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RETS
International Network of Health Technicians Education

EXPERIENCE REPORT
Course aims to classify users and managers to enhance the Brazilian health system.

The Rockefeller Foundation and Bill & Melinda Gates Foundation: philanthropy that defines the course of international/global health

SUMMARY

Editorial

Dear readers,

This RETS Magazine publishes yet another report on health technical workers training experiences and follows the idea of replacing the publication of two special issues, as set forth in the Network's Work Plan, through the dissemination of continuous reports sent in all magazine issues. However, this shall only be possible if institutions interested in publishing their work in the field of training forward the material appropriately (see the call in section 'Network News', p. 7).

Besides the report, we opted to dedicate a different section of the magazine to present a very controversial issue that has generated much debate in the field of global/international health: philanthrocapitalism. To start this process, we have prepared a review on the article "Philanthrocapitalism, past and present: the Rockefeller Foundation, the Gates Foundation and the setting(s) of the international/global health agenda", authored by Anne-Emanuelle Birn, professor at the University of Toronto (Canada). Our intention was to go beyond a conventional review, bringing to readers as much as possible of the original text, published in English only in the Hypothesis Journal in November 2014. The review will be published in two parts, and we shall be more than pleased to publish any comments received on the subject.

In the article, the Canadian researcher shows how private interests can establish the path of public health in the world, affecting the organization of national health systems and consequently building a specific context for the training of health professionals at all levels.

Finally, we seize the opportunity to welcome the newest member of RETS – the Higher School of Health Technology of Porto – and we kindly ask you to accept our apologies for the recent delays in our publication, this issue is still for the last quarter of 2014. We undertake to restore the publication of the magazine to its regular intervals by the end of this year.

Have a nice reading!

Executive Secretariat of RETS

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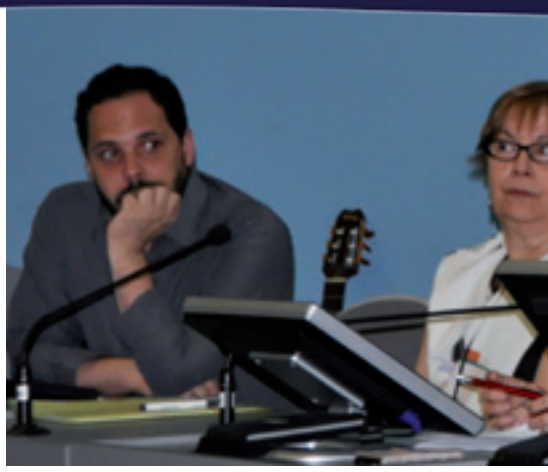

Social engagement and health management: health workers and population side by side

*Adapted by Julia Neves**

In Brazil, social control, that is, the participation of users (population) in the management of services is crucial to the organization of the Unified Health System (SUS) established by the 1988 Federal Constitution and regulated in 1990 by Law nº 8080. Despite its recognized importance, the challenge of developing effective forms of engagement of popular segments in public health policies still remains. It is therefore clear need to formulate educational proposals that favor business segments traditionally excluded from decision-making arenas of public policies, in order to enable the guidelines provided for constitutionally.

There is therefore a clear need to formulate educational proposals that favor segments traditionally excluded from public policy decision-making arenas, in order to enable the guidelines provided for constitutionally.

This demand led the Joaquim Venâncio Health Polytechnic School (ESPJV/Fiocruz) to design, in 2012, the "Social Engagement and Health Management" qualification course, whose coordination at the time was headed by professors Valéria Cristina Gomes de Castro and Marcello de Moura Coutinho, members of the Professional Education and Health Management Laboratory (Labgestão). Designed for health counselors, managers, health workers (CHWs and preferably health technicians) and all those interested in the subject, the course aims to boost the participation of people in social control positions, contributing to their performance in SUS decision-making processes.

The course, which was part of a research project of Fiocruz Development and Technological Innovation in Public Health Program (PDTSP-TEIAS Manguinhos), was designed as a space of participation and debate, where the coalescence of different interests resulted in the promotion of effective improvements to the lives of health users. Valéria says that this process is complex, contradictory and challenging but essential. "We believe in methodologies built with the involvement of different social stakeholders through collective action", he said.

The first class with 30 students was primarily aimed at training health counselors in the Manguinhos favelas complex located in the vicinity of Fiocruz, especially resi-

The Brazilian Unified Health System (SUS) was established pursuant to the 1988 Constitution, but it was only regulated in 1990 with Law No. 8.080/90, known as health organic law. The SUS has three doctrinal principles supporting its legitimacy: universality, comprehensiveness and equity. In addition to the principles, one should also consider the organizational guidelines that seek to ensure a better functioning of the system. They are: decentralization with single command, regionalization and hierarchization of services and social control through the incentive to promote popular participation. According to the final report of the 9th National Conference on Health, held in 1992, participation from the perspective of social control allows the population to interfere in health management, directing the State's actions toward collective interests. What is public should be under the control of users. Social control should not be translated only in formal mechanisms, but rather be reflected in the real power of the population in modifying plans and policies, and not only in health.

The PDTSP-TEIAS Network formally started in June 2010 and was organized into two main lines: The Management Model subnetwork and the Ecosystem Approach to Health subnetwork. It aims to develop and assess experiences that are a healthcare integrated territory management model in Manguinhos, a set of validated experiences that can be used by managers in the implementation of other TEIAS or Health Care Integrated Networks, using the methodology of Ecosystem Approach to Health.

Located north of the city of Rio de Janeiro, the Manguinhos neighborhood, where Fiocruz main campus is situated, houses a set of favelas and communities, such as the 'Mandela', 'Amorim' and 'Coreia'.

***Original text:** 'Relato de Experiência: Construção do Curso de Participação Social e Gestão em Saúde'. Available on RETS website (www.rets.espjv.fiocruz.br), in 'Library'.

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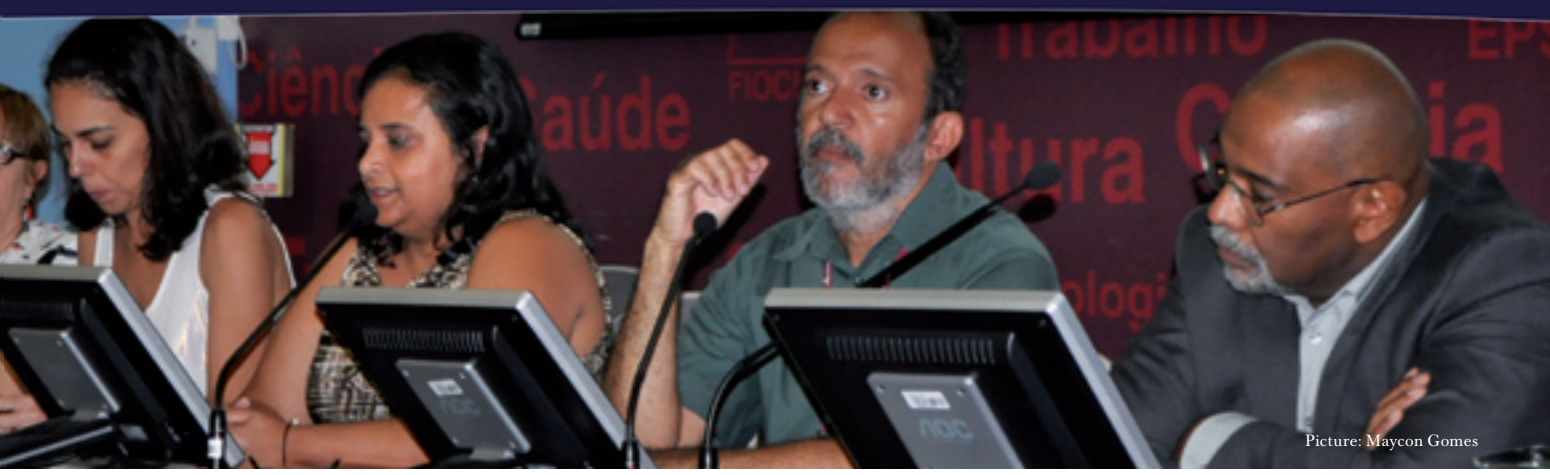

Picture: Maycon Gomes

EPSJV/Fiocruz and Ministry of Health representatives at the opening session of the inaugural class of 2014, with sociologist and social movement's expert Maria da Glória Gohn.

dents and professionals working at community health centers. Throughout the course, people from other places joined in, which, according to coordinators, enabled the reflection and exchange of important experiences on different realities.

