within global health circles about colonialism and health evolved and expanded over time. Initially, discussions about decolonizing global health colonialism were focused on the legacies of the specific form and geographic contours of European colonialism that began in the 16th century and ended in the second half of the twentieth century with the formation of a spate of new independent states in Asia, Africa and the Pacific region. Much of the early emphasis was thus on the post-colonial structures and relationships between these newly independent states and their populations and their former colonizers, and with the concept of coloniality. Coloniality is a term used to describe how the attitudes, assumptions, values, ideas and culture of European colonizing societies – including racist ideas about white and/or Christian superiority - continue to influence post-colonial societies and help perpetuate Eurocentric or western dominance.

However, colonialism can (and should) be used as a generic term to refer to any situation in which a group of people use power to dominate, subjugate

and/or exploit another group or groups of people to enable the large-scale and systematic misappropriation or extraction of resources.[6] Colonialism is tied closely to capitalism. Finance capital, for example, helped create the economic, military and technological power that enabled the expansion of European colonialism in the eighteenth and nineteenth centuries, while capitalism's need to constantly find new sources of profit further drives colonization. Indeed, much contemporary colonialism is organized around a globalized form of capitalism that is mediated by powerful transnational financial institutions and corporations with control over large parts of a globalized economy.[7]

The term colonialism may thus be applied not only to other periods or examples of imperial conquest (e.g. the Mughal, Mongolian and Ottoman empires); but also to current and new forms of extractive capitalism that are not manifest as colonial relationships between groups of people defined by their nationality, race, religion, ethnicity or locality; or that involve the direct control or occupation of foreign lands and peoples.

As noted by Ghana's first President, Kwame Nkrumah, when he coined the term neocolonialism, resources and wealth continued to be extracted from newly independent states by former colonial powers,[7] through indirect forms of political and economic control. This control included the private capture of assets and markets; the creation of advantageous global monetary, trade and investment systems[3]; and the corruption of post-independent governments and structures working to preserve systems of exploitation established during the colonial period. The large net outflow of resources from sub-Saharan Africa to beneficiaries in high-income countries coupled with the emergence of an African elite is evidence of neocolonialism (Figure 1).[8,9]

Figure 1: Annual Capital Flight from Africa (2020)

From *Tackling Illicit Financial Flows for Sustainable Development in Africa*, by UNCTAD, © 2020 United Nations. Reprinted with the permission of the United Nations.

Note: between $30 and $52 billion of capital flight is illicit (illegal).

In today's globalized economy, the extractive power wielded by powerful private financial institutions and transnational corporations has been underpinned by a process of financial deregulation and growth in the volume and mobility of private financial capital. This has enabled private ownership of and control over assets and resulted in powerful political forces driving public policy towards ever greater commercialization and privatization, including of institutions and

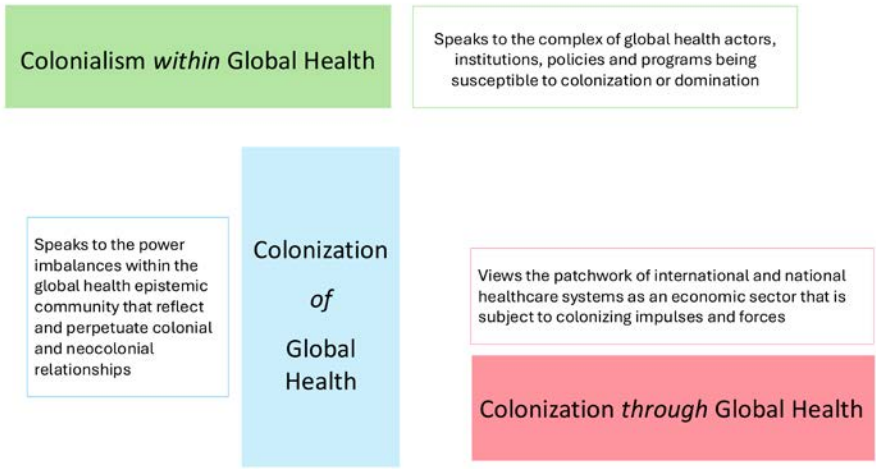
utilities that were once considered exclusively or generally public (e.g. education, health care, public utilities such as water and sewerage, and even prisons and policing). This further expands opportunities for private wealth extraction and accumulation.[10, 11] Other elements of globalized financial and corporate colonialism include the strengthening of intellectual property rights which may be equated to a colonization of knowledge, and the enablement of vast amounts of tax avoidance and illicit financial flows through the under-regulation of banks and the tolerance of secretive banking regimes (see Chapter C4).

In today's increasingly digitalized world, many valuable resources are intangible and require us to think about new forms of colonialism. The private ownership and control of global digital platforms, knowledge and large datasets underlie a type of digital or virtual colonization by which wealth is extracted from billions of people through unavoidable and exploitative rent-seeking arrangements. While the direct control of land and other tangible natural resources remain important, as evident by recent land grabs,[12 13] the virtual colonization of the digital world by monopolistic technology (tech) companies, and the manipulative and highly individualized forms of surveillance capitalism and predatory marketing enabled by digitalization[14] should be viewed as important parts of contemporary colonialism.

The effects of contemporary colonialism are considerable and observable in the ever-increasing share of profits across all economic sectors enjoyed by a small transnational elite, as workers experience falling wages and deteriorating and increasingly precarious working conditions. Today, while hundreds of millions of people remain in extreme poverty,[15] by one estimate, 10 men own more wealth than the poorest 3.1 billion people in the world.[16] Although the pattern of wealth distribution today still mirrors the social fault lines of nineteenth and early twentieth century colonialism, contemporary colonialism is marked by the existence of a globalized class structure with an elite that transcends national, racial and religious identities, alongside rising numbers of impoverished people in high-income countries.

To help relate this broader perspective on colonialism to global health, a three-part framework was recently published to give the global health community a more complete framework for undertaking both decolonial and anti-colonial analysis and action.[17] The three parts of this framework are: a) colonialism within global health; b) colonization of global health; and c) colonialism through global health (Figure 1). These three parts highlight different aspects of the relationship between colonialism and global health, although they do also interact with each other. The first part speaks to power imbalances *within* the global health community; the second to the global health complex of actors, institutions, policies and programs being itself subject to colonization; and the third part refers to the contribution of international and national healthcare systems to contemporary forms of colonialism.

Figure 2: Three Approaches to Anti-Colonial Analysis of Global Health[18]



Colonialism within global health

The first part of the framework views global health as a community of organizations and individuals across which power asymmetries and unequal relationships reflect and reproduce colonial and neocolonial mindsets and arrangements. Key among these are the power imbalances between better resourced and privileged institutions in high-income countries and their counterparts in lower-income countries, reflecting not just political and economic inequalities, but also exploitative arrangements in the conduct of global health practice.

Much of the recent literature connecting colonialism and global health has been focused on decolonizing academic global health. Among the issues highlighted are the funding and conduct of global health research in ways that replicate and reproduce power imbalances between institutions in the Global North and their counterparts in the Global South, including through the practice of 'parachute research' (a term used to describe the practice of external researchers dropping into low-income countries and communities for short periods of time to collect research data and then leaving), and the maldistribution of the benefits arising from publications, authorship, citations, kudos and patentable knowledge.[19] Another issue highlighted is the neglect and marginalization of indigenous knowledge systems and cultures, and the reification of Eurocentric epistemic traditions with calls being made for the adoption of less hierarchical and more pluralistic epistemological frameworks.[20]

At the heart of these colonial relationships *within* global health are the major funders of global health, including the major bilateral providers of development assistance for health (DAH) from the United States and Europe, as well as private

foundations such as the Bill and Melinda Gates Foundation (BMGF) and the Wellcome Trust. An important critique of these funders is that they reinforce coloniality and reproduce power asymmetries by privileging actors and institutions in the Global North over those in the Global South, even when the funding is concerned with health challenges in the Global South. This occurs not just in the field of academic research but also in the field of policy development and program implementation where research institutes, think tanks and non-government organizations (NGOs) from high-income countries are funded to develop and deliver solutions and interventions in poorer countries. These solutions are often through top-down and vertical channels of development assistance that fragment and undermine coherent health systems strengthening efforts,[21] or that impose the cultural norms of high-income countries onto communities in poorer countries.[22]

Perhaps more importantly, high levels of dependency amongst poor countries on the development assistance of high-income countries creates an environment in which the current injustices of the neocolonial political economy are more easily ignored. Moreover, the international aid complex of international NGOs and charities, largely funded and managed by institutions in the Global North, project western benevolence and create aid dependencies that help obscure or legitimize the reality of a global political economy in which there is a net flow of resources out of the Global South to beneficiaries mostly located in the Global North. Today's international and global aid complex can be viewed as the modern day equivalent of the nineteenth century European missionaries who often acted as the benevolent and charitable arm of a colonial enterprise that included direct and violent forms of subjugation and oppression.

Colonization of global health

The framework's second part is concerned with representing the structures and systems of global health governance as a terrain that certain (powerful) actors with particular interests and ideas may colonize. In the same way that the ecosystem of global health academia and research may be colonized by dominant actors from the Global North, so too is the system of global health governance vulnerable to being colonized.[23]

Indeed, the weakened status of WHO due to the erosion of its core budget and reliance upon conditional grant-based funding, the rise in influence of the World Bank and IMF over health systems policy, and the emergence of public–private partnerships as a form of global health governance have contributed to a considerable concentration of global health power in the hands of a few actors. Although multistakeholder models of governance claim to provide opportunities for participation of previously neglected stakeholders including civil society organizations, they typically expand opportunities for more powerful private actors to exert their influence over public policy while co-opting other stake-

holders in the process.[24]

Notably, the last two decades have seen the BMGF emerge as the single most influential actor in global health by virtue of being one of the biggest sources of DAH, including being the second biggest single funder of WHO, and its ability to shape the thinking and activities of a vast and strategic network of grantees that include global heath academic departments, think tanks, journalists, NGOs, major global health partnerships, private companies and even the World Bank. Crucially, the BMGF operates both as a pro-active funder and directly as an active and powerful political actor engaged in public debate, influencing governments and public policy.

The result is a global health ecosystem that is dominated by an approach that emphasizes the role of selective and commodifiable biotechnological interventions (often packaged as innovations), as well as a philanthrocapitalist mode of development assistance in which commercial actors are not just cast as development partners but expected also to expand their markets and opportunities to generate profits.

Astonishingly, in the years since the Foundation became active in global health and Bill Gates resigned from Microsoft and dedicated all his time to the Foundation, both the Foundation and Bill Gates have seen their financial resources and power expand. It would therefore not be peculiar to consider global health as an epistemic discipline and community of actors and institutions that has been colonized by the BMGF, with Bill Gates playing the role of a modern-day emperor who has accumulated not just more financial wealth for himself and his foundation, but also more social and political power – all at the expense of others.

Colonialism through global health

The framework's final part relates to the fact that health care is a trillion-dollar economic sector that contributes to the broader system of corporate and financialized colonialism in two ways. First, global health policies and narratives, including the modes of philanthrocapitalism mentioned earlier, can help open the sector to privatization and commercialization policies that allow financial and corporate actors to capture markets and extract profits and wealth from healthcare consumers and governments.

The COVID-19 pandemic illustrated this potential. The power of oligopolistic pharmaceutical companies and their financial backers, supported by an intellectual property rights regime that protects extensive monopoly rights and legal regimes that privilege commercial confidentiality over public accountability, resulted in billions of dollars of profit being generated from a global health emergency that left hundreds of millions of households economically overwhelmed.[25] The past few years have also seen the health sector become increasingly financialized and privatized, creating greater opportunities for corporate health providers to control growing segments of national and global health systems for the purpose

of extracting profits for shareholders, inevitably at the expense of ministries of health, patients and frontline workers through downward pressure on wages and increased precariousness in employment conditions (see Chapters A1 and B1).[26] The increasing control of a few big tech companies over the growing digital health industry similarly provides opportunities for exploitative commercial activity. A large proportion of the profits generated by transnational corporations from health systems are in turn channeled through tax havens and elaborate tax avoidance schemes, contributing to the hyper-concentration of wealth amongst a global super-elite while simultaneously denying public institutions and services vital revenue.

The second way in which the global health system contributes to corporate and financialized colonialism is by acting as an alibi for the very same actors that are engaged in and benefiting from an extractive and unjust political economy. We see, for example, in the celebration and lionization of Bill Gates as a public health expert a legitimization of unaccountable multibillionaires as global problem-solvers, rather than as the beneficiary of a rapacious capitalist system, or as political actors with an agenda and undemocratic influence over public policy. Similarly, in embracing corporate social responsibility programs and in inviting corporate and financial representatives to sit on the governing boards of public private partnerships, global health is essentially complicit in the 'health washing' of actors who may currently engage in egregious or unethical marketing, tax avoidance or political lobbying practices.

Conclusion

This exploration of the links between colonialism and global health in this edition of *Global Health Watch* has a number of implications for health activists concerned with promoting global health equity.

Although much of the material in this chapter refers to issues about health equity that have been discussed in previous editions, the use of the lens of colonialism to examine the structural and social drivers of global health inequities is relatively novel and provides an opportunity to ride the current wave of interest in decoloniality in a more holistic manner.

Specifically, this chapter seeks to combine efforts to combat the legacies of historical colonialism with efforts to resist contemporary forms of globalized colonialism that are mediated through transnational corporations, private financial institutions and private foundations. In addition, the framework presented here challenges global health researchers, practitioners and technocrats to consider how the global health system itself has been colonised, and how the healthcare sector is implicated in the globalized system of corporate and financialized colonialism.

Any anticolonial agenda within global health must therefore involve actions to challenge power imbalances not just between global health actors and institutions in the Global North with their counterparts in the Global South, but also

the imbalance of power between powerful private actors, public institutions and the general public, as well as between health actors rooted in the neoliberal and conservative ideology of selective primary health care and those committed to a more comprehensive agenda as exemplified by the 1978 Alma Ata Declaration's call for a New International Economic Order (see chapter A1).

Such an agenda would include anti-colonial challenges to unethical and egregious wealth extraction being conducted through the health sector as well as support to wider efforts to reform the international financial system and end the corrupting influence of illicit financial flows and high levels of tax avoidance that enable and perpetuate wealth extraction and inequality.

An agenda to decolonize global health should also seek to restore the authority and capabilities of the WHO, whilst promoting practical ways to correct the democratic deficits in the wider system of global level governance by, for example, enabling the participation of grassroots voices and social movements in global health discussions; improving representation of perspectives from lower-income countries on technical working groups and in global health conferences; and creating mechanisms to monitor and hold powerful global health actors more accountable.

This may require global health actors to question their own positions and behaviors, and to critically examine whether they are tacitly legitimizing actors who engage in exploitative and extractive practices, or whether they have endorsed charitable or philanthropic capitalist models of development that are exploitative, or which act to launder the reputations of actors engaged in colonial or neocolonial extractivism.

Reference List

1. Khan M, Abimbola S, Aloudat T, Capobianco E, Hawkes S, Rahman-Shepherd A. Decolonising global health in 2021: a roadmap to move from rhetoric to reform. BMJ Global Health. 2021 Mar 1;6(3):e005604. Available from: https://bit.ly/3E29N5G
2. Affun-Adegbulu C, Adegbulu O. Decolonising Global (Public) Health: from Western universalism to Global pluriversalities. BMJ Global Health 2020;5:e002947. Available from: https://bit.ly/4hQGP6F
3. Abbasi K. Decolonising medicine and health: brave, hopeful, and essential BMJ 2023; 383 :p2414. Available from: https://bit.ly/3Yc11ZD.
4. Ahmed AK. #RhodesMustFall: How a Decolonial Student Movement in the Global South Inspired Epistemic Disobedience at the University of Oxford. Afr Stud Rev. 2020 Jun; 63(2):281–303. Available from: https://bit.ly/3XBeABN
5. Hernandez J, Mueller B. Global anger grows over George Floyd death, and becomes an anti-Trump cudgel. New York Times. 2020 Jun 1; Available from: https://bit.ly/4iO1WaW
6. McCoy D, Kapilashrami A, Kumar R, Rhule E and Khosla R, 2024. Developing an agenda for the decolonization of global health. Bull World Health Org. 2024 Feb 1;102(02):130–6, Available from: https://bit.ly/4lqlnZo
7. Nkrumah N. Neo-Colonialism: The Last Stage of Imperialism. Reprinted. London: Panaf; 2004. 280 p.
8. Sharples N, Jones T, Martin C, 2017. Honest Accounts? The true story of Africa's billion-dollar losses. 2014 Jul. Available from: https://bit.ly/3XEG89w
9. Hickel J, Sullivan D, Zoomkawala H. Plunder in the Post-Colonial Era: Quantifying Drain from

the Global South Through Unequal Exchange, 1960–2018. New Political Economy. 2021 Nov 2;26(6):1030-47. Available from: https://bit.ly/4lhCUmy

10.˜Storm S, 2018. Financialization and Economic Development: A Debate on the Social Efficiency of Modern Finance. Development and Change. 2018 Mar;49(2): 302–29. Available from: https://bit.ly/41VBnLf

11.˜Gallagher KP and Kozul-Wright R, 2021. A New Multilateralism for Shared Prosperity: Geneva Principles for a Global Green New Deal. Global Development Policy Center: Boston University and United Nations Conference on Trade and Development; 2019. Available from: https://bit.ly/4hODu85

12.˜Zoomers A. Globalisation and the Foreignisation of Space: Seven Processes Driving the Current Global Land Grab. The Journal of Peasant Studies. 2010 Apr;37(2):429–47.

13.˜Borras SM, Mills EN, Seufert P, Backes S, Fyfe D, Herre R, et al. Transnational Land Investment Web: Land Grabs, TNCs, and the Challenge of Global Governance. Globalizations. 2020 May 18;17(4): 608–28.

14.˜Zuboff, S. The age of surveillance capitalism. London, England: Profile Books; 2019.

15.˜Riddell R, Ahmed N, Maitland A, Lawson M, Taneja A. Inequality Inc. Oxfam International; 2024 Jan [cit-ed 2024 Aug 23] p.11-2. (Methodology Note, Table 1.6). Available from: https://bit.ly/4jcwsLC.

16.˜Ahmed N, Marriott A, Dabi N, Lowthers M, Lawson M, Mugehera L. Inequality Kills: The unparalleled action needed to combat unprecedented inequality in the wake of COVID-19. Oxfam; 2022 Jan. Available from: https://bit.ly/4hZwcPd

17.˜McCoy D, Kapilashrami A, Kumar R, Rhule E, Khosla R. Developing an agenda for the decolonization of global health. Bull World Health Org; 2024 Feb 1;102(02):130–6. Available from: https://bit.ly/4lqlnZo

18.˜McCoy D, Kapilashrami A, Kumar R, Rhule E, Khosla R. Developing an agenda for the decolonization of global health. Bull World Health Org; 2024 Feb 1;102(02):130–6. Available from: bit.ly/4lqlnZo

19.˜Kumar R, Khosla R, McCoy D. Decolonising global health research: Shifting power for transformative change. Banerjee A, editor. PLOS Glob Public Health. 2024 Apr 24;4(4): e0003141. Available from: https://bit.ly/3FQB63B

20.˜Büyüm AM, Kenney C, Koris A, Mkumba L, Raveendran Y. Decolonising global health: if not now, when? BMJ Glob Health. 2020 Aug;5(8):e003394. Available from: https://bit.ly/4jdL798

21.˜Spicer N, Agyepong I, Ottersen T, Jahn A, Ooms G. 'It's far too complicated': why fragmentation per-sists in global health. Global Health. 2020 Jul 9;16(1):60. Available from: https://bit.ly/3XEVDy7

22.˜Levich J. The Gates Foundation, Ebola, and global health imperialism. Am J Econ Sociol. 2015 Sep 7;74(4):704–42. Available from: https://bit.ly/4iSyv7U

23.˜Iwunna O, Kennedy J, Harmer A. Flexibly funding WHO? An analysis of its donors' voluntary contributions. BMJ Glob Health. 2023 Apr;8(4):e011232. Available from: https://bit.ly/43DLWDR

24.˜Transnational Institute. Multistakeholderism: a critical look. Amsterdam: Transnational Institute; 2019 Mar. Available from: https://bit.ly/3DPVpO1

25.˜Marriott A, Maitland A. The great vaccine robbery. Boston: Oxfam America; 2021 Jul. Available from: https://bit.ly/3FQBlM3

26.˜Marriot A. Sick development. how rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped. Oxford: Oxfam International; 2023 Jun. Available from: https://bit.ly/3FQBlM3

SECTION C

Beyond health care

War, Conflict and Displacement

Introduction

War, conflict and displacement are not new to human societies, but the scale of human and ecological destruction that they bring increases with the technological capacities of the warring groups. At global scale, and by numbers alone, the health and human costs of war reached its zenith in World War Two, although centuries earlier wars in Asia (the Mongol invasions and Chinese dynastic wars) also had multiple millions of casualties. Since World War Two conflicts have been more regional than global, often involving competing regional hegemons, or are regarded in whole or in part as 'proxy wars' between two or more of the world's present handful of 'great powers' (i.e. the USA, China, India, Russia (see Introduction Chapter)). The death toll from regional conflicts is rapidly rising, with over 237,000 conflict-related deaths in 2022, the highest number seen over the past thirty years.[1]

These numbers say little about the emotional and psychosocial impacts of war, conflict and displacement; nor of the destruction and toxic contaminations of the environment the health impacts of which could be years in manifesting. The Ukraine war has created widespread chemical contamination of air, water and soil, and damaged a third of environmentally protected areas.[2] The first four months of bombing of Gaza (to January 2024) released more greenhouse gas emissions than the annual amounts of New Zealand and 135 other countries.[3]

In documenting war's human costs, this chapter also attempts to get beneath the forces that lead to conflict. It begins by discussing the geopolitical context of war and the deliberate creation of conflict and instability. It focuses on the Middle East and North African (MENA) region but includes analyses of countries 'invaded in the name of democracy' and an examination of the economics of war and the humanitarian and reconstruction responses. The health tolls of four MENA countries (Libya, Yemen, Sudan and Palestine) round out the chapter before it concludes with the challenges to peace now confronting activists.

The geopolitical context of war

Understanding the geopolitical context is essential to analyzing the causes behind the emergence and evolution of military conflicts throughout history. The geopolitical context involves international and regional power structures and dynamics, economic domination and dependencies, and historical legacies, all of which intertwine and drive the onset and escalation of hostilities.

Geopolitical strategies encompass approaches and tactics that countries may employ to assert or expand their influence and manage the intricacies of global relations. Major powers use their military capabilities, economic strength, diplomatic

efforts, cultural influence and technological advancement to shape international geopolitics.[4,5,6] For instance, the United States of America (USA) upholds its strategic reach through a vast global network of military bases and alliances, including the North Atlantic Treaty Organization (NATO);[7] China strives to extend its economic influence across Asia, Africa and Europe, through initiatives like the Belt and Road;[8] and Russia capitalizes on energy resources and military interventions to regain aspects of the global role of the Soviet Union.[9] Russia has also engaged militarily in many of the former Soviet republics to sustain its sphere of influence, the most recent being the invasion of Ukraine with the intent of reabsorbing much or all of Ukraine within Russian territory (see Box C1.1).

Box C1.1: The war in Ukraine

One of the major conflicts of the past three years is the ongoing war in Ukraine that began with Russia's full-scale invasion of the country in February 2022, eight years after it had re-claimed Crimea as part of Russia. There are competing narratives concerning the war, with one analysis seeing it as Russian president Vladimir Putin's effort to reassert and strengthen control over Russia's historic 'sphere of influence,' which includes all of the former Soviet republics or at least those not yet aligned with NATO.[10] For European countries this represents a return to Cold War politics, in which their nominal security in the decades following the dissolution of the USSR could no longer be presumed. The threat of Russian military expansion became palpable.

A countervailing narrative, contrary to then US President Biden's claim that Russia's invasion was an 'unprovoked attack', argues that NATO and the USA itself were actually the provocateurs by expanding NATO membership eastwards right up against Russian borders. This was something that they had promised Soviet President Mikhail Gorbachev they would not do, when Gorbachev disbanded the Warsaw Pact military alliance.[11] The USA, in particular, was promoting NATO membership for Ukraine and Georgia to encircle and contain potential Russian expansionism, and along with France, Germany and the UK, undermined a potential peace agreement between Russia and Ukraine shortly after the war began.

There is little agreement over geopolitical roots of the Russo-Ukraine war and how the war might be ended. The same applies to estimates of the human costs of the war, with the number of troops killed (as of June 2025) varying between 111,000 and 250,000 (Russia), and 60,000 and 100,000 (Ukraine).[12] The number of injuries is thought to approach one million. Around 13,000 Ukrainian civilians have also died from the conflict,[13] with 6 million having fled to escape war and military conscription, and 4 million more internally displaced.[14]

As European economist Mario Pianta recently wrote:

> Three years after the war in Ukraine began, this logic of war must be stopped. A new accord between Trump and Putin will not bring lasting

Continues on next page

Box C1.1 continues

peace to Ukraine. But Europe cannot pursue an agenda of war at any cost, nor should it chase dangerous ambitions of becoming a (small) military and nuclear power. Nostalgia for a fractured Atlantic alliance is of little use. Europe's future now depends on its ability to end the war in Ukraine, initiate negotiations and build a lasting peace order on the continent—through political means, not military escalation.[14]

In recent decades, the USA has carried out the greatest number of military interventions, either independently or as part of a coalition.[15] The US's prominent role in global military operations is attributed to protecting and sustaining its global plutocracy, with military interventions playing a crucial role in securing trade routes and access to natural resources.[4,16] Many of its interventions have been in regions rich in oil, rare minerals and other strategic resources the USA needs to maintain its status as the world's leading superpower and preventing the rise of regional powers that could challenge its global geopolitical influence.[16,17,18]

The creation of military conflicts and political instability

Leading global and regional colonial powers persist in deliberately fostering controlled internal or regional conflicts as a means to uphold their influence, manipulate political developments and legitimize military or economic interventions. This tactic, often referred to as 'managed instability' or 'controlled chaos' serves multiple strategic objectives. Fostering divisions within a country or a region – along ethnic, sectarian or political lines – prevents the emergence of unified authorities or oppositions and allows external powers to sustain political influence over the fragmented nations(s).[19]

The imperialist use of the Arab Spring

The Arab Spring, which began in 2010, consisted of massive waves of uprisings fueled by demands for political freedom, social justice and economic reform. Imperialist powers* strategically harnessed these movements to advance neoliberal economic agendas and implement neocolonial strategies that reinforced their geopolitical and economic interests in the region. This influence manifested through several key mechanisms, including economic restructuring, political intervention and military involvement. In the aftermath of the uprisings, international financial institutions such as the International Monetary Fund and the World Bank advocated economic reforms characterized by market liberalization, deregulation and reduced state intervention. These policies frequently resulted in higher unemployment, greater social inequities and economic instability, which fueled disappointment with the results of the revolutions.[20]

*Imperialist powers are countries that exert dominance over others. 20th-century imperialist powers are generally considered to be the USA, the UK, Germany, France, Italy, Netherlands, Russia, Belgium, Japan, Turkey (Ottoman Empire), Portugal and Spain.

Imperialist powers employed various other strategies to maintain influence over the region's political and economic landscapes, including military interventions, regime support, expanded Western corporate presence and strengthened neocolonial dependence.

Military intervention in Libya

NATO countries intervened militarily in Libya in 2011, overthrowing Muammar Gaddafi* and opening up the nation's substantial oil reserves to Western corporations. This intervention precipitated widespread instability, enabling armed groups to proliferate and fostering the emergence of a warlord economy. The ensuing chaos allowed entities like the Arkenu Oil Company, linked to military commander Khalifa Haftar and his son, leaders of one of the armed groups, to export oil valued at over $600 million since its establishment in 2023. This development signifies a departure from the previous monopoly held by the National Oil Corporation and underscores the growing influence of armed factions over Libya's oil sector.[21]

The fragmentation of Libya's political landscape has further exacerbated the situation. The country remains divided between rival governments in the east and west, each backed by various armed groups vying for control over the nation's resources. This division has led to the emergence of a war economy characterized by smuggling, extortion and the illicit exploitation of state resources, as armed groups and criminal networks capitalize on the country's instability. The competition for control over oil facilities has intensified, with competing factions seizing key terminals to exert influence and generate revenue.[22,23,24] The illicit oil trade has further deepened Libya's divisions, with armed groups profiting from smuggling activities that fuel internal conflicts and hinder national reconciliation efforts. The entanglement of armed groups in the oil sector and the resulting economic incentives have perpetuated the conflict, making it challenging to establish a unified and peaceful Libya.

In summary, NATO's intervention in Libya has had profound and lasting effects on the nation's political and economic landscapes. The (announced) goal of protecting civilians led to an expected consequence of empowering armed groups and destabilizing the country, with Libya's oil wealth becoming both a blessing and a curse in the ensuing power struggles.

Selective support for regimes

While advocating for democratic reforms in some countries, imperialist powers continued to support authoritarian regimes in others, provided these regimes were aligned with Western interests. This selective approach exposed the fake calls for democratic transitions and highlighted the prioritization of geopolitical

*Muammar Gaddafi ruled Libya from 1969 to 2011 after leading a coup against King Idris. His rule combined Arab nationalism, socialism and his unique ideology, outlined in the Green Book. Gaddafi's reign saw economic growth but also repression. NATO-backed rebels overthrew and killed him during Libya's 2011 uprising.

objectives, e.g., protecting the Israeli occupying forces and the economic interest in the region, over the promotion of democracy or even saving lives. Western governments maintained close ties with the Egyptian, Saudi Arabian, and Emirati leadership, recognizing their pivotal role in regional stability, energy markets and global trade. This relationship endured despite the country's authoritarian governance and resistance to any democratic reforms, reflecting the West's strategic interests in preserving alliances with conservative regimes.[25]

Expansion of Western corporate presence and influence

Following the Arab Spring, Western transnational corporations (TNCs) expanded their presence in the Middle East and North Africa (MENA) region, capitalizing on market liberalization and the privatization of state-owned assets. This influx of foreign direct investment often prioritized profit repatriation over local economic development, leading to the exploitation of local labor and resources and perpetuating economic dependency. Despite the increased presence of TNCs, the anticipated widespread economic benefits for the local populations often failed to materialize. For instance, in Egypt, the privatization of state enterprises frequently resulted in layoffs and wage reductions, exacerbating unemployment and social inequality. Similarly, in Tunisia, the influx of foreign investment did not significantly reduce high unemployment rates, particularly among youth. These outcomes underscore the challenges of implementing neoliberal economic reforms in the MENA region and highlight the need for policies that balance foreign investment with the promotion of inclusive economic growth and social equity.[26]

Strengthened neocolonial dependency

The combination of economic reforms, military interventions and corporate expansions served to entrench neocolonial relationships in the region. In the aftermath of the Arab Spring, several nations in the MENA region increasingly depended on loans from international financial institutions to address economic challenges (e.g. Tunisia, Jordan, Egypt, Morocco and Lebanon), where debt service payments equaled or exceeded expenditures on essential services such as education, health and social protection.[27] Continued military aid and cooperation with Western powers further ensured that regional security forces remained aligned with Western interests, often at the expense of democratic governance and human rights.

The increase in firearm sales

After the Arab Spring, many countries in the MENA region significantly increased their military expenditures. This surge was driven by heightened security concerns, political instability and the desire to maintain internal order.[28] In 2013, Saudi Arabia's military spending escalated to $67 billion, making it the world's fourth-largest military spender after the USA, China and Russia. This increase was partly driven by tensions with Iran and concerns over potential internal unrest.[29] In Egypt, the military's role in the economy expanded post-2011, with the armed

forces engaging in various commercial activities. This expansion was facilitated by state stimulus spending and capital from Gulf states, allowing the military to venture into new sectors. This development underscores the intertwining of military spending and economic interests in the post-revolutionary period.[30]

These patterns highlight a broader trend in the MENA region, where political instability has led to increased military spending, often at the expense of social and economic development and health system financing. The prioritization of defense expenditure raises questions about long-term stability and resource allocation in these countries.

Invasions in the name of democracy

Imperial powers have often claimed the necessity to invade countries in order to promote or create democratic states. The following two recent examples indicate consistent failure, with high human costs: Afghanistan and Iraq.

Afghanistan

Although the 2001 US-led invasion of Afghanistan was officially framed as a mission to bring democracy, critical scholarship argues this was fundamentally a post-hoc rationalization masking counterterror objectives. The rapid insertion of Western-style electoral systems overlooked the deep tribal, ethnic and religious structures of Afghan society, effectively imposing formal institutions without building legitimacy.[31,32] Scholars warn that such democratic illusions often catalyze instability, as they legitimize foreign military intervention while failing to secure genuine local or regional public support.[33]

Afghanistan's religious extremism has roots in Cold War geopolitics. During the 1980s Soviet–Afghan war, the US Central Intelligence Agency (CIA), through 'Operation Cyclone', channeled massive funding ($300–600 million annually) via Pakistan's Inter-Service Intelligence (ISI) exclusively toward Islamist mujahideen, favoring ideologically driven leaders like Gulbuddin Hekmatyar and Jalaluddin Haqqani.[34] This policy undermined moderate factions and nurtured religious radicalism. The Haqqani network's ascendancy, broadly acknowledged as "one of the Reagan administration's most CIA-funded anti-Soviet groups" illustrates this trajectory.[35] Although direct CIA–Osama bin Laden links remain debated, evidence confirms that US money and materiel flowed through ISI into Islamist camps that incubated extremist militancy.[36,37] This strategy reinforced Salafist and Deobandi ideologies via madrassas in Pakistan, creating a transnational pipeline of militants who later coalesced into groups like Al Qaeda and the Taliban.[38] This funding choice was a key driver for the eventual structure of Afghan fundamentalism: institutions that became deeply embedded in local and regional power structures.

After two decades of military occupation, billions in aid and the deaths of over 170,000 people, the USA completed its withdrawal from Afghanistan in August 2021. In a matter of weeks, the Western-backed Afghan government

collapsed, and the Taliban reclaimed power without significant resistance. The failure of the USA and its allies to establish legitimate, locally rooted institutions led to the rapid unraveling of the state,[39] an outcome that laid bare the unsustainable nature of externally 'promised' democracy, ultimately returning the country to the very group the invasion had sought to remove.

Iraq

Among many examples in modern history, the US Army and intelligence successfully used the 'divide and rule' tactic after the invasion of Iraq in 2003. The United States (and its decorative coalition) restructured the political system in Iraq, emphasizing ethnic and sectarian identities after enforcing a de-Ba'athification policy (removing former Ba'ath Party members, who are mostly Sunni Arabs, from government and military positions).[40] This tactic alienated the Sunni population, fueling resentment and sectarian violence, and played a key role in the emergence of insurgent groups, including Al-Qaeda in Iraq.[41] Other tactics used by the USA included dividing the capital city Baghdad into sectarian enclaves, which led to physical and psychological separation of communities and exposed families with inter-ethnicity marriage to a high risk.

After the 2003 US-led invasion, Iraq's oil economy was subject to massive changes shaped by foreign intervention, internal political instability, social unrest and corruption. As one of the world's largest oil producers, with the fourth-largest proven oil reserves in the world (approximately 145 billion barrels[42]), Iraq heavily relies on oil revenue which accounts for more than 90 per cent of government income. The USA opened Iraq's previously publicly-owned oil sector to foreign companies – including ExxonMobil, BP, Shell, TotalEnergies, and China's CNPC - to extract a good portion of the revenue out of 4.5 million barrels daily, yielding these companies $300 billion in oil revenue generated since 2003.[43] After the large portion of revenues go to foreign companies, the remainder goes to the powerful political parties and militias that control much of the oil sector, using revenues for patronage and influence rather than public investment.[44] Despite the significant profits that foreign companies have been making since the US invasion, the big transnational companies requested changing the traditional oil service contracts which pay them a flat rate for each produced oil barrel after reimbursing the actual costs. They complained that these traditional contracts did not allow them to benefit from rising oil prices. In July 2023, the Iraqi government made a $27 billion indecent deal with the French TotalEnergies, adopting a revenue-sharing model. Total takes a 45 per cent share, Basra Oil (a state-owned company) takes 30 per cent, and Qatar Energy 25 per cent.[45]

The economies of war*

The financial underpinning of warfare is shaped by a multifaceted blend of economic tactics and governmental policies, reflecting the broader political and fiscal context of each nation. To sustain military engagements, states usually rely on a tetrad of funding mechanisms: increased taxation, public borrowing, military aid and, at times, the expansion of the money supply. Taxation allows governments to collect revenue directly from citizens, though it may provoke political resistance. Borrowing—often through the issuance of war bonds—spreads the financial burden over time but contributes to rising national debt. Meanwhile, printing money can provide immediate liquidity but carries the risk of inflation, especially during prolonged conflicts. Historically, the US financed World War I through a mix of increased taxes and war bonds, while the Vietnam War saw a heavier reliance on deficit spending.[46]

Box C1.2: The case of Gaza: Who pays for the genocide?

The military aggression unleashed by the occupying power in Palestine is fueled by a mix of internal funding and massive foreign backing. Domestically, the Israeli Netanyahu regime has earmarked approximately $31 billion for its 2025 defense budget—a stark escalation that underscores its war-first priorities.[47] This ballooning military expenditure has driven the debt-to-GDP (gross domestic product) ratio to 69 per cent in 2024, up sharply from 61.3 per cent the year before, revealing the steep economic cost of sustaining perpetual domination and destruction.[48]

A significant portion of the occupying regime's military funding is underwritten by the United States. Under a decade-long Memorandum of Understanding signed in 2016, Washington commits $3.8 billion annually in military aid. More recently, in a move that effectively bankrolls the ongoing campaign of destruction, US lawmakers approved an additional $12.5 billion in supplemental aid since October 2023 and an additional $8.7 billion in 2024.[49] These funds bolster nearly every facet of the occupation's war machine — from acquiring state-of-the-art weaponry to sustaining sophisticated defense infrastructure — fueling the systematic assault with American taxpayer dollars.

Defense contractors sit at the heart of the war economy, absorbing vast sums of foreign aid through lucrative arms deals and military services. Giants like Lockheed Martin, Boeing, General Dynamics, Raytheon Technologies and Northrop Grumman are among the chief profiteers, supplying the occupying force with cutting-edge weaponry and battlefield logistics. As the genocide unfolds, these corporations have reaped staggering financial rewards, with their stock prices surging in lockstep with the bloodshed. Their entanglement with the machinery of occupation lays bare the seamless fusion of corporate profit and military aggression.[50]

*The economics of the military/industrial complex has been a recurrent theme in past Global Health Watch editions, starting with GHW1 (Chapter D5 on the health impacts of war), continuing with GHW2 (Chapter C2 deconstructing the 'war on terror') and GHW6 (Chapter C6 overviewing health, conflict, and war in the context of the COVID-19 pandemic). The dominant analysis across these chapters is the economic financing of war outstripping that for health and social protection, and why this perverse inversion of wellbeing priorities needs to be constantly challenged.

Once war coffers are filled, the machinery of violence consumes them across multiple fronts: bloated personnel salaries, massive arms procurement, sprawling logistical operations and relentless research into more efficient tools of destruction. The distribution of these funds mirrors the demands of each conflict, both tactical and technological. In World War II, the USA poured billions into industrial mobilization and weapons innovation, birthing technologies that later permeated civilian life. In the Iraq and Afghanistan wars, spending ballooned into trillions, with billions lost to corruption, failed reconstruction projects and inflated contracts handed to private firms like Halliburton and Blackwater.[51,52] More recently, the occupier's siege on Gaza has triggered a fresh wave of arms sales and defense subsidies, lining the pockets of contractors while obliterating civilian infrastructure. This militarized spending binge routinely cannibalizes national budgets, draining resources from education, healthcare and climate resilience—mortgaging public welfare to sustain endless war.

Defense contractors play a pivotal role in absorbing wartime finances, often securing substantial portions of military budgets; from 2001 to 2020, the US Department of Defense allocated over $14 trillion, with contractors receiving between one-third to one-half of this amount.[53] Defense contractors exert significant influence over military strategies and policies, extending beyond mere financial transactions. This dynamic was notably highlighted by President Dwight D. Eisenhower in his 1961 farewell address, where he warned of the "military-industrial complex"—a term describing the intertwined relationships between the military, government, and defense industries. Eisenhower cautioned that this nexus could lead to policy decisions favoring prolonged conflicts or increased military spending, primarily benefiting contractors.[54]

With the war in Ukraine persisting and concerns that Putin may extend military aggression to other former Soviet republics (Moldova is seen as the likely next country),[55] the second Trump administration demanded that all NATO member states increase their defense spending to 5 per cent of their GDP or risk the USA no longer defending them.[56] Stocks in aerospace and defense corporations (many of them American) rose sharply,[57] while social justice groups expressed grave concern with expected cuts to health and social protection programs to pay for the increased militarization costs.

The other businesses of war: humanitarian aid and post-conflict reconstruction

The humanitarian aid industry

Wars and conflict create a humanitarian aid industry which, while often portrayed as a benevolent force, has faced substantial criticism for perpetuating systemic issues and, at times, exacerbating the very crises it aims to alleviate. Humanitarian assistance can be manipulated to serve political and military objectives. In Yemen, aid has been weaponized by conflicting parties, with reports indicating

that humanitarian resources are diverted to support war economies and prolong conflict. Similarly, in Gaza, the control and restriction of aid have been used as a means of exerting pressure on the population by the Israeli's occupying regime, raising concerns about the use of starvation as a weapon of war.[58]

The arrival of large-scale foreign aid can destabilize local economies by fostering dependency and weakening indigenous industries. In the aftermath of disasters in Pakistan, aid initiatives have been criticized for introducing unsuitable technologies and establishing cumbersome administrative frameworks, which have skewed income distribution within the country. These kinds of interventions can obstruct long-term development and erode the capacity of local communities to achieve economic self-reliance.[59]

The business of destruction and reconstruction

The intertwined industries of destruction and reconstruction in wartime contexts have garnered significant criticism for perpetuating cycles of conflict and profit. This phenomenon, often referred to as the "conflict-reconstruction complex," suggests that the same entities involved in warfare also benefit from post-conflict rebuilding efforts, raising concerns about motivations and ethical implications. The profiteering agendas of foreign contractors sidelines the very communities it claims to rebuild. In Iraq, following the 2003 invasion, the US earmarked around $60 billion for reconstruction, an effort that quickly devolved into a textbook case of corruption and crony capitalism. At least $8 billion vanished into a black hole of mismanagement and fraud, with contracts frequently handed to politically connected American corporations through opaque, no-bid processes. Meanwhile, local firms and workers were largely excluded, turning what could have been a foundation for national recovery into a lucrative business model for foreign profiteers.[60] The reconstruction of Gaza following its wholesale destruction by the Israeli occupying force has been estimated at well over $50 billion and is still rising.[61]

Neoliberal policies and economic disruption

The imposition of neoliberal economic policies in post-conflict environments has often deepened socioeconomic divides and sowed the seeds of future instability. These policies, characterized by aggressive privatization, deregulation and market liberalization, are typically implemented under the guise of promoting efficiency and modernization. In post-2003 Iraq, this approach proved disastrous. The rapid sell-off of state-owned enterprises and the abrupt removal of subsidies dismantled the economic safety nets that had supported millions. State employees, many of whom were dismissed without alternatives, found themselves jobless almost overnight. The collapse of domestic industries in favor of foreign contractors not only decimated local production but also stripped the country of economic sovereignty. This upheaval fueled widespread disenfranchisement, intensified poverty and ultimately contributed to the rise of insurgent groups who capitalized on the

growing resentment. Rather than stabilizing Iraq, neoliberal restructuring exacerbated the conditions for conflict and prolonged unrest.[62]

Health impacts of war (selected cases)

Wars involve casualties, and almost invariably the brunt of death, injury and disease is borne by civilians. The recent cases below, again drawing from the MENA region and beginning, in historic order, with Libya, Yemen, and Sudan, and concluding with Palestine (Gaza).

Libya

The protracted conflict in Libya since 2011 has severely impacted the nation's health landscape, leading to high mortality and injury rates, mass displacement, the degradation of healthcare infrastructure and increased vulnerability to infectious diseases. Between 2012 and 2017, Libya recorded 16,126 conflict-related deaths and 42,633 injuries. The mortality rate stood at 2.7 per 1,000 population, while the injury rate was 7.1 per 1,000. Young males, particularly those aged 20–30, were disproportionately affected, accounting for over 40 per cent of fatalities. A third of all injuries led to permanent disabilities, often due to blast-related trauma.[63]

The ongoing conflict has devastated Libya's healthcare infrastructure. Numerous hospitals have been damaged or destroyed, leading to closures and a severe shortage of medical supplies, including essential medications like insulin and antiretrovirals. The exodus of healthcare professionals and the targeting of medical facilities have further strained the system, rendering it ill-equipped to address both routine and emergency health needs. The conflict has also displaced approximately 435,000 individuals within Libya, forcing them to reside in overcrowded conditions with limited access to clean water, sanitation and healthcare services, heightening the risk of disease transmission and exacerbating existing health challenges.[64]

The breakdown of Libya's public health system has facilitated the spread of infectious diseases, with studies indicating that internal displacement and the collapse of healthcare services have contributed to the dissemination of new HIV strains across different regions of Libya.[65]

Yemen

The conflict in Yemen has similarly precipitated a multifaceted health crisis, with severe impacts on people's health, characterized by widespread disease outbreaks, malnutrition, high maternal and child mortality, and mental health crises, all of which were exacerbated by the COVID-19 pandemic.[66] Yemen experienced the largest recorded cholera epidemic globally, with over 1.2 million suspected cases reported since April 2017. This unprecedented outbreak is attributed to the collapse of water, sanitation and healthcare infrastructures due to ongoing conflict.[67] Malnutrition among children under five remains alarmingly high. A study analyzing data from 13,624 Yemeni children found that 47 per cent were stunted,

16 per cent wasted and 39 per cent underweight. These conditions are closely linked to socioeconomic factors, maternal education and access to prenatal care.[68]

The maternal mortality rate in Yemen escalated amidst the conflict. In 2019, it was reported that one woman and six newborns died every two hours due to complications during pregnancy or childbirth, reflecting a mortality rate of 164 per 100,000 live births.[69] The war, as in many other Middle East and North African countries experiencing conflict, has severely impacted mental health, with widespread psychological distress reported among the population. However, mental health services are virtually nonexistent, leaving many without necessary support.[70]

Addressing these challenges requires urgent action to stop the war initiated by the Saudi-led coalition in its proxy conflict with Iran, allowing sustained international humanitarian assistance and efforts to begin restoring domestic peace and rebuilding the healthcare infrastructure.

Sudan

As the genocide in Gaza becomes more brutal (see below), the civil war in Sudan continues with less international attention. At least 150,000 people have been killed and more than 14 million people displaced since April 2023 when two factions, the Sudanese Armed Forces (SAF) and the Rapid Support Forces (RSF), began a violent armed struggle over control of the country and its resources.[71]

The roots of the conflict lie in the post-colonial period that saw civil war between the country's better-off north (majority Arab and Muslim) and its poorer south (predominantly Christian and animist) with tensions that worsened during the subsequent dictatorship of Omar al-Bashir. Bashir seized power in 1989 and oversaw the Darfur war (2003-2005) in which over 300,000 people died in what is considered a genocide largely perpetrated by the Janjaweed (later formalizing as the RSF), a Arab-majority paramilitary group funded by Bashir to repress southern Sudanese rebels.[72] The country divided in two in 2011, with the south forming an independent state of South Sudan. Bashir's oppressive regime was overthrown in 2019 in a coup carried out jointly by the SAF and RSF, where competition over power led to the present civil war.

Sudan is considered an arena for regional proxy conflict, with Egypt and Iran the major backers of the SAF, and the United Arab Emirates (UAE), which is heavily invested in both Sudans, is allegedly supporting the RSF.[73]

The UAE has made large-scale agricultural investments in Sudan as part of a broader strategy to secure food supplies, access land and water, and control strategic infrastructure. Recently, UAE-linked companies such as International Holding Company (IHC) and Jenaan have leased and cultivated over 50,000 hectares (ha) in Sudan. In 2022, IHC partnered with Sudan's DAL Group to develop an additional 162,000 ha near Abu Hamad, designed to connect via a new 500 km road to a planned Red Sea port.[74] This Abu Hamad–Red Sea agricultural corridor is backed by approximately US $6 billion in investments. The project links farmland

to the proposed Abu Amama port and an integrated economic zone operated by Abu Dhabi Ports Group, enabling agro-exports and enhancing UAE influence over regional logistics.[75] Hence, the involvement of UAE has a critical dimension involving both security and politics, described as a type of non-military colonialism. The UAE has been accused of supporting RSF to protect its territorial investments and logistical networks; in response, Sudan's government cancelled the port agreement in November 2024 over concerns about Emirati support for the RSF.[76]

*Palestine**

The humanitarian and health impact of the ongoing genocide in Palestine by Israeli occupation forces has reached catastrophic levels. From October to December 2023, in just the first few months of the war, over 8,000 Palestinian children were killed. More than 15,000 children lost their fathers, and nearly 10,000 lost their mothers, underscoring the scale of almost immediate familial devastation.[77] As the Netanyahu regime intensified its bombardments of Gaza the scale of death and destruction grew unimaginably worse.

A January 2025 study estimated Gaza mortality in the war with Israeli occupying forces at between 55,298 and 78,525 between October 2023 and June 2024.[78] 59 per cent of the deaths were women, children and people over the age of 65. Using officially reported deaths only, and a conservative multiplier for indirect deaths due to conflicts, researchers estimate that by June 2024 186,000 Palestinians had died from the conflict.[79] During the first 12 months of the war, life expectancy dropped by 35 per cent to just half of its former average of 75 years;[80] and more women and children were killed than in any other 12-month period of armed conflict over the past two decades.[81]

Healthcare infrastructure has been deliberately targeted, with over 300 attacks on medical facilities reported and only 19 of Gaza's 36 hospitals partially operational (7 providing only basic emergency care), with 94 per cent damaged or destroyed, by early 2025. The collapse of water and sanitation systems has driven surges in disease: 180,000 upper respiratory infections, 136,400 diarrhea cases and over 55,000 cases of lice and scabies were reported as of December 2024.[82] The mental health burden is profound. PTSD symptoms affect 5 per cent of children and 40 per cent of adults; depression and anxiety rates are similarly high.[83] (see also Chapter C2)

At end of 2024, two million Palestinians in Gaza were living in internal displacement; with 92 per cent of housing destroyed, the combined rubble of the destruction (including Gaza's schools, health facilities, roads and public buildings) is 14 times greater than all conflicts combined since 2008. These figures highlight the scale of collective punishment and forced expulsion practices.[84]

*Our focus on the impacts of the war on Palestinians does not ignore the 7 October 2023 Hamas attack that killed 1,200 people, sometimes brutally, and abducted 251 hostages, many of which subsequently died. The response by the Israeli occupying force, however, has been hugely disproportionate to the initial Hamas assault and continues with the reported intent (by some Israeli ministers) to force all Palestinians out of Gaza.

Figure 1: Al Shifa Hospital after a two-week Israeli siege, April 2024

World Health Organization (http://bit.ly/4eCH1Xo)

These numbers are now dated, given the continued occupation and destruction of Gaza and, in March 2025, the Israeli blockade of all aid, food and fuel, and shutting off electricity to its main desalination plant virtually eliminating access to water. These actions have induced severe malnutrition, extreme hunger and high levels of starvation. Since late May 2025, when a US/Israel private agency set up two inadequately supplied emergency distribution sites, over 400 Palestinians have been killed, most by Israeli occupying forces, as they desperately attempted to obtain food.[85] These genocidal actions by the Israeli occupying forces are considered war crimes. UN Security Council calls for an immediate cease fire and resumption of full aid to Gaza are routinely vetoed by the US Trump administration. The Israeli occupying force (at the time of writing in mid-June) continues its fighting and bombardment with flagrant impunity.

One other notable and horrific feature of the war on Gaza: The targeting of health facilities and health workers. As of June 2025, this weaponization of health has destroyed or severely damaged at least 94 per cent of all health facilities in Gaza.[86] Over 1,400 health care workers have been killed,[87] and many others have been injured, detained, tortured or disappeared. This is the systematic dismantling of an entire health system, a grave breach of the Geneva Convention agreed upon in the aftermath of World War Two's destructiveness. The Israeli occupying force disagrees, arguing that Hamas uses these facilities from which to engage in armed conflict, or that the facilities (and patients within them) are used as human shields. This would remove the 'protected status' of such facilities, and their targeting would no longer constitute a war crime; but international law is clear that for this to occur the attackers must show clear proof (in all instances) that this is

the case. Otherwise, the assumption is that these facilities (along with most of the other buildings destroyed by the bombing of Gaza) are protected places.[88]

The Israeli occupying force is not alone in targeting health facilities and health workers. Since February 2022, there have been almost 2,000 Russian attacks on health care facilities in Ukraine, destroying or damaging over 900 hospitals and clinic,[89] resulting in the death of over 244 health workers.[90] Attacks on health facilities and health workers in Sudan's civil war have also occurred, though not at the same extent as in Gaza or Ukraine.[91] Hamas's (or Iran's) indiscriminate retaliatory bombings of Israel, and especially the recent Iranian targeting of an Israeli hospital in Soroka (June 2025), similarly violate international law governing conflict.

Conclusion: The excesses of neoliberal capitalist wars

War, conflict and the mass displacement of people are not new phenomena but have been regrettable features of human societies for millennia. The degree of physical damage and human carnage they create depends on the technologies of the weaponry available and the narcissistic viciousness of their combatting leaders. What this chapter illustrates is that the growth and consumption logic of capitalism incentivizes war and conflict to become larger, more destructive, and more profitable over time, with both world wars marking extremes in mortality and morbidity of combatants and civilians alike. Recent conflicts and displacements may now be more regional than global (though the risk of global war is increasingly present, see Introduction) but regional conflicts often function as competitions between the world's 'great' or imperialist powers. Their enmeshment with the logic of neoliberal capitalism has emboldened autocratic leaders and strengthened the wealth generation and power of the 'military/industrial complex' we were first warned about at the close of the second world war. Our systems of global governance, notably the UN and its Security Council, embody the countries that emerged victoriously from that war, and no longer reflect the multipolar global order (see Chapter A1).

Russia's invasion of Ukraine, the Trump administration's trade war and bullying demand that NATO member states increase their military spending, a non-diminishing number of regional conflicts, the intensification of xenophobic 'othering' of migrant and refugee populations (see Chapter C2) and the US desire to restrain the rise of China as a hegemonic competitor bode ill for a peaceful near future. This underscores the importance of strengthening counter-narratives drawn from those described in Chapters A1, A2, and A3; and embracing, as health activists have long done, the political imperative of peace and the moral imperative of care.

Reference List

1 Council on Foreign Relations. Center for Preventive Action. Council on Foreign Relations; Available from: http://bit.ly/3Tng00c

2 Hryhorczuk D, Levy BS, Prodanchuk M, Kravchuk O, Bubalo N, Hryhorczuk A, et al. The environmental health impacts of Russia's war on Ukraine. J Occup Med Toxicol. 2024 Jan 5;19(1):1. Available from: https://doi.org/10.1186/s12995-023-00398-y

3 Lakhani N. Emissions from Israel's war in Gaza have 'immense' effect on climate catastrophe. The Guardian. 2024 Jan 9; Available from: http://bit.ly/403vSsp

4 Mearsheimer JJ. The Tragedy of Great Power Politics. New York City: W.W. Norton & Company, 2014.

5 Rid T. Active Measures: The Secret History of Disinformation and Political Warfare. New York City: Farrar, Straus and Giroux, 2020.

6 Stengel R. Information Wars: How We Lost the Global Battle Against Disinformation and What We Can Do About It. New York city: Grove Press, 2019.

7 Ikenberry GJ. Liberal Leviathan: The Origins, Crisis, and Transformation of the American World Order. Princeton: Princeton University Press, 2012.

8 Ferdinand P. Westward ho—the China dream and 'one belt, one road': Chinese foreign policy under Xi Jinping. International Affairs 2016;92(4):941-57. Available from: https://doi.org/10.1111/1468-2346.12660.

9 Stent A. Putin's World: Russia Against the West and with the Rest. New York Boston: Twelve, 2019.

10 Kendall-Taylor A. Reverberations From Ukraine. Council on Foreign Relations: Center for Preventive Action; 2024 Jun. Available from: http://bit.ly/45TueNN

11 Sachs J. The War in Ukraine Was Provoked—and Why That Matters to Achieve Peace. Common Dreams. 2023 May 23; Available from: http://bit.ly/44MIwi4

12 Sauer P. One million and counting: Russian casualties hit milestone in Ukraine war. The Guardian. 2025 Jun 22; Available from: http://bit.ly/44wCbGn

13 United Nations (Ukraine). Civilian Harm and Human Rights Abuses Persist in Ukraine as War Enters Fourth Year. United Nations; 2025 Feb. Available from: https://bit.ly/4kgYqWB

14 Pianta M. What has been the Cost of Ukraine's War—And Who Pays? Social Europe. 2025 Mar 10; Available from: http://bit.ly/44tYFrD

15 Kushi S, Toft MD. Introducing the Military Intervention Project: A New Dataset on US Military Interventions, 1776–2019. Journal of Conflict Resolution. 2023 Apr;67(4):752–79. Available from: https://doi.org/10.1177/00220027221117546

16 Harris P. The Geopolitics of American Exceptionalism. Asian Perspective. 2022 Sep;46(4): 583–603.

17 Klare MT. The race for what's left: the global scramble for the world's last resources. New York: Metropolitan Books, 2012.

18 Bacevich AJ. America's War for the Greater Middle East. New York: Penguin Random House; 2016.

19 Biddle S, DeGruyter. Military Power: Explaining Victory and Defeat in Modern Battle. Princeton, NJ: Princeton University Press, 2010.

20 Khalil Y. Neoliberalism and the Failure of the Arab Spring. New Politics. 2015 Jul 15; Available from: http://bit.ly/3Gy3qrY

21 Saba Y, Ghaddar A. Libya's first private oil firm grows in eastern commander's shadows. Reuters. 2025 Feb 17; Available from: http://bit.ly/4lg8EI8

22 Lederer E. UN announces initiative to overcome political deadlock in Libya. AP News. 2024 Dec 16; Available from: http://bit.ly/4lI3IM9

23 Chatham House. Libya's War Economy: Six Things You Should Know. The Royal Institute of International Affairs: Chatham House; 2020 Oct. Available from: http://bit.ly/4nxBxB7

24 Wehrey F. The website of Carnegie Endowment for International Peace: Carnegie Endowment for International Peace. 2025; Available from: http://bit.ly/40BvEZN

25 Byman D. Explaining the Western Response to the Arab Spring. Journal of Strategic Studies. 2013;36(32).

26 Roy-Mukherjee S. Connecting the Dots: The Washington Consensus and the 'Arab Spring'. Journal of Balkan and Near Eastern Studies. 2015 Apr 3;17(2):141–58. Available from: https://doi.org/10.1080/19448953.2014.993258

27 Sherry H. Challenging Mainstream Sovereign Debt Narratives: A Rights-Based Approach for the Arab Region. Arab NGO Network for Development; 2024. Available from: http://bit.ly/3THUtj7

28 Gibson CW. Determinants of State Spending Patterns in Arab League Member States: A Post-Arab Spring Analysis, 1996–2014. Int J Polit Cult Soc. 2020 Mar;33(1):23–48.

29 Elshinnawi M. Study: Mideast Military Expenditures Increasing. VOA. 2014 Apr 23; Available from: http://bit.ly/4eDzXtC

30 Hassan O. The $74 billion problem: US–Egyptian relations after the 'Arab Awakening.' Int Polit. 2017 May;54(3):322–37. Available from: https://doi.org/10.1057/s41311-017-0032-1

31 Barfield TJ. Afghanistan: A Cultural and Political History, Second Edition. New Jersey: Princeton University Press, 2022.

