Peter Wall Institute for Advanced Studies

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Official Scribe Report

What Difference does the Advent of Civil Society Mean to Global Health Governance?

Co-Sponsored by:
The Peter Wall Institute for Advanced Studies at UBC
The Munk Centre for International Studies, University of Toronto

Convened by: Dianne Newell, Director, Peter Wall Institute

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EXECUTIVE SUMMARY

For four days, between June 25th and June 29th 2007, 18 invited junior and senior academics and global health professionals met at the Peter Wall Institute for Advanced Studies at the University of British Columbia to deliberate the impact that civil society organizations have had on global health governance. The purpose of the Wall Summer Institute for Research 2007 was to bring together a diverse group of individuals working and researching different aspects of global public health in order to analyze critical and controversial phenomena that have not yet been analyzed and to advance thinking and dialogue in this area in order to improve global health outcomes.

The event was structured as a discussion seminar. Each day was broken down into a morning session that was open to students and members of the community and an intensive closed afternoon session. Between four and six observers attended the open sessions each morning. To further open the event to the broader community, a major public talk was given on the second evening by James Orbinski on the topic of "Why Civil Society Matters to Global Health." A month prior to the WSIR, ten participants submitted papers on a variety of topics relevant to global health and governance. The papers and the public talk helped to frame the debate and discussion throughout the four days. All participants had the opportunity in advance of the meeting to read and reflect upon the arguments and theories put forward in the papers, but two discussants were specifically assigned each day to begin the morning proceedings with commentary based on a detailed assessment of the papers. Each day was also assigned a specific focus question, designed to provoke discussion that would feed into the overall theme of the event regarding the impact of civil society on GHG. The focus question for the first day of proceedings was: "What are the strategies, resources, consequences and challenges of civil society organizations in global health governance?" The question for both the second and third day was: "What are the intended and unintended consequences of the relationship of CSOs to IGOs on global health governance? Finally, the focus question for the fourth day was: "The phenomenon of hybrids: Is it really new? What are the consequences of hybrids for global health governance?"

Discussions on each day varied significantly; however, the main recurrent themes of the deliberations throughout the four days included:

- What are the **gaps in health governance**? How and why are CSOs behaving to remedy governance failures?
- What is the **nature of civil society**? What groups are included in the term Civil Society Organization? How does their diversity affect governance?
- **Governance Feedback Loops**: How does practice inform governance and how does governance shape the behaviour of health practitioners.
- **Power**: What is the nature of the power held by CSOs and how is it employed to alter the shape of global health governance.
- What are the **legitimate roles** of different actors—governments, IOs, and CSOs—within health governance?

- The **politicization and securitization of health**: Is health different from other issue areas? If so, in what way? Is health a unique issue in global politics because it is at the basis of the human condition? Or can it be politicized like other issues in global politics?

Certain key questions and ideas provoked by the Vancouver WSIR will be further developed at a follow-up event, which will be a weekend retreat in London to be hosted by the Peter Wall Institute and co-sponsored by the London School of Hygiene and Tropical Medicine and the Munk Centre for International Studies in October, 2007.

Participants

Kenneth W. Abbott: Professor in College of Law and the School of Global Studies, Arizona State University, Tempe

Sonja Bartsch: Senior Research Fellow at the German Institute of Global and Area Studies, Hamburg

Jillian Clare Cohen-Kohler: Director of the Comparative Program on Health and Society and an Assistant Professor at the Leslie Dan Faculty of Pharmacy, University of Toronto

Ronald J. Deibert: Associate Professor of Political Science and Director of the Citizen Lab at the Munk Centre for International Studies, University of Toronto.

Nick Drager: Acting Director in the Department of Ethics, Trade, Human Rights and Health Law at the World Health Organization, Geneva

Brett Finlay: Professor of Biochemistry & Molecular Biology and Immunology, and Director of the Michael Smith Laboratories and Peter Wall Distinguished Professor at Peter Wall Institute for Advanced Studies, University of British Columbia

Margaret Hilson: Coordinator, International Practicum, and Global Health Advisor for the Faculty of Health Sciences, Simon Fraser University

Kelley Lee: Reader in Global Health and Director of the WHO Collaborating Centre on Global Change and Health, London School of Hygiene & Tropical Medicine, University of London

Thelma Narayan: MD PhD, Joint Convener of the Peoples Health Movement in India and Co-founder and Public Health Policy Consultant, Community Health Cell, Bangalore

James Orbinski: Research Scientist and clinician at St. Michael's Hospital in Toronto, and an Associate Professor of both Medicine and Political Science at the University of Toronto

Richard Price: Associate Professor of Political Science at the University of British Columbia

Daniel Sahleyesus: (Ethiopia) SSHRC Post-Doctoral Fellow at the Centre for International Health and Research Associate at the Comparative Program on Health and Society, Munk Centre, at the University of Toronto

Paul Shaw: (Vancouver) Health Economist and Program Advisor of the World Bank Institute's Human Development Group (Vancouver)

Devi Sridhar: Postdoctoral Researcher in the Global Economic Governance Programme in the Department of Politics and International Relations and a Postdoctoral Associate at the Institute of Social and Cultural Anthropology, University of Oxford

Janice Stein: Belzberg Professor of Conflict Management in the Department of Political Science and the Director of the Munk Centre for International Studies at the University of Toronto (Co-Director of WSIR 2007)

Y. Andrea Wang: (Candidate) M. Phil. Programme in International Relations at the University of Oxford

Mark Zacher: Professor Emeritus, Department of Political Science, Senior Research Fellow at the Centre of International Relations, and Research Fellow, Liu Institute for Global Studies, University of British Columbia (Co-Director of WSIR 2007)

Other Involved Parties

Tania Keefe: Research Fellow at the Centre of International Relations, University of British Columbia (WSIR 2007 Scribe)

David McCoy[1]: Public health physician, member of the People/s Health Movement, and manager of *Global Health Watch*, currently based at University College London

Dianne Newell: Director of the Peter Wall Institute for Advanced Studies (Convener of WSIR 2007)

[More comprehensive biographies can be found at:
http://www.wsir.pwias.ubc.ca/2007/participants.php]