The population an agent of change

In Brazil, community engagement in health management mechanisms has been implemented with the establishment of the SUS, through Law 8.080/90, and more specifically Law 8.142/90. Today, however, after more than two decades, many hindrances in ensuring a critical participation that enables the autonomy and the political debate at all levels of the SUS can still be seen. As stressed by the course coordinator, the concept of Social Engagement is relational and polysemic, since it refers both to social cohesion and social change and may involve understanding the actions that mobilize individuals and the political nature of democratization or broad participation of citizens in decision-making in a given society.

A discussion on engagement in health includes, among other things, the political understanding of the recognition and importance of community participation and education as reflection and practice transformation, building democratic communication and management tools and the discussion on the funding mechanisms of State actions. "Thus, education must be understood not as a transfer of information and content, but rather in view of the reflection on reality, seeking solutions to the problems faced in everyday life", emphasizes Marcello.

Valeria adds that the State is constituted in hegemonic fashion in spaces advocating the interests of capital-holding segments of society, which enables through ideological, cultural, educational and even coercive strategies the defense of their interests. However, even for the sustenance of its ruling class situation, the interests of other non-capital-holding population segments must be considered. "As pointed out by ENSP/Fiocruz professor and researcher Eduardo Stotz, the state ends up being the expression of society tensions. So we can only define social engagement when we understand the multiple actions that different social forces develop in order to influence the establishment, implementation, monitoring and evaluation of public policies in the social sector (health, education, housing, transportation etc.)", stresses Valéria.

In their account, teachers point out that it is in this complex relationship that counter-hegemonic projects of the popular classes in the state may favor the achievement of significant improvements to the lives of the most vulnerable social class. They do, however, recognize that the concept of "engagement" is broad and controversial. For some authors, public participation in health projects occurs asymmetrically and horizontally, where the population appears as receiver of knowledge. And even when the population prominence speech is there, the directionality of actions remains in the exclusive hands of the government.

Social engagement in health: from law to practice

In Brazil, social participation in formal spaces was mainly strengthened with the creation of the SUS and crucial in the health municipalization process, serving even as a reference for other areas of public policy in the country.

"In the Brazilian administrative model decentralization, although some argue to the contrary, the primary definition is that the actual active performers are municipal governments, which have command at the local level. However, the implementation of society engagement and control legal mechanisms was not able to allow the real participation


Picture: Labgestão/EPSJV/Fiocruz

Class of 2014: thematic workshop.


Picture: Labgestão/EPSJV/Fiocruz

Class of 2014: activities during the course.

Picture: Maycon Gomes

Maria da Glória Gohn's inaugural class aroused the interest of students and had a positive impact on the beginning of the course in 2014.

of a large portion of the population on issues related to services and conditions needed to solve their health problems", they explain.

According to them, the very decentralization of services has brought new challenges to be overcome, such as the strengthening of local government (subject to different interests) and all the implications for effective participation of the population in decision-making. "In her article 'Saúde e Cidadania: Análise de uma Experiência de Gestão Local' (Health and Citizenship: Analysis of a Local Management Experience'), published in 1996, sociologist Amelia Cohn already drew the attention to the fact that decentralization, when understood as municipalization of health or as the establishment of the Unified Health System (SUS) at municipal level does not automatically imply the democratization of health nor does it establish a universal and equal right", recalls Valéria. "She believes that the highly centralized tradition of the State tends to surface strongly at the local level, and the executive branch ends up predominating and lording over the others", added Marcello.

Moreover, as emphasized by the coordinators, in most of the Brazilian cities, especially in large urban centers, the issue of violence has made it impossible to guarantee access to basic sanitation, health and nutrition, enabling decent survival, being true exception territories in which social and citizenship rights are strongly linked to local authorities.

This is the context in which Manguinhos community is inserted and where the first class of the course was developed. A territory marked by violence and, according to epidemiological data, with the worst Human Development Index (HDI) in the city of Rio de Janeiro. The proposal of course, in turn, is related to the emergence of a new political scenario that, on achieving high investments in infrastructure and social projects in the territory, rekindled the hope of residents to build another living space.

"We seek to meet the challenge of combining the engagement prospect in a territory with serious social problems and the prospect of an emancipatory education project that enables knowledge sharing between teachers and students in a common project, recognizing, however, the boundaries, possibilities and contradictions of this reality, conditioned by historical circumstances, proximity and funds provided by the Oswaldo Cruz Foundation", adds Valéria.

Collective construction: paramount to achieve the objective of the course

Creating this course aimed to contribute to an increased engagement of popular segments in formal political spaces of the SUS and in the people's struggles to achieve their rights. Its specific objective, however, is to build participatory methodologies of curriculum design to favor the participation and performance of students as subjects of educational processes and transformation of society. "The education approach we use is based on the polytechnic conception that qualification goes beyond training for work, involving different prospects, such as the formation of individuals able to act ethically and politically in social relations, with a view to achieving better living conditions for themselves and the community", says Marcello, noting that the political learning of engagement occurs in formal and non-formal spaces of society and that, although many people have little experience of councils and managing collegiate bodies, they have vast experience and performance in non-institutionalized public management spaces, working in important decisions, including health policies.

Inspired by sociologist Maria da Glória Gohn who, in the text "Educação não-formal, participação da sociedade civil e estruturas colegiadas nas escolas" ('Non-formal education, civil society participation and collegial structures in schools'), says the shared management needs to develop a new participatory culture in the name of rights of the majority and not lobbyist groups, the coordinators built on the idea that non-formal education is that you learn 'in the world of life', through the processes of sharing experiences, especially in daily collective spaces and action.

The development project was based on the conception of reflection with the student about their importance in the political context of society, discussing knowledge on the organization and foundation of public policies that affect their daily lives, especially health policy, including discussions about the extended concept of health, to the struggle for civil rights and democratization in Brazil, history and organization of SUS, the new management models and intersectorality as health promotion factor.

The course has a workload of 96 hours and is divided in once or twice-weekly classes. It was built around four thematic lines: Territory's Historical and Social Context and the Conceptions of the Population Health; State and Public Policy; Public Health and Social Engagement; and Social Engagement and Health Management. All matters discussed, some of which were introduced throughout the process, such as religiosity, social engagement and organization of educational material for popular mobilization were discussed from a dialogic perspective and related to the reality lived by students.

In addition to the discussion, the course also enabled coordination with people working in Manguinhos, such as the various Fiocruz technicians and managers of health facilities in the region who participated in the classes and the final graduation event. At the end of the training experience, students received printed and digitized educational materials for future reference.