32 Suhrke A. Reconstruction as Modernisation: The 'Post-Conflict' Project in Afghanistan. Third World Quarterly. 2007;28(7):1291-1308. Available from: https://doi.org/10.1080/01436590701547053

33 Ginty RM. Hybrid Peace: The Interaction Between Top-Down and Bottom-Up Peace. Security Dialogue. 2010;41(4):391-412. Available from: https://doi.org/10.1177/0967010610374312

34 Coll S. Ghost wars: The secret history of the CIA, Afghanistan, and bin Laden, from the Soviet Invasion to September 10, 2001. London: The Penguin Press, 2002.

35 Crile G. Charlie Wilson's War: The Extraordinary Story of the Largest Covert Operation in History. New York: Atlantic Monthly Press, 2003.

36 Rubin BR. The Fragmentation of Afghanistan: State Formation and Collapse in the International System, Second Edition. New Haven: Yale University Press, 1995.

37 Bergen PL. Holy War, Inc.: Inside the Secret World of Osama bin Laden Washington, DC: Free Press, 2002.

38 Rashid A. Taliban. New Haven: Yale University Press, 2022.

39 Saikal A. The fall of the Islamic Republic of Afghanistan: Internal and external causes. Third World Quarterly. 2022.

40 Dodge T. Iraq: from war to a new authoritarianism. London: The International Institute for Strategic Studies; 2012.

41 Visser R. The territorial aspect of sectarianism in Iraq. International Journal of Contemporary Iraqi Studies. 2010 Dec 1;4(3):295–304. Available from: https://doi.org/10.1386/IJCIS.4.3.295_1

42 Hernandez A. TotalEnergies begins construction on Iraq gas project. Reuters. 2025 Jan 10; Available from: http://bit.ly/4miuDye

43 Jiyad A. Iraq's oil industry post-2003: Between state control and foreign dependence. Energy Policy 2019;132:11.

44 Gunter M. Political corruption and oil mismanagement in Iraq. Middle East Policy 2019;28(8).

45 BOE Report. Iraq's massive Total oil deal heralds new revenue-sharing formula. 2013.

46 Capella Zielinski R. How States Pay for Wars. NY: Ithaca, 2017.

47 Elmas D. Second only to Ukraine: The cost of Israel's defense burden. Jerusalem Post. 2024 Nov 5; Available from: http://bit.ly/45TtUi3

48 Scheer S. Israel's war spending in 2024 lifts debt burden to 69% of GDP. Reuters. 2025 Jan 21; Available from: http://bit.ly/41cLREX

49 Masters J, Merrow W. U.S. Aid to Israel in Four Charts. Council on Foreign Relations. 2024 Nov 13; Available from: http://bit.ly/47bYqnM

50 Corbett J. Meet the Companies Profiting From Israel's War on Gaza Common Dreams. Volume 2025, 2023; Available from: http://bit.ly/4l3zB0O

51 Hartung W. Corporate America Cashed In on 9/11. The Nation. 2021 Sep 24; Available from: http://bit.ly/4lF8dHi

52 Young A. Cheney's Halliburton Made $39.5 Billion on Iraq War. Volume 2025, 2013.

53 team UF. This chart tells you everything you want to know about government spending. USA Facts. 2025. Available from: http://bit.ly/4oh2cmg

54 National Archives. President Dwight D. Eisenhower's Farewell Address (1961). 2024. Available from: http://bit.ly/44fWyZu

55 Rogin J. If Ukraine falls to Russia, Moldova knows it's next. Washington Post. 2024 Apr 25; Available from: http://bit.ly/3Id2Hgs

56 Staff. Trump casts doubt on willingness to defend Nato allies 'if they don't pay.' The Guardian. 2025 Mar 7; Available from: http://bit.ly/3ZZmVAp

57 Baccardax M. Defense Stocks Are a 'Mega Force.' NATO, New Tech Make the Case. Barron's. 2025 Jun 24; Available from: http://bit.ly/4nBUnXW

58 Elayah M, Fenttiman M. Humanitarian Aid and War Economies: The Case of Yemen. The Economics of Peace & Security 2021;16. Available from: http://bit.ly/3GsqFnl

59 Diefenderfer K. Distortive Economic Impacts of Humanitarian Aid. MUsings: The Graduate Journal 2024. Available from: http://bit.ly/4knH2j5

60 Ackerman S. Over $8B of the Money You Spent Rebuilding Iraq Was Wasted Outright. Wired. 2013 Mar 6; Available from: http://bit.ly/4knE1iS

61 United Nations (Palestine). UN Official: $53.2 billion needed for Palestinian recovery. United Nations; 2025 Feb. Available from: http://bit.ly/3ZWKKcc

62 Sanford J. Iraq's economy: Past, present, future. reliefweb. 2003 Jun 3; Available from: http://bit.ly/402Paya

63 Daw MA, El-Bouzedi AH, Dau AA. Trends and patterns of deaths, injuries and intentional disabilities within the Libyan armed conflict: 2012-2017. Fischer F, editor. PLoS ONE. 2019 May 10;14(5):e0216061. Available from: https://doi.org/10.1371/journal.pone.0216061

64 Wikipedia. Health in Libya. Wikipedia. 2024. Available from: http://bit.ly/3GsqAA3

65 Daw MA, El-Bouzedi AH, Ahmed MO. The Impact of Armed Conflict on the Prevalence and Transmission Dynamics of HIV Infection in Libya. Front Public Health 2022;10:779778. Available from: https://doi.org/10.3389/fpubh.2022.779778

66 Edrees WH, Abdullah QY, Al-Shehari WA, Alrahabi LM, Khardesh AAF. COVID-19 pandemic in Taiz Governorate, Yemen, between 2020 and 2023. BMC Infect Dis. 2024 Jul 25;24(1):739. Available from: https://doi.org/10.1186/s12869-024-09650-0

67 Federspiel F, Ali M. The cholera outbreak in Yemen: lessons learned and way forward. BMC Public Health. 2018 Dec;18(1):1338. Available from: https://doi.org/10.1186/s12889-018-6227-6

68 Dureab F, Al-Falahi E, Ismail O, Al-Marhali L, Al Jawaldeh A, Nuri NN, et al. An Overview on Acute Malnutrition and Food Insecurity among Children during the Conflict in Yemen. Children. 2019 Jun 5;6(6):77.

69 Butt MS, Tharwani ZH, Shaeen SK, Alsubari AM, Shahzad A, Essar MY. Maternal mortality and child malnutrition: Complications of the current crises in Yemen. Clinical Epidemiology and Global Health. 2022 May;15:101051.

70 Sana'a Center for Strategic Studies. The Impact of War on Mental Health in Yemen: A Neglected Crisis Volume 2025: The Sana'a Center for Strategic Studies, 2017. Available from: http://bit.ly/4et8R88

71 Mbaku J. Sudan: foreign interests are deepening a devastating war – only regional diplomacy can stop them. The Conversation. 2025 Jun 26; Available from: http://bit.ly/44cvQkv

72 Center for Preventive Action. Civil War in Sudan. Center for Preventive Action. 2025 Apr 15; Available from: http://bit.ly/3THVKqp

73 International Crisis Group. Sudan: A Year of War. International Crisis Group; 2024 Apr. Available from: http://bit.ly/44J4uCG

74 GRAIN. Land and power grabs in Sudan. GRAIN. 2025. Available from: http://bit.ly/3Tm3qyc

75 Emirates Leaks. Militia-Backed UAE Seizes Control Of Sudan's Abundant Resources. Emirates Leaks. 2024 Sep 23; Available from: http://bit.ly/403vlqp

76 MEMO. Sudan cancels deal to establish port with the UAE. Middle East Monitor. 2024 Nov 5; Available from: http://bit.ly/4nLkOKS

77 Schlüter BS, Masquelier B, Jamaluddine Z. A demographic assessment of the impact of the war in the Gaza Strip on the mortality of children and their parents in 2023. Popul Health Metrics. 2025 Mar 3;23(1):8. Available from: https://doi.org/10.1186/s12963-025-00369-x

78 Staff. Gaza death toll 40% higher than official number, Lancet study finds. The Guardian. 2025 Jan 10; Available from: http://bit.ly/4nuEYbB

79 Khatib R, McKee M, Yusuf S. Counting the dead in Gaza: difficult but essential. The Lancet. 2024 Jul;404(10449):237–8. Available from: https://doi.org/10.1016/S0140-6736(24)01169-3

80 Guillot M, Draidi M, Cetorelli V, Monteiro Da Silva JHC, Lubbad I. Life expectancy losses in the Gaza Strip during the period October, 2023, to September, 2024. The Lancet. 2025 Feb;405(10477):478–85. Available from: https://doi.org/10.1016/S0140-6736(24)02810-1

81 Oxfam. More women and children killed in Gaza by Israeli military than any other recent conflict in a single year – Oxfam. Oxfam International. 2024 Sep 30; Available from: http://bit.ly/40wz93E

82 Wikipedia. Gaza humanitarian crisis (2023–present). Wikipedia. 2024. Available from: http://bit.ly/3TnfaR6

83 Aqtam I. A narrative review of mental health and psychosocial impact of the war in Gaza. East Mediterr Health J. 2025 Mar 4;31(2):89–96, Available from: https://doi.org/10.26719/2025.31.2.89; Boukari Y, Kadir A, Waterston T, Jarrett P, Harkensee C, Dexter E, et al. Gaza, armed conflict and child health. bmjpo. 2024 Feb;8(1):e002407. Available from: https://doi.org/10.1136/bmjpo-2023-002407

84 iDMC. State of Palestine. Internal Displacement Monitoring Centre; 2025 May. Available from: http://bit.ly/3IcNcFb

85 Trew B, Hall R. 'My son went to get flour. He came back in a coffin': As the world focuses on Iran, Palestinians are being shot dead seeking aid. Independent. 2025 Jun 19; Available from: http://bit.ly/4nwZJ6w

86 World Health Organization. Health system at breaking point as hostilities further intensify in Gaza, WHO warns. 2025 May 22; Available from: http://bit.ly/4lDi0NX

87 MAP. 1,400 healthcare workers killed in Israel's systematic attacks on Gaza's health system. Medical Aid for Palestinians. 2025 May 9; Available from: http://bit.ly/3G8uf6d

88 Staff. Can hospitals be military targets? What international law says. The Guardian. 2023 Nov 17; Available from: http://bit.ly/4lA8Hy9

89 Physicians for Human Rights. 1762 attacks on health care over three years as Russia escalates its war on Ukraine's doctors and hospitals: PHR. reliefweb. 2025 Feb 18; Available from: https://bit.ly/4kiNgRn

90 MedGlobal. MedGlobal Strongly Condemns Russian Attacks on Medical Facilities in Ukraine. 2024 Dec 11; Available from: https://bit.ly/4012raw

91 Insecurity Insight. Attacks on Health Care in Sudan, 25 December 2024 - 07 January 2025. reliefweb. 2025 Jan 13; Available from: http://bit.ly/3ZZcTPU

People On The Move

Introduction

Regular migration is increasing but, even more rapidly, informal, irregular and refugee-seeking movements are on the rise, as people attempt to escape conflict, environmental degradation and entrenched poverty. A growing number of populations are also internally displaced, forced to move within their country's borders or to refugee camps in neighboring states. This chapter applies an intersectional lens to examine the critical importance of safeguarding migrants' health during transit and at their destinations. It also highlights the urgent need to challenge the criminalization and mistreatment of migrants after they cross borders. By analyzing the complex interplay of social, political and economic factors shaping migration experiences, this chapter underscores the ethical and human rights imperatives for equitable healthcare access and humane treatment in migration policies.

The first section introduces key foundational concepts and describes the dimensions of global migration. The second section explores the main drivers of migration, with particular attention to the increasing impact of climate change-induced displacement. The third section examines the structural causes of migration, emphasizing how contemporary patterns are deeply rooted in past and present colonial practices. The fourth section presents an approach for assessing migrants' health through the lens of the social determinants of health. The fifth section focuses on prospective actions for migration advocacy within right-to-health social movements.

Additionally, the chapter includes three case studies: migration in Italy, the mental health challenges of Palestinian refugees and the self-organized Health for Migrants conference in Brazil.

The dimensions of global migration

Global migration is a complex phenomenon that has shaped human societies for centuries, driven by a multitude of factors and producing significant impacts on economies, political systems and social structures. According to the International Organization for Migration (IOM), there were approximately 281 million international migrants worldwide in 2020,[1] a figure that underscores the increasing relevance of migration in global policy debates.

An immigrant is someone who relocates to a new country with the intention of settling or residing there for an extended period. Many receiving countries operate formal systems to review and accept new immigrants based on criteria such as work opportunities, education, family reunification or humanitarian needs. Despite these pathways, the immigrant experience often involves

navigating complex legal frameworks and bureaucratic processes, including visa applications, medical examinations and sponsorship requirements.

Individuals from lower-income regions may encounter particular hardships. For instance, prospective migrants from sub-Saharan Africa, parts of Latin America and Southeast Asia frequently face additional financial and logistical barriers, including limited access to diplomatic missions for visa processing or the necessity of undergoing medical exams in distant urban centers. These challenges are compounded by socioeconomic constraints and can impede migrants' ability to fulfill visa prerequisites.

After entry, immigrants typically face further obstacles related to registration for social services, such as public healthcare and education. They also grapple with social and psychological challenges, including linguistic barriers, limited professional networks, difficulties in securing stable employment or underemployment relative to their qualifications due to a lack of recognition of foreign credentials.

Within the group of immigrants, there are two subgroups that should be understood further: refugees and asylum seekers, and immigrants without legal status.

Refugees and asylum seekers are individuals fleeing persecution, conflict or violence in their home countries. Under the 1951 Refugee Convention and its 1967 Protocol,[2] states are obliged to provide protection and a range of rights to people who meet the legal definition of a refugee. The process of obtaining refugee status is managed at both international and national levels, often with support from the United Nations High Commissioner for Refugees (UNHCR). However, the willingness of certain Global North countries to accept refugees has declined in some instances, limiting resettlement and assistance. This discrepancy in reception policies often results in refugees living in protracted situations, with restricted access to healthcare, education and legal protection.*[,3]

Undocumented migrants, or immigrants without legal status, are individuals who enter a country without following official procedures or who overstay their visas. In many cases, socioeconomic pressures, conflict or environmental degradation compel such migrants to seek rapid relocation, leaving them unable to comply with formal entry processes. Because they lack recognized immigration status, undocumented migrants often have limited or no access to social services and formal employment, placing them at heightened risk of exploitation. According to the IOM, undocumented migrants frequently face greater exposure to labor and human rights violations, while also contending with the possibility of detention, deportation or punitive measures by host governments.

Another prominent category of migrants includes those who move for temporary or seasonal employment opportunities, whether in agriculture,

*The United Nations High Commissioner for Refugees (UNHCR) reported that by mid-2022, over 103 million people were forcibly displaced worldwide, including refugees, asylum seekers, and internally displaced persons (IDPs). Recent large-scale examples include the displacement of populations from Syria, Afghanistan, and Ukraine, many of whom have sought refuge in neighboring states or farther afield.

construction, caregiving or domestic work. The International Labour Organization (ILO) estimates that there were about 169 million migrant workers globally in 2019, highlighting the economic significance of labor migration.

Drivers of migration

Economic migration is one of the most prevalent forms of population movement worldwide, driven primarily by poverty, lack of opportunities and unfavorable economic conditions. This phenomenon can emerge from both acute economic crises and long-term structural inequalities. An example is the pattern of economic migration involving long-standing flows from Latin American nations to the United States, reflecting broader socioeconomic disparities between the Global South and the Global North.

Economic migration also encompasses highly varied scenarios. Some migrants lack formal status and cross borders seeking basic employment opportunities, while others are skilled workers or professionals aiming to improve their quality of life in a new country. A well-documented case is the global migration of healthcare professionals, including nurses and physicians from low- and middle-income countries who move to high-income countries to fill labor shortages and secure better wages.

Violence-induced or conflict-driven migration typically occurs when individuals and families flee situations of war, widespread violence or political persecution. Such movements often involve refugees and asylum seekers who require international protection under frameworks like the 1951 Refugee Convention. Recent large-scale examples include the displacement of Syrians, where an estimated 6.8 million people have fled the country since the onset of conflict in 2011, and the exodus of Ukrainians following the 2022 escalation of hostilities, with millions of people crossing into other European nations.[4]

While international law generally obligates states to offer protection to those fleeing persecution or armed conflict, the treatment of refugees can vary significantly. Observers have noted differential responses by certain high-income countries, with some receiving swift humanitarian assistance and more favorable migration pathways, while others face more stringent barriers. Critics argue that these discrepancies in reception may reflect underlying biases and raise concerns about equitable treatment under international refugee and human rights norms.

Climate change migration, though sometimes falling under economic or conflict-driven categories, is increasingly recognized as a distinct form of displacement. In this case, environmental factors linked to climate change constitute the primary catalyst for migration, whether through acute disasters (e.g. hurricanes, floods) or slow-onset crises (e.g. drought, desertification, sea-level rise). For instance, drought conditions in Nigeria have severely impacted traditional farming livelihoods leading to internal and cross-border movements. In 2009, the IOM adopted the concept of environmental migrants.[6,7]

Box C2.1: Migration of health workers

Although migration of health workers is not the primary focus of this chapter, it remains a highly pertinent issue with significant implications for health systems, particularly in countries of origin. A recent study by Hanrieder and Janauschek (2025) examined the outcomes of an agreement between the German government and Brazil's nursing regulatory authority which aimed to facilitate the migration of Brazilian nurses to Germany.[5] This case exemplifies a broader pattern of health worker migration from the Global South to the Global North, often actively encouraged by destination countries while insufficiently considering the collective interests and potential consequences for source countries.

To address ethical concerns surrounding international health workforce mobility, the World Health Organization (WHO) established a framework for ethical recruitment through its Global Code of Practice on the International Recruitment of Health Personnel. However, this framework applies only to a limited number of countries and remains non-binding, reducing its effectiveness in mitigating the adverse effects of health worker migration.

Another example is associated with Inuit communities in northern Canada that have moved to southern urban centers, often facing disruptions in communal ties and cultural practices. The absence of culturally appropriate services, coupled with barriers to employment and housing, can exacerbate vulnerabilities, including risks of homelessness and substance abuse.[8] Additionally, small island developing states in the Pacific face the prospect of relocation due to rising sea levels, illustrating how environmental degradation can threaten the cultural and social fabric of entire communities.

A structural approach to migration

At its core, economic migration stems from profound disparities in the global economic system and systemic inequalities in migrants' home countries. These inequalities are often rooted in a colonial history—or its modern counterpart, neocolonialism—that continues to shape global economic dynamics (see Chapter B5).

Colonialism historically established a system in which some nations dominated by exporting high-value technologies and controlling global supply chains, while others were relegated to providing raw materials and cheap labor. This exploitative model can be traced to past colonial practices, such as the Spanish and Portuguese colonization of Latin America, which relied on natural resource extraction and slave labor. The enduring effects of this exploitation are evident in persistent poverty, marginalization and systemic racism. Similarly, during the 19th century, European powers and the United States imposed economic domination on regions in Asia and Africa. These methods often entailed destruction and violence, as seen in Belgium's exploitation of the Congo or Britain's

dismantling of Bengal's once-thriving economy and intellectuality (nowadays Bangladesh).[9]

In contemporary times, the same economic imbalances prevail. Wealthy nations maintain their neocolonial dominance through mechanisms like monopolistic intellectual property protections and economic policies that ensure peripheral countries remain dependent as suppliers of cheap labor and raw materials. These dynamics stifle the economic growth of less economically developed nations, trapping them in cycles of poverty and dependency.

From an individual perspective, the decision to migrate despite its challenges is often a logical response to these structural conditions. High-income countries, particularly in the latter half of the 20th century, developed robust social security systems and created employment opportunities that are appealing to migrants.

Migrants' access to healthcare in times of crisis

Access to healthcare of migrants is a matter that should be addressed through the lenses of social determination of health. This perspective reminds us that health, including access to healthcare, is rooted in societal factors that are shaped by structural features of society. The analysis of access to healthcare for migrants starts with acknowledging the roots of the issues, based on colonialism and racism. Critical epidemiology and collective health offer a rich perspective for that by proposing a political framework for action that starts with the mobilization of the people who use healthcare services (see Box C2.2).[10]

Box C2.2: The mobilization of migrants in Brazil for the self-organized conference

The Brazilian Unified Healthcare System (SUS) is one of the world's largest universal health systems, established through social mobilizations that culminated in the 1988 constitutional right to health. Community participation plays a crucial role in SUS governance with mechanisms such as health councils and National Health Conferences, where elected representatives shape health policies. A significant milestone occurred in 2023 when, for the first time, migrants were formally represented at the national level, following mobilization by the National Front for Migrant Health (FENAMI). This growing participation underscores the increasing recognition of migrant healthcare issues in Brazil's public health agenda.

Although migrants legally have unrestricted access to SUS, numerous practical barriers hinder their ability to obtain care. These include language barriers, lack of information about SUS and bureaucratic obstacles, such as health professionals unlawfully requiring proof of residence or legal documentation. During the COVID-19 pandemic, migrant communities mobilized to advocate for their rights, leading to

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Box C2.2 continues

initiatives such as the 1st National Plenary on Health and Migration (2021) and the National Free Conferences on the Health of Migrants (2023 and 2024). These events facilitated discussions on healthcare accessibility and resulted in approved policy proposals aimed at strengthening migrant health rights within SUS.

Migrant-led mobilization has had a tangible impact on policy development. The 1st National Free Conference on Migrant Health (2023), organized by FENAMI, brought together 876 participants and led to the inclusion of 51 migrant-related guidelines in the 17th National Health Conference. The 2nd National Free Conference (2024) continued refining these discussions, ensuring that migrant health remains a priority in Brazil's broader National Migration Policy. The Ministry of Health has also responded to civil society demands by forming a Working Group (2023) to develop a National Health Policy for Migrants, Refugees, and Stateless Populations, highlighting a shift toward more inclusive healthcare governance. The same year 2023 marked a turning point in Brazil's migration policies, with the establishment of the National Policy on Migration, Refuge, and Statelessness (PNMRA). This policy replaces outdated security-based migration laws with a rights-based approach.

Despite these advancements, health and migration were not traditionally central to migration policy discussions, necessitating new frameworks to guarantee migrants' right to healthcare within SUS. Recognizing the barriers migrants face, healthcare policies must align with broader equity initiatives, such as those for Black, Indigenous and LGBTQIA+ populations, ensuring comprehensive and culturally sensitive approaches to healthcare. To effectively uphold the constitutional right to healthcare, Brazil must implement intersectoral policies that integrate migrant healthcare needs into regional realities. This involves expanding existing programs such as Brazil's National Oral Health Program, the More Doctors initiative* and Indigenous health services, which play crucial roles in improving access to primary care and specialized services. Achieving equitable healthcare for migrants requires inclusive policymaking, social participation and strengthened public health initiatives that promote intercultural care. Ultimately, ensuring migrant health within SUS is a fundamental human rights obligation, reinforcing Brazil's commitment to universal and equitable healthcare.

The current context of human mobility highlights critical issues related to the right to health for migrant populations, particularly during times of health and social crises. Migrant populations generally face barriers to accessing healthcare services due to health systems that are often unprepared to accommodate and meet their needs.[11]

*The More Doctors program in Brazil, launched in 2013, was an effort to deploy doctors, many of whom were from Cuba, to underserved areas.

Figure 1. Health workers in the UK protest against racist immigration controls in healthcare settings

Docs Not Cops / Patients Not Passports Campaign

The COVID-19 pandemic exacerbated these challenges, revealing deficiencies in the healthcare systems of various countries in response to the demands of a constantly moving migrant population. Border closures and mobility restrictions directly impacted migrants, forcing them to confront even more precarious living conditions and difficulties accessing essential healthcare services.[12] This situation exemplifies how global crises expose and amplify social inequalities, making it clear that the right to health must be a transnational priority.

Countries' disordered responses to COVID-19 illustrated the limitations of states to address the pandemic in isolation,[13] underscoring the urgency of a coordinated global health system capable of uniformly responding to health crises that impact the entire world (see Chapter D2). Transnational problems require transnational responses, reinforcing the idea that health must be approached as a collective right that transcends national borders.

Current migration flows are "more numerous, rapid, diverse, and complex than in the past"[14] necessitating a health governance system that transcends borders and integrates the health of migrants as a global priority. This perspective suggests the creation of policies that treat healthcare as a transnational right, allowing for a coordinated and solidarity-based response to public health challenges in an interconnected world. A global health rights framework should consider not only healthcare provision but also the promotion of dignified living conditions for all migrants, for which social assistance and cultural integration policies are seen as fundamental to ensuring the well-being of these populations.[15]

Future positive vision: what would be possible?

Access to healthcare and the social determinants of health: applying the framework to migrant health

A key lesson in studying migrants' right to health is that migration itself must be analyzed within the broader context of the social determination of health. This framework recognizes that health outcomes are rooted by social, political and economic structures that influence living conditions, access to services and overall well-being. A comprehensive understanding of migrants' health necessitates interdisciplinary approaches beyond the biomedical sciences to fully grasp the complexities involved.

The situation of the Bolivian migrant community in São Paulo, Brazil, exemplifies this reality. Many migrants relocate in pursuit of better employment opportunities, yet they often face exploitation in informal or precarious labor markets. In São Paulo, for instance, the textile industry has long been associated with exploitative labor conditions for Bolivian migrants. The profound impact of labor on migrant health underscores the need for policy interventions addressing occupational hazards, fair wages, and workers' rights. Their precarious working and living conditions increase their vulnerability to specific health conditions, such as Chagas disease. Beyond biomedical factors, barriers to healthcare access—such as language difficulties and procedural complexities in public health services—exacerbate their health risks. A nuanced analysis of migrant health must therefore account for both structural barriers and social determinants, which together shape their health outcomes.

The need for specific health policies for migrants

As illustrated by the experiences of Bolivian migrants in São Paulo and of Inuit populations in urban centers of Canada, migrant populations require tailored health policies that incorporate principles of equity and address their unique vulnerabilities and challenges. Migrant-specific policies should account for sociocultural, linguistic and administrative barriers that limit their ability to access healthcare services. In Brazil, the National Conference on Migrants' Rights has advocated for the enforcement of a dedicated health policy for migrant populations. Such policies should not be regarded as exceptional but rather as essential components of a broader health equity agenda.

Migrants at the center of the debate

Beyond specific policies, it is imperative to place migrants at the center of discussions on health and social rights. The Brazilian case highlights the role of collective organization and social movements in advancing migrant health rights. Migrant-led organizations serve as crucial platforms for advocacy, mutual support and political mobilization, ensuring that their voices shape public policies and service provisions.

Box C2.3: Health workers' mobilization for migrants' health in Italy

In recent decades, Italy has transitioned from an emigration country to a major destination for immigrants, with foreign residents now comprising approximately nine per cent of its population. While most migration is driven by family reunification and employment, Italy also experiences unplanned refugee and asylum seeker arrivals due to conflicts, political instability, and climate change. Although the National Health Service (SSN) formally guarantees healthcare access to documented migrants and provides essential and emergency care for those without legal status, significant health inequalities persist. These stem from socio-economic disadvantages, fragmented primary healthcare and barriers to service access. Instead of addressing these inequities, trends such as privatization of healthcare services and institutional racism have further marginalized migrant populations, exacerbating disparities in public service provision.

The SSN faces systemic challenges in ensuring equitable healthcare access, with regional disparities and a fragmented primary care model hindering effective service delivery. Despite its foundational principles of equity and solidarity, the system has struggled with weak territorial networks and a reactive approach to care, which became evident during the COVID-19 syndemic. Additionally, discretionary practices by healthcare authorities—such as bureaucratic hurdles to access the SSN for undocumented migrants—have further restricted access. Institutional racism exacerbates these disparities, as illustrated by preferential treatment of Ukrainian refugees compared to asylum seekers from African and Middle Eastern countries, highlighting systemic biases in migration and healthcare policies and practices.

A lack of robust information technology infrastructure further disrupts healthcare continuity for migrants, excluding them from health data systems and reinforcing disparities. Linguistic and cultural mediation services are also undervalued and underfunded, with mediators lacking formal recognition as professionals. Meanwhile, the increasing privatization of healthcare, driven by funding cuts and outsourcing, has led to longer waiting times, staffing shortages and greater reliance on private and non-profit organizations. Many marginalized groups, including migrants, depend on third-sector services such as grassroots clinics and humanitarian organizations to access care. This trend reflects a governance model where public oversight is minimal, reinforcing inequalities within the SSN.

Beyond healthcare, Italy's migration policies have become increasingly restrictive, characterized by the criminalization of migration and solidarity ("crimmigration"). Since 2018, nationalist governments have pursued policies that defund migrant reception services, restrict access to international protection and limit pathways to legal migration. Measures such as expanded detention centers (CPR), harsher penalties for irregular migration and restrictions on NGO-led search-and-rescue operations in the Mediterranean Sea further marginalize migrants, leaving many in

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Box C2.3 continues

precarious legal and social conditions. Simultaneously, Italy has externalized border control, funding Libyan and Tunisian coast guards to block departures and negotiating controversial migrant reception centers in Albania. These policies, alongside administrative restrictions such as the recent ban on SIM card purchases for undocumented migrants, exemplify growing efforts to exclude migrants from basic rights and public services.

Despite these exclusionary trends, grassroots organizations and civil society initiatives continue to resist and advocate for migrant rights. Networks such as the International Network of Social Clinics oppose neoliberal healthcare policies and provide vital community-based care, while the Italian Society of Migration Medicine (SIMM) influences health policy through research and advocacy. The "NO CPR" campaign challenges the expansion of detention centers, recently securing a declaration from Italy's National Medical Association condemning medical participation in forced transfers to detention facilities in Albania. Additionally, Afro-descendant healthcare professionals and second-generation immigrant activists are driving conversations on decolonizing healthcare and migration policies, advocating for systemic reforms that center on the lived experience of racialized communities.

In Italy, the mobilization of healthcare workers advocating for migrant rights is increasingly driven by the descendants of early migrant populations (Box C2.3). This underscores the importance of recognizing migrants not as passive beneficiaries of support but as active agents of change in shaping healthcare systems and social policies. While broader society must support migrants in their struggles, these efforts should center on their leadership and lived experiences.

Universal health systems and migrant health

The fight for migrant health rights should not be seen in isolation but as part of a broader struggle for universal, public healthcare systems. A robust and accessible healthcare system—grounded in the right to health—is crucial for ensuring high-quality care for all, including migrants. However, in many contexts, migrants are unfairly scapegoated for the deterioration of public services when, in reality, the erosion of healthcare quality is often linked to austerity policies and structural underfunding rather than migration itself.

The Brazilian healthcare system (SUS) provides a compelling example of how universal access policies benefit migrant communities. Despite facing challenges, its non-restrictive approach ensures that migrants can access essential services, reinforcing the importance of universalist health policies. Conflict-affected regions such as Palestine, however, illustrate the devastating consequences of the destruction of health infrastructure due to war and prolonged occupation (Box C2.4). In such settings, access to healthcare becomes not only a public health issue but also a humanitarian and political concern.

Box C2.4: Refugee health in Palestine

*Interview with a psychologist, researcher of conflict and occupation zones, and coordinator of mental health intervention projects in the Palestinian territories.**

The refugee context

The status of refugee was given to Palestine when the UN established the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in 1949 to support the Palestinian people. They are considered refugees because they were displaced from their lands but still live in their own territory, thus being refugees from their own land. In the Palestinian case there is the complexity of Palestine not being recognized as a country with autonomy to protect rights. UNRWA, by recognizing and naming them as 'refugees', assures the Palestinian population that has been forcibly displaced the possibility of protection of their rights by the UN.

Since 1948, since the Nakba, what we have in Palestine are countless groups of people who have been displaced and cannot return to their own lands. For example, many people in Jerusalem cannot visit their land, homes and families in the West Bank. There are cases of families who have been unable to see each other for decades, because part of the family is in one place and does not have the validation to cross the checkpoints. In relation to Gaza today, there is the situation of several displaced people who have left and are living on the border with Egypt.

So, migration in Palestine has been going on for a long time, this internal and external migratory process as well forced displacement and diasporas. Many have also taken refuge in other countries. Years ago, most of the territory was still Palestinian, now most of it is occupied. This fragments the territory in what is called area A, B and C, with different controls and possibilities of access and movement. Israeli control, Palestinian Authority control and a third area that is practically uncontrolled, where there is a limbo, areas close to a settlement that is not under Israel's control, but also which do not respond to the Palestinian Authority because it is in that gray zone. The population living in these regions finds themselves in a state of exception, literally, because they do not have a state of protection that can legally respond so that their rights are guaranteed. There are no resources in these areas, because there is no authority, so they are prevented from accessing all types of rights.

Thinking about the health field, it is not just about the difficulty of access, like certain more isolated regions, but the impossibility of having access to health.

Access to health and mental health in the Palestinian territories

In regions like the city of Tubas, in the northeastern West Bank, we found several villages that have no access to healthcare. Which is something so contradictory,

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*For security reasons, the interview is published anonymously.

Box C2.4 continues

because in regions where there is access to healthcare, there is also a system that works and that is not as precarious as with other countries that receive humanitarian aid. When we talk about the West Bank, there is a certain organization and resource for health, but there are certain areas, these zones that I mentioned, the fragmentation of the territory into areas B and C, the conditions of access to rights are also fragmented, among them health, creating precarious access, a consequence of the occupation.

There is mental health in the tertiary system, which would be the psychiatric hospital. At the secondary level, there is a certain psychiatric component and in primary health care there is, in some areas, what they call primary mental health care. There are some nurses who were trained to provide this more psychosocial support, and health educators and social workers, but there is no psychologist in the public health system. So, psychotherapeutic work, the decentralization of specialized services for access to the community is non-existent. The healthcare system in the Palestinian territories has what they call psychosocial support, which is often offered by a social worker. There are several organizations, including local organizations, that have psychosocial support, but specialized, decentralized psychotherapy services with free access to the community are not included. International organizations end up trying to cover some of this gap. There is a private system that works, but it is accessible only to a minority that may have financial resources.

Main challenges for realizing the right to health in the Palestinian territories

The primary care system exists, even in a remote village there is some health service, in most of the territory, but it is limited, you have a doctor going once a week. When we talk about access to health in this context, the barrier is in the existing occupation system, which is also dismantling the health system. For example, with the pharmaceutical system in Palestine, the import of medication arrives at a pharmacological center that distributes the medication. For this to happen, any import needs validation from Israel. This validation takes place by parties and different departments, with the different departments in Israel responsible for different medications often changing and so, the medication no longer arrives. There is an interruption in supply and no guarantee of when it will be resumed. This disruption of treatment destabilizes the entire care network. When we talk about chronic cases, those in vulnerability, people living with mental health issues, people with life experience of mental disorders, this medication disruption ends up having effects that increase the vulnerability of this community.

When talking about Gaza, the situation is even more complex. Gaza is another world; everything is completely controlled. There are times when pain medication has not

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Box C2.4 continues

been validated, so surgeries are performed without pain medication. Situations like these were already occurring before October 2023. There was access to healthcare in Gaza, there was already a university for courses in different areas of health care, they were setting up a master's degree in psychology, but everything was destroyed, it was bombed, in particular in the last year [2024]. And what we see in the history of Palestine is that when a minimum is reconstructed, it is soon destroyed again.

Today, the scenario we have in Gaza, in talking about access to health, is closed borders, looted medical and humanitarian cargo, even with Israel's validation. We are talking about resources, donations, medications looted and destroyed when they are left stored without the necessary conditions for preservation. We are witnessing a direct attack on hospitals, clinics, and healthcare teams, even though under international and humanitarian law, medical facilities should be respected (see Chapter C1).

Everything in a hospital is generated from energy, from the baby's incubator to the temperature of the medication, to carrying out surgery, the operating room, everything needs energy. So, when there is a power shutdown, when electricity is cut-off, there is no way to maintain minimum health care operations. So, without electricity, without fuel for the generator, it's a whole medical system that doesn't work. How can we offer care to this huge contingent of people forced to move?

Future perspectives

It's hard not to think about the increase and continuity of occupation. With this movement of occupation from the top of the hill down, to the point where the occupation reaches the lower part and closes and suffocates the Palestinian city, with this, these islands are formed, and a checkpoint is placed, isolating the city. What we see in the West Bank is the increase in these island isolations. As a result, the mobility of communities decreases and the possibility of employment decreases, access to healthcare decreases. This has intensified in recent years, not just in 2023 and 2024, with this absurdity, this genocide in Gaza, this strategy has existed for years, it is repeated in the same way.

Thinking about the future and the realization of the right to health, the first thing that needs to happen is the recognition of the Palestinian territory as a State. Palestine needs to be recognized urgently so that there can be a possibility of a state organizing itself. Because today what happens is a territory with a highly militarized State that has legal power over that territory. And not only that but, from a legal aspect, we need to recognize Palestinians as humans, as beings with rights. That is why the name 'refugees' makes the situation a little better. There is no way to talk about access to health without talking about the protection of rights.

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Box C2.4 continues

But now also speaking of a discursive dimension, so that there is also a recovery of a social bond, it is necessary to hold accountable actors who disrespected all of this, who were actors in this violence. I think this accountability of actors is extremely necessary as well, for a collective healing of this wound. It's an important point, in my opinion.

In a discursive loop, looking at the Palestinian territories, I see a lot of potential. It is a community that has resources. It is a politicized community in the sense of politics in the polis. I'm not talking about political group politics, but rather about polis, about agency actors in a polis. It is a community that has this strength. It is a community that manages to have this collective reconstruction, collective memories. And I see this potential for collective reorganization if they have the opportunity. It is important to highlight that, with all these issues, they can reorganize themselves, rebuild themselves, there is this collective possibility, so that we can talk about the right to health and access.

Addressing Structural Causes and the Need for Political Action

Any meaningful debate on migration and health must acknowledge the structural causes of migration, which are deeply intertwined with historical and geopolitical factors. As the case of Palestinian displacement demonstrates, colonialism, armed conflicts and economic inequalities continue to drive forced migration and shape migrants' health vulnerabilities. Addressing migrant health requires not only policy reforms but also a broader political commitment to addressing systemic injustices that fuel displacement. The health and well-being of migrants cannot be divorced from the broader struggles for social justice, economic equity and human rights at both national and global levels.

Reference List

1 IOM. World Migration Report 2022. Geneva: International Organization for Migration; 2021. Report No.: PUB2021/032/L. Available from: https://bit.ly/4iyVVOv

2 United Nations. Convention Relating to the Status of Refugees. Geneva: United Nations; 1951. Report No.: Assembly Resolution 429 (V). Available from: https://bit.ly/44M7hLQ; United Nations. Protocol relating to the Status of Refugees. New York: United Nations; 1967. Report No.: Resolution 2198 (XXI). Available from: https://bit.ly/3EutfbH

3 UNHCR. Mid-Year Trends 2022. Geneva: United Nations High Commissioner for Refugees; 2022. Available from: https://bit.ly/4m8w43d

4 Eurostat. Temporary protection for persons fleeing Ukraine – monthly statistics [Internet]. Eurostat; 2025. Available from: https://bit.ly/4c0z68g

5 Hanrieder T, Janauschek L. The 'ethical recruitment' of international nurses: Germany's liberal health worker extractivism. Review of International Political Economy. 2025 Feb 18;1–25. Available from: https://bit.ly/42C7hwI

6 Kaczan DJ, Orgill-Meyer J. The impact of climate change on migration: a synthesis of recent empirical insights. Climatic Change. 2020 Feb;158(3–4):281–300. Available from: https://bit.ly/3GvY5Be ; Beine M, Jeusette L. A meta-analysis of the literature on climate change and migration. J Dem Econ. 2021 Sep;87(3):293–344. Available from: https://bit.ly/4cYiTO6

7 Beine M, Jeusette L. A meta-analysis of the literature on climate change and migration. J Dem Econ. 2021 Sep;87(3):293–344. Available from: https://bit.ly/4cYiTO6

8 Tungasuvvingat Inuit, Smylie J, Firestone M, Spiller MW. Our health counts: population-based measures of urban Inuit health determinants, health status, and health care access. Can J Public Health. 2018 Dec;109(5-6):662-70. Available from: https://bit.ly/3EIpaAA

9 Rahman A, Ali M, Kahn S. The British Art of Colonialism in India: Subjugation and Division. PCS. 2018 [cited 2025 Apr 2]; Available from: https://bit.ly/3GoZR7l

10 Breilh J, Krieger N. Critical epidemiology and the people's health. New York, NY: Oxford University Press; 2021. 1 p.

11 Granada D, Carreno I, Ramos N, Ramos MDCP. Discutir saúde e imigração no contexto atual de intensa mobilidade humana. Interface (Botucatu). 2017 Jun;21(61):285–96. Available from: https://bit.ly/4jU2hsZ

12 Brage E. Migración y salud: reflexiones a partir de una etnografía en centros de salud en São Paulo, Brasil, y Buenos Aires, Argentina, durante la pandemia de COVID-19. TRAVESSIA - Revista Do Migrante. 2023;1(95):39–56. Available from: https://bit.ly/4jrBPab

13 Siqueira Garcia H, Gerei Dos Santos K, Teixeira Ghilardi L. A pandemia da Covid-19 como realidade transnacional. Opin jurid. 2020 Oct 20;19(40):495–512. Available from: https://bit.ly/433gHkJ

14 Ventura M. Imigração, saúde global e direitos humanos. Cad Saúde Pública. 2018 Mar 29 [cited 2025 Apr 2];34(4). Available from: https://bit.ly/3GsHcaF

15 Bravo Shuña R del P, Galeão-Silva LG. Mujeres migrantes y el SUS: desafíos del cuidado como derecho. Périplos: Revista De Estudios Sobre Migraciones. 2023 Dec 21;7(2). Available from: https://bit.ly/3EJyB2G

Putting the Right to Health to Work

Introduction

The COVID-19 pandemic was very instructive about the relationship between work and health. On the one hand, it demonstrated how important labor is for our society, as the powers that be designated 'essential' a number of sectors that are often overlooked, including retail, health work, cleaning, and other service work. On the other hand, the pandemic laid bare how important people's working conditions are for their health. Some workers, such as those in the meatpacking industry, care workers, and migrant or temporary laborers staying in dorms, were more at risk than others. Moreover, preventive measures like social distancing and working from home were not options for most people because their work did not permit these. COVID-19 brought attention to much more than the work/health relationship. It also shone a bright light on the importance of work, or more precisely, employment conditions, as a social determinant of health. This underscores the need for decent work, including workplace safety and the right of workers to organize as trade unions and engage in social dialogue.

As early as the beginning of February 2020, frontline doctors and nurses in Hong Kong embarked on strike to protest inadequate supply of personal protective equipment (PPE) and failure of hospitals to apply the precautionary principle, i.e. by prioritizing measures such as isolating suspected cases, using enhanced protective protocols for healthcare workers, and implementing infection control practices even when definitive evidence of transmission routes was still emerging. They had the support of Public Services International (PSI), the global trade union federation of health and care workers, and the International Trade Union Confederation (ITUC).[1] Similarly, between March and April 2020, doctors in Zimbabwe and nurses in both Zimbabwe and Malawi went on strike to protest poor working conditions and workplace safety that put them at graver risk. These demands, as well as the work burden due to staff shortages, were central to a global wave of healthcare workers' strikes and protests during the pandemic.[2] Even now, they remain issues of concern that need to be addressed, both for the health of care workers, and for the attainment of health for all.

In a health-positive way, work can provide satisfaction, enable individuals to develop their talents, and allow people to contribute to society. Paid employment is linked to improved health outcomes, particularly mental health, in both the short and long term.[3] However, the health benefits of employment depend on job quality. A study published in *The Lancet* revealed that workers with greater job autonomy, such as flexibility in managing their work and having supportive supervisors, experience better well-being and health.[4] Work can also harm health

when workers do not have any autonomy, when workload is too high, and when workers are exposed to dangerous conditions or toxic substances. Unfortunately, workers often do not have much choice and must accept unhealthy working conditions to make a living and sustain their families.

How Capitalism Shapes Our Work—and Our Well-being

Working conditions are related to the tasks performed by workers, the way the work is organized, the physical and chemical work environment, ergonomics, the psychosocial work environment, and the technology being used. Two people can do the same job, in the same enterprise, and yet their status might differ greatly. One might be a regular employee, while the other could be a temporary worker employed by a subcontractor. Their working conditions might be similar, but their level of stress or exposure to risks of injuries may be quite different. One's work-related health is therefore greatly determined by his or her place in the chain of production. Whether one is a trainee, an irregular worker with a subcontractor, a manual worker with a regular contract, an employee, a supervisor, a manager, or the CEO makes a big difference.

Employment relations vary greatly between countries and evolve over time. Slavery and bonded labor might be almost extinct in large parts of the world, yet millions of men, women, and children are still forced to work under physical or mental threat, abuse, or physical constraints. A report by the International Labor Organization (ILO), Walk Free—an international human rights group working on the eradication of modern slavery—and the International Organization for Migration (IOM) estimates that 50 million people were living in modern slavery in 2021, including human trafficking, forced labor, and debt bondage.[5] Apart from commercial sexual exploitation, forced labor is found predominantly in services, manufacturing, construction, agriculture, and domestic work. Child labor is also often based on violence, abuse, and other human rights violations. According to UNICEF, about 160 million children were subjected to child labor at the beginning of 2020, including or leading to sex trafficking and child prostitution.[6] Additionally, the Kafala system, which binds a migrant worker's legal status to their employer's sponsorship, exists in several Arab states and has subjected migrant domestic workers from Africa and South Asia to extreme exploitation and, in some cases, death.

Box C3.1: Croatia Airlines Cabin Crew Unites to Improve Occupational Health and Safety

As early as 2009, cabin crew members at Croatia Airlines, the country's national carrier, began pushing for the recognition of occupational health and safety needs specific to their demanding working conditions. It took approximately a decade for their efforts to achieve a major milestone: the recognition of health and retirement-related benefits. Flight attendants and stewards often experience the toll of

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long and irregular shifts, on-call duties, and limited rest between flights. These conditions frequently led to disrupted sleep patterns, musculoskeletal issues, and stress.

In socialist Yugoslavia, the health impacts of cabin crew work were acknowledged, and specific benefits were granted to these workers. However, this recognition was lost during the political and economic transitions of the 1990s. In the decades that followed, Croatia Airlines' management and state institutions largely ignored workers' calls to address the issue, despite their responsibility to protect workers' health.

Determined to fill this gap, the cabin crew trade union, SKOZ, took the lead. The union allocated its own resources to conduct an in-depth analysis of the health effects of airline work. Former SKOZ officials highlight that this initiative relied heavily on the active participation and support of union members. Without their involvement, the effort might not have succeeded.

The analysis drew from a combination of cabin crew observations, expertise in occupational health and safety, and the experiences of other trade unions in transport and logistics, including seafarers. Lacking support from state health authorities, SKOZ managed to invest around €15,000 into the project—an amount that would be unattainable for many unions in lower-income sectors. This underscores the challenges faced by other workers experiencing similar health issues who lack the resources to fight for necessary protections and benefits.

While campaigning for better health and safety standards, SKOZ was simultaneously working to organize cabin staff employed through agencies. Croatia's labor market, marked by high rates of temporary contracts and agency employment, left many workers without the protections negotiated for permanent staff. Without union intervention, agency workers often remained excluded from collective agreements, jeopardizing both their health and material rights. By addressing occupational health and safety standards at a systemic level, SKOZ succeeded in extending protections for workers and demonstrated the power of unified trade union organizing.

In the end, the efforts of SKOZ bore fruit. Cabin crew members in Croatia gained formal recognition of the specific challenges posed by their working conditions, including irregular sleep patterns, high noise levels, temperature fluctuations, and physical demands. This recognition brought vital protections and benefits to a workforce whose health had long been overlooked.

Informal employment is still the most widespread employment arrangement globally. The informal economy is defined by Women in Informal Employment: Globalizing and Organizing (WIEGO), a research-policy-action network of workers in the informal economy and their allies, as a diverse set of economic activities, enterprises, jobs, and workers that are not regulated or protected by the

state. The concept originally applied to self-employment in small, unregistered enterprises, but is has since been expanded to include wage employment in jobs without social or legal protection.[7] It is also sometimes referred to as the popular economy, so as not to marginalize or discredit it.

The ILO estimates that two billion people worldwide – more than 61 per cent of all the world's employed population – make their living in the informal economy, in an array of jobs, such as farming and agriculture, street and market vending, waste picking, domestic or home-based work, construction work and digital platform work. Ninety-three per cent of the world's informal employment is in emerging and developing economies (Figure 1).[8]

Figure 1. Distribution of informal employment: A Statistical Picture

REGION*	%
Sub-Saharan Africa (excluding Southern Africa)	92
Sub-Saharan Africa as a whole	89
Southern Asia	88
East and South-Eastern Asia (excluding China)	77
Middle East and North Africa	68
Latin America and the Caribbean	54
Eastern Europe and Central Asia	37

*Excluding developed countries.

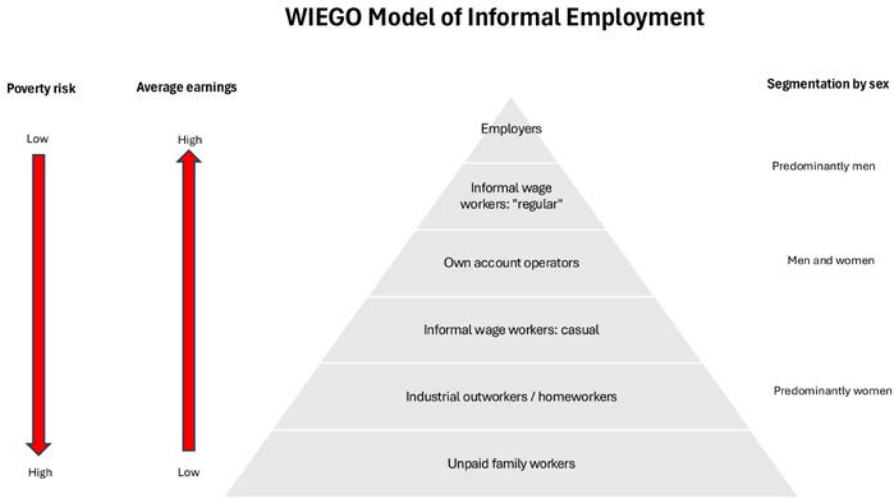
Source: ILO, Distribution of informal employment: A Statistical Picture, 2018[9]

Formal work relations are not a guarantee for decent work, though. That is why precarious work—or job insecurity—is another important category of employment relations. In recent decades, labor market flexibility (a code word for rolling back labor rights) has increased in both high-income and low- to middle-income countries. This trend is marked by a growing number of temporary contracts, largely driven by the rise of the platform economy and the expansion of the service industry. In the platform or 'gig' economy, tasks are assigned through an open call system, where work is allocated to individuals such as drivers and delivery personnel.

Meanwhile, the service industry has seen the emergence of a peripheral workforce comprising of temporary agency workers, with part-time positions evolving into contracts that lack guaranteed hours and often involve irregular or on-call schedules. These types of jobs typically offer lower job quality, with greater exposure to occupational risks, reduced income security, and lower wages – all of which can negatively impact workers' health.[11]

There are important gender dimensions to the informal economy, with women and marginalized genders concentrated in the most vulnerable and most exploited forms of work—particularly within domestic work or market vending—where they face gender-specific workplace risks that impact their health and livelihoods (Figure 2).

Figure 2: Concentration of women in most vulnerable workforce



Source: Based on Chen et al., 2005[10]

Time is also a factor that affects working conditions. Capitalist production subjects workers to increasing demands. Every action can be timed. In a car plant, workers have a limited time, counted in seconds, before the next car passes on the assembly line. Care workers in a nursing home have only a few minutes to wake up, bathe, and get an elderly person to the table. This time pressure conflicts with what is taught in schools as the correct posture. It can cause various illnesses, such as repetitive strain injuries (RSIs), a term doctors use for all complaints related to repeatedly performing the same, sometimes small, and not inherently strenuous, movements over a long period.

In industrialized countries, stress and burnout are becoming the black lung of the 21st century. Fifty years ago, it was the lungs of workers that suffered from exposure to asbestos and other pollutants, while patients struggled with the silent enemy of lead poisoning. Toxic substances and workplace accidents are still a problem, but now there is also an epidemic of mental health problems and physical overwork.

The pressure to constantly juggle work hours and dozens of job applications for a new job weighs heavily. Uncertainty about a job or stress from combining two part-time jobs or temporary assignments is a daily reality for many.

In agrarian societies, as well as in industrialized countries, day labor is rampant. People often only find out a few hours beforehand whether they will have a job that day.

Working with temporary and insecure contracts is associated with poorer mental health, negative stress, psychological suffering, anxiety, depressive symptoms, antidepressant use, and longer duration of depression-related work disability.[14] In the industry and construction sectors, precarious and unstable jobs are associated with more frequent and more serious work accidents, as well as musculoskeletal complaints.

Job loss and job insecurity resulting from the wave of restructuring and bankruptcies after the financial-economic crisis of 2008 similarly impact mental health, with research finding that people from lower social classes and lower education backgrounds become more susceptible to suicide.[15]

Competition and the capitalist drive for profit often comes at the expense of the well-being and health of workers. In pursuing ever higher profit margins, most employers ensure that people work faster, provide only temporary contracts so that they are hired only when necessary, and work longer hours. All three of these strategies have negative consequences for health. Under capitalism, the balance between work and health is continuously under pressure.

The right to health at work

The right to health is indivisible from the right to healthy, safe, and dignified working conditions. Global frameworks, such as the Universal Declaration on Human Rights and the International Covenant on Economic, Social and Cultural Rights, set out the human right to health for all, including workers of the world.

Figure 3: Kenyan medical workers stage a protest

Source: People's Health Dispatch, photo by Dr. Ayub (ýobo on dà flag)/X

Box C3.2: The Struggle of Health Workers in Kenya

The struggle of healthcare workers in Kenya offers an insightful picture of the importance of strong unions for defending workers in the face of challenging working conditions, profiteering by global health companies, and state repression.

In February 2024, members of the Kenya Medical Practitioners Pharmacists and Dentists Union (KMPDU) were violently dispersed by the police when the union organized "a peaceful protest to demand the release of funds allocated for the deployment of interns and payment of postgraduate fees, essential for the future of healthcare in Kenya."[12] The union's Secretary General was shot in the head with a teargas canister and had to undergo surgery. These actions led to a 56-day strike before a collective agreement was reached.

The claims by the Kenyan government that it lacked the resources to fund decent conditions for healthcare workers and the public provision of universal access to quality healthcare have been proven false. In September 2024, the Centre for International Corporate Tax Accountability and Research (CICTAR) issued its Kenya's Health Care Crisis: Where is the Money? report, which revealed how Vamed, a subsidiary of the global health company Fresenius, was fleecing Kenya of millions of dollars through shady contracts, while the Kenyan public health system remained grossly underfunded.[13]

Despite this, billions of working people continue to face astronomical out-of-pocket payments when accessing healthcare, lack of insurance coverage when informally employed, stigma from healthcare professionals due to discriminatory perceptions of their class, inadequate quality of health services due to privatization, commercialization, and austerity, and a lack of universal basic occupational health services. These conditions threaten the health and livelihoods of workers, especially those engaged in informal employment.

In 2022, after extensive discussion in the shadow of the COVID-19 pandemic, the 110th session of the International Labour Conference adopted a 'healthy and safe working environment' as the fifth Fundamental Right and Principle at Work. This development, at least in theory, represented a wide-reaching extension of workers' rights worldwide.

The ILO Fundamental Rights and Principles serve as both an international framework and an important point of reference for governments and capital in the regulation of labor. The inclusion of a healthy and safe working environment as a fundamental right and principle means that ILO Member States are legally obligated to implement two workers' health-related ILO Conventions—Convention 155 on Occupational Safety and Health, and Convention 187 on the Promotional Framework for Occupational Safety and Health. Both of these had previously been ratified by only a minority of ILO Member States, reflecting the lack of importance paid to workers' health by states in both the Global South and the Global North, as well as the typically low rate of ratification of ILO Conventions by Member States.[16]

In practice, however, the ratification of Conventions 155 and 187 does not automatically translate into advancements in the right to health for many workers, particularly those in the informal economy. In countries that ratified these Conventions before 2022, such as Argentina, Sierra Leone, and Viet Nam, informal workers often lack access to occupational safety and health protections due to poor implementation of relevant laws. In other countries, informal workers face either explicit or de facto exclusion from occupational safety and health policies and regulations because of their non-standard employment arrangements. This exclusion stems from the fact that many informal workers lack a formal employer or work in settings not traditionally recognized as 'workplaces,' such as street corners, landfills, fields, and private homes. Furthermore, the language of these Conventions does not explicitly address workers in the globally dominant informal economy, providing little incentive for states to adopt inclusive measures that truly extend the right to health to all forms of employment.

The 2022 recognition of a healthy and safe working environment as a Fundamental Principle and Right at Work establishes an important precedent for future ILO instruments on workers' health. These include upcoming instruments focused on protection against biological and chemical hazards. Collectively, these advancements bolster the efforts of worker organizations worldwide, creating new opportunities to advocate for the adoption of inclusive ILO Conventions. They also enhance national, local, and municipal advocacy efforts aimed at ensuring the full implementation of ratified instruments.

How to advance the right to health of workers?

Improvements in working conditions that protect workers' health have always been the result of labor movement struggles, rather than concessions by capital or the state. While workplace health and safety have not always been top priorities for the labor movement compared to issues like compensation or job security, the issue has gained prominence whenever poor working conditions have directly impacted workers' health and lives. These struggles have led to demands for mechanisms to promote health, prevent workplace accidents and illnesses, ensure access to adequate medical care, and secure financial compensation for workers who lose their ability to work or die due to job-related causes.

There are numerous examples of workplace health improvements achieved through labor struggles. One historic milestone was the establishment of the "8-hour workday" in the late 19th century, which divided the day into 8 hours for work, 8 hours for rest, and 8 hours for sleep. This achievement significantly reduced the burden of excessive working hours and had a positive impact on workers' health and lives.

Another significant achievement of 19th-century Prussia (later Germany) was labor activism that led to the establishment of a social security system offering workers medical and economic benefits for work-related health issues. This "Bismarckian model" remains influential even into the 21st century. Similarly, in the

Box C3.3: The Struggles of Domestic Workers in Colombia

Domestic workers in Colombia have been engaged in various struggles for several decades to obtain recognition of their rights and to make progress in improving their working and living conditions, including the formation of trade union organizations. There are currently at least four major unions. Through union organizations, workers and supporting activists have promoted campaigns to make visible and protect labor rights, one focus of which has been the ratification of international standards, and particularly ILO Convention 189 on decent work for domestic workers. This Convention seeks to ensure the effective promotion and protection of the human rights of all domestic workers; the promotion of legal and political advocacy actions; and the right to participate in working groups and dialogues with the national government to improve legislation and its implementation.

Promoting adoption of this Convention was not easy given a profound context of racism, patriarchy, classism, social exclusion, and political violence, and so we highlight and celebrate the ratification of ILO Convention 189 by the Colombian State in 2014. Ratification of this Convention established a domestic legal framework for the protection of the rights of domestic workers, including improvements in social security by obliging those who hire them to protect them and link them to the social security system for coverage of health benefits and occupational hazards. It also brought visibility and awareness-raising to change the social perception of domestic work by recognizing it as a dignified job with rights. The Convention further requires the development of training programs for labor inspectors and for the workers themselves, thus improving the implementation of their rights. These struggles and their achievements are testimony of the effort and determination of women domestic workers in Colombia, an example for domestic workforce throughout the world, and for the global labor movement.