[1] Dr. McCoy contributed a co-authored paper with Margaret Hilson and provided commentary on papers submitted to WSIR, but was unable to attend due to schedule conflicts

Acronyms

CIDA: Canadian International Development Agency
DFID: Department for International Development (UK)
DNDi: Drugs for Neglected Diseases Initiative
DOTS: Directly Observed Treatment, Short-course (treatment for tuberculosis patients)
IO: International Organization
IR: International Relations
IPR: Intellectual Property Rights
NGO: Nongovernmental Organization
GHG: Global Health Governance
GHP[2]: Global Health Partnership
PIH: Partners in Health
PPP: Public Private Partnership
MDGs: Millennium Development Goals
MoH: Ministry of Health
MDRTB: Multi Drug Resistant Tuberculosis
MSF: *Medecins Sans Frontieres* (also commonly referred to as Doctors without Borders)
TRIPS: Agreement on Trade Related Aspects of Intellectual Property Rights
WB: World Bank
WHO: World Health Organization
WSIR: Wall Summer Institute for Research

[2] The terms Global Health Partnership and Public Private Partnership are used synonymously in this report.

Report on Commentary
Day 1

Focus Question: What are the strategies, resources, consequences and challenges of civil society organizations in global health governance?

Moderator: Margaret Hilson

Discussants: Richard Price and Janice Stein

Papers: "Innovations in Global Health and the Global Governance System" - Kenneth Abbott

"The Transformation of global Health Governance: Utilization and Expansion of Control Strategies" - Mark Zacher and Tania Keefe

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Following welcoming comments from WSIR 2007 Convener **Dianne Newell** and Co-Director of WSIR 2007 **Mark Zacher**, **Margaret Hilson** began the proceedings by commenting on the value of participating in a seminar on global health and politics with a diverse group of experts who rarely have the opportunity to come together. This was the first comment of many regarding the lack of communication and collaboration between various groups working to improve health governance. Many groups active in global health issues function autonomously; dialogue often remains introverted rather than inclusive. Thus one of the challenges for those working to improve global health governance is to foster better dialogue with those working from different sides of the same issue and in related fields. This marked an auspicious beginning to the weeks' event, as fostering interdisciplinary debate and fundamental research on critical problems is one of the key goals of the WSIR.

Presentations by Discussants

Janice Stein began the discussant presentations by pointing out certain issues common to the **Abbott** and **Zacher** and **Keefe** papers. A critical point was made here in regard to the role that CSOs play in promoting and developing governance agendas. Both papers gave prominence to CSOs as norm creators and agenda setters, but she stated that it is necessary to go beyond that and recognize the important role that CSOs play as mobilizers and implementers. Nowadays, CSOs influence policies and programs in their capacity as norm setters, but they do more in that they implement policies on the ground. According to her, the papers made implementation of the norms affected by CSOs seem an easy and logical flow, but she questioned whether or not this is the case in practice. At this point in the proceedings, she asked a question that was to recur throughout the following four days: **How does practice shape governance?**

This question flowed into a discussion on the existence (or lack thereof) of 'feed-back loops'. Participants were given the opportunity to consider the issue of whether global health governance is solely top down, or whether there are mechanisms that allow on-the-ground practices to feed back into governance decisions. Stein stated her opinion that important practical knowledge, possessed by many CSOs, often does not reach the 'headquarters' of governance. She stated that there is a large and growing gap between on the ground activities and governance leadership in the realm of health as well as virtually all other governance systems. In subsequent open discussions among the WSIR participants, this emerged as one of the key challenges for CSOs in GHG: how ought practice to influence governance? How can effective feedback loops be established so that pragmatic lessons learned during on the ground operations inform the International Organizations and state governments who are leading decision-making regarding the direction and goals of the health governance regime?

The next key section of **Stein's** presentation that influenced subsequent discussions was the theme of **mapping for order** that was common to many of the WSIR discussion papers. She noted a tendency running through the papers that ordering GHG was a necessary and desirable goal; that we need to make sense of the "mess that is health governance". While this is an understandable tendency, and indeed sometimes a necessary practice in order to develop explanatory paradigms, if we force order on an inherently messy system, we risk missing the ecological diversity of governance. Governance is rich, complex and messy; and, as Stein argued, 'messy' is not necessarily a negative feature of governance.

The next discussant, **Richard Price**, began his commentary by noting that he is an 'outsider' to the health governance regime. An expert on civil society and norms, he has mainly focused his research on other issue areas such as arms control. His examination of health governance from an outside perspective provided valuable insight into the workings of governance activities on a general scale in term of overall IR literature and research.

Price remarked that the papers were interesting in the fact that they took the pervasiveness and influence of CSOs in global health governance as a standard and unremarkable fact of life. He commented that only in the past 10 to 15 years has international relations literature, with regard to arms control and other issues areas, granted CSOs a high degree of legitimacy and a role in decision making. Taking CSOs seriously as legitimate actors in IR is a new phenomenon; however, their pervasiveness in global health governance implies that they have quickly become entrenched in the processes of health governance. Next, Price commented that the papers approached the discussion with the assumption that CSOs are largely positive actors in IR. He cautioned the WSIR participants to not be blind to the fact that unsavory groups, such as armed and violent rebel groups, are CSOs as well and that a nuanced discussion of civil society has to recognize this fact. Indeed, with regard to health, rebel groups (e.g.: Hamas) are particularly important and interesting as they are frequently the on the ground actors that are providing medical services for people living in conflict zones. This sometimes can

create a dilemma regarding the necessity of forging alliances between violent and non-violent political actors.

Next**,** Price stated that activists in other CSO activity areas often deliberately frame their issues as health concerns in order to get more traction, whereas people in the health field are focused on the under-provision of health and the reality that health concerns often lose out to trade and security issues. The Partial Test Ban Treaty, the Ozone Treaty and the banning of female genital mutilation have all gained traction and support because they have been framed as a health issue. He stated that "This field is the envy of other CSO activity areas: GHG has never been more organized and denser and better funded than it is now". The challenge now is to translate that focus, funding and organization into better health outcomes.

