

Civil Society Organizations and the Functions of Global Health Governance: What Role within Intergovernmental Organizations?

Kelley Lee

Amid discussion of how global health governance should and could be strengthened, the potential role of civil society organizations has been frequently raised. This paper considers the role of Civil Society Organizations (CSOs) in four health governance instruments under the auspices of the World Health Organization – the International Code on the Marketing of Breastmilk Substitutes, Framework Convention on Tobacco Control, International Health Regulations and Codex Alimentarius - and maps the functions they have contributed to. The paper draws conclusions about the opportunities and limitations CSOs represent for strengthening global health governance (GHG).

INTRODUCTION

A wide range of studies of global health governance (GHG) have drawn attention to significant shortfalls in existing institutional arrangements to deal with the challenges posed by a rapidly changing world. Problems such as gaps or overlaps in mandates and activities,¹ undemocratic representation, insufficient transparency and accountability,² irrational distribution of resources,³ and ultimately a lack of effectiveness in meeting global health needs, are longstanding concerns.⁴ The emerging assemblage of institutions, rules and resources concerned with global health has evolved on a largely *ad hoc* basis, defined as much by political and economic power, as by health needs and priorities. Overall, there is a sense that GHG is characterised by a considerable degree of dysfunction.⁵

Within this context, discussion over the past decade of how GHG should, and could, be strengthened has included consideration of the potential role of civil society organizations (CSOs). While CSOs have been defined in a myriad of ways, within the context of this paper, CSOs are defined as distinct from organizations and institutions of the state and the market. According to the World Health Organization (WHO), CSOs inhabit “the social arena between the state and citizen, and is not part of the state or market (for profit sector).”⁶ Similarly, the World Bank defines CSOs as

the wide array of non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. Civil Society Organizations (CSOs) therefore refer to a wide of array of organizations: community groups, non-governmental organizations (NGOs), labor unions, indigenous

groups, charitable organizations, faith-based organizations, professional associations, and foundations.⁷

Within health development, CSOs have historically focused on health service delivery, notably in low and middle-income countries. Since the 1980s, health-related CSOs have proliferated in type, number and functions they perform, a development largely seen in positive terms.⁸ Where governments have not delivered basic health services, for example, CSOs have stepped in as contracted by the state or donors, or have sought to fill gaps through charitable work. Where specific population groups have been neglected by the state and/or market, CSOs have campaigned to influence policy priority setting on their behalves. Where there has been a lack of public or private funding for health needs, CSOs have raised public awareness and mobilized resources. Where corporate conduct has adversely affected population health, CSOs have advocated for appropriate regulation. In short, there has been an increase in CSO activity in recent decades, including a diversification in the functions they perform.

As CSOs have come to play a more prominent role, there has been more critical reflection on the governance of CSOs themselves, as well as their performance of specific health governance functions. As state and market-based actors have come under greater scrutiny, so too has there been a desire to assess CSOs against principles of “good governance.”⁹ What functions do CSOs play and are they appropriate? How well are these functions fulfilled? Are CSOs sufficiently accountable and transparent, and to whom? To what extent is there sufficient evaluation of CSO activities? As described in the *Human Development Report 2002*:

[W]hen such groups spring from agendas or use tactics that are contrary to democratic values, they can be both civil and “uncivil”. The rise of such groups poses challenges for truly democratic political engagement....many civil society groups recognize that they must be publicly accountable for their actions.¹⁰

There is a particular need for systematic analysis of the functions CSOs perform in *global* health governance. While built on health governance at the subnational, national and regional levels, GHG is distinguished from *international* health governance by

health needs and interests that increasingly cut across and, in some cases, are oblivious to state boundaries. To effectively address these global health challenges, there is a need to strengthen, supplement and even replace existing forms of IHG. ... [S]tate and nonstate actors have long interacted on health governance. The difference for GHG will lie in their degree of involvement and nature of their respective roles, varying with the health issue concerned.¹¹

The emergent relationship between state and non-state actors (including CSOs) is particularly significant in GHG.

This paper examines the interaction of CSOs with intergovernmental health organizations (IGOs), defined as organizations ostensibly concerned with health in which states comprise their core membership. It briefly reviews four health governance instruments—the International Code on the Marketing of Breastmilk Substitutes, Framework Convention on Tobacco Control, International Health Regulations and Codex Alimentarius—under the auspices of the WHO, the United Nations (UN) specialised agency for health with 193 member states. The fourth is also a joint instrument under the Food and Agriculture Organization (FAO), another UN specialised agency with 191 member states. Following a brief overview of the engagement of CSOs by WHO, this paper draws on a framework by Haas (2003) to map their contribution to specific governance functions in relation to these four instruments. The paper discusses how effective CSO involvement has been, and draws conclusions about the opportunities and limitations CSOs represent for strengthening GHG.

INCREASING ENGAGEMENT WITH CSOs IN HEALTH GOVERNANCE

Given the growing complexity of these health and security challenges and the response required, these issues concern not only governments, but also international organizations, civil society and the business community. Recognizing this, the World Health Organization is making the world more secure by working in close collaboration with all concerned.—Margaret Chan, Director General, WHO, World Health Day, 2007

Since the early 1990s, there has been widespread support within IGOs for enhancing the role of CSOs in health development including governance. The Development Assistance Committee of the OECD, for example, argues that civil society “can play a crucial role in preventing violent conflict and in building peace.”¹² UNAIDS describes CSOs as being “at the forefront of prevention, care and support programmes, particularly among the most vulnerable and hard-to-reach populations.”¹³ The World Bank’s consultations with civil society are seen to have “improved the quality of policymaking, positively influenced the direction of country programmes, strengthened national ownership of key reforms, and promoted public sector transparency and accountability.”¹⁴

In WHO, a Civil Society Initiative (CSI) was launched in 2001 “to undertake a review of both official and informal relations between WHO and Civil Society Organizations (CSOs); to develop a renewed policy for more effective collaboration, information exchange and dialogue with CSOs and improve the support offered by WHO to Member States in their work with NGOs and CSOs.”¹⁵ Critics long pointed to the organization’s traditional emphasis on ministries of health, while formal relations with non-state (civil society and market-based) institutions remained limited. The increased prominence of public-private partnerships in WHO from the late 1990s raised concerns about undue influence by corporate interests.¹⁶ Following a meeting with representatives of the People’s Health Assembly (PHA), Director-General Gro Harlem Brundtland initiated efforts to improve engagement with CSOs. An internal review found 482