1960s, automotive industry workers in Italy, in collaboration with health professionals, spearheaded significant theoretical and methodological advancements. This effort, known as the Italian Workers' Model, became a vital tool for advocating and researching the right to health in the workplace.[17]

The long history of labor struggles has resulted in numerous significant achievements, including the prohibition of child labor; improved workplace safety to prevent accidents and occupational illnesses; access to medical services and workplace risk insurance; recognition of occupational diseases such as asbestosis, byssinosis, and, more recently, work-related stress and psychological disorders; the acknowledgment of rights for migrant and temporary workers; demands for gender equality and non-discrimination; and the establishment of safe working conditions during public health crises, such as the COVID-19 pandemic, which included providing personal protective equipment and vaccines.

As previously discussed in this chapter, neoliberal capitalism has reshaped working conditions in ways that jeopardize workers' health, including significant increases in labor market flexibility and the prevalence of precarious employment. In many low- and middle-income countries, particularly in extractive industries, health and safety standards are often weak, nonexistent, or poorly enforced. Over the past 40 years of neoliberal economic dominance, unionization rates have declined in many countries, accompanied by a reduced labor market share of economic output. However, there are signs that unionization and labor movement activism may be on the rise post-pandemic, fueled in part by inflation.

Advancing the right to health in the workplace requires various strategies that must necessarily involve the active participation of workers and their organizations, exerting pressure on states and employers to protect health in the workplace.

Key strategies to advance the right to health in the workplace should include:

- Establishing and enforcing inclusive public and corporate policies, practices and standards to create safe and protected work environments.
- Implementing health promotion and prevention programs in all workplaces and providing universal occupational health services to promptly address workers' health issues.
- Ensuring that all workers - whether in the formal or informal economies – enjoy social protection, including sick pay and other income protections.
- Rejecting austerity politics and ensuring adequate financing of urban, public infrastructure critical for workers in public space, such as water and sanitation, toilets and waste management systems.
- Conducting information processes to clarify for workers what their occupational exposures mean for their health.
- Developing continuous education and training processes, with a focus on worker organizations, on workplace health for all workers, integrated into a strategy to promote a culture of self-care and care for colleagues.
- Establishing participatory processes for dialogue and decision-making on workplace health issues is essential. These processes should take place both in workplaces and at municipal and local government levels, ensuring that workers and their organizations have a meaningful voice and a decisive vote.
- Developing monitoring processes, with active worker participation, to assess working conditions and their potential effects on workers' health.
- Creating appropriate safety protocols tailored to specific production processes, including the provision of adequate personal protective equipment.
- Promoting freedom of association to strengthen workers' abilities to organize themselves in the struggle for the right to health.

In this journey, examples from around the world highlight the transformative power of collective action, such as transport unions in Croatia fighting for the recognition of occupational diseases, healthcare workers in Kenya pushing for better working conditions, domestic workers securing the right to decent work in Colombia, and Community Health Workers in Pakistan achieving significant

Box C3.4: Lady Health Workers in Pakistan Dared to Struggle and Won!

In 1994, the Pakistani government launched a Community Health Workers program with an initial group of 30,000 Lady Health Workers (LHWs). Today, these workers number over 125,000 and are often referred to as "the unsung heroes of Pakistan's healthcare system."[18] However, for years they endured deplorable working conditions. Despite long hours, they were classified as "volunteers," receiving no wages and only meagre "incentives" that fell far below the national minimum wage.

In 2009, the LHWs began organizing themselves by forming the All Pakistan Lady Health Workers Association (APLHWA). Supported by Public Services International (PSI) and the Workers' Education and Research Organization (WERO), they launched a multi-pronged campaign to demand trade union and labor rights. Their efforts included street rallies, sit-ins, media conferences, parliamentary lobbying, and petitions to both government officials and the Supreme Court. The movement garnered support from trade unions, informal workers' organizations, civil society groups, activist lawyers, and journalists.

Their efforts paid off in 2012, when a mass protest of LHWs from across the country culminated in a demonstration outside the Supreme Court. The Chief Justice ordered that their employment must be regularized, recognizing them as workers entitled to no less than the national minimum wage. Yet, the struggle was far from over. LHWs continued to face delayed wages and worsening working conditions, particularly in Sindh Province. This led to the formation of the All-Sindh Lady Health Workers Association (ASLHWA), which launched a "Campaign Against Stolen Wages" in 2016.

The following year, ASLHWA sought official recognition as a trade union but faced bureaucratic hurdles from the registrar of trade unions. Undeterred, the Lady Health Workers mobilized their members across districts, organizing mass meetings, peaceful demonstrations, and sit-ins. They also lobbied women members of parliament and the newly appointed health minister. In October 2018, their efforts culminated in a major victory when the labor department in the Sindh province issued ASLHWA a certificate of registration as a trade union. Soon after, they applied for and obtained a collective bargaining agent certificate, enabling them to negotiate for wages above the national minimum. With the continued support of PSI, Lady Health Workers associations across the country deepened the organizing of community health workers in all the provinces, in the wake of the COVID-19 pandemic.

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And at the end of 2024, they established the Pakistan Community Health Workers Federation (PCHWF).

The Lady Health Workers' struggle exemplifies the nimbleness required of labor movements in response to changes in social, labor, and political contexts, and the importance of tenacity for workers' triumph. As capital adopts more flexible and exploitative labor practices, creating precarious conditions that weaken unions and harm workers' health, labor movements must respond with innovative organizational forms and collective actions. The LHWs' success demonstrates the importance of workers' power and the need for forging connections with broader social movements, advancing comprehensive demands, and embracing new methods of struggle, like leveraging support from civil society, to confront modern challenges in the world of work.

representation milestones. These struggles underline that working conditions and employment relations are critical determinants of health. Without addressing these factors, the right to health will remain an unattainable goal. While much work remains, history has shown that collective action can play a pivotal role in challenging and reshaping economic systems to better respect and uphold workers' rights.

Reference List

1 Public Services International & International Trade Union Confederation, Letter to the Chief Executive of Hong Kong, February 7, 2020, https://bit.ly/41ZGutQ

2 Craveiro et al., Impacts of industrial actions, protests, strikes and lockouts by health care workers during COVID-19 and other pandemic contexts: a systematic review, Human Resources for Health 22(47), https://bit.ly/3YmbPEC

3 Benach, Muntaner & Santana, Employment Conditions and Health Inequalities: Final Report to the WHO Commission on Social Determinants of Health (CSDH), Employment Conditions Knowledge Network (EMCONET), September 20, 2007, https://bit.ly/425Nh5m

4 Burdorf, Fernandes & Robroek, Health and inclusive labour force participation, Lancet, 402(10410), 1382-1392, https://bit.ly/4cm6hQf

5 ILO, Walk Free & IOM, Global Estimate of Modern Slavery: Forced Labour and Forced Marriage, September 2022, https://bit.ly/4i1qoED

6 UNICEF, What is child labour? (n.d.) https://bit.ly/4i1ojbS

7 WIEGO, Understanding the Informal Economy (n.d.) https://bit.ly/4jgs2Dj

8 ILO, Women and men in the informal economy: A statistical picture, Third edition, April 30, 2018, https://bit.ly/43HramU

9 ILO, Women and men in the informal economy: A statistical picture, Third edition, April 30, 2018, https://bit.ly/43HramU

10 Chen, Vanek, Lund, Heintz, Jhabvala & Bonner, Progress of the World's Women: Women, Work & Poverty, 2005, UNIFEM (UN Development Fund for Women), https://bit.ly/41ZEIZF

11 Burdorf, Fernandes & Robroek, Health and inclusive labour force participation, Lancet, 402(10410), 1382-1392, https://bit.ly/4cm6hQf

12 Public Services International, PSI condemns violent attack on Kenyan health union leader, February 29, 2024, Nairobi, https://publicservices.international/resources/news/psi-condemns-violent-attack-on-kenyan-health-union-leader-?id=14761&lang=en

13 Kenya Medical Practitioners Pharmacists and Dentists Union (KMPDU), Kenya's health care crisis: Where is the money? A corporate case study reveals broader problems, September 2024, Centre for International Corporate Tax Accountability and Research (CICTAR), https://bit.ly/4lyXMps

14 Benach, Muntaner & Santana, Employment Conditions and Health Inequalities: Final Report to the WHO Commission on Social Determinants of Health (CSDH), Employment Conditions Knowledge Network (EMCONET), September 20, 2007, https://bit.ly/425Nh5m

15 Lorant, Kapadia & Perelman, Socioeconomic disparities in suicide: Causation or confounding? PLOS One 16(1), e0243895, January 4, 2021, https://bit.ly/3EiyECk

16 Boockmann, The ratification of ILO conventions: A hazard rate analysis, Economics and Politics, 13(3), 281-309, February 7, 2003, https://bit.ly/4i1eGK7

17 ETUI, The struggle for health at work: The Italian workers' model of the 1970s as a source of inspiration, February 15, 2016, (blog post), European Trade Union Institute (ETUI), https://bit.ly/3FVtLzH

18 Naqvi, Lady health workers: The unsung heroes of Pakistan healthcare system, April 7, 2023, DAWN (e-paper), https://bit.ly/43D7Xmg

Tax Justice: A Pathway to Better Health

National governments, independently through their policy choices and collectively through global institutions, influence nearly all determinants of health: from providing access to public health care, adequate housing, social protection, and universal education, to ensuring decent work and employment, a fair income, food security, and a sustainably healthy environment. To do so, governments must raise revenue through taxation and use it effectively and accountably.

Taxes have been described as society's superpower. Yet deep historic and structural global injustices mean governments are often unable or unwilling to effectively generate and allocate taxes in ways that dismantle inequalities. Tax injustice infringes on the lives, rights, and well-being of all people and further marginalizes discriminated groups. This is the *status quo*.

There is an alternate path possible, the *status futurus*. Activist communities and engaged policymakers are already shaping a world where tax abuse is being stemmed, tax systems within and across countries are becoming fairer, and taxes are effectively contributing to healthier societies. Resistance to this movement is strong and from many sides; what role are health activists playing in challenging this resistance?

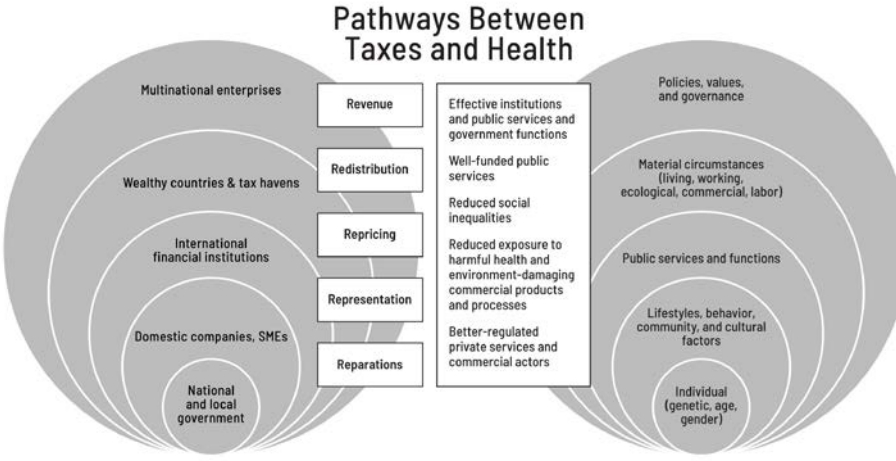
Why does tax matter for health?

The principles of tax justice—often called the 5Rs of tax justice—capture the transformative power of tax for society: revenue, redistribution, repricing, representation and reparations. When used as a force for good, taxes raise *revenue* for public services and carrying out other government functions, constituting 70-85 per cent of total government revenue, with the remainder made up of social contributions, grants and other non-tax revenue like licenses, fees and fines. Progressive tax systems help *redistribute* wealth to address inequalities by ensuring that larger, wealthier taxpayers, including multinational companies, pay more than the lowest-income households and small/informal enterprises, and by pooling tax revenue to finance universal benefits and services, such as public health care, that are delivered based on needs rather than ability to pay. Taxes are fundamental to fund universal public sector health services provided free at the point of access and public health actions, and to effectively redistribute resources from high- to low-income groups and low-to-high health risk groups through income and risk cross-subsidies, preventing disease and contributing to improved wellbeing. Taxes can also be designed to *reprice* or discourage and limit the social, environmental, and economic costs of health-harming products, such as tobacco, alcohol, and obesogenic (ultra-processed) foods. When taxation underpins the social contract

between public *representatives* and populations, it helps build effective states and democratic accountability. Though *reparations* through the tax system are unlikely to ever meet the cost of historic colonial (and continuing capitalist) plunder and extraction, they can ensure that perpetrators pay for injustices and their legacies. However, the current international financial system and influential global and national actors often undermine these principles.

The pathways between taxes and health are depicted in Figure 1. Here, the left-hand circle illustrates the key national, regional, and global influencers on international and national policy and tax, while the right-hand circle represents the determinants of health. The central boxes illustrate the principles of tax justice and how they can have a positive impact.

Figure 1: Pathways between taxes and health



B O'Hare and authors 2024

Multinational (MNC) and domestic companies significantly impact health both directly and indirectly. Company taxes directly contribute to positive health outcomes through *revenue*, which funds public services, contributing to *redistribution*. Indirectly, increased employment opportunities can benefit workers' health, especially if workers are represented by unions and work in safe and secure conditions with supportive management and training. Workers' income, in turn, contributes a significant share of national tax revenue which strengthens *representation*.

On the other hand, MNCs undermine the right to health when they reduce their contribution to public *revenue* by avoiding taxes, using tax havens often based in wealthy countries. Estimates suggest that 35 per cent of profits are deposited in tax havens. All countries lose when MNCs avoid or evade taxation. For example, American pharmaceutical companies, by exploiting both domestic tax codes and tax havens, can report global profits but still record losses in the USA. In 2023, the sum of the reported US taxes paid by the top seven American pharmaceutical

companies was zero. Some of this tax dodging may be 'legal,' but 'the private enablers of tax avoidance actively exploit all these grey areas, and plenty more.'[10] Notably, tax audits of corporate accounts carried out by tax authorities typically lead to MNCs having to pay more.

The power of large global monopolies enables lobbying of international financial organisations to make recommendations in their interest, including reduced trade barriers, lowered tax rates, and curtailed regulation. These recommendations reduce *revenue,* and the ability of governments to *reprice* and to *represent* the best interests of their citizens, and in recent decades this has led to a race to the bottom in tax rates as countries 'compete' for investment (Box C4.1).

In response to reduced corporate revenue, governments often resort to less progressive taxes, like value-added tax (VAT), which is added to the purchase price of most commodities or services. VAT can disproportionately burden low-income informal sector enterprises, households and women, particularly if applied to basic products. Additionally, governments may intensify tax collection from small low-income informal businesses, which is highly regressive, targeting people who are often already living with minimal material means. This can negatively affect a large proportion of black and brown women and girls, as in Brazil. Efforts from some African countries to bring informal sectors into the tax bracket have been linked to efforts to reduce aid dependency, as in Rwanda, or to increase political representation of organized informal sectors, as in Ghana.[14] However, these efforts may be made without first adequately capturing tax from larger domestic enterprises and MNCs.

This situation often leads to increased borrowing and escalating debt service payments. Governments find their sovereign right to determine fiscal and monetary policy narrowed by lending institutions such as the International Monetary Fund (IMF), where the US holds most influence and which continues to impose austerity measures as a condition of emergency loans to help countries recover from the COVID-19 pandemic. Debt in African countries is particularly burdensome (see chapter A1). Most is held by international lenders in foreign currency, making it hard to restructure or refinance, and 40 per cent of borrowing is from private lenders, charging higher interest rates but imposing fewer conditions than multilateral lending institutions like the IMF.

Although taxation is critical for funding strong and equitable national health services, financing for health is being choked in the neoliberal global economy with a bias toward so-called 'innovative' financing models such as privatized services, public-private partnerships, and segmented voluntary insurance. These approaches undermine taxation as a way for the state to redistribute and pay for universal public sector health systems. In 2018/19, five countries in East and Southern Africa were found to be funding their public sectors above the estimated per capita expenditure requirements needed for a comprehensive health system, but the remaining twelve countries in the region had a financing gap averaging between

Box C4.1: Tax incentives reducing resources for health and environment in Africa

Many low-income countries use tax exemptions, tax holidays, tax deferments, and low royalty rates to attract foreign investors without addressing health and environmental standards. These arrangements are often negotiated directly between government officials and multinational companies without parliamentary consultation. These public subsidies significantly reduce revenues for public sector provisioning and investment. They respond to global pressures and investor lobbies without evidence of economic benefit for countries. They also allow polluting companies, for example in the shipping and extractive industries, to pay less tax, depriving governments of revenue and running counter to the polluter pays principle. Tax holidays have been used in land leasing for agricultural investors in Mozambique, Tanzania, Mali and Ethiopia. For example, a five-year exemption from corporate income tax in the Ethiopian Regional State of Benishangul-Gumuz resulted in an annual tax loss of $12.1 million. The extractive industries have often been a beneficiary of these tax exemptions, despite their contribution to significant health and environmental costs. In Tanzania, Zambia, Malawi and the Democratic Republic of Congo, extractives contribute to government revenues largely from royalties on the production value and payroll taxes, although Zambia imposes taxes on windfalls and variable profits. All these countries give exemptions on VAT on imports or export sales; no customs duties on imports or exports; often lower corporate income tax rates; lower withholding tax rates and reductions on taxes on profits and on royalties.

US$28-84 per capita, or US$36 billion annually.[5] This funding shortfall undermines the achievement of Sustainable Development Goal 3 on universal health coverage. If three tax reforms were applied in the region—improved tax capacity, stopping tax losses from profit shifting to tax havens, and applying a minimum effective tax rate of 25 per cent across countries globally—the estimated improved tax collection could meet most of the funding gap for universal health coverage.[5]

Tax injustice, the status quo

The status quo of tax rules and resistance to their progressive reform echoes a longer exploitative colonial past. The extraction of wealth from African countries' rich mineral and biodiversity resources fueled industrial wealth and improved nutrition and conditions for health in colonizing countries. The continent exemplifies the wider extraction of resources and significant wealth outflows from Southern economies, at the expense of domestic wealth generation and population wellbeing.

A series of economic crises in the 1970s were marked by declining profit rates, high unemployment and increasing prices, exacerbated by the oil embargo. These intersected with the election of conservative governments in the USA and UK. Together with transnational private (corporate) actors, these two countries led the charge in embracing a free-market neoliberal agenda. The resulting global

diffusion of neoliberal economic policies, initially as structural adjustment programs, has seen many countries dramatically reduce their taxation rates in the name of remaining competitive in a globalizing economy, as covered elsewhere in past issues and this current edition of the GHW.

Over the 40+ years of liberalized global financial markets and neoliberal economic dominance, there has been a downward trend in corporate income tax rates and revenue. This can be attributed to the increased power of global and transnational private actors and tax wars between countries.[14] Each country responds to low tax rates by lowering their own, with MNC profit-shifting to tax havens or low-tax countries diminishing the effective tax rate for MNCs and increasing the share of less progressive consumption taxes.

At the same time, tax cuts for the rich have increased. While justified by right-wing and market fundamentalist think tanks, like the Cato Institute in the USA, there is no evidence of this 'trickle-down' working. When taxes were slashed for the rich in 18 Organisation for Economic Co-operation and Development (OECD) member countries, income inequality grew, while their economies and job creation did not.

For the Global South, a narrow and distorted tax base caters more to the demands of high-income taxpayers. Economies in the Global South have high levels of natural resource extraction, with the tax system failing to capture fair portions of revenue from these resources due to exemptions and a lack of democratic accountability in the tax system. This limits the revenue, redistributive, representation and repricing role of tax systems noted in Figure 1, particularly for low-income countries that most need these roles. The visible signs are the poor progress in access to safe water, rising unmanaged waste, overcrowded housing, poor diets, lack of access to energy, and other deficits in key health determinants for high shares of the population.

International tax abuse—its enablers and impacts

The current international tax architecture is built on foundations of plunder: from colonial extraction by force in the 1500s onwards, to the transfer of wealth and income at the end of empire in the 20th century from the country of origin to tax havens typically controlled by colonial powers. The City of London, the center of the British Empire, became the center of the offshore system, with its spider's web of overseas territories and crown dependencies, such as Jersey and the British Virgin Islands. The United Kingdom and territories remain chiefly responsible for enabling tax abuse.

In 2023, the world lost $480 billion in tax revenue due to cross-border corporate abuse and wealth tax evasion, and this may be just the tip of the iceberg. Over three-quarters of these global tax losses suffered by countries worldwide are caused by the club of wealthy nations and their dependencies that form the OECD. Higher-income countries consistently lose the most in absolute terms. However,

lower-income countries consistently face the deepest losses as a share of current tax revenues or budgets for health and its determinants, where per capita spending is skewed. Further, many health and social interventions are implemented by women outside formal systems and may go uncounted in economic data.

Tax abuse enabled by the international tax system undermines all human rights. If governments had revenue equivalent to the losses documented in the State of Tax Justice 2023, *every day,* 15 million people would have their right to basic water, 32 million their right to basic sanitation, 3.2 million additional children would attend school, 101 additional children would survive, and 11 additional mothers would not die during childbirth. Increased government revenue leads to steady improvements in governance, which means additional revenue has a greater impact on human rights, creating a virtuous circle between government revenue and governance.

The OECD, representing 38 of the world's wealthiest countries, many of which are former colonizing nations, has decided international tax rules favoring MNCs for the last 60 years, maintaining the status quo of colossal tax abuse. Efforts over the past decade have done little to curtail these rules. The OECD's work, while technically rigorous, nurtures neutrality at best, while operating from a set of principles and approaches that resists change in the global order of power. Tax transparency measures adopted have been watered down or compromised, such as the automatic exchange of information between tax authorities to overcome bank secrecy and undeclared offshore wealth. The OECD's Common Reporting Standard (CRS) for exchanging information is ineffective. It excludes all major financial centers, and the information that is shared cannot be used to investigate money laundering or other suspected criminal activity. In 2023, only 5 of 54 African nations exchanged information automatically on a reciprocal basis.

In the OECD's most recent iteration of international tax rules, the so-called 'two-pillar solution' aims to address the challenges of taxing MNCs in a digital age. Pillar One focuses on distributing taxing rights between countries. However, it will only affect a fraction of MNC profits, applying only to those with a turnover above $20 billion. Even this proposed change is likely to amount to nothing, as the USA, which has effective veto powers, is unlikely to ratify the agreement. Pillar Two sets a global minimum tax for corporations, but it's only 15 per cent. This is well below the average in most countries. As the primary body representing African tax authorities, the African Tax Administration Forum (ATAF), noted:

> ...for such a rule to be effective, the minimum effective rate needed to be at least 20%... as most African countries have a statutory corporate income tax rate of between 25% and 35%. Multinationals will only be disincentivized from such profit shifting in Africa if all its profits are taxed at least at 20% no matter in which jurisdiction the profits are reported.

In an act of global solidarity and resistance among non-OECD members, the Africa Group at the United Nations (UN) proposed a resolution in 2022, adopted unanimously by the UN General Assembly, giving the UN Secretary-General the mandate to report on options and modalities for negotiating a UN Framework Convention on Tax. A year later, a further resolution was passed to start negotiations on such a Convention. No OECD member voted in favor yet, despite resistance, a majority of UN member states passed the resolution, and negotiations are ongoing. This UN-led initiative presents 'an opportunity for an institutional and conceptual reset, to re-establish a global perspective that has been disrupted by the assumption of an increasingly dominant role in international tax by the OECD.'

Tax justice, the 'status futurus'

Countries can and must use their tax superpower. As Tax Justice Network Africa emphasizes, 'Any reversal [of tax injustice] is most likely to start from the bottom up, with taxpayers becoming the key drivers of change', with population interest groups, parliaments, professionals, southern states, diplomats, and regional economic communities demanding transparency in tax decisions and the use of tax money.[14]

Since all tax ultimately belongs to the people, populations and taxpayers have the right to know and be literate on how taxes are collected, where they are being levied, and how this affects them. This means that revenue data, including sources and allocation, should be regularly published. All agreements and treaties that affect revenue should be disclosed and discussed in parliament. Tax justice requires tax policies that promote vertical equity that disproportionately benefits poorer groups. Countries should reject tax exemptions that reduce direct taxes on products that harm health or that exempt tax contributions to health services.

It is both possible and essential to meet the health financing gap for public sector health systems worldwide through sufficient funding from progressive taxation. Public interest constituencies within and across countries need to clearly state that public sector funding demands addressing the right to health care, universal health coverage, primary health care, and other health-related sustainable development goals, and to show that this calls for progressive taxation as a major source of revenue.[5] This implies redoubling national efforts to address tax gaps by building domestic capacity within revenue authorities, expanding the tax base through the expansion of wealth and other progressive taxes, and increasing transparency in and blocking of illicit outflows. It also calls for work at the regional level to reduce tax competition, and to reduce incentives and exemptions for corporations that lessen a country's capacity to mobilize tax revenue.[5] Regional bodies like ATAF in Africa and the Regional Platform for Tax Cooperation in Latin America and the Caribbean (PTLAC) can strengthen regional cooperation on tax matters, including in acting as a bloc in international spaces.

These actions within countries and regions call for wider international action, specifically focusing on negotiations of the UN Framework Convention on Tax. In contrast to the OECD's dominion over setting tax rules, the UN is inclusive and representative. Member states are legally bound to implement the provisions of conventions and agreements, and are held accountable for this by various UN bodies. As of August 2024, the terms of reference for the Convention have been adopted and negotiations will continue through to 2026. The work toward a UN Framework Convention on Tax responds to the promotion of human rights frameworks and conventions. UN committees have consistently urged that tax haven nations reform domestic rules to ensure that their tax policy (enabling profit-shifting) does not undermine the rights of citizens in other countries, and that nations have maximum available resources for developing and delivering human rights.

Demands around international tax reform, and a shift to the UN as the framework for rule setting have become more urgent with the scale of global health challenges, including pandemics and the climate emergency. Leaving these challenges to overseas development aid and other forms of unpredictable, voluntary, or concessional financing is problematic for the equity and sustainability in investment that these challenges call for. Climate financing in the form of overseas development aid has failed to meet pledges or needs, with climate-related loans adding debt burdens to what are already inequitable climate burdens, carbon credit schemes using carbon markets while leaving the drivers of climate change unmanaged, and power left in the hands of high-income countries that are the primary drivers of climate change. Tax reform based on principles of tax justice can overcome these limitations while disincentivizing ecologically destructive extractive industries.

African leadership at the 2023 Africa Climate Summit noted an 'unjust configuration of multilateral institutional frameworks that perpetually place African nations on the back foot through costly financing.' African countries in the September 2023 Nairobi Declaration from this Summit called for climate financing to be derived from a carbon tax on fossil fuel trade, maritime transport, and aviation, alongside a global financial transaction tax, to shift financing towards more predictable, equitable forms. In Latin America, Colombia is leading the way on environmental taxation, having already adopted three kinds of taxes: a national tax on carbon, a national tax on the consumption of plastic bags, and an additional tax on vehicles. Based on this experience, Colombia is coordinating the environmental tax working group of PTLAC.

Some key global tax reforms and technical solutions require international measures and national implementation to curtail international tax abuse. These have been described as the ABCs of tax transparency, as set out by the Tax Justice Network, and part of the larger Global Alliance for Tax Justice. Initially described as utopian, these measures formed the basis for global OECD-designed and

watered-down tax transparency measures. They are now considered to be essential transparency rules that support domestic enforcement so that tax authorities can audit corporations and trace untaxed offshore wealth. From 2020, the Tax Justice Network developed its core platform beyond the ABCs of tax transparency to include the DEFGs of tax justice. (See Box C4.2)

Global influencers promoting tax transparency and tax justice, including redistribution, are also emerging from unlikely places. A small and growing number of MNCs have Fair Tax Mark accreditation under the Global Multinational Business Standard, which signals that they abide by the principles of fair tax. This includes paying the right amount of tax (but no more) in the right place at the right time, according to both the letter and the spirit of the law, and readily providing sufficient public information to enable its stakeholders to form a rounded and informed view of its beneficial ownership, tax conduct, and financial presence (across the world if they are a multinational). Additionally, wealthy individuals associated with the organizations Patriotic Millionaires and Millionaires for Humanity have asked to be taxed more on their assets and inheritance. In a letter millionaires and billionaires sent to leaders attending the World Economic Forum in Davos, Switzerland, in 2022, they wrote,

> As millionaires, we know that the current tax system is not fair...This injustice baked into the foundation of the international tax system has created a colossal lack of trust between the people of the world and the elites who are the architects of this system. Bridging that divide will take more than billionaire vanity projects or piecemeal philanthropic gestures—it's going to take a complete overhaul of a system that, up until now, has been deliberately designed to make the rich richer.
>
> To put it simply, restoring trust requires taxing the rich. The world—every country in it—must demand that the rich pay their fair share. Tax us, the rich, and tax us now.

The way ahead

Health activists are rightly concerned that public health systems be adequately and equitably financed to achieve individual and communal health. But change will not come by tinkering at the edges. Health movements should not expend energy on dead-end struggles that focus only on 'sin' or earmarked taxes. These collect little revenue while distracting attention and resources from extensive and necessary structural reforms and the closing of loopholes for corporate tax abuse and wealth tax evasion.

National governments are central to tax justice as they are responsible for design, collection, and expenditure. However, there is fierce resistance to positive pathways for positive health outcomes domestically and internationally, with MNCs,

Box C4.2: The ABCDEFGs of Tax Justice

A—Automatic exchange of tax information on financial accounts is critical to overcome the scourge of bank secrecy and the associated undeclared offshore accounts. By 2022, more than 110 jurisdictions had signed up for automatic exchange including all the major financial centres except the USA. But many still refuse to provide information to lower-income country signatories.

B—Beneficial ownership of companies, trusts, foundations and partnerships is increasingly made transparent through public registers, identifying who and how is benefiting through these private entities. While uncovering major corruption, these registers still lack robust verification.

C—Country-by-country reporting by multinational companies is necessary to reveal the misalignment between where their real economic activity takes place, and where profits are declared for tax purposes. The OECD now requires this data to be provided to home country tax authorities and a growing number of major companies are already publishing voluntarily to the Global Reporting Initiative standard. Investors with trillions of dollars of assets under management are actively demanding this from others.

D—Disclosure, including consistent, aggregate performance measures of the tax authority, and a full accounting of tax incentives and subsidies provided, as well as online publication of company financial accounts and related information. Aggregate statistics from country-by-country reporting can tell a similar story for corporate tax abuse.

E—Enforcement is also critical and has been especially vulnerable in several high-income countries including the UK and US. 'Austerity' has often provided political cover to cut resources of tax authorities and other relevant agencies (and often their independence too), and this remains a key threat to effective and accountable taxation. It is the falsest of all false economies to cut the resources of tax authorities in order to 'save' public funds.

F—Formulary apportionment is the basis towards which international tax rules must now finally move. Global taxable profit globally should be at the unit of the multinational, and not the separate corporate entities within the group, and taxes apportioned to countries according to the share of the multinational's economic activity taking place in each.

G—Global governance of tax in the 21st century requires a genuinely inclusive and representative forum at the UN to replace the rich country members' club, the OECD. This will be in the form of a UN Framework Convention on Tax, currently under negotiation, that could also ensure that the full benefits of the ABC of tax transparency are delivered to all countries and peoples.

Continues opposite

Box C4.2 continued

G_2—Global asset register, or a GAR, is a key piece of the puzzle. This proposal, now supported also by the Independent Commission for the Reform of International Corporate Taxation, would join up national-level registers of ultimate beneficial ownership, coupled with the broadening of coverage to include high-value assets of all types, from property and financial accounts to art works and aircraft, and including all types of legal vehicles. The GAR provides the basis both to facilitate wealth taxes of all types and to ensure their effectiveness.

G_3—Good taxes is a catchall including a range of taxes that can contribute most to the 5Rs of tax justice. Direct taxes (mainly income taxes on corporates and individuals) are the most salient and can do most to strengthen state-citizen relations of accountability and providing the strongest basis for redistribution. Specific taxes on wealth, land value, inheritance, and capital gains as well as taxes responsive to the climate crisis are also important 'good taxes'.

international financing institutions, and tax havens bending the rules in ways that do not serve the common good. We must not be discouraged. The past years have shown the incredible power of collective action at the global level towards a UN Framework Convention on Tax, which must deliver on the principles of tax justice. Examples included in this chapter also shine a light on domestic action, reversing decades of eroding tax and narrowing public service delivery.

Tax can be society's superpower if used for good:

- To improve revenue collection for public health, governments must focus on taxing the highest income earners and largest companies, targeting multinational enterprises, and designing tax codes that do not give them a free ride. This includes resisting awarding profit-based tax incentives and national governments collaborating to prevent a regional race to the bottom in tax rates. National and regional support must continue in the negotiations of substantive elements of the UN Framework Convention on Tax, including fundamental principles, crucial tax transparency measures, and reforms to how wealth and corporate income are taxed.
- To ensure that revenue raised addresses inequalities, it must be redistributed from high- to low-income households and from low to high health need, including through financing universal health coverage and primary health care that is free at the point of access. Efforts to privatize health systems or crowd out public healthcare improvements through privatization must be resisted.
- Although it's not game-changing for domestic revenue collection, repricing to increase the cost of socially harmful products, including carbon, can affect behavior and contribute to government revenue needed to meet the health needs that result from some of these products. These should target the multinational and large corporate producers, such as ultraprocessed foods, not consumers.

- Improved tax capacities, strengthened public tax 'literacy', and greater transparency and democratic accountability need to be built within countries and internationally to fulfil representation, including in the global tax architecture.
- Countries must seek reparations for the impacts of the climate crisis, which affects many determinants of health. Interim approaches can include ensuring tax and grant-based climate financing and debt relief, and increased contribution to taxes to protect longer term health and ecosystems in the extractive sectors.

Reference List

1 The World Health Organisation. Social determinants of health [Internet]. 2024 [cited 2024 May 22]. Available from: https://bit.ly/3DRkVCp

2 Cobham A. What Do We Know and What Should We Do About Tax Justice? London: SAGE Publications Limited; 2024. 137 p.

3 Nsenduluka M, Etter-Phoya R. The Principles of Tax Justice and the Climate Crisis in Africa's Resource-Rich Nations [Internet]. Feminist Action Nexus for Economic and Climate Justice; Tax Justice Network; Tax Justice Network Africa; 2023 [cited 2023 Oct 12]. Available from https://bit.ly/3XvDOS0

4 UNU Wider. Government Revenue Dataset (August 2023) [Internet]. 2023 [cited 2024 Jul 7]. Available from: https://bit.ly/4j7LXVd

5 Loewenson R, Mukumba C. Recovering lost tax to meet the health financing gap for universal public sector health systems in East and Southern Africa. BMJ Global Health. 2023;8(Suppl 8): e011820. Available from: https://bit.ly/4iG6z6T

6 Decolonising Economics. Tax as a tool for racial justice [Internet]. Decolonising Economics; 2022 [cited 2023 Aug 24]. Available from: https://bit.ly/4l3JwVj

7 Hannah E, O'Hare B, Lopez M, Murray S, Etter-Phoya R, Hall S, et al. How can corporate taxes contribute to sub-Saharan Africa's Sustainable Development Goals (SDGs)? A case study of Vodafone. Globalization and Health. 2023 Mar 20;19(1):17. Available from: https://bit.ly/42g7chL

8 EU Tax Observatory. Global Tax Evasion Report 2024 [Internet]. EU Tax Observatory; 2023 [cited 2023 Nov 6]. Available from: https://bit.ly/4iNgyYq

9 Setser BW, Weilandt M. American Pharmaceutical Companies Aren't Paying Any Tax in the United States [Internet]. Council on Foreign Relations. 2024 [cited 2024 Jul 30]. Available from: https://bit.ly/440EItJ

10 Shaxson N. No, corporate tax avoidance is not legal. Financial Times [Internet]. 2019 May 16 [cited 2024 Aug 8]; Available from: https://bit.ly/4j3GSNB

11 Meinzer M, Ndajiwo M, Etter-Phoya R, Diakité M. Comparing tax incentives across jurisdictions: a pilot study [Internet]. 2019 [cited 2019 Jul 3] p. 43. Available from: https://bit.ly/4j91iox

12 Loewenson R, Mukumba C. Tax justice for universal public sector health systems in East and Southern Africa. EQUINET. 2022;126. Available from: https://bit.ly/4hQamh1

13 Loewenson R, Hinricher J, Papamichail A. Corporate responsibility for health in the extractive sector in East and Southern Africa. EQUINET [Internet]. 2016 [cited 2024 Aug 8];108. Available from: https://bit.ly/3Y6w5Kn

14 Tax Justice Network Africa. Tax us if you can: Why Africa Should stand up for Tax Justice [Internet]. Nairobi, Kenya; 2011 [cited 2024 Aug 8]. Available from: https://bit.ly/4l2tCur

15 Mager F, Meinzer M, Millán L. How corporate tax incentives undermine climate justice. Tax Justice Network; 2024 Jun. Available from: https://bit.ly/3Y2PXhk

16 Grown C, Valodia I, editors. Taxation and Gender Equity: A comparative analysis of direct and indirect taxes in developing and developed countries [Internet]. Routledge; 2010 [cited 2024 Jun 11]. Available from: https://bit.ly/3QNxJMZ

17 Anyidoho NA, Gallien M, Rogan M, van den Boogaard V. The Price of Simplicity: Skewed and Regressive Taxation in Accra's Informal Sector [Internet]. Brighton: International Centre for Tax and Development; 2024 [cited 2024 Jul 23]. Report No.: ICTD Working Paper 195. Available from: https://bit.ly/4jol5R1

18 Zigoni C, Finette C, Lorenzo F, Guerrero García K, Hofman L, Gerbase L, et al. Submission to the Committee on the Elimination of All Forms of Discrimination against Women: Brazil [Internet]. INESC; Tax Justice Network; Latindadd; Red de Justicia Fiscal – de América Latina y el Caribe; 2024 [cited 2024 Aug 14]. Available from: https://bit.ly/4hNRpeS

19 Mo Ibrahim Foundation. Global, Africa: Africa in the world and the world in Africa [Internet]. 2023 Jul [cited 2024 Jul 30]. Available from: https://bit.ly/4hRhdqq

20 Sanders D, De Ceukelaire W, Hutton B. Health Policies and Health Care in the Context of Neoliberal Globalisation. In: Sanders D, De Ceukelaire W, Hutton B, editors. The Struggle for Health: Medicine and the politics of underdevelopment [Internet]. Oxford University Press; 2023 [cited 2024 Oct 24]. p. 0. Available from: https://bit.ly/3RkTa8h

21 Rincke J, Overesch M. What Drives Corporate Tax Rates Down? A Reassessment of Globalization, Tax Competition, and Dynamic Adjustment to Shocks. The Scandinavian Journal of Economics. 2011;113(3):579–602.

22 Garcia-Bernardo J, Jansky P, Torslov T. Decomposing Multinational Corporations' Declining Effective Tax Rates [Internet]. Working Papers IES. Charles University Prague, Faculty of Social Sciences, Institute of Economic Studies; 2019 Dec [cited 2020 May 18]. (Working Papers IES). Report No.: 2019/39. Available from: https://bit.ly/3QLdkrZ

23 Thunecke G. Are Consumers Paying the Bill? How International Tax Competition Affects Consumption Taxation [Internet]. Rochester, NY; 2023 [cited 2024 Jul 25]. Available from: https://bit.ly/4iH4mZ5

24 Seip J, Harper DW. The Trickle-Down Delusion: How Republican Upward Redistribution of Economic and Political Power Undermines Our Economy, Democracy, Institutions and Health—and a Liberal Response. UPA; 2016. 465 p.

25 Hope D, Limberg J. The economic consequences of major tax cuts for the rich. Socio-Economic Review. 2022 Apr 1;20(2):539–59. Available from: https://bit.ly/3DVVD6b

26 Cobham A. Imperial extraction and 'tax havens'. In: Bhambra GK, McClure J, editors. Imperial Inequalities [Internet]. Manchester University Press; 2022 [cited 2023 Aug 30]. p. 280–98. Available from: https://bit.ly/4j0iJbf

27 Shaxson N. Treasure Islands: Uncovering the Damage of Offshore Banking and Tax Havens. St. Martin's Griffin; 2012. 272 p.

28 Tax Justice Network. State of Tax Justice 2023 [Internet]. Tax Justice Network; 2023 [cited 2024 Sep 18]. Available from: https://bit.ly/4hPZTC9

29 Cobham A. The Uncounted. 1 edition. Cambridge, UK ; Medford, MA, USA: Polity; 2020. 200 p.

30 Government Revenue and Development Estimations (GRADE) Project. The impact of tax abuse on human rights on all countries SOTJ#2023 estimations [Internet]. University of St Andrews; University of Leicester; 2023 [cited 2024 Jul 25]. Available from: https://bit.ly/428xOQI

31 Hall S, O'Hare B. A Model to Explain the Impact of Government Revenue on the Quality of Governance and the SDGs. Economies. 2023 Apr;11(4):108. Available from: https://bit.ly/429dFdn

32 Ovonji-Odida I, Grondona V, Chowdhary AM. Two Pillar Solution for Taxing the Digitalized Economy: Policy Implications and Guidance for the Global South [Internet]. Geneva: The South Centre; 2022 Jul [cited 2022 Aug 18]. (The South Centre: Research Paper). Report No.: 161. Available from: https://bit.ly/3RpEd4M

33 African Tax Administration Forum. International taxation rules – What does this mean for Africa? [Internet]. 2021 [cited 2024 Jul 25]. Available from: https://bit.ly/3E2377y

34 United Nations General Assembly. Promotion of inclusive and effective international tax cooperation at the United Nations Report of the Secretary-General [Internet]. 2023 [cited 2023 Aug 29]. Available from: https://bit.ly/3DVvwMG

35 Picciotto S. The Design of a UN Framework Convention on International Tax Cooperation [Internet]. Rochester, NY; 2024 [cited 2024 Jul 25]. Available from: https://bit.ly/4j2dx61

36 Comissão Econômica para a América Latina e o Caribe. Países que conforman la Plataforma Regional de Cooperación Tributaria para América Latina y el Caribe emiten declaración conjunta, en respaldo a la presidencia de Brasil del G20 [Internet]. Comissão Econômica para a América Latina e o Caribe; 2024 [cited 2024 Aug 15]. Available from: https://bit.ly/4i63f4d

37 Chaparro S, Snyckers T, Hofman L, Nelson L. Why the world needs UN leadership on global tax policy [Internet]. Tax Justice Network. 2023 [cited 2024 Mar 28]. Available from: https://bit.ly/4c4zijr

38 Committee on Economic, Social and Cultural Rights. Concluding observations on the fourth periodic report of Ireland, E/C.12/IRL/CO/4 [Internet]. 2024 [cited 2024 Apr 3]. Available from: https://bit.ly/4l4rvGp

39 Hannah E, Etter-Phoya R, Lopez M, Hall S, O'Hare B. Impact of higher-income countries on child health in lower-income countries from a climate change perspective. A case study of the UK and Malawi. PLOS Global Public Health. 2024 Jan 4;4(1):e0002721. Available from: https://bit.ly/41YpGSI

40 Euractiv. African leaders call for new global taxes to fund climate change action. Euractiv [Internet]. 2024 Sep 7 [cited 2024 Aug 8]; Available from: https://bit.ly/4j7ij2d

41 Ministerio de Ambiente y Desarrollo Sostenible. Impuestos Verdes Vigentes en Colombia [Internet]. Ministerio de Ambiente y Desarrollo Sostenible. [cited 2024 Aug 15]. Available from: https://bit.ly/41JF5HG

42 Etter-Phoya R, Harari M, Meinzer M, Palanský M. Global Financial Systems and Tax Avoidance. In: Sims K, Banks N, Engel S, Hodge P, Makuwira J, Nakamura N, et al., editors. The Routledge Handbook of Global Development [Internet]. New York, NY / Abingdon, Oxon: Routledge; 2022 [cited 2023 Jun 5]. p. 326–40. Available from: https://bit.ly/3DVZxfl

43 Tax Justice Network. Beyond20 [Internet]. Tax Justice Network; 2023 May [cited 2023 Jul 7]. Available from: https://bit.ly/4iAeHpA

44 Fair Tax Foundation. Global Multinational Business Standard: Guidance Notes [Internet]. 2021 [cited 2024 Jul 31]. Available from: https://bit.ly/4iE4oRj

45 Frequently Asked Questions [Internet]. Fair Tax Foundation. [cited 2024 Jul 31]. Available from: https://bit.ly/3Y2o35a

46 Signed by millionaires and billionaires. ATTN Davos Attendees: In Tax We Trust [Internet]. 2022 [cited 2024 Jul 31]. Available from: https://bit.ly/4hKt2Pb

Commercial/corporate determination of health

Introduction

The commercial determinants of health (CDoH) are not a new global public health concern, but their impacts on health since last being addressed in *Global Health Watch 6* have intensified. CDoH are the systems, practices, and pathways through which commercial actors drive health and equity. Although all levels of commercial activity pose potential threats to health, the greatest harms arise from the actions of national or transnational corporations.[1]

Over the past two decades, world economic arrangements have increasingly changed to suit the interests of corporations, setting the stage for the twenty-first century disease epidemics grounded in the political and economic system that demands unhealthy hyper-consumption. This 'corporate-consumption' complex promotes a pattern of consumption directly linked to premature mortality through preventable illness and injury.[2] Public relations or marketing-inspired strategies are part of the broader suite of overlapping corporate tactics employed to promote the interests of transnational corporations (TNCs) that result in these health harms.

Figure 1: The Indian junk food industry

Abhisek Sarda, Flickr

The marketing of unhealthy products and activities including ultra-processed foods[3], gambling,[4] tobacco[5] and fossil fuels[6] is wide-spread. Fossil fuel industries and other powerful health-harming industries have unique access to mainstream media to shape the narratives of media reports, publish advertisements, and exert political influence.[7] Advertising by energy and mining companies is often selective, highlighting renewable energy solutions, corporate social responsibility (CSR) and greener technology, while largely excluding their negative health and environmental impacts.[8] Such advertising is designed to paint TNCs in a positive light despite their purpose being to make a profit. The practices of TNCs have been depicted as following a corporate 'playbook' which puts profits above public health.[9]

CDoH also include global consultancy firms, news media companies which promulgate misinformation on health-related matters, and key social media actors and global technology firms which seek to thwart attempts to regulate their operations. Global consultancy firms facilitate corporate operations by promoting neoliberal ideology and practices that advocate for small government and free market capitalism.[10] By 2016, their global operations in support of private capital, including taxation advice to corporations, cost governments and taxpayers worldwide an estimated $US1 trillion per annum.[11] The propagation of health misinformation through corporate-owned social media has become a major public health concern[12], with notable examples being false statements concerning vaccines and diseases.[13] Many of the practices of social media platforms in themselves result in health harms, especially to the mental health of young people. Such concerns led Australia in 2024 to pass legislation restricting access to specific social media platforms for children under 16 years of age and to strengthen existing measures against risks associated with harmful on-line content.[14] At the same time X (formerly Twitter) and Meta platforms (Facebook, Instagram, Threads) have eliminated fact-checkers to curry favor with the new Trump administration's opposition to such 'censorious' practices.

Tech billionaires are also gaining increasing economic and political power. As greater wealth accrues to the leaders of global technology firms, inequalities within firms and more broadly across societies are widening, creating social tensions and political unrest.[15] The recent alliance between US President Trump and Elon Musk demonstrates the political power that social media oligarchs can exert despite any lack of democratic process leading to their appointment to positions of power. Musk is overseeing Trump's Department of Government Efficiency (DOGE) and causing massive damage to USAID and many Federal government departments. The power he has seized is unheard of in a democratic country. The conflicts of interest it raises are huge as companies he controls hold contracts with the US government worth billions of dollars.

The power of corporations in the global political economy

Transnational corporations (TNCs) engage in a wide range of practices that endanger planetary and human health, encompassing financial, political, scientific, marketing, labor market, supply chain and reputational management. Their operations are underpinned by neoliberal policy norms that bolster their power and wealth[16] while state power and revenue decline and the costs of damaging commercial activities are externalized to state and society.

Neoliberal norms, values and beliefs, including the importance of 'free markets, flexible workers, freedom, open societies', dominate the global economy to the detriment of public health and equity.[17] Buttressed by these neoliberal norms, corporations exert power by ensuring that voluntary codes of business practice remain in place of enforceable regulations. The United Nations Global Compact established in 2000, for example, is a non-binding, voluntary initiative that calls on corporations to align their strategies and operations with a range of universal principles in order to be 'a force for good'.[18] NGOs quickly pointed out that the only guarantee that companies can be made accountable for equitable and sustainable policy is through a mandatory legal framework.[19]

The United Nations Guiding Principles on Business and Human Rights[20] maintain that nation states must protect against human rights abuses by third parties, including business enterprises within their territory and/or jurisdiction. This requires taking appropriate steps to prevent, investigate, punish and redress such abuse through effective policies, legislation, regulations and adjudication.[21] Negotiations to transform these principles into a binding treaty were initiated in 2014, with a third draft released in 2023 that still awaits ratification. Even if it is ratified, it is non-binding and lacks real teeth to control the behaviors of corporations.[22]

The lack of global taxation regulations to address offshoring of corporate profits to tax havens is another critical issue (see Chapter C4). Corporate tax evasion is often facilitated by global consultancy firms[23] which offer advice to TNCs on using variable tax rates across different jurisdictions. As part of taxation strategies these firms generate paper losses to allow TNCs to benefit from favorable tax assessment of depreciation or debt[24] These financial practices are part of a much wider suite of corporate strategies to support their financial interests.

Corporate power is also bolstered through regulatory capture (whereby corporations are able to influence regulatory processes to the extent that regulations become non-effective), aided and abetted by political donations and other political practices.[25] The influence of corporate players on the US Trump administration is going beyond capture to dismantling regulation in many areas including environmental protection, affirmative action, finance, and health and education sectors. President Donald Trump's January 31, 2025, executive order (EO) titled Unleashing Prosperity Through Deregulation[26] is a part of his broader policy to slash federal regulation. The EO posits that federal regulations impose

significant costs and complexities on American citizens and businesses that hinder economic growth, innovation, and global competitiveness. The impacts of the cuts on health and the environment are likely to be massive, favor corporations and harm poor people most.

Another form of corporate profit seeking is the practice of channeling profits into 'share buy-back' schemes that drive up the value of shares that now form much of executive pay packages, rather than into job-creating new investment. The difference between CEO pay and average salaries has grown hugely. The Economic Policy Institute reports that cumulatively from 1978–2023, top CEO compensation shot up 1,085 percent compared with a 24 percent increase in a typical worker's compensation. In 2023, CEOs were paid 290 times as much as a typical worker in contrast to 1965, when the pay gap was only 21 times.[27] These extraordinary CEO salaries are funded in part by tax avoidance and evasion and directly take away from the public goods that the foregone taxation revenue could pay for.

Corporations hold a range of rights including intellectual property rights, globally enforced under the World Trade Organization's Agreement on the Trade-Related Aspects of Intellectual Property Rights (TRIPS). TRIPS protections of pharmaceutical patents allow large pharmaceutical companies to prioritize secrecy and profits over the right to health. Some of these effects include high prices of medicinal products, prevention of local manufacture of generic products through reverse engineering of patented products, preventing importation of cheaper medicinal products from off-patent countries or under licensing agreements, and delayed market entry for generic products.[28] Attempts to create a temporary waiver in TRIPS rules governing medical products (including vaccines) during the COVID-19 pandemic failed due to stalling tactics and objections by high-income countries intent on protecting the patent rights and profitability of pharmaceutical and other medical corporations based within their borders (see Chapter D2).

As well as intellectual property rights, corporations are granted certain rights of 'personhood', such as the right to sue and be sued, the right to own stock, and the liability of shareholders for debts only up to the value of their shareholdings.[29] Three quarters of countries for which there is data (110 nations worldwide) allow corporations to fund candidates in elections; this includes over half of the countries in the Americas, although some may place limitations on the total amount allowed.[30] Some for-profit corporations can, on religious grounds, refuse to comply with US mandates to include birth control in their employee health plans.[31]

Further corporate power inheres in Investor-State Dispute Settlement (ISDS) rules in bilateral or regional trade and investment treaties. ISDS tribunal decisions often have health negative outcomes due to exorbitant compensation awards paid to TNCs by states attempting to strengthen environmental or health protections in

ways perceived to violate the profitability of foreign investors.[32] One of the best known examples is Australia's 2012 'victory' over the tobacco giant Philip Morris in the High Court that held that Australia's plain cigarette packaging laws were legal and 'did not constitute an unjust confiscation of trademarks and intellectual property'.[33] In response, the corporation moved ownership of its Australian operations to Hong Kong to take advantage of the Australia-Hong Kong investment treaty which would have potentially allowed for massive compensation. Even though Australia won the case, the legal fees amounted to $AU24million, for which Philip Morris was ultimately ordered to pay only half.[34] Such costs have a 'chilling effect', which in the tobacco case cautioned other countries against pursuing a plain-packaging law. By 2019, ISDS provisions had led to 942 known cases involving health and environmental laws, increasingly preventing, weakening, or 'chilling' changes in regulations or policies intended to address climate change[35] (see Chapter E2).

Ultimately, the power of corporations in the political economy is expressed in the reality that corporations represent the top 71 of the largest 100 revenue generators globally, with only 29 being nation states.[36] To place this reality into a broader context, the US retail giant, Walmart, holds greater revenue than Spain or Australia, Costco has equivalent revenue to Argentina, with Nestle's revenue being equivalent to that of Greece.[37]

Corporate practices that are damaging to health

TNCs have been described as 'the primary "movers and shapers" of the global economy'[38], engaging in a range of health-harming corporate practices. This role of TNCs is aided and abetted by global consultancy firms. One example being when the 'Big Four' (Deloitte, KPMG International, PricewaterhouseCoopers (PwC), and Ernst & Young (EY)) used strategies including positive ratings for subprime mortgages or uncritical audit opinions for their clients which underpinned the reckless financial gambling that eventually led to the 2008 Global Financial Crisis. As Global Health Watch 4 documented, the financial and health costs of the economic recession and austerity measures that followed were borne largely by poorer populations lacking any responsibility for the crisis.[39] These firms have also had to pay millions in compensation to shareholders of companies they had audited for the billions more they had lost in fines and shareholder value after the egregious accounting was detected.[40] The consulting firms nonetheless still audit all of the Fortune 500 companies.

Engaging scientists to advance corporate aims

Corporations also engage key scientists or respected figures to appear to be independent while speaking in their favor.[41] They influence the conduct and publication of science, often as an attempt to pre-empt or refute independent science which may present corporations or their products in a negative light.[42] Funding provided by food and beverage, chemical, mining, computer and automobile

companies and others influences researchers and suppresses research, leading to a loss of academic freedom.[43]

Lobbying governments and international institutions

Other health damaging corporate practices are lobbying governments and international institutions to promote their financial interests. Nyberg uses the term "post-democracy" to describe how businesses exercise excessive political power to shape government policy.[44] One example is the WHO Framework of Engagement with Non-State Actors, based on accepting the need to protect global public goods. This framework was devised to 'foster the use of non-State actors' resources (including knowledge, expertise, commodities, personnel and finances) in favor of public health, and to encourage non-state actors to improve their own activities to protect and promote health'.[45] However, concerns have been raised that entering into closer relations with corporations as 'indispensable stakeholders' in decision making processes will sideline those who work in the spirit of "health for all" and expand the influence of business corporations and venture philanthropies over issues of global public health.[46]

Discrediting critics and engaging in deceptive practices

Corporations often discredit opponents, including NGO representatives, scientists and environmentalists, and commonly accuse NGOs of instigating conflict and influencing local actors protesting corporate actions inimical to human or environmental health. To protect profits, corporations have developed legal, scientific, and public relations tactics, including creating their own (fake) grassroots or 'astroturf' campaigns which are usually sponsored by large corporations or other for-profit or politically motivated funders and are often lacking in transparency.

Using public relations and 'health washing'

Corporations also use public relations as a form of 'education' and set up dialogues with NGOs, governments, and the public.[47] They 'wash' their corporate image through feigning corporate social responsibility and by 'health'.[48] For example, calls for greater regulation of the gambling industry has resulted in corporate social responsibility 'camouflage' which is best described as health washing, with the Gambling Awareness Trust providing gambling addiction counselling, education and research, funded by more than 30 bookmakers.[49] Corporations employ large numbers of public relations professionals and use public relations services to help promote a positive impression and engineer mass consent for corporate practices through glossy presentations and language that is often appropriated from the civil society groups that oppose corporate activities. Words including 'respect', 'democracy', 'dialogue', 'transparency', and 'sharing' are carefully employed, even if practices damage planetary or human health.[50]

Engaging the strategic use of corporate social responsibility

Many corporations push the idea of corporate social responsibility (CSR) which in theory means they are concerned with the 'triple bottom line' of social, economic and environmental impact.[51] But CSR has faced wide-ranging criticisms and is mainly a way of them trying to create a positive image rather than really doing good. CSR is often not only a superficial, public relations exercise, but also a tax deductible way to shape policy outcomes that work against public welfare.[52] One example is McDonald's promotion of a 'Ronald McDonald' clown mascot as an 'ambassador for health' in children's hospitals, and the Ronald McDonald House charity to support sick children which is managed by McDonald's and largely funded by public donations.[53]

Adopting taxation avoidance strategies

Tax evasion or avoidance is another corporate practice that is ultimately damaging to health as it reduces the capacity of nation states to provide decent social security and health services. The International Consortium of Investigative Journalists publishes extensive information on corporate tax evasion, and other forms of corporate malfeasance, citing the enablers (owners) as well as facilitators, including large global consultancy firms.[54] They expose the reality that corporate tax 'cheats' are less likely to face sanctions, and receive lighter punishments than smaller entities[55] (see Chapter C4).

Under international taxation legal structures, transfer pricing between two of the same companies allows for distortions in the price of trade, and for minimizing taxation through reporting profits in tax havens (offshoring).[56] Furthermore, no single authority necessarily sees the complete tax accounts of the TNC as a whole,[57] with implications for transparency and accountability.

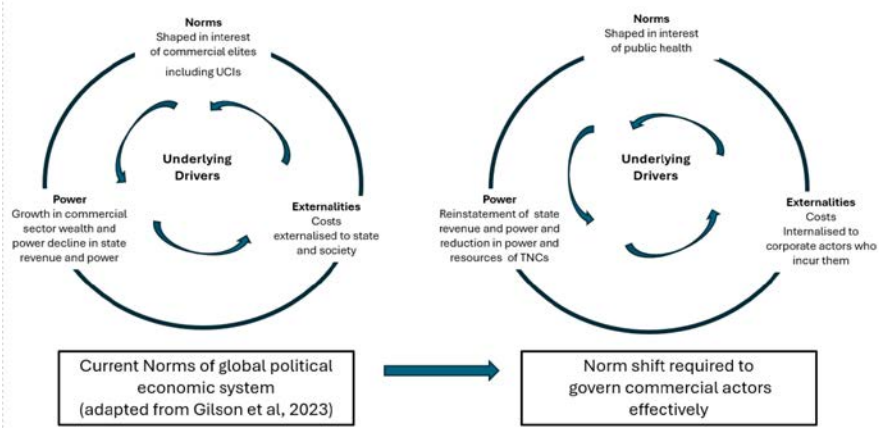
Engaging in strategic litigation

Corporations are powerful and strategic litigants. Their use of Strategic Lawsuits Against Public Participation (SLAPP), a form of retaliatory lawsuit intended to deter freedom of expression on issues of public interest, poses a significant threat to individuals and civil society organizations advocating for health and social justice. SLAPP suits are used by corporations, wealthy individuals, or even governmental bodies with the key feature being their tendency to transfer debate from the political to the legal sphere.[58] The use of SLAPP suits by powerful corporations and individuals is not intended to pursue (an uncommon) legal victory, but to deploy procedural costs and the threat of disproportionate damages to silence respondents, and to impose a broader "chilling effect" on the work of journalists, NGOs and civil society (see Chapter E2). Globally, large oil and other corporate interests have filed lawsuits against groups and individuals who advocate for environmental and climate protection and who seek to hold key corporate and government players to account.[59] Corporations' 'deep pockets' provide an often unfair advantage over civil society actors.[60]

What is to be done?