The proposed themes and the developed methodology were intensively discussed in the three thematic workshops preceding the course, which focused on bringing these contents closer to the reality experienced by the student in a space of dialogue and education. Based on the principles of popular and polytechnic education, the

workshops had the collaboration of Fiocruz researchers with extensive experience in the field of Popular Education in Health and territorial knowledge, as well as the directors, technicians, managers, teachers and people from other segments interested in the topic.

"We ask them to assess the proposed structure and include topics they would like to be worked on throughout the course. We started from the idea that everyone has knowledge and that to address health is a constituent part of daily life for all people who develop actions and have knowledge about coping with everyday problems", analyzed Valéria.

The course is designed in a strategic perspective and seeks to bring teachers and students closer through educational experiences to reflect on their role as public manager. "The exchange of experiences with segments of the population historically excluded from decision-making systems and health services was essential to understanding the importance of our professional work in building a more just and equitable society", added the coordinator.

A positive evaluation ensures continuity of the course

The experience brought some special features and constraints, but addressed issues related to effective social control and social engagement by seeking to build, through the intersection of Popular Education and Polytechnic Education knowledge, information to share knowledge and transformative actions in health. "The reference in different fields of knowledge ends up bringing the discussion on the need to have both professional education and SUS management recognize and gather academic and popular knowledge present in the actions of health professionals and the community served in the facilities in order to address and solve the problems experienced daily in the SUS", says Marcello.

The course evaluation occurred procedurally. At the end of each meeting, students took notes on their experience during the activity and filled a form to evaluate not only the content worked, but also the way it was developed. On record there was also room for suggestions of new themes or further study of issues they found most relevant.

The coordination said that the value of learning was better than expected. Because of the proximity to the theme, they could have the experience of working in other school projects as educators and in the development of educational material on the subject for technical health workers.

"We had to overcome some challenges, including the territory's peace process occurring during the course period. However, despite all the hindrances, students and teachers stated that the course had been very important as it contributed to the qualification of user participation in health and the understanding of the different problems faced before the engagement of users in the management the system", assured Valéria.

In the aftermath of this first experience, the course was included in the ESPJV catalog and held regularly not only for directors, but also representatives and members of various segments of civil society and another course class was completed in 2014. As from 2015, Valéria shall be the sole coordinator of the initiative. ■

Picture: Labgestão/EPSJV/Fiocruz

Class of 2012: closing activities.

"On August 13, 2014, the Social Engagement and Health Management Qualification Course started at the ESPJV/Fiocruz. We were a large group, around 40 students from different areas, with different expectations and experiences, but with a common interest: to gain more knowledge on public health and on the various forms of social engagement.

At the beginning of the course, we discussed a lot about the concept of health and disease. We understand that health is more than the absence of disease, it is a complex idea that involves many factors, including social welfare, physical and mental. To better understand this process, another issue addressed was the importance of knowledge of the territory, whose features are crucial to the quality of life of the population.

During the classes, we got acquainted with some of the history of Brazilian health policies and understood the importance of social engagement for the implementation of the SUS. We can say that, theoretically, we have one of the world's best health systems, but it is necessary that social participation become indeed effective in various areas so that the theory is transformed into practice.

And how do we turn theory into practice?

Knowledge is key to social participation. The education we've had over the course and the constant exchange of knowledge and experiences between students and teachers made us reflect on our role as stakeholders in civil society. So today we feel more empowered to make a difference in our territories and fight for improving public health in the country" (collective text prepared by the students for final activity of systematization – 2014 class).

New member: the Polytechnic Institute of Porto School joins the RETS

Yet another member from Portugal joins the RETS in January 2015, namely, the Superior School of Health Technology of Porto ('Escola Superior de Tecnologia da Saúde do Porto'). The School is an organic unit of the Polytechnic Institute of Porto ('Instituto Politécnico do Porto'), it offers 1st and 2nd cycle education in healthcare, especially in Health Technology, granting bachelor (13 courses), master's degrees (five courses) and running postgraduate courses.

The School's mission is "to contribute to the development of society, oriented to the creation, transmission and dissemination of culture and knowledge through education and teaching, research and community outreach activities in directly or indirectly health-related areas under a national and international framework".

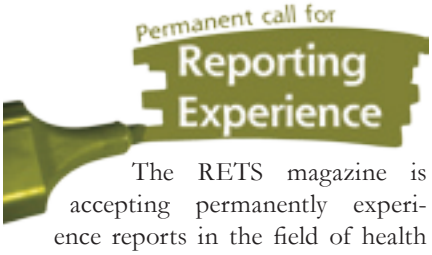
In the health area, it is currently the largest higher education institution in the country and is the third largest School of the Polytechnic Institute of Porto. It is distinguished not only due to the wide range of courses offered, but also for its quality dynamic growth.

Learn more about the ESTSP by accessing the website (www.estsp.ipp.pt).■

Fiocruz launches a new Journal Portal

Fiocruz has recently launched a new space for the dissemination of Science: The Journal Portal. On the same web environment, the public will have free and open access to articles of all scientific publications produced by Fiocruz. With the integrated search in seven magazines, readers may get a broader view of health knowledge from different approaches.

In addition to articles, the new channel provides information in several formats: news, interviews, videos and infographics. Editora Fiocruz Chief John Canossa says this "varied content menu" allows society to capture the vast knowledge produced in the institution. "Thus, this production may be used by people from other research centers, universities, at work, at home and in this or other countries. The Journal Portal has everything to become yet another powerful tool for achieving this". Learn about the new portal at (www.periodicos.fiocruz.br/pt-br).■



The RETS magazine is accepting permanently experience reports in the field of health technical workers education for publication. The idea is to promote the highest number of possible experiences in all areas and levels of training, ranging from those for assistants and health agents to those related to the mid- and/or high-level technicians and technologists. Please join and send your report. Reports on experiences occurring from 2010 onwards shall be selected, according to the guidelines specified in RETS website (www.rets.epsjv.fiocruz.br), in: 'Home'> 'Reports'.■

Publications

Investing to overcome the global impact of neglected tropical diseases

The report presents an investment strategy for NTDs and analyses the specific investment case for prevention, control, elimination and eradication of 12 of the 17 NTDs.

The article registers progress and challenges and signals those that lie ahead. Climate change is expected to increase the spread of several vector-borne NTDs, notably dengue. Investments in vector-borne diseases will avoid the potentially catastrophic expenditures associated with their control. The presence of NTDs will thereby signal an early warning system for climate-sensitive diseases.

The report is available, in English, at RETS (www.rets.epsjv.fiocruz.br), at: 'Library'> 'Investing to overcome the global impact of neglected tropical diseases'.■

Health in all policies training manual

This manual is a training resource to increase understanding of the importance of Health in All Policies among health and other professionals. The material will form the basis of workshops.

The manual is available, in English, at: WHO website (www.who.int), at: 'Social determinants of health'> 'Publications'> 'Health in all policies training manual'.■

Philanthrocapitalism: What does this term mean to global health? (part 1)

By Ana Beatriz de Noronha

In 2008, journalist and editor of the English weekly magazine 'The Economist' Matthew Bishop declared himself surprised by the impact and the amount of debate that the term 'philanthrocapitalism', which he created two years earlier, had produced. This word used to associate philanthropy and capitalism, which underscores the growing role of several of the richest and most powerful men in the world in some important social issues affecting humanity, has really aroused heated discussions worldwide. On the one hand, those who clearly believe in the good will of the rich in their ability to solve poor people's problems based on their business success; on the other, those who remain on alert to the risk that the uncritical association between the public sphere and the private capital, driven by profit and with immense political power can pose to the most disadvantaged and vulnerable layers of the world population.