“relationships” between CSOs and WHO headquarters, of which 56 percent were “official relations.”¹⁷ The review was intended to pave the way for greater involvement in WHO activities through, for example, reforming the process of granting official relations status and enhancing informal participation. The rationale for this change was described as follows:

The engagement with civil society profoundly affects the ways in which international organizations understand and respond to the needs of people all over the world. Concepts about poverty, equity, justice, security, rights and responsibilities take on new meaning. Exposure to the complexities of cultures and communities hone critical thinking and sensitivity. Assumptions are challenged, power is redefined, change is initiated.¹⁸

Brundtland’s departure in 2003, however, saw the CSI largely shelved under her successor Lee Jong-wook. Many CSOs continued to lament the difficulties of working with WHO, the closed nature of its activities, and allegedly blind romance with public-private partnerships.¹⁹ One important exception was the Commission on the Social Determinants of Health (CSDH), which adopted a strategy for meaningful CSO engagement in 2005:

CSDH has adopted an innovative approach, departing from standard practice in international organizations and previous global commissions, where civil society “participation” has often meant rubber-stamping decisions made by others.

The CSDH has asked civil society organizations to take an active role and share decision-making power in the Commission process. The specificity of the CSDH model of collaboration with civil society is that civil society actors themselves are defining how they want to work with the Commission, elaborating their strategies through national and regional consultative processes. In this way, the knowledge and concerns of civil society inform the agenda for collaborative action from the start.²⁰

Upon her election in 2006, Director-General Margaret Chan sought to build on this renewed effort by making “partnerships” one of six priorities, to be pursued through “strengthening relationships with civil society and the private sector, and creating greater alignment between partnerships.”²¹ To date, however, ongoing tensions between WHO and CSOs over access to medicines²² and the organization’s publications policy²³ have created some degree of uncertainty over relations.

FUNCTIONS OF GLOBAL HEALTH GOVERNANCE

To address the limited theorising to date on the role of CSOs in GHG, this paper draws on the work of Peter Haas. In assessing global environmental governance, he describes “two new geopolitical realities that challenge the old geographical principles of national sovereignty.”²⁴ The first is the complexity of a

globalising world “whose management requires more holistic or comprehensive policies”. The second is “the proliferation of new political actors and the diffusion of political authority over major governance functions.”²⁵ These new actors include CSOs, transnational corporations, organized transnational scientific networks (epistemic communities), global policy networks and selected intergovernmental organizations capable of exercising discretionary behaviour independently of their dominant member states (e.g. World Bank, European Commission). Haas maps the division of labour among these diverse actors, evaluating how they perform and identifying comparative advantages, according to twelve governance functions (see Table 1). Some functions are performed formally, that is, “by the direct commitment by somebody to a clear actor to perform the designated function or functions.” Others are carried out informally, in that, “the functions may be observed but are not the consequence of intended action by those contracting some set of activities to be performed by the relevant actors.”²⁶

Table 1: Matrix of Functions

Function	Formal/direct	Informal/indirect
<i>Issue linkage</i>	<ul style="list-style-type: none"> • By inter-governmental negotiations • By new information provided by epistemic communities • Through financial mechanisms (GEF) • By IOs (GEO/WEO) 	<ul style="list-style-type: none"> • By scientists • By business/industry
<i>Agenda setting</i>	<ul style="list-style-type: none"> • By IOs and member states • By scientists 	<ul style="list-style-type: none"> • By NGOs • By media • By scientists
<i>Developing usable knowledge</i>	<ul style="list-style-type: none"> • By scientists 	<ul style="list-style-type: none"> • By scientists • By NGOs • By business/industry
<i>Monitoring</i>	<ul style="list-style-type: none"> • By IOs • By committees nominated by MEA secretariat • By MEA signatory governments 	<ul style="list-style-type: none"> • By NGOs (particularly in developing countries) • By Scientists
<i>Rule making</i>	<ul style="list-style-type: none"> • Negotiations by national governments • By NGOs (principled standards) 	<ul style="list-style-type: none"> • By Business/Industry (de facto standards) • By NGOs (principled standards)
<i>Norm development</i>	<ul style="list-style-type: none"> • Epistemic communities 	<ul style="list-style-type: none"> • By NGOs (equity & environmental preservation) • By Business/Industry (efficiency)
<i>Policy Verification</i>	<ul style="list-style-type: none"> • Governments 	<ul style="list-style-type: none"> • NGOs • IOs
<i>Enforcement</i>	<ul style="list-style-type: none"> • (Hard) Law • WTO and MEA rules 	<ul style="list-style-type: none"> • NGO campaigns

<i>Capacity building (tech transfer)</i>	<ul style="list-style-type: none"> • Official technical assistance (national and local government) • Business/Industry • Science community (education/training) 	<ul style="list-style-type: none"> • Business/Industry (joint venture)
<i>Capacity building (organizational skills)</i>	<ul style="list-style-type: none"> • By IOs • By NGOs • Science community (education/training) 	<ul style="list-style-type: none"> • By Business/Industry
<i>Promote vertical linkage</i>	<ul style="list-style-type: none"> • IOs • National and Local Governments 	<ul style="list-style-type: none"> • NGOs • Scientific community
<i>Financing</i>	<ul style="list-style-type: none"> • Government (ODA) • Regional Development Banks • Multilateral bodies 	<ul style="list-style-type: none"> • By Business/Industry

Source: Peter M. Haas, *Is there a Global Governance Deficit and What Should be Done About It?* (Geneva: Ecologic, 2003).

This paper uses this framework heuristically to map the roles of different institutional actors by function in relation to four key instruments of health governance. The four instruments were selected as case studies because, while formally adopted by WHO member states, they illustrate different contributions by CSOs. Drawing primarily on secondary sources, the case studies map the functions CSOs, alongside state and market-based actors, have contributed. This mapping enables the beginning of a comparative analysis of the relative roles of different types of actors, whether this has differed across the four case studies, and how this might relate to the effectiveness of the four health governance instruments. Recommendations on further analysis and, in particular, the need for primary data on CSO involvement in GHG, are provided in the discussion below.

