

Wall Summer Institute 2007
Civil Society Organizations and Global Health Governance

Innovations in Global Health
And the Global Governance System

Kenneth W. Abbott

ABSTRACT

The growing role of civil society in global health governance reflects profound and well-known changes in the overall system of global governance. In many respects, however, health governance is actually leading those changes. This paper uses the lens of Liberal international relations theory to explore innovations in global health governance that are not only interesting and significant in their own right, but are also of broader importance for global governance. These include (1) the role of civil society organizations (CSOs) as “proponents” or advocates of policy and the advocacy partnerships formed by CSOs and public organizations; (2) the changing nature of inter-state regimes, such as the WHO/international health regime, due to the growing participation of domestic, non-state actors; (3) the strategies of organizations like the Global Fund to Fight HIV/AIDS, TB and Malaria to engage with and empower domestic CSOs in dealings with their own governments; and (4) the emerging role of CSOs, private sector firms and other non-state actors as “protagonists” or direct participants in international governance, independently or in collaboration with states and international organizations. The paper uses the Governance Triangle to map and analyze the forms and patterns of private and private-public governance arrangements.

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I. Introduction

The rapidly growing role of civil society in international health governance reflects profound changes in the overall system of global governance. In many respects, however, global health governance (GHG) is leading those changes, not reflecting them; in these respects it is setting an example for actors in other areas. This paper highlights and analyzes several innovative aspects of GHG that are not only interesting and significant in their own right, but also have important implications for the broader international system of governance.

The paper views these developments through the lens of Liberal theory, one of the major paradigms of international relations (IR). Because of the rapid evolution of GHG, however, using a Liberal lens is not simply a matter of applying well-developed models and insights to GHG institutions: in important respects GHG has advanced more quickly than IR theory. As a result, GHG innovations should drive theoretical development in IR as well as concrete developments in real-world governance.

Section II introduces Liberal theory, focusing on the actors, influences and political arenas to which it directs attention. The succeeding sections examine four GHG innovations from a Liberal perspective, while suggesting where those advances require theoretical development. Section III considers the role of civil society organizations (CSOs) and other non-state actors as “proponents” or advocates of global health policy, often in association with states or international organizations (IGOs). Section IV

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considers the roles private actors play within the structure and operations of the WHO and the larger health regime. Section V reverses direction, considering strategies by IGOs and international regimes to engage domestic civil society, with potentially significant effects. Section VI, the longest in the paper, analyzes the actions of CSOs, private sector firms (PSFs) and other non-state actors as “protagonists” or direct participants in global governance, independent of states and IGOs or as collaborators with them.¹

II. Liberal IR Theory

Liberal theory has traditionally been normative, like the “liberal-internationalist” approach described by Dodgson, Lee and Drager (2002).² “Realists” in IR have long been able to caricature the traditional Liberal approach as optimistic, utopian and naïve. Fairly recently, however, scholars have reinvented Liberalism as a positive theory that seeks to explain major outcomes in international politics. I use that approach here.

Positive Liberalism directs analysts to focus on particular actors, causal factors, and political arenas. Most importantly, to Liberals the major actors in world politics are not states, but individuals, CSOs, PSFs, interest groups and other non-state actors. Those actors are typically assumed to be rational and egoistic, pursuing their interests through market transactions and politics. Actors may also be motivated by values or norms; “ideational” Liberalism views moral factors as shaping many areas of politics. In both cases, non-state actors are seen as operating primarily in domestic politics. Liberalism is thus a “bottom up” theory in which societal actors influence the preferences and policies of their governments (Moravcsik 1997).

By opening the “black box” of the state, Liberalism renders areas ruled out by other IR approaches integral to the study of international relations.³ Most important is the effect of domestic politics on international behavior. In Andrew Moravcsik’s Liberalism, since individuals and social groups constantly work to shape their governments’ policies,

¹ David Fidler analyzes CSOs as “antagonists” (or advocates) and “protagonists” (Fidler 2003). I borrow the latter term, but substitute the more positive term “proponents” for the former.