With a view to stimulating debate on global health, this issue of RETS Magazine presents to its readers the first part of a review of the article "Philanthrocapitalism, past and present: The Rockefeller Foundation, the Gates Foundation, and the setting(s) of the international/global health agenda" by historian and professor at the University of Toronto Anne-Emanuelle Birn. The original article was published in English in November 2014 in the Hypothesis Journal and is freely available at: www.hypothesisjournal.com/?p=2503.

In her text, the author analyzes how private funding has acted to set the global health agenda. Thereunto, it outlines a parallel between goals, paradigms, principles and modus operandi defined and used in different historical contexts, for two of the largest existing philanthropic organizations – the Rockefeller Foundation (RF) and the Bill and Melinda Gates Foundation (BMGF) –, drawing attention to the ability of these organizations to interfere both in global health governance and scientific production for the industry. She says that we need to be, more than ever, attentive to this issue and willing to challenge what is being said, while seeking some viable alternatives to philanthrocapitalism in global health.

The Hypothesis Journal (www.hypothesisjournal.com) aims to stir and stimulate scientific thinking through the dissemination of new discoveries and hypotheses in any field of knowledge, promoting the publication of articles that go far beyond data reports or work summaries, and in which authors are free to express their most intriguing ideas. Articles may be freely accessed.

The emergence of modern international health and "scientific philanthropy"

According to Anne-Emanuelle, the history of international health begins in Paris in 1851, with the First International Sanitary Conference, whose main objective was to initiate the development of an international action plan to combat epidemic disease transmission. However, due to political and economic differences between countries, the creation of the International Office of Public Hygiene (OIHP) only materialized more than 50 years and 11 conferences later. The difficulty for European countries in reaching an agreement allowed the American continent to pioneer the area, and, in December 1902, representatives from 11 countries gathering at the First International Sanitary Convention of the American Republics created the Pan American Sanitary Bureau (PASB), the future Pan-American Health Organization (PAHO/WHO), to discuss and plan an effective fight against the yellow fever epidemic that was spreading over the continent due to the intensification of maritime trade between Latin America and the United States.

The International Committee of the Red Cross, which was founded in Geneva in 1863 to provide aid to war victims, as well as other bodies established by colonial powers to watch over their troops and ensure increased

Established in Paris in December 1907, it mainly aimed at developing guidelines and overseeing the international standards on ships and ports quarantine and, thus, preventing the spread of plague and cholera, as well as managing other public health conventions. It was dissolved by Protocols signed on July 22, 1946 and its epidemiological service was incorporated into the Interim Commission of the World Health Organization on 1 January 1947.

production in the colonies and trade of such goods joined these two bodies, who at the beginning of their existence focused their efforts on establishing and monitoring sanitary conventions and collecting disease statistics.

The author states that, in this context, a new stakeholder would eventually rise and radically transform over a couple of years the emerging field of international health, namely, the Rockefeller Foundation (RF), created in 1913 by known American oil magnate and philanthropist John Davison Rockefeller (1839-1937), "to promote human welfare around the world". The Canadian historian says that the RF not only popularized the concept of international health, but also had a great influence on the agenda, approaches and actions undertaken in this sector throughout the 20th century.

Anne-Emanuelle reminds us that Rockefeller was a representative of the American "scientific philanthropy" movement, created by Andrew Carnegie (1835-1919), a Scottish billionaire living in the United States. She points out that, despite all the "good intentions" suggested by Carnegie, the millionaire philanthropists ended up being very criticized: due to the origin of their fortune resulting from income derived from the exploitation and repression of workers; due to their role in the turbulent late 19th century and early 20th century, serving as a containment tool of labor movements that threatened the interests of industry and commerce; and for undertaking the state's role in social protection, valuing volunteer efforts instead of civil rights and weakening the State against the private sector in the provision of social welfare services.

She also says that, inspired by the scientific philanthropy idea, Rockefeller shifted from simple welfare contributions addressed to hospitals, churches and universities to support to public education, science and medicine, funding large-scale research and campaigns aimed at social improvement. Public health, in turn, became the focus of Rockefeller's interests because of its emerging nature, since this field began to professionalize with limited support from the US government, something which provided the millionaire with considerable space to test ideas and practices.

Carnegie, who became the richest man in the world, published in 1889, the essay "The Gospel of Wealth", in which he argued that the poor did not know how to manage money and the rich should become increasingly richer in order to use their fortunes to favor society, supporting systematic social investment instead of random forms of charity. The man who, according to a biography published by David Nasaw in 2006, bribed and corrupted politicians, choked union movements and increased working hours of his employees from eight to 12 hours a day, seven days a week, donated 90% of his fortune during his lifetime, leaving a legacy of thousands of public libraries and grants for higher education and the arts and setting an example for many other millionaires colleagues.

First steps

At first, the issue to be tackled in the midst of many public health needs was defined jointly by three Rockefeller advisers: Frederick T. Gates (a Baptist preacher), Charles Wardell Stiles (a zoologist) and Wickliffe Rose (a Southern US educator). The Rockefeller's troika chose hookworm disease, a verminosis that causes anemia and was considered one of the economic "slowdown" factors and a hindrance to industrialization in the South. The easy detection of the presence of the worm causing the disease in a rapid stool test and the existence of an effective treatment for the disease, previously tested in campaigns in Costa Rica and Puerto Rico, the US-occupied territory, would have been, according to the article, fundamental to this decision. On the other hand, the fact that the disease did not have a high mortality rate and the treatment itself would have been responsible for occasional deaths among patients did not prevent the realization of a huge campaign funded by the RF and developed in the 11 U.S. southern states, from 1910 to 1914.

Picture: Rockefeller Foundation

John Rockefelle (1885)

Russian word for a three-member committee. In politics, it is used to name an alliance of three characters of the same level and power gathered for the management of an entity or to complete a mission.

The campaign enrolled medical doctors, health inspectors and laboratory technicians, as well as churches and agricultural clubs and included: worm elimination with the administration of anthelmintics, promoting the use of footwear and latrines, and the dissemination of public health advertising, addressing both health education and positive publicity for RF. After achieving the arousal of public interest in public health, the RF created, in 1913, an International Health Commission, which became the International Health Board (IHB) in 1916, which was later reorganized as International Health Division (IHD) in 1927.

According to Anne-Emanuelle, choosing international public health as performance area was quite convenient to Rockefeller, since the family faced many difficulties at the national level. As she points out, in 1890, the Sherman Antitrust Act broke the oil monopoly and workers of various family companies rebelled against poor

working conditions. Negative publicity would achieve its peak in 1914, with the so-called Ludlow Massacre. Strengthened philanthropy actions, with high investments in education and health, eased the situation and neutralized harsh criticism.

The author says that, from there on, about four decades of intensive participation in international health elapsed, in which Rockefeller was assisted by experts from various fields of knowledge and established regional IHD offices in Paris, New Delhi, Cali (Colombia) and Mexico and invested billions of dollars in several disease control and health issues campaigns. In 1951, when IHD merged into the newly created Medicine and Public Health Division of the RF, the focus shifted to medical education.

Over the years, the RF sponsored the establishment of 25 public health schools in North America, Europe, Asia and South America, funded postgraduate courses and granted scholarships to about 2500 public health professionals. Interestingly, however, it always stressed the "official aid for public health organizations in the development of appropriate administrative measures to local customs, needs, traditions and conditions" as its most important contribution.

Thus, while setting out a vertical model of action in international health with large strictly scientific and transnational medical training campaigns, the RF took a strong role in generating political and popular support for public health, helping to create national health departments around the world and defending the institutionalization of international health. As noted by Anne-Emanuelle, this double movement eventually resulted in the transfer of the agenda, the structure and working procedures (modus operandi) of the RF for local, national and multilateral institutions.