Constraining corporations from continuing their health harming practices will require a dramatic change in current regulation and legislation. Fundamentally a shift is required (see Figure 2) from a global economic system that is biased in favor of corporate elites to one that is shaped in the interests of public health and equity.

Figure 2: Norms of Global Political Economic System: current and potential



Baum and Anaf (2024)[61]

This shift will require:

- Empowering actors who can enforce regulations and legislation.
- Making binding treaties really binding.
- Reversing privatization which have enriched corporations and returning services to public management and ownership.
- Stopping subsidizing global corporations through corporate welfare.
- Breaking up global consultancy firms and ensuring they no longer undermine public services.
- Implementing global taxation strategies to address profit shifting and tax avoidance.
- Adopting alternative economic and business models which support planetary and human health.

Such a shift in norms will not happen under a Trump presidency. Rather the cycle of norms in the interests of commercial elites will be strengthened and intensified. As this happens in the US it is likely that other countries will follow suit. Yet moving towards a healthy and sustainable world requires tight corporate governance and must involve those actors who seek to uncover the ways in which TNC activity is detrimental to health, and then act to mitigate associated health

harms.[62] These actors include civil society advocacy groups, politicians, public servants, international organizations, professional associations, local citizen advocacy groups, academics, trade unions, and investigative journalists.

Civil society is important in advocating against the adverse practices of TNCs. Examples include environmental groups protesting the destructive practices of mining corporations, actions against fast food corporations including protesting new McDonalds outlets, and against adverse practices of pharmaceutical companies. An example of the latter was the People's Health Movement Equal Access to Vaccines initiative during the early days of the COVID-19 pandemic. Tax Justice International advocates for measures to ensure that corporations pay adequate taxes. While civil society organizations have much less power than TNCs they can still be effective in naming and shaming corporate misbehavior.

Politicians can use the legitimate power of the state to devise sound public policy to protect the public interest by regulating the products and operations of TNCs. Too often, however, they are bought off by large donations to their political parties which blunts their appetite to pass legislation that allows for effective regulation.[63]

Professional associations and trade unions use the collective agency of their members to address the power of entities to act as CDoH. Examples are public health associations advocating against the tobacco, alcohol and gambling industries and health professionals lobbying for measures to mitigate the effects of global warming.

The United Nations (UN) has been an arena for advocating regulation of TNCs and their value chains since the 1970s when developing countries pushed for a Code on TNCs. In the evolving regulatory environment surrounding TNCs, the UN now can augment the gains achieved through the UN Guiding Principles on Business and Human Rights to advance corporate and state accountability through finally agreeing upon, and then ensuring ratification of, a legally binding instrument. However, a range of constraints are noted,[64] including that the draft is shaped by 'selectivity and ambiguity' and a reluctance for shortcomings in host state governance being included in the treaty. There is insufficient attention given to compliance and ratification, and the ramifications of market competition on the treaty content.*

Investigative journalists are a critical force for holding powerful commercial actors to account. The International Consortium of Investigative Journalists exposes wide ranging corruption and tax evasion by multinational corporations, including through documentation in the Panama Papers, Paradise Papers and Pandora Papers. Their work has led to public protests, wide-ranging legal reform, multiple arrests and official inquiries in more than 70 countries.[65] In Australia, Michael West Media continues to expose the negative aspects of the operations of both TNCs and global consultancy firms and other networks of influence and power.[66]

*See PHM position on the treaty negotiations: https://bit.ly/4lW5qdC

Whistleblowers from inside corporations can also reveal details of corporate misbehavior but rarely receive the legal protection they should be afforded.

Reversing privatizations which have enriched corporations and returning services to public management and ownership

A major source of corporate profits in the last decades has been through the privatization of previous public services (see Chapters A1 and B1). Corporations have come to run previously (largely) publicly provided water and energy, health, aged care, disability, job search, and childcare services. Through this they have extracted profits from the public purses. Trade Unions and others continue to call for renationalization or "remunicipalization" of these privatized services.[67] Doing so would be an effective way to prevent the profit-taking from public funds and with suitable governance would offer improved and more equitable services, especially for poorer population groups. Examples of successful renationalization include Water Services in Paris, France in 2010 and Buenos Aires, Argentina in early 2000s, and energy utilities in Hamburg, Germany in 2013.[68]

In terms of health services there needs to be a reversal of the trend towards corporatized health systems which are being pushed through public-private partnerships schemes and private health insurance (see Chapter B1). The People's Health Movement 2024 Mar del Plata Call to Action denounces this trend saying:[69]

> PHM denounces the global trend towards privatization of health care, especially in recent decades and the push for the implementation of market-oriented, publicly financed insurance schemes (especially in Asia and Africa). These are being implemented in the name of achieving universal health coverage instead of strengthening public services for ensuring universal access to health care and basing health systems on comprehensive primary health care. This current crop of insurance schemes reinforces privatization and commercialization of health, without increasing coverage or financial protection.

Health systems need to be designed to promote publicly funded and delivered services and the trends towards corporatized health services that involve the generation of large profits for health insurance and healthcare corporations be urgently reversed. The murder of a CEO of a large US health insurance company in December 2024 was greeted with social media comments saying the act was understandable given the voracious nature of the company in refusing to cover insured services and/or delaying access to medical treatment.

Break up the conflicting roles of global consultancy firms

Global consultancies, both in their consulting and auditing arms, work for specific companies or industries as well as for governments. When working for the government, consultancies are unlikely to recommend any policy that would

significantly disadvantage their private sector clients.[70] An initial move in reducing the adverse consequences of the Big Four consultancy firms would be to separate out their tax, consulting and audit functions to reduce conflicts of interest and make audit independence more likely.[71]

Devise global taxation structures to address profit shifting and tax avoidance

Global tax havens enable corporations to profit shift and avoid paying tax.[72] The way international corporate income is taxed is based on a century-old approach which was adopted prior to the formation of TNCs. Currently, individual entities that comprise a TNC hold separate accounts as if they were independent companies. However, the corporation optimizes its tax liabilities as a single entity.[73] Instead, a unitary model of taxation should be adopted to tax profits in the place of the economic activity, instead of where profits are reported. In this way the corporation would report on both overall global profit and each country in which it operates. Governments would then have the capacity to impose taxation according to specific country activity[74] (see Chapter C4).

Adopt alternative business models to support planetary and human health

TNCs clearly do not promote planetary and human flourishing. This then begs the question of what models might. Marx advocated that workers should own the means of production under a socialist vision of society. More recent commentaries on a radically reformed or transformed capitalism include calls for degrowth, circular, and wellbeing economies (see Chapter A1 and *Global Health Watch 6* Chapter A3). Degrowth posits a society based on sufficiency, autonomy, and democracy, liberated from the drive to consume and produce, and therefore able to downscale economies' material throughput, beginning with all excess.[75] The circular economy is often framed as 'the end of waste'[76] and requires available underused resources in order to thrive.[77] Both models recognize that the current, linear chain of production-consumption-disposal is environmentally and socially destructive.[78] Wellbeing economies place human and planetary needs ahead of economic growth as an end in itself, with societal success shifting beyond GDP growth to delivering shared wellbeing through fundamental systems change.[79] All these alternative models challenge the current regressive and damaging neoliberal policy environment that places the profit motive ahead of health and wellbeing.

Stop corporate welfare

Addressing the negative impacts from the CDoH will also require stopping corporate welfare, that is, the raft of financial benefits corporations accrue that include direct and indirect government subsidies (e.g. for fossil fuel corporations), tax breaks, government 'bailouts' (such as the public debts incurred for bailing out 'banks too big to fail' whose avaricious and largely unregulated investment practices caused the 2008 Global Financial Crisis), and forms of 'light touch'

regulation of harmful industries including fast food, gambling, and alcohol corporations. Commercial entities including TNCs and global consultancy firms are significant political donors and wield the power and influence to attract corporate welfare that is largely obscured from the public gaze. Both governments and corporations often collude to ensure this obscurity, while business and other commercial entities succeed in portraying the poor as the main beneficiaries of state largesse.[80]

Corporate welfare programs are a particular manifestation of structural power which is not derived from strategic or intentional business activities, but through the operation of global market pressures. These compel states into providing policies that privilege the interests of business.[81] However, corporate welfare reduces the fiscal space for investing in health and social welfare and improving health equity, and denies the state a capacity to enforce its own logic of action within the economy.[82]

Although no one solution can negate the harms of the CDoH, there is some suggestion that strong international frameworks, regenerative business models that incorporate environmental, health and social goals, government regulation and strict compliance mechanisms, together with civil society advocacy may lead to systemic, transformative change.[83] Systematic change, however, requires a change to the dominant neoliberal global economic system which privileges profit over people's health.

Conclusion

The role of government should be to promote the public good. Tackling the CDoH is formidable, and progress is often incremental and sequential. However, transformative change can be achieved with committed advocacy. It will be necessary to identify and mobilize those actors who can assist in governing, including political actors supportive of transforming neoliberal capitalism and reigning in the wealth and power of TNCs. Examples of actors with similar stated views include former US presidential candidate Bernie Sanders and former UK Labour leader Jeremy Corbyn.[84] We also need to rethink public policy and regulatory approaches and ensure adequate taxation revenue to allow for health and social investment. Public procurement can be used as a policy lever to achieve sustainable development goals as budgeting promotes policy integration and policy continuity beyond electoral cycles. Enforceable international agreements are required to ensure that health and human rights triumph over profits. A current attempt to do so, the UN Binding Treaty on Business and Human Rights, unless enforcement measures are included, will likely be too weak to make much difference. The People's Health Movement calls for a New International Economic Order (NIEO) in which corporations would not have the massive power they have now and would be dismantled (see Chapter A1). Until the NIEO is achieved, the PHM Mar del Plata Call to Action demands the following changes:

- Progressive taxation of income, wealth, inheritance and corporations imposed globally with all loop-holes closed.
- Regulation of the size and influence of global corporations and the introduction of anti-trust legislation to break up their monopoly power.
- Replacement of voluntary codes of conduct for corporations with binding regulations.
- Immediate ratification of the UN Guiding Principles on Business and Human Rights moving towards regulations that are enforceable.
- Elimination of intellectual property barriers that limit access to health technologies as public goods, including removing them from TRIPS.
- Transformation of the model on which health technologies are researched and developed from one focused on private sector profit to one based on open access to products and knowledge and focused on curing diseases of public health concern.
- Elimination of Investor–state dispute settlement (ISDS) provisions in trade agreements.
- Break up the big global consulting and management firms to resolve conflicts of interest between TNCs, auditors, accountants, consultants, and governments globally.
- Cease use of global consulting companies to advise on and write government policies.
- Strong support for businesses that are owned and controlled by their workers and creation of co-operative businesses.
- Regulation and legislation of unsafe employment practices and the promotion of employment that brings satisfaction and wellbeing.

To achieve these changes, we must challenge the international norms that enable the current neoliberal regime. This regime drives the commercial/corporate determination of health by ensuring that national and global economic policy almost invariably biases in favor of corporate interests. Rather, we need to redirect government fiscal and economic policy to the provision of public goods including health and education. The continued and dominating power of TNCs is incompatible with a healthy and sustainable world. Their operations and practices must be regulated and ultimately replaced in the process of establishing a NIEO which will see workers' co-operatives flourish and economic policies determined by, and meeting the needs of, people and planet.

Reference List

1 Wiist, William H. 2006. "Public Health and the Anticorporate Movement: Rationale and Recommendations." *American Journal of Public Health* 96(8): 1370–75. https://bit.ly/4jH2CzG.

2 Freudenberg, Nicholas. 2023. *At What Cost: Modern Capitalism and the Future of Health*. First issued as an Oxford University Press paperback. New York, NY: Oxford University Press.

3 Freudenberg, Nicholas. 2023. *At What Cost: Modern Capitalism and the Future of Health*. First issued as an Oxford University Press paperback. New York, NY: Oxford University Press.

4 Di Censo, G, and P Delfabbro. 2024. "Celebrities, Influencers, Loopholes: Online Gambling Advertising Faces an Uncertain Future in Australia." *The Conversation*, March 24, 2024. https://bit.ly/4d65dAE

5 Chapman, Simon. 2011. "Why the Tobacco Industry Fears Plain Packaging." *Medical Journal of Australia* 195 (5): 255–255. https://bit.ly/3ESxrSw.

6 Australasian Centre for Corporate Responsibility. 2022. "Advertising Tricks of the Fossil Fuel Sector." Australasian Centre for Corporate Responsibility. 2022. https://bit.ly/4lTYQ7l.

7 Climate Change News. 2023. "Consultants Close to Industry Shaped Australia's Controversial Carbon Credit Policy." *Climate Change News*, March 30, 2023. https://bit.ly/3EHQK10.

8 Australasian Centre for Corporate Responsibility. 2022. "Advertising Tricks of the Fossil Fuel Sector." Australasian Centre for Corporate Responsibility. 2022. https://bit.ly/4lTYQ7l.

9 Lacy-Nichols, Jennifer, Robert Marten, Eric Crosbie, and Rob Moodie. 2022. "The Public Health Playbook: Ideas for Challenging the Corporate Playbook." *The Lancet Global Health* 10 (7): e1067–72. https://bit.ly/4d2CBZ4

10 Mazzucato, Mariana, and Rosie Collington. 2023. *The Big Con: How the Consulting Industry Weakens Our Businesses, Infantilizes Our Governments and Warps Our Economies*. London: Allen Lane.

11 West. 2016. "Break up the Big Four: Interview with George Rozvany." *Michael West Media Independent Journalist* (blog). July 12, 2016. https://bit.ly/42YInpP

12 Venkatraman, Anand, Dhruvika Mukhija, Nilay Kumar, and Sajan Jiv Singh Nagpal. 2016. "Zika Virus Misinformation on the Internet." *Travel Medicine and Infectious Disease* 14 (4): 421–22. https://bit.ly/42VGeLw.

13 Suarez-Lledo, Victor, and Javier Alvarez-Galvez. 2021. "Prevalence of Health Misinformation on Social Media: Systematic Review." *Journal of Medical Internet Research* 23 (1): e17187. https://bit.ly/4jKmXDS.

14 Montpetit, J, Fact-checking has become partisan. Can it survive the backlash from conservatives and Big Tech, CBC News, January 11, 2025, https://bit.ly/3GzHa0D; E-Safety Commissioner. n.d. "Social Media Age Restrictions." Canberra: Australian Government. Accessed January 1, 2025. https://bit.ly/3RH6X9u

15 Arogyaswamy, Bernard. 2020. "Big Tech and Societal Sustainability: An Ethical Framework." *AI & SOCIETY* 35 (4): 829–40. https://bit.ly/4lU1TMX.

16 Harvey, David. 2007. "Neoliberalism as Creative Destruction." *The Annals of the American Academy of Political and Social Science* 610 (1): 21–44. https://bit.ly/4jzObgL.

17 Wiegratz, J, and D Whyte. 2016. "How Neoliberalism's Moral Order Feeds Fraud and Corruption." *The Conversation*, June 20, 2016. https://bit.ly/42SXX6t

18 United Nations Global Compact. 2015. United Nations Global Compact: Business as a Force for Good, https://bit.ly/42WekPK

19 Hartwig. 2005. "The Global Compact: Symbolic or Regulative Politics? The United Nations and Transnational Corporations" (conference proceedings).

20 United Nations Office of the High Commissioner for Human Rights. 2011. "Guiding Principles on Business and Human Rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework." HR/PUB/11/04. Geneva and New York: United Nations.

21 United Nations Office of the High Commissioner for Human Rights. 2011. "Guiding Principles on Business and Human Rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework." HR/PUB/11/04. Geneva and New York: United Nations.

22 Business and Human Rights Resource Centre. 2023. "UN Intergovernmental Working Group Releases Updated Draft of Legally Binding Instrument on Business and Human Rights," August 7, 2023. https://bit.ly/3GKFykC

23 Baum, Fran, and Julia Anaf. 2024. "Practices of Trans-National Corporations: The Need to Change Global Economic and Political Norms Comment on 'National Public Health Surveillance of Corporations in Key Unhealthy Commodity Industries – A Scoping Review and Framework Synthesis.'" *International Journal of Health Policy and Management* 13 (September):8660. https://bit.ly/4iHRT6I.

24 Tsokhas, 2019. The Big Four: The Curious Past and Perilous Future of the Global Accounting Monopoly. *Review of Radical Political Economics*, 52, 785-88

25 Nyberg, Daniel. 2021. "Corporations, Politics, and Democracy: Corporate Political Activities as Political Corruption." *Organization Theory* 2 (1): 2631787720982618. https://bit.ly/42CFXyk.

26 White House. 2025. "Executive Order – Unleashing Prosperity through Deregulation." Office of the President. https://bit.ly/4jKnzcE.

27 Bivens, Gould and Kandra, 2024. "CEO pay declined in 2023," *Economic Policy Institute*, https://bit.ly/3Gxu2cu/

28 Motari, Marion, Jean-Baptiste Nikiema, Ossy M. J. Kasilo, Stanislav Kniazkov, Andre Loua, Aissatou Sougou, and Prosper Tumusiime. 2021. "The Role of Intellectual Property Rights on Access to Medicines in the WHO African Region: 25 Years after the TRIPS Agreement." *BMC Public Health* 21 (1): 490. https://bit.ly/3ScMucK.

29 Wiist, William H. 2006. "Public Health and the Anticorporate Movement: Rationale and Recommendations." *American Journal of Public Health* 96 (8): 1370–75. https://bit.ly/4jH2CzG.

30 Ohman, Magnus. 2012. "Political Finance Regulations Around the World: An overview of the international IDEA database" International Institute for Democracy and Electoral Assistance, https://bit.ly/3GzIfWf

31 Totenberg, N. 2014. "When Did Companies Become People? Excavating The Legal Evolution." NPR, July 28, 2014. https://bit.ly/4jSfmnb.

32 United Nations Office of the High Commissioner. 2023. "Investor-State Dispute Settlements Have Catastrophic Consequences for the Environment and Human Rights: UN Expert." UN – Press Release, October 20, 2023. https://bit.ly/3YU50uc

33 Ranald, P. 2019. "When Even Winning Is Losing. The Surprising Cost of Defeating Philip Morris over Plain Packaging." *The Conversation*, March 26, 2019. https://bit.ly/3EWQpYa.

34 Hepburn, J. 2019. "Final Costs Details Are Released in Philip Morris v. Australia Following Request by IAReporter." *Investment Arbitration Reporter*, March 21, 2019. https://bit.ly/44iKo2r.

35 Ranald, P. 2019. "When Even Winning Is Losing. The Surprising Cost of Defeating Philip Morris over Plain Packaging." *The Conversation*, March 26, 2019. https://bit.ly/3EWQpYa.

36 Green, D. 2018. "Of the World's Top 100 Economic Revenue Collectors, 29 Are States, 71 Are Corporates." OXFAM. *From Poverty to Power* (blog). August 3, 2018. https://bit.ly/3SkXFjD.

37 Green, D. 2018. "Of the World's Top 100 Economic Revenue Collectors, 29 Are States, 71 Are Corporates." OXFAM. *From Poverty to Power* (blog). August 3, 2018. https://bit.ly/3SkXFjD.

38 Dicken, Peter. 2001. *Global Shift: Transforming the World Economy*. 3. ed., Repr. London: Paul Chapman

39 Peoples Health Movement, 2014. *Global health watch 4: an alternative world health report*. London, England: Zed Books, https://phmovement.org/global-health-watch-4/

40 Tsokhas, 2019. The Big Four: The Curious Past and Perilous Future of the Global Accounting Monopoly. Review of Radical Political Economics, 52, 785-88; Management Consulted. 2024. "Big Four Audit Clients." *Management Consulted* (blog). September 19, 2024. https://bit.ly/4lV8c2E.

41 Paul, Helena, and Ricarda Steinbrecher. 2003. *Hungry Corporations: How Transnational Biotech Companies Colonise the Food Chain*. London; New York : New York: Zed Books in association with Econexus and the Pesticide Action Network Asia-Pacific (PAN-AP).

42 Legg, Tess, Jenny Hatchard, and Anna B. Gilmore. 2021. "The Science for Profit Model—How and Why Corporations Influence Science and the Use of Science in Policy and Practice." Edited by Stanton A. Glantz. PLOS ONE 16 (6): e0253272. https://bit.ly/4lWhhZa.

43 Bero, L. 2019. "When Big Companies Fund Academic Research, the Truth Often Comes Last." *The Conversation*, October 2, 2019. https://bit.ly/4cWxkCd.

44 Nyberg, Daniel. 2021. "Corporations, Politics, and Democracy: Corporate Political Activities as Political Corruption." *Organization Theory* 2 (1): https://bit.ly/42CFXyk.

45 World Health Organization. 2016. "Framework for Engagement with Non-State Actors." Geneva: United Nations. https://bit.ly/44k9GgM.

46 Richter, J. 2014. "Time to Turn the Tide: WHO's Engagement with Non-State Actors and the Politics of Stakeholder Governance and Conflicts of Interest." *BMJ* 348 (may19 5): g3351-g3351. https://bit.ly/44e8onr.

47 Paul, Helena, and Ricarda Steinbrecher. 2003. *Hungry Corporations: How Transnational Biotech Companies Colonise the Food Chain*. London; New York : New York: Zed Books in association with Econexus and the Pesticide Action Network Asia-Pacific (PAN-AP).

48 Fooks, Gary, Anna Gilmore, Jeff Collin, Chris Holden, and Kelley Lee. 2013. "The Limits of Corporate Social Responsibility: Techniques of Neutralization, Stakeholder Management and Political CSR." *Journal of Business Ethics* 112 (2): 283–99. https://bit.ly/4iHZ3I3; Baum, F., and R. Labonte. 2014. "Health Wash in Helsinki." Health Promotion International 29 (1): 141–43. https://bit.ly/4jw4Am7.

49 Houghton, F. 2022. "Feigning Corporate Social Responsibility (CSR) Through Health Washing: Gambling Industry Conflicts of Interest in Health Service Provision and Training in Ireland." Medicina Internacia Revuo – International Medicine Review 30 (118). https://bit.ly/4cVxSIp.

50 Paul, Helena, and Ricarda Steinbrecher. 2003. *Hungry Corporations: How Transnational Biotech Companies Colonise the Food Chain*. London; New York : New York: Zed Books in association with Econexus and the Pesticide Action Network Asia-Pacific (PAN-AP).

51 Australian Human Rights Commission. 2008. "Corporate Social Responsibility & Human Rights." 2008. https://bit.ly/42OKpIZ.

52 Gilmore, Anna B, Alice Fabbri, Fran Baum, Adam Bertscher, Krista Bondy, Ha-Joon Chang, Sandro Demaio, et al. 2023. "Defining and Conceptualising the Commercial Determinants of Health." *The Lancet* 401 (10383): 1194–1213. https://bit.ly/4jUwmbJ.

53 Anaf, Julia, Fran Baum, Matthew Fisher, and Sharon Friel. 2020. "Civil Society Action against Transnational Corporations: Implications for Health Promotion." *Health Promotion International* 35 (4): 877–87. https://bit.ly/42T60zX; McDonald, David. 2012. "Challenging Ronald: McDonald versus McDonald's." *Journal of Paediatrics and Child Health* 48 (2): 103–5. https://bit.ly/3EFKWoJ

54 Alecci, S. 2023. "Investigators Worldwide Continue to Open 'Pandora's Box' to Pursue Criminals Identified in Pandora Papers Two Years after ICIJ's Landmark Investigation." *International Consortium of Investigative Journalists,* October 3, 2023. https://bit.ly/4cSFawy; Woodman, S, and N Weinberg. 2023. "As Sanctions Loomed, Accounting Giant PwC Scrambled to Keep Powerful Russians a Step Ahead." *International Consortium of Investigative Journalists*, November 14, 2023. https://bit.ly/42T0sWp.

55 Woodman, S. 2024. "How the IRS Went Soft on Billionaires and Corporate Tax Cheat." *International Consortium of Investigative Journalists*, June 11, 2024. https://bit.ly/44hMNdH.

56 Tax Justice Network. n.d. "What Is Transfer Pricing." https://bit.ly/3YpEt7Z.

57 Picciotto, S. 2012. "Towards Unitary Taxation of Transnational Corporations." Tax Justice Network. https://bit.ly/4jtCGXW.

58 Borg-Barthet, J, B Lobina, and M Zabrocka. 2021. "The Use of SLAPPs to Silence Journalists, NGOs and Civil Society." PE 694.782. Brussels: European Parliament's Committee of Legal Affairs, Policy Department for Citizens' Rights and Constitutional Affairs. https://bit.ly/4m9wXIK.

59 Levantesi, S. 2024. "New Report Shows a Surge in European SLAPP Suits as Fossil Fuel Industry Works to Obstruct Climate Action." *DeSmog*, December 17, 2024. https://bit.ly/4k1WqlA; Abrams, Robert. 1989. "Strategic Lawsuits against Public Participation (SLAPP) Address." *Pace Environmental Law Review* 7 (1): 33. https://bit.ly/3YUysQQ.

60 Anaf, Julia, Fran Baum, Matthew Fisher, and Sharon Friel. 2020. "Civil Society Action against Transnational Corporations: Implications for Health Promotion." *Health Promotion International* 35 (4): 877–87. https://bit.ly/42T60zX.

61 Anaf, Julia, and Fran Baum. 2024. "Health and Equity Impacts of Global Consultancy Firms." *Globalization and Health* 20 (1): 55. https://bit.ly/3GwBODn.

62 Baum, Fran, and Julia Anaf. 2024. "Practices of Trans-National Corporations: The Need to Change Global Economic and Political Norms Comment on 'National Public Health Surveillance of Corporations in Key Unhealthy Commodity Industries – A Scoping Review and Framework Synthesis.'" *International Journal of Health Policy and Management* 13 (September):8660. https://bit.ly/4iHRT6I.

63 Edwards, B. 2022. "The Implications of Corporate Political Donations." American Bar Association – Human Rights Magazine, October 24, 2022. https://bit.ly/3GsHYEG; Browne, B. 2023. "The Hidden Political Expenditure of Australian Corporations." The Australia Institute. September 29, 2023. https://bit.ly/4iKuYaX.

64 Mares, Radu. 2022. "Regulating Transnational Corporations at the United Nations – the Negotiations of a Treaty on Business and Human Rights." *The International Journal of Human Rights* 26 (9): 1522–46. https://bit.ly/44cCDep.

65 *International Consortium of Investigative Journalists*. n.d. "About the ICJ," n.d. https://bit.ly/3GuIj9X.

66 Michael West Media. 2021. "Revolving Doors: Democracy at Risk." *Michael West Media Independent Journalist* (blog). 2021. https://bit.ly/43inwOD.

67 Cibrario, D. 2024. "Remunicipalisation." *Public Services International,* 2024. https://bit.ly/3RHG0Cz.

68 Albalate, Daniel, Germà Bel, and Eoin Reeves. 2024. "Extent and Dynamics of the Remunicipalisation of Public Services." *Local Government Studies* 50 (4): 663–76. https://bit.ly/4iDdQDF.

69 Peoples Health Movement. 2024. "PHA5 Mar del Plata 2024 Call to Action." https://bit.ly/42l6O1y

70 Browne, B. 2023. "The Hidden Political Expenditure of Australian Corporations." The Australia Institute. September 29, 2023. https://bit.ly/4iKuYaX.

71 Michael West. 2016. "Break up the Big Four: Interview with George Rozvany." *Michael West Media Independent Journalist* (blog). July 12, 2016. https://bit.ly/42YInpP.

72 Nerudová, Danuše. 2021. *Profit Shifting and Tax Base Erosion: Case Studies of Post-Communist Countries*. Contributions to Finance and Accounting Ser. Cham: Springer International Publishing AG.

73 Palanský, M. 2019. "How Multinationals Continue to Avoid Paying Hundreds of Billions of Dollars in Tax – New Research." *The Conversation*, October 3, 2019. https://bit.ly/4jKqsdu.

74 Palanský, M. 2019. "How Multinationals Continue to Avoid Paying Hundreds of Billions of Dollars in Tax – New Research." *The Conversation*, October 3, 2019. https://bit.ly/4jKqsdu.

75 Savini, Federico. 2023. "Futures of the Social Metabolism: Degrowth, Circular Economy and the Value of Waste." *Futures* 150 (June):103180. https://bit.ly/42VHcrd.

76 Ragossnig, Arne M, and Daniel R Schneider. 2019. "Circular Economy, Recycling and End-of-Waste." *Waste Management & Research: The Journal for a Sustainable Circular Economy* 37 (2): 109–11. https://bit.ly/3RHcixy.

77 Savini, Federico. 2023. "Futures of the Social Metabolism: Degrowth, Circular Economy and the Value of Waste." *Futures* 150 (June):103180. https://bit.ly/42VHcrd.

78 Savini, Federico. 2023. "Futures of the Social Metabolism: Degrowth, Circular Economy and the Value of Waste." *Futures* 150 (June):103180. https://bit.ly/42VHcrd.

79 Wellbeing Economy Alliance. n.d. "What Is a Wellbeing Economy?" https://bit.ly/3EPENGt.

80 Farnsworth, Kevin. 2012. *Social versus Corporate Welfare: Competing Needs and Interests within the Welfare State*. Basingstoke: Palgrave Macmillan.

81 Bulfone, Fabio, Timur Ergen, and Manolis Kalaitzake. 2023. "No Strings Attached: Corporate Welfare, State Intervention, and the Issue of Conditionality." *Competition & Change* 27 (2): 253–76. https://bit.ly/3SeTmXa.

82 Bulfone, Fabio, Timur Ergen, and Manolis Kalaitzake. 2023. "No Strings Attached: Corporate Welfare, State Intervention, and the Issue of Conditionality." *Competition & Change* 27 (2): 253–76. https://bit.ly/3SeTmXa.

83 Friel, Sharon, Jeff Collin, Mike Daube, Anneliese Depoux, Nicholas Freudenberg, Anna B Gilmore, Paula Johns, et al. 2023. "Commercial Determinants of Health: Future Directions." *The Lancet* 401 (10383): 1229–40. https://bit.ly/42Dxzi3.

84 Frase, Peter. 2016. "The Survivors." *Jacobin*. July 5, 2016. https://bit.ly/3YWJoNP; Bloodworth, James. 2018. "Two Paths for the Left: The Dueling Visions of Bernie Sanders and Jeremy Corbyn." *Tablet*. November 27, 2018. https://bit.ly/3YqTBlD

SECTION D

Watching

WHO's Compromised Role in Global Health Leadership

Introduction

As the UN's specialized health agency, the World Health Organization (WHO) has a broad mandate related to the promotion and protection of health and the prevention of ill-health. In recent decades WHO's position as the chief coordinating authority in global health governance has come under threat.[1] Notwithstanding its expertise, and perceived authority, it is unclear to what extent the organization is still actually shaping the global health policy agenda and driving progress in global health.

In this chapter, we build on previous Global Health Watch discussions on the challenges facing WHO, which have only intensified since the onset of the COVID-19 syndemic. In recent years, the space for civil society to shape WHO decisions and processes has notably been diminished, while the organization's agenda is becoming increasingly politicized. Recent funding changes, intended to boost resources, could paradoxically constrain WHO's capacity for rational and agile decision-making and threaten its ability to deliver on its core mandate and principles. By some reckonings, on account of its resource constraints, it is at risk of being reduced to a vessel for the hosting of programs dictated by donors.

These developments come at a critical time when mounting global health crises – conflicts, famine, natural disasters and setbacks in women's rights – and the disruptive impact of the second Trump presidency require genuine leadership from WHO, backstopped by a robust role for public interest civil society organizations in the WHO's governance.

Geopolitics, gender and the "politicization" of the World Health Organization

The governance of WHO seems more polarized than ever. Geopolitical tensions, sociocultural divisions and international conflict (see Chapter A1) shape all multilateral deliberations in one way or another, and WHO is not immune to these effects. Economic and political resources are routinely mobilized by the global powers to assert their "national interests", to insulate their allies from criticism and sanction and to marginalize the interests of other states. International health debates cannot avoid being colored by broader contemporary political trends. Indeed, the global health governance community ignores these forces at its peril.

In recent years, deliberations of the World Health Assembly (WHA) – the principal governing body of WHO – have revealed deep divisions between states with respect to gender, sexual health and reproductive rights. To the great shame of the Assembly, debate on initiatives as innocuous and well-intended as sexual health and HIV prevention, and the "gender responsiveness" of natural disaster relief, have been prolonged or derailed because of petty complaints about terminology related to gender and sex from the representatives of reactionary governments. In one of several instances, the final day of debate of the 75th WHA (2022) stretched painfully late into the evening as member states, led by socially conservative governments, held up the approval of the most recent global strategy on HIV, Hepatitis B and sexually transmitted infections over inclusion in the document of a glossary containing terms considered objectionable, such as "sexual health", "sexual orientation" and "men who have sex with men".[2]

These ideological divides reflect a complex struggle between a freshly emboldened socially conservative reactionary international, and the fragile liberal status quo in public health devoted (at least rhetorically) to the affirmation of sexual and gender diversity and to evidence-based principles. As this struggle unfolds, the rights of women (and, indeed, their lives) hang in the balance (see Box D1.1).

Box D1.1: The silent power of postmodern patriarchy: women's rights under siege from Gezira to Geneva

As we write, mass murders and the abduction of women and girls define the appalling reality of atrocious human rights violations perpetrated by the Rapid Support Forces (RSF) militia in East El-Gezira in Sudan. Reports indicate severe violence and destruction, leaving families and entire communities devastated. The October 2024 account of the UN's Independent Fact-Finding Mission revealed how this devastation particularly targets women. The RSF have committed large-scale sexual violence against women and girls in areas under their control, reportedly including gang-rape, forced marriages and the detention of victims in conditions of sexual slavery.[3] Hundreds of women have killed themselves after recurrent waves of dehumanization by the paramilitary troops.[4]

History repeats itself, conflict after conflict. As warfare becomes the new normal, we can only faintly imagine the brutality on women's bodies, while the violence of war escalates into genocide in the Gaza Strip.[5] The UN Human Rights Office estimated that almost 70 per cent of verified victims in Gaza from November 2023 to April 2024 were women and children, largely due to Israel's indiscriminate shelling in densely populated areas. The report found "unprecedented" levels of international law violations, war crimes and other possible atrocity crimes (see Chapter C1).[6]

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Box D1.1 continues from previous page

Women's bodies are the borderless battleground of society's historic power structures, recently revived by the wild flames of warfare. While feminist and other social movements have long been organizing to resist and disrupt patriarchal forces, the undeclared war against women continues, even pervading our multilateral institutions, including WHO. The agency has been the stage of accusations of sexual misconduct pursued by WHO senior officials, persistently covered over by a heavily flawed internal justice process.[7] In 2020, it was revealed that dozens of women were sexually exploited and raped in the Democratic Republic of the Congo by WHO and UN responders during the 2018-20 Ebola outbreak, leaving behind a trail of survivors, at least 20 of whom later bore children.[8] Loopholes in WHO policies allowed exoneration of the DRC managers, as revealed by an independent report.[9]

The backlash against women's rights has found renewed legitimation in national populisms and the alignment of varyingly authoritarian regimes, especially (but not exclusively) from the Global North. In a world rife with division and oppression, this historic backsliding in politics, culture and economics – most recently confirmed by the re-election of Donald Trump – has profound effects on women's sexual and reproductive health.

The fact that WHO and other UN agencies find themselves reformulating their house documents to remove references to sexual and reproductive rights and gender, so as to avoid tedious suspensions of disparate negotiations, is an alarming sign.[10,11] This has led a group of public health champions to prepare a statement,[12] now translated into several languages, as a wake-up call for urgent action in this regressive political climate of renewed nativist policies and patriarchal norms. The pushback against women's rights must be resisted.

The legitimacy and effectiveness of the WHA itself as a venue for deliberation and cooperation on matters of international health has been called into question. Member states frequently accuse one another of "politicizing" the Assembly (which is nominally intended to be an exclusively "technical" forum), misusing it to pursue matters beyond the organization's "competence" and hijacking it to score political points and domestic public relations victories.

The 77th WHA, held in 2024, was described disparagingly by some as "one of the most political World Health Assemblies in recent times", owing in part to the fact that the body was forced to hold eight roll-call votes, including five on matters related to Palestine (in governing bodies generally characterized by consensus-based procedures, the use of roll-call voting is considered to be a marker of (undesirable) political disagreement). In fact, WHA77 was a reminder that global health deliberations are in dire need of more, not less, explicit engagement on political matters (see Box D1.2).

Box D1.2: The health crisis in Palestine and the "politicization" of the World Health Assembly

On the eve of the 77th World Health Assembly (WHA77), the Israeli army attacked a displaced persons camp in Tal al-Sultan in Rafah, an area that they had previously declared a "safe zone". Two US-made bombs were dropped from Israeli fighter jets,[14] striking the camp, which sat within 200 meters of the largest UN aid storage complex in Gaza. The bombing and the inferno it sparked killed at least 49 Palestinians, many of whom burned alive in the makeshift shelters in which they had been forced to take refuge after being repeatedly displaced by Israel's incessant shelling of the Strip.[15] Over 200 people sustained injuries in the attack. Horrific images of the lifeless body of 18-month-old Ahmed Al-Najjar, who had been decapitated in the strike, circulated worldwide.

WHA77 was convened in May 2024 amidst Israel's then eight-month-old assault on Gaza, which has been widely labelled by international legal experts as genocidal in character.[16] By the end of May 2024, over 36,000 Palestinians had been confirmed killed and nearly 100,000 injured by Israel's military violence, to say nothing of the thousands more missing and presumed dead, trapped under the rubble of their former homes and communities, while over 100 Israeli captives remained in Gaza following their abduction during the Hamas-led attack of 7 October 2023.[17] Gazans who survived Israel's incessant bombardment faced an epic public health and humanitarian catastrophe, with manufactured crises of hunger, thirst and sanitation affecting virtually everyone in the Strip, and the deliberate targeting of healthcare infrastructure and personnel leaving Gaza's health system barely functioning.[18]

Against this backdrop, WHO member states discussed two Director-General reports detailing the dire health situation in Palestine and recommending a humanitarian ceasefire and unrestricted delivery of essential aid. Discussion of Palestine has been included on each WHA agenda since 1968 and the validity of the topic has always divided member states, with the majority (particularly though not exclusively from the Global South) endorsing its importance, and a smaller bloc, led by the United States and Israel, vociferously rejecting the agenda item on the basis that it allegedly "singles out" Israel for criticism and unduly "politicizes" the Assembly. Debate tends to be heated, and WHA77 was no different.

A draft decision, proposed by a diverse group of 32 countries, referred to "the wanton destruction of the Palestinian health system" and "the catastrophic humanitarian conditions that have been inflicted [on] the public health system." Israel accused the decision's supporters of "choos[ing] politics over health" and responded by proposing an amendment (which was narrowly adopted) calling for the release of its hostages held in Gaza and condemning the alleged use of health facilities by armed

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Box D1.2 continues from previous page

groups. Several countries reacted with dismay, with the Arab group accusing Israel of "politicizing" an otherwise "technical" discussion by introducing issues "out[side] of the mandate of the WHO." For its part, the United States accused the decision's supporters of "singl[ing] out one country clearly on a political basis." Following further amendments, the decision was eventually adopted by the Assembly, but not before being taken to a tedious country-by-country roll-call vote.

The hesitation to delve too far into "the political" seems also to extend to the WHO Secretariat, whose reports studiously avoid mention of Israel's criminality. Thus, the Secretariat can describe "[t]he collapse of the health system in the Gaza Strip [as] a result of systematic attacks, and health care workers being killed, as well as shortages of fuel, essential goods and medical supplies" without naming the state responsible for bombing health infrastructure, murdering healthcare workers and deliberately depriving a population of over two million of the essentials of life.

While it has become cliché to declare that "health is political," it is nonetheless a truism. Even before 7 October 2023, the most important determinants of health for Palestinians – apartheid rule, settler-colonial occupation and the blockade of Gaza, for example – were political determinants. Now, amidst Israel's crimes of genocide, ethnic cleansing and collective punishment, a WHO empowered to convene difficult political discussions on the health emergency facing Palestinians is needed more than ever.

Responding to WHO's perpetual state of financial crisis

WHO's health programs are funded from two sources: member state dues (assessed contributions, or ACs) and voluntary contributions (VCs) from a wide range of public and private donors, including member states, other international organizations, international financial institutions, philanthropic foundations and multinational pharmaceutical companies.* Between 2010 and 2021, the proportion of WHO's General Fund coming from VCs grew from 75 to 88 per cent.

This reliance on VCs is a problem for WHO. While ACs are completely flexible in how WHO allocates the funding (in line with WHA approved work plans), and highly predictable, VCs are mostly highly specified with conditions attached: WHO can have the money, so long as it spends it on whichever issue or program the donor prioritizes. This makes it difficult for the Secretariat to meet its goals. Since earmarked VCs are overwhelmingly provided by foundations, states and private corporations from the Global North, they are not reliably used to fund the most pressing concerns of the Global South or even of the international community as a whole. This has obvious implications for the accountability and legitimacy of WHO's work and can lead to so-called 'pockets of poverty': health

*Chapters in GHW2 (GHW, 2008) and GHW5 (GHW, 2017) include detailed analyses of WHO's funding situation.

Figure 1: WHO for sale

Feminists for a People's Vaccine Campaign; Development Alternatives with Women for a New Era (DAWN) and Third World Network (TWN)

issues, such as non-communicable diseases and health emergencies, that receive relatively little funding despite their great importance to the world's collective health.

It can also mean that WHO becomes reliant on the largesse of this small group of wealthy donors and thus at risk when their generosity wanes. This was demonstrated in April 2020 when the US President Trump, in his first administration, announced that he would temporarily suspend funding to the organization. More generally, donors are now reducing the increased funding they gave to WHO during the pandemic. For example, in 2023 the organization received $906 million less in VCs than in the previous year. Most of this reduction – $746 million – was due to reductions in funding from amongst WHO's top 10 donors.[20]

Responding to these so-called "structural deficits" in WHO's funding model,[21] member states agreed to a landmark decision in 2022: to increase ACs by 50 per cent (approximately $500 million) by 2030, alongside improving the quality of voluntary funding to ensure more sustainable and independent financing for WHO. In May 2024, WHO and member states launched an Investment Round,[22] an initiative aimed at encouraging more donors to commit up front and (ideally) fully flexible VCs to WHO for the duration of its four-year 14th General Program of Work. In doing so, the Secretariat argued that it is responding to the challenges of inflexible and unpredictable financing that has plagued WHO for decades.

By the end of November 2024, the Investment Round had attracted $3.8 billion – just over half of its $7.1 billion target.[23]

Despite the WHO's efforts to escape its perpetual financial crisis, critiques of its Investment Round persist – and for good reason. The Investment Round mirrors the "replenishment" model used by global health partnerships like Gavi and the Global Fund, which operate on a business-oriented logic. This model emphasizes measurable outcomes, "value for money", and return on investment to attract donor funding. While such an approach aligns with the corporate governance of public-private partnerships, applying a private-sector investment logic risks undermining WHO, a public institution whose legitimacy stems from its normative authority and democratic governance structure.[24]

On 20 January 2025, his first day back in office, US President Donald Trump signed an Executive Order to withdraw from WHO, despite unpaid US contributions for 2024-25 – a legal prerequisite for withdrawal. In response, the WHO Secretariat announced the immediate freezing of recruitment, significant reductions in travel and the suspension of capital investment. As the Trump administration proceeds with the US withdrawal, the proposed $356 million WHO budget increase for 2026-27 is likely to falter, and the goal of securing $7.1 billion through the Investment Round is at risk, compounding an existing $933 million shortfall. The US withdrawal poses a significant threat not only to the WHO but also to global health cooperation and undermines the principles of multilateralism.[25]

The rise of multistakeholderism and the shrinking space for civil society at WHO

Civil society participation in WHO processes is perhaps best described as uneven and unequal, especially if one distinguishes between public interest CSOs, on the one hand, and public-private partnerships, philanthropic foundations and CSOs aligned with for-profit industries (e.g. lobby groups), on the other. Over the past two decades, each of these categories of CSO have experienced different patterns of incorporation into WHO processes.[26] While philanthropic groups have exerted a growing influence, public interest CSOs have a steadily diminishing voice. This has led many to be disillusioned with the prospects of meaningfully shaping the outcomes of WHO and other multilateral processes.

Public interest CSOs include community-based organizations, social movements, networks of networks with formal organizational structures that assist with coordination (e.g. the People's Health Movement) and relatively formal, professionalized non-governmental organizations (NGOs). Some of these organizations are in official relations with WHO and thus are eligible to participate in and observe some processes – notably the Executive Board (EB) and WHA meetings.

Public interest CSOs that enjoy this status have often engaged in acts of solidarity to expand CSO participation at WHO proceedings, principally through

registering representatives of organizational allies as members of their delegations, thereby allowing them access to official meetings. This has somewhat expanded civil society presence and participation in EB and WHA meetings, especially during the pre-COVID period when non-state actors (NSAs) in official relations with WHO were not subject to a cap on their delegation size. Since the pandemic, participation has been capped at six delegates per NSA. This significantly limits the number of CSO participants with the ability to directly engage with member state delegate and to share information, inform their positions and establish networks for future engagement. These are not the only barriers constraining meaningful CSO engagement with WHO (see Box D1.3).

In contrast to the declining space given for public interest CSOs, WHO has expanded its involvement in multistakeholder initiatives that undertake work aligned with its mandate, like universal access to childhood immunizations (e.g. Gavi) and promoting pandemic preparedness (e.g. CEPI) and response (e.g. super-public-private partnerships, or PPPs, like Covax). These structures often have opaque decision-making procedures and, unlike WHO, are primarily accountable to their boards and funders rather than to the governments or patients who are their intended beneficiaries.

WHO has also increasingly accepted voluntary contributions from an array of NSAs. Through their contributions these actors have significantly influenced WHO's areas of work by tying their funds to specific focus areas. For example, the Bill and Melinda Gates Foundation has focused on shaping WHO's work on polio eradication; and in 2024 the Wellcome Trust announced a grant of $25 million to support WHO's work on health and climate change. Not all such targeted voluntary contributions are ones that health activists should discourage or necessarily criticize, but the lack of intergovernmental or public / civil society engagement in setting the terms of such decisions undermines democratic norms.

In contrast, longstanding work on contentious issues like the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property that seeks to "promote new thinking on innovation and access to medicines" have languished, despite the gross inequalities in access to medicines during enduring epidemics (e.g., HIV/AIDS-TB) and more recent pandemics and global health emergencies (e.g. COVID-19, Mpox). However, a multistakeholder initiative like Gavi, invoking the need to promote equitable access to vaccines, has been able to move rapidly to shape the future of access to vaccines through vehicles like the African Vaccine Manufacturing Accelerator. While this approach boosts private sector investment, it does little to address the structural drivers of vaccine inequity (e.g. the TRIPS intellectual property rights regime, see Chapter D2). One could argue that public-private partnerships tied to the WHO like Gavi exist to prevent it from pursuing visionary programs of knowledge and technology transfer, an ideal it once actively championed.[27]

Box D1.3: Shrinking space and time for meaningful civil society participation in the governance of WHO

In recent years, the ability of social movements, community-based organizations and progressive activists to influence WHO constructively and substantively has precipitously declined. This is no accident: a number of structural barriers have been introduced which systematically decrease the space and time available to public interest CSOs and other groups to participate in WHO meetings:

- **Shrinking delegations:** Early on during the COVID-19 pandemic, a cap of six delegates per organization was introduced. While the cap was framed as temporary, it has yet to be lifted.
- **Reduced speaking time:** While in the past NSAs were afforded three minutes to deliver statements on each agenda item, it is now common for NSAs to be allocated only one minute. When running over time, meeting chairs typically reduce NSA speaking time, sometimes to as little as 30 seconds.
- **Agenda lumping:** It is now typical to group a number of agenda items (whether or not they relate to similar topics) under a common umbrella, with speaking time for NSAs remaining at one minute.
- **Deprioritization of NSA statements:** NSA statements are delivered toward the end of debates when member state diplomats often take the opportunity to leave the meeting room. The substance and impact of statements suffer as a result.
- **Constituency statements:** In recent years, WHO introduced so-called constituency statements, which allow a self-organized grouping of CSOs to deliver a three-minute joint statement slotted in the middle of member state debate. However, the WHO Secretariat decides which agenda items will be open to this option. Though the constituency statement permits greater speaking time per statement, CSOs may face pressure to moderate their positions in order to achieve consensus within constituency groupings, leading to more progressive or radical language being diluted or excluded altogether.
- **The ever-expanding duration of meetings**: WHO governing body meetings are growing longer and longer. During WHA76 and WHA77, for example, meetings typically started at 10 am and stretched into the evenings, ending after 10 pm on some days. Many CSOs lack the capacity to attend these deliberations in their entirety. Additionally, Geneva's Palais des Nations does not permit non-state participants to reenter the meeting facility if they choose to leave the building any time after normal working hours (5 pm), meaning that a civil society representative wishing to stay for a meeting stretching late into the night may have to choose between accessing food, drink and rest outside the facility, and waiting inside the building in hopes of an opportunity to deliver their one-minute statement (often to a diminished and exhausted audience of diplomats).

Civil society at WHO: navigating a new era of participation

For over 20 years, the People's Health Movement (PHM) has actively participated in WHO Governing Body meetings, held each January (EB) and May (WHA), respectively. Through its WHO Watch initiative (see Box D1.4), PHM follows the meetings, generates analysis and critical commentary on the state of WHO's work and attempts to equip progressive activists, public interest CSOs and the broader public with the information required to hold member states (and private foundations, private commercial actors and others) accountable for their contributions to global (ill) health.*

Engaging critical voices, particularly from the Global South, has historically been challenging, even before COVID-19. However, WHO governance meetings are even less accessible now than they were before the pandemic. At the WHA, an increasing number of informal meetings, side events and closed-door discussions to which civil society delegations are not privy have moved key decisions and critical discussions away from public scrutiny. CSOs and smaller delegations, often stretched thin as it is, struggle to attend (if they are even welcome). The formal proceedings of WHO meetings are at increasing risk of becoming almost exclusively performative exercises with the real decisions of substance made elsewhere, away from public view and activist scrutiny.

Conclusion

WHO is the only multilateral agency in which member states of the Global South enjoy – at least on paper – equal representation and decision-making power to their Global North counterparts. This relatively favorable position has been undermined and militated against from multiple directions, as WHO has been weakened and bypassed in 21st century global health governance reforms. The organization's funding has been tightly circumscribed by donors (most of whom lack democratic accountability), and the voices of grassroots civil society representatives have been pushed to the margins of WHO decision-making. All the while, member states and commentators lament what they perceive as the undue politicization of WHO deliberations, even as it grows increasingly impossible to deny that the most pressing concerns requiring global cooperation in health – climate breakdown, military violence against health workers and infrastructure and the renewed assault on sexual and reproductive healthcare – are anything but politically neutral.

The result of all of this is an international organization that is insufficiently democratic in its governance, ill-equipped financially to fulfill its ambitious mandate and at risk of functioning more as a vehicle for donor-driven projects than as the world's chief coordinating authority in global health.

*For more details on People's Health Movement activities and WHO, see summaries in previous editions of *Global Health Watch:* Box E1.2 of GHW1 (GHW, 2005) and Box D1.7 of GHW4 (GHW, 2014) at https://phmovement.org/global-health-watch

As this edition goes to print, tension in the WHO's governing body meetings have worsened against the backdrop of the US's intended withdrawal from the organization. Argentina has also announced its departure from WHO, citing distrust in the multilateral system. Other countries may well follow suit.

Box D1.4: PHM's WHO Watch Initiative and the struggle for a progressive civil society voice in global health governance

Established in 2011 as an initiative of PHM's Global Health Governance program, WHO Watch was founded with the lofty goal of helping to democratize global health governance. During each World Health Assembly and Executive Board meeting, WHO Watch endeavors to make the rarefied proceedings of WHO's gatherings in Geneva accessible to the civil society community and the public. WHO Watch participants – principally young activists from around the world – follow the proceedings, meet with delegations and deliver floor statements in the meetings themselves. The generational knowledge embedded in PHM's initiative has often proven invaluable for policymakers with limited understanding of the context behind WHO's agendas or lacking technical expertise. WHO Watch publishes daily updates and engages in meetings and webinars throughout meetings, offering real-time analysis of Geneva's power dynamics. In addition to supporting activists, this helps sympathetic delegates – particularly those from small, overstretched delegations – to report promptly to their governments and support timely policymaking. PHM has also maintained a repository of analyses and commentaries on WHO's governing bodies meetings for the past 14 years, which has now become a vital knowledge resource for both state delegations and civil society.*

WHO Watch seeks to create a policymaking feedback loop, acting as a facilitator to and from grassroots movements around the world, especially in countries where health challenges are most acute. It empowers activists to advocate for policies that meet community needs, highlights neglected issues such as the social determination of health and decolonial critiques and demystifies global policies to make them more accessible. Additionally, WHO Watch seeks to raise awareness among local and national actors of emerging developments, like budding discussions of the pandemic treaty, that they might otherwise miss in the early stages of their evolution. While WHO Watch operates in the face of persistent challenges – including those affecting all public interest CSOs seeking to influence global governance processes (see Box D1.3 above) – it nevertheless continues to provide an indispensable source of critical commentary and information on the workings of WHO. Supported by its network in the Geneva Global Health Hub (G2H2), a civil society platform for collaboration and advocacy, WHO Watch continues to strive for the ideal of a more democratic system of global health governance.

*WHO Tracker, PHM (People's Health Movement), https://who-track.phmovement.org/index.php/.

With the loss of its largest sovereign donor and growing reluctance among member states to fulfill financial pledges amid a global economic downturn, WHO's ability to sustain its core programs is now in question. This crisis risks pushing the organization further into the arms of private donors, undermining its independence, stifling the progressive priorities that are already under threat and deepening public distrust. If WHO is going to be the force for good in global public health that we want it to be, it needs to be on the side of, and democratically accountable to, the people, not to private benefactors. It has to be financed principally through untied, flexible funding that empowers it to use its reservoir of technical experience and scientific expertise – which, after all, remains its principal strength – to respond to health challenges and promote international solidarity on health matters. This includes convening debate and taking action on issues of a politically divisive character that are nonetheless directly related to health, such as political, economic and historical determinants of health, from military violence and colonial occupation to the global intellectual property regime, corporate malfeasance and sexual and reproductive rights.

The world's need for a strong, flexible, inclusive and democratic WHO is greater now than ever before.

Reference List

1 Syam N. Leading and Coordinating Global Health: Strengthening the World Health Organization. South Centre; 2023 Feb;Research Paper No.174. Available from: https://bit.ly/3Y4JYZF

2 Heilprin J, Fletcher ER. WHA Approves New Strategy After Sexual Health Debate. Health Policy Watch. 2022 May 28; Available from: https://bit.ly/3ErJiXG

3 OHCHR. Findings of the investigations conducted by the Independent International Fact-Finding Mission for the Sudan into violations of international human rights law and international humanitarian law, and related crimes, committed in the Sudan in the context of the conflict that erupted in mid-April 2023. Geneva: Office of the United Nations High Commissioner for Human Rights; 2024 Oct. (Fifty-seventh session). Report No.: A/HRC/57/CRP.6. Available from: https://bit.ly/4imX8bP

4 Gichuki L. Sudanese women turn to mass suicide to escape rape by militia. Development Aid. 2024 Nov 14; Available from: https://bit.ly/42UrRIA

5 OHCHR. Onslaught of violence against women and children in Gaza unacceptable: UN experts. Geneva: Office of the United Nations High Commissioner for Human Rights; 2024 May. Available from: https://bit.ly/44306i3

6 OHCHR. Six-month update report on the human rights situation in Gaza: 1 November 2023 to 30 April 2024. Geneva: Office of the United Nations High Commissioner for Human Rights; 2024 Nov. Available from: https://bit.ly/42TrAWj

7 Fletcher ER. In WHO's Internal Justice System, All Roads Lead to Director General. Health Policy Watch. 2023 Mar 28; Available from: https://bit.ly/4irdd08

8 Dodds P. How we helped investigators in the WHO sex abuse probe. The New Humanitarian. 2021 Oct 4; Available from: https://bit.ly/44wPA2G

9 Flummerfelt R, Dodds P. Sex abuse scandal rocks World Health Organization, but what now? The New Humanitarian. 2021 Sep 29; Available from: https://bit.ly/44CeAFR

10 Heilprin J, Fletcher ER. WHA Approves New Strategy After Sexual Health Debate. Health Policy Watch. 2022 May 28; Available from: https://bit.ly/3YGbAV7

11 Cullinan K. Conservative Member States Balk at References to 'Gender' in WHA Resolutions. Health Policy Watch. 2024 May 28; Available from: https://bit.ly/3RWdVHF

12 Stop the Pushback. Our Statement - The Pushback on Women's Rights must be Stopped. Stop the Pushback. n.d. [cited 2025 Feb 20]. Available from: https://bit.ly/42Usa6c

13 Patnaik P. WHO Secures Half Its Target For Funds Amid Dire Geopolitics. More Predictable Financing, But Insufficient. Geneva Health Files. 2024 Nov 22; Available from: https://bit.ly/4cGlbB1

14 Stein R, Triebert C, Willis H. Israel Used U.S.-Made Bombs in Strike That Killed Dozens in Rafah. The New York Times. 2024 May 29; Available from: https://nyti.ms/3GwhFgz

15 Al-Mughrabi N, Williams D. Israeli attack on Rafah tent camp kills 45, prompts international outcry. Reuters. 2024 May 27; Available from: https://reut.rs/3Evix4I

16 A Amnesty International. "You feel like you are sub-human": Israel's genocide against Palestinians in Gaza. London: Amnesty International; 2024 Dec. Report No.: MDE 15/8755/2024. Available from: https://bit.ly/3RY12Nm

17 OCHA. Reported impact snapshot | Gaza Strip (31 May 2024). United Nations Office for the Coordination of Humanitarian Affairs; 2024 May. Available from: https://bit.ly/4ioehBC

18 OHCHR. Attacks on hospitals during the escalation of hostilities in Gaza (7 October 2023 – 30June 2024. Geneva: Office of the United Nations High Commissioner for Human Rights; 2024 Dec. Available from: https://bit.ly/4iAnVS8

19 Smith D. Trump halts World Health Organization funding over coronavirus 'failure'. The Guardian. 2020 Apr 15; Available from: https://bit.ly/3Gxc0H2

20 World Health Organization. Audited financial statements for the year ended 31 December 2023. World Health Organization; 2024 May. Report No.: A77/20. Available from: https://bit.ly/3EwisNZ

21 M'ikanatha NM, Welliver DP. Strengthening the WHO in the pandemic era by removing a persistent structural defect in financing. Global Health. 2021 Dec;17(1):142. Available from: https://bit.ly/3GkTCBu

22 World Health Organization. Seventy-sixth World Health Assembly: Geneva, 21-30 May 2023: resolutions and decisions, annexes. World Health Organization; 2024 May. Report No.: WHA76/2023 /REC/1. Available from: https://bit.ly/3RWeilx

23 Patnaik P, Yang Y. Countries Voted Eight Times in a Politicized World Health Assembly Revealing Geopolitical Fissures [WHA77]. Geneva Health Files. 2024 Jun 4; Available from: https://bit.ly/4jlY8y6

24 de Bengy Puyvallée A, Storeng KT. WHO's 'Investment Round' - will mimicking global health partnerships' replenishment model pay off? Global Policy. 2024 Nov; Available from: https://bit.ly/3YDZo7i

25 Kickbusch I. US exit from WHO: it is about much more than WHO. The Lancet. 2025 Feb;405(10477):444–6. Available from: https://bit.ly/3RXApbn

26 Van De Pas R, Van Schaik LG. Democratizing the World Health Organization. Public Health. 2014 Feb;128(2):195–201. Available from: https://bit.ly/3EFZHYt

27 Barber M. Technology transfer, intellectual property, and the fight for the soul of WHO. Wenham C, editor. PLOS Glob Public Health. 2024 Dec 5;4(12):e0003940. Available from: https://bit.ly/4lWKwez

Unpacking our Pandemic Failures for Future Pandemic Prevention, Preparedness and Response

Introduction

In March 2020, the World Health Organization (WHO) declared COVID-19 a "global pandemic" – just over a month after it had officially been declared a Public Health Emergency of International Concern (PHEIC).[1] Though no official legal definition of the term "pandemic" existed in 2020, renaming the "PHEIC" a "pandemic" signaled that the world was being confronted with a public health crisis of disastrous proportions. This chapter explores the aftermath of the COVID-19 pandemic and considers whether the initiatives pursued in its wake have heeded the call to use the pandemic as an inflection point for creating a more just and equitable pandemic prevention, preparedness and response (PPR) system.