INTERNATIONAL CODE ON THE MARKETING OF BREASTMILK SUBSTITUTES

Adopted in May 1981 by WHO member states, and prompted by concerns about the general decline in breastfeeding in many parts of the world, the International Code of Marketing of Breastmilk Substitutes²⁷ represented the culmination of a prominent campaign by WHO, United Nations Children's Fund (UNICEF) and CSOs led by the International Baby Food Action Network (IBFAN).²⁸ CSOs were particularly prominent in prompting global action, including the mounting of a boycott of the food manufacturer, Nestlé, for its marketing practices. The campaign was highly successful at drawing worldwide public attention to the health consequences arising from such practices, and for creating a code of practice against which the actions of food manufacturers could be assessed.

For the purposes of this analysis, a mapping of governance functions concerning the Code (see Table 2) confirms that CSOs were critical actors for some functions. The Code was formally adopted by WHO and UNICEF, with the authority of their member states, after a process of consultation with governments, the infant food industry, professional associations and CSOs. CSOs, such as War on Want and Save the Children, were particularly

instrumental at drawing widespread public attention to the problem, organising the Nestlé boycott, and campaigning for governments to adopt an internationally recognised code of practice. This put the issue on the agenda and chivvied states to act collectively. Following adoption of the Code, CSO campaigning supported the adoption of follow-up resolutions in the WHA that reinforced or extended specific provisions. Such efforts were also central to incorporating the Code into provisions under FAO, Codex Alimentarius, World Trade Organization (WTO) and other relevant international forums in the form of nutritional guidelines and trading principles.

However, the Code's status, as an international code of practice, fell short of CSO hopes for a binding instrument that compelled action by states to adopt legislation with punitive measures for non-compliance. As set out in Article 11, responsibility for implementation and monitoring of the Code is given to member states which "should take action to give effect to the principles and aim of the Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures." By 1997, only 17 countries had adopted the Code's provisions in whole or in part as legal requirements, with most member states adopting no provisions. Monitoring of compliance to the Code was also made a relatively weak function, left largely to CSOs to undertake:

Nongovernmental organizations, professional groups, institutions, and individuals concerned should have the responsibility of drawing the attention of manufacturers or distributors to activities which are incompatible with the principles and aim of this Code, so that appropriate action can be taken. The appropriate governmental authority should be notified.²⁹

While violations of the Code have been regularly reported by CSOs,³⁰ including the claim that 4000 babies continue to die each day from unsafe bottle feeding,³¹ the lack of designated resources for this function or, perhaps most importantly, resort to a punitive mechanism for non-compliance has left the monitoring function effectively "toothless."

Table 2: Functions in the Global Governance of Breastmilk Substitutes

Function	Formal/Direct	Informal/Indirect
<i>Issue linkage</i>	<ul style="list-style-type: none"> By CSOs (drawing attention to link between health problems and marketing practices) 	<ul style="list-style-type: none"> By health workers (reporting of infant and child health problems)
<i>Agenda setting</i>	<ul style="list-style-type: none"> By CSOs and health professionals (campaigning for regulation) 	
<i>Developing usable knowledge</i>	<ul style="list-style-type: none"> By IGOs (WHO development of evidence base) By CSOs (contribution of evidence from different countries) 	<ul style="list-style-type: none"> By scientists (research on infant feeding practices and health)

<i>Monitoring</i>	<ul style="list-style-type: none"> • By CSOs (i.e. <i>Breaking the Rules, Stretching the Rules</i> and <i>Look What They're Doing</i> reports) • By business/industry (i.e. monitoring own marketing practices) 	
<i>Rule making</i>	<ul style="list-style-type: none"> • By IGOs (WHO and UNICEF adoption of Code) • By other IGOs (FAO, WTO and Codex Alimentarius) • By national governments (adoption of code into domestic law) 	<ul style="list-style-type: none"> • By business/industry (bringing legal action challenging interpretation of Code's requirements)
<i>Norm development</i>	<ul style="list-style-type: none"> • By IGOs (WHO adoption of follow up resolutions) 	<ul style="list-style-type: none"> • By business/industry (CSR initiatives and legal action challenging reported violations) • By CSOs (drawing public attention to Code and violations, promoting breastfeeding)
<i>Policy verification</i>	<ul style="list-style-type: none"> • By national governments (reporting progress to WHO) • By CSOs (periodic reports on state of the code by country and company) • By health workers (e.g. reporting violations to government officials) 	
<i>Enforcement</i>	<ul style="list-style-type: none"> • By national governments (e.g. adoption and enforcement of penalties under domestic law) 	<ul style="list-style-type: none"> • By CSOs through public approbation (e.g. consumer boycott) • By health workers and individuals (e.g. complaints to manufacturers)
<i>Capacity building (technology transfer)</i>	<ul style="list-style-type: none"> • By national governments (i.e. providing information on infant feeding) • By CSOs (International Code Documentation Centre) • By business/industry (only if strictly approved by government) 	
<i>Capacity building (organizational skills)</i>	<ul style="list-style-type: none"> • By CSOs 	
<i>Promote vertical integration</i>	<ul style="list-style-type: none"> • By IGOs and national governments (i.e. promoting code within broader maternal and child health strategy) 	
<i>Financing</i>	<ul style="list-style-type: none"> • By national governments (i.e. allocation of resources for implementing Code) 	

Overall, this case study suggests the increased importance of CSOs to the functions of issue linkage, agenda setting and developing usable knowledge. The Code's limited authority over member states, dependence on CSOs to monitor compliance, and reliance on moral suasion rather than sanctions reduced the Code to an effectively voluntary standard. This suggests that, where health-harming behaviours require regulation, particularly when they involve powerful and well-resourced economic interests, CSOs are necessary but not sufficient to the effective functioning of GHG.

FRAMEWORK CONVENTION ON TOBACCO CONTROL

The Framework Convention on Tobacco Control (FCTC) was adopted in 2003 and entered into force in February 2005. As of January 2010, 168 countries have signed and ratified the agreement. While negotiation of the FCTC was ostensibly an intergovernmental process, CSOs played a key role in fulfilling certain functions.