The action of the Rockefeller Foundation in the Age of Imperialism

The author states in her article that RF's work in international health courted politicians and public officials around the world, creating a deep loyalty among health professionals and connecting local elites to prestigious international medical networks. Also, it spread the idea of public health among populations around the world and helped build and modernize dozens of public health institutions. Anne-Emanuelle says that, however, RF's endeavors outreach would have gone far beyond health. They stabilized colonies and emerging nations, in that they helped governments meet the social demands of their populations; encouraged the transfer and internationalization of scientific, bureaucratic and cultural values; stirred economic development, growth and expansion of consumer markets; and prepared vast regions to receive foreign investment, ensuring increased productivity of enterprises and the incorporation into the global capitalism expansion system. Formerly identified with military and colonial powers, international health gained a more positive and diplomatic vision and was thus seen as the driving force of social progress.

The Canadian researcher affirms that RF's work in international health would have strengthened simultaneously and in close relationship with US imperialism. A clear example is the invasion of Cuba by the United States in 1898, which, despite being a clear expansionist movement, was justified as a way to contain the annual threat of yellow fever outbreaks along the east coast of the United States. RF's action in the fight against yellow fever and malaria was instrumental to the construction completion of the Panama Canal, the existence of which, in turn, helped convince governments of Latin American countries about the importance of containing the spread of epidemics resulting from the intensification of maritime trade between the Atlantic and the Pacific.

Over three decades, the IHB/D conducted research in West Africa and major campaigns throughout Latin America to reduce the presence of A. aegypti mosquitoes by spraying insecticides, draining wetlands and distributing larvicide. In parallel, it funded and planned research that resulted in the discovery of the yellow fever vaccine and helped expand and strengthen scientific knowledge in the USA. By acting in the Latin American countries, linking the fight against communicable diseases to known geo-economic interests, as emphasized by Anne-Emanuelle, RF helped expand the "good neighbor policy" advocated by US President Franklin Roosevelt in the 1930s.

> The massacre took place in April 1914, when the National Guard and the Ludlow (Colorado State) coal mines guards charged into about 1200 miners who were on strike and their families. The death of more than ten people, including children, caused a great wave of press attacks on the company and its owners.

The RF always took care in avoiding disease control campaigns that were too expensive or too complex and time consuming, except the one waged against yellow fever, regarded as an essential investment for the interests of US companies and port trade. Those that did not conform to the technically oriented model of public health or that could not have their results translated in the quarterly reports used by the growing bureaucracy of the organization were also left out. On that account, says the historian, childhood diarrhea, tuberculosis (TB) and other major causes of death in countries were addressed only a few times, given that their control (or elimination) would depend on long periods of socially oriented investments – for example, basic sanitation – even if it could help solve a much broader set of public health problems.

The need to adapt its designs to local contexts led the RF to develop its agenda seemingly jointly with governments in processes that often ended up creating permanent national structures – agencies or public health offices – maintained by governments and focused on the control of diseases defined by the Foundation's campaigns. Presence in the field work, while guiding activities and in the political negotiations of professionals hired and trained by the RF also facilitated and naturalized the widespread use

of ideologies and practices defined and advocated by the "philanthropic organization" in the institutions and national policies, often at the expense of local knowledge and interests. While sponsoring the training of doctors, nurses and engineers in public health in North American and European programs, the RF ended up setting staff that later became their own partners in countries and the organizations themselves.

Anne-Emanuelle points out that such RF procedure faced resistance in some countries and ended up requiring reformulations. She quotes Mexico as an example, noting that, despite having worked directly with the RF, public health physician Miguel Bustamante, who did also hold the position of Secretary-General of the Pan American Sanitary Bureau (PASB) and State Health Secretary of his country, resisted the imposition of the public health's technical model and decided to implant a socially-based model that would meet the real health needs of the Mexican population. Thus, the RF never appeared as a monolith, but rather a very flexible organization that, over time, was able to follow the change of political priorities in its own country and abroad.

Comprehensive and lasting influence

To spread his gospel of public health, the author states that the RF would have strengthened the image of philanthropic institution, supposedly independent from government and devoid of commercial interests, with limited autonomy and responsibility. Its work patterns included the establishment of national partnerships, the use of specific and technically proven disease control methods and an almost missionary zeal of their own agents. The national commitment to the idea of public health, in turn, was a valuable strategy to ensure the permanence of its approach at the country level. For that to happen, the established partnerships envisaged governmental co-financing of actions, which ranged from 20% of campaign costs to 100% over a few years. In parallel, the Foundation was involved in countless inter-country cooperation actions, allowing the direct or indirect mapping of the institutional landscape of international health.

The health agency of the League of Nations created after the First World War was partly shaped by IHB/IHD and went on to share their values, experts, modus operandi and medicalized vision of health. Moreover, given the lack of financial resources to carry out its agenda and maintain its operations, it had to ask for assistance to RF, which, during the Second World War, even undertook some key activities in the field of public health in Europe.

Anne-Emanuelle contextualizes that, in the interwar period, the institutionalization process of public health in the countries and the international context presupposed the clash between different political currents, which forced the RF to consider, hear, take advantage of and even finance progressive political foundations initiatives, supporting admittedly leftist researchers and public health leaders. While this support has always been subordinate to the dominant model, funding scientists who advocated for social medicine, as Johns Hopkins, Henry Sigerist and Andrija Stampar revealed a providential ideological flexibility of the Foundation. The research carried out, in turn, contributed to the RF's effort to collect information on a large scale around developments in science and public health, including those from socialist countries.

In the US landscape, the RF helped the government to strengthen the international health strategy as a foreign policy. When, in the mid-1930s Germany began using medical help to get closer to some Latin American countries, in search of essential raw materials, the RF doubled their public health efforts in the region, favoring the approach of these countries with the US.

In a nutshell, the author says that what enabled this enormous influence on setting the agenda and the establishment of public health institutions were RF's massive performance at international level and its powerful tentacles outreaching nearly all public health activities.

RF's strong presence was not only the result of unilateral efforts, because its actions always entailed giving and receiving and were marked by moments of negotiation, co-optation, enforcement, resentment and even outright rejection. "Uniquely for the era, it operated not only as philanthropy, but also as, at one and the same time, a national, bilateral, multilateral, international, and transnational agency", summarizes Anne-Emanuelle.

In 1951, three years after the creation of the World Health Organization (WHO), IHD was extinct and the RF just ended up reducing its leading international health role, remaining, however, linked to various health-related and international development-related activities.

In the 1970s, for the first time under the command of a doctor – John Knowles –, the RF rose once again to its strength in the international health sphere. In 1977, it launched the Great Neglected Diseases of Mankind Program and started discussions on primary health care with the WHO. In 1980, it established the International Clinical Epidemiology Network (INCLEN) and, in 1984, helped launch the Task Force for Child Survival, a joint initiative with the United Nations Children's Fund (UNICEF), WHO, the United Nations Development Programme (UNDP) and the World Bank.

In the 1990s, the RF established the project of Public Health Schools Without Walls and co-founded the International AIDS Vaccine Initiative and the Children's Vaccines

The "Public Health Schools Without Walls" (PHSWOW) project was created in 1992 with the goal of bringing to developing countries the possibility of training public health personnel at graduate level, in the technical, managerial and leadership skills necessary for the functioning of increasingly decentralized health systems. The first Masters Course initiative was offered at the University of Zimbabwe in 1993. Uganda and Ghana followed in the next two years, all with strong links of cooperation between them and based on the skills model. Among other things, the initiative enabled the dissemination of materials and experiences among various African public health institutions.