Research and development (R&D) success

In a very narrow technological and biomedical sense, the global response to COVID-19 achieved the spectacular "success" of rapidly producing safe and efficacious vaccines. Scientists drew on decades of publicly-funded research on mRNA technologies,[2] and in the USA especially benefited from billions in public financing for derisking research and development (R&D) efforts to create COVID-19 vaccines.[3,4,5] The first vaccines to receive emergency use authorization from the WHO were the Comirnaty (developed by Pfizer and BioNTech),[6] and Covishield (AstraZeneca and University of Oxford).[7]

While the sharing of digital sequencing information for COVID-19 and vaccine development moved at spectacular speed, reports of the initial outbreak in China were not shared rapidly enough, undermining the ability of these technological measures to contain the initial outbreak before it reached pandemic proportions.[6] This is one reason why, in later reforms for pandemic preparedness and response (PPR) discussed in this chapter, WHO and Global North countries have emphasized improving surveillance and containment through rapid and unconditional access to pathogens required for R&D in diagnostics, therapeutics and vaccines. Many Global South countries focused more on the implications of sharing such data, and its role in developing international PPR frameworks that operationalize legally binding, equity-promoting responses.

Manufacturing and intellectual property challenges

From a right to health perspective, PPR efforts were an utter failure: most populations in the Global South did not have timely access to vaccines.[9] Partly this

failure could be the approach of governments allowing the companies to assert the intellectual property rights on the publicly funded vaccines and other health products. Under the global legal framework demands, inventors of new medical products – including COVID-19 vaccines – could register their inventions as their own private intellectual property (IP), thereby being given the exclusive right to decide the terms on which these products could be produced, sold, priced and distributed. In practice what this meant was that pharmaceutical companies refused to transfer the technology to facilitate diversified production and chose to first sell their products to high-income markets in the Global North (thereby leading to vaccine hoarding in these markets), and at relatively high prices in middle income markets or not at all in low income markets (leading to under-supply in low and middle income countries). This maldistribution of vaccines, which became known as "vaccine apartheid", was irrational from a public health perspective as often vulnerable populations in need of vaccines supplies (e.g. elderly or immunosuppressed populations in the Global South) could not access vaccines until very late in the pandemic – when younger, healthier populations in the Global North had already been fully vaccinated (or even received booster doses).

The vaccine shortages experienced by low and middle income countries (LMICs) were intensified by the fact that many, with the exception of India, Brazil and China, did not have the infrastructure or know-how to produce their own vaccines.[10] In the Global North vaccine manufacturing capabilities were boosted by a massive expansion of public subsidies for (re)building domestic production of vaccines (especially in the USA).[11] The pandemic also led to the use of flexibilities of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement in Canada and the USA, and spurred the European Union to work on establishing a legal framework for Union-wide compulsory licensing flexibilities, which would allow it to more easily manufacture medical products during health emergencies without the IP owner's consent.*[12] Hypocritically, these countries were either neutral (Canada) or opposed some (USA) or all of the (EU) components in relation to the TRIPS waiver proposal tabled by India and South Africa in October 2020. The waiver requested the temporary suspension of TRIPS rules in order to facilitate expanded production capabilities and trade in COVID-19 diagnostics, therapeutics and vaccines. Though it was supported by over 100 members of the World Trade Organization (WTO), the aforementioned countries were amongst those who successfully blocked a meaningful intellectual property rights waiver from being implemented.

Containment measures: deepening socioeconomic costs and trust deficits

Globally, the lockdowns and social isolation regulations many countries implemented to contain the spread of COVID-19 left already-vulnerable populations

*See Chapter B4 in GHW6.

Global Day of Action in support of the TRIPS waiver Campaign to end the Vaccine Apartheid (Geneva, 30 November 2021)

Public Services International / CC

like women, migrants, people living with disabilities, children and racialized minorities burdened with the socioeconomic and care work costs of the pandemic.[13] These burdens were acutely felt in societies where the state provided little social assistance, while at the same time imposed measures that disrupted and sometimes criminalized the solidarity practices poor and marginalized communities relied on to navigate the many "slow catastrophes" that structured their lives even before the pandemic.[14]

In many countries, public discourses centered on suspicion of being manipulated and exploited by government and big corporations. In the USA, significant portions of the population reacted to public health guidelines and government officials' advice on pandemic prevention and containment measures (e.g. masking, getting vaccinated) with mistrust and skepticism.[15] There and elsewhere, significant numbers of people believed public institutions could not be trusted to protect them, because they were beholden to powerful interests within the scientific, philanthropic and business communities that made government more prone to surveillance or economic exploitation of their populations than to advancing the right to health.[14] These groups regarded the WHO, the leading intergovernmental organization mandated to coordinate the pandemic response, as incompetent and beholden to geopolitical competition.[17,18]

Skepticism and disdain towards WHO was also displayed by some Member States and pharmaceutical corporations. WHO recommendations were sometimes

simply ignored by other intergovernmental organizations (e.g. its support for the TRIPS waiver was largely ignored by the WTO). In 2022, WHO's Dr. Mike Ryan stated that "We failed [to distribute vaccines equally] because of the greed of the north, we failed because of the greed of the pharmaceutical industry, we failed because of self-interest of certain member states that were not prepared to share."[19] Member States not only ignored WHO's ethical pleas to prevent the "catastrophic moral failure"[20] of inequitable vaccine distribution, but also its technical advice such as asking for greater solidarity in vaccine procurement,[21] lifting irrational travel restrictions,[22] or supporting the TRIPS waiver proposal.[23,24]

Restoring trust in WHO? Revising the International Health Regulations

In response to the difficulties the WHO experienced in coordinating an equitable and effective response to the COVID-19 pandemic, Member States undertook revisions to the International Health Regulations (IHR) of 2005. The revisions mean that equity and solidarity are now included in Article 3.1 as guiding principles for interpreting significant provisions. The IHR now also defines a "pandemic emergency" as a new category of public health emergencies of international concern (PHEIC) that "requires rapid, equitable and enhanced coordinated international action, with whole-of-government and whole-of-society approaches".

Article 13 of the IHR now provides for international assistance to facilitate equitable access to health products such as diagnostics, vaccines and therapeutics for responding to both PHEICs and pandemic emergencies. Three new paragraphs in Article 13 further specify the role of WHO during PHEICs and pandemic emergencies: Art. 13.7 mandates WHO to support IHR State parties during emergencies; Art 13.8 suggests the role of WHO in facilitating timely access to relevant health products; and Art 13.9 obligates State Parties to support the WHO in implementing Art.13 (subject to applicable law and available resources).

The definition in Article 1 of relevant health products that are needed to respond to PHEICs and pandemic emergencies now includes an illustrative list of health products but, significantly, also references "other health technologies" which may not be explicitly mentioned in the list.

Article 44 was amended to increase international collaboration and assistance including mobilization of additional financial resources. More specifically, it establishes a Coordinating Financing Mechanism to promote the "provision of timely, predictable, and sustainable financing" for implementing the IHR and notes the importance of developing, strengthening and maintaining core health system capacities described in Annex 1. The Mechanism is also mandated to "maximize the availability of financing for the implementation needs and priorities of States Parties, in particular of developing countries", and with working to "mobilize new and additional financial resources" relative to effectively implementing the IHR.

From a governance perspective, Article 54bis establishes the State Parties Committee for Implementation of IHR – a forum to discuss in detail the challenges, strengths and weaknesses in the implementation of IHR.

These amendments are a micro step towards creating an equity-based response system during PHEIC and pandemic emergencies, which was otherwise absent in IHR.

The Pandemic Accord (PA) negotiations*: "prioritizing the need for equity"?[25]

In December 2021 a special session of the World Health Assembly established an intergovernmental negotiating body (INB) mandated to "develop a new instrument for pandemic prevention, preparedness and response with a whole-of-government and whole-of-society approach, prioritizing the need for equity".[26] Member States were called on to develop an instrument defined by the "principle of solidarity with all people and countries, that should frame practical actions to deal with both causes and consequences of pandemics and other health emergencies."[27] However, at the time of writing this chapter (early April 2025), the INB is failing to deliver on this mandate in a number of respects.

Health systems

Immediately prior to the COVID-19 pandemic, health systems in both the Global North and South were overstretched, partly due to being reconfigured by longstanding efforts to privatize and commercialize the public health sector.[28] Globally, private health care facilities catered to the minority of the population who could afford them (see Chapter B1).[29] Both the public and private health and care sectors in the Global North sought to address staffing constraints by intensifying recruitment of health workers that had migrated from poorer countries from neighboring regions in the North, but also from the Global South, leaving these systems further weakened.[30,31]

The WHO's emphasis on Universal Health Coverage (UHC) from about 2008 onwards has tried to ensure that everyone can access care when they need it and without financial hardship. However, UHC as envisioned by WHO has been agnostic about whether care should be provided by the public versus private sector. As implemented in many countries, UHC has effectively amounted to designing health financing reforms while neglecting interventions to bolster public capabilities to provide care.† Consequently, the limited UHC reforms that have been rolled out to date have often failed to strengthen public health systems.[32]

These UHC weaknesses compromised efforts to manage the COVID-19 pandemic in both the Global North and South, as pandemic response efforts were weakest in countries where health systems were fragmented and understaffed.[33] While the November 2024 text of the PA encourages governments to "develop,

*This chapter focuses on the 12 November 2024 version of the Pandemic Accord text, as issued by the Intergovernmental Negotiating Bureau.

† See Chapter B1 in GHW6.

strengthen and maintain a resilient health system, particularly primary health care"[34] and to be mindful of equity while doing so, this is framed entirely as a national responsibility. The text imposes no binding obligations with regards to international cooperation for health systems strengthening. Previous versions of the PA text had included references to global measures that could unlock financing for health systems strengthening – e.g. debt relief – but these were absent from later version so of the negotiating text.[35]

Research suggests that countries with higher levels of human resources for pandemic preparedness reported lower COVID-19 cases and deaths in the initial eight weeks of their pandemics.[36] The PA text of 12 November 2024 acknowledges the importance of national governments taking "appropriate measures with the aim to develop, strengthen, protect, safeguard, retain and invest in a multi-disciplinary, skilled, adequate, trained, domestic health and care workforce" for PPR. "[T]aking into account its national circumstances, and in accordance with its international obligations" it also recognizes the need to "take appropriate measures to ensure decent work, protect the continued safety, mental health, wellbeing, and strengthen capacity of its health and care workforce".[37] The protections offered to workers, including migrant workers, in this Article are welcome.

However, shortcomings remain. Despite an injunction to support "individual and collective empowerment" of the health and care workforce, the text imposes no obligation on governments regarding social dialogue or consultation in relation to PPR measures. It is therefore unclear what rights workers have to participate in deciding on the terms of their involvement in PPR efforts. The text also does not acknowledge the overwhelmingly feminized nature of this labor force, nor the gender-specific pressures this imposes on women workers during PHEICs and pandemics. Women worldwide disproportionately take on the burdens of reproductive and care work in their households. During the COVID-19 pandemic female health workers had to work extended hours and in high-risk situations, and struggled with accessing childcare and isolation facilities that would limit household members' exposure to infection.[38,39] The text makes no mention of obligations to provide childcare and elderly care services or isolation facilities for health workers working extended working hours or at risk of infection. Nor is mention made of giving household members priority access to pandemic-related products.

Non-State actors: multistakeholderism, public private partnerships, NGOs and global health initiatives

Since the 1970s, structural adjustment and austerity policies in the Global South, together with debt repayment obligations and an embrace of neoliberal policies, have contributed to public health facilities being poorly maintained, governed and staffed – even though most of the population depend on these facilities. From the 1990s onwards many of these countries have depended on a patchwork of global health initiatives to provide basic health care services. These interventions often take a siloed approach to health care, contributing to health systems fragmentation.

Box D2.1: Geopolitics and the Pandemic Accord negotiations

The Pandemic Accord (PA) negotiations are coordinated by the Bureau of the Intergovernmental Negotiating Body (INB). The INB was established in December 2021 and started its work the following year under the leadership of its founding co-chairs, Ambassadors Roland Driece (Netherlands) and Dr. Precious Matsotso (South Africa). The INB Bureau hosted talks about the PA in parallel with the proceedings to revise the IHR (2005).

Between first INB meeting (February 2022) and the 8th (February / March 2024), no text-based negotiations took place. This modality was only introduced during the 9th INB meeting, which took place in two sessions (March 2024, and then April / May 2024). Prior to this, and throughout the subsequent process, Member States engaged in informal discussions organized around particular Articles of the PA document and until the 13th round negotiations, there were only five days of text-based negotiations. All discussions, except for the opening and closing proceedings of the INB meetings, are closed to the public. Throughout the proceedings, the media and non-state actors have relied on briefings hosted by the INB Bureau, formal consultation sessions with select non-state actors, and personal exchanges with insiders, to gauge the state of the negotiation process.

Reporting on the INB negotiations, as covered in Geneva Health Files and Third World Network, have raised the concerns of Global South delegates who have indicated that they feel their interventions are not always reflected in the texts developed by the INB Bureau. Throughout the process these delegates, particularly members of the Africa Group and the Group for Equity, have proposed binding measures to operationalize equity in the PA.

Reporting on the PA negotiations suggest the process has been plagued by opposed interests between the Global North and South, but also within the Global South. One notable example of alleged "intense pressure"[40] by the US and EU includes reports that Namibia was asked to replace its chief negotiator, a strategic and emphatic voice for equity in the PA, in order to curtail his influence over the process. In some ways this attests to the influence even smaller delegations can have in multilateral processes. Whether true or not, smaller countries like Namibia and Bangladesh have made significant contributions in articulating and defending equity provisions for inclusion in the PA – and have perhaps shaped the PA conversations to a greater extent than other countries in their regions with bigger economies, populations and a bigger national pool of technical experts.

Numerous reports on tensions within the South have surfaced, and of attempts by Global North countries to break unity within regional blocs that are making pro-equity demands. For example, in March 2024 Politico[41] reported that Africa CDC was

Continues on next page

Box D2.1 continued

being lobbied by US and EU representatives to encourage African Health Ministers to soften their demands on the Pathogen Access and Benefit-Sharing (PABS) system. In May 2024 Geneva Health Files reported[42] that the US and EU had a closed-door meeting with four African countries aimed at "bridging" their positions on Article 12 (PABS).

In November 2024, Donald Trump was re-elected as the US President. Within hours of entering office Trump signed an Executive Order announcing the US's withdrawal from the WHO. This has intensified the uncertainty about the prospects for concluding an Accord that contains robust equity demands but also raises concerns about implementing an Accord not endorsed by a major superpower.

Overseas development assistance programs (e.g. PEPFAR), global health initiatives (e.g. Gavi), private sector initiatives (e.g. hospitals and clinics established by religious groups), and humanitarian non-governmental organizations (e.g. MSF field hospitals) have effectively been given the authority to determine health system resource allocation and programmatic priorities at the national level.*

The Pandemic Accord discussions risk further institutionalizing Public Private Partnerships (PPPs) and multistakeholderism by referencing them as integral components of pandemic preparedness and response. For example, Article 10(d) encourages states to "promote and/or... incentivize public and private sector investments, purchasing arrangements, and partnerships, including public-private partnerships, aimed at creating or expanding manufacturing facilities or capacities for pandemic-related health products".[43] Article 9(5) uses highly qualified and non-binding language to encourage states to include provisions on publicly funded research conducted by private entities or PPPs that promote equitable access to "pandemic-related health products", "particularly for developing countries" during PHEICs and "pandemic emergencies". Striking in these two passages is the relatively unqualified call for engaging in PPPs, and the highly qualified call to impose equity provisions on publicly funded research.

While PPPs are envisioned as essential to R&D and geographically diversified production, multistakeholderism is framed as a viable modality for governing pandemics more equitably, despite the critiques that multistakeholder initiatives like COVAX lacked transparency and accountability.[44] In some instances stakeholders are given a seat at the decision-making table as "partners" in designing key PPR infrastructures. For example, Article 13 proposes that a global supply chain and logistical network "shall be developed, coordinated and convened by WHO in full consultation with the Parties, WHO Member States that are not

*The rise and significance of PPPs and multitstakeholderism has also been discussed in previous issues of GHWs. See for example Chapters B3 and D5 in GHW6; Chapters B5 and D4 in GHW5; and Chapter D6 in GHW3.

Parties, and in partnership with relevant stakeholders"[45] and gives them a role in periodically reviewing its functions and operations.[46] This potentially opens space for for-profit companies (especially pharmaceutical corporations) to be involved in processes they stand to benefit from financially."

Pathogen access and benefit sharing

A focus on technological fixes, and a less robust engagement with structural impediments to the right to health, has also been part of the negotiating posture of many Global North countries during the Pandemic Accord process. Negotiations have made little progress in developing a mechanism for Pathogen Access and Benefit Sharing (PABS). During negotiations Global North countries have frequently insisted that pathogen sharing should happen rapidly, so that technical "fixes" to pandemics – e.g. vaccines – can be developed with urgency. They have argued that pathogen sharing should be delinked from obligations to provide equitable access to the medical products developed thanks to pathogen sharing.

This line of argument has been justified on the basis that such conditions will impede scientific research into diagnostics, therapeutics and vaccines, and thus ultimately result in avoidable deaths. However, this ignores the avoidable deaths that resulted from, and continue to result from, inequitable access to pandemic response products that, once developed and achieving regulatory approval, remain beyond the reach of the world's poor and marginalized because of high costs or limited manufacturing capabilities in regions where outbreaks, PHEICs and pandemics occur.

R&D and medical manufacturing

The Pandemic Accord text contains three Articles (9, 10, and 11) aimed at correcting the structural constraints to building R&D and medical manufacturing capabilities in the Global South, to promote more equitable access to medicines. There is an implicit acknowledgement in these Articles that vaccine equity was undermined by their lack of control over the infrastructure and know-how required for manufacturing these products, and states' reluctance to impose conditionalities on the use of publicly funded R&D and / or its commercialization. Global North governments tended to avoid such regulations as their economic interests are to some extent aligned with those of the hugely profitable pharmaceutical corporations registered in their territories. Global South countries tended to avoid imposing such regulations for fear of political blowback and / or lack of technical and financial resources to do so. Despite this, the Pandemic Accord text does not introduce language that obliges WHO Member States to facilitate technology transfer or imposing conditions on publicly funded R&D to enable more equitable access to pandemic-related products through diversified production. These articles are couched in best endeavor language which does not translate into concrete obligations to facilitate sustainable and predicable access to health products during pandemics.

The role of the state

These dynamics have contributed to re-opening a longstanding debate about governments' and intergovernmental organizations' obligations to prioritize provision of public goods, rather than focusing on privatizing the "health commons" or fixing market failures. The WHO's Council on the Economics of Health for All (2020-22), though emphasizing a rights-based approach to health, framed health spending as an "investment" rather than a cost. This echoes the market-based language of the World Bank (which typically emphasizes health as an investment in human capital) or as being instrumental "for economic development".[47]

The Council positions the state as a coordinator of public and private investments in health and its manifesto mentions valuing and measuring health from a "human security" and risk reduction perspective. This idea of improving health outcomes and reducing risks through "better investment" is echoed in a number of other post-pandemic initiatives, all of which emphasize the commercial viability of such investments as an important component of "channeling" financing for PPR. This includes the European Union's Global Gateway strategy of using PPP to invest in vaccine manufacturing in Africa and Latin America, and Gavi's African Vaccine Manufacturing Accelerator financing instrument to support commercial viability of African vaccine manufacturers.[48]

Other initiatives, like the WHO mRNA Hub, support technology transfer and Global South researchers' capacities to harness the voluntary licensing mechanisms recognized by the TRIPS framework, within the parameters of commercial viability.[49] However, they do not explicitly acknowledge that TRIPS flexibilities are rarely used by Global South countries due to political pressure by Global North countries.[50] In this regard, it is significant that Colombia has also sought a comprehensive review of the TRIPS agreement at the WTO to better document who has benefited from the agreement since its adoption in 1994.[51]

Civil society initiatives have focused less on the state's role in allocating capital and more on its role as a potential owner of health infrastructure (e.g. the Public Pharma for Europe Coalition;[52] PHM's public pharma research project), the public's contributions to R&D (e.g. the MSF Access Campaign's efforts to map public contributions to Ebola vaccine trials),[53] and the state's potential to promote greater accountability of "powerful and wealthy nations, organizations and individuals" in global health (e.g. a United Nations University Research Project on Power and Accountability).[54] These projects proceed from the assumption that power inequalities are likely to influence how governments coordinate public resources, and the conditionalities they are able to impose on beneficiaries of such funding. This was starkly exposed during the pandemic when the US government was unable to compel Moderna to recognize it as a co-owner of the company's vaccine, which had benefited from public subsidies for R&D and commercialization.[55]

Conclusion: Working towards a public goods/commons approach to PPR?

The reforms to the international legal architecture that are taking place in response to the COVID-19 pandemic suggest that most countries recognize that the impact of the pandemic and its aftermath was / is deeply inequitable and unjust. Failing health systems, an intellectual property rights regime that impeded the expansion of much-needed health products, and the prioritization of national health security over global solidarity have been acknowledged by politicians and researchers as drivers of inequality in access to COVID-19 vaccines and life-saving health services within and between countries. There has also been a recognition that women in many ways functioned as the shock absorbers of the pandemic, through the paid and unpaid social reproductive work they were forced to do in the absence of social safety nets and functional health systems.

However, this recognition has not translated into "lessons learned": though the IHR amendments have institutionalized some measures that promote more equity in responding to outbreaks and PHEICs, the Pandemic Accord negotiations seem unlikely to institutionalize mechanisms that will address the fundamental drivers of inequality. The negotiations also seem unlikely to develop an international legal framework for governing the production and distribution of medical products and health technologies as global public goods, even during extreme events such as pandemics.

At the current moment, the increased volatility and declining trust in the multilateral system, the normalization of xenophobia in many countries, and the economic difficulties of the post-pandemic period make possibilities for international cooperation during pandemics seem highly unlikely. This risks creating a dynamic where national health security is once again prioritized in future pandemics – and with it the cruel logic of "letting die" that was embodied by COVID-19 vaccine apartheid.

Reference List

1 World Health Organization. Coronavirus disease (COVID-19) pandemic. World Health Organization; n.d. (Emergencies). Available from: https://bit.ly/4cGMSKf

2 Dolgin E. The tangled history of mRNA vaccines. Nature. 2021 Sep 14. Available from: https://bit.ly/44B6yNs

3 Cross S, Rho Y, Reddy H, Pepperrell T, Rodgers F, Osborne R, et al. Who funded the research behind the Oxford–AstraZeneca COVID-19 vaccine? BMJ Glob Health. 2021 Dec;6(12):e007321. Available from: https://bit.ly/42CL0xl

4 Rizvi Z. Sharing the NIH-Moderna Vaccine Recipe. Public Citizen; 2021 Aug. Available from: https://bit.ly/42FjSxU

5 DiNapoli J. Novavax bosses cash out for $46 million with COVID-19 vaccine trials still under way. Reuters. 2021 Jan 11. Available from: https://bit.ly/42ob9RN

6 World Health Organization. WHO issues its first emergency use validation for a COVID-19 vaccine and emphasizes need for equitable global access. World Health Organization. 2020 Dec 31. Available from: https://bit.ly/3EydjFh

7 AstraZeneca. AstraZeneca COVID-19 vaccine authorised for emergency use by the World Health Organization. AstraZeneca webpage. 2021 Feb 15. Available from: https://bit.ly/42HoMdN

8 The Independent Panel for Pandemic Preparedness & Response. COVID-19: Make it the Last Pandemic. 2021 May. Available from: https://bit.ly/4ishf8yf

9 Health Justice Initiative. Pandemics and the illumination of "hidden things" – Lessons from South Africa on the global response to Covid-19. Health Justice Initiative; 2023 Jun. Available from: https://bit.ly/4irqLIW

10 OECD. Securing Medical Supply Chains in a Post-Pandemic World. OECD; 2024. (OECD Health Policy Studies). Available from: https://bit.ly/4lLGhT0

11 Bown CP. How COVID -19 Medical Supply Shortages Led to Extraordinary Trade and Industrial Policy. Asian Economic Policy Review. 2022 Jan;17(1):114–35. Available from: https://bit.ly/42E7uxT

12 Love J. Summary of KEI's September 28, 2023 comments to the TRIPS Council On Paragraph 8 Of The Ministerial Decision On The TRIPS Agreement. Knowledge Ecology International. 2023 Oct 12. Available from: https://bit.ly/44lYqk3

13 Paremoer L, Nandi S, Serag H, Baum F. Covid-19 pandemic and the social determinants of health. BMJ. 2021 Jan 28;n129. Conway T. Globally, the pandemic hits women. Alternative Information & Development Centre. 2020 Sep. Available from: https://bit.ly/3GvDxsp

14 Cairncross L. COVID-19: We need both physical distancing and social solidarity. Spotlight. 2020 Mar 20. Available from: https://bit.ly/3Rr9pAQ

15 Guzman-Cottrill JA, Malani AN, Weber DJ, Babcock H, Haessler SD, Hayden MK, Henderson DK, Murthy R, Rock C, Van Schooneveld T, Wright SB. Local, state and federal face mask mandates during the COVID-19 pandemic. Infect Control Hosp Epidemiol. 2021 Apr;42(4):455-6.

16 Hotez PJ. COVID19 meets the antivaccine movement. Microbes and infection. 2020 May;22(4):162-4.

17 Yang H. Contesting legitimacy of global governance institutions: The case of the World Health Organization during the coronavirus pandemic. International Studies Review. 2021 Dec;23(4):1813-34.

18 Lee K, Piper J. The WHO and the Covid-19 pandemic: less reform, more innovation. Global Governance: A Review of Multilateralism and International Organizations. 2020 Nov 23;26(4):523-33.

19 Merelli A. The WHO is done playing nice about vaccine equity. Quartz. 2022 Oct 19. Available from: https://bit.ly/4lGPaNw

20 BBC. Covid vaccine: WHO warns of "catastrophic moral failure." BBC. 2021 Jan 18. Available from: https://bit.ly/4jgyWsH

21 Ravelo JL. Tedros calls out "me-first" approach to COVID-19 vaccines: "This is wrong." Devex. 2021 Jan 18. Available from: https://bit.ly/4lzOrgV

22 Nebehay S. WHO's Tedros warns against over-reaction to Omicron. Reuters. 2021 Nov 30. Available from: https://bit.ly/3GveG88

23 Cullinan K. WHO Director General Calls On WTO To Take 'Practical' Action On IP Waiver For COVID Vaccines & Medicines. Health Policy Watch. 2021 Feb 26. Available from: https://bit.ly/3GdS7Vp

24 The Bureau of Investigative Journalism. Who Killed the Vaccine Waiver? The Bureau of Investigative Journalism. 2022 Nov 10. Available from: https://bit.ly/4jHfkhi/

25 World Health Organization. The World Together: Establishment of an intergovernmental negotiating body to strengthen pandemic prevention, preparedness and response. World Health Organization; 2021 Dec. Report No.: SSA2(5). Available from: https://bit.ly/44z9k5P

26 ibid.

27 ibid.

28 De Ceukelaire W, Bodini C. We Need Strong Public Health Care to Contain the Global Corona Pandemic. Int J Health Serv. 2020 Jul;50(3):276-277. Available from: https://bit.ly/4jgRRn7

29 Williams, OD. COVID-19 and Private Health: Market and Governance Failure. Development. 2020 Dec;63(2–4):181–90. Available from: https://bit.ly/4jBb7eY

30 Eaton J, Baingana F, Abdulaziz M, Obindo T, Skuse D, Jenkins R. The negative impact of global health worker migration, and how it can be addressed. Public Health. 2023 Dec;225:254–7. Available from: https://bit.ly/3GiXUt3

31 Pillinger J, Yeates N. Building Resilience Across Borders: A Policy Brief on Health Worker Migration. Public Services International; 2020 Dec. Available from: https://bit.ly/3Y7xmAZ

32 Mattos L, Giovanella L, Sundararaman T, Paremoer L, Freire JM, Stolkiner A, et al. Universal Health Systems: A better pathway to achieving universal and equitable acess to comprehensive healthcare. G20 Brasil; 2024. Available from: https://bit.ly/42RO8Xs

33 The Independent Panel for Pandemic Preparedness & Response. COVID-19: Make it the Last Pandemic. 2021 May; p.33. Available from: https://bit.ly/4cCmcKo

34 World Health Organization. Intergovernmental Negotiating Body to draft and negotiate a WHOP convention, agreement or other internaitonal instrument on pandemic prevention, preparedness and response – Proposal for the WHO Pandemic Agreement; 2024 Nov; Article 6(1). Available at: https://bit.ly/3EyqNkn

35 Patnaik P. Financing: don't let it be an afterthought in the pandemic agreement. Wemos. 2024. Available from: https://bit.ly/3YEj4YE

36 Duong DB, King AJ, Grépin KA, Hsu LY, Lim JF, Phillips C, et al. Strengthening national capacities for pandemic preparedness: a cross-country analysis of COVID-19 cases and deaths. Health Policy and Planning. 2022 Jan 13;37(1):55–64. Available from: https://bit.ly/442xQfr

37 World Health Organization. Intergovernmental Negotiating Body to draft and negotiate a WHOP convention, agreement or other internaitonal instrument on pandemic prevention, preparedness and response – Proposal for the WHO Pandemic Agreement; 2024 Nov; Article 7(1)-(2). Available from: https://bit.ly/3EyqNkn

38 Amandla. Women are the Frontline. Amandla. 2020 Oct;(71/2). Available from: https://www.amandla.org.za/past-editions/

39 Llop-Gironés A, Vra??ar A, Eder B, Joshi D, Dasgupta J, Paremoer L, et al. A Political Economy Analysis of the Impact of Covid-19 Pandemic on Health Workers. Yale Law School; 2021 Jul. Available from: https://bit.ly/42xUdbH

40 Patnaik P. Did Some Developed Countries Oust Africa Group's Key Negotiator, a Forceful Voice on Equity Provisions in INB-IHR Negotiations? Geneva Health Files. 2023. Available from: https://bit.ly/4cGZsZZ

41 O'Neill R. EU, US court Africa with pandemic side deals amid crunch WHO talks. Pro Politico. 2024 Mar 18. Available from: https://bit.ly/3RrVXN5

42 Patnaik P. A Turning Point? The EU & the U.S. Draw Out Four African Countries to Bridge Positions on Pathogen Access & Benefit Sharing. Geneva Health Files. 2024. Available from: https://bit.ly/42G0nFe

43 World Health Organization. Intergovernmental Negotiating Body to draft and negotiate a WHOP convention, agreement or other internaitonal instrument on pandemic prevention, preparedness and response – Proposal for the WHO Pandemic Agreement; 2024 Nov; Article 10(d). Available from: https://bit.ly/3EyqNkn

44 Storeng KT, de Bengy Puyvallée A, Stein F. COVAX and the rise of the 'super public private partnership' for global health. Global Public Health. 2023 Jan 2;18(1):1987502. Available from: https://bit.ly/3EzWZDT

45 World Health Organization. Intergovernmental Negotiating Body to draft and negotiate a WHOP convention, agreement or other internaitonal instrument on pandemic prevention, preparedness and response – Proposal for the WHO Pandemic Agreement; 2024 Nov; Article 13(1). Available from: https://bit.ly/3EyqNkn

46 ibid.

47 Sachs J, Weltgesundheitsorganisation, editors. Macroeconomics and health: investing in health for economic development; report of the Commission on Macroeconomics and Health. Geneva: World Health Organization; 2001. 200 p. Available from: https://bit.ly/3GkGMD3

48 Gavi. African Vaccine Manufacturing Accelerator (AVMA). n.d. Available from: https://bit.ly/3Ewb1GM

49 Herder M, Benavides X. 'Our project, your problem?' A case study of the WHO's mRNA technology transfer programme in South Africa. PLOS Global Public Health. 2024 Sep 23;4(9):e0003173. Available from: https://doi.org/10.1371/journal.pgph.0003173

50 Gopakumar K, Namboodiri S. WIPO: Africa Group & Brazil raise concerns on political pressure against use of TRIPS flexibilities. Third World Network. 2024 Nov 25. Available from: https://bit.ly/4inaeFJ

51 Rizvi Z. Sharing the NIH-Moderna Vaccine Recipe. Public Citizen; 2021 Aug. Available from: https://bit.ly/42VnJbi

52 Public Pharma for Europe Coalition. Public Pharma for Europe Coalition. n.d. Available from: https://bit.ly/4jAFm5I

53 Médecins Sans Frontières/Doctors Without Borders. Ensuring Access to New Treatments for Ebola Virus Disease. Médecins Sans Frontières / Doctors Without Borders; 2023 May. Available from: https://bit.ly/3RYyFyB

54 UNU IIGH. Power and Accountability. United Nations University webpage. n.d. Available from: https://bit.ly/4cKU5Ja

55 Rizvi Z. Sharing the NIH-Moderna Vaccine Recipe. Public Citizen; 2021 Aug. Available from: https://bit.ly/42VnJbi

Financing Pandemic Recovery, Prevention, Preparedness and Response

Introduction: A seismic shift in the financing of global health and pandemic preparedness

On 20 January 2025, the newly elected administration of the United States (US) signed an executive order that will have significant implications for how we finance global health in general, and pandemic prevention, preparedness and response (PPPR) in particular. The order gave notice that the US is withdrawing from the World Health Organization (WHO). In addition, the US froze nearly all US State Department and USAID international aid for three months while it reassesses its alignment with an America First strategy (see chapter D1). The expectation is that most global health funding will return, but to what degree and to what programs remain unknown. Whatever transpires, the actions of the US are seismic and could have lasting effect on how we finance PPPR as well as global health writ large.

In terms of PPPR, Section 4 of the executive order declares that the US will also "cease" negotiations on the WHO Pandemic Agreement and reject the amendments to the International Health Regulations (IHRs). In practice this means that the US and other non-adopting states will still be signatories to the 2005 IHRs. Nevertheless, "ceasing" activities would presumably also include US withdrawal from the Coordinating Financing Mechanism (CFM) for the Pandemic Agreement (PA) and the amended IHRs. The CFM was introduced hours before voting for the amended IHRs at the World Health Assembly (WHA) in June 2024 and it will act as its primary financing instrument. The CFM was cut-and-pasted from Article 20 of the PA (in which the text has now been agreed) and the operating assumption is that this mechanism will coordinate financing for both the PA and the new IHRs. It is also largely assumed that this will be hosted and merged with the World Bank's Pandemic Fund* even though this relationship has not been formally agreed by Member States.

Although the removal of the US still leaves 193 Member States to finalize and finance any PA by May 2025, the exiting of the US does spell trouble for the Agreement since the US brings considerable normative, technical, political and economic force to it. In terms of financing, it is hard to imagine either the PA or

*The Pandemic Fund is a global financing mechanism under the World Bank designed to support strengthening PPPR particularly in LMICs, established in November 2022 with support from the G20 and other international partners. A fuller discussion of the Pandemic Fund is presented later in the chapter.

the amended IHRs fulfilling their remit under the CFM without the considerable funding and "norm setting" that the US injects into global health policy.

As a result, significant PPPR financing now largely hinges on whether the US is using its threat of withdrawal simply as a bargaining chip to force further concessions and commitments from other multilateral bodies and states (e.g. China was explicitly singled out as being a free rider). If so, there is the possibility of an actual increase in overall available funds for PPPR, since giving into US demands will require greater financial commitments from a wider range of stakeholders. This was the result of similar actions the US made to withdraw from the North Atlantic Treaty Organization (NATO) during Trump's first administration.

It is important to reflect upon the implications of this seismic shift because it is within this new context that an already sub-optimal PPPR financing architecture will operate. Poor financing strategies and instruments will either become further strained under the weight of US pressure or expanded further. Yet, more of the same would be a disaster, since current instruments reside within an overly securitized, biomedicalized and commoditized financing environment for PPPR. Although it remains a possibility that recent US actions will be a catalyst for positive change, skepticism abounds, and it could simply lead to more business as usual.

In consideration of this development, the present chapter aims to make sense of the existing financial landscape for PPPR and to outline some of its drivers, moderators, harms and alternatives. To do so, the chapter outlines the historical financialization of health and its implications for both global health and PPPR; the emerging pandemic preparedness agenda post-COVID-19 and its financing instruments; and argues the need for an alternative approach to global health and PPPR financing.

The financialization of global health

Financialization of global health refers to the growing dominance of financial motives, markets, actors and institutions in both domestic and global economies, which increasingly dictate the type of healthcare accessible to those in need (see Chapters A1 and B1).[1] Its pervasive influence today demands critical reflection on how it has shaped health policies and systems and affected health equity. Over the past five decades, the Bretton Woods Institutions (the World Bank and the International Monetary Fund) have played a central role in driving this transformation. The World Bank has been pivotal in shaping health and finance policies through its development projects, advocating for market-based solutions and public-private partnerships. The Bank's involvement in the health sector began in the 1970s, introducing market principles into a domain largely regarded as a public good. Meanwhile, the International Monetary Fund (IMF) has set fiscal conditions that facilitate the neoliberalization of health systems, often mandating structural adjustments that prioritize austerity, deregulation and liberalization of

the economies. Their joint Structural Adjustment Programs (SAPs) notoriously steered developing countries and newly independent states toward neoliberal economic models, reshaping their health systems by emphasizing efficiency and market-driven reforms at the expense of equity and universal access to care.

In the 1990s financialization of global health accelerated. The World Bank championed privatization, user fees and health insurance schemes, driven by an ideology that treated health as an economic asset rather than a basic right. Its 1993 *Investing in Health* report solidified the Bank's influence on global health policy, embedding market-oriented frameworks at its core. This shift coincided with the WHO's declining role as leader in global health governance due to its chronic underfunding. The Bank's promotion of public-private partnerships (PPPs)* paved the way for financial and commercial actors, positioning private sector involvement as key to solving global health challenges. This philosophy aligned seamlessly with the rise of philanthropists like the Bill & Melinda Gates Foundation, which combined business-like efficiency with social objectives. It is here that commitments to "results-based" financing modalities became normalized, which favor measurable vertical programs that can be quantified. New institutions such as Gavi, the Vaccine Alliance and the Global Fund to Fight HIV/AIDS, TB and Malaria, alongside bilateral programs like PEPFAR (the US President's Emergency Plan for Aids Relief), emerged to address gaps in global health financing. These platforms channeled donor funds toward specific diseases or projects, measuring success through quantifiable outputs that appealed to donor priorities, but which may not be aligned with or able to cover the broader needs of the people.

The Bank's health reforms also created opportunities for global consultancy firms (see Chapter C5).† Governments, constrained by debt repayment obligations and stringent loan conditions, turned to these firms for expertise in designing and implementing health reforms. With limited experience in health policy and strong ties to major healthcare and pharmaceutical firms, these entities operate within and beyond health ministries to ensure corporate influence in governance.‡ Operating largely detached from the populations they served, these firms shaped health systems through their promotion of insurance schemes, privatization strategies and supply chain solutions. Their practices revolve around the principles of limited governance and free-market capitalism, enabling transnational corporations to expand easily their influence and reach.[2] Applying the profit-driven logic of financial markets to the health sector raises serious concerns, amplified by issues of transparency and accountability. As outlined in section two, this market logic underpins the discussion around the use of "innovative financing" models as a panacea for meeting the needs of PPPR, yet again without reflecting on the downsides of such approaches.

*See GHW4 Chapter D6 for the World Bank's IFC's "Health in Africa" initiative.

†See GHW5 Chapter D3 for the role of management consulting firms in global health.

‡See GHW4 Chapter D3 for private sector influence on public health policy.

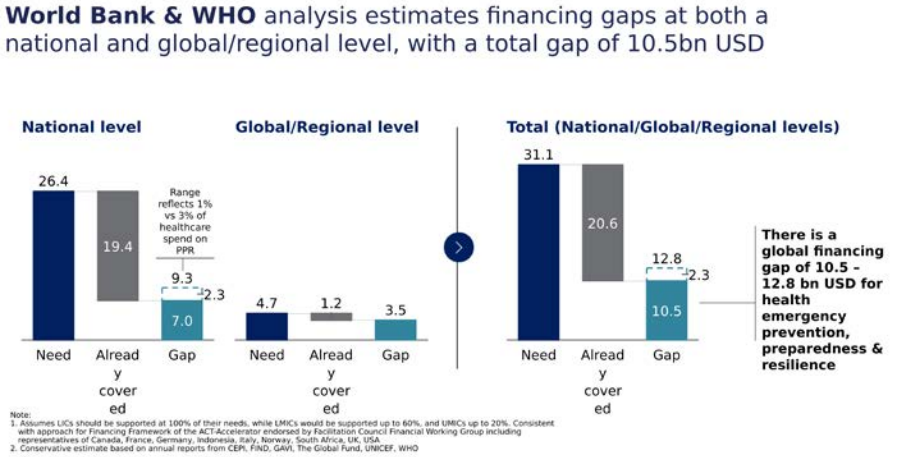
Many influential national and global institutions have communicated increased threat of more frequent and severe international-scale infectious disease outbreaks to mobilize a new wave of financialization in global health. The 2014 West Africa Ebola outbreak is often used to highlight the economic risks of uncontrolled epidemics, prompting Global North donors to push for stronger global health security measures.[3] Many of these measures eventually made their way into policy recommendations of the Independent Panel for Pandemic Preparedness and Response,[4] the WHO/World Bank PPPR Gap Analysis and Financing Needs report[5] and the Group of 20 (G20) High Level Independent Panel report on "Financing the Global Commons on Pandemic Preparedness and Response".[6] Despite remaining questions about the accuracy of these reports[7] the COVID-19 pandemic ultimately presented the opportunity to bring these ideas forward and fast-track their implementation.

These reports argue that outbreaks like Ebola spiraled out of control and became threats to global health security due to failures of both global leaderships, particularly the WHO, and local governance. Although the Ebola outbreaks had a relatively low disease burden and geographical profile in comparison to endemic diseases such as malaria and tuberculosis (the 2014 Ebola outbreak killed 14,000 people compared to 600,000 from malaria that year),[8] the reports recommend an aggressive co-financing approach that could pressure governments in poorer countries to invest in healthcare, particularly PPPR – a seemingly promising but nonetheless complex solution.

As outlined in the WHO / World Bank report,[9] the estimated cost of PPPR is US$31.1 billion per year, requiring annual investments by low- and middle-income countries (LMICs) of US$26.4 billion per year, with US$10.5 billion in new official development assistance (ODA) required from donors (see Figure 1). Yet, countries in the Global South already grapple with mounting debt and chronic underinvestment across sectors. One critique of the World Bank's new Pandemic Fund is that it employs a "results-based framework" upon which grants, and potentially future loans, are conditional.[10] To secure favorable assessments, poorer countries may be compelled to take on more debt, aid and foreign direct investment for pandemic preparedness, further opening their "health markets" to external players. There are emerging signs that this is already taking place and evidence that limited resources are being diverted to PPPR activities at the expense of other health priorities.

Global North institutions, philanthropists and corporate actors exert now even greater influence over Global South health policies and systems. These entities rarely provide resources without securing the power to shape markets and intervene to support their own interests.[12] This new phase of global health financialization has deepened the entanglement of health and finance, further commodifying health and marginalizing the actual needs of the majority.

Figure 1: Gap in financing needs for PPPR (World Bank vs. WHO estimates[11])



World Health Organization Secretariat, 2023

Business as usual: financing PPPR in a post COVID-19 world

COVID-19 is often heralded as a watershed moment for PPPR. Since the discovery of SARS-CoV-2 in 2020, PPPR quickly became a pandemic industry directed by large international organizations with the backing of powerful private interests.[13] Multilateral bodies including the G20, Group of 7 (G7), United Nations (UN), European Union (EU) and World Bank have emphasized the importance of PPPR and have accelerated its agenda. The WHO, being the health arm of the United Nations, has been the primary focus for coordinated policy. Supporters are seeking, and already receiving, substantial funding from international ODA budgets for PPPR, whilst domestic research agendas and spending are being similarly directed.

The prioritization of PPPR in global health is affecting wider global health financing. For example, although COVID-19 era ODA budgets saw an increase in overall dispersals for health since 2019, 63.9 per cent of that increase was for the COVID-19 response with a further US$1 billion disbursed for infectious disease control. Contemporaneously, ODA for basic health care fell from US$3.4 billion in 2019 to US$2.3 billion in 2020, a drop of 34.5 per cent, while that for nutrition declined by 10.1 per cent. Although ODA for basic health rose again in 2022, it has not recovered to 2019 funding levels. In contrast, ODA for COVID-19 and infectious disease control saw increases of US$1 billion and US$500 million respectively in 2022. There is evidence that national budgets are also reallocating existing resources to PPPR, potentially increasing vulnerabilities for universal health coverage (UHC) and threatening to reverse previous positive health outcomes.[14]

Moreover, the debt crisis in developing countries has reached a critical state, further exacerbated by the economic fallout from the COVID-19 pandemic.

According to the UN Trade and Development[15] this has broad implications on population health and health systems worldwide. This unsustainable situation is not a sudden development, but the result of decades of macroeconomic policies driven by international institutions chiefly among them, the IMF and the World Bank, which eventually trap Global South countries in debts.

Prior to COVID-19, there had been alarming reports of fast rising debt burdens and vulnerabilities. IMF started to sound an alarm in their 2018 report stating that fiscal deficits were widening in 70 per cent of lower income developing countries between 2010-2017. While the majority of LMICs remain at low or moderate risk of debt distress, the number of countries at high risk or in debt distress almost doubled between 2013 and 2018, and half of them are poor countries.[16,17] As debt levels rise, governments allocate more public funds to interest payments. In low-income countries (LICs), the cost of servicing debt almost doubled between 2013 and 2017, far outpacing the growth of government revenues needed to cover these payments.[18]

Over the past 15 years, low interest rates in wealthy countries made borrowing cheaper globally, leading to a surge in public and private debt. From 2010 to 2012, central banks in the North lowered rates to near zero, encouraging capital to flow to developing nations seeking higher returns and making debt refinancing easier.[19] Even poor countries in Sub-Saharan Africa gained access to global markets as investors looked for better yields. The World Bank and IMF encouraged these nations to borrow heavily and open their economies, instilling the belief that it would drive growth. However, this advice left them vulnerable to external shocks — such as the pandemic, the war in Ukraine and rising interest rates — which exposed their economic fragility and worsened the debt crisis. The situation is further exacerbated by the high costs of renegotiating these debts and the lack of a coherent international framework for addressing debt issues.[20]

Debt relief measures were introduced to help countries face the pandemic, such as the IMF's cancellation of $727 million in debt service obligations for 29 countries[21] and the G20's Debt Service Suspension Initiative (DSSI) for 43 countries[22], both implemented during 2020–2021. However, these measures were merely a drop in the ocean of debt, and the temporary deferral of debt payments for one year does little to reduce the total amount owed. Counterintuitively, new loans were also contemporaneously issued to pay for costly and in many cases questionable responses to COVID-19.[23]

By the end of 2022 many developing countries had fallen into severe debt distress and a few had started to default, among them Lebanon, Sri Lanka, Russia, Suriname and Zambia.[24] In 2023, UNCTAD warned that global public debt had reached a historic peak of US$97 trillion, with 3.3 billion people in developing countries spending more on loan interest than on education or healthcare.[25] This is a key failure of a financialized capital market approach for development more broadly, but also particularly for health, made acute by COVID-19. As recently reported (in 2024), increased debt servicing by LMICs to account for costly

COVID-19 response measures has led to health budgets reducing 8.9 per cent on average.[26] The result of such cuts will negatively affect health outcomes and put additional pressure on countries that are also being encouraged to invest heavily in PPPR. Without significant financing from the Global North, the prospect of generating sufficient PPPR investments from LMICs is improbable.[27] This requires a total rethink of PPPR risk / benefit, opportunity costs and health needs, particularly since many low-income countries (LICs) have significant disease burdens that already kill millions of people year on year.[28]

Box D3.1. Debt in public health pathology

The growing indebtedness among LMICs to multilateral, bilateral and private lenders over several decades has limited public investment in basic social and health services[29] and created constraints on resources available for pandemic preparedness. The International Development Association (IDA) of the World Bank Group indicated that by February 2020, just before the COVID-19 pandemic, 50 per cent of the low-income countries eligible for grants or loans were already at high risk of debt distress or in debt distress. The pandemic then further undermined local economies in the Global South as the war in Ukraine added to a surge in inflation, especially in the food and energy sectors. Central banks raised interest rates to tackle inflation, which dramatically increased debt service burdens. The IMF also reported that 36 LMICs were in debt distress by the end of 2023, with many more facing major challenges. Total LMIC debt servicing costs, excluding China, reached a record US$971.1 billion in 2023, double the amount a decade ago.[30]

Debt repayment diverts critical public spending from social sectors in ways that affect social determinants of health, reduce health system financing and undermine population health in many settings. Public financing for any additional pandemic preparedness may thus be curtailed, as has already been reported in Argentina, Pakistan, Sri Lanka and Zambia.[31] Debt repayment now exceeds health sector spending in 116 countries and exceeds total social sector spending in 33. For those countries most deeply in debt, the reductions have been extreme, directly undermining the scale and quality of service delivery, with potential impact on pandemic preparedness (e.g., workforce, number of health facilities, medicines, transport).[32] The WHO recommends that countries spend a minimum of $86 per capita per year on health services to achieve Universal Health Coverage, but many indebted low-income countries can only afford to spend between $20-40 per capita.[33] The Debt Service Suspension Initiative (DSSI) ended in 2021, but the debt burden still grew over that period. In late 2020, the IMF and G20 also initiated the "Common Framework" for longer term creditor coordination to restructure debt, but its complexities led to long delays and only a few countries (notably Zambia and Ghana by 2024) have entered the pipeline. The World Bank concedes that "the common framework is not working".[34]

Continues on next page

Box D3.1 continued

To add to these challenges, the IMF's own debt relief strategies signal a return of harsh austerity measures. The IMF recently added "social spending floors" to its debt restructuring programs, which in principle define a minimum required level of spending for health, education and other social services. But critics argue that the floors are too low and in practice they often serve as expenditure ceilings or caps. Austerity remains the policy imperative even when debt relief or debt cancellation is provided.[35]

Private creditors, especially the predatory so-called "vulture funds", have also complicated debt relief efforts. Vulture funds buy distressed country debt at a steep discount and aggressively seek full repayment, often through lawsuits in New York or London.[36] In the 2010s, after the Great Recession, the IMF and World Bank pushed Global South nations to pursue private credit,[37] so this category of debt increased considerably. But most private creditors (e.g. commercial banks, investment funds, private equity firms) will not participate in public debt restructuring efforts and have extracted large profits through high interest loans in struggling nations. Given the post-pandemic struggles among debt-distressed countries, risk averse private creditors have backed away from providing new credit while still earning major returns from previous lending. As the World Bank reports: "Since 2022, foreign private creditors have extracted nearly US$141 billion more in debt service payments from public sector borrowers in developing economies than they disbursed in new financing…[which] has upended the financing landscape for development".

Within this troubling scenario global civil society advocacy and humanitarian organizations are again mobilizing for debt relief without austerity conditionalities, like the Jubilee 2000 movement 25 years ago that led to some debt cancellation and creation of the IMF's Heavily Indebted Poor Countries Initiative.[38] In addition to ongoing calls for debt cancellation, especially for "odious" and other illegitimate debt,[39] debt justice organizations are also mobilizing around several new strategies. Jubilee USA is leading an effort in the New York State legislature to pass the "Sovereign Debt Stability Act" that would require private creditors on Wall Street to participate in public debt restructuring. DebtJustice UK is leading a similar effort in parliament for London-based creditors.[40] The "Global Crisis Relief with Special Drawing Rights" (SDRs) coalition, led by Action Corps, is campaigning for the IMF to issue $650 billion in SDRs for debt relief,[41] to help pay debt, bolster foreign reserves or purchase vaccines and food supplies. The new "Global Public Investment Network" is also working to support greater public investment in health and other services through a multilateral investment fund.[42] In 2023, the American Public Health Association (APHA) adopted a policy statement calling for debt cancellation for those countries in deepest crisis, rejection of IMF austerity measures and new issuance of SDRs in line with Global Crisis Relief.[43] If these efforts make an impact, the resulting debt relief can create "fiscal space" for more sustained public investment in health generally, but also pandemic preparedness. The second Trump administration may make such advocacy initiatives more challenging to succeed, but no less important to continue.

Designs for global PPPR Coordinating Financing Mechanism (CFM)

In June 2024, with several last-minute additions, the WHA adopted the amendments to the IHRs. In terms of PPPR financing, one last-minute provision was to establish a Coordinating Financial Mechanism (CFM). This mechanism was in-whole borrowed from the latest Intergovernmental Negotiating Body (INB) Pandemic Agreement draft for Article 20 and added to the IHRs when it became clear that a vote on the Pandemic Agreement was to be delayed. Although negotiations on the Pandemic Agreement were extended up to May 2025, they remain under discussion and the Article 20 sub-committee has now fully agreed a final text, which also designates the CFM as its primary financing instrument. Although the CFM has a general architecture (see Figure 2), its technical details are currently under design at WHO, with an understanding that any final decision about who will host the CFM, and under what governance model, will take place within the Conference of Parties (CoP) established under the Pandemic Agreement.

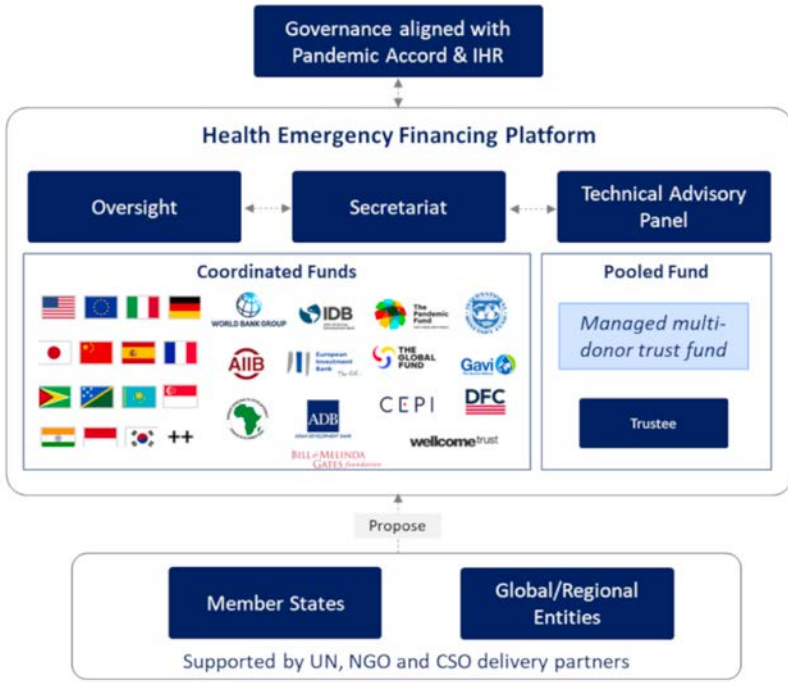
There have been wide-ranging estimates regarding the cost of PPPR and how these costs can be financed through the CFM and other instruments. The G20 High Level Independent Panel (HLIP) recommends global and country level investments of US$171 billion over five years with an unspecified amount annually thereafter.[45] The World Bank estimates that an additional US$10.3 to US$11.5 billion will be required to boost One Health as a preventative complement to PPPR.[46] An influential report written by McKinsey and Company estimated PPPR to cost anywhere from US$85 to US$130 billion over two years, with annual costs thereafter of US$20 to US$50 billion.[47] The joint 2022 WHO and World Bank report to the G20, as noted earlier, estimates new LMIC costs of US$26.4 billion (Figure 2).

Beyond concerns with the reliability of these cost estimates,[48] there have been several critiques of the CFM and the processes in which it was adopted by the WHA. For many, the process is seen as an entrenchment of business as usual, with many misgivings voiced by the Global South. Many countries argued against the World Bank hosting the CFM within a revamped Pandemic Fund (discussed below), worried that donors will demand that the CFM be managed by the World Bank. In addition, there was also contestation about the last-minute inclusion of the CFM prior to the IHR vote, that countries were not given the appropriate legal notice required for text changes before a vote can be taken. Many from the Global South argued that this created procedural inequities, since low-resource Member States were at a significant disadvantage. This undermined a sense of democratic legitimacy as well as any post-COVID paradigm shift in global health policy-making.

IMF's expanding reach: from economic mandates to pandemic emergencies

Founded in 1944, the IMF was designed to uphold a fixed exchange rate system anchored to the US dollar and gold. Known as "the Fund", it was tasked with stabilizing international trade, aligning countries' monetary policies and providing

Figure 2: Proposed Coordinated Financing Mechanism (CFM) for the IHRs and Pandemic Agreement[44]



Source: World Health Organization Secretariat, 2023.

temporary financial support to nations facing balance of payments issues. Balance of payments (BOP) includes all transactions of a country with the rest of the world, such as the import and export of goods and services, capital flows and transfer payments like foreign aid and remittances. When a country spends more on these transactions than it earns, it results in a deficit.

Civil society groups have long condemned the IMF's parallel and neoliberal push for privatization, deregulation, liberalization and austerity, arguing that these policies entrench developing country debt dependency and strip nations of their sovereignty, handing control to powerful countries that dominate IMF decisions.* Over the past decades, the IMF has influenced countries' health sectors by shaping their fiscal policies. Although its focus has now expanded beyond core economic issues to include broader concerns like social protection and climate change,[49] it continues to uphold archaic practices.