A mapping of the governance functions for global tobacco control (see Table 3) suggests the FCTC process was strongly influenced by CSOs. WHA resolution 52.18 (May 1999) established two bodies to draft the convention: a Technical Working Group to prepare the proposed draft elements; and Intergovernmental Negotiating Body (INB) to draft and negotiate the agreement and possible related protocols. Participation in both bodies was open to all member states, regional integration organizations, and observers including CSOs. WHA Resolution 53.16 (May 2000) called upon the INB "to examine the question of extended participation by nongovernmental organizations as observers" in the negotiations. A report on NGO participation was presented to the Executive Board in January 2001 and two organizations, the International Nongovernmental Coalition Against Tobacco and Infant Feeding Action Coalition (INFACT), were admitted into official relations for this purpose. Accreditation of additional CSOs, usually a time-consuming process, was fast-tracked by WHO which recognised the importance of their presence at negotiations.³² In addition, prior to the INB's first of six sessions, public hearings were convened by the Director-General in 2000 "to provide a forum for the public health community, the tobacco industry and farmers' groups to submit their case."³³ Finally, the WHO Tobacco Free Initiative (TFI) held regional pre-negotiation consultative meetings where CSOs were invited to attend as observers.

Table 3: Functions in the Global Governance of Tobacco Control

Function	Formal/Direct	Informal/Indirect
<i>Issue linkage</i>	<ul style="list-style-type: none"> By IGOs (WHO Tobacco Free Initiative) 	<ul style="list-style-type: none"> By scientists (smoking and health research)
<i>Agenda setting</i>	<ul style="list-style-type: none"> By IGOs (FCTC Working Group and ING) By national governments 	<ul style="list-style-type: none"> By CSOs as observers in FCTC Working Group and ING) By business/industry lobbying policy makers
<i>Developing usable</i>	<ul style="list-style-type: none"> By IGOs (WHO TFI surveillance 	<ul style="list-style-type: none"> By scientists (smoking

<i>knowledge</i>	<ul style="list-style-type: none"> surveys; World Bank, FAO National governments (CDC youth survey) 	<ul style="list-style-type: none"> and health research) By business/industry (industry funded research) By legal action (discovery of internal industry documents)
<i>Monitoring</i>	<ul style="list-style-type: none"> By IGO (national reports to WHO FCTC Interim Secretariat) 	<ul style="list-style-type: none"> By CSOs (FCA reporting lack of compliance by governments and violations by industry)
<i>Rule making</i>	<ul style="list-style-type: none"> By IGOs (WHO member states adopting FCTC and protocols) By national governments (adoption of national legislation) 	<ul style="list-style-type: none"> By CSOs (as observers at ING sessions) By legal systems (litigation against tobacco industry)
<i>Norm development</i>	<ul style="list-style-type: none"> By IGOs (WHO TFI awareness building among member states) By national governments (support of tobacco control programmes) By health workers (public education) 	<ul style="list-style-type: none"> By CSOs By business/industry (e.g. CSR initiatives)
<i>Policy verification</i>	<ul style="list-style-type: none"> By IGO (WHO FCTC Secretariat national reporting; Global Information System on Tobacco Control; Global Youth Tobacco Survey) 	<ul style="list-style-type: none"> By CSOs (scrutiny of industry CSR initiatives against practices; public health and scientific conferences)
<i>Enforcement</i>	<ul style="list-style-type: none"> By IGO (WHO FCTC Secretariat) 	<ul style="list-style-type: none"> By CSOs (campaigning and exertion of public pressure)
<i>Capacity building (technology transfer)</i>	<ul style="list-style-type: none"> By WHO FCTC Secretariat (technical assistance to member states) 	<ul style="list-style-type: none"> By CSOs (RITC; Fogarty International Centre; Rockefeller Foundation; Globalink)
<i>Capacity building (organizational skills)</i>	<ul style="list-style-type: none"> By WHO FCTC Interim Secretariat (technical assistance to member states) 	<ul style="list-style-type: none"> By CSOs (RITC; Bloomberg Global Tobacco Initiative)
<i>Promote vertical integration</i>	<ul style="list-style-type: none"> By WTO TFI (development of comprehensive tobacco control strategies) By national governments (through adoption and support of comprehensive tobacco control policies) 	
<i>Financing</i>	<ul style="list-style-type: none"> By CSOs (e.g. Bloomberg Global Tobacco Initiative, Rockefeller Foundation Trading Tobacco Initiative) 	<ul style="list-style-type: none"> By research funding bodies (e.g. Fogarty, NIH)

The capacity of CSOs to participate in the FCTC process was enhanced significantly by the formation of the Framework Convention Alliance (FCA) comprised of more than 250 organizations in over 90 countries. Created to support the negotiation, ratification, and implementation of the FCTC, the FCA's

mission was to achieve this through the promotion and support of a global network for campaigning against tobacco; development of tobacco control capacity, particularly in developing countries; and monitoring compliance with FCTC provisions.

The increased prominence of CSOs at the FCTC, facilitated through the FCA, was evident at the INBs. Individual CSOs were permitted to submit statements at the end of each negotiating session which, while not equivalent to the rights of member states to participate in negotiations, was an advance on usual WHO procedure. Allowing CSOs to table their views was deemed especially important by tobacco control advocates given efforts by some governments, notably the US, Germany and Japan, to weaken the strength of the treaty's measures. For example the Japanese government, which owns half of Japan Tobacco International, argued for the extensive use of optional language (e.g. "appropriate measures") to weaken the authority of the FCTC.³⁴ CSOs publicised the positions of intransigent governments, communicated worldwide through the internet as negotiations unfolded, enhancing the transparency of the process. In addition, CSOs lobbied delegates and hosted informal briefings between negotiation sessions to delegates on key topics, such as cigarette smuggling, taxation and cross-border advertising.