Initiative. During this period, after several changes imposed by the end of the Cold War and the rise of neoliberal ideology, which resulted in strong internal debate, the RF began to shift its traditional support to the public sector to public-private-based partnerships initiatives. According to the historian, despite being partially eclipsed by other stakeholders that have emerged in this context and having lost the leadership of the first half of the 20th century, the RF ended up leaving a powerful, albeit problematic legacy to international public health (see box).

The Cold War and the rise of neoliberalism

In terms of context, Anne-Emanuelle recalls that, in post-World War II decades, many organizations related to international health were created or renewed, including aid and bilateral development agencies, the World Bank and the International Monetary Fund (IMF), the various agencies of the United Nations (UN), countless and local and international non-governmental organizations (NGOs), research institutes, private foundations, business groups and so on. The liberation movements of postwar Asia, Africa, and later the Caribbean have also contributed to more complex geopolitical dynamics, in which various stakeholders started to act in various settings, and dozens of newly independent countries gained voice, at least nominally, in the development of international policies.

From 1946 until the early 1990s, the field of international health ended up being shaped by political and ideological rivalry between the Western bloc, identified with the American capitalism and the East Block, linked to Soviet communism, as well as the paradigm of economic development and modernization built by Western powers as the only way to progress and the decolonization of the Third World. The setting made health an important way for the establishment of alliances. In both blocs, the major powers have deployed hospitals, pharmaceutical companies and clinics in the poorest countries and sought to carry out RF-like disease control actions and sponsored a large number of scholarships for advanced training of industry professionals.

In the 1950s, the fact that reconfiguration of world power brought little benefit to the former colonies was made clear. In 1964, countries not aligned with the Soviets or Americans created the G-77 movement, which sought to confront the new colonialism implemented through support to development and demanded respect for the sovereignty in decision making, and to report unfair international trade agreements and the lack of democracy in UN agencies. The international health had become a pawn in the Soviet-American competition for power and influence.

As stated by the author, clearly controlled by the interests of the Western bloc, WHO continued to operate under RF's bias, encouraging professionalization and bureaucratic growth, as well as performing global campaigns technically oriented to the control or elimination of specific diseases: firstly, against yaws (with penicillin) and tuberculosis (BCG), and then, unsuccessfully, against malaria (DDT insecticide-based, widely used during World War II). This stage culminated in a bold vaccine-based campaign to fight smallpox, which resulted in the disease eradication statement in 1980.

In the 1970s, this type of disease-focused and donor-driven approach used by WHO began to be challenged, especially by the G-77 countries, which, under the leadership of Danish Halfdan Mahler, sought to establish actions to cooperate in an intersectoral perspective. In 1978, the movement of primary health care enshrined in the Alma-Ata Declaration and WHO "Health Care for All" policy, states that health is a fundamental human right and should be achieved through integrated social and public health measures and that recognize the economic, political, social and health context, and not through technical and biological campaigns defined from top to bottom.

The Canadian says that, in the face of primary health care, the resurrection of social medicine in the 1970s would have created bitter divisions within WHO and between it and UNICEF, allowing the RF to rise again to play a small role,

Rockefeller Foundation's legacy

Some principles established by the RF and that permeated its relationships with countries and even its performance in the broader field of international health are still strongly present in the sector, including:

- The definition of a top-down schedule, i.e. by donors, both through direct activity financing in countries or through the award of grants;
- Partial funding of activities, creating commitments of beneficiaries with the input of human, material and financial resources enabling cooperation projects;
- Guiding activities in accordance with the technical and biological paradigm, usually in actions aiming disease control through the use of technical tools with wide range of settings and considering the behavior and individual biological features as the main cause of disease;
- Establishing a priori success criteria, which tend to establish geographical and stricter time limits for activities, while reducing its intervention object in order to ensure the visibility and the possibility to measure results objectively;
- The use of professionals trained abroad and officials of donor agencies, usually involved in international networks to facilitate in-country translation of initiatives and approaches used by donors; and
- Ability to adapt the proposed activities to the conditions and local economic, cultural and political contexts.

Anne-Emanuelle says these principles were continuously fed with alignments between the RF and a variety of national interests and its permanence seems to be a consequence of the sharp disparities in the political and medical power that still characterize most of the international and global health interactions.

According to her, RF's legacy created strong roots within the WHO and PAHO, through the performance of some professionals like Fred Soper and Marcolino Candau, who assumed leadership positions in these organizations after working directly with the RF.

yet fundamental for the promotion of primary health care. Thus, in a technically reduced prospect of broad social justice agenda of Alma-Ata to primary health care, whose emphasis was on 'low cost' approaches, RF invested, for example, in immunization and oral rehydration therapy, which became the main driving force of UNICEF child survival campaigns in 1980.

While trying to get rid of international health principles established by the RF, WHO began to face crises of political, financial and bureaucratic nature that affected its legitimacy and budget. The oil shocks and economic crises of the late 1970s and 1980s prevented many member countries from paying their contribution quota. In addition, WHO has been accused of having many employees at headquarters and few in field work.

According to Anne-Emanuelle, the rise of the neoliberal political ideology, which strengthened the idea of a 'free' market while minimizing the role of government in redistributing wealth and promoting social well-being, as well as regulating industrial and economic activity, eventually leading to a break with the model that the RF had adopted in the period between wars, which strongly supported international health institutions. The administration of US conservative President Ronald Reagan, in turn, froze the US financial contribution in order to retaliate against the WHO because of its essential drugs program, which established a pharmacopeia of generic drugs, and the International Code of Marketing of Breast-milk Substitutes, published in 1981, both considered deliberately contrary to the interests of US companies. In the early 1990s, less than half the WHO budget coming from the annual country contributions was subject to 'democratic' decisions of the World Health Assembly and an increasing share of donor-derived funds, including then a variety of private entities, was aimed at pre-defined activities and programs.

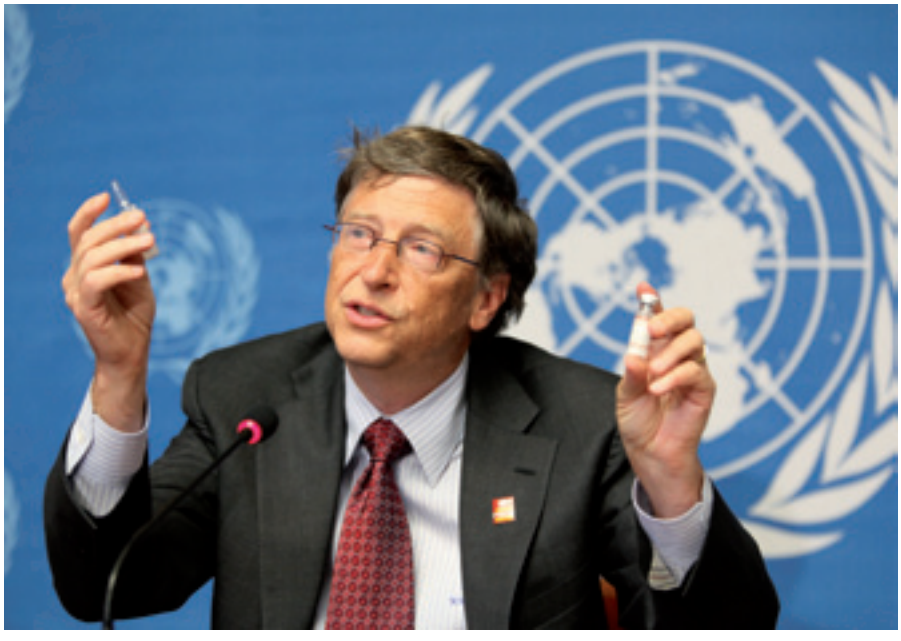
The Cold War was over, leaving in its wake the promotion of global trade, the commodification of health and the idea of health surveillance and safety as justification for international health. At the time, says the Canadian, WHO was far from taking charge of international health activities, as stipulated in its 1946 Constitution, limiting itself to exercise its health safety function, in the monitoring, reporting and control of re-emerging infectious diseases (such as tuberculosis), and especially pandemics. In the same period, the World Bank, whose proposal spoke of efficiency and privatization of health care services reforms, had a much larger budget than the WHO, and several other bilateral agencies that developed international health activities simply ignored its existence. Throughout the 1990s, international health expenditure stagnated and the future of the WHO and the whole field seemed to be at risk.