Price ended with a provocative question regarding the future of CSOs: should these groups be 'creating the seeds for their own obsolesce'? Or are CSOs becoming a permanent fixture within health governance? Does health governance now require CSOs to perform tasks that governments are no longer capable of or willing to do? Is the role of CSOs to act as a stop-gap while the health governance system is mended, or are they an integral part of the new system?

Group Discussion

Participants commented on surveillance as one of the new and crucial tasks of CSOs in health governance. CSO monitoring activities have spawned the use of a new term '*su-veillance,* which refers to monitoring activities from below instead of watching from above as per traditional surveillance arrangements. This led directly into a discussion on **SARS** and how Western states and health professionals first heard of this new disease from non-state sources months before receiving information from official state sources. **Brett Finlay** stated that he became aware that there was a new and serious disease in China via a Health Canada operated computer monitoring system.[3] **Stein** noted that she had tracked the very first reports of a new disease in China to traders working for a Swiss Bank that had offices in southern China; these traders had reported a disease in the region to their headquarters in November the year before the outbreak breached China's borders and became a global issue. This discussion highlighted the opportunities for better surveillance given new technologies, but also fostered questions regarding the obligations of non-state actors to disseminate information to whom and in what forum and the obligations for states to accept information from non-state actors.

Thelma Narayan made the comment that it is necessary to question who benefits from surveillance activities. It is important to ask which diseases and outbreaks are chosen for

[3] The internet based monitoring system operated by Health Canada is called the Global Public Health Intelligence Network (GPHIN)

surveillance - the ones that could potentially impact rich countries (and trade routes) or the ones that impact poor countries? Her perspective from a public health background and from working in a country that does not have a fair or equally accessible health system has made her sensitive to the fact that social determinants of health (poverty, gender, caste, etc.) are a key part of the political background to GHG. She encouraged the participants to keep this important issue in mind throughout the subsequent discussions. Improved health systems and governance, in the areas where it is needed most, is an issue of **equity and justice** as well as illness and disease. Health governance cannot be improved until other systemic changes are made to the global governance system regarding poverty, economic development, women's rights and other linked issues.

Paul Shaw outlined three key outcomes or goals of the health governance system:

- Health Status: The goal of improving overall health indicators
- Patient Satisfaction: Developing better treatment options
- Risk Pooling: The notion of keeping people from falling into debt when they experience illness: in essence, a health insurance system.

There is significant focus on the first two outcomes by CSOs, states, and even the papers for the WSIR, but that there is little to no activity with regard to the third outcome. He argued that this is because there are very large barriers to entry with regard to this issue, but that overcoming those barriers will be the next crucial area for progress in health governance, as if successful it can eliminate the key financial issues that prevent people from accessing health care and can prevent the economic devastation that often follows an illness in poor parts of the world. **Margaret Hilson** picked up on the point of barriers to entry for CSOs and re-stated **Stein's** question from earlier in the discussion regarding how practice shapes governance. She noted that if a core demand among the people who need health governance the most is a type of health insurance system, and that there is no activity on this front, then **Stein's** question must be answered in the negative: if we are not implementing the programs that people need the most, we obviously do not have effective feedback loops between practice and governance.

James Orbinski responded to this conversation with an anecdote pertaining to multidrug resistant TB. He relayed the story of a Boston based NGO, called Partners in Health, which was operating a TB treatment program in Haiti in the 1980s and how they began to notice that many patients were developing resistance to standard treatments. Around the same time, *Medicins sans Frontieres* noted the same problem among their patients in different locations. Based on their findings, PIH and MSF petitioned WHO to update the recommended TB treatment policy. According to **Orbinski**, WHO employees initially responded negatively to the request, stating that WHO health experts were responsible for determining the correct treatment protocols. MSF and PIH then worked together to develop a database of information and a public advocacy campaign. After 18 months of data dissemination and campaigning, WHO altered its policy regarding DOTS treatment protocols for TB. Thus, two CSOs were able to bring about a change in practice by employing the strategies of information and advocacy. This anecdote provides an

important example of what kind of resources and power CSOs hold, and how then can influence the global system under certain circumstances. It also implied that the feedback loop, while non-existent in some areas of health governance, can be made to work in others.

At this point in the discussion, **Price** brought the participants back to the **ethical and social justice aspect of the health governance system** and how it was peculiar that neither paper for the day elaborated on the ethical aspect of health and the motivation for improved health governance. He argued that health is a morally driven human rights issue, and that the vastly unfair and unequal distribution of good health care systems is a key factor driving activism in this area. **Orbinski** picked up on this point by explaining that the public health movement arose as a reaction to mass suffering brought about by epidemics of cholera, maternal morbidity, and other common medical problems of the 20th century. From this, he identified three sources of motivation behind the drive for a functioning global public health system:

- The moral imperative that it is unacceptable to allow humans to live in obscene conditions.
- The pragmatic concern regarding economics: A healthy work force is necessary to drive a country's economy forward.
- The self interested desire to protect our own health, by ensuring the people around us are not sick.

In his view (in accordance with the research and writing of David Fidler) we are living in a post-securitized governance system and that GHG has in large part become a security issue due to the threat of bioterrorism and the need for increased outbreak surveillance in order to protect the citizenry and economies of the West. While the security and economic interests of rich countries largely define the global health agenda, there also remains an element of health governance that can be called a **global ethic of concern**, which ensures that health governance about people and justice as well as about security and economics.

Ken Abbott then brought up the question of the role of CSOs within public private partnerships. He asked the participants to consider whether NGOs were being co-opted by working with private businesses and with governments. He asked how NGOs can be expected to act independently for their own agenda, when they are dependent on other GHG actors for funding. The discussion on this point was contested. Some participants felt that **co-optation** is not occurring; rather **'contracting out'** and **'convergence of agendas'** is occurring, and that is a positive phenomenon indicating how the varied actors within health governance can work together effectively by exploiting their comparative advantages. Others felt that co-optation is occurring, with some participants arguing that it is sometimes necessary and good, and others arguing that it is undermining the role of CSOs in GHG. While no consensus was reached, the discussion proved interesting and fruitful in developing a deeper understanding of the nature of the impact of CSOs on GHG.