Following the agreement of the FCTC in 2003, the FCA continued to play an active role in supporting the signing and ratification of the treaty by member states. This was achieved, in part, through efforts to improve the evidence base for FCTC implementation. Working alongside WHO and donors, organizations such as Tobacco Free Kids, Cancer Research UK and Bloomberg Family Foundation provided much needed support for research on tobacco supply and demand in low and middle-income countries. Nevertheless, resource constraints have remained a major problem. Funding for tobacco control in all countries remains disproportionately low, relative to the disease burden caused. Increased recognition of the public health impact of non-communicable diseases has resulted in increased attention in recent years. Funding for tobacco control research, especially in relation to LMICs, has remained scarce despite the predicted 7 million deaths from tobacco annually by 2030.³⁵

Like the International Code on the Marketing of Breastmilk Substitutes, much has also hinged on the adoption and enforcement of FCTC provisions into national tobacco control policy by member states. Evidence suggests that, in countries where industry interests have lobbied to prevent or weaken national policies, the active counter lobbying of CSOs has been critical to sustaining political support for tobacco control.³⁶ Once again, compliance has been hindered by the lack of punitive measures other than moral sanction.

REVISED INTERNATIONAL HEALTH REGULATIONS OF 2005

The origins of the IHR lie in the nineteenth century (then known as the International Sanitary Regulations) as measures to govern the sanitary conditions required by all forms of transport for preventing the international spread of disease. The agreement of the IHR was ostensibly driven by the desire to facilitate growing trade relations.³⁷ Limited to selected diseases and functions,

the IHR has been subject to periodic revision. Economic globalization, with its intensified trade flows and incorporation of virtually all countries into the world trading system, led to a process of fundamental review of the IHR in the late 1990s. This proved an initially protracted process because of a lack of political will and resources. The SARS outbreak and prospects of an influenza pandemic, however, lent renewed urgency to the process. The revised IHR was unanimously adopted by the WHA on 23 May 2005, and entered into force in June 2007.³⁸ The broadened purpose and scope of the IHR (2005) are to “prevent, protect against, control and provide a public health response to the international spread of disease and which avoid unnecessary interference with international traffic and trade.”³⁹

The provisions adopted under the IHR (2005) provide a good example of efforts to enhance GHG through, *inter alia*, broader engagement with non-state actors. Perhaps the most significant achievement of the revised IHR (2005) is its capacity to draw on information sources beyond governments. In the past, a key limitation of disease surveillance, monitoring and reporting was dependence on government data sources which, if not forthcoming or inaccurate, weakened the capacity for collective action. The narrow scope of the IHR also meant that governments were only obligated to disclose information on yellow fever, cholera and plague. The IHR (2005) states that, while national IHR Focal Points will liaise with WHO IHR Contact Points, WHO “may take into account reports from sources other than notifications or consultations and shall assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring.”⁴⁰

This enhanced institutional structure is what WHO calls a “network of networks” whereby surveillance is based on links among national health care systems, mass media, health organizations, laboratories and institutions focusing on particular disease conditions. These networks are increasingly linked across countries, regions, and globally, through governments, centers of excellence (e.g. US Centers for Disease Control, Pasteur Institutes), WHO offices, military networks (e.g. US Department of Defence Global Emerging Infectious Disease System) and internet discussion sites such as Promed (<http://www.promedmail.org>) and Epi-X (<http://www.cdc.gov/epix>). In 1997, WHO initiated the Global Outbreak Alert and Response Network (GOARN) which was formally adopted by member states in 2000. In 2009, the network boasted more than 150 partners around the world.

Table 4: Functions in the Global Infectious Disease Surveillance Through the *International Health Regulations*

Function	Formal/Direct	Informal/Indirect
<i>Issue linkage</i>	<ul style="list-style-type: none"> • By national governments (reporting of disease outbreaks) • By IGOs (WHO EPR outbreak reporting) 	<ul style="list-style-type: none"> • By health workers (reporting of disease outbreaks) • By business/industry (economic losses incurred as a result of

		infectious disease threats or responses)
<i>Agenda setting</i>	<ul style="list-style-type: none"> • By national governments (need for improved surveillance systems) • By IGOs (WHO EPR) 	
<i>Developing usable knowledge</i>	<ul style="list-style-type: none"> • By national governments (national public health systems) • By IGOs (WHO EPR development of standards of reporting; coordination and dissemination of data) 	<ul style="list-style-type: none"> • By CSOs (ProMed, disease monitoring and reporting networks)
<i>Monitoring</i>		<ul style="list-style-type: none"> • By CSOs (through ongoing reporting of outbreaks)
<i>Rule making</i>	<ul style="list-style-type: none"> • By IGOs (WHO member states revise IHR) • By national governments (adoption of national legislation and surveillance systems) 	<ul style="list-style-type: none"> • By research institutions
<i>Norm development</i>	<ul style="list-style-type: none"> • By IGOs (WHO standards setting, nomenclature) 	
<i>Policy verification</i>	<ul style="list-style-type: none"> • By national governments (ministries of health) • By IGOs (WHO EPR) 	<ul style="list-style-type: none"> • By CSOs (disease monitoring and reporting networks) • By mass media
<i>Enforcement</i>	<ul style="list-style-type: none"> • By IGOs (WHO EPR issuance of travel advisories and restrictions) 	
<i>Capacity building (technology transfer)</i>	<ul style="list-style-type: none"> • By IGOs (WHO Office for National Epidemic Preparedness and Response) • By national governments (aid to build surveillance capacity in LMICs) 	<ul style="list-style-type: none"> • By research institutions (training of health workers/epidemiologists)
<i>Capacity building (organizational skills)</i>	<ul style="list-style-type: none"> • By national governments (aid to build surveillance capacity in LMICs) • By IGOs (WHO Office for National Epidemic Preparedness and Response) 	
<i>Promote vertical integration</i>	<ul style="list-style-type: none"> • By governments and IGOs (building of national, regional and global networks) 	
<i>Financing</i>	<ul style="list-style-type: none"> • By national governments (health sector aid) 	

Overall, government institutions remain central to the global governance of infectious disease surveillance, acting as the key institutional nodes within networks for surveillance, monitoring, reporting and response. This is reflected in the requirement, under the IHR (2005) for States Parties to build capacity through the development, strengthening and maintaining of core surveillance and response capacities to detect, assess, notify and report public health events to

WHO and respond to public health risks and public health emergencies. To date, CSOs have played a supplemental albeit critical role—filling information gaps or confirming reports—in a timely manner to enable government institutions to respond. In this way, disease surveillance has become a more open process, allowing information to flow in a more open and transparent manner.