An interesting observation of the author is about changing the term "international health" to "global health", which, she said, aimed at removing the field of past ideological uses and having international health cease to be seen as a "servant" to colonialism or a pawn of Cold War rivalries and development policy. Thus, she says that the new term "global health" sought to strengthen a vision of shared responsibility for health, referring to health and disease patterns in terms of the interaction of global, national and local forces and the processes and conditions in the political, economic, social and epidemiological fields. However, she makes a caveat that, despite alleged differences, in practice, the new "global health" term still has many similarities with its predecessor "international health", and words still generate some confusion.

In short, after the Cold War, international health philanthropy returns with a new look at the time when the volume of resources used to win the Cold War began to wane and the context was to attack the State's role, favoring the for-profit private sector.

The Gates Foundation: a new version of philanthrocapitalism

Regarding the Bill & Melinda Gates Foundation (BMGF), Anne-Emanuelle remember that this new Seattle-based entity emerged in 2000 and, since then, began to shape the global health agenda. Established by Bill Gates (Microsoft founder) and his wife Melinda, it surely became the largest philanthropic organization involved in global health, with interests in other areas, such as development, agriculture, global defense, education, etc. A budget for global health higher than the



Picture: WHO/Pierre Albouy

Bill Gates – 64th WHA 2011.

WHO budget in recent years, coupled with the fame and active participation of its founders were, in the opinion of the author, the main factors that led the Gates Foundation to a leadership position in global health practically overnight.

According to its Global Health Division, BMGF's main objective in this field is to "build on advances in science and technology to reduce health inequalities", through innovation and application of health technologies that cover both the treatment (through partnerships and diagnostic tools for drug development) and prevention (through, for example, microbicides and vaccines). Initially, according to Anne-Emanuelle, the Foundation has focused on some disease control programs, especially as a grant-making agency. This, however, has changed over the past few years, with efforts reaching more than 100 countries, the establishment of offices in the UK, China and India, and staff growth to more than 1100 people.

As for the RF in the past, the BMGF operates according to co-financing incentives, adopting a technically oriented approach - with programs to achieve positive reviews in strictly defined goals – and following a business model that prioritizes short-term goals. There is a clear preference for the choice of highly successful activities that can prove very efficient and effective, especially within a single political cycle to the detriment of those who, combining social and public health policies, can achieve better long-term results.

Another striking feature of BMGF highlighted in the text is its extraordinary ability to attract partners to its efforts, including organizations recognized for using a social justice approach, such as Norad (a Norwegian Agency for Development Cooperation) and other bilateral donors that, although annually contributing together ten times more funds to global health than the Foundation itself, receive much less recognition.

According to Anne-Emanuelle, the FBMG ended up being a lifeline to global health , in a context in which: global health expenditure (considering the WHO and other multilateral and bilateral organizations) was stagnant; the political elite, the economic elite and, influenced by a mainstream media, voters in many countries began to question the amount of public funds earmarked to external assistance; and many low- and middle-income countries had to face serious health issues (HIV/AIDS, re-emerging infectious diseases and increasing burden of chronic diseases) aggravated by decades of social spending cuts imposed by the World Bank and the International Monetary Fund (IMF).

Undoubtedly, as the author points out, the Gates Foundation has injected money and life in global health and encouraged the participation of other stakeholders. However, even those who recognize the importance of this role criticize their lack real-time accountability and transparency (especially with subsidized taxpayers' dollars) and the undue power it and other private stakeholders, including those privileged by the PPP model employed within the Gates Foundation have gained on the public good.

The BMGF approach: scope and limits

Although it supports a large number of entities, including the World Bank, WHO and other multilateral agencies, private and government companies, universities and NGOs, most BMGF global health funds are channeled to (or through) entities based in developed countries. As explained by Anne-Emanuelle, since early 2014 until the publication of the article, nearly three-quarters of the amount paid by the BMGF's Global Health Program was destined to 50 organizations, 90% of which are located in the United States, the United Kingdom and Switzerland.

In general, the BMGF's Global Health Program supports research, development of diagnostic, preventive measures and treatment and campaigns related to HIV/AIDS, malaria, tuberculosis, pneumonia, diarrheal diseases and the so-called "neglected diseases" (for which control technical tools are already in place, from drugs to vaccines, oral rehydration salts and insecticide-treated mosquito nets), as well as finances research in the context of translational science and cervical cancer screening methods. Also since 2011, it has overseen a series of activities related to family planning; maternal, newborn and child health; nutrition; polio; distribution of vaccines; and water, sanitation and hygiene, always in initiatives related to tools, procedures and other interventions, often with partners from the private sector. With respect to sanitation, for example, BMGF supports "the development of radically new sanitation technologies radically, as well as markets for new sanitation services and products."

The researcher says, however, that BMGF stands out in supporting the development of vaccines, and, in 2010, pledged to invest US$ 10 million in 10 years to this end. Recognizing that vaccines are important public health tools, the author warns about the need to consider the nature of BMGF's investments in vaccines and on what is overlooked by the approach used. She points out that, just as it happened with the RF, BMGF's approach is reductionist, and this can be proven in the speech that Bill Gates delivered in May 2005, when he was invited to open the 58th World Health Assembly. Invoking the vaccination-based smallpox eradication model and without quoting the unpatented status of vaccines used then, he would have sought to define WHO's future course, by saying: "Some point to the better health in the developed world and say that we can only improve health when we eliminate poverty. And elimi¬nating poverty is an important goal. But the world didn't have to eliminate poverty in order to eliminate smallpox – and we don't have to eliminate poverty before we reduce malaria. We do need to produce and deliver a vaccine".

"Strikingly, Gates appealed to his audience with a deceptively simple technological solution to an enormously complex problem just two months after WHO launched its Commission on Social Determinants of

These aim to promote interdisciplinary research and speed bidirectional exchange between basic and clinical science, shifting the basic research findings from the laboratory to applied settings where patients and populations are involved.

Health, established precisely to counter overly biomedicalized understandings of health and to investigate and advocate for addressing the range of fundamental structural and political factors that influence health", says the author, and adds: "Furthermore, Gates' assertion directly contradicts an abundance of public health and demographic research that demonstrates that the modern mortality decline since the 19th century has been the consequence of, first, improved living and working conditions, followed by a combination of these socio-political approaches with medico-technologies that emerged since WWII".

She affirms that, unlike the RF that, in the early 20th century, opened to social medicine research and showed the importance of this association of factors. However, Gates said that leftist alternatives may summarily be rejected or ignored. In 2008, for example, BMGF launched the "Grand Challenges Explorations" program that complements the "Grand Challenges in Global Health" initiative and provides funding for scientists from dozens of countries to carry out "bold" and "unorthodox" research projects addressing health in technological, circumscribed terms and not through integrated technical and socio-political understandings. As stressed by Anne-Emanuelle, not even Challenge 16 – "Finding new ways to achieve healthy birth, growth and development" – makes any reference whatsoever to the lives of newborns and their families.