The discussion then led into a debate on how CSOs can contribute to improving governance and what they ought to be responsible for within the governance system. The participants generally agreed that there is currently a failure on the part of international organizations, state governments and markets to provide the essentials of health care worldwide, and that CSOs are voluntarily taking on the task of filling some of those gaps. Numerous important questions arose here regarding **which actors can legitimately direct the global health agenda**, and whether or not CSOs have the appropriate levels of accountability to be considered legitimate governance actors.

The participants contributed various ideas and suggestions in developing the following list of how CSOs impact and contribute to health governance:

- **Agenda Setting**: CSOs are very powerful advocates for health issues as they can often make their point in resonant terms of human suffering.
- **Surveillance and Su-veillance**: CSOs are a vast source of data (sometimes invited, sometimes unwelcome) to states and IOs. Furthermore, numerous civil society groups have become self-appointed watch dogs for treaties and agreements in many governance areas.
- **Implementation**: In the poorest countries where governments are dysfunctional, NGOs, church missions, and volunteer associations are often the only providers of medical services.
- **Pathfinding**: Bringing new issues onto the radar screens of governments and IOs, or framing old issues in new ways that providing meaning and content for campaigns for change.
    - E.g.: During the post-TRIPS negotiations for the Doha Declaration, CSOs provided crucial knowledge, policy connections and strategic planning.
- **Mobilizing Money**: Foundations, particularly the Gates Foundations, are supplying huge sums of money to health issues, and are actually altering the research agenda with their donations.

At this point in the discussion, **Stein** made the suggestion that each participant ought, in turn, to identify what they think the **biggest challenge** for global health governance will be over the next 5 to 10 years. This list is included here as an interesting academic experiment to see how experts operating from different vantage points see the key issues in health governance.

Price - The vast un-evenness in ‘provision versus needs’. E.g.: afflictions like anemia do not get attention because they are not communicable, shocking or globally threatening - it is a global issue, but does it affect everyone around the world, and so there is no ‘cause’.

Drager - The globalization of health services: movements of people; movements of medical staff, provision of e-health. Globalization is fundamentally and drastically changing the landscape of GHG.

Zacher – The health crisis in sub-Saharan African. It will lead to systemic breakdown of political structure, potentially leading to breakdown of society.

Shaw – We are not going to meet the MDGs; our current strategies and approaches are not working. The area where some hope for positive change lies, is an area where not much is currently happening and that is community insurance programs. This is the provision of cost effective health insurance/benefit packages that, if successfully implemented prevent individuals and families from economic disaster due to a illness. Currently, the big CSOs are not talking about this; lots of small CSOs are, but they are not coordinated.

Sahleyesus – National health systems are disintegrating especially in terms of their trained man-power. GHG will not survive without strong national health systems. In Ethiopia, the situation is alarming. In the next 5 or 10 years there will be no one left to run the health infrastructure. We need new ways of training and maintaining medical staff.

Keefe – Zoonotic diseases. While surveillance for certain diseases is improving, there is a large and growing gap in the surveillance of diseases that can be transmitted from animals to people. Organizations that deal with animals diseases do not communicate with organizations that deal with human diseases, and there is virtually no reporting system in place to track and monitor animal diseases.

Bartsch – From perspective of global health partnerships, the biggest problem facing GHG is the verticalization of global health and issue linkages of health and trade and heath and security.

Lee – How is GHG going to address the disconnect between the reality of the disease burden and the resource allocation that we see now? The 10/90 gap[4] remains a key issue is health governance. There is a clearly irrational system in so many areas now: effective GHG could alleviate the disparity.

Narayan - National health systems need strengthening. The underlying determinants of health need to be examined and understood, including issues such as privatization of water, lack of food security, loss of livelihood. Health is cross-sectoral; we need to understand the links between health and other development issues.

Abbott – Environmental issues. Climate change may bring about new diseases that we will not know how to treat. Also, new technologies are making the inequities in health care exponentially larger than they are now. In the West (thanks to developments in sciences such as genetic analysis and engineering and nano-technology) we are soon going to have highly personalized health care unsurpassed in human history. How will we share that health care with inhabitants of poor countries?

[4] The 10/90 gap refers to the fact that only 10 percent of drug research and development is allocated to diseases that cause 90 percent of the global disease burden, because they occur in the poorest regions of the world where there is no viable market to sell pharmaceutical products.

Hilson – Vast populations living in poverty; and the concern that dire poverty is going to become permanent and accepted: the "**institutionalization of unacceptable human misery**". At least the Millennium Development Goals are an attempt to make things better; what happens if failed MDGs are not replaced with another goal? However, we are also in an economic situation where a small number of people are amassing vast fortunes: what will happen with this wealth? What are the new and developing roles for philanthropy as it relates to GHG?

Wang – Improving the capacity of national governments to deal with health issues, especially in terms of health care workers. The capacity of local institutions is crucial in dealing with health issues.

Sridhar – Climate change: droughts, monsoons, etc. causing loss of livelihood, migration and an increase in new and re-emerging infectious diseases.

Cohen-Kohler – The biggest fear is that 10 years from now, we will be talking about the same problems in the same way, not having fixed them yet.

Stein – The demographic divide. The proportion of young people is becoming concentrated in poor parts of the world, whereas the proportion of old people is becoming concentrate in rich countries. This will dramatically skew the domestic health agenda. Donor societies will look fundamentally different from recipient countries.

Report on Commentary
Day 2

Focus Question: What are the intended and unintended consequences of the relationship of CSOs to IGOs on global health governance? (Part I)

Moderator: Sonja Bartsch

Discussants: Jillian Clare Cohen-Kohler and Daniel Sahleyesus

Papers: "The Interface between CSOs and the World Bank: An Input to Global Health or Global Harm?"
- Paul Shaw

"The Cutting Edge of Global Health Diplomacy: Foreign Policy, Trade and Health"
- Nick Drager (David P. Fidler, Benedikte Dal, Sabrina Ballet, and Basil Kim)

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Presentations by Discussants

Jillian Clare Cohen-Kohler began her discussant presentation by disclaiming that although she consults for the World Bank periodically, she is able to maintain a critical perspective. Her discussion of the paper by Shaw and of the Bank in general revolved around the differences between role the Bank was originally designed to play, and the expanded role it has taken on in recent years. The Bank, which is a composite of several institutions, was created in 1945 as a financial lending institution to rebuild Europe in the post-WWII era. It has, in recent years, expanded its mandate to include numerous other responsibilities, the most important here being its predominant focus on health issues. Taking on too many projects and trying to be too much to too many, has weakened the Bank and it is currently in a state of flux and transformation following numerous perceived failures, including the most recent presidential scandal. Cohen-Kohler expanded upon the comments in **Shaw's** paper on how the Bank needs to be restructured to reflect the realties of the new globalized system.