In 2021, the IMF allocated $650 billion in Special Drawing Rights (SDRs) to support global reserves during the COVID-19 pandemic.[50] SDRs are a reserve asset allocated to countries by the IMF. They aren't actual money, but countries

* Discussions of the IMF's governance, policies, and critiques can be found in previous Global Health Watch editions (see GHW1 Chapter E3 and GHW6 Chapters D4 and C1).

can convert them into monetary currencies that they can use to fund essential needs like vaccines and healthcare equipment without the burden of high interest payments, stringent conditions or accruing new debt. However, since SDRs are allocated based on countries' quotas in the IMF, most of the $650 billion went to wealthy countries, leaving only a small share for Africa. Oxfam calculated that Malawi received $190 million worth of SDRs, while the USA got over $113 billion.[51] SDRs offered a crucial liquidity boost for many LMICs trapped in cycles of debts and grappling with the economic fallout of the COVID-19 pandemic. Unlike wealthy nations, which had little need for SDRs, these countries relied heavily on them.[52] The Center for Economic and Policy Research estimated that just a quarter of rich countries' unused SDRs could cover the entire debt owed by all developing countries to the IMF.[53]

Figure 3. Anti-austerity protests

Revolutionary Communist Party

Under growing pressure to donate unused SDRs and inspired by the Bridgetown Initiative led by Barbados Prime Minister Mia Mottley, the G7 and G20 committed to "rechannel" $100 billion of SDRs to vulnerable countries. The Bridgetown Initiative sought to fulfill climate finance pledges by leveraging SDRs to drive private investment into climate transition projects in LMICs.[54] It also advocated for disaster and pandemic clauses in all major loans to ensure automatic debt suspension during significant disruptions. This "rechanneling" of SDRs would be delivered through the IMF's Resilience and Sustainability Trust (RST) and Poverty Reduction and Growth Trust (PRGT) facilities. Hundreds of civil society organizations demanded more opportunities for engagement and a more transparent, equitable rechanneling of SDRs.[55] Nevertheless, the RST was created behind closed doors and was swiftly established by early 2022, with little consultation. By the end of 2024, the pledge to "rechannel" SDRs remained only partially fulfilled and the majority of which were allocated to loan programs.[56]

Powerful countries have an unwillingness to give up control or resources. Thus, it is no surprise that the IMF announced that access to RST would be burdened with conditionalities and debt. "Rechanneling" became a euphemism for more debt.[5] The IMF boasted the Resilience and Sustainability Facility (RSF) funded by RST would offer long-term loans with a 20-year maturity, a shift from the IMF's typical short-term lending terms of 3–5 years, limited conditions and tiered interest rates.[57] This "groundbreaking" facility was expected to help vulnerable countries build resilience to structural challenges like climate change and pandemics. However, on closer examination, only countries with sustainable debt profile and already enrolled in traditional IMF programs are eligible for RSF loans. These programs, notably the Stand-By Arrangement (SBA) and Extended Fund Facility (EFF), carry extensive and stringent structural conditions, such as austerity measures that include freezing public sector wages, increasing taxes on low-income populations, trade liberalization, labor reforms and privatization. EFF programs are often preceded or followed by SBA loans.[58]

Simply put, vulnerable countries are expected to navigate layers of IMF loans, endure harsh austerity reforms and somehow manage their debts sustainably just to access funds that were initially intended as straightforward assistance with few or no conditions. Over decades IMF programs have harmed public health through cuts in health personnel, frozen or reduced salaries for health workers and increased health service fees.[59] These measures weaken health systems, particularly in chronically underfunded areas like community primary care and rural health programs, which are critical for monitoring and controlling disease outbreaks, but also keeping people healthy and more resilient when there is an outbreak.[60] The RST's conditional lending is not designed to address these issues and is contrary to what countries need to build resilient health systems; namely, increased public investment in infrastructure and services and a shift away from policies that exploit both people and the environment.

It is troubling that the WHO has partnered with the IMF and the World Bank on pandemic preparedness,[61] lending credibility to health-harmful policies and allowing the IMF to further extend its influence into health development. So far, none of the five RSF-supported programs address pandemic preparedness.

The World Bank recaptures the pandemic agenda

The World Bank's general role in the financialization of global health was covered in section one, but the Bank also had a unique historical role in global PPPR policy. With support of the G7, and in response to the 2014 Ebola outbreak, the Bank launched the Pandemic Emergency Financing Facility (PEF) in 2015 to develop "an innovative, insurance-based financing mechanism". This mechanism, in conjunction with WHO and public and private partners, was designed "to provide surge financing for response efforts to [the world's poorest] countries affected by a large-scale outbreak to prevent the outbreak from reaching

pandemic proportions".[62] In doing so, the PEF comprised two "windows" – a cash window and an insurance window – to channel financing.

The cash window was meant to provide fast financial support to eligible countries fighting disease outbreaks. The PEF insurance window only provided coverage for viruses with pandemic potential, namely, "large-scale outbreaks of a pre-established group of diseases [on the WHO priority disease list]". Under this window, the Facility had capacity to provide payments over a three-year period to a maximum of US$425 million. As part of this financing strategy, "the World Bank sold pandemic bonds to the value of $320m and swaps to the value of $105m".[63]

Quickly labelled an "an embarrassing mistake"[64] the PEF notoriously failed to deliver surge funding for the 2018 and 2019 Ebola outbreaks and was further panned during COVID-19 for delivering insufficient financing that amounted to US$195.84 million for 64 countries, and only after considerable delay.[65] The major beneficiaries before the PEF was closed in 2021 were the pandemic bond holders.[66] As one economic analysis of the PEF argued, "the PEF has cost more than it has brought in" making the PEF "a good deal for investors, not for global health".[67]

Despite the PEF's failure, the World Bank launched its Pandemic Fund (PF) in 2022 to catalyze additional funding for PPPR. The aim of the PF is to fill funding gaps and to expand the ability of UN agencies and multilateral development banks to support capacity building at country and regional levels, thus providing "greater agility at the global level through initial bridge financing, as other sources are mobilized".[68] To date the PF has held two rounds of financing with a third round planned for March 2025. In terms of financing, the Pandemic Fund has dispersed US$885 million to 75 countries and claims to have mobilized US$6 billion in partner contributions and country level additionality. All funding is dispersed as grants conditional on being evaluated through a "results-based framework." In terms of coverage, only three PPPR capacities can be funded: surveillance, diagnostics and human resources to support those capacities. All applicants must apply with at least one of the 13 approved "implementing agencies", which include development banks, specific UN agencies and major global health institutions.[69]

Although it is too early to fully evaluate the Pandemic Fund and its implications for pandemic financing, it is worth noting some existing concerns. First, the PF was established quickly and with limited consultation. As a result, its design phase has been criticized as being a "deeply retrograde, insular design" with a lack of wider stakeholder input and a persistent unwillingness to consider establishing an external multisectoral secretariat and governing board like that created for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).[70] Instead, the Governing Board and Secretariat for the PF resides within the World Bank, which many argue stifles wider consultation and accountability.[71]

Second, and relatedly, the PF is managed by an exclusionary group of the usual global funders and agencies. Although two civil society organizations were eventually added to the Governing Board, this was well after PF had been designed and only after considerable contestation from key actors.[72] Moreover, the list of 13 "implementing agencies" has excluded organizations such as the African CDC, which was purposefully excluded as an implementing agency by the WHO.[73] As a result, the PF continues to limit multistakeholder representation and inclusion, perpetuating a chronic problem within global health policy (see Chapter B5).[74]

Third, the PF has a remit to generate the estimated US$10.5 billion in annual funding for PPPR (see Figure 2). As of November 2024, the Fund has only secured financial commitments of US$1.9 billion from 28 donors, most of whom are G20 countries, the Bill & Melinda Gates Foundation, the Rockefeller Foundation and the Wellcome Trust.[75] In terms of existing demand, the PF in the first round received 179 bids totaling to US$2.5 billion, but committed only US$338 million.[76] Whether or not the US$10.5 billion estimates are correct,[77] the track record of the PF to date suggests that demand for financing will be far greater than available capacities, which raises concerns about its ability to effectively and equitably govern PPPR.[78] These concerns increase now that the PF has been favored to manage the CFM for the IHRs and any Pandemic Agreement.

Lastly, there is a lack of clarity about how the Governing Board made their final decisions during the first two rounds of funding and with what criteria. Although the Technical Advisory Panel (TAP) has a "score card" with criteria for assessing proposals, there is not something similar for the Governing Board. During the first round, 179 individual proposals were submitted, yet only 19 were successful applications, with suggestions that many proposals cleared the TAP but were ultimately rejected by the Board.[79] This raises questions about decision-making, gatekeeping, transparency and fairness.

The market solution: innovative financing as the new panacea for pandemic preparedness

Innovative financing is being promoted as a key solution to help secure sufficient funding for PPPR, as stated in Article 20 of the draft Pandemic Agreement.[80] This repeated emphasis raises numerous questions regarding the potential use and effectiveness of largely untested financing instruments specifically for PPPR.

Comprising a range of financial solutions and mechanisms, innovative finance's promise lies in "[b]ringing additional sources of funding and unlocking the potential of existing capital to accelerate and increase impact."[81] This definition marries two distinct dimensions: 1) an additional source of capital mobilized to complement traditional sources of global health financing (i.e. ODA from donor governments) and the financing required to meet global health objectives; and 2) the use of capital in a way that maximizes its efficiency and effectiveness to address global health challenges.[82,83] The latter is at the heart of the World Economic Forum's (WEF) enthusiasm for the "huge untapped potential" of innovative

financing for PPPR to "put an early stop to outbreaks and protect countless lives and livelihoods" by "making fast and efficient use of funds to make health interventions available rapidly".[84] To achieve this goal, the WEF advocates expanding the scope of "tried and tested" innovative financing mechanisms, such as the International Financial Facility for Immunization (IFFIm).

Launched by Gavi in 2006, the IFFIm relies on an approach known as frontloading, which involves issuing bonds backed by long-term donor government pledges onto capital markets, to make the committed funding immediately available for global health initiatives.[85] The IFFIm quickly became the poster child for innovative financing for global health on account of raising US$9.7 billion for Gavi's vaccination programs[86] helping it to immunize over one billion children sooner than would have been possible otherwise and purportedly "saving 17 million lives and reducing child mortality by half across 73 low-income countries."[87]

Since 2020, this Facility has expanded its scope and impact with a focus on supporting future PPPR financing.[88] With its support for the COVAX Advance Market Commitment (AMC) (frontloading approximately $1 billion) and a new mandate to back the Coalition for Epidemic Preparedness Innovations (CEPI) in developing new vaccines, including a $272 million contribution towards its 100 Day Mission, the IFFIm has positioned itself as a self-professed "ideal" innovative financing tool for PPPR.[89] Relatedly, according to the WEF, the IFFIm's frontloading approach would perform well in the current economic climate, as it "could improve global pandemic preparedness now, while allowing donor governments to spread the cost" in the future.[90]

While self-referential claims to the IFFIm's effectiveness and potential to become the go-to mechanism for PPPR financing by the IFFIm and its affiliates (Gavi and the WEF) sound promising, external analyses suggest that such claims are heavily distorted. Critics expose a lack of transparency around "who benefits and by how much" which conceal the mechanism's failure to live up to its claims to effectiveness and excessive private sector profiteering at the expense of donors and beneficiaries.[91] The concentration of decision-making power and the financialization of global health in the Global North raise additional concerns about the lack of inclusivity and its impact on normative aspirations to promote equity in global health policy.[92]

The ambition to promote equitable outcomes failed to materialize in the most significant attempt to wield the potential of innovative financing mechanisms for PPPR during the COVID-19 pandemic, namely the Gavi COVAX AMC. By guaranteeing a market for successfully developed vaccines, the COVAX AMC (2020-2023) incentivized vaccine manufacturers to develop and "accelerate the manufacture of a COVID-19 vaccine on a massive scale and to distribute it according to need, rather than ability to pay" with the intent of ensuring equitable access to vaccines for the world's poorest countries.[93]

While vaccines were developed and authorized for emergency use with unprecedented speed, significant delays in the provision of vaccines to LMICs meant that they were left far behind high and middle income countries.[94] High income countries (HICs) vaccine nationalism and hoarding, along with their lack of commitment to the COVAX facility (in favor of securing doses through bilateral purchase agreements with manufacturers) were among the many reasons that undermined the ambition of ensuring equitable access for countries who could not afford to independently secure vaccine doses for their populations.[95] In addition, the lack of transparency surrounding the mechanism and the contracts with vaccine manufacturers signed under its umbrella raised serious concerns about the price/affordability of vaccines and whether public funds were well-spent.[96] The secrecy behind the COVAX AMC created opportunities for excessive private sector profiteering that compromised the "effective and efficient use" of global health funding that innovative financing solutions promises to offer.

The recent application of innovative financing mechanisms for pandemic preparedness reveals several observations of import for future policy development in this area. First, the innovative financing landscape has been dominated by Gavi-backed initiatives, which has contributed to an over-reliance on vaccine strategies for PPPR. This has overshadowed less reactive and more holistic public health approaches to PPPR, which are better-suited to preparing for yet-unknown pathogens with pandemic potential. Second, the inefficient use of scarce resources for PPPR comes with potentially high opportunity costs, as it hides the risk of diverting efforts, attention and resources from other high-priority global health concerns, making innovative financing endeavors not only futile but also a net harm in the broader global health context. Hence, it is imperative that decision makers carefully assess the pros and cons of different innovative financing tools before committing to their deployment in the context of PPPR. Alternatively, thorough consideration should be given to ways to adapt existing mechanisms and learn from past mistakes when designing new innovative financing tools (e.g. AMCs). Finally, the proliferation of various innovative (and other) financing mechanisms (and institutions) for PPPR comes at the cost of fragmentation, whereby "multiple financing mechanisms make financial and programmatic monitoring complex and challenging" rather than focusing efforts on harmonizing financial investments "in a way that contributes to building comprehensive and resilient health systems to address current and future public health emergencies".[97]

Beyond business as usual in PPPR

If the emerging PPPR agenda and its financing looks to be "business as usual" then so are the potential solutions, and this remains true regardless of recent US actions to "freeze" development aid for health funding. As is well rehearsed in discussions about global health financing, there are key structural reforms

that are required. First, as discussed in Chapter C4 of this edition, sustainable and self-reliant financing requires the mobilization of sufficient public finances, which requires tackling illicit financial flows and tax dodging, particularly in LMICs where deficiencies compound. Second, there is a need to rethink debt for PPPR, for example, the use of debt cancellation to promote full PPPR investment, debt relief to increase liquidity for rebuilding and / or debt suspension for PPPR surge response (see Box D3.1). These tools can have immediate benefits for PPPR, but more so for promoting health systems and public health outcomes. Third, there remain many challenges in the governance of global health financing, and current PPPR mechanisms seemingly offer limited solutions.[98] These concerns include the fact that international organizations continue to sideline national ownership as called for and specified in the Paris Declaration on Aid Effectiveness, and to systematically malign voices from the Global South, while remaining overly influenced by powerful private and vested interests and remain weak in transparency and accountability. As a result, the first step in finding solutions might be to ask those most affected by disease burdens and risk, and to be more accountable to those needs.

Additional considerations are also needed. These include a return to traditional public health and a more reflective cost-benefit calculation for the level of PPPR investment required to assure health security without "breaking the bank" particularly in light of other endemic infectious diseases with much higher disease burdens. This is because the estimated cost and financing requirements associated with PPPR pose significant opportunity costs with the additional risk of redirecting scarce resources from global and national health priorities of greater burden. It is therefore vital that pandemic risk and cost estimates are accurate, reliable and proportionate.[99] Moreover, PPPR investments cannot be determined in isolation and skewed only toward surveillance, diagnostics and vaccines, but must also be measured against wider health, social and economic priorities and determinants,[100] since the recommended investments for pandemic PPPR at US$31.1 billion a year carry broad implications for overall human health.

Conclusion

The window to finalize the pandemic treaty is closing fast. The treaty negotiations presented a critical opportunity to ensure equitable financing, address debt burdens, reform global financial systems and commit to robust public healthcare. Yet, the current trajectory of the financing mechanisms to be approved under Article 20 risks undermining these goals by prioritizing profit over equity. Instead, it appears to be setting the stage for the commercialization and commodification of PPPR, dominated by the same actors who have long shaped global health agendas.

The over-reliance on private financing as a panacea for resilient PPPR is deeply flawed. Mounting evidence suggests that such models often exacerbate inequities. Yet, these lessons are being ignored. Meanwhile, debt crises continue to strangle

social development in LMICs. Debt reduction is essential to create fiscal space for health investments, yet initial proposals from Global South countries to address these issues in the event of public health emergencies have been systematically diluted and ultimately erased from the treaty. This regression to "business as usual" reflects not only a failure of political will but also a lack of sustained advocacy from civil society to center financing issues in the health equity debate.

Despite these setbacks, the global health community still has a role to play, now more so than ever. While the chance to enshrine equitable financing mechanisms in the treaty may be slipping away, there remain opportunities to push for debt cancellations and to resist the unregulated financialization of global health. By uniting experts and advocates, the global health community can push for wealth redistribution, expanded public financing and stronger accountability measures for an effective PPPR.

Reference List

1 Stein F, Sridhar D. The financialisation of global health. Wellcome Open Res. 2018 Feb 26;3:17. Available from: https://bit.ly/42M5xQf

2 Anaf J, Baum F. Health and equity impacts of global consultancy firms. Global Health. 2024 Jul 25;20(1):55. Available from: https://bit.ly/42AOikM

3 Dzau VJ, Rodin J. Creating a Global Health Risk Framework. N Engl J Med. 2015 Sep 10;373(11):991-3. Available from: https://bit.ly/3EIvg3Q

4 The Independent Panel for Pandemic Preparedness and Response. Policy Brief: The global architecture for pandemic preparedness and response;2021. Available from: https://bit.ly/3EzcLPt

5 WHO, World Bank. Analysis of Pandemic Preparedness and Response (PPR) architecture, financing needs, gaps and mechanisms. G20 Joint Finance & Health Task Force;2022 Mar. Available from: https://bit.ly/42EWXT7

6 G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response. A Global Deal for our Pandemic Age. 2021 Jun. https://bit.ly/4ivhvUj

7 Bell D, Brown GW, von Agris J, Tacheva B. Urgent pandemic messaging of WHO, World Bank, and G20 is inconsistent with their evidence base. Global Policy. 2024 Sep;15(4):689–707. Available from: https://bit.ly/4jC01GA

8 Bell, D, Brown GW, Tacheva B & von Agris J. Rational Policy over Panic: Reexamining Pandemic Risk within the Global Pandemic Prevention, Preparedness and Response Agenda. UK: University of Leeds; 2024. (REPPARE Report) Available from: https://bit.ly/42Ti2KR

9 WHO, World Bank. Analysis of Pandemic Preparedness and Response (PPR) architecture, financing needs, gaps and mechanisms. G20 Joint Finance & Health Task Force;2022 Mar. Available from: https://bit.ly/42EWXT7

10 Brown GW, Rhodes N, Tacheva B, Loewenson R, Shahid M, Poitier F. Challenges in international health financing and implications for the new pandemic fund. Global Health. 2023 Dec 5;19(1):97. Available from: https://bit.ly/42WcJdK

11 World Health Organization Secretariat. Technical input requested to INB & IHR Working Group. Presentation slides presented at; 2023 Nov 29; Geneva: World Health Organization.

12 Jamison DT, Summers LH, Chang AY, Karlsson O, Mao W, Norheim OF, et al. Global health 2050: the path to halving premature death by mid-century. The Lancet. 2024 Oct;404(10462):1561-614. Available from: https://bit.ly/3GepDuW

13 Sparke M, Williams O. (2024). COVID and structural cartelisation: market-state-society ties and the political economy of Pharma. New Political Economy. 2024 Jul 3; 29(4):579–96. Available from: https://bit.ly/3GmxoPy

14 Brown GW, Tacheva B, Shahid M, Rhodes N, Schaferhoff M. Global health financing after COVID-19 and the new Pandemic Fund. Brookings Institute; 2022 Dec. Available from: https://bit.ly/3YcdNrj

15 United Nations Trade and Development. A world of debt 2024: A growing burden to global prosperity. 2024. Available from: https://bit.ly/4ior47d

16 International Monetary Fund. Macroeconomic Developments and Prospects in Low-Income Developing Countries. 2018. Available from: https://bit.ly/4lC2fHX

17 Aizenman N. A Debt Crisis Seems To Have Come Out Of Nowhere. NPR. 2018 Apr 20; Available from: https://bit.ly/3GiUdDE

18 Essl S, Celik SK, Kirby P, Proite A. Debt in Low-Income Countries: Evolution, Implications, and Remedies. World Bank Group; 2019 Marc. Report No.: WPS8794. Available from: https://bit.ly/4d2Htxn https://bit.ly/4d2Htxn

19 Toussaint E. "Developing countries" are trapped in a new debt crisis - World Bank : How can this be explained? Committee for the Abolition of Illegitimate Debt (CADTM). 2023 Dec 18; Available from: https://bit.ly/4iC87hK

20 Public Services International, UNCTAD. Fixing a rigged system: fairer global debt rules 2019. 2019. Available from: https://bit.ly/4jsljG4

21 Third World Network. United Nations: Global growth to hit 5.3% in 2021, but uncertainty remains. 2021 Sep 16; Available from: https://bit.ly/4cDUw7U

22 Fresnillo I. Shadow report on the limitations of the G20 Debt Service Suspension Initiative: Draining out the Titanic with a bucket? European Network on Debt and Development (Eurodad); 2022 Oct. Available from: https://bit.ly/3GkVNoA

23 Paul E, Brown GW, Bell D, von Agris JM, Ridde V. Royal Society report: what would a comprehensive evaluation suggest about non-pharmaceutical interventions during COVID-19? Critical Public Health. 2024 Dec 31;34(1):1-10. Available from: https://bit.ly/3ErTTSv

24 Jones M. The big default? The dozen countries in the danger zone. Reuters. 2022 Jul 15; Available from:https://reut.rs/3GilJ46

25 United Nations Trade and Development. Global public debt hits record $97 trillion in 2023, UN urges action. UNTAD. 2024 Jun 4; Available from: https://bit.ly/4jFFrFd

26 Institute for Health Metrics and Evaluation (IHME). Financing Global Health 2023: The Future of Health Financing in the Post-Pandemic Era. Seattle, WA: IHME, 2024. Available from: https://bit.ly/4lYrlB5

27 Shahid M, Schäferhoff M, Brown G, Yamey G. How feasible is it to mobilize $31 billion a year for pandemic preparedness and response? An economic growth modelling analysis. Global Health. 2024 Jul 19;20(1):54. Available from: https://bit.ly/3ElaI1s

28 Bell D, Brown GW, Tacheva B & von Agris J. Rational Policy over Panic: Reexamining Pandemic Risk within the Global Pandemic Prevention, Preparedness and Response Agenda. UK: University of Leeds; 2024. (REPPARE Report) Available from: https://bit.ly/42Ti2KR

29 Kentikelenis AE. Structural adjustment and health: A conceptual framework and evidence on pathways. Soc Sci Med. 2017; Aug 187: 296-305. Available from: https://bit.ly/4cEpBbI

30 World Bank. International Debt Report 2024 [Internet]. Washington, DC: World Bank; 2024 [cited 2025 Feb 12]. Available from: https://bit.ly/44DVMpJ

31 Rogoff K. Emerging Market Sovereign Debt in the Aftermath of the Pandemic. Journal of Economic Perspectives. 2022 Nov 1; 36(4):147–66. Available from: https://bit.ly/4jJcTLd

32 Stuckler D, Basu S. The international monetary fund's effects on global health: Before and after the 2008 financial crisis. Int J Heal Serv. 2009 Oct;39(4):711-81. Available from: https://doi.org/10.2190/HS.39.4.j

33 Watkins DA, Qi J, Kawakatsu Y, Pickersgill SJ, Horton SE, Jamison DT. Resource requirements for essential universal health coverage: a modelling study based on findings from Disease Control Priorities, 3rd edition. Lancet Glob Heal. 2020 Jun;8(6):e829-39. Available from: https://bit.ly/42sCSRq

34 Elliott L. World Bank official calls for shake-up of G20 debt relief scheme. The Guardian. 2024 Apr 21 [cited 2024 Sep 12]; Available from: https://bit.ly/42H4nVU

35 Kentikelenis A, Stubbs T. Social protection and the International Monetary Fund: promise versus performance. Global Health. 2024 May 8;20(1):41. Available from: https://bit.ly/4itM9g0

36 Debt Justice. The colonial roots of global south debt. 2023 Sep [cited 2025 Feb]. Available from: https://bit.ly/4isWtpc

37 Potts S. Debt in the time of COVID-19: creditor choice and the failures of sovereign debt governance. Area Development and Policy. 2023 Apr 3;8(2):126–41.

38 Roodman D. The Arc of the Jubilee. Center for Economic and Policy Research; 2010 Oct [cited 2024 Sep 11]. Available from: https://bit.ly/4cMae0Y

39 DebtJusticeUK. Debt swaps won't save us: briefing 2024. Debt Justice; 2024 [cited 2025 Feb 12]. Available from: https://bit.ly/3ExyvLG

40 Watkinson E. How we can win a new law to cancel the debt. Debt Justice; 2024 Mar [cited 2024 Sep 11]. Available from: https://bit.ly/3EzkLQu

41 Action Corps. Global Crisis Relief. [cited 2024 Sep 11]. Available from: https://bit.ly/3YdD0lc

42 Expert Working Group on Global Public Investment. Global Public Investment: A Transformation in International Cooperation. [cited 2024 Sep 16]. Available from: https://bit.ly/3EzK4Sv

43 APHA. A Call to Expand International Debt Relief for All Developing Countries to Increase Access to Public Resources for Health Care. American Public Health Association; 2022 Nov [cited 2024 Sep 11]. Report No.: 20222. Available from: https://bit.ly/4cSkGEk

44 World Health Organization Secretariat. Technical input requested to INB & IHR Working Group. Presentation slides presented at; 2023 Nov 29; Geneva: World Health Organization.

45 G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response. A Global Deal for our Pandemic Age. 2021 Jun. https://bit.ly/4ivhvUj

46 World Bank. Putting Pandemics Behind Us: Investing in One Health to Reduce Risks of Emerging Infectious Diseases. Washington, DC: World Bank; 2022 Oct. Available from: https://bit.ly/3EjNzMT

47 Craven M, Sabow A, Van der Veken L, Wilson M. Not the last pandemic: Investing now to reimagine public-health systems [Internet]. McKinsey & Company; 2021 May. Available from: https://bit.ly/42DqKM6

48 Bell, D, Brown GW, Tacheva B & von Agris J. Rational Policy over Panic: Reexamining Pandemic Risk within the Global Pandemic Prevention, Preparedness and Response Agenda. UK: University of Leeds; 2024. (REPPARE Report) Available from: https://bit.ly/42Ti2KR

49 Georgieva K, Weeks-Brown R. The IMF's Evolving Role Within a Constant Mandate. Journal of International Economic Law. 2023 Mar 9;26(1):17–29. Available from: https://bit.ly/3EJ26l8

50 Mariotti C, Munevar D. The 3 trillion dollar question: What difference will the IMF's new SDRs allocation make to the world's poorest? Eurodad. 2021 Apr 7; Available from: https://bit.ly/3S1GBz4

51 Daar N. How to Get the Biggest Bang for your IMF Buck.: Oxfam International – Medium. 2021. Available from: https://bit.ly/3GeV4VY

52 Cashman K, Merling L. Special Drawing Rights: The Right Tool to Use to Respond to the Pandemic and Other Challenges: Center for Economic and Policy Research (CEPR); 2022 Apr. Available from: https://bit.ly/4lHnRCA

53 Vasic-Lalovic I. Three Years After SDRs Were Issued, Debt-Based SDR Rechanneling Has Failed. Center for Economic and Policy Research (CEPR); 2024 Oct. Available from: https://bit.ly/4lI6rpk

54 Persaud A. Bridgetown Initiative calls for new Global Climate Mitigation Trust financed via Special Drawing Rights. Bretton Woods Project. 2022 Nov; Available from: https://bit.ly/443J1og

55 Latindadd. CSO launches call for the fair channeling of Special Drawing Rights / OSC lanza llamado para la canalización justa de los Derechos Especiales de Giro: Latindadd; 2021 Sep 29; Available from: https://bit.ly/4lCzgDT.

56 Plant M, Adrogué BC. Empty Words, Empty Wallets: The G20's Broken Promise on SDR Recycling. Center for Global Development. 2023. Available from: https://bit.ly/42pRgKa

57 Georgieva K. IMF Managing Director Kristalina Georgieva Announces Operationalization of the Resilience and Sustainability Trust (RST) to Help Vulnerable Countries Meet Long-Term Challenges: International Monetary Fund; 2022 Oct. Report No: PR22/348. Available from: https://bit.ly/3Gm3B9r

58 Vreeland JR. The International Monetary Fund (IMF) Politics of Conditional Lending. 1st edition ed: Routledge; 2007. p. 31.

59 Rodriguez Malagon N. The BMJ Appeal 2023-24: IMF austerity policies are strangling healthcare systems in the Global South. BMJ. 2024 Jan;384:q189.Available from: https://bit.ly/42CpUiz

60 Kentikelenis A, King L, McKee M, Stuckler D. The International Monetary Fund and the Ebola outbreak. The Lancet Global Health. 2015 Feb;3(2):e69-e70. Available from: https://bit.ly/3RYBaAT

61 Elnagar R. The International Monetary Fund, the World Bank Group, and the World Health Organization Step Up Cooperation on Pandemic Preparedness: International Monetary Fund. 2024. Available from: https://bit.ly/3Gm3MS9

62 Gavi Staff. What is the International Finance Facility for Immunisation (IFFIm)? Gavi. 2024. Available from: https://bit.ly/3YKyElB

63 IFFIm. Vaccine Bonds: financing immunization and saving lives. Available from: https://bit.ly/4jIFccE

64 World Bank. The Pandemic Emergency Financing Facility: Operational Brief for Eligible Countries. 2019 Feb. Available from: https://thedocs.worldbank.org/en/doc/478271550071105640-0090022019/original /PEFOperationalBriefFeb2019.pdf

65 Shinh R. Pandemic bonds: what are they and how do they work? 2021 March 2. Available from: https://bit.ly/3YKRpp5

66 Financial Times (2020): World Bank Ditches Second Round of Pandemic Bonds. Financial Times. 2020; Available from: https://bit.ly/3ErRwz3

67 Jonas O. Pandemic bonds: designed to fail in Ebola. Nature. 2019 Aug 15; 572(7769): 285-6. Available from: https://bit.ly/3El2qql

68 World Bank. A Proposed Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness and Response Hosted by the World Bank: White Paper. 17. 2022 May. Available from: https://bit.ly/4iv9Ll7

69 World Bank. Background & Overview. The Pandemic Fund. 2025. Available from: https://bit.ly/4jtgiOE

70 Mazzucato M, Ghosh J. An Effective Pandemic Response Must Be Truly Global. Project Syndicate [Internet]. 2022 Jul 20; Available from: https://bit.ly/4jMfHHu

71 Brown GW, Rhodes N, Tacheva B, Loewenson R, Shahid M, Poitier F. Challenges in international health financing and implications for the new pandemic fund. Global Health. 2023 Dec 5;19(1):97. Available from: https://bit.ly/42WcJdK

72 McDade KK, Yamey G. Three big questions facing the World Bank's new pandemic fund. BMJ. 2022 Nov 25;o2857. Available from: https://bit.ly/42FgC5D.

73 Jerving S. Africa CDC criticizes the Pandemic Fund's first grant allocation. Devex. 2023 Jul 28. Available from: https://bit.ly/42B997r

74 Brown GW, Rhodes N, Tacheva B, Loewenson R, Shahid M, Poitier F. Challenges in international health financing and implications for the new pandemic fund. Global Health. 2023 Dec 5;19(1):97. Available from: https://bit.ly/42WcJdK

75 World Bank. Contributors. The Pandemic Fund. 2025. Available from: https://bit.ly/42HYrMu

76 World Bank Group. Pandemic Fund Allocates First Grants to Help Countries Be Better Prepared for Future Pandemics [Internet]. World Bank Group; 2023 Jul. Report No.: 2024/005/HD. Available from: https://bit.ly/3YIhWDn

77 World Health Organization Secretariat. Technical input requested to INB & IHR Working Group. Presentation slides presented at; 2023 Nov 29; Geneva: World Health Organization.

78 Glassman A. How a Pandemic FIF Should Be Different: Reflections on the World Bank [Internet]. Centre for Global Development; 2022 Jun. Available from: https://bit.ly/3GiU6rE

79 World Bank Group. Pandemic Fund Allocates First Grants to Help Countries Be Better Prepared for Future Pandemics [Internet]. World Bank Group; 2023 Jul. Report No.: 2024/005/HD. Available from: https://bit.ly/3YIhWDn

80 WHO. Revised draft of the negotiating text of the WHO Pandemic Agreement [Internet]. 2024 Mar [cited 2025 Jan 29]. Report No.: A/INB/9/3. Available from: https://bit.ly/4jlo0Kv

81 MedAccess. What is innovative finance? [Internet]. MedAccess. [cited 2025 Jan 28]. Available from: https://bit.ly/434FoMP

82 Innovative Financing Initiative. Innovative Financing for Development: Scalable Business Models that Produce Economic, Social, and Environmental Outcomes [Internet]. Paris: Global Development Incubator; 2014 Jun [cited 2025 Jan 28]. Available from: https://bit.ly/3YFIBkc

83 MedAccess. What is innovative finance? [Internet]. MedAccess. [cited 2025 Jan 28]. Available from: https://bit.ly/434FoMP

84 Berkley S, Anderson M. How innovative financing will help prepare for future pandemics. World Economic Forum [Internet]. 2022 Apr 7 [cited 2025 Jan 29]; Available from: https://bit.ly/3Y7030X

85 IFFIm. IFFIm Resource Guide 2019. 2019 [cited 29 Jan 2025]. Available from: https://bit.ly/3Yc5mMC.

86 IFFIm. Donors. [cited 29 Jan 2025]. Available from: https://bit.ly/4jkNk35

87 IFFIm. Homepage. [cited 29 Jan 2025]. Available from: https://iffim.org/

88 IFFIm. How has IFFIm made a difference for Gavi? 2022 [cited 29 Jan 2025]. Available from: https://bit.ly/42VJ6Jx

89 IFFIm. How has IFFIm made a difference for Gavi? 2022 [cited 29 Jan 2025]. Available from: https://bit.ly/42VJ6Jx

90 Berkley S, Anderson M. How innovative financing will help prepare for future pandemics. World Economic Forum [Internet]. 2022 Apr 7 [cited 2025 Jan 29]; Available from: https://bit.ly/42nZUbV

91 Hughes-McLure S, Mawdsley E. Innovative Finance for Development? Vaccine Bonds and the Hidden Costs of Financialization. Economic Geography. 2022 Mar 15;98(2):145–69. Available from: https://bit.ly/3Est40v

92 Dentico N. Banking on Health: the surging pandemic of health financialization. Society for International Development (SID). 2023 Apr [cited 2024 May 24]. Available from: https://bit.ly/3RuUdTl

93 Usher AD. COVID-19 vaccines for all? Lancet (London, England). 2020; 395(10240): 1822-3. Available from: https://bit.ly/4lBePqJ

94 de Haan E, ten Kate A. Pharma's Pandemic Profits Pharma profits from COVID-19 vaccines. Amsterdam: SOMO. 2023 Feb. Available from: https://bit.ly/4cGbsuy

95 Eccleston-Turner M, Upton H. International Collaboration to Ensure Equitable Access to Vaccines for COVID-19: The ACT-Accelerator and the COVAX Facility. Milbank Quarterly. 2021 Jun;99(2):426–49. Available from: https://bit.ly/44yxNZ2

96 de Haan E, ten Kate A. Pharma's Pandemic Profits Pharma profits from COVID-19 vaccines. Amsterdam: SOMO. 2023 Feb. Available from: https://bit.ly/4cGbsuy

97 Ndembi N, Dereje N, Nonvignon J, Aragaw M, Raji T, Fallah MP, et al. Financing pandemic prevention, preparedness and response: lessons learned and perspectives for future. Global Health. 2024 Aug 21;20(1):65. Available from: https://bit.ly/42CsSUf

98 Brown GW, Rhodes N, Tacheva B, Loewenson R, Shahid M, Poitier F. Challenges in international health financing and implications for the new pandemic fund. Global Health. 2023 Dec 5;19(1):97. Available from: https://bit.ly/42WcJdK

99 Bell D, Brown GW, von Agris J, Tacheva B. Urgent pandemic messaging of WHO, World Bank, and G20 is inconsistent with their evidence base. Global Policy. 2024 Sep;15(4):689–707. Available from: https://bit.ly/4jC01GA

100 Paul E, Brown GW, Bell D, Ridde V, Sturmberg J. Preparing for pandemics needs a dose of public health and a booster of "complex thought" (Errare humanum est, perseverare diabolicum). Global Policy. 2024 Nov;15(5):969–78. Available from: https://bit.ly/3YJGa02

SECTION E

Resistance, actions and change

National Struggles for the Right to Health

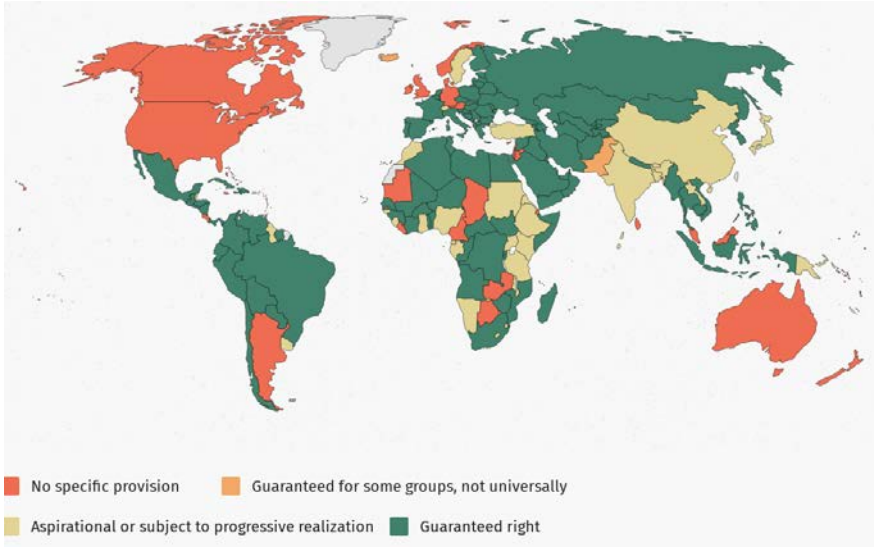
In the wake of World War II, international human rights law started gaining legitimacy as a mechanism for maintaining peace and promoting wellbeing. The broad understanding of health as defined in the Constitution of the World Health Organization (WHO) was reflected in other United Nations (UN) agreements. In 1948, the Universal Declaration of Human Rights stated that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."[1] Building on this agreement, in 1966 the UN adopted the International Covenant on Economic, Social and Cultural Rights (ICESCR), which guarantees the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" calling on states to fulfill this right through disease prevention, the reduction of infant mortality and universal access to medical services.[2] In detailing this right, the UN Committee on Economic, Social and Cultural Rights affirmed that "the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends 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."[3]

At the national level, health rights have become more common over time. Only 29 per cent of the current constitutions adopted before the 1970s explicitly protect health for all citizens, while health is emerging as a priority area among newer constitutions.[4] All constitutions adopted in 2000-2017 include the right to health, public health and/or medical care. Significantly, all four of the constitutions newly adopted following the Arab Spring, in Egypt, Tunisia, Libya and Yemen, guarantee in different forms the right to health and / or healthcare.[5]

Overall, 74 per cent of countries worldwide include some form of protection for the right to health in their constitutions (see Figure 1): 58 per cent guarantee health rights, while 16 per cent specify that health rights are aspirational or subject to progressive realization.[6]

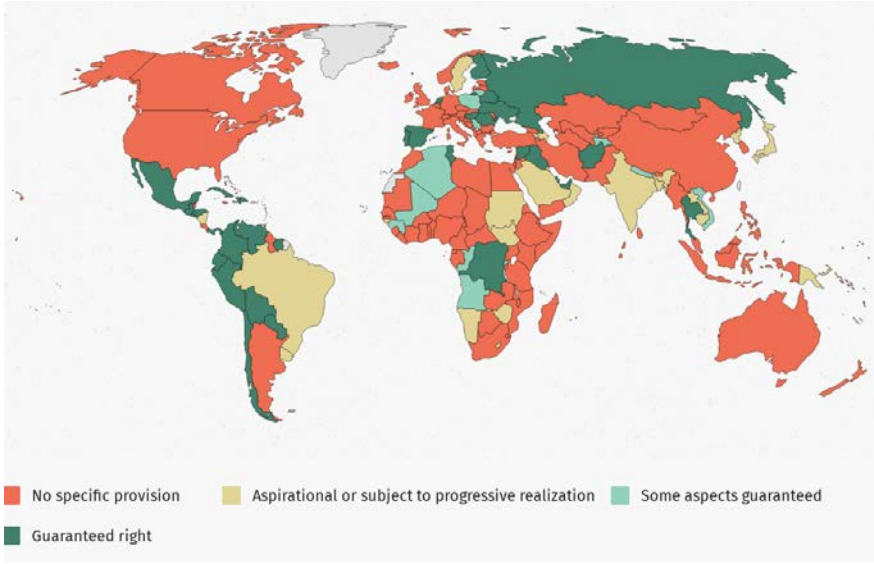
In terms of health rights coverage at the national level, however, the situation varies greatly. In order to address the right to health, constitutions must address both access to health services and the social determinants of health. Protecting and enforcing the right to public health, rather than medical care alone, helps prevent diseases and injuries rather than treating them after they occur. The

Figure 1: Constitutions that explicitly guarantee an approach to the right to health



World Policy Analysis Center. Map reflects constitutions in place as of January 2022.

Figure 2: Constitutions that explicitly guarantee citizens' right to public health



World Policy Analysis Center. Map reflects constitutions in place as of January 2022.

rights to clean water, sanitation and a healthy environment are all aspects of public health. However, relatively few constitutions protect public health for all citizens: 56 per cent address medical care, 47 per cent address the right to health generally, and 36 per cent address public health (see Figure 2). This means that, far more often, countries guarantee a right to medical care than a right to preventive healthcare. Moreover, countries that provide a broad right to health have overwhelmingly interpreted it as a right to medical care.[7]

Among the constitutions guaranteeing the right to public health, the provisions vary widely in scope. Some countries focus narrowly on preventing the spread of disease or providing for specific public health measures, while other constitutions provide for broader public health protections such as organizing a national public health system. Interestingly, although relatively few countries explicitly guarantee the right to public health, nearly half guarantee the right to a healthy environment.

Having the right to health enshrined in the national constitution is not absolutely necessary to fulfill its obligations, as a comprehensive social safety net in legislation and policy may also achieve the goals of fostering healthy environments and ensuring universal quality care. However, evidence suggests that constitutional health rights have the potential to yield additional benefits that strengthen health systems overall[8] including through providing tools for advocacy.

In this chapter we explore through six case studies – from Rajasthan (India), Mexico, Colombia, Kenya, South Africa and Argentina – the interplay between legal provisions in favor of the right to health and the efforts of social movements to promote them, highlighting their shortfalls and proposing how to address them and monitoring the gaps towards their real implementation.

The first three case studies illustrate examples of comprehensive reforms implemented at the state or national level by progressive governments, backed by strong social movements. In different ways, the case studies show that resistance to change may come from within the health sector itself, when corporate interests are threatened. In the case of Colombia, such interests are so powerful that a full reform cannot be enacted. The two case studies from the African continent, from Kenya and South Africa respectively, show attempts to ensure coverage for healthcare services through public insurances. The role of social movements in these countries has been to critically analyze the reforms demonstrating their shortfalls and proposing measures to strengthen their impact on health and equity. Finally, the last case study from Argentina focuses on a reform of mental health care. A progressive legislation focusing on deinstitutionalization, human rights, holistic care and participation was approved as the result of sustained advocacy by human rights organizations, mental health professionals and civil society groups. Despite this success, activists are denouncing an uneven implementation of the provision, revealing significant gaps between legislative

intent and practical outcomes. Overall, the case studies demonstrate how, in many cases, progressive legislations are the result of social struggles, and how sustained mobilization is needed in order to move from a right on paper to a right that is fulfilled for all citizens.

The Right to Health Act in Rajasthan (India): from civil society's triumph to an uncertain future

Rajasthan, the largest state of India, on 21 March 2023 became the first and the only state in the country to legislate the right to health. The "Rajasthan Right to Health Act-2022"[9] (RTH Act) aims to protect and fulfil rights and equity in health, as stated in its preamble. The Act is being hailed as a landmark legislation (as the Indian Constitution does not explicitly provide a fundamental right to health) and the RTH Act is the first ever law in the country that distinctly provides a legal framework for health rights. For a state like Rajasthan with historically weak health indicators, this Act can be hugely transformative.

Provisions of the RTH Act

Contrary to its title, the Act largely focuses on enhancing access to 'health care' rather than addressing the wider determinants of health. Most of the Act caters to strengthening the public health care system and has little on private sector regulation except for the sections on emergency treatment and patients' rights which apply to all health institutions.

One of the most important provisions in the Act is the commitment to provide all health care services, including medicines and diagnostics, completely free from public health establishments to every resident of the state. This provision builds on Rajasthan's earlier schemes such as that of free medicines (2011), free diagnostics (2013) and elimination of all user charges from public health care facilities (2022) with the aim to enhance access to health care and reduce out of pocket expenditure on treatment. The Act also ensures emergency health services in case of accidents and animal bites from private health establishments without any prepayment, committing the government to pay for the services if the patient cannot afford to. This section was one of the Act's major points of contention as we discuss later in this chapter.

The Act outlines various patients' rights and commits to safeguarding the rights of health care providers. It also calls for the establishment of a grievance redressal mechanism and even includes penalties in case of rights violations. For advisory, planning and monitoring purposes and to cater to patients' grievances, the Act mandates the constitution of State and District Health Authorities. The Act also lays down the various obligations of the government such as allocating an adequate health budget.

Civil society struggles and advocacy

The RTH Act is an outcome of years of advocacy by civil society groups in the state led by Jan Swasthya Abhiyan (JSA) Rajasthan (the state chapter of People's

Health Movement India), which called for a legal framework for protecting health rights. The rationale for the demand lay in the fact that Rajasthan, despite some extremely progressive health schemes and relatively decent health infrastructure, continued to struggle with health care delivery gaps alongside high out of pocket payments and below par health outcomes. The JSA's campaign for the Act gained momentum just before the State Legislative Assembly elections of 2018 when it vigorously pushed political parties to commit to the RTH Act in their election manifestos. The party which eventually won the election had done so.

This was followed by JSA's sustained campaigns to push the newly formed government to legislate the Act. JSA provided the first ever blueprint of the Act to the government and maintained continuous public and political pressure for its passage. When the Act faced fierce opposition from the doctors, JSA led counter-campaigns through mass and social media to highlight its importance. They also organized diverse interventions including social media campaigns, memorandum submissions and public meetings to foster public solidarity around the Act.[10]

Agitation by doctors and compromises made into the Act

The Act in its journey faced one of the largest doctor-led protests in the history of the country. Private doctors vehemently opposed the Act, labelling it as "draconian", "anti doctor" and "anti-patient". They perceived that it was a futile law which would sabotage the private health care sector in the state and demanded its withdrawal. The protests were marked by sporadic strikes, huge rallies and massive media campaigns against the Act. The agitation also marked complete shutdown of private health institutions in the state for more than two weeks terribly crippling health care services and causing huge inconvenience to the patients. The protests garnered support from doctors in other states, too. While government doctors refrained from overtly opposing the Act there were instances when a section of them implicitly supported the ongoing protests by private doctors by wearing black ribbons on arms and suspending services briefly. Despite the protesting doctors trying to portray the Act as "anti-patient", people of the state largely appeared to be in favor of the Act as was evident from discussions and citizen led rallies and sit in protests held in different places. While JSA made substantial efforts to translate this support into large scale public mobilization to effectively counter the protests, this remained challenging and met only limited success.

To calm down the agitation, the government was compelled to make some serious compromises in the Bill, such as removing public health experts and local people's representatives from the health authorities and diluting the grievance redressal mechanism. Additionally, as part of negotiations external to the Act, the applicability of the Act on private health institutions was agreed to be limited to medical college hospitals and hospitals with more than 50 beds availing government subsidies, or those under public private partnership.

Current status of the Act, lessons and the way forward

While the Act was passed in March 2023, its implementation remains stalled in the absence of formulation of detailed rules and guidelines. With the change in the state government in late 2023, progress in framing the rules seems to be in a limbo with the new government showing little interest in taking things forward. The future of the Act thus remains uncertain, while civil society groups like JSA continue to advocate for the Act's implementation.

The journey of Rajasthan's RTH Act reaffirms how sustained advocacy rooted in public interest can yield significant results even if it takes a while. It also underscores the significance of mass awareness and people's engagement in a campaign. While it exposes how private interests may obstruct public health goals, it also reassures that if there's a political will any impediments can be overcome.

The future of RTH Act in Rajasthan yet again depends on the efforts by the civil society in pushing for the framing of the rules and their implementation. Hopefully, the Act will overcome the challenges as it did before and will soon see effective implementation. The Act is also envisaged to pave the way for other states to legislate similar laws ensuring health rights across the country.

The right to health during Mexico's Fourth Transformation*

Since 2018, Mexico has been experiencing a significant shift with the arrival of a left-wing government, the result of a social movement that, for over a decade, transformed public outrage into hopeful activism. Under the presidency of Andrés Manuel López Obrador[11] the new government called on its members to commit to dismantling a neoliberal model that, over five decades, had severely impacted fundamental social rights, including the right to health.

Redefining health priorities in a new political scenario

The Fourth Transformation has faced the challenge of redefining health priorities within a fragmented system that could not be fully deconstructed quickly. Given these constraints, the government chose to address two deeply rooted issues as priorities: corruption and the privatization of the healthcare system. In this vein, a constitutional reform was promoted to establish the State's role as the principal guarantor of public health. This led to creating a new institution, the Instituto Mexicano del Seguro Social (IMSS) Bienestar[12] which has centralized healthcare services under the federal government's authority in 23 of the 32 states (the governors of the outstanding states have not joined the federalization), promoting equity in access and quality of health services for the uninsured population.

*Mexico has undergone four major transformations. The first was its Independence from Spain; the second, the Reform War, which separated the clergy from the State; the third, the Mexican Revolution; and, since 2019, we have experienced the Fourth Transformation of public life in the country, peacefully and without violence.

Community engagement for the right to health

During the neoliberal era, so-called "civil society" primarily operated through organizations that obtained tax benefits from donations made by private corporations and agencies like USAID, fostering a sector more aligned with private interests than with advocating for the right to health. In contrast, the Fourth Transformation encouraged the involvement of activists and workers from social movements within the healthcare system, promoting republican austerity* and focusing on collective health and community well-being.

An essential strategy in this context has been to work directly with communities to redefine health as a social right. The COVID-19 pandemic illustrated how health as a human right was sometimes used for selfish purposes, with individual interests often prioritized over the common good. For example, when the first vaccines, such as Pfizer's, became available, it was impossible to immunize the entire population. Thus, vaccines were administered in stages, starting with healthcare workers treating COVID-19 patients. The second phase included national authorities, like the president, teachers, the elderly, and people with chronic illnesses. Subsequent stages prioritized other vulnerable groups. Seven out of ten Mexicans patiently waited for their turn to be vaccinated. Through campaigns and field activities, the government promoted the importance of prioritizing the common good, encouraging the population to protect and promote collective health actively. This shift has reinforced solidarity and a sense of community responsibility around public health.

Specific organizations that previously enjoyed tax benefits expressed criticism of the Fourth Transformation, defending their interests under the guise of being a "social movement." However, this period also revealed the persistence of patriarchal privileges within some organizations, where men continued to intervene in women's spaces, such as midwifery. In response, the government is working to ensure that the right to health is genuinely inclusive, respecting women's knowledge and rights in their practices and traditional knowledge.

Reforms within the healthcare system

Another essential advancement in this transformation has been the creation of the "megafarmacia para el bienestar", a centralized resource guaranteeing free access to prescribed medications in public health institutions. This initiative, supported by revitalizing national laboratories, has been essential for reducing dependency on private pharmaceutical companies and advancing the country toward greater health sovereignty.

*The principle of austerity in contemporary Mexico aims to use the health budget more efficiently. Previously, more than 50 per cent of this budget was allocated to salaries. When President Andrés Manuel López Obrador took office, he reduced his salary and ruled that no public official could earn more than the president. As a result, officials now receive a modest salary, but one that is sufficient to live with dignity. Another measure was to improve the organizational structure by eliminating duplicated areas to optimize resources.

For the second phase of the Fourth Transformation (2024-2030), with Claudia Sheinbaum Pardo as the first woman president, there are plans to formally integrate traditional medicine into the healthcare system across all states, recognizing its cultural value and contributions to comprehensive care. One challenge will be the local restructuring of the health system and the strengthening of comprehensive and integrated primary health care. A current tendency to prioritize curative over preventive services limits the reach of public health policies.

Way forward

Eight out of ten citizens in Mexico support the Fourth Transformation. This broad acceptance is partly explained by the fact that each decision is communicated and explained to the public, and, when necessary, submitted to popular decision through citizen consultation. In this context, the population has understood and accepted this reengineering of the health system. The detractors represent the remaining 20 per cent of the population, with a conservative and largely exclusionary ideology, favoring only allopathic medicine and supporting transnational pharmaceutical companies.

In sum, the health reforms promoted by the Fourth Transformation aim to redefine the right to health in Mexico with an active role for the State as the guarantor of this right. Through actions aimed at combatting corruption and privatization, alongside the federalization of services and incorporating traditional and community practices, Mexico is advancing toward a more equitable and socially responsible healthcare model.

Attempts to institutionalize the right to health in Colombian legislation

The institutionalization of the right to health in Colombian legislation has been one of the components of the political struggle in health that has taken place in this country over the last three decades. The struggle was between the hegemonic sectors that developed health as a private consumer and market good against the counter-hegemonic sectors that understand health as a common good and a fundamental human right.

The right to health or the right to privatize health?

The Colombian Constitution of 1991 did not establish health as a fundamental human right, but rather as a public service run by public and private entities regulated by the State. This constitutional decision laid the groundwork for a process of privatization of the health system, which was implemented with Law 100 of 1993[13], based on the approach of structured pluralism.

This Law established a health insurance system with the participation of insurance companies, mainly of a private nature, which took control of the public resources of the health system. With the subsequent approval of Law 100, a political dispute intensified in Colombia between various political, social, union and academic sectors over the type of orientation of the health system and the recognition of health as a fundamental human right.

This social confrontation, which took many years and multiple exercises of denunciation, collective action and demand from various expressions of the social health movement in Colombia, bore fruit with the issuance in 2015 of Law 1751, known as the Statutory Health Law (LES, for its acronym in Spanish).[14] LES explicitly enshrined health in the constitutional order as a fundamental right and established the basis to guarantee its effective protection. Its implementation, however, has faced challenges due to the structure of the health system model based on insurance through assurance entities and service providers, which generated a mixed, fragmented and inequitable vision of access to care. As part of the political contest, since 2015 the social health movement in Colombia has been demanding that the LES be truly implemented, an issue that has not yet been achieved.

The health system reform: health as a public good

The current administration of President Gustavo Petro (2022-2026) proposed a comprehensive reform of the health system, which has sought to align the legislation and the service delivery model with the principles of the LES with a focus on guaranteeing the right to health as a public good rather than as a business. The objectives of the health system reform proposed by the Petro government include the need for the State to take a more active role in the management and provision of health services, eliminating the financial intermediation of insurers, with the State contracting directly with the service provider network, thereby strengthening the public care network to guarantee equitable coverage throughout the national territory. This coverage would be organized under the PHC approach with services that are not limited to curative care but that include health promotion and disease prevention and prediction, aligning with a comprehensive public health approach.

This proposed reform of the health system has reflected many of the historical aspirations of social and health professional associations and trade union movements in the health sector. This is why it has received the support of these sectors with public statements, the development of forums and public debates, presence in the Congress of the Republic and with mobilizations, among other strategies, although the reform has not had broad popular support due to confusing reporting by the mass media to create opposition to it. In particular, health workers have supported the reform initiative but have stated that the proposals for the formalization of the workforce in this sector must be adjusted to overcome the precariousness of work established by the neoliberal labor and social security policies in health at the beginning of the 1990s.

Lessons learned and future prospects

This experience of promoting a reform of the health system leaves us with the lessons that the design of a good technical proposal by the government is not enough, even when it reflects the historical aspirations in this field of the social

and labor sectors. A broad social and popular mobilization is required to achieve a reform of this type, as it is necessary to confront and prevent the political and economic sectors that historically control the health sector from continuing to do so, and to apply social pressure on the Congress of the Republic to make legislative decisions that effectively guarantee the right to health.

The content of the reform must seek to truly overcome the vested interests of the medical-industrial-pharmaceutical and insurance complex and effectively manage to go in a different direction to that imposed by the hegemonic biomedical model, because otherwise it means reforming the system so that everything remains the same.

It is certainly not possible to comply with the LES without reforming the health system, which removes health from the commercial logic and ensures equitable and fair access to health based not on people's ability to pay, but on their social and health needs. At the moment, the hegemonic sectors have not allowed the approval the health system reform in the Congress, and the political battle to institutionalize and operationalize the right to health in Colombian legislation is still in force.

The right to health in Kenya: legal framework and recent developments

The right to health is enshrined as a fundamental human right in the Constitution of Kenya, 2010, which provides a comprehensive legal framework for health services based on human rights.[15] Article 43(1)(a) ensures every person the right to the highest attainable standard of health, including sexual and reproductive health rights. Articles 43(2) and 43(3) guarantee emergency medical treatment and social security for those unable to support themselves. For children and marginalized groups, the constitution mandates affirmative action to ensure reasonable access to health services and other basic amenities. Nevertheless, healthcare workers continue to violate this provision especially as gay men stay silent for fear of harassment or stigma. In most cases the Kenyan LGBTQIA+ do not reveal their sexual identity while accessing health care, unlike refugees in the refugee camps and those living in urban areas where their status is known. This exposes them to risks of attack and discrimination while accessing healthcare services, such as being denied treatment.

Universal health coverage and national hospital insurance fund reforms

Kenya has prioritized universal health coverage (UHC) through the National Hospital Insurance Fund (NHIF), which had previously provided medical cover to government staff and salaried employees of private firms in the formal sector.[16] In 2015 NHIF introduced new premium contributions, expanded benefits and reformed provider payment methods. These reforms have faced challenges. Premiums were unaffordable for the majority of Kenyans working in the informal sector. Further, the changes were inadequately communicated, creating barriers

for equitable access. Additionally, health services were distributed unevenly, favoring urban areas and private providers, which undermined access to services for rural communities and the urban poor. The new provider payment rates were often delayed, which impacted service quality and financial accountability. Finally, social accountability was consistently undermined, with NHIF governance manipulated for political spoils.

In 2018, the Kenyan government piloted a new model for UHC in four of the country's 47 counties. By mid-2019, PHM Kenya and others across civil society were already identifying major gaps in both the design and implementation of this flawed UHC model. In early 2020, all four governors in the four pilot counties declared the UHC pilot a failure and suspended further implementation. The onset of the COVID-19 pandemic in March 2020 further exposed the gaps in the national and county health systems.

Social Health Insurance Fund Act and new health laws

Health remained a key social and political priority through the 2022 national elections, which led to a change in government. During the political campaigns, health was a priority for both major political formations and was part of their manifestos, so to some extend health played a role even if the election was won based primarily on better economic promises.

In 2023, the new Kenyan government promised free healthcare and later announced the dissolution of NHIF, replacing it with the Social Health Authority (SHA) under the Social Health Insurance Fund Act 2023 (SHIF Act).[17] Despite aims to broaden coverage and reduce out-of-pocket expenses, the SHIF Act introduced several contentious elements:

- The benefits package does not match with premium contributions to market rates, particularly affecting low-income households.
- Contributions, set at 2.75 per cent of gross salary, are higher than under NHIF, potentially creating financial strain, especially for those also paying for private insurance.
- The contribution framework for informal workers relies on a means-testing instrument that lacks validation, risking inequity and discrimination against these workers.

These issues were addressed in a court ruling that deemed the SHIF Act and accompanying laws unconstitutional due to their design flaws, lack of required public notice and participation, and inequitable impact on certain populations.