The author affirms that, although the technical and managerial solutions to health problems seem more attractive than the complex approaches based on social conditions, it is clear that in neither case is there a quick and scientifically correct solution. She says that Bill Gates himself acknowledges that many of the Grand Challenges will only provide results within 15 years or more after onset, which is enough time for social and political investments that support, for example, the construction of comprehensive systems based on primary health care and equity in health, to achieve good outcomes on a much larger scale.

As an example, she quotes the "Barrio Adentro" program, implemented in 2003 in Venezuela, which, according to the WHO and other evaluations, would have curbed, among other things, infant mortality from 19 to 13.9 deaths for 1,000 live births over a decade. The initiative stemmed from the 1999 constitutional definition of health as a human right guaranteed by the state, along with heavy investment in health policies and social services, nutrition, housing, education and better jobs focused mainly on low-income population. Anne-Emanuelle reminds us that the likely billions of dollars invested in this effort by the Venezuelan government is a much larger amount than the BMGF and all donors together can spend in a single country with primary health care, and that such spending would not really be expected from any donor. However, as she emphasizes, the lack of BMGF's and most traditional donors interest who reject these types of redistributive measures of favoring or even considering integrated approaches as a legitimate and effective (though not flawless) route to global equity in health says a lot. "It is clear that societies fighting for social justice do not offer a politically palatable way in a neoliberal environment marked by extreme concentration of wealth and power", ensures the Canadian.

Admittedly, the BMGF is also sponsoring, on a much smaller scale, some initiatives that, while not strictly technical and biomedical, provide support for the construction and maintenance of national public health systems. In 2006, for example, the BMGF contributed with US$ 20 million to create, among others, the International Association of National Public Health Institutes (IANPHI) and the Cuban National Institute of Public Health. However, this type of support, which also receives much less publicity, is very far from being an alternative to BMGF's modus operandi.

The fact is that, despite all the clear deficiencies, approaches based on technologies and specific diseases still prevail in the formal decision-making bodies of global health, under a primary influence of BMGF, whose role was, according to the article, enhanced by the establishment and performance of Health 8 (H8), a group consisting of eight major global health-related institutions, namely: WHO, UNICEF. UNFPA, UNAIDS, the World Bank, the BMGF, the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, tuberculosis and malaria. The H8 holds meetings such as the G8, in which the dominant global health agenda is shaped behind closed doors, and organizations strongly influenced by the BMGF are a plurality.

PPPs in a neoliberal environment

In her text, Anne-Emanuelle quotes the growth of so-called Public-Private Partnerships (PPPs) as one of the main levers of BMGF's influence and reminds us that they are a financing and operation mode in global health that can only occur from the massive inflow of private capital in health and development. Although philanthropic and business interests have always been present in international health, by the 1990s, PPPs were formalized as a central element to global health, following the prescription of the World Bank and IMF to privatize public goods. And if this approach first emerged with the RF, it was consolidated and strengthened through the BMGF. Today, Stop TB, Roll Back Malaria and the International AIDS Vaccine Initiative are just some of the dozens of major global health PPPs – with budgets ranging from a few millions to billions of dollars – that were established by or receive funds from the BMGF.

"There is no PPP for social justice in health"
Anne-Emanuelle Birn

Portrayed as an opportunity to increase global health funding and visibility, these "collaborations" between the private sector and (multilateral and national) government agencies end up hiding a range of commercial interests and allowing the business sector to exercise an unprecedented role in formulation of international public health policies without assuming their entailing responsibility.

As noted by the author, it is necessary to keep in mind that PPPs are not unique to health and that the BMGF is not the only player on the ball, but it is also worth noting that the prominent role played in the creation of the Global Fund and GAVI Alliance, both H8 members, emphasizes the primacy of the PPP model within the Foundation.

Created in 2002 with a US$ 100 million BMGF grant, the Global Fund to Fight AIDS, Tuberculosis and Malaria is currently the largest PPP in health and its goal is to circumvent bureaucratic hindrances imposed by the UN in funding services and therapies to combat these three diseases. Its action, however, ends up weakening the WHO and any expectation of democratic global health governance. The Global Fund raises monies, analyzes proposals and disburses grants and contracts, rather than directly implementing programs. The Global Fund has distributed more than US$ 22.9 billion to about a thousand programs in more than 140 countries since 2013. In December 2013, donors also pledged an additional US$ 12 billion over the next three years.

Anne-Emanuelle says that the creation of the Global Fund also affected an important transnational movement for the reform of intellectual property. The movement emerged in the late 1990s had targeted the speculation of pharmaceutical companies, which prevented access to HIV/AIDS drugs in low- and middle-income countries, especially Africa. In this case, philanthropic and bilateral donations that have made drugs more affordable, also eased tensions between the huge pharmaceutical profits and health of the world's poor, thus weakening the struggle for reforms related to drug patents in the world.

Twenty members are entitled to vote in the Global Fund Board, namely, eight representatives from donor governments and seven representatives from low- and middle-income nations. Private philanthropy, the private sector, "communities" and NGOs from developed countries and developing countries have a representative each. "Amazingly, WHO and UNAIDS have no right to vote in the Council, while such right is granted to the private sector, represented by the pharmaceutical Merck/MSD, and private foundations, represented by BMGF, which gave about US$ 1.5 billion to the Fund", says the author.

The fact that the Global Fund, like many other PPPs, also mentions "business opportunities" (www.theglobalfund.org/en/business) – lucrative contracts – as a hallmark of its work shows, in the opinion of the author, how global health is being captured by commercial interests in an unprecedented way.

According to Anne-Emanuelle, between 20 and 25% of WHO's biennial budget is related to working together with these partnerships, making it increasingly dependent on private capital. She says that, although in 2007, the WHO Executive Board has recognized the many problems caused by PPPs – fragmentation of efforts and global health policies, the issue of cost-effectiveness and the lack of commitment to results, etc. – as from 2012-2013, the organization failed to systematically report in its biennial budget data on its participation in PPPs, admitting that it "does not always have complete control of outcomes and products". The researcher says that the strongest evidence of the paradoxical role that WHO takes on PPPs' issues and the increasing participation of the private sector in its work is a 2010 World Health Assembly Resolution (WHA63.27), which calls on countries to "constructively engage the private sector in providing essential health services".

Indeed, as Anne-Emanuelle acknowledges, some global health PPPs have helped in the research, development and increased access to pharmaceutical products, but, in general, they end up repeating the same vices of regular health donors: imposition of external agendas, poor harmonization with stakeholders and national governments, under-funding and debasement of the public sector.

Ultimately, the programs developed by PPPs – focusing on disease, defined from top to bottom – endanger health systems and prevent integrated approaches. "There is no PPP for social justice in health", jokes the teacher, reminding us that these concerns are exacerbated by the existing incongruity between the for-profit mandates of companies and WHO commitment to health as a human right. She affirms that PPPs grant incentives for academic researchers so that they perform the valued work for industry partners, which is a disguised way of private industry influencing research in global health and how scientific results are released and adapted. When all the benefits of PPPs are accounted for, the net result is that most PPPs channel public money to the private sector and not the opposite.

In short, PPPs strongly shaped by the BMGF allow private interests to define the public health agenda, give legitimacy to the activities of corporations through association with UN agencies, match corporate and public objectives and result in a series of conflicts of interests, in which private partners seek to market their own products through their involvement in the partnership. Furthermore, they add the profit to the already problematic RF acting style, with some aggravating factors. "In contrast to the RF of the past, PPPs promote profit as primary purpose of work in global health, as opposed to strategic public health activities (against yellow fever, for example), which benefited capitalist interests since public health work has been done", says the author. ■