Of key importance to the focus question of the day is the integration of CSOs into the Bank's governing processes. Cohen-Kohler argued that CSOs were invited into the Bank around the time of the Bank's fiftieth anniversary in a reaction to violent protests in Madrid regarding perceived failures on the Bank's part to effectively manage globalization and poverty issues. Inviting CSOs to table was a survival tactic. We need to carefully assess whether CSOs are playing an effective role in monitoring and judging the Bank's activities, or by being included in Bank processes are they being co-opted and merely part of the bureaucracy.

Cohen-Kohler finished by asking the participants to consider whether or not the bank as an 'old' institution is capable and willing to respond to new actors in a meaningful way. She asked the participants to consider the question of whether the Bank is too mired in its internal bureaucracy and over-burdened by mission-creep to be an effective global institution.

The next discussant, **Daniel Sahleyesus**, agreed that the Bank is facing an identity crisis. He provided an overview of the main argument of **Shaw's** paper, which is that the Bank should return to its original mandate of being a financial institution: its purpose was to develop and fund sustainable development but it has moved far beyond that narrow mandate. Following the logic of comparative advantage, the Bank should recognize where its strengths and assets lie and focus its money and attention on those areas.

Sahleyesus picked up the idea within Shaw's paper, that at least partial blame for the Bank's mission-creep problem falls at the feet of CSOs, which have pushed the Bank into 'doing more' and 'being more' than was intended by its creators. The relationship between the Bank and CSOs needs to be improved in such a way that will, in turn, improve health governance. According to **Shaw's** paper, CSOs have affected change at the WB in four areas he calls CSO Pressure Points:

- Debt relief
- Aid effectiveness
- MDGs
- Human Capital and Knowledge transfer

Focusing on the fourth pressure point, Sahleyesus argued that the **brain drain of health professionals** from low income countries is proving to be one of the most serious issues in global health currently. He relayed a story of how he recently met a medical school colleague from Ethiopia in Ontario; the colleague said that of the 40 doctors who graduated with him, 20 have already left Ethiopia. If the brain drain of medical personnel is allowed to continue at this rate, there will soon be grossly insufficient numbers of trained medical personal in the countries where they are needed most. He concluded by commenting that it is important not to forget that **CSOs are not a homogenous, cohesive, or cooperative group**. They do not approach IOs, such as the World Bank with a unified mandate or even similar goals. CSOs compete with each other and have different goals and agendas.

Inspired by the **Drager et al.** paper on the links between health and other issue areas, **Cohen-Kohler** argued, in line with **Drager**, that Ministries of Health are usually not the strongest ministries within a government, but that health has a larger and growing focus now than in the past, increasing the importance of these ministries.

At this point, Cohen-Kohler provided an example of the links between health and trade in the Canadian context. After the TRIPS Agreement entered into force, Canada rewrote its trade laws to become compliant with the Agreement. Several years later, in the aftermath

of the Doha Declaration, which avowed the importance of the public health loopholes in TRIPS, the Canadian government passed Bill C-56, more commonly referred to nowadays as the Canadian Access to Medicines Regime (CAMR). The Bill was designed to ensure the ability of Canadian firms to exploit the compulsory licensing clause within TRIPS and legally export cheap, generic drugs to poor countries. The passing of Bill C-56 was deemed a success story and a perfect example of how health, trade and foreign policy can work together in harmony. In reality, however, the passing of the Bill has achieved nothing because no drugs have actually left Canada. Efforts have been made to export generic drugs, but commercial interests have dominated.[5]

The moral of this important story is that although policy coherence is necessary, we must recognize the fact that resource-rich interest groups are generally able to dominate a country's foreign policy agenda. In essence, this story tells us that, while health is gradually becoming a higher priority, trade and economic interests often still trump health interests.

Group Discussion

Sridhar discussed the fact that the lending environment has fundamentally changed since the Bank came into inception. The global **lending environment is now competitive** because countries like China and India have recently begun to provide loans to developing countries, and the terms they are willing to lend under are usually more lenient than World Bank conditionalities. Essentially, this means that poor countries have choices about who they can borrow from and under what conditions, and this will have a very serious impact on how the Bank will be able to operate in future.

Shaw responded with the comment that there is a strong need for a new global aid architecture. He argued that even though the Bank has been weakened by mistakes of the past, it can and should be part the new lending system because it provides public money; public financing, and had the power to raise and leverage large sums of money. He listed several financial and administrative skills the Bank possesses that ensure its continued relevance and value to lending systems:

- The ability to tracks flow of money going into a country for health purposes
- The ability to assess the economic burden of taxes for health
    - E.g.: the impact of user fees
- The ability to tracking public expenditures:
    - Is money being spent right way?
    - Are poorest people benefiting from outputs?
- The ability to manage health insurance systems in terms of risk pooling and risk weighting

[5] For a detailed analysis of the negotiations and implications surrounding Bill C-56, see "Medicines for All? Commitment and compromise in the fight for Canada's law on compulsory licensing for export" by Richard Elliott, in The Power of Pills. Jillian Clare Cohen, Patricia Illingworth, and Udo Schuklenk Eds. London: Pluto Press. 2006

- The ability to administer cost effective analysis of health spending

Narayan explained that the Indian experience with World Bank loans has not been positive, as the loans are conditional and often not in the country's own best interest. The conditions are not constructive because they reflect the external priorities of the global governance system, not the internal realities of the Indian health system. CSOs have protested regarding the illogical conditionalities, but the situation has not changed.