Challenges and struggles

PHM Kenya and other civil society organizations mobilized and together evaluated the proposed Act and its accompanying new laws (bills), analyzed gaps in the bills and presented a petition to the parliament for consideration, identifying these concerns:

- There is no clear definition of emergency care.
- No representation of civil society seats on the SHIF board.
- The benefits package under SHIF are much lower than the market rate.
- The lower benefits package for households with lower tariffs would be discriminating.
- The structure of benefits and contribution promotes classism, thus giving better quality care to those with higher incomes.
- Identification of the destitute through use of means testing tool is likely to attract costly administrative implications.
- Emergency treatment and ambulance costs are not covered.
- It eliminated the provision for return of unused funds to treasury (consolidated fund) at the end of each financial year.

The parliament ignored the proposals by civil society and hurriedly passed the bills into law on 27 September 2023, comprising the Primary Health Care Bill, the Digital Health Bill, the Facility Improvement Bill and the Social Health Insurance Bill.

There has been a serious gap in the service delivery by the health service providers during the system changeover from NHIF to SHIF that left patients without cover as they were neither in SHIF nor in NHIF. Patients seeking dialysis and oncology care were at risk of not being able to access services affordably and on time.

Figure 3: PHM Kenya comrades in solidarity with Kenya Medical practitioners and dentists Board championing for better healthcare system and advocating for the right to access proper healthcare

PHM Kenya

Public participation and multi-stakeholder engagement

PHM Kenya submitted a memorandum to Parliament with recommended changes to the health laws. Meanwhile, the government initiated a national rollout of the new SHA program from 1 October 2024 following a stay order on the high court ruling, although public concerns about the reforms remain high, and many analyses of its design identify serious flaws in terms of equity and universality of coverage, affordability, accountability and even gaps in benefits as compared to the flawed NHIF that is being replaced.

PHM Kenya continues to highlight service delivery strengths and lapses in SHIF through workshops and campaigns targeting health activists, service consumers and grassroots service providers, in trying to demystify SHA including constitutional health rights in Kenya.

The National Health Insurance Act in South Africa

In May 2024 South Africa passed the National Health Insurance (NHI) Act into law.[18] The Act establishes a National Health Insurance Fund that will be financed through a mandatory prepayment system. This fund aims to move South Africa towards a "single payer" system that provides a comprehensive package of health care services free at the point of care. Both public and private providers can apply to provide services and receive payments from the fund, and private medical aid schemes will eventually only be able to finance services that are not covered by the NHI Fund (though these have not yet been specified). The fund will only be used to purchase services for citizens, permanent residents and inmates in detention facilities. Adult asylum seekers and undocumented foreign nationals are only eligible to receive coverage for notifiable conditions and emergency medical services. All children, regardless of nationality, will be eligible for the full package of benefits purchased by the NHI Fund.

Reaction by Social Movements

People's Health Movement South Africa (PHM SA) took part in a series of actions and engagements aimed at advancing a "People's NHI" that points out the dangers of corporate capture under the current version of the NHI Scheme.[19] These dangers stem from the fact that there is no clear legal framework for: (1) ensuring community participation in decision-making about resource allocations, (2) prioritizing allocation of NHI funds to facilitate improvements in and expansion of the public health system, (3) operationalizing an intersectoral and preventative approach to health care, and (4) ensuring that everyone in South Africa has access to healthcare, including non-citizens.

From the time the first draft of the NHI Bill was published PHM SA organized several interventions aimed at ensuring it creates more than just a public financing model, and to prevent public resources being used to subsidize and strengthen the private sector. This included co-hosting a strategy seminar in 2010 with key civil society organizations with the objective of influencing the NHI Green Paper (released in 2011).[20]

Figure 4: Activist mobilizing for National Health Insurance

Rosetta Msimango/Spotlight www.SpotlightNSP.co.za

Subsequently, PHM SA drafted 5 different submissions on various iterations of the Bill,[21] including a special "Young People's Position Paper" on the 2015 NHI White Paper. The content of these submissions was generated collectively by the PHM SA steering committee and in consultation with community health workers (CHWs), community health forums, and clinic committees that PHM SA works with. An archive of the numerous NHI materials PHM SA has developed can be found online,[22] including more recent analyses of the NHI.[23,24,25]

NHI shortcomings and way forward

These contributions, in collaboration with those of other civil society organizations such as SECTION27, helped to increase oversight and accountability provisions in the NHI Act. The NHI Act, however, remains problematic in a number of ways: the legislation enacts a health financing mechanism but does little to:

- regulate private actors in the health market as recommended by the Competition Commission in its Health Market Inquiry;[26]
- specify legally binding obligations to ensure the strengthening of the public health sector;
- give formal recognition to CHWs as public sector employees;
- include mechanisms for communities to hold to account private sector actors that provide services under the NHI;
- give all non-citizens full access to the rights and privileges granted to citizens and permanent residents;
- address the climate impact of the health system; and
- move beyond being illness- and hospital centric.

PHM, alongside other civil society organizations in South Africa, continue to organize to address these shortcomings in the legislation, and to defend the principle of a primary care oriented and solidarity-based health system from co-optation by private healthcare providers and their allies.

The implementation of National Mental Health Law in Argentina

The enactment of Argentina's National Mental Health Law (Law 26.657) in 2010 marked a milestone in the country's legislative framework for health.[27] This law was celebrated as a progressive step toward institutionalizing the right to health, specifically mental health, within a human rights framework. It emphasized deinstitutionalization, community-based care and the protection of human rights for individuals with mental health conditions. Despite its groundbreaking approach, the law's implementation has faced numerous challenges revealing the complexities of translating legislative gains into tangible improvements for health equity.

Background: the right to health in Argentina

Argentina's health system is characterized by a mix of public, private and social security sectors, with disparities in access and quality of care. Historically, mental health was a neglected area, with policies heavily reliant on institutionalization in psychiatric hospitals. Patients were often subjected to poor living conditions and human rights abuses. The National Mental Health Law aimed to address these systemic failures by aligning Argentina's mental health policies with international human rights standards, including the United Nations Convention on the Rights of Persons with Disabilities.

Key provisions of Law 26.657

The law was groundbreaking in several ways:

1. Deinstitutionalization: it mandated a shift from hospital-based care to community-based services, aiming to integrate individuals with mental health conditions into society.
2. Human rights focus: it prohibited involuntary treatment and the prolonged institutionalization of individuals, unless under strict judicial review.
3. Holistic care: the law advocated for an interdisciplinary approach to mental health, integrating social, psychological and medical perspectives.
4. Participation: it emphasized the involvement of individuals with lived experiences and their families in the design and implementation of mental health policies.

The role of social movements

The passage of Law 26.657 was the result of sustained advocacy by human rights organizations, mental health professionals and civil society groups. These actors highlighted the abuses within the psychiatric system and framed mental health as a fundamental human right. The movement also drew strength from broader

campaigns for social justice and equity in Argentina, leveraging the country's robust tradition of activism.

Challenges in implementation

Despite its promise, the implementation of the law has been uneven, revealing significant gaps between legislative intent and practical outcomes:

1. Insufficient resources: the transition from institutional to community-based care requires substantial investment in infrastructure, workforce training and social support systems. However, funding for mental health has remained limited, with less than 2 per cent of the national health budget allocated to the sector.
2. Resistance from institutions: psychiatric hospitals, which have historically dominated mental health care in Argentina, resisted the changes mandated by the law. This resistance has slowed the process of deinstitutionalization.
3. Lack of training and awareness: many healthcare professionals lack the training to adopt the interdisciplinary and human rights-oriented approach required by the law. Public awareness of the rights enshrined in the legislation is also low, limiting its impact.
4. Judicial bottlenecks: while the law requires judicial oversight for involuntary treatment, delays and inconsistencies in the judicial process have often undermined the protection of patients' rights.

More than a decade after its passage, the National Mental Health Law's transformative potential remains only partially realized. Deinstitutionalization is far from complete, and community-based services remain underdeveloped. Moreover, stigma and discrimination against individuals with mental health conditions persist, undermining the law's goal of social inclusion.

Lessons learned and strategies

Several lessons emerge from Argentina's experience with Law 26.657:

1. Sustained advocacy is crucial: the role of social movements in pushing for the law's enactment demonstrates the importance of grassroots mobilization. However, these movements must remain active to ensure effective implementation.
2. Institutional resistance requires addressing power dynamics: the reluctance of traditional psychiatric institutions to adopt the new framework highlights the need for political will and leadership to overcome entrenched interests.
3. Investment in community-based care: adequate funding and resource allocation are critical to realizing the law's vision of community-based mental health services.

4. Public engagement: raising awareness about mental health rights among the general population can create pressure for better implementation and hold institutions accountable.

Argentina's National Mental Health Law offers valuable insights into the complexities of institutionalizing the right to health through national legislation. While it represents a significant legislative achievement, its challenges underscore the need for continued activism, adequate funding and systemic reform to translate legal frameworks into real-world equity and justice. The case of Law 26.657 is a poignant reminder that legislative victories, though essential, are only the beginning of the struggle for health as a human right.

Conclusion

Over the past few decades, a growing number of constitutions and legislations across the world have started to recognize and enforce the right to health, shaping citizens' access to public health and medical services.[28] Despite the challenges explored in this chapter, this has both yielded positive impacts for individuals and populations, and allowed for structural improvements to national health systems.

As the case studies in this chapter illustrate, the growing recognition of the right to health is the result of decades of social struggles in which social movements, including health movements, have played a central role. The challenge for such movements is to sustain the advocacy effort which often requires skills and capacities at both the technical and analytical level, and at the level of popular mobilization. As the cases of Colombia and Argentina show very well, without the capacity to alter the power dynamics and challenge the interests of those who benefit from the status quo, any reform project becomes disempowered. Moreover, activist pressure must be sustained over time to move from a good legislation proposal, to its approval without compromises that weaken it, to its real implementation. Despite the described limitations, all case studies show that the engagement of social movements and civil society activism are essential drivers of any reform that may enhance the recognition and the enforcement of the right to health.

Reference List

1 United Nations General Assembly. Universal Declaration of Human Rights. United Nation General Assembly; 1948 Dec. Report No.: A/RES/217(III). Available from: https://bit.ly/4kvCis0

2 United Nations General Assembly. International Covenant on Economic, Social and Cultural Rights. 14531 Dec 16, 1966. Available from: https://bit.ly/3SM5uz9

3 United Nations Economic and Social Council. General Comment No. 14: The Right to the Highest Attainable Standard of Health. UN Committee on Economic, Social and Cultural Rights; 2000 Aug. Report No.: E/C.12/2000/4. Available from: https://bit.ly/4je5hja

4 Heymann J, Sprague A, Raub A. Advancing Equality: How Constitutional Rights Can Make a Difference Worldwide. California: University of California Press; 2020. Available from https://doi.org/10.1525/luminos.81

5 Saleh SS, Alameddine MS, Natafgi NM, Mataria A, Sabri B, Nasher J, et al. The path towards universal health coverage in the Arab uprising countries Tunisia, Egypt, Libya, and Yemen. The Lancet. 2014 Jan;383(9914):368–81. Available from: https://bit.ly/43byxCq

6 World Policy Analysis Center. Constitutional Approaches to the Right to Health. WORLD Policy Analysis Center. 2020. Available from: https://bit.ly/3SNozRz

7 Heymann J, Sprague A, Raub A. Advancing Equality: How Constitutional Rights Can Make a Difference Worldwide. California: University of California Press; 2020. Available from: https://bit.ly/4dy5ZGP

8 Heymann J, Sprague A, Raub A. Advancing Equality: How Constitutional Rights Can Make a Difference Worldwide. California: University of California Press; 2020. Available from: https://bit.ly/4dy5ZGP

9 PRS Legislative Research. The Rajasthan Right to Health Bill, 2022. Rajasthan; 2022. Available from: https://bit.ly/4jq8ufK

10 Newsclick. JSA urges Raj Govt to make clarifications in health bill to ensure effective implementation. Newsclick. 2023 Apr 3; Available from: https://bit.ly/3FudxNY

11 López Obrador AM. A mitad del camino. México: Editorial Planeta Mexicana; 2021. 327 p.

12 Secretaría de Salud. IMSS Bienestar. 2023; Available from: https://imssbienestar.gob.mx/

13 El Congreso de la Republica de Colombia. Ley 100 de 1993. 41.148 Diciembre, 1993. Available from: https://bit.ly/3SNovkN

14 El Congreso de la Republica de Colombia. Ley 1751 de 2015. 49427 Feb 16, 2015. Available from: https://bit.ly/4du8wBP

15 El Congreso de la Republica de Colombia. Ley 1751 de 2015. 49427 Feb 16, 2015. Available from: http://bit.ly/4du8wBP

16 National Health Insurance Fund (Kenya). Bima Bora Afya Bora! Available from: https://bit.ly/45cLSfh

17 Government of Kenya. The Social Health Insurance (General) Regulations. Available from: https://bit.ly/3H5v1kt

18 Department of Health Republic of South Africa. National Health Insurance Backgrounder. Available from: https://bit.ly/4kdD1OY

19 People's Health Movement South Africa. The People's NHI Campaign. People's Health Movement South Africa. Available from: https://bit.ly/43GCkYr

20 Department of Health Republic of South Africa. National Health Insurance in South Africa Policy Paper. 2011 Aug. Available from: https://bit.ly/3Ft5aCl

21 Health Justice Initiative. National Health Insurance Library: User guide. Available from: https://bit.ly/4dxyvbx

22 People's Health Movement South Africa. The People's NHI Campaign. People's Health Movement South Africa. Available from: https://bit.ly/43GCkYr

23 Bust L, van Duuren J, Reynolds L, London L, De Keukelaere A. Critical Health Perspectives #1: National Health Insurance in South Africa – A Brief History and Critical Analysis. People's Health Movement South Africa. 2022. Available from: https://bit.ly/4dtXBYB

24 Bust L, Reynolds L, Paremoer L, De Keukelaere A. Critical Health Perspectives #2: Financing of the South African National Health Insurance and involvement of the private sector. People's Health Movement South Africa. 2022. Available from: https://bit.ly/4dDRVvl

25 Twala B. Critical Health Perspectives #3: How strengthening governance can improve NHI. People's Health Movement South Africa. 2022. Available from: https://bit.ly/3SOg3li

26 Competition Commission South Africa. Health Market Inquiry: Final findings and recommendations report. Competition Commission South Africa; 2019 Sep. Available from: https://bit.ly/4kooZd0

27 Barcala A, Faraone S. Advancements in mental health reform in Argentina: towards comprehensive and human rights-respecting care. The Lancet Regional Health – Americas. 2023 Oct;26:100615. Available from: https://bit.ly/43AVBJO

28 Heymann J, Sprague A, Raub A. Advancing Equality: How Constitutional Rights Can Make a Difference Worldwide. California: University of California Press; 2020. Available from: https://bit.ly/4dy5ZGP

Taking Extractives to Court

As the climate crisis worsens there is a worldwide trend of climate litigation, in which governments (sometimes) and civil society groups (often) mount court challenges to private and public policies that threaten an increasingly perilous environmental health. Many of these court challenges have been brought by youth, Indigenous, and women's groups, as well as by environmental activist non-governmental organizations (NGOs):

- In Switzerland, a group of elder women took their country to court for its failure to protect the environment and stop climate change, arguing it violated their fundamental human rights. In April 2024 the European Court of Human Rights, after several lower court losses, ruled definitively in the group's favor.[1]
- In 2020, a local Zambian community successfully challenged a government decision to allow development in forest reserve that was source of half of the capital's (Lusaka) drinking water.[2]
- In 2021, Friends of the Earth Netherlands (on behalf of six other organizations and over 17,000 individual plaintiffs) won a court verdict requiring Shell to reduce its CO_2 global emissions by 45 per cent by 2030.[3,4]
- In 2024, Indigenous communities successfully challenged Shell government-granted rights to explore for fossil fuels off South Africa's pristine Wild Coast, specifically arguing a violation of their Indigenous rights.[5] A growing number of Indigenous-led court challenges are based on land rights and the loss of biodiversity resulting from resource extractions.
- In 2020, nine Ecuadorian girls lodged a constitutional injunction against their government for allowing gas flaring (open air pipes expelling high temperature natural gas) that damaged their environment, water, health, biodiversity loss, and climate change. In 2021 they won, and the government must eliminate all gas flaring by 2030.[6]
- In the US state of Montana, a youth-led group in 2023 won its case that the government, by prohibiting consideration of greenhouse gas emissions and climate impacts change in its energy and mining projects, violated their constitutional right to a clean and healthy environment.[7] The government has appealed the decision but no verdict on the appeal (as of January 2025) has been issued. Youth-led constitutional climate lawsuits, brought by the Our Children's Trust, a nonprofit offering free legal support to youth plaintiffs bringing court challenges to protect their rights to a safe climate, are also pending in four other states.[8]

Of 2,180 documented climate litigation cases, over 1,500 are in the USA, a highly litigious nation, although the number in other countries is rising rapidly.[9,10] An early and inspiring case was brought by citizen activists against the Netherlands government in 2013, demanding a more rapid abatement in CO_2 emissions to protect their human rights. Repeated government appeals failed, and the country's Supreme Court in 2019 sided with citizens in what is considered the first time a government was found responsible for reducing greenhouse gas emissions.[11] The government undertook a number of steps to comply with the judgement, albeit not quite meeting the initial target requirement of 25 per cent reduction by 2020.

Figure 1: Fossil fuel emissions

Chris LeBoutiller on Unsplash

The right to a healthy environment, and to a stable climate

Over 150 countries have the right to a healthy environment explicitly stated in their constitutions. In October 2021, a UN human rights council resolution recognized the human right to a clean, healthy and sustainable environment, subsequently adopted by the UN General Assembly in 2022. Invoking this and other fundamental human rights have been pivotal in most climate litigation cases, although not all cases win. Several that targeted EU government policies benefiting airlines responsible for 4 per cent of global warming failed. So did a 2022 Canadian case brought by a youth environment group that made arguments similar to those that succeeded in the Netherlands and Montana cases described earlier, but which were dismissed as outside the competence of the court. The ruling considered the youth claim that Canada's emission targets were insufficient to ensure their human rights and was found by the court to be a

political, rather than legal, concern.[12] Similar dismissals were made for several other youth-led litigations. Even the landmark Netherlands case experienced a setback: Shell appealed the initial lower court ruling and in November 2024, the appeal court ruled in favor of Shell. The court acknowledged the importance of reducing fossil fuel emissions for planetary and human health but ruled that no single company can be held responsible for emission targets that are global and industry-wide.[13]

But scores of new cases are still before the courts, many in the US and EU, and reasonably so, given their disproportionate historic contributions to the climate crisis. Although the Netherlands case in the end was not legally sustained, its losing court decision nonetheless clearly stated that people have a human right to be protected from fossil fuel emissions and climate change; and that Shell's plans for 800 new oil and gas projects were at odds with the Paris Agreement goals.[14] Friends of the Earth Netherlands (Milieudefensie) believe this ruling may provide a new opportunity for a court challenge, important given Shell's recent decision to pull back from investments in green energy and to focus on its fossil fuel holdings.[15] And in a separate case, a provincial appeal court in Canada reinstated a lawsuit brought by a youth group challenging the government's rollback of its climate change targets, acknowledging the 'right to a stable climate'. While the final outcome is still before the courts, the appeal court ruling:

> ...puts governments across Canada on notice that climate change targets and plans are not just "glossy brochures." When they make statutory commitments to combat climate change, governments must implement measures that actually "do something about climate change" and uphold Canadians' constitutional rights.[16]

Many of the newer cases target corporations for their contributions to greenhouse gas (GHG) emissions, directly via fossil fuel production and exploration, and indirectly through agricultural and food production and manufacturing practices. Recent cases in Norway and the UK (both in early 2024) ruled that climate change impacts must be considered with all new fossil fuel project developments.[17] Other cases directly challenge corporations over 'greenwashing' (false or misleading information about climate change) or failing to disclose known human and environmental health damages of their products or industry.[18]

Latin American activists pushing back against the extractives

Although much of the world remains under ecohealth threat by the predatory actions of mining and fossil fuel industries, Latin American countries have faced enormous challenges in holding the extractives to legal account. The experience of Panama's successful case that led to a nation-wide moratorium expresses both hope, and caution (Box E2.1).

Box E2.1: Panameños vs. Open-Pit Copper Mining

In late 2023, Panamanians took to the streets in record numbers to protest a mining contract between Canada's First Quantum Minerals and the Government of Panama.[19] For years, First Quantum has operated its massive open-pit copper mine in legal limbo in the ecologically sensitive Donoso protected area, having its concession declared unconstitutional in 2017. When a new contract was announced that would extend the mine's life 20 years, organizations like Panama Vale Más Sin Minería (Panama is Worth More Without Mining) – a coalition of conservation and environmental organizations, together with educators, workers, health professionals, youth groups, Indigenous communities and farmers – protested daily for nearly two months against the way the contract was awarded and the widespread environmental and social harm caused by existing mining operations.

The protests were met with excessive police force. Five people died, over 1,500 people were arrested, and 175 criminal cases were opened against individuals. Despite the violence, they achieved what many thought impossible: the Supreme Court declared the contract unconstitutional once again and the government declared a country-wide moratorium on new mining.[20] This historic victory against Toronto-headquartered First Quantum Minerals was the result of long standing national pedagogy about the socio-environmental impacts of the mine, street protests and legal mobilizations.

First Quantum inherited the mine's contract from another Canadian company, Petaquilla Gold, in 2013. Petaquilla had signed a contract with the Panamanian government in 1997, which the country's Supreme Court ruled unconstitutional in 2017 after Panama's Environmental Advocacy Center (CIAM) filed a lawsuit against it. The lawsuit argued that "the concession was given without public bidding, without consultation with the communities and without a true environmental impact study."[21] CIAM, which is also part of Panama is Worth More Without Mining, was "motivated to file this lawsuit because of the importance and urgency of protecting key ecosystems and the mine's surrounding rural communities from metallic mining." CIAM highlights that one of the strengths they see in undertaking such legal challenges in Panama is "that both legislation and jurisprudence has clearly established the active legitimacy of any citizen to act in defense of the Constitution and the Law."

However, there are many limitations in undertaking such challenges. As CIAM advocates explain, "Decisions related to environmental cases take a long time, between two or three years, and in the worst cases, nine or ten years. Furthermore, citizens are usually at a disadvantage with respect to the companies promoting these extractive activities. These are generally large companies with large budgets that do not skimp on having huge legal and technical teams, while citizens and communities only have the support of small organizations such as CIAM or independent lawyers with small practices, who try to challenge with little resources companies' sophisticated defenses in courts."

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Box E2.1 continued

The mine remains closed, with the mining company seeking permission to export over 120,000 tonnes of copper that sits stockpiled on top of the site. Polls suggest that Panamanians are of two minds about any future mining at the site, concerned with the impact of its closure on the country's revenue (when operating, about 5 per cent of GDP) while also worried about the environmental costs.[22]

Confronting legal counterchallenges

Legal challenges are not the sole prerogative of citizen or health and environmental activist groups. One of the key challenges corporations mount against citizen efforts to protect their health and environment take the form of 'investor-state dispute settlement' (ISDS) suits. Bilateral and regional investment treaties, initially intended to promote foreign investment for development purposes in low-income countries, entitle foreign investors to challenge government policies or regulations that they consider undermines the value of their investment. International investment treaties and ISDS cases mushroomed in the 1990s and early 2000s, leading to multi-billion dollar claims by foreign investors, many involving government actions to protect their environments, meet their human rights obligations, or comply with international climate change commitments. ISDS is a form of international law, but the rulings are made by a secretive tribunal comprised of international trade and investment lawyers. ISDS rules have

Figure 2: A highway blockade organized by Indigenous Kitchwa land defenders and allies, protesting unwanted development and human rights violations by the Ecuadorian government

Credit: Ricochet Media, photo by Ian Willms

been resoundingly critiqued for their lack of democratic process and the vague language of investment treaties, leaving decisive interpretation up to a majority of tribunal lawyers. Ecuador has not been alone in facing ISDS suits costing it billions in public monies no longer accessible for public good purposes. It also has a long history of activists pushing back, so far successfully (Box E2.2).

Box E2.2: Ecuador Rules Against ISDS

In 2012, the Ecuadorian government terminated all international treaties that included investor-state dispute settlement (ISDS) arbitration. In doing so, it cited how exorbitant arbitration cases were undermining its national budget for education and healthcare;[23] with Ecuador having faced 29 separate ISDS cases . Since then, successive governments have tried to reinstate ISDS mechanism. Multiple UN bodies and experts, however, have recommended that ISDS not be included in new trade agreements and be removed from existing ones. They warn that the mere threat of a lawsuit leads to regulatory chill, shackling states in their efforts to combat climate change and live up to their international human rights obligations.[24]

In April 2024, when the issue of returning to a system of international arbitration was put to a national referendum, 65 per cent of Ecuadorians voted against it. Ecuador's social movements successfully mounted a nationwide citizen campaign, despite having little time to organize it and limited resources to fund it. In a matter of three weeks, they raised funds and organized a national awareness campaign on radio, television and especially on social media, such as WhatsApp, that was supported and joined by the National Confederation of Indigenous Nationalities of Ecuador (CONAIE), the largest Indigenous rights organization in Ecuador, unions and other popular sectors.[25]

Social media was fundamental in raising awareness about the referendum and how international arbitration works, resulting in strong support for the campaign. As Acción Ecológica, one of the leading organizers of the campaign puts it, "for Ecuadorian social movements it was imperative to explain to fellow citizens how ISDS claims threaten state finances, potentially taking funds away from critical budgets like health and education." ISDS mechanism is used widely by mining companies under other such agreements to file multi-million or multi-billion-dollar lawsuits against host countries in private supranational tribunals if they are denied, for example, mining permits. As Acción Ecológica adds, "cases such as those of Chevron (formerly Texaco), Occidental, Burlington, Perenco; or Canadian Copper Mesa, have imposed payments of billions of dollars to Ecuador exceeding what Ecuador planned to spend on education and health and other public services. While the territories and communities affected by these companies are left with the aftermath of destruction of nature and deep damage to their social fabric."

At the same time, mining affected communities and environmental and human rights organizations in Ecuador are urgently calling for a stop to the Canada-Ecuador free

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Box E2.2 continued

trade agreement negotiations that may include ISDS provisions in spite of the ban and increase Canadian mining. A free trade agreement, particularly one which includes an ISDS clause, will severely limit Ecuador's ability to uphold democracy, respect the self-determination of Indigenous communities who say "no" to mining, and protect the health and environment of all Ecuadorians. The CONAIE said in a statement that this treaty appears to include "international arbitration clauses that could restrict the sovereignty and regulatory autonomy of the Ecuadorian State, putting at risk the human, environmental, and collective rights of Indigenous Peoples."[26]

The two countries have since reached a proposed agreement, which includes a controversial ISDS clause. Civil society organizations in both countries are condemning this inclusion and are calling on legislators to vote against.

Not all efforts to counter-challenge corporate ISDS or government policies to permit environmentally destructive practices succeed. Recent events in El Salvador illustrate that governments can still use the courts to undermine opposition, in this instance to renewed mining developments (Box E2.3).

Box E2.3: El Salvador Invokes History to Silence its Environment Critics

In El Salvador, the courts are being used to frame environmental defenders. On January 11, 2023, five water defenders, known as the Santa Marta 5, were arbitrarily detained on trumped-up charges.[27] They played a key role in the 2017 historic ban on metals mining in El Salvador. This ban was the culmination of more than a decade of struggle of the Salvadoran people to protect their country and its water from attack by international mining corporations.

The Economic and Social Development Association of Santa Marta (ADES) Water Defenders were also part of the popular resistance during the 1980-1992 civil war in El Salvador. The FMLN subsequently became a political party and won presidential, legislative, and mayoralty elections several times before suffering electoral defeat 2021 by the new government of President Nayib Bukele. Without credible evidence, the Santa Marte 5 were charged with murder, unlawful deprivation of liberty, and unlawful association – alleged crimes that took place 33 years earlier within the context of the civil war.

On October 18, 2024, almost two years after their detention, and thanks to national and international pressure, a Salvadorean tribunal ruled they were innocent of the false charges against them.[28] However, a month later the Attorney General's office appealed this decision denying the definite freedom of the five water defenders once again. The eyes of the world remain on El Salvador and on this politicized, unwarranted retrial set for February 2025.[29]

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Box E2.3 continued

At a time when the current government of Nayib Bukele declared its intention to recommence mining (which it did in late December 2024), environmental organizations in El Salvador maintain that their arrests are politically motivated and a tactic to demobilize substantial community resistance to mining. Since their arrests in January 2023, organizations and individuals have led a national and international campaign spanning 31 countries demanding that the charges be dropped and denouncing the political motivations behind their detention given the lack of evidence presented by the Salvadoran Attorney General's office. As Ever Hernandez of the Association for Economic and Social Development (ADES) said on a recent speaking tour in Canada to seek solidarity from Canadian organizations to ensure that the trial that took place in October was fair, "the trial against water defenders should be of interest to anyone who defends nature in the face of corporate threats. This is a trial against everyone in the world, because it is a trial against the protection of the environment."

Another 'chill' that environmental defenders face is the use of SLAPP injunctions (Strategic Lawsuit Against Public Participation) by individuals who may have been named publicly in advocacy statements (Box E2.4).

Box E2.4: Environmental Justice gets 'SLAPP'-ed in Greece

Through the last twenty years and partly a consequence of the 2010 International Monetary Fund (IMF) imposed austerity measures, the environment has been targeted for exploitation by big companies and its protection neglected by governments. On the one hand, Greece, like many other countries, is experiencing increased extraction of precious metals and fossil fuels. At the same time it is part of a global "green" transition with renewable energy technologies (such as solar panels and wind turbines) that are often built in forests, national parks and areas of high biodiversity, far from the regional and urban centers consuming the energy, with little or no democratic decision-making. Environmental movements turned to the courts to overturn governmental decisions that allowed environmentally damaging companies to be established in their region.

An exemplary case which sparked one of the greatest environmental movements in Greece occurred in 2012 in North Chalkidiki, where Hellas Gold, a subsidiary of the multinational Eldorado Gold, began pursuing the opening of surface goldmining after already destroying more than 500 acres of ancient forest in the mount of Kakavos.[30] The movement, numbering thousands of citizens of the villages around the targeted area and from all around Greece, organized diverse actions, including

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Box E2.4 continued

demonstrations in the village and informative events. It also appealed many times to the country's Supreme Court against the government's approval decision, with a multitude of arguments about environmental and social impacts of the mining. Activists in the movement tried using the Court as an additional but vital means of stopping the ongoing destruction of the forest and the different production activities in the area. Using courts for such purposes was a proposed advocacy method because for years the government violently suppressed the movement with police oppression during rallies and other events that were often ignored by mainstream media. It was hoped that appealing to the court would also break through the absolute silence on the issue. Unfortunately, Greece's Supreme Court ruled that the higher economic interest of the state and the creation of jobs were more important than the irreversible damage suffered by the environment.

One of the few cases in which a company was prosecuted via its responsible representatives involved Hellas Gold, when a penal court in October 2020 convicted two executives for alleged pollution of water sources in North Chalkidiki. The court ruling, which gave the executives a suspended sentence, was based on citizen complaints, a report issued by the local municipality, and a series of mining inspectorate findings of repeated company violations of environmental legislation. On the same day, an article was published in the cooperative media outlet Alterthess reporting on the court conviction. In October 2021, one of the executives filed a lawsuit against the environmental journalist who wrote the article, and Alterthess which had published it. The lawsuit demanded €100,000 compensation for defamation and illegal violation of private data, since his full name and position were made public in the report of his conviction. The lawsuit, based partly on the EU's General Data Protection Regulation (GDPR) has been characterized by many international journalist organizations as SLAPP (Strategic Lawsuit against Public Participation).[31] Greece does not yet have a legal framework for protecting journalists and civil society organizations from these abusive SLAPP practices, which have the purpose of silencing and socially intimidating critics. In May 2022 the Supreme Court ruled on the SLAPP case, partially accepting the civil lawsuit, and ordering payment of €3,000 in damages to the plaintiff.

As the Europe based International Press Institute (member of the European Center for Press and Media Freedom) declared, "if upheld, this decision could trigger a wave of similar lawsuits based on the GDPR to suppress public interest journalistic information and keep certain information secret. Therefore, this decision risks encouraging other powerful individuals or companies to use GDPR regulations to try to keep certain information or names out of the public sphere. We believe, therefore, that this decision is a threat to the freedom of the press in Greece, which is already under considerable pressure."[32]

The appeal of the SLAPP case was held on September 19, 2024, and a decision is still pending.

Strategic Climate Litigation

Nicole Loser, an attorney who worked for eight years with the South African Centre for Environmental Rights (CER) defines 'strategic climate litigation' as cases "that are intended to advance climate action and which change the bigger picture."[33] Sometimes the cases try to compel governments to commit to certain greenhouse gas emission targets, or to confirm the human rights impact of climate change, or to challenge new projects damaging to the environment. Strategic litigation can also be used simply to generate media and political attention to the climate issue.

Such cases are almost invariably part of larger campaigns initiated by activists, communities, and NGOs. Health may (or may not) be a central element in the legal arguments. Climate change may (or may not) be named as the issue in a case. Concerns over mining and risks to life (not always human) may be the spark that initiates a legal challenge. Increasingly, human rights enshrined in international law and national constitutions comprise the bulk of the argumentation, as many of the examples in this chapter illustrate. In 2019, social and environmental justice groups groundWork and Vukani Environmental Movement (VEM) took the South African government to court for failing to promulgate regulations to ensure clean air in a region dominated by coal-powered industries. With legal representation by the CER, the groups won their case in 2022, successfully arguing that the poor air quality in certain areas marked by the government due to high levels of air pollution violates Section 24 of the South African Constitution. This section guarantees the right to an environment not harmful to health and well-being. Furthermore, the judgment held that the government has a duty to promulgate regulations to implement air quality improvement and management plans. The government, however, appealed against the decision, and in the meanwhile has granted industry exemptions to emission standards (Box E2.5).[34]

Box E2.5: The Deadly Air Case

In 2022, the South Africa Minister of Environmental Affairs ("the Minister") instituted an appeal against the 2022 judgment to the Supreme Court of Appeal. The Minister appealed only the part of the judgment relating to the interpretation of section 20 of the Air Quality Act and left the constitutional declaration unchallenged and undisputed. The Minister argued that the Court of first instance erred in its interpretation of section 20 of the Air Quality Act and that the provision merely confers a discretion on the Minister to promulgate the relevant regulations, and not a legal duty. The Minister therefore challenged a technical but significant point of the 2022 judgment. The Air Quality Act states that the Minister *"may"* make the regulations sought, but the Court of first instance held that, in the context, the *"may"* effectively means *"must"*.

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Box E2.5 continued

This crucial point was argued before the Appeal Court judges, with groundWork and VEM maintaining that there is both a legal duty and compelling contextual factors that make the publishing of these regulations obligatory in the circumstances. The regulations are essential to implement and enforce the Highveld Priority Area Air Quality Management plan. Without them, the plan has proven ineffective for years in addressing the toxic air quality. These facts were traversed in the court papers and during oral argument before the Courts by the legal team. The health impacts of the poor air quality played a crucial role in both the legal arguments and the campaign launched to raise awareness on air quality and health. Health impacts because of this ongoing pollution include lung cancer, ischemic heart disease, chronic obstructive pulmonary disease, strokes, lower respiratory infections and asthma.

In both the lower and Appeal court, storytelling was an important aspect of the case. It was crucial to highlight to the courts how exactly the poor air quality affected ordinary people residing in communities that are in the vicinity of coal-fired power stations, mines and other industrial activities that emit harmful pollutants. This impact is compounded by the lack of available healthcare services tailored to the needs of impacted by the poor air quality. It was important to reflect the voice of community members in the court papers by attaching individual testimonials.

The Minister's appeal was heard by the Supreme Court of Appeal on 28 August 2024.* Although the appeal was based on the narrow technical legal point as described above, on 26 August 2024, the government did indeed finalize and publish the required regulations necessary to implement air quality improvement plans in air quality priority areas. The regulations include air quality management measures such as emission reduction targets and reporting requirements for polluters. The government, however, continues to exempt Eskom, a big coal-fired power polluter and the country's electricity producer, from compliance with air pollution legal standards. The next phase of the campaign is to make the constitutional declaration in the Deadly Air case real for residents of priority areas and implementable at a practical level. This includes ensuring that the newly promulgated regulations are adhered to and that no further exemptions from air quality laws are allowed.

*At the time of writing, judgment was yet to be handed down in the Appeal.

Strategic litigation can also be global in scale, as in the UN General Assembly, at the prompting of the climate-endangered South Pacific nation of Vanuatu, agreeing in April 2023 to ask the International Court of Justice (ICJ) for an advisory opinion on the obligations of States in respect of climate change.[35] Activist NGOs and governments, especially those of poorer countries contributing least to climate change while facing the worst impacts, looked to the ICJ to clarify the legal obligations of all countries to safeguard the climate system from GHG emissions, and to clarify the legal consequences when these emissions cause significant harm. Public hearings concluded in December 2024, during

which 96 countries and 12 international organizations (including the WHO) made written and oral submissions to the court. Health and human rights arguments figured prominently, with concern not only for the need to accelerate mitigation efforts but also with equitable global financing for adaptation measures, both of which lag far behind what is needed. African Union countries in particular called on the ICJ "to recognize an international law legal duty on states to reduce their GHG emissions and to pay reparations, including in the form of debt relief or cancellation."[36] Arguments from most developing countries for mitigation and adaptation financing by high-emitting countries were opposed by most developed countries and some Petro-States.

The ICJ's eventual advisory opinion, expected in 2025, is not legally binding, but is likely to be used normatively in ongoing negotiations for climate financing for poorer countries, especially if it agrees with developing countries that international customary law implies obligations for restitution and reparation by countries with high GHG emissions, both past (e.g. the US) and present (e.g. China). Other international courts have also been asked for advisory opinions on climate change and marine life (e.g. the International Tribunal for the Law and the Sea ruled that countries have legal obligations to reduce GHG emissions and to mitigate and disproportionately fund small island states' efforts to sustain the health of their oceans); and the scope of state obligations in response to the climate emergency within the framework of international human rights laws (e.g. Inter-American Court of Human Rights, decision still pending).[37]

Beyond the Courts

Even when citizens and NGOs win in the courts, there remains the problem of how court rulings might be enforced. There is also the matter of the length of time involved and the costs associated with using courts to intervene on policy and regulatory decisions that are, as courts themselves have sometimes ruled, inherently political rather than primarily legal. This does not exempt countries' legal systems, or the law from engaging in suits that challenge health and climate-damaging policies and practices of governments, industries, and even individuals. But they are arguments that 'taking extractives to court' (even when the legal representation is offered *pro bono*) is only one important activist strategy and always undertaken in concert with other advocacy and civil society actions.

One such action is the use of people's tribunals – civil society initiatives that provide quasi-judicial forums in which citizens, groups, and experts consider allegations of international law violations. Human rights and environmental concerns are often the foci of such tribunals which, in contrast to the legally binding and secretive investment tribunals used by transnational corporations (TNCs) to sue governments, are fully and intentionally open. One recent tribunal, focusing on health implications of two large fossil fuel TNCs, took place in South Africa (Box E2.6).

Box E2.6: People's Health Tribunal: African peoples vs. Shell and Total

The People's Health Tribunal of Shell and Total focused on African resistance against extractivist violence and its health impacts. The Tribunal took place in May 2023 in the form of a mock class action suit against multinational oil giants Shell and Total with 5 testimonies against each company, and a jury and judge to deliver a verdict through the lens of radical reparative justice. In particular, the Tribunal highlighted the health impacts of these industries, centering the deep relationship between the health of the land and the bodies of the people living there. It was screened across multiple countries, translated into 6 languages, and produced a verdict outlining a reparative vision of healing for affected communities.

It was organized by the People's Health Hearing Collective, a global group that emerged in the lead up to COP26 in Glasgow to highlight the root causes of the climate crisis and health injustice – colonialism and racial capitalism. The group aims to bear witness to the public and collective health impacts of extractive industries and the climate crisis, connect people's struggles, dismantle knowledge hierarchies, and set out a global vision for intersectional and transformative climate justice which honors the symbiosis between land, body, and community. The focus is on organizing toward accountability and reparative justice for the health harms of extractivism. The Collective's work centers around a political and ecological understanding of health in its most expansive sense, and views health justice as healing for all oppressed peoples, preserving healthy ecosystems and territories, and ensuring community collective care.

The People's Tribunal of Shell and Total arose from the failure of existing legal and justice systems to hold colonial corporations to account for their violence. As written by Gustavo Rojas-Páez:

> Since colonial times, courts around the world have rarely questioned the violent practices of the extractive industries. In fact, they have struggled to understand claims posed by Indigenous peoples and their cosmovisions, which often entail different practices about the relationship between humanity and nature.[38]

Many communities have struggled for decades to gain recognition of their claims in the courts, either to be rejected or offered meagre compensation whilst their land remains poisoned.

People's Tribunals come from a long history of resistance, using testimony and deep listening to center on those impacted by injustice. For our methodology we took inspiration from the *Tribunal Popular Internacional de Salud* against Gold Corp, held by mining affected communities in Guatemala. In a People's Tribunal, legitimacy is subverted, centering community elders and activists as judges. As people give testimony, they are free to express themselves and narrate on their own terms the relationship between their community, their land, their health, and their spirituality. The harm caused by these

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Box E2.6 continued

violent industries can be exposed without restraint, not limited by the narrow understandings of established legal systems.

Testimony givers from areas affected by Total spoke of how displacement from their land, with little to no compensation, has damaged their health, livelihoods, and communities. They described how Total came with promises to improve standards of living but, instead, the people affected by the project are now "landless and are the poorest in the country." Human rights defender from South Africa, Nonhle Mbuthuma, described how Shell's planned offshore drilling threatens not only the fishing livelihoods of her people, but their spiritual wellbeing and deep relationship with the water. Resource redistribution to communities at the frontlines of extraction was an essential component of the tribunal methodology, supporting the health, wellbeing, and capacity of communities on the frontline through support with security, translation, care check ins, and bereavement.

> *We propose that the systematic large-scale direct and social murder – whether through military and para-military violence (as shared in testimonies from Mozambique), deleterious health impacts of extractivist practices (such as the pollution of water sources highlighted in testimonies from Ogoniland, Niger Delta) or indeed the downstream impacts of the climate crisis (such as flooding, again described in the Niger Delta) constitutes effective genocide, in addition to ecocide* - The People's Health Tribunal of Shell & Total Verdict[39]

As a strategic intervention, the People's Tribunal of Shell and Total enabled communities to build power by speaking out against these companies and spread consciousness among people impacted by them. Widespread translation, testimony proliferation, and resources for gatherings enabled exchange between communities. The Tribunal enabled young people in South Africa, where Shell is attempting to start the extractive process, to witness the violence produced after decades of extraction by Shell in the Niger Delta. The Tribunal indicted the wider system of racial capitalism that creates this violence, seeing these not as separate struggles but symptoms of the same system.

By centering the demands of the communities themselves, People's Tribunals create space to imagine and demand real healing and reparations. Community demands included cleaning-up after extractive industries and restoration of land rights, also emphasizing self-determination and access to healthcare. Free from the hostile gaze of a justice system often rigged against them, communities were able to radically reimagine a repairing of the people and the land.

The internationalist element of the Tribunal connected these communities to organizers in countries like the UK and France, where Shell and Total are based. Activists

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Box E2.6 continued

took direct action at the companies' Annual General Meetings and the African Energies Summit in solidarity with those most affected. We continue to campaign in support of community demands for reparations, including complementing legal cases which have been successfully brought to the UK.

The Collective aims to continue its work, taking forward the demands of the verdict locally and internationally, expanding its methodologies of testimony and deep listening rooted in health justice, enabling more communities to tell their stories on their own terms.

You can find out more about the People's Health Hearing collective and the People's Health Tribunal of Shell and Total here: ***https://peopleshealthhearing.org/***

Conclusion

Court judgements will not in themselves bring about the *buen vivir* or wellbeing economies that might transform and replace the toxicity of predatory capitalism in which we find ourselves. And activists are wary of using the law in ways that de-politicize what is a political issue of power and influence. But using courts to press forward on needed health and environmental reforms and economic transformations is likely to continue and grow, especially as the impacts of climate continue to affect Indigenous communities disproportionately, along with the range of their court challenges:

> Whether by physically disrupting construction, legally challenging projects, or effecting procedural delays, Indigenous land defenders and Nations utilize a multi-tiered approach to resist fossil fuel projects. These tactics demonstrate that Indigenous Rights and Responsibilities are far more than rhetorical devices – they are tangible structures impacting the viability of fossil fuel expansion.[40]

Reference List

1 Verein KlimaSeniorinnen Schweiz and Others v. Switzerland: the European Court of Human Rights' Answer to Climate Change [2024] ECHR 304, 53600/20. Available from: https://bit.ly/4ie7T04

2 Rumble, Climate litigation in Africa: Where to from here? African Climate Wire, April 24, 2024. Available from: https://bit.ly/3RzEqCz

3 Joselow, Court orders Shell to slash emissions in historic ruling, Scientific American, May 27, 2021. Available from: https://bit.ly/3XNu8T1

4 MacLean, Montana youth win unprecedented climate case: What does this ruling mean for Canada? The Conversation, August 18, 2023. Available from: https://bit.ly/4iYfZuU

5 Krase, Shell didn't consult communities properly about mining the Wild Coast – but how much legal protection do South Africans have? The Conversation, June 26, 2024. Available from: https://bit.ly/3XM9D9s

6 Herrera Carrion et al. v Ministry of the Environment et al. ("Caso Mecheros") [2021] Juicio No. 21201202000170 (Appeal) Climate Rights and Remedies (online database). Available from: https://bit.ly/42w1iJr

7 Miller, Judge sides with youth in Montana climate change trial, finds two laws unconstitutional, Daily Montanan, August 14, 2023. Available from: https://bit.ly/3RBFHJn

8 Noor, Why 2024 will be a crucial year for climate litigation, The Guardian, January 22, 2024. Available from: https://bit.ly/42o2f5y

9 Mathur v Ontario [2024] ONCA 762 (Appeal) CanLII (online database). Available from: https://bit.ly/3GaIqa8

10 United Nations Environment Programme, Global Climate Litigation Report: 2023 Status Report, 2023. Available from: https://bit.ly/4i03ZaH

11 Urgenda Foundation v State of the Netherlands [2019] ECLI:NL:HR:2019:2006. Available from: https://bit.ly/4cl0E4P

12 United Nations Environment Programme, Global Climate Litigation Report: 2023 Status Report, 2023. Available from: https:bit.ly/4i03ZaH

13 Kaminski, Shell defeats landmark climate ruling ordering cut in carbon emissions, The Guardian, November 12, 2024. Available from: https://bit.ly/43HwxlZ

14 Milieu Defensie, Climate case shell: 5 takeaways from the appeal judgement that inspire hope for the future, November 15, 2024. Available from: https://bit.ly/43G39g3

15 Follow This, Shell's investments in renewable energy have dropped to 8%, October 31, 2024. Available from: https://bit.ly/4cuTdbC

16 Wood, Recent Ontario appeal court ruling on youth-led climate case could be a constitutional game-changer, The Conversation, November 10, 2024. Available from: https://bit.ly/41ZkmQd

17 Kaminski, Shell defeats landmark climate ruling ordering cut in carbon emissions, The Guardian, November 12, 2024. Available from: https://bit.ly/43HwxlZ

18 Setzer & Higham, Global trends in climate litigation: 2023 Snapshot (report), Grantham Research Institute on Climate Change and the Environment and Centre for Climate Change Economics and Policy, 2023. Available from: https://bit.ly/4jhuLwj

19 Croft, People's power and pushback: First quantum's stock price plummets amidst massive protests in Panama, Mining Watch Canada (blog) November 1, 2023. Available from: https://bit.ly/42kpyNs

20 Mining Watch Canada, Report reveals serious human rights violations as First Quantum enters annual shareholder meeting, Mining Watch Canada (blog) May 9, 2024. Available from: https://bit.ly/43D1VCd

21 Centro de Incidencia Ambiental – Panama, Le Corte Suprema de Justicia nos da la razon, el contrato ley de minera cerro (n.d.). Available from: https://bit.ly/4jilXGx

22 Jamasmie, Panamanians divided over reopening Frist Quantum's copper mine, Mining.com, December 5, 2024. Available from: https://bit.ly/43C33G8

23 IISD, Ecuador referendum rules outs ISDS return, underlining public support for a sustainable path, International Institute for Sustainable Development, April 22, 2024. Available from: https://bit.ly/41YBmGm

24 Special Rapporteur on human rights and the environment, Paying polluters: the catastrophic consequences of investor-State dispute settlement for climate and environment action and human rights, United Nations Human Rights Office of the High Commissioner, July 13, 2023. Available from: https://bit.ly/3YhOofI

25 Ghiotto, Ecuador holds the line on ISDS, TNI Institute (blog) April 22, 2024. Available from: https://bit.ly/3EbJSbV

26 Confederacion de Nacionalidades Indigenas del Ecuador, Los pueblos indigenas rechazan la inversion minera que noboa Busco en Canada, CONAIE Communications, March 7, 2024. Available from: https://bit.ly/3FRh1u2

27 Artiga-Purcell et al, State of deception – Fact finding report on the detained El Salvador water defenders, mining, and the state of human rights under the Bukele administration, Institute for Policy Studies, January 11, 2024. Available from: https://bit.ly/43GmLk8

28 International Allies Against Mining in El Salvador, International allies applaud the dropping of the false charges against the five Salvadoran water defenders, October 18, 2024. Available from: https://bit.ly/42jxQW2

29 International Allies Against Mining in El Salvador, International allies against mining in El Salvador condemns decision to retry ADES Santa Marta five water defenders and Bukele's attempts to overturn the mining ban (n.d.). Available from: https://bit.ly/3RHXkqV

30 Halkidiki People's Committees against Gold Mining, The Destruction of Halkidiki has begun! (n.d.) https://bit.ly/42kfbcq

31 European Centre for Press and Media Freedom, Mining executive targets independent media outlet with SLAPP lawsuit, Mapping Media Freedom, November 2, 2021. Available from: https://bit.ly/3G9Cle7

32 IPI Newsroom, Greece: MFRR to fund legal appeal for lawsuit against Alterthess, International Press Institute, April 19, 2023. Available from: https://bit.ly/4iZZIWi

33 Rumble, Climate litigation in Africa: Where to from here? African Climate Wire, April 24, 2024. Available from: https://bit.ly/3RzEqCz

34 CER, Deadly air case in Supreme Court of Appeals, Centre for Environmental Rights, August 28, 2024. Available from: https://bit.ly/4cqJ1AY

35 United Nations General Assembly, Request for an advisory opinion of the International Court of Justice on the obligations of States ion respect of climate change, A/RES/77/276, 64th plenary meeting, March 29, 2023. Available from: https://bit.ly/3R0TVU2

36 Rumble, African countries argue for climate justice at International Court of Justice, African Climate Wire, December 19, 2024. Available from: https://bit.ly/3FXwFUI

37 Tigre & Barry, Climate Change in the Courts: A 2023 Retrospective, Sabin Center for Climate Change Law, December 2023. Available from: https://bit.ly/41YBWnw

38 Rojas-Páez, Understanding Environmental Harm and Justice Claims in the Global South: Crimes of the Powerful and Peoples' Resistance, September 2017, pp.57-83. In: Rodríguez Goyes, Mol, Brisman & South (eds) Environmental Crime in Latin America. Palgrave Studies in Green Criminology. Palgrave Macmillan, London. Available from: https://bit.ly/41Zha7e

39 People's Health Tribunal – Verdict (n.d). Available from: https://bit.ly/4iXyU8U

40 Goldtooth, Saldamando & Gracey, Indigenous resistance against carbon, Indigenous Environmental Network & Oil Change International, August 2021. Available from: https://bit.ly/4ljC4FIwww

Fear and hope in 'speaking truth to power': struggles for health in times of repression and shrinking spaces

The cases and the conclusions in this chapter are drawn from discussions in a session organized by health activists of the People's Health Movement (PHM) at the 5th People's Health Assembly (PHA5), on 8 April 2024 in Mar del Plata, Argentina.

Overview

The last few years have been characterized by multiple and overlapping crises: the COVID-19 pandemic followed by a global economic recession, wars and an increasing frequency and intensity of natural disasters reinforced by the advancing climate crisis make for a continuous state of emergency. What used to be an exception seems nowadays like the "new normal". These crises strengthen the global rise of populist right and authoritarian regimes, diminishing the space for civil society engagement and critique.

This applies for health care as well (see Chapter B1). The urgently needed transformation of healthcare systems to secure health for all is being hindered by austerity measures, commercially driven interest politics and the increasing repression of health activists in many places. These are not locally isolated phenomena but confirm a trend that can be observed globally.

These "shrinking spaces" present themselves in very different ways: increasing securitization of health policy, "red-tagging" of health activists or accusations of supporting terrorism at a political level, but also through increasing xenophobia, gang violence and local militias at a community level. Against this background, four cases from different countries and contexts are shared – Turkey (with examples of resistance), Kenya (primarily sharing the extent of repression), Philippines (where activists have had some success in pushing back) and South Africa (where repression still dominates activist concerns). As a group, these cases elucidate how repression affects health and describe activists' experiences and strategies that exist to counter this repression.

Securitization of the Turkish Medical Association and the struggle for the right to health

Three concepts are key to describe and understand the repressive policies in Turkey: civic space, deconstitutionalization and securitization.

Civic space "is the environment that enables civil society to play a role in the political, economic and social life of our societies. In particular, civic space allows

individuals and groups to contribute to policy-making that affects their lives, including by accessing information, engaging in dialogue, expressing dissent or disagreement, and joining together to express their views".[1] The definition makes it clear that the concept refers to the *enabling conditions* ("the environment") by means of which individuals and groups effectively engage in public processes of opinion. It is important to talk about 'civic space' because the political pressure on civil society has intensified and diversified over the last two decades.[2] Many governments employ new and subtle techniques of oppression which do not abolish civil society as such, but undermine its legitimacy, capacity and efficacy. In other words, civil society formally continues to exist but lacks the substantive environment without which it cannot properly fulfil its function.[3,*]

Deconstitutionalization refers to a process in which the constitution is stripped of its binding force due to deliberate and systematic breaches by constitutional organs refusing to comply with certain constitutional provisions as they see fit without facing legal consequences.[4]

Securitization refers to discursive and institutional practices by means of which political issues are redefined as existential threats to national security and thereby taken out of the sphere of public debate and ordinary democratic politics.[5] When successful, it helps to justify the de facto use of emergency powers in relation to the "securitized" issues and / or groups and enables the "securitizing actor" to act in ways that would otherwise be impermissible.

How has repression evolved over time?

Turkey's history is shaped by military coups, memoranda and coup attempts. Security policies that accompanied the liquidation of the welfare state and the implementation of neoliberal policies, including health services, are realized by force, not by consent.

In the aftermath of the June 2015 elections and following the termination of the resolution process between the Turkish government and representatives of the Kurdish politicians, securitization in Turkish politics swung into full gear and encompassed the entire public sphere, while firmly interlocking with the deconstitutionalization process that had already been underway. The more the constitution lost its capacity to restrain the exercise of political power, the easier it became to criminalize opposition and to use counterterrorism measures against dissenting voices in civil and political society. That is, deconstitutionalization facilitated the securitization of civic space and democratic politics. The effective process of securitization, in turn, provided decision makers and public authorities with a convenient pretext to set aside the law as they saw fit. That is, securitization legitimized deconstitutionalization.[6]

*The report of Human Rights Foundation Turkey deals with these conceptual definitions in depth. It has an executive summary in English.

Organizations, defenders, journalists, academics and opposition politicians conducting rights-based work in Turkey, particularly after 2015, have been designated as security threats by the political power and are, in this respect, being singled out, discredited and 'otherized'. Multiple rights violations, notably of freedoms of expression, media, assembly and association, have gradually been closing down civic space.

Turkish Medical Association and right to health struggle

The Turkish Medical Association (TMA) is a respected professional and democratic mass organization that is one of the cornerstones of Turkish civil society. It has a long history of defending the right to health and health services of the population. Expressing loudly that the indefinite-unlimited curfews announced in July 2015 constitute a violation of the right to life and access to health services, TMA also prepared a report that made visible the violations of rights regarding access to health services.[7] TMA made these problems visible to international physicians' organizations such as the World Medical Association and the Standing Committee of European Physicians and ensured that these organizations published position papers on rights violations in Turkey.[8] From this period onwards, due to TMA's statements on protecting the right to life and health based on professional values, TMA itself began to be accused of "supporting terrorism and terrorists" and was included in the field of securitization discourses and practices.

From the day the statement "War is a Public Health Issue" was released by the TMA in January 2018, regarding the military operation carried out in northern Syria, a campaign of targeting, defaming, devaluing, discrediting, criminalizing and securitizing was launched against the organization. This included raids on the homes of the elected central council members, searches of their homes and workplaces and their detention. In the lawsuit filed against them, they were charged with the crime of "inciting the people to hatred and enmity". At the end of four years of judgement, in 2022 the appellate court overturned the criminal decision, and the council members were acquitted.

A study conducted at the Human Rights Foundation Turkey (HRFT) focused on four critical cases epitomizing rights violations against "rights defenders, local administrations, democratic mass organizations and, journalists and press". One of the cases involved the TMA. Study includes in depth interviews with the central council members and the lawyer of the council and narratives of the newspapers about the case. It found that narratives taken from pro-government newspapers were connecting TMA with terrorist organizations, claiming that TMA was promoting terrorism and spreading terrorist propaganda. Securitizing actors claimed that TMA was not representing physicians and called for restrictive measures such as closing TMA and punishing its elected bodies, although the elected members and the lawyer of the organization stated that these attacks did not lead to a change in their course of defending the right to life and right to health. One interviewee explained:

> TMA has always been an organization that has acted with the awareness that health always includes social well-being... Although making such statements falls within the scope of freedom of expression, they were aware that their statements as the organization of physicians could be met with an attack. Therefore, they had to take steps, not unconsciously, but consciously, taking this into account every time [they made a statement or took an action]. However, I think that if they had not been faced with such an attack...they could have acted more freely and differently.

The right to a healthy life, to access health services, to live in a healthy environment, to work in a safe job, to receive decent wages, not to be subjected to human rights violations, can only be realized in conditions where people can freely express themselves. It is precisely for these reasons that the struggle for the right to health is a political struggle.

Although the threat of closure of the TMA did not succeed to push it out of what remains of Turkey's civic space, this case is an important example of securitization of the activities of a constitutional professional organization, activities that are rooted in law and professional values. The TMA case also highlights the importance of international solidarity through the World Medical Association and the People's Health Movement. Despite the risk of repression of its activities, TMA and its members continue to advocate for the right to health, and TMA remains one of the most significant actors in the struggle for a democratic society as a component of labour and democracy forces. It functions beyond being merely a professional organization; it acts as a democratic mass organization and engages in a struggle with a perspective that does not perceive healthcare services as merely a technical issue but recognizes the positive and negative impacts of societal conditions on health.

Right to 'Health for all' on trial in Kenya

As a concept, many in Kenya – both activists and increasingly the wider public – have seen repression as a way in which those who hold power silence people from the community who do not have similar power, especially when community activists aim to hold the powerful to account for their commitments such as to constitutional rights. These duty-bearers include government, corporations, political institutions, people and other organizations. In Kenya, repression has meant actions taken by the Kenyan government and other powerful entities to suppress dissent, stifle freedom of expression, curtail civil liberties and undermine democratic principles in various forms. These forms include political intimidation, harassment of activists and journalists, direct and indirect censorship, arbitrary arrests and detention, use of excessive force against protesters, abuse of the judiciary and restrictions on peaceful assembly and association.