CODEX ALIMENTARIUS

The *Codex Alimentarius* - a collection of 250 or so standards, codes of practice, guidelines and other recommendations - was created in 1963 by the FAO and WHO to be “the single most important international reference point for developments associated with food standards.”⁴¹ The Codex is governed by the Codex Alimentarius Commission (CAC), comprised of 172 member states, which meets in plenary every two years (alternately in Rome and Geneva). Total participation numbers around 600 delegates. National delegations are led by senior officials appointed by their governments. Delegations may, and often do, include representatives of industry, consumers’ organizations and academic institutes. Countries that are not yet members of the Commission sometimes attend in an observer capacity. To facilitate continuous contact with member states, the CAC, in collaboration with national governments, has established country *Codex Contact Points* and many member states have *National Codex Committees* to coordinate activities nationally.

Officially recognised non-state actors may attend the CAC in an observer capacity. Although “observers”, the tradition of the CAC allows such organizations to put forward their points of view at every stage except in the final decision, which is the exclusive prerogative of member states. Criticism has been raised about the extent to which the food industry is represented within the CAC, and thus the balance achieved between the goals of for-profit trade and consumer protection. According to the report, *Cracking the Codex*, 81 percent of non-governmental participants on national delegations came from industry between 1989 and 1991, while only one percent represented public interest groups.⁴² The study examined participation on all Codex committees, which met from 1989-1991, and found that industry representatives accounted for 26 percent of participants. Industry participation increased on committees dealing with particularly controversial issues. For example, one-third of the 387 participants in the two meetings of the Committee on Pesticide Residues were industry representatives, and 86 of these participants represented specific agrochemical and food companies; only three participants at these meetings represented public interest groups. Forty-one percent of the participants in the two meetings of the Codex Committee on Food Additives and Contaminants were food industry representatives. On the Codex Committee for Nutrition and Special Dietary Uses, 47 percent of participants represented industry.

This imbalance in the representation of market-based actors has led to criticisms that this results in food standards, which favour trade interests. Many Codex standards, it is argued, remain lower than some national standards, allowing, for example, residues of hazardous pesticides banned or strictly limited in many countries. Lang writes, “With an increased role for Codex, nations will

effectively hand a great deal of control over the regulation of food safety and quality to global trade and corporate interests.”⁴³

Table 5: Functions in the Global Governance of Food Standards Through the *Codex Alimentarius*

Function	Formal/Direct	Informal/Indirect
<i>Issue linkage</i>	<ul style="list-style-type: none"> • By national governments • By business/industry 	<ul style="list-style-type: none"> • By business/industry • By CSOs (consumer groups drawing attention to food safety issues) • By health workers (reporting of foodborne diseases)
<i>Agenda setting</i>	<ul style="list-style-type: none"> • By national governments • By business/industry • By IGOs (WHO, FAO and WTO) 	<ul style="list-style-type: none"> • By CSOs (consumer groups) • By mass media (reporting on food related issues)
<i>Developing usable knowledge</i>	<ul style="list-style-type: none"> • By IGO (CAC expert committees) • By business/industry (support for industry funded research) 	<ul style="list-style-type: none"> • By research institutions (research on food safety and nutrition issues)
<i>Monitoring</i>	<ul style="list-style-type: none"> • By national governments (food standards authorities) 	<ul style="list-style-type: none"> • By CSOs (consumer groups)
<i>Rule making</i>	<ul style="list-style-type: none"> • By IGOs (Codex sub and coordinating committees draft regulations) • By national governments • By business/industry (representation on national delegations and consultation as “interested parties”) 	<ul style="list-style-type: none"> • By CSOs (consumer group proposals on food safety, labelling etc.)
<i>Norm development</i>	<ul style="list-style-type: none"> • By IGOs (WTO SPS and TBT on food harmonisation) • By business/industry (representation on technical and standard setting bodies) 	<ul style="list-style-type: none"> • By business/industry (marketing of food products)
<i>Policy verification</i>	<ul style="list-style-type: none"> • By national governments • By IGOs (WHO, FAO and WTO) 	<ul style="list-style-type: none"> • By CSOs (consumer groups)
<i>Enforcement</i>	<ul style="list-style-type: none"> • By national governments (customs checks; legal action against violations) 	
<i>Capacity building (technology transfer)</i>	<ul style="list-style-type: none"> • By IGOs (WHO and FAO support to member states to build technical and administrative infrastructure to implement Codex) • By IGO (WTO Standards and Trade Development Facility) 	
<i>Capacity building (organizational skills)</i>	<ul style="list-style-type: none"> • By IGOs (as above) 	
<i>Promote vertical</i>		

<i>integration</i>		
<i>Financing</i>	<ul style="list-style-type: none"> • By national governments (inspection and enforcement) • By business/industry (production costs to comply with regulations) • By IGO (WHO/FAO Trust Fund to participate in Codex) 	

In summary, this case study suggests that appropriate governance to protect and promote population health within an increasingly globalised food production system requires an improved system of representation and participation. This is especially relevant given the enhanced role of Codex in trade liberalisation, and growing evidence of the links between weak global food regulation and nutrition-related health problems.⁴⁴ At present, CSOs representing consumer interests are not well represented, and occupy a largely informal role in governance functions.

CONCLUSIONS: CSOs AND THE STRENGTHENING OF GLOBAL HEALTH GOVERNANCE

A review of GHG, in relation to the social determinants of health, concludes that “[t]he past two to three decades has brought a period of transition from international to global governance including health governance. Societies around the world are faced with the challenge of finding more effective means of collectively addressing issues of global relevance.” The review found that, to date, this challenge has been far from met. There is a need for the overall structure of global governance to be fundamentally reviewed, in the context of the needs, priorities and political culture of the early 21st century.

This brief review finds that CSOs have contributed to diverse functions across the four health governance instruments. Traditionally, CSOs have played a supplementary role where government institutions have been weak or nonexistent, where there are gaps in funding and resources, or where neglected issues or constituencies require advocacy. Perhaps most visibly, CSOs are accepted as playing a critical watchdog role, ensuring that formally mandated governmental institutions fulfil their responsibilities appropriately, and keeping a watchful eye on corporate actors exerting undue influence or engaging in health harming activities. These functions have been essential to the International Code on the Marketing of Breastmilk Substitutes, where ongoing campaigning and advocacy by CSOs have been critical to achieving policy attention. CSOs played an even more significant role in the negotiation and implementation of the FCTC, fulfilling an unusually wide range of functions traditionally dominated by governments. However, CSOs have been less involved in formal proceedings of the CAC or revision process for the IHR (2005). In the case of the latter, there is now formal recognition of the importance of CSOs to effective disease surveillance, playing a supplementary role when state institutions cannot or will not report to WHO promptly.