Shaw agreed that the Bank has made mistakes, and cited the example of the controversial user fees that caused extreme barriers to access health care in some countries. However, he pointed out that the failures in areas like sub-Saharan Africa were not only due to Bank activities. He made the statement that: "**we all failed**" and that we need a new and better practices because the entire system, including CSOs, states, and IOs have failed to improve the health conditions of people living in poor countries.

At this point, **Stein** point to the different roles of different actors in GHG. She pointed out that in the world's poorest places people function on **'non-monetized' economies,** which means there is no basis for taxation and thus no funding for government-provided health care. In situations like this, neither the market, nor the government can address the problem. This is a visible and obvious gap in the governance system and it is an area where CSOs and global institutions like the World Bank could play a vital role.

The next main topic of conversation centered on the point that **Sahleyesus** made regarding the fact that **CSOs are not a homogenous, cohesive, or cooperative group**. Sahleyesus had stated there are numerous and varied CSOs in developing countries and that they are competing with each other for funding. Discussion on this point led to a debate as to whether it is valuable to have duplication of services, due to the existence of numerous competing CSOs. Some participants felt that the duplication is a valuable feature of governance as it creates constructive competition and innovation. Other participants felt that the numerous, competing CSOs act as a dead-weight on the governance system because they occupy the time and resources of government and IO officials.

The day's discussion finished with commentary from WHO representative, **Nick Drager**, who stated that as health governance becomes deeper, more rules will be created and that strong negotiators in all areas are becoming a crucial asset to states and IOs. He argued that **CSOs make for better negotiations** because they bring knowledge and long-term strategic planning to the table.

Report on Commentary
Day 3

Focus Question:	What are the intended and unintended consequences of the relationship of CSOs to IGOs on global health governance?(Part II)
Moderator:	James Orbinski
Discussants:	Ronald Deibert and Andrea Wang
Papers:	"The Role of CSOs in Intergovernmental Health Organizations: Contributions to Global Health Governance" - Kelley Lee "Civil Society, Civil Society Organizations and the Governance of Health at the Global Level" - Margaret Hilson and David McCoy (Sections 1 – 3) "Public Mobilization and Lobbying Strategies in the South: The People's Health Movement in India" - Thelma Narayan

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Presentations by Discussants

Ron Deibert began the third day of discussions with a presentation that focused on the changing role of the state in world politics and how that is making room for new actors to participate in IR and also making room for old actors to behave in new ways. He argued that governance is moving away from a Westphalian state-centric system to a postmodern structure; a system that contains multi-actor and multi-dimensional arrangements. He argued that the global structure is neo-medieval in that it contains multiple and overlapping layers of authorities. Thus, architecture around the state is crumbling and there are no clear boundaries delineating the role of state and non-state actors. The situation facing the World Health Organization highlights this problem: health has become everyone's issue, and so the mandate of WHO has lost its focus. Furthermore, there is no functional differentiation as to what CSOs are responsible for as opposed to what states and markets are responsible. Some CSOs provide treatment, some perform advocacy roles, some conduct research, meaning that civil society is acting at all levels of governance and feeding into the new layered and overlapping system.

This situation poses interesting questions such as:

- Should CSOs have a formal involvement in setting the rules?
- Should they be at the voting table?

- Under what conditions and how should CSOs be included in the decision making process?
- Whom do you include? Whom do you exclude? (This is a particularly thorny question in light of the fact that CSOs include violent groups, as per the discussion on Day 1)
- Accountably and Legitimacy: If we are to have a rule-making process which involves CSO, we have to determine if and how they are accountable

Deibert then discussed his own work in terms of how communications technologies affect CSO participation in governance networks. He discussed his involvement in a hybrid academic/NGO open net initiative, which is a research project of four universities and numerous other actors. The internet used to be the crux upon which most non-state groups were based, because states could not control the internet. However, now governments have developed ways to filter and control information. For example, two weeks prior to the most recent national election, the Cambodian government disabled all text messaging over cellular networks, which prevented opposition groups from mobilizing. Another example of how information can be limited is through the state use of ‘smart filters’. Originally designed to prevent employees from accessing inappropriate websites at work, smart filters are now being used to prevent the general populace in certain countries from gaining information on specific topic. For example, the Indonesian government filters the word ‘breast’ to prevent people accessing pornography sites, but a consequence of that filter is that people are preventing from finding information on breast cancer.

The second discussant, **Andrea Wang**, focused her commentary on four themes she determined were relevant to the three papers and the focus question. First, she argued that there is a need to recognize that **CSO have two faces**. We assume that CSOs enhance good governance, but that assumption must be questioned. We lean towards the positive and we study the ‘good groups’ in part because it is easier to study groups that are linked to government frameworks and that participate in the system. But in order to develop a more nuanced understanding of new global arrangements, it is necessary to examine the concept of **uncivil society**. Do more rules need to be developed to reign the activities of CSOs?

Second, CSOs are not distributed evenly across the globe or across sectors. There is a **geographical imbalance** in that the majority of large and rich CSOs are located in the North. There is also a **power imbalance** in terms of the number and clout of CSOs that are business oriented rather than human rights oriented. Most often, CSOs arise out of ‘civic vigilantism’; they are clustered around specific issues and therefore some voices within societies are left unheard, even in the best cases.

Third, Wang suggested that the role of national governments has been left out of the discussions. She brought up important questions regarding the impact that CSO/IO networks have on state governments. In many countries, CSOs can bypass government, but this fact begs the question of whether government can bypass CSOs. For example SARS: while it was true that non-state actors circumvented the Chinese government by

releasing information on the disease autonomously, in the aftermath of SARS new laws were passed in China restricting the flow of information via state owned media networks.

Finally, Wang raised the amorphousness and heterogeneity of the discussion of civil society. CSOs have, consistently been defined in terms of what they are not (e.g.: they are not the state; they are not the market). This negative description is not overly useful. Large analytical case studies which examine the roles of CSOs in important global agreements such as the IHRs and the Breast Milk Marketing Code could help us develop better definitions about what CSOs are, not simply what the are not.