Kenya is a democratic country governed by the rule of law and the constitution. The sovereign power belongs to the people of Kenya and the people may exercise their sovereign power either directly or through their democratically elected representatives. Although Kenya has signed all the major international human rights and governance treaties and conventions, space for civil society is shrinking in the country. Not only does the government attempt to silence civil society by restrictive legislative measures, arbitrary funding limits and harassment, but also by jailing bloggers critical of government officials. The space for media freedom, independence and civil society as an accountability instrument to achieve the 2030 Agenda is heavily challenged. The *Kenya Information Communications Act* and the *Media Council Act* impede media freedom by allowing undue control by government, political and commercial interests.

The use of excessive force by the police on those who are peacefully demonstrating against government policies, decisions or programs, represents another current form of repression. In Kenya, there have recently been cases of citizens protesting the high cost of living, as well as health activists and doctors protesting lack of hiring. In both these cases, police fired live bullets and teargas canisters on those exercising their constitutional right to picket, resulting in injuries and deaths.

How state repression has affected health and health systems

These increasing forms and instances of state repression of citizens are intertwined with Kenya's tribal politics, in which elite political actors divide the population in order to stymie effective citizen resistance to power grabs and economic exploitation. With a population divided internally, the political elite is free to drive the commercialization of essential social services spanning health care, food, housing, education, transportation and others, from which they and their allies derive profits. The health sector is particularly affected by partisan politics due to the large amounts of funding that passes through public procurement for equipment, commodities and other supplies, presenting opportunities for corruption or theft.

Health system governance and accountability

Weak health system governance and accountability mechanisms have undermined transparency, integrity and the rule of law. In 2023-24, Kenya witnessed new health laws being enacted without legally mandated public participation, which was ultimately reduced to a token three days. Those laws – the Social Health Insurance Act (SHIF), the Digital Health Act and associated other acts – were declared by courts of law as unconstitutional and yet were implemented regardless of court orders. The union representing physicians, pharmacists and dentists were concerned that reforms to the SHIF Act requiring a fixed financial contribution from Kenyan households (2.75 per cent of gross salary or wage) as a precondition for accessing services would disenfranchise many Kenyan citizens.

The union succeeded in delaying implementation of the Act,[9] which did come into effect in late 2024 although with provisions to lessen the financial burden on households (see Chapter E1).[10]

Repression in Kenya has thus appeared both as police action against citizens' demands for health laws as well as soft forms such as illegally curtailing public involvement in enacting laws that ultimately favoured profit over people's health. Corrupt practices, political interference and impunity have eroded public confidence in health institutions and in efforts to combat corruption, fraud and malfeasance. Together, these forms of repression have inhibited civil society oversight, independent media scrutiny and whistle-blower protection, impeding efforts to expose and address systemic failures that promote profit-seeking in the health sector and corruption of health systems.

Health equity and social justice

Health inequities and social injustices have disproportionately affected poor, marginalized, vulnerable and disadvantaged populations because, as noted earlier, health services are provided as economic commodities rather than a human right as specified in the Kenyan Constitution. Some hospitals have brazenly refused to provide emergency medical services to patients due to a lack of funds. Lives have been lost as a result. Moreover, innocent Kenyans have been held hostage in hospitals because of their inability to afford the medical bill. Subsequently, inequities and inequalities are propagated through such tragedies. Statistics of the government expenditure reveal that the Kenyan government spends between 4 and 6 per cent of the national budget on health, falling short of the 12 and 15 per cent that is suggested by the Kenya Health Sector Strategic Plan and Abuja Declaration, respectively. Inequitable resource distribution for healthcare also exists, with shortages being experienced in rural areas. Lack of medical professionals is another major barrier: the current doctor-to-population ratio of 1:5263[11] which is far from the recommended ratio of 1:1000.

Government actions to implement an anti-people health agenda has eroded social cohesion, trust and solidarity within marginalized communities, leading to poorer community health and resilience. For people living in relatively remote counties such as Baringo, Garissa, Isiolo and Turkana, fear of reprisals, surveillance and even local informants has inhibited collective action, community engagement and mutual support networks for health promotion, disease prevention and disaster response.

Repression has jeopardized the safety and well-being of healthcare workers. Two recent examples are (a) police brutality against doctors and other health workers who were protesting outside the Ministry of Health and the Treasury, demanding hiring of interns and payment of fair wages in March 2024, and (b) health workers who are intimidated or kidnapped by armed groups like Al-Shabaab, who subject them to harassment, intimidation and violence while carrying out their duties. There are cases where healthcare facilities become targets of repression, including attacks,

looting or occupation by armed gangs in absence of security forces, endangering the lives of staff and patients. Fear of reprisals has at times deterred healthcare workers from providing care in high-risk areas.

Figure 1: Health workers' protests in Kenya

People's Dispatch

Repression and red-tagging in the Philippines

The Cambridge dictionary defines repression as the use of force to control a group of people. In the Philippine context, repression/political repression is the suppression and curtailment of democratic and political rights and opposition. It is state sponsored, as historically demonstrated in the long reign of the Marcos dictatorship (1965-1986) and the imposition of Martial Law in 1972, and the consequent regimes following the downfall of the Marcos regime.

Political repression has been weaponized into laws and Executive Orders. Over the last decade, in the guise of "fighting terrorism" the following were enacted:

- Republic Act 10168: An Act Defining the Crime of Financing of Terrorism (20 June 2012);
- Executive Order 70: An Act Creating the National Task Force to End Local Communist Armed Conflict (NTFELCAC), signed by President Rodrigo Duterte on 4 December 2018;
- Republic Act 11479: Anti-Terrorism Act of 2020. It is an amendment to the Philippines' Human Security Act of 2007 and was enacted on 3 July 2020 amidst the militarist lockdowns during the COVID-19 pandemic and despite intense opposition and protests from civil society organizations.

These laws and Executive Orders have the potential, and are already being used, to criminalize and suppress individuals and organizations that are working to

address the root causes of inequalities, or who speak up for and protect human rights and to defend democracy.

KARAPATAN, a leading human rights organization in the Philippines, has documented as many as 1,609,496 victims who have been threatened, harassed and intimidated under the first 18 months term of President Ferdinand Marcos Jr (June 2022 to December 2023), mainly through red-and-terrorist-tagging,* mainly committed by the state. The practice became very vicious when the NTFELCAC was created in 2018: with billions of funds allocated for its operation, NTFELCAC has been rabidly red-tagging activists and organizations. The Marcos presidency has further shown its ugly face of repression in terrifying forms, including extra-judicial killings (89), illegal arrests and detention (122), illegal arrests without detention (207), illegal search and seizure (546), bombings of communities (22,391), forced evacuation (24,670), demolition of urban poor communities (14,634) and many more.

Figure 2: Filipino activists protest 'red-tagging'

Karapatan

Repression's impact on health and health systems

Philippine health realities show the gaping weaknesses of the Philippine health care system that is commercialized and privatized, urban-centered and hospital-based. Many Filipinos have been struggling to attain even the most basic of health services. Six out of ten deaths are not medically attended by a physician, public health officer, hospital authority or other medical personnel, and household out-of-pocket expenses account for 53.9 per cent of the total health expenditures. The budget for public health programs, specifically for programs

*Red-tagging, a relic of the Cold War, is the labeling of individuals or organizations as communists, subversives or terrorists, regardless of their actual political beliefs or affiliations, and threatens the lives or safety of individuals.

on immunization, prevention and control of infectious diseases, epidemiology and surveillance have been slashed despite the polio and measles outbreak and dengue epidemic in recent years. Concretely, the budgets for public health and for epidemiology and surveillance declined in 2024.

And yet, health workers and health organizations active in advocacy and campaigns to assert the people's right to health are not spared from political repression. Individuals and organizations such as the Alliance of Health Workers, the Health Alliance for Democracy, the Council for Health and Development, Filipino Nurses United and five other networks were targeted in a series of vilification and smear campaigns by top military officials with NTFELCAC and via Facebook accounts.

On 7 March 2019, the Facebook account "Stop Communists in the health sector" started posting pictures and messages that maliciously listed a number of health organizations, including the Health Alliance for Democracy, Alliance of Health Workers, HEAD and several others, as acting as front groups for the CPP-NPA-NDP (organizations in armed conflict with the Philippine government). The page also posted activity photos of press conferences, rallies and forum where faces of leaders and members were visibly shown. Three days after, on 30 March 2019, in a news article released by the Philippine News Agency, National Security Adviser Hermogenes Esperon Jr. listed a number of non-governmental organizations accused of fronting for the Communist Party of the Philippines (CPP), including reference to the Alliance of Health Workers.

Some were killed, like Zara Alvarez, a health activist and advocacy officer of the Negros Island Health Integrated Program for Community Development who was gunned down in the early evening on 17 August 2020. She was active in building the capacity of communities in taking care of their own health, training community health workers and helping to set up community-based health programs. Before her death, she was red-tagged and continued experiencing threats and surveillance in her work.

Four months later, Dr. Mary Rose Sancelan and her husband Edwin Sancelan were gunned down near their home in barangay Poblacion, Guihulngan City, Negros Oriental. Dr. Sancelan was the City Health Officer and chairperson of the Inter-Agency Task Force on Emerging Infectious Diseases in Guihulngan City, the sole doctor for Guihulngan City's 33 barangays (a barangay is the smallest administrative unit in the Philippines).

Dr. Sancelan had been a victim of red-tagging since 2017 and was on top of the hit list of the armed anti-communist group Kawsa Guihulngan Batok Komunista, which falsely tagged her as "spokesperson" of the New People's Army. In 2019 Dr. Sancelan made a public appeal on how she feared for her life, and how the red-tagging hindered her in continuing the immunization program especially in the city's remote barangays.

Robert Mendoza and Benjamin Santos, president and secretary general respectively of the Alliance of Health Workers, were red-tagged by Dr. Lorraine Badoy

of the NFTELCAC at the height of the health workers struggles for benefits and protection during the COVID-19 pandemic.

Dr. Natividad Castro, a community-based health program doctor, was arrested on 18 February 2022 over alleged charges of kidnapping and illegal detention. She was released in March 2022 but was re-arrested in June 2022. In December 2022, Dr. Castro was designated as a terrorist by the Anti-Terrorism Council.

Jonila Castro and Jhed Tamano, community volunteers of the Alliance for the Defense of Livelihood, Housing, and Environment in Manila Bay and network partners of Samahang Operasyong Sagip, were abducted on 2 September 2023 by masked armed men while doing important social preparation activity for the relief delivery operation to communities affected by Typhoon Egay in the province of Bataan. The NTFELCAC and the Philippine National Police held a press conference on 15 September 2023 announcing that Castro and Tamano were not abducted but instead, "voluntarily surrendered". On 19 September 2023 the NTFELCAC and the Armed Forces of the Philippines held another media conference to present Castro and Tamano, during which they both said that they were forcibly abducted by men who said that they were from the military.

The country's health care system incentivizes new graduates and health professionals to work in hospital-based and urban centered practices, to pursue further specialization or to work abroad, already creating a serious problem in terms of health access in many remote communities. The very few who choose to stay and serve in remote rural communities are being harassed, threatened or killed.

In addition, the increasing frequency and number of forced evacuations, bombings and militarization as part of the government's anti-insurgency campaigns have severe implications for health in rural areas. Food / agricultural production and livelihoods have been halted while bombing has destroyed farmlands. Blockades have reduced the food supply and community members, especially children, suffer from psychological and mental health problems because of their traumatic experience.

Standing up against repression

Repression induces resistance. The Filipino people have a long history of struggles against repression, culminating in the Epifanio de los Santos Avenue (EDSA) people's power that ended the two-decade Marcos dictatorship. Protests and struggles in various forms continue.

Legal and meta-legal battles (protest actions) call for the scrapping of the Anti-Terror Law (ATL), abolition of the NTFELCAC and ending of many other human rights violations. The ATL has been met with protests and more than 30 civil society organizations and legal luminaries filed petitions to the Supreme Court questioning its constitutionality.

Concerning the NTFELCAC, many personalities and organizations filed cases and petitions to the Supreme Court, Ombudsman and other judicial institutions regarding the abuses of the organisation. Doctors and health workers filed charges against Lorraine Badoy, a medical doctor, officer and spokesperson of

the NTFELCAC, to the Ombudsman and the Professional Regulation Commission (PRC) for red-tagging leaders and organizations in the health sector. The complaint includes the call for the PRC to revoke the medical license of Badoy on the ground that her behavior in red-tagging and vilifying groups and individuals runs counter to the oaths that she took when she entered the medical profession and assumed the position of Communications Undersecretary.

These actions led to some gains. The Supreme Court ruled two parts of the ATL unconstitutional "for being overbroad and violative of the freedom of expression." It also declared as unconstitutional a provision that allows the Anti-Terrorism Council to adopt requests by other entities, including organizations, to designate individuals and groups as terrorists. The Supreme Court also found Dr. Lorraine Badoy of the NTFELCAC guilty for threatening a judge and fined her P30,000. Finally, the PRC is now hearing the complaint filed by doctors and health workers against Badoy.

Other campaigns are aimed at defending and supporting victims of repression and human rights violations. A campaign to free Jonila Castro and Jhed Tamano gathered the active support of various organizations and legal personalities. The two community volunteers narrated their harrowing experience in the hands of the military. The campaign succeeded, Jonila and Jhed were freed.

Health activists also engage with and lobby UN human rights bodies and local human rights institutions. The human rights situation in the Philippines was presented by CSOs during the Universal Periodic Review of the UN High Commission on Human Rights from 7-18 November 2022. The Philippine CSO delegates also shared the country's human rights situation with several UN special rapporteurs in 2022, and dialogues were undertaken with the Philippine Commission on Human Rights.

On official invitation, UN special rapporteur on the promotion and protection of human rights in the context of climate change, Dr Ian Fry, and UN special rapporteur for freedom of expression and opinion, Irene Khan, visited the Philippines from 6-15 November 2023 and from 23 January to 2 February 2024, respectively. In their respective press briefing, Dr. Ian Fry and Irene Khan expressed concern on the situation of human rights in the country and recommended the NTFELCAC be abolished.

South Africa: divided by design: xenophobia as a tool of oppression

> I have fought against white domination, and I have fought against black domination. I have cherished the ideal of a democratic and free society in which all persons live together in harmony and with equal opportunities. It is an ideal that I hope to live for and to achieve. But if needs be, it is an ideal for which I am prepared to die. – *I Am Prepared to Die* speech, 1964 by N Mandela.

Despite 30 years of democracy, South Africa remains deeply divided and marked by stark inequalities. The legacy of apartheid continues to shape social, economic and political structures, leaving many communities marginalized and impoverished. Wealth and opportunities are still concentrated in the hands of a few, while access to quality education, healthcare and employment remains out of reach for many. The promise of equity and justice has yet to be fully realized, making the fight for social justice and dismantling systemic inequalities as urgent as ever.

Despite the country's democratic framework, social justice activism in South Africa faces significant repression. Activists advocating for human rights, land reform and economic justice frequently encounter harassment, intimidation and even violence. Whistle-blowers are being threatened, killed and victimized because they are demanding justice. For instance, Babita Deokaran, who was serving as the acting chief director of financial accounting at the Gauteng Department of Health, was tragically killed after exposing corruption within the department.[12]

Mam'Fikile Ntshangase, an environmental activist, was slain for her roles in speaking out against corruption and for the rights of marginalized people. Fikile Ntshangase was a well-known activist who always stood up for the mining-affected communities, protecting mining-affected communities, and enforcing the right to a healthy environment. She is remembered for her courage in fighting against big coal mine expansion and for speaking the truth.

The Abahlali baseMjondolo movement, which advocates for spatial justice and the rights of people living in precarious conditions while also actively opposing xenophobia, has suffered the tragic loss of many of its leaders through targeted killings, many of which remain unreported. Their website stands as a powerful testament to the relentless oppression and violence they continue to endure.[13]

Xenophobia in South Africa represents another form of oppression rooted in structural inequalities driven by neoliberal economic policies. These policies prioritize corporate profits over social welfare, fostering poverty, unemployment and competition for limited resources. As public services decline due to austerity and privatization, marginalized communities are manipulated into blaming foreign nationals for their struggles. This scapegoating, often fuelled by political rhetoric, distracts from deeper issues such as wealth concentration, systemic exploitation and government failures. By dividing oppressed groups, xenophobia weakens collective resistance and sustains the power of entrenched elites ensuring that the root causes of inequality remain unchallenged.

In 1998, South Africa enacted the Refugees Act, which established a non-encampment policy for refugees and asylum seekers. This approach allows individuals to integrate into local communities rather than reside in designated camps, granting them rights to work, access healthcare and pursue education. This policy reflects South Africa's commitment to human rights and aligns with its constitutional principles. While this seems positive in theory, the reality for

foreign nationals is much harsher. Foreign nationals often enter the informal economy because there are no other opportunities for them. This puts pressure on already fragile economic systems where people scramble for work and services, perceiving anyone who takes a piece from this as a threat. The root cause is a political economic system that does not address the inequities within the South African society, despite progressive laws being in place such as the Refugees Act.

During the period 2008-2021 the reported number of xenophobic violent incidents across South Africa shows 612 people killed, 1,184 physical assaults, 122,298 persons displaced, and 6,306 foreign national-owned shops looted or damaged.[14] Time and again Africans and Asians who live in South Africa are attacked by local South Africans. This happens mainly in the black townships, and the accusations are perpetuating crime, selling drugs, taking jobs and causing unemployment and taking women.

South Africa's constitution protects both citizens and non-citizens and states that everyone has the right to freedom and security of the person, including the right "to be free from all forms of violence from either public or private sources. "Non-citizens continue to stay but are fearful of being victimized. The xenophobic attacks happen directly and indirectly, and have major impacts on health, especially for women and children.

Xenophobia inflicts both direct and indirect violence on foreign nationals. Directly, they are often forcibly removed from public clinics, denied medical care and subjected to harassment and intimidation. For example, in January 2023, members of Operation Dudula (see below) were reported to have turned away immigrants, including those with chronic illnesses, from the Jeppe Clinic in Johannesburg.[15] Indirectly, the hostile environment created by xenophobic attitudes and policies instils fear, discouraging many from seeking medical help or accessing essential social services. This climate of exclusion and fear jeopardizes their health, safety and overall well-being, deepening their marginalization and reinforcing systemic oppression.

Despite the South African Constitution and the Refugees Act, more recently political parties openly blame migrants for the failure of government to establish a social welfare state. The political narrative that poverty, poor service delivery and inequality are caused by migrants is not only used to gain popularity and win votes of poor South Africans, it also diverts attention away from the failure of government to deliver upon its promises.

Xenophobia has now been institutionalized and organized with groups such as Operation Dudula. Operation Dudula, which is a Zulu word for "to push out", is a South African nationalist movement that emerged in 2021, focusing on anti-immigrant activism. The group was formed in Soweto and has now grown with branches across South Africa. The Socio-Economic Rights Institute of South Africa (SERI) believes that Operation Dudula was orchestrated by some political parties under the misguided pretext of protecting employment for vulnerable

South Africans. Its members advocate for prioritizing South African citizens in employment, housing and business opportunities, often targeting undocumented migrants. The movement has gained notoriety for organizing protests and conducting community raids aimed at expelling foreign nationals accused of taking jobs or engaging in illegal activities.

> I saw our brothers and sisters marching for hatred, marching for injustice, marching against the same things that we know are keeping us down. Foreigners are not stealing our jobs, Clover is stealing our jobs, MassMart is stealing our jobs... it is the small 1% in South Africa that owns 50% of the bulk. These people do not live in Alexandra, but they live in Sandton. – Spokesperson of Anti-xenophobia organisation KAAX

Additionally, Operation Dudula has created a hostile environment for anti-xenophobia activists. These activists often face intimidation and attacks from Operation Dudula groups when they stand up for the rights of immigrants.[16]

Organizations combating xenophobia face attacks and harassment from various quarters. For instance, during the 2008 xenophobic attacks, Abahlali baseMjondolo stood against the violence and has since remained resolutely opposed to xenophobia. This stance has subjected the organization and its members to threats and hostility from those promoting anti-immigrant sentiments as well from the police.[17]

Political figures in South Africa have, at times, employed anti-immigrant rhetoric, which not only fuels xenophobic sentiment but also creates an environment where it is increasingly difficult for these organizations to operate without facing backlash from both individuals and communities. For instance, during election campaigns, parties legitimized xenophobic attitudes and actions. This political climate fosters hostility towards groups advocating for immigrant rights, as they are perceived to oppose the prevailing nationalist sentiments. Consequently, these organizations often encounter resistance and threats, hindering their efforts to combat xenophobia and protect vulnerable populations.

These examples illustrate the multifaceted challenges that anti-xenophobia organizations in South Africa encounter, not only highlighting the need for greater protection and support for those advocating for social justice and human rights but also emphasizing the need to promote a more inclusive and healthy society, which requires addressing and combating the root causes of xenophobia. This involves the South African government, civil society organisations, the African Union and the United Nations working closely with the nations of origin to address the driving forces of migration, like war, violation of human rights, political instability, conflict and economic factors in many African countries (see Chapter C2). These are themselves driven by capitalism, colonialism and imperialism, forces that break down trust, solidarity and social cohesion. To foster

meaningful change, we must build solidarity within our communities by starting at the local level, listening to people's needs, and working together toward shared goals. Creating a safer environment for social justice advocates requires proactive measures that ensure their security and support their vital work. By strengthening community bonds and fostering mutual understanding, we can collectively challenge the social inequalities deepened by neoliberal policies and advance the fight for a more just and inclusive society.

Key themes across the case studies

"Repression breeds resistance"

As People's Health Movement (PHM), we continuously strive to encourage our members to become and remain active activists. Equally important is the need to prevent violations of their rights. As a movement, we must focus more on discussing preventive measures to safeguard ourselves against human rights violations.

"Standing Strong Against Repression"

As a movement, we commit to fighting all forms of repression including moral dictatorship from global institutions and power, religious repression and conventional suppression.

We need to deal with repression at the root cause. While a political economic analysis is important, it is equally important to talk about what is happening in and with the communities where we live. Rooted in the grassroots, repression must be challenged through the power of the people. We need broader alliances, a narrative and a political strategy while rebuilding our divided communities

The health movement globally is small so we need to fight repression together with other movements. The struggle for health is the struggle for life. While global movements have facts and analysis and research, it is people who have the narrative needed to mobilise against repression.

Concluding our examination of repression in these cases, we see that our movement needs a broader strategy at both community and political levels. The perpetuation of crises from the current economic political paradigm is dividing our communities, who have lost their mobilising character of 20 years back. A new strategy will guide the movement on how to reconnect people within and across communities, not only the most marginalized but also health workers and the larger public. As a movement we need to rebuild our communities AND we need to redefine health as a political issue. As one of the discussants concluded:

> There is a huge disconnect in what we hear of professionals in global health community and what is happening on the ground – we as a movement need to close that gap

Reference List

1 United Nations Office of the High Commissioner of Human Rights. OHCHR and protecting and expanding civic space. Available from:https://bit.ly/3ENieCf

2 Buyse A. Squeezing civic space: restrictions on civil society organizations and the linkages with human rights. The International Journal of Human Rights. 2018 Sep 14;22(8):966–88. Available from: https://bit.ly/4jyy174

3 Davas A, Tekin S. Kuşatma Altındaki Yurttaşlık Alanı TİHV Yayınları. Human Rights Foundation Turkey; 2021. Available from: https://bit.ly/4k0FGLq

4 Kaboğlu İ. The Dilemma of Constitutional Fetishism and De-constitutionalization. Anayasa Hukuku Dergisi. 2013;2(4):10–2.; Gözler K. 1982 Anayasası Hala Yürürlükte Mi? Anayasasızlaştırma Üzerine Bir Deneme. 2016. Available from: https://bit.ly/4iDEQ63

5 Buzan B, Waever O, Wilde J de. Security: a new framework for analysis. Boulder, CO: Lynne Rienner Publishers; 1998. 1 p.; Özen Z, Özatağan G, Aksu Tanık F, Kurt H. Türkiye'de Güvenlikleştirme Söylem ve Pratikleri. Izmir: Human Rights Foundation Turkey; 2021. Available from: https://bit.ly/3YDZ9t9

6 Davas A, Tekin S. Kuşatma Altındaki Yurttaşlık Alanı TİHV Yayınları. Human Rights Foundation Turkey; 2021. Available from: https://bit.ly/453RFU4

7 Vatansever K, Aksu Tanık F, Gökalp Ş, Civaner M, Bilaloğlu E, Özçelik Z, et al. Güneydoğu ve Doğu Anadolu Bölgesinde 20 Temmuz 2015 Sonrası Çatışma Dönemında Sağlık Hızmetleri Hızlı Değerlendırme Araştırması, Türk Tabipleri Birliği Yayını, Ankara. 2015. Available from: https://bit.ly/42CWqCE

8 WMA. Resolution to Stop Attacks Against Healthcare Workers and Facilities In Turkey, Adopted By The 66th General Assembly. Moscow: World Medical Association; 2015 Oct. Available from: https://bit.ly/3GBaBzC

9 Muoki M. High Court suspends implementation of Social Health Insurance Fund. Citizen Digital. 2023 Nov 27; Available from: https://bit.ly/44SkDWX

10 Ochieng J, Omondi LR. Highlights of the Social Health Insurance (Amendment) Regulations. Oraro & Company Advocates. 2024. Available from: https://bit.ly/453RFU4

11 Mwaura W. Kenyans Are Dying Due To Lack Of Healthcare Even As Plans To Export Health Workers Are Underway. Africa Uncensored. 2024. Available from: https://bit.ly/4dduUiK

12 News24. Silenced. News24. Available from: https://bit.ly/4dciwj1

13 Abahlali baseMjondolo. Abahlali baseMjondolo – In memoriam. Available from: https://bit.ly/3Sd3cZw

14 Xenowatch. Civil Society Consultative Meeting: Towards a Strategy for Civil Society Mobilisation in Post-Election Cape Town. 2021 Dec; Available from: https://bit.ly/4iGKPHc

15 Mutandiro K. Foreign nationals chased away from Joburg clinic. News24 [Internet]. 2023 Jan 18; Available from: https://bit.ly/3Gu0xYT

16 Nqunjana A. Anti-xenophobia activists, organisations call for home affairs minister to step down. News24 [Internet]. 2022 Mar 26; Available from: https://bit.ly/4m9LRia

17 Abahlali baseMjondolo. Abahlali baseMjondolo Statement on the Ongoing Xenophobic Attacks. Abahlali baseMjondolo. 2015. Available from: https://bit.ly/4d0l9nS

Fifth People's Health Assembly: Advancing in the Struggle for Liberation and Against Capitalism

PHA5 stands as a testament to the power of collective action in the relentless pursuit of a healthier, more equitable world for all.

– PHA5 report[1]

World Health Day falls on April 7 and in 2024 it was celebrated under the theme "My health, my right". On the same day, health activists from the People's Health Movement (PHM) and allied networks traveled from around the world to meet in Mar del Plata, Argentina, and to participate in the Fifth People's Health Assembly (PHA5).

This was no coincidence. From its inception, PHM was created to address the failure of global economic and health governance to achieve the vision of "Health for All" by the year 2000, well-articulated in the Alma Ata Declaration.[2] At the first People's Health Assembly held in Dhaka, Bangladesh, in 2000 (see Box E4.1) health activists began strategizing on how to build community-based social political movements to confront governments' inaction on their 'Health for All' commitments.

Since then, PHM has explicitly addressed the role of capitalism in the social determination of people's health, focusing on the structures, forces, processes and dynamics which shape the conditions in which we grow, learn, play, work and age. This usage contrasts with the common public health adoption of 'social determinants of health' which focuses attention on the prevailing features of our social environment that shape people's health without giving systematic attention to the political and economic processes which reproduce those features.

Confronting capitalism in the struggle for health starts from challenging the myriads of local and immediate health issues that communities are facing, from access to healthcare to equity in social and ecological resources needed to promote and sustain health. The challenge for health activists is to address the local and immediate issues in ways which also address the macro and longer-term structural political economy issues. How this idea is realized depends on local circumstances, but it involves putting together the narratives which speak about these macro-micro relationships.

Doing so is precisely the work of People's Health Assemblies, among other movement strategies. This chapter is an effort to share some of the collective

energy generated from the work of participants during the PHA5. In addition to the direct experience of its contributors, the text draws from three key documents prepared for the Assembly: a background paper confronting the role of capitalism and imperialism in the struggle for health (of people and planet)[3]; a concept note looking at "Health for All in a post-pandemic world", highlighting challenges and strategies for health social movements and detailing the Assembly's five axes for discussion, exchange and strategizing (see below)[4]; and the PHA5 Call to Action, noting that the struggle for health is a struggle for liberation and against capitalism.[5]

Figure 1: The PHA5 logo, representing the universality and diversity of the marching people with elements of identification of the different cultures of the world

People's Health Movement

Making "Health for All" our struggle for *Buen Vivir*

> *...health is not the same as medicine, since health refers to* Buen Vivir, Vivir Sabroso, *and other expressions of the peoples themselves, articulated with the strengthening of the capacities that every person and community has to organize themselves in health, demand health-related rights, take care of Nature and remain in wellbeing.*
>
> – PHA5 Call to Action

The PHA5 organization was a massive undertaking. For months PHM members mobilized in their countries and regions through local and regional assemblies to reach a consensus on the issues relevant and important to be included in the program, to raise funds for their participation, and to build momentum towards the Assembly. This process was coordinated through PHM country and regional circles, and by global committees that ensured diverse participation representing the movements' constituents as well as its allied networks.

Since its inception, in 2000, PHM has been a mainly Anglophone social movement, despite continuous efforts to work across other languages (Spanish, French and Arabic as the main ones). It was not the first time that a People's Health Assembly was held in Latin America (see Box E4.1), but times were now more mature for a greater 'hybridization' between different political cultures that underpin health movements in different world regions.

Box E4.1: People's Health Assemblies

People's Health Assemblies (PHAs) are an important part of the People's Health Movement, as they provide a unique space for sharing experiences, mutual learning, and the development of joint strategies for action.

Held approximately every five years, they attract progressive social movements, civil society organizations and networks, academics, health activists, health workers and students from around the world.

Prior to PHA5 in Mar del Plata, four PHAs were held in different continents:

- PHA1 was held in **Dhaka, Bangladesh**, in 2000, and marked the birth of PHM with the motto "Health for All: Now!" and the collective endorsement of the People's Charter for Health, a document now translated into 40 languages.[6]
- PHA2 was held in **Cuenca, Ecuador**, in 2005, and was attended by nearly 1,500 health activists from 80 countries. Special cultural and religious gatherings expressed solidarity with the struggles of Indigenous peoples. The Cuenca Declaration was endorsed.[7]
- PHA3 was held in **Cape Town, South Africa**, in 2012 and was attended by around 800 people from over 90 countries. The Cape Town Call to Action denounced the inter-related crisis (political, food, economic, financial and ecological) rooted in the neoliberal model of globalization, stating that no change is possible without the mobilization of people through the building of social and political power amongst people and communities[8]
- PHA4 was held in **Savar, Bangladesh**, in 2018 and attended by around 1400 people from 73 countries. Amidst a challenging political climate, the movement decided to organize its global work also around six different thematic and action areas: gender justice and health; environment and ecosystem health; nutrition and food sovereignty; trade and health; equitable health systems; war and conflict, occupation and forced migration.[9]

In planning PHA5, different views about how to frame health issues were shared and negotiated. A strong call coming from Latin America was to root PHA5 in a deep understanding of *Buen Vivir* (see Chapter A3). Several months of discussion led to an agreement on the five axes that would support the Assembly's program:

1. Towards the transformation of health systems
2. Gender justice in health
3. Ecosystem health: food, energy, climate
4. Resistance to forced migration and war
5. Ancestral and popular knowledge and practices

Although articulated as discrete thematic axes to allow focused discussions on each of them, their deep interconnectedness was reflected by the program structure. Each of the Assembly's five days began with a plenary dedicated to one of the axes for participants to share experiences of resistance and struggle from all continents. Parallel sessions and workshops offered opportunities for deeper discussions across all of the axes, allowing for cross-regional exchanges and debates, and for interconnections and convergence to take place. This choice sustained the idea that, although the struggle for health takes place alongside many other struggles that address different priorities in different settings, they are often driven by the same underlying structures. While different movements pursue their own objectives and strategies, without collaboration across movements these underlying structures, including transnational capitalism and patriarchy, remain unchallenged. Coordinating people's voices across these different movements requires pathways of convergence across various progressive social movements. Convergence calls for deep listening across difference, for solidarity where others are hurting, and for recognition of the common structures of oppression and degradation.

Acknowledging the importance of this convergence happens not only in structured thematic sessions, but also in the different forms of encounter participants experience during an Assembly. PHA5 was structured to allow significant room in the program for practical workshops, open sessions, arts and movies, and social events.*

Throughout the Assembly participants analyzed and discussed the main obstacles that prevent achieving Health for All:

- the ecological, climate and food crisis
- the increase in economic and social inequalities
- the extension of the unjust wars and occupations of the territories of the people of the Global South

*This was achieved thanks to the local organizing committee supported by a large number of volunteers. Working tirelessly and on a limited budget, they were able to provide the logistics that – coherent with the political views of the assembly – could support a meaningful exchange among people based on solidarity.

- the growing privatization, commercialization and corporatization of health systems
- the challenges of inequalities and discrimination due to gender, ethnic/racial, caste and social class conditions.

Discussions also addressed problems related to the persistence of capitalist, colonial and imperial power in the economic relations between the countries and nations of the Global North and Global South.

Figure 2: Indigenous people's movements at PHA5

People's Health Movement

Facing these challenges, the philosophy and approach of Buen Vivir represents both something that we have always known, embedded in ancestral knowledges from all the continents, and something that we have to learn again and envision, to foresee a future of health and social justice. The (long debated) decision not to translate *Buen Vivir* implies an intended effort for all those who are not Spanish native speakers or unfamiliar with its meaning, mirroring the effort that's often implicitly requested of non-English native speakers when approaching the predominantly Anglophone world of global health. Language brings with itself modes of thinking, of structuring sentences, of understanding concepts that may not be readily translated to other languages. The choice to politically and geographically center the Assembly's focus in Latin America was to promote a different circulation of power within the movement. In the same respect, *Buen Vivir* is the translation to Spanish – a colonial language – of concepts that have different names in a variety of Indigenous cultures (such as *Küme Monguen* in Mapuche language, or

Lekil Kujlejal in Tzeltal language). Rooting PHA5 in Buen Vivir meant giving space and attention to those voices: a great opportunity for the global movement to learn from the deep political and historical tradition of the Latin American continent, starting from the ancestral wisdoms that still inhabit it.

The collective energy of a movement

> *I left the Assembly with the certainty that the collective force is the engine that can change everything. The energy shared during those days was a beacon that illuminates the path of resistance and the construction of alternatives.*
>
> – PHA5 participant

When people gather, they are not just the sum of individual beings; they create something new and different which takes the form of the collective. The Latin American tradition of 'collective health' has a lot to teach in this respect. The collective at PHA5 was granted special attention through the different subtle skills that are needed to visibilize, maintain, nurture and restore the energy flow that comprises our health. Songs, rituals, silence, arts... all were intertwined in the discussions, acknowledging that words are embodied, and that it is through our bodies that we make change happen. As the words of a PHA5 participant reported above testify, experiencing such force is a powerful engine that sustains activism through the daily challenges of trying to change an oppressive economic and political system.

This is a great teaching for social movements, particularly in an era where virtual meetings have almost completely substituted in-person gatherings, contributing to social isolation already heavily embedded in the 'modern' individualistic lifestyle that is very functional for capitalism. Stubbornly, perhaps, PHM continues to take incredible efforts to raise enough resources to organize large in-person Assemblies. We recognize that one cannot (yet?) replicate the energetic exchange that happens when meeting face-to-face with people who are engaged in one's own struggle, yet in a different part of the world. The direct account of a people's challenges, injustices, struggles and victories, and the possibility to meet the persons embodying such experiences, have invaluable meaning for the ties that hold a movement together.

The case of Palestine is emblematic in this respect. Since its inception, PHM has been a space where direct testimonies of the oppression of Palestinians could be shared, listened to, collectively processed and disseminated to raise awareness and to mobilize and advocate for justice and peace. Unfortunately, due to the escalating genocidal war (see Chapter C1), the Palestinian delegation for PHA5 was not allowed to leave the country. After all efforts to break such a blockade were thwarted, a challenging decision was taken on how to acknowledge and address

such injustice. The Assembly did this by dedicating the whole first morning - after the Opening Ceremony - to a Solidarity Act with Palestine, with multiple testimonies from the field shared online, accompanied by live slogans, chants and statements in support of the Palestinian people. In this case, the power of solidarity overcame physical distance and political barriers, even though deciding to host a global Assembly without such a relevant part of the movement is a wound that has still to be healed. And, while Palestine is probably the most symbolic and painful case, this is also true for all those whose mobility is impeded by costly and inaccessible visa procedures and who were therefore prevented from joining the Assembly in person.

Marching in resistance and solidarity

> *The Assembly expressed its solidarity with the struggle of the Palestinian people, as well as with other peoples who suffer from wars, occupations, and forced displacements, among them Yemen, Tigray, Haiti, Uganda, Democratic Republic of the Congo. The Assembly also supported the struggles of the Argentinian people against the government's neoliberal policies that make their income precarious, generating unemployment, increasing the cost of living, and curtailing their rights and freedoms.*
>
> – PHM Global Coordinator Roman Vega

When the process to organize PHA5 started in 2022, a venue had to be selected, taking into consideration political and strategical aspects. Due to recent political changes towards more progressive governments, a venue in Latin America provided a unique opportunity for strengthening PHM in the region and inspiring social movements around the world. After considering other options, Argentina was identified as the host country, not imagining that the October 2023 elections could bring to power a far right-wing government, with heavy consequences on the security and the economy of the country. The devaluation of local currency and consequent inflation deeply altered the projected Assembly budget, while the hostile context against popular movements raised concerns over safety of local and international activists.

Economic and security concerns permeated the organizing process, together with a sense of growing solidarity with the situation that people in Argentina were facing. It was important for the local health movement to have international witnesses of the deteriorating political and social environment in their country. International delegations, in turn, were exposed to first-hand testimonies about brutal police violence on peaceful demonstrators and massive layoffs of public servants, and to the impact of the escalating inflation on daily life.

Figure 3: PHA5 closing march

People's Health Movement

It was important that health activists stand together as a movement facing such violence and oppression. Symbolically, the closing march of the Assembly represented the will of the movement to face such oppression head-on, affirming not only that 'another world is possible', but that such a world is already present and strong. The pursuit of social and environmental justice is woven into ever-extending networks of local, regional, and international solidarity, with threads that run uninterrupted from peoples to peoples and ancestors to future generations, across languages and human-made boundaries.

Our Call to Action: The struggle for health is a struggle for liberation and against capitalism and imperialism

> *This Call to Action has been inspired by People's Health Movement activists who have died since our last Assembly in Savar, Bangladesh. The memory and spirit of our comrades has guided us through the process of producing this Call to Action. Their struggles for a fairer, healthier, and ecologically sustainable world free of corporate influence continue to inspire us all: David Sanders, Zafrullah Chowdhury, Julio Monsalvo, Prem John, Amit Sen Gupta, Margarita Posada, Bala Subramanium, Maija Kagis.*
>
> *– PHA5 Call to Action Dedication*

The Mar del Plata Call to Action affirms that the struggle for health is a struggle for liberation and against capitalism and imperialism. The capitalist world is in a persistent and deepening crisis with on-going structural problems becoming ever more evident. The PHM sees capitalism's polycrisis as presenting opportunities to upend its political hegemony and to transform the world into one that makes Health for All a reality.

At PHA5, PHM rose up against the violations of human rights and international humanitarian law in the recent assaults on the right to health, especially in the shadow of war and forced migration in different parts of the world. The movement raised its voice against the overwhelming control of transnational corporations over the world economy, taking a stand against the corporatization, commercialization and colonization of public goods. The Assembly emphasized the profound role women play in the struggle for health, peace and gender justice, and adopted *Buen Vivir* as a means to give voice to the struggle for Health for All.

Based on debates and discussions prior to and during PHA5, the Call to Action envisages a world in which people can enjoy their lives to the full, with decent work, full participation in health issues and the removal of the political, economic, cultural and social obstacles and limitations that prevent the existence of comprehensive, quality health and education systems: a world free of social class exploitation, and ethnic, racial, caste and gender discriminations, and the subjugation and exploitation of nature.

To this end, the Assembly called for building an ecological and democratically planned economy that ensures the health of ecosystems, food sovereignty and the energy transition away from fossil fuels. It emphasized respecting and promoting diverse, ancestral, Indigenous, feminist, decolonial, anti-imperialist and anti-capitalist knowledge. The Assembly also called on activists to build a world free from the control of transnational corporations, underscoring the goal of a just and sovereign global peace, and peoples' right to asylum and free movement. It emphasized the importance of advancing gender justice, resisting patriarchal and racist relations, and transforming and decolonizing health systems into public systems that guarantee universal and comprehensive access.

The Assembly committed participants to continue strengthening PHM by consolidating and building new country circles, modernizing its organizational structures, improving its political and advocacy capacity, and developing alliances with other social movements, political forces and progressive governments to move towards a new economic, political and social order in the context of a multipolar world. Transformation of the transnational and imperialist capitalist system to a new international economic, political and social order, based on the sovereignty and self-determination of peoples, will only happen through the joint action and solidarity of social movements, of progressive political parties and nation states. Class struggle will be a vital part of actions to achieve this aim.

Figure 4: Activists from all the world regions read the PHA5 Call to Action

People's Health Movement

Conclusion

As we write, slightly more than a year has passed from the closing ceremony of PHA5. While looking at the big picture, as analyzed in the Introduction and throughout many chapters of this GHW7, there's even more suffering and injustice in the world compared to one year ago. Not only the crazy and dangerous policies of the Trump 2.0 administration (see Introduction Chapter), but the continuing genocide in Palestine, the war between Israel and Iran, and many more civil and regional conflicts that continue to flourish, alongside the rising profits of a wide range of corporations and supporting governments.[10] Multilateral institutions are prevented from doing their job effectively and only a few governments dare to take bold initiatives that speak of restoring peace and justice, while civil society initiatives are repressed with violence.[11,12,13]

Yet, many people and communities around the world continue their resistance to a global order that promotes death and destruction, particularly for the generations to come. Many of their stories are woven into the narratives of the GHW7 chapters, and many others are still to be discovered, linked in a broader network of solidarity and resistance.

The days in Mar del Plata attested to the collective strength of the movement, experienced by participants as something tangible and real. In the words of Roman Vega, Global Coordinator of PHM, "The Fifth People's Health Assembly was more than an event; it was a milestone for global health movements. As we gather to share insights and forge alliances, we're reminded that our collective action is the most powerful medicine against ill health and health inequality, at

the human and planetary levels." It is our responsibility to keep that 'planetary energy' alive starting from our local contexts, our communities, expanding the networks that can sustain and center life, and Buen Vivir, in our struggle for Health for All.

Reference List

1 People's Health Movement. PHM 2024 annual report: a year of struggles, transitions, commitments and a glimpse into the future. People's Health Movement; 2025 Feb. Available from: http://bit.ly/4fbaxnj

2 World Health Organization: Regional Office for Europe. Declaration of Alma-Ata. World Health Organization; Report No.: WHO/EURO:1978-3938-43697-61471. Available from: http://bit.ly/46vCx2B

3 People's Health Movement. Confronting Capitalism and Imperialism in the Struggle for Health. Argentina: People's Health Movement; 2024. Available from: http://bit.ly/45oTnz6

4 People's Health Movement. Concept Note to the Fifth People's Health Assembly. People's Health Movement; 2024. Available from: http://bit.ly/455S7j5

5 People's Health Movement. PHA5 Mar del Plata 2024 Call to Action. 2024. Available from: http://bit.ly/46pDLfQ

6 People's Health Movement. The People's Charter for Health. Bangladesh: People's Health Movement; 2000 Dec. Available from: http://bit.ly/4loPyj0

7 Editors. People's Health Assembly II (PHA2) one year later: An interview with Dr. Ravi Narayan. Social Medicine. 2006 Dec 3;1(3):175–8. Available from: https://doi.org/10.71164/socialmedicine.v1i3.2006.47

8 People's Health Movement. PHA3: Cape Town Call To Action. South Africa: People's Health Movement; 2012 Jul. Available from: http://bit.ly/3Ud0PXC

9 People's Health Movement. The Struggle for Health is the Struggle for a More Equitable, Just and Caring World. Bangladesh: People's Health Movement; 2018 Nov. Available from: http://bit.ly/4kyOS9G

10 Albanese F. From economy of occupation to economy of genocide: Report of the Special Rapporteur on the situation of human rights in the Palestinian territories occupied since 1967. United Nations Human Rights Council; 2025 Jun. Report No.: A/HRC/59/23. Available from: http://bit.ly/4kYZZsI

11 Staff. What happens next to the Gaza flotilla's Madleen and its crew? Al Jazeera. 2025 Jun 9; Available from: http://bit.ly/46wRcuC

12 Staff. Gaza march activists say participants in Egypt beaten, detained. Reuters. 2025 Jun 17; Available from: http://bit.ly/4kZ0bIs

13 The Hague Group. The Hague Group (homepage). Available from: http://bit.ly/40cMYnY

List of Contributors

Joana Abrego is an environmental lawyer. She is the Legal Manager at Environmental Advocacy Center (CIAM) and part of Panama is Worth More Without Mining.

Feride Aksu Tanık is a physician, public health specialist and founding board member of Human Rights Foundation Turkey.

Julia Anaf is a Research Fellow at Stretton Health Equity University of Adelaide, working mainly on commercial determinants of health.

Laura Avalos is Americas Policy Group (APG) – Mesoamerica working group convener and part of International Allies Against Mining in El Salvador. She is also the founder and former president of the Salvadorian Canadian Association of Ottawa and National Capital Region (ASCORCAN).

Baba Aye is the health and social services sector policy officer of Public Services International (PSI) and Co-President of the Geneva Global Health Hub (G2H2). He is also a Council member of the Progressive International (PI) and contributing editor of the Review of African Political Economy [ROAPE].

Susana Barria is subregional secretary for the Andean region at Public Services International (PSI), a member of PHM's Global Health Governance (GHG) coordination team, and of the PHM country circle in Colombia.

Fran Baum is Director of Stretton Health Equity, University of Adelaide and past Co-Chair of the PHM Global Steering Council and current PHM Advisory Committee member.

Dian Maria Blandina is a primary care physician, researcher, and health and social justice activist. She is a member of PHM's Global Health Governance Programme Coordination Group, serves on the Steering Committee of the Geneva Global Health Hub (G2H2), and is part of the Global Health Watch 7 (GHW7) editorial committee.

Marcela Bobatto, Pediatrician, specialist in Chinese Medicine and medicinal plants, Master in Neural Therapy. 35 years of work in Primary Health Care. Founder of the National and Latin American Health Movement LAICRIMPO. Member of the Organic Agriculture Network of Misiones (RAOM) and MAELA (Agroecological Movement of Latin America and the Caribbean). PHM activist. Founder of the community theater group "La murga del Tomate".

Chiara Bodini is with the Center for International and Intercultural Health, Bologna, Italy, and with PHM. She is co-editor of *Global Health Watch 7*.

Christy Adeola Braham serves as Workers' Health Coordinator at Women in Informal Employment: Globalizing and Organizing (WIEGO). She is also a Senior Atlantic Fellow for Health Equity at Milken Institute School of Public Health at the George Washington University and is a member of People's Health Movement.

Garrett Wallace Brown is Professor and Chair of Global Health Policy at the University Leeds; he has over 25 years policy and research collaborations in global health, working with NGOs, governments, WHO, the G7 and the G20.

Cecilia Chérrez works with Acción Ecológica (Ecological Action). She specializes in the intersection of environmental issues,

human rights and the impacts of provisions in international trade and investment agreements that are designed to protect investments in Ecuador.

Delia Da Mosto, is a researcher at the Centre for International and Intercultural Health (Bologna). With a background in medicine and medical anthropology, her work focuses on migrant health, community-based healthcare models, activism, and mental health.

Julianna Dale Coutinho, MPH, is a psychologist specializing in Health Education and Gender & Race Policies (University of Brasilia) and is a technical analyst at the Ministry of Health focusing on institutional support. She is health coordinator at LGBT+Movimento, supporting LGBTTQIA+ migrants and refugees and is a PHM member.

Wim De Ceukelaire is a health and social justice activist and member of the global PHM Steering Council. He is co-author of "The Struggle for Health: Medicine and the politics of underdevelopment." with David Sanders and Barbara Hutton.

Anneleen De Keukelaire is a health activist with PHM South Africa, based in Cape Town. She has served in numerous capacities with PHM globally.

Nicoletta Dentico is a senior health activist and journalist. She leads the Global Health Justice Programme at Society for International Development (SID), co-chairs the Geneva Global Health Hub (G2H2), and teaches global health at La Sapienza University in Rome.

Vanessa Dourado is a member of ATTAC Argentina and Argentina Mejor sin TLC.

Dr Sara el-Solh is a doctor and medical anthropologist. She researches and organises around health justice, with a focus on migration, colonialism and climate.

Francisca Fernández Droguett is a member of Movimiento por el Agua y los Territorios MAT and Escuela Popular Campesina de Curaco de Vélez, Chiloé, Chile.

Matheus Zuliane Falcão is a PhD Candidate at the University of São Paulo. He is a researcher at the Health Law Research Centre of the University of São Paulo and at ENSP/Fiocruz, and is co-director of the Brazilian Centre for Health Studies (Cebes/Alames – Brazil).

Adsa Fatima, based in Delhi, India, works on gender and health issues with a focus on Sexual and Reproductive Health and Rights, and Gender-based Violence. She is a member of the Sama Resource Group for Women and Health and participates in the coordination of the PHM Gender Justice and Health thematic group.

Guadalupe Granja is a child and adolescent psychologist, with a diploma in Mental Health and Human Rights, and a human rights activist in the field of Mental Health in Argentina. She is a member of ADESAM (Association for Rights in Mental Health) and the PHM Movement Southern Sub-Region.

Andrew Harmer is a Senior Lecturer in Global Public Health in the Centre for Public Health and Policy at Queen Mary's University of London. He is the Director of the Centre's online MSc in Global Public Health. He is also a keen blogger – you can read his posts at andrewharmer.org.

Frauke Heller is a health activist with Medico International, based in Berlin, Germany.

Ever Hernandez is a Community Water Systems expert and member of the Association for Social and Economic Development (ADES) "Santa Marta", El Salvador. He works closely with the valiant group who have become known as the

"Santa Marta Five", who led a successful transnational movement for a ban on metal mining.

Viviana Herrera is the Latin America Program Coordinator at MiningWatch Canada.

Peninah Khisa is a health activist from Kenya and director of SODECA, working to raise awareness and action of health rights for people around Kenya. She served as Regional Representative for the People's Health Movement in East and Southern Africa from 2018-2025.

Kavian Kulasabanathan is an Eela-Tamil NHS primary care doctor, researcher and organiser, focused on state violence as a determinant of poor health - with the understanding that (health)care is something we are all in practice of everyday. He is committed to an abolitionist approach to public health globally, and toward supporting the flourishing of community-owned, plurally-knowledged, politicised healing spaces.

Ronald Labonté is Professor Emeritus in the School of Epidemiology and Public Health, University of Ottawa, Canada. He is co-editor of *Global Health Watch 7* and a member of the global PHM's Steering Council.

Sagrario Lobato is anti-patriarchal; a medical surgeon, specialist and master in social medicine, and a doctor in applied sciences for the use of natural resources. Her line of action: environmental health and the health of Mother Earth. She is co-coordinator of the People's Health Movement, México.

Rene Loewenson is a Zimbabwean epidemiologist and director of the Training and Research Support Centre. She is a cluster lead in the Regional Network for Equity in Health in East and Southern Africa (EQUINET), and a member of the GHW7 editorial committee.

Joyce Souza Maldonado, PhD, is a researcher at the Laboratory of Free Technologies (Federal University of ABC, Brazil) where she focuses on the economic and social implications of digital technologies and public health. She works as a consultant for international organizations and social movements, developing research and projects on data governance, cybersecurity, and data mapping.

Leonardo Mammana is a public health doctor and PhD candidate at the University of Bologna. He is part of the Centre for International and Intercultural Health (Bologna) and of the Italian Society of Medicine and Migration (SIMM). His works are focused on social epidemiology and primary health care

Ntombi Maphosa is an attorney at the Centre for Environmental Rights (South Africa) in the Pollution and Climate Change programme working mostly on air quality and climate change issues.

Sandra Marín, member of "Red Jarilla de plantas saludables de la Patagonia" and PHM. Activist in seed fairs and fair trade networks. She has worked as a formal teacher of adults.

Mariluz Martín Martínez is a member of PHM and the Latin American Association of Social Medicine (ALAMES). She is a researcher with CLACSO's Social Studies for Health Working Group, focusing on health systems, inequalities and intersectionality, gender-based violence and social justice.

Juliette Mattijsen is a medical doctor, activist, and researcher dedicated to advancing health justice, decolonizing medicine and addressing ecological and social determinants of health. She is affiliated with the University Medical Centre Utrecht, where she works as a project manager, lecturer

and researcher, focusing on climate justice and planetary health education.

David McCoy is a public health specialist and professor of global public health at the UN University in Kuala Lumpur, Malaysia. He's a long-standing member of PHM.

Liz Nelson (UK) is the Director, Advocacy and Research, at the Tax Justice Network and leads a team of high-level advocates and researchers addressing issues of international tax reform and governance. Liz is a Senior Atlantic Fellow for Social and Economic Equity.

Christie Neufeldt is the Global Partnerships Coordinator for Latin America and Caribbean of The United Church of Canada. The United Church of Canada is a member of International Allies Against Mining in El Salvador.

Tinashe Njanji is a social justice and human rights activist, and the coordinator of the People's Health Movement South Africa.

David Oginga Makori is a health and human rights activist with People's Health Movement-Kenya and SODECA, based in Nairobi, Kenya.

Roselyne Onyango is the is the Associate Programme Officer Africa at the Global Initiative for Economic, Social and Cultural Rights (GI-ESCR).

Rhiannon Mihranian Osborne (UK) is a doctor, organiser, writer and researcher focussed on the political economy of health. She works on environmental justice, health systems and border violence.

Dan Owala is the national coordinator of the People's Health Movement in Kenya, a Human Rights Defender (activist), and a paralegal.

Lauren Paremoer is an Associate Professor of Political Studies at the University of Cape Town, and a member of PHM's Global Steering Council, where she represents the Democratising Global Health Governance Program.

Sandra Isabel Payán Gómez is a medical doctor and community health promoter, member of PHM and Hope International, working at the Indigenous University of Cauca, Colombia UAIIN CRIC.

Chhaya Pachauli is Director at Prayas, India and the National Co-convenor of Jan Swasthya Abhiyan (JSA), the Indian chapter of the People's Health Movement (PHM). She has been a key voice in the campaigns for access to medicines, resisting privatisation of public health facilities, and the enactment of the landmark Right to Health Act in the state of Rajasthan in India.

James Pfeiffer is Professor in the Department of Global Health in the School of Public Health at the University of Washington. He has 30 years of public health research and implementation experience in Africa and is former Executive Director of Health Alliance International (HAI).

Ravi Ram is a health activist focused on evidence-based critiques of health policy and interventions and expanding civil society influence on health systems. He has supported PHM in Kenya and regionally, and serves as co-chair of the WHO Civil Society Commission.

Rocio del Pillar Bravo Shuna, PhD, is Andean migrant, poet, and social psychologist; a researcher with the Health and Migration Observatory working on migration, human rights, social mobilization, and inclusion; and a member of the LGBTQIA+ Health Committee (São Paulo) and activist in the MILBi+ Network.

Rosalinda Tablang is the Program Director of Samahang Operasyong Sagip or SOS, based in the Philippines, with long-term experience in humanitarian and development work, including examination of human rights of health workers.

Blagovesta Tacheva is a post-doctoral fellow in the School of Politics and International Studies at the University of Leeds, with experience in collaborative research on pandemic preparedness and response cost and the potential of innovative financing for pandemic preparedness.

Gabriela Teixeira is a psychologist with specialisation in Public Health Policy and Management at FIOCRUZ. She is Mental Health Supervisor at Doctors Without Borders (MSF) and a researcher focusing on migration, mental health and human rights.

Mauricio Torres-Tovar is a member of the People's Health Movement and Latin American Association of Social Medicine (ALAMES) and professor of the Universidad Nacional de Colombia. He is author of Workers' struggles for health at work in Colombia and co-author of Social mobilizations for health in Colombia.

Ben Verboom is a Lecturer in Global Public Health at Queen Mary University of London and a volunteer with PHM's Global Health Governance program.

Ana Vračar is an activist with PHM Europe and the Organization for Workers' Initiative and Democratization (BRID) in Croatia. She contributes to the People's Health Dispatch, a fortnightly bulletin published by PHM Global and the media organization Peoples Dispatch.

Maria Hamlin Zuniga, health worker, activist, feminist. American origin with 57 years of living in Central America. Popular educator and founder of several community health networks and organizations, particularly with indigenous peoples. Currently on the Advisory Board of PHM.

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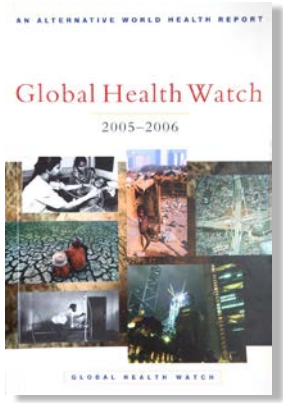

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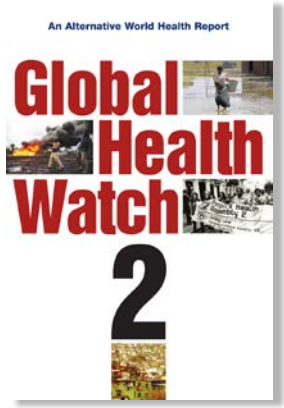

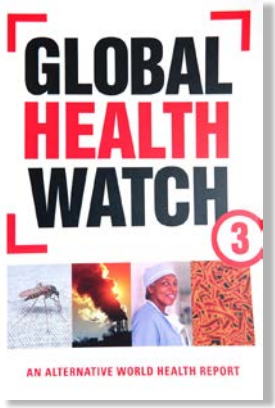

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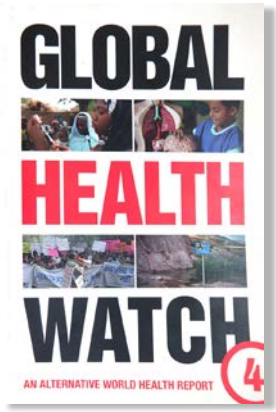

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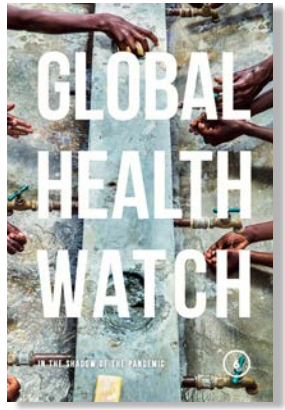

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This edition, created by activists worldwide, is being released during a turbulent transition where the former US-led (neo)liberal world order is shifting into an uncertain new form, with global health caught in its chaotic aftermath. Autocratic governments and repression of civil society are increasing. Consequently, there is a greater need to continue our mobilization for health justice, the main theme of many chapters in this book. In this spirit, this book is dedicated to Palestinians and their international supporters, many of whom often risk their personal safety to oppose Israel's ongoing genocide and crimes against humanity. This dedication also extends to all eco-justice health activists worldwide and their persistent 'optimism of the will.'

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