² All three of the IR approaches the authors describe are presented as normative theories. The thrust of IR as a social science, however, is primarily to develop positive or explanatory theory.

³ I do not discuss here the possible influences on national preferences and international behavior of different domestic constitutional and political structures and procedures, or more broadly the possible differences in the international behavior of different types of states or regimes, notably liberal democracies and authoritarian states.

“national interests” are neither inherent nor unchanging; they result from decisions by governments to represent particular constellations of interests. Once those decisions have been made, governments act free of civil society on the international stage to further the favored interests (Moravcsik 1997). In public choice theory, government officials are not mere “transmission belts” for private preferences, but are non-state actors in their own right, pursuing their own personal and institutional interests. In this view state policies are shaped by political market transactions: interest groups supply, e.g., electoral support and campaign contributions, while officials supply, e.g., laws and international negotiating positions (Mueller 2003).

National officials also play more positive Liberal roles. Anne-Marie Slaughter highlights the contributions of “transgovernmental” institutions. Here officials, agencies, ministries, and other units of national governments negotiate rules, establish cooperative procedures, and diffuse norms on their own, distinct from their “states” as such. Informal arrangements like these are common in economic relations, law enforcement and other areas. Slaughter argues that they are often superior to IGOs: faster and more flexible, less coercive, and still democratically accountable (Slaughter 2004).

Liberal paradigms like Moravcsik’s that limit the activities of societal groups to domestic politics are severely limited in an era when non-state actors manifestly seek to influence foreign governments, IGOs, international conferences and other forums. Transnational Liberals have begun to study these activities extensively. Most focus on efforts by NGOs to influence foreign governments. In reviewing this literature, for example, Thomas Risse finds that NGOs have the greatest influence at the agenda-setting stage, especially when they use IGOs as platforms for advocacy; NGO influence also depends crucially on access to national officials (Risse 2002). Richard Price identifies organizational features such as expertise and moral authority as crucial to success (Price 2003). Other scholars analyze transnational NGO techniques, such as the “boomerang” process used by human rights groups (Keck & Sikkink 1998).

Still, as suggested above, the complex innovations in GHG go beyond current Liberal insights in all three of these areas: the relation between domestic politics and

international behavior, the transnational role of government units, and the transnational activities of non-state actors.

III. CSOs as Transnational Proponents

CSOs, PSFs and other non-state actors are active and influential “proponents” or advocates of policy, seeking to persuade foreign governments, IGOs and international institutions to take (or not take) particular actions. In analyzing advocacy, it is important to consider the entire policy process. Duncan Snidal and I conceptualize that process as including five stages represented by the acronym ANIME: (1) Agenda setting; (2) Negotiation or other forms of rule-making; (3) Implementation; (4) Monitoring; and (5) Enforcement or other responses to non-compliance (Abbott & Snidal 2006).⁴ That sequence applies to binding rules like the Framework Convention on Tobacco Control (FCTC), non-binding norms, and policies such as WHO medical recommendations.

As Risse observes, influencing the international agenda is the best-known and most effective role of CSOs.⁵ But agenda-setting alone cannot ensure sound and effective policies. Advocates also need to influence negotiation, by external pressure or through formal or informal participation; follow up on or participate in implementation; and carry out or assist with monitoring and enforcement, a major role for CSOs in most regimes. Since implementation, monitoring and enforcement resemble the operational activities discussed below, this section focuses on agenda-setting and negotiation.

CSO advocacy in GHG differs from many areas of international relations in two respects: it combines advocacy techniques that often characterize different issue areas, and it relies on IGOs as partners, not mere “platforms” for advocacy.

First, GHG advocacy blends two distinct techniques. On one hand, because of the value-laden character of global health policy, classic NGO mobilization campaigns are prominent. Examples include the MSF Campaign for Access to Essential Medicines and the parallel Oxfam Medicines for Life campaign; the International Baby Food Action Network (IBFAN) campaign for a marketing code, with its long-running Nestle boycott;

⁴ Peter Haas’ matrix of governance functions, Lee 2