Group Discussion

Kelley Lee furthered **Deibert's** commentary on the lack of discrete categories for political actors in global health governance by providing an example of an individual in Thailand who is simultaneously a Ministry of Health official, a researcher at university, an NGO activist, and a representative of the media. She also questioned the use of the term 'voluntary' with regard to the formation of CSOs. She argued that while some civil society groups coalesce voluntarily, others are deliberately created to skew the agenda. Here she used the example of the tobacco industry creating smokers' rights groups to counter the anti-smoking lobby. She also noted the fact that the discussions thus far had revolved almost exclusively around NGOs, which are merely a sub-set of CSOs, and that the participants should include other parts of the CSO community, such as labour unions, religious groups, and academic groups.

Orbinski brought the discussion back to the broader issues of governance by stating that it is not just the *structure* of governance – who participates in what roles – that matters, but also the *process* of governance. Discussing the process of governance necessitates a discussion on power; **what and where is the power within GHG**? What kind of power does a group like MSF have and why? Where does the power derive from and what is the nature of that power?

Price provided commentary on the broader international relations literature regarding the topic of civil society and power. He explained that the first round of literature examined the question of what is civil society. The second round focused on arguments explaining why civil society matters. The third round is currently attempting to explain why civil society matters in some places and some times, but not at others. The answer to the latter question, according to much of the literature to date, is socialization, specifically how CSOs socialize the international community. Successful CSOs get governments to implement rules and then monitor the same government to ensure they follow the rules. He pointed to the three contending IR theories for explaining power:

- It derives powerful and works because they can enforce it with sanctions and penalties
- It derives from mutual interest. Rules are functional rules and self enforcing because states and other actors want them

- It derives from legitimacy and/or bandwagoning. Sometimes the power to change behaviour comes from the moral imperative to do the 'right thing'. Sometimes behaviour changes are brought about because of self definitions.

An interesting example of the latter source of power is that during the campaign to ban landmines, neither Australia nor Japan thought that banning landmines was militarily the correct decision to make, but they joined the movement to ban these particular weapons because they wanted to be categorized with the 'good countries' (e.g.: Canada, Norway) rather than the 'bad ones' (e.g.: Iraq, North Korea).

Orbinski suggested that there might be a fourth explanation of power as well that could be defined in terms of market influence. He provided an example of this with regard to the access to medicines campaign. Getting the rules changed at the global level was easier than getting pharmaceutical firms and states to actually change their behaviour. The access campaign brought the debate into the public discourse, and when the pharmaceutical firms could see that there source of legitimacy was being questioned, there was a behavior change. **Orbinski** argued that coalition of pharmaceutical firms that were challenging South Africa's right to produce and import generic drugs changed their behaviour entirely due to public perception and loss of market share and not because of the law. Thus, it can be argued that even if the law is inconsequential for powerful actors, public opinion can still alter behaviour.

Price responded to this by stating that IR theory explains this phenomenon in two ways: CSOs are most successful not in challenging a firm or state's interest, but rather in making them redefine that self interest. The second explanatory model focuses on reputation. He argued that we can tap into those who care about their reputation solely for the sake of their reputation. For example, President Clinton cared about his reputation in a way that President Bush does not so Clinton was easier to influence.

Report on Commentary
Day 4

Focus Question:	The phenomenon of hybrids: Is it really new? What are the consequences of hybrids for global health governance?
Moderator:	Ronald Deibert
Discussants:	Thelma Narayan and Devi Sridhar
Papers:	"Global Health Governance through Public-Private Partnerships: A Question of Accountability and Legitimacy" - Sonja Bartsch "Civil Society, Civil Society Organizations and the Governance of Health at the Global Level" (Sections 4 – 5) - Margaret Hilson and David McCoy

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Presentations by Discussants

Thelma Narayan began the formal discussion by reviewing the categories of GHPs examined in **Sonja Bartsch's** paper. These are: research & development, technical assistance and service support, advocacy, and financing.[6] Understanding the functions of global health partnerships is crucial because global health partnerships behave differently based on their key mandates. The main theme of the day's papers was accountability and legitimacy but **Narayan** made the important point that even if Global Health Partnerships/Public-Private Partnerships are accountable and legitimate it may not be effective, and she argued that **efficacy must be the paramount determinant of the success of a GHP.** If a partnership is not effective, having a good governance mechanism is pointless.

She then reviewed some of the negative consequences of the proliferation of GHPs brought up in the **Bartsch** and **Hilson** and **McCoy** papers. Two of the key negative consequences that those working on the ground witness are the **verticalization** of initiatives and the **diversion of** scare resources. In India the health system is weak and has limited resources. Having vertical initiatives, such as mass vaccination campaigns, removes people from the day-to-day running of the health infrastructure. These are the kind of realities that do not feed back into the governance system. For example, there is so much pressure to carrying out multiple rounds of polio vaccines that some children get as many as 20 doses of the vaccine (3 is sufficient to confer immunity). But many parts of India are seeing a rise in diphtheria cases but they do not get attention or even reported because diphtheria does not fit with the mandate that is being given to the health practitioners by the government and the international community. This demonstrates that **health resources are being diverted to match external priorities rather than internal**

[6] Sonja Bartsch used the categorized first described in a 2004 DFID publication in her discussion paper.

needs. There must be a greater understanding and ability to measure the opportunity cost of accepting direction from outside groups (foreign governments, IOs, CSOs, Public-Private Partnerships) because distorted priorities can lead to real needs being ignored.

Devi Sridhar began her discussion with an explanation of the environment in which GHPs emerged. She identified four factors:

- Changing political/economic world order
  - Increasing financial flows
  - The convergence power in fewer hands since the 1950s
  - Media revolution
  - Kofi Anan's embracing of the private sector in UN doctrine
- Privatization
  - If not the World Bank, or other IOs, who will provide global public goods and whose responsibility is it?
- The establishment of the Gates Foundation in 2000
  - This foundation is playing a major role in GHG due to the amount of money it wields and by supporting market driven initiatives
- Changing technology
  - Biotechnology advances
  - Vertical concentration of power
  - Fewer big pharmaceutical firms due to horizontal mergers

Seen as a reaction and outgrowth of these conditions, GHPs can be viewed as a compromise between the market and the public sector. But important questions must be asked about the way GHPs affect global health governance. Primarily we need to understand whether GHPs strengthen or weaken GHG. We also need to understand the motivation of actors to join these multi-partner initiatives. She identified four reasons why pharmaceutical firms join GHPs:

- An attempt to gain legitimacy
- Co-branding with reputable organizations can enhance their own reputation
- The desire to follow societal norms (or at least to be seen as following norms)
- Recognition of the 'economy of regard' and the importance of public opinion for profit making firms

Sridhar next spoke to the example of a Gates Foundation funded initiative called Avahan, which was initially conceived to be a five year long HIV/AIDS prevention program. However, when the employees of the initiative were designing the prevention programs they decided to do market research to determine what the target market was for the prevention program. They determined the target market to be sex workers and truck drivers, but in the course of their research they also learned that the priority of recipients was not lack of condoms or abstinence programs, it was domestic and police violence. Due to this discovery, they changed the scope and nature of program to reflect what the recipients wanted and needed. This example demonstrates the important lesson that the

public sector can learn from the private sector about how to develop efficient and effective programs.