What conclusions can we draw from these examples for the strengthening of GHG? First, CSOs have played the biggest roles in initiating, formulating and implementing formal rules in GHG. Given the intergovernmental nature of the instruments reviewed, CSOs perhaps understandably have not been given formal authority to make and enforce policy decisions. Although the formal authority of CSOs participating in GHG remains limited, the FCTC and IHR (2005) suggest that informal participation can be highly effective. Governments are likely to continue to fulfil the formal functions of rule making, but can enhance the policy process by broadening the scope for involvement by CSOs through improved consultation, granting of observer status, and provision of resources to participate in specific functions. This is especially important where states may fail to uphold agreed rules or powerful vested interests seek to limit their effectiveness. This fits with Haas' argument that decentralised governance (or multi-level governance) should structure reform of global environmental institutions, with effective governance resting on the performance of multiple functions performed by a range of institutional actors including CSOs. This model could be applied to further reflection on the reform of GHG.

Second, there are certain functions that require fulfilment by state institutions to ensure GHG instruments are effective. The adoption of the International Code on Marketing of Breastmilk Substitutes was a remarkable achievement, but the failure to follow this up with formal mechanisms for monitoring and enforcement by government institutions, with punitive measures embodied in national legislation, has limited its capacity to protect public health. Heavy reliance on CSOs to implement the Code, without commensurate resources or legislative authority, has been problematic. This lesson should be applied in the process of FCTC implementation where WHO is supporting member states in the adoption of comprehensive tobacco control policies backed by legislative powers.

Third, despite a more institutionally crowded playing field, GHG remains far from pluralist in a true sense. The case studies suggest that, like global governance as a whole, GHG is being characterised by greater, rather than lesser, concentration of power in fewer hands. In some cases, increased CSO participation can enhance the diversity of interests represented. In food standards setting, corporate actors remain far more prominent, prompting concerns about the representativeness of decision-making. At the same time, CSOs can themselves be elitist, and their membership must also be critically assessed.

Finally, more detailed understanding of the respective roles of state, market and civil society actors is needed in terms of specific functions, and across different GHG institutions and instruments. Beyond this initial mapping of functions based on secondary sources, systematic collection of primary data across a fuller range of intergovernmental institutions and instruments is needed such as the World Bank, UNAIDS and OECD. Moreover, there is need to analyse the multitude of global health initiatives that have been formed since the 1990s, including the numerous global public-private partnerships.⁴⁵ Such initiatives, by their very nature, are comprised of state, market and civil society actors. Understanding how meaningfully CSOs have been involved in such partnerships,

and GHG in general, would be an important step towards ensuring appropriate checks and balances in a system of GHG.

Kelley Lee is Reader in Global Health, London School of Hygiene & Tropical Medicine and Adjunct Professor in the Faculty of Health Sciences, Simon Fraser University. Her research focuses on the global governance of communicable and non-communicable diseases. Her most recent book is *The World Health Organization* (Routledge 2009).

¹ Kelley Lee, Sue Collinson, Gill Walt and Lucy Gilson, "Who should be doing what in international health: A confusion of mandates in the United Nations?" *British Medical Journal*, 312 (1996): 302-307; Kent Buse and Gill Walt, "An unruly mélange? Coordinating external resources to the health sector: A review," *Social Science and Medicine* 45, no. 3 (1997): 449-463.

² Lawrence Gostin and Emily Mok, "Grand Challenges in Global Health Governance," *British Medical Bulletin* 90, no. 1 (2009): 7-18.

³ Jeremy Shiffman, "Has donor prioritization of HIV/AIDS displaced aid for other health issues?" *Health Policy and Planning* 23 (2008): 95-100; Nirmala Ravishankar, Paul Gubbins, Rebecca J Cooley, Katherine Leach-Kemon, Catherine M Michaud, Dean T Jamison, Christopher JL Murray, "Financing of global health: tracking development assistance for health from 1990 to 2007" *The Lancet* 373, no. 9681 (2009): 2113-24; Paolo Riva and Rebecca Dodd, "Where did all the aid go? An in-depth analysis of increased health aid flows over the past 10 years," *Bulletin of the World Health Organization* 87 (2009): 930-38.

⁴ Ilona Kickbusch, "Action on global health: Addressing global health governance challenges," *Public Health* 119 (2005): 969-73.

⁵ Kelley Lee, Meri Koivusalo, Eeva Ollila, Ronald Labonte, Ted Schrecker, Claudio Schuftan and David Woodward D, "Global Governance for Health," in *Globalization and Health: Pathways, Evidence and Policy*, eds. Ronald Labonte, Ted Schrecker, Corinne Packer and Vivien Runnels (London: Routledge, 2009).

⁶ Rene Loewenson, *Civil society influence on global health policy, Annotated Bibliography on Civil Society and Health* (Zimbabwe: WHO Civil Society Initiative and Training and Research Support Centre, 2003).

⁷ World Bank. "Defining Civil Society." Available at: <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/CSO/0,,contentMDK:20101499~menuPK:244752~pagePK:220503~piPK:220476~theSitePK:228717,00.html>.

⁸ Pal Jareg and Dan Kaseje, "Growth of civil society in developing countries: implications for health," *The Lancet* 351 (1998): 819-22.

⁹ George Gellert, "Non-governmental organizations in international health: past successes, future challenges," *International Journal of Health Planning and Management* 11, no. 1 (1998): 19-31.

¹⁰ United Nations Development Programme, *Human Development Report 2002: Deepening democracy in a fragmented world* (New York: UNDP, 2002).

¹¹ Richard Dodgson, Kelley Lee, and Nick Drager, *Global Health Governance: A Conceptual Review* (Geneva: World Health Organization and London School of Hygiene and Tropical Medicine, 2002).

¹² Organisation for Economic Co-operation and Development. "Engaging with civil society. Mainstreaming with Conflict Prevention," Available at: <http://www.oecd.org/dataoecd/26/55/35785435.pdf>.