Group Discussion

Hilson responded to the commentary on her paper by stating that she is skeptical of PPP arrangements, but that the private sector could play a valuable role in improving health if corporate responsibility programs were bettered. She argued that self interest can lead to a common good if that self interest can be harnessed. While recognizing the point made by **Narayan** regarding polio, she commented that polio is not what kills most children in India

With regard to the commentary about the verticalization of health initiatives, **Shaw** commented that the World Bank has recently experienced going into a developing country ready to provide loans and assistance, only to learn that there are numerous competing and disconnected programs already in place. He cited the example of how the government of Tanzania completed 2000 separate reports to donor sources in just one year. He asked how it is possible to have effective governance when the actors operate in such a fragmented system.

Orbinski explained that his view of public private partnerships is that they are not an ideological choice, but rather a practical response or experiment to a problem. He stated that based on his involved in numerous PPPs, working with the private sector can be an effective way of bringing about measurable results. He discussed a recent success story within global health governance, the establishment of the DNDi in 2003 and the release of its first new drug combination for malaria in 2007. DNDi is a public-private research oriented partnership the goal of which is to foster research and development for neglected diseases. To this end, it has created multi-partner research and advocacy group with contracts to pharmaceutical firms that will foster new medical research for neglected diseases. Orbinski argued that initiatives like DNDi are an example of CSOs partnering with private and other public groups to fill a gap in governance.

The afternoon closed session on this day focused on establishing research questions arising from the deliberations over the past days and discussed the agenda for the October follow-up retreat in October 2007 in London. **(See “Summary of Central Themes and Questions” p. 28 of this report.)**

Public Gala Event Tuesday 26 June 7-9pm

In keeping with the goal of the Wall Institute to share the expertise and research agendas of WSIR participants with the general public, a public talk was held at UBC's Chan Centre for Performing Arts on the second night of the Summer Institute. Approximately 400 members of the public attended the free talk and received words of welcome from **Dianne Newell**. **Janice Stein**, the moderator for the evening, introduced the keynote speaker, **James Orbinski**, who gave a 45-minute presentation entitled 'Why Why Civil Society Matters to Global Health. Following Orbinski's talk, **Brett Finlay** provided a short commentary, and then both Orbinski and Finlay answered questions put to them from members of the audience via Janice Stein.

James Orbinski's talk focused on the importance of health as a global public good. He explained the history of how a public health system was achieved in Canada through campaigning, debate, and struggle. He argued that public health on a global level, as on a domestic level, will not be granted by governments, but rather demanded by citizens. He further argued that civil society groups like MSF are a reflection of people's refusal to accept the unacceptable. To corroborate this point, he cited the fact that over 80 percent of *Medecins sans Frontieres's* half a billion dollar annual budget comes from private individuals who donate because they believe the system is unjust and wish to bring about change. **Brett Finlay** discussed primarily his research as funded by the Bill and Melinda Gates Foundation and how the Gates Foundation, through the Grand Challenges program, has altered the research agenda and forced scientists to think about old issues in new ways, that, for example, the Gates grant has forced UBC to alter its policy regarding intellectual property rights, as knowledge attained through Gates' funding must not be protected.

The evening ended on a particularly encouraging note. The last question put to **Orbinski** and **Finlay** was how they kept positive and hopeful given the abject failures in health governance. Both panelists enthusiastically declared that hope is easy to maintain as we live in an era of unprecedented scientific achievement and that even though the system is broken, opportunities and the desire to mend it abound. MSF volunteers on site were swamped with inquiries from the audience after the talk.

Summary of Central Themes and Questions

At the core of the 2007 WSIR was the common consensus that the existing global health governance system is failing. 17 million people, disproportionately located in poor countries, die of diseases that we have the knowledge and capability to cure. The participants at the 2007 WSIR determined key areas within GHG where it is failing and tried to examine what is being done to try to fill the gaps in governance, which actors are performing which roles, and what the motivation is behind the behaviour. Particularly with regard to CSOs, the participants debated and discussed what functions and roles these actors can legitimately play in health governance and

The participants determined that the October follow-up meeting, at the London School of Hygiene and Tropical Medicine, ought to foster interdisciplinary research between public health and international relations about CSOs within GHG. A secondary goal is to establish networks between established and young scholars in the field, and to exchange ideas and foster collaboration. To that end, seven or eight doctoral students in the UK will be invited to attend the retreat and to prepare and present papers on their research, addressing the key questions listed below concerning the role of CSOs in global health. The key questions, suggested by **Kelly Lee** and agreed upon by the participants, in terms of the role of CSOs in global health, are:

- What role do CSOs play in GHG independently and in relation to other actors?
- What does the role of CSOs in GHG tell us about the emerging/changing nature of politics?
- What theoretical perspectives can we use to better understand these changes from IR/political science?
- What lessons can we draw from the selected case studies and theoretical perspectives for strengthening or transforming GHG?

Flowing from the discussion on the first day of discussions regarding the most serious crises facing GHG, the participants determined six areas where case studies in governance activities would be particularly valuable in advancing understanding of activities of CSOs within health governance.

- Climate Change
- Migration of Health Workers
- Tobacco Control
- Health as a Human Right
- Innovation and Intellectual Property Rights
- Access to Medicines (Especially with regard to HIV/AIDS)