¹³ UNAIDS, *Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2006).

¹⁴ World Bank, "Consultations with Civil Society Organizations, General Guidelines for World Bank Staff," Available at:

<http://siteresources.worldbank.org/INTRANETSOCIALDEVELOPMENT/873204-1111663470099/20489515/ConsultationsWithCSOsGuidelines.pdf>.

¹⁵ Christophe Lanord, *A Study of WHO's Official Relations System with Nongovernmental Organizations* (Geneva: WHO, 2002).

¹⁶ Chakravarthi Raghavan, "HAI voices concern over WHO's 'partnership' with private sector," Available at: <http://www.twinside.org.sg/title/hai.htm>; Kelley Lee, *The World Health Organization* (London: Routledge 2008).

¹⁷ WHO, "Inventory of WHO/HQ Relationships with Nongovernmental Organizations," Available at: <http://www.who.int/civilsociety/documents/en/inventory.pdf>.

¹⁸ World Health Organization, "WHO and Civil Society: Linking for Better Health." Available at: <http://www.who.int/civilsociety/documents/en/CSICaseStudyE.pdf>.

¹⁹ Michael Read and E. Jim Pearse, "Whither the World Health Organization?" *Medical Journal of Australia* 178, no. 1 (2003): 9-12.

²⁰ World Health Organization Commission on Social Determinants of Health, "Development of a Strategy for Civil Society Engagement in the Commission on Social Determinants of Health: Progress Update," Available at:

http://www.who.int/social_determinants/resources/cs_update.pdf.

²¹ Margaret Chan, "Speech to the First Special Session of the World Health Assembly Geneva," Geneva, Nov 9, 2006. Available at:

http://apps.who.int/gb/ebwha/pdf_files/WHASSA1/ssa1_div6-en.pdf.

²² Margaret Chan, "Strengthening multilateral cooperation on intellectual property and public health," Address at the World Intellectual Property Organization Conference on Intellectual Property and Public Policy Issues, Geneva, 14 July 2009. Available at:

http://www.who.int/dg/speeches/2009/intellectual_property_20090714/en/index.html.

²³ People's Health Assembly, "Civil Society Letter to Dr. Margaret Chan, Director General of the World Health Organization regarding WHO's publications policy," May 27, 2008. Available at: <http://www.phmovement.org/en/node/591>.

²⁴ Peter Haas, *Is there a Global Governance Deficit and What Should be Done About It?* (Geneva: Ecologic, 2003).

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ World Health Organization/United Nations International Children's Fund, "International Code of Marketing of Breastmilk Substitutes." Available at:

<http://whqlibdoc.who.int/publications/9241541601.pdf>.

²⁸ World Health Assembly, *International Code on Marketing of Breastmilk Substitutes, WHA Resolution 34.22* (Geneva, WHA, 1981).

²⁹ *Ibid.*, Article 11.4.

³⁰ Anna Taylor, "Violations of the international code of marketing of breast milk substitutes: prevalence in four countries," *British Medical Journal* 316, 11 April (1998): 1117-22.

³¹ Baby Milk Action, "Nestle's Public Relations Machine Exposed," *Press Release*, May 30, 2002. Available at: <http://www.babymilkaction.org/boycott/prmachine.html>.

³² Jeff Collin, Kelley Lee and Karen Bissell, "Negotiating the Framework Convention on Tobacco Control: The politics of global health governance" in *The Global Governance Reader*, ed Rorden Wilkinson (London: Routledge, 2004).

³³ WHO, "WHO Framework Convention on Tobacco Control: Report by the chair of the intergovernmental negotiating body." Available at

http://apps.who.int/gb/archive/pdf_files/WHA56/ea56id7r1.pdf.

³⁴ Mary Assunta and Simon Chapman, "Health treaty dilution: a case study of Japan's influence on the language of the WHO Framework Convention on tobacco control," *Journal of Epidemiology and Community Health* 60, no. 9 (2006): 751-56.

³⁵ Harry Lando, Belinda Borrelli, Laura Klein, Linda Waverley, Frances Stillman, Jon Kassel and Kenneth Warner, "The Landscape in Global Tobacco Control Research: A Guide to Gaining a Foothold," *American Journal of Public Health* 95, no. 6 (2005): 939-45.

³⁶ Kelley Lee, Luis Carlos Chagas and Thomas Novotny, "Brazil and the Framework Convention on Tobacco Control: Global health diplomacy as soft power," *PLoS Medicine* (in press); Raul

Mejia, Veronica Schoj, Jaoquin Barnoya, Maria Laura Flores and Eliseo J. Perez-Stabel, "Tobacco industry strategies to obstruct the FCTC in Argentina," *CVD Prevention and Control* 3 (2008): 173-179.

³⁷ David P. Fidler and Lawrence Gostin, "The New International Health Regulations: An historic development for international law and public health," *Journal of Law, Medicine and Ethics* 85 (2006): 85-94.

³⁸ All Member States of WHO will become States Parties to the IHR (2005) except for any that reject the Regulations before 15 December 2006. States not Members of WHO may become States Parties to the IHR (2005) by notifying the Director-General of WHO of their acceptance.

³⁹ World Health Organization, *International Health Regulations, 2nd Edition* (Geneva: WHO, 2005).

⁴⁰ Article 9(1), WHO, *International Health Regulations (2005)*, 2nd Edition, Geneva, 2008.

Available at <http://www.who.int/ihr/9789241596664/en/index.html>

⁴¹ FAO/WHO Food Standards, 2005: 1-2. Available at:

http://www.codexalimentarius.net/web/index_en.jsp

⁴² Natalie Avery, *Cracking the Codex: An analysis of who sets world food standards* (London: National Food Alliance, 1993).

⁴³ Quoted in Natalie Avery, "How TNCs Influence Global Food Standards," Third World Network Features, Oct. 24, 1995. Available at: <http://www.hartford-hwp.com/archives/28/076.html>.

⁴⁴ C. Hawkes, M Chopra, S. Friel, AM Thow, "Globalization, food and nutrition transitions," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health, 2007.

⁴⁵ Kent Buse and Andrew Harmer, "Seven habits of highly effective global public-private partnerships: Practice and potential," *Social Science and Medicine* 64 (2006): 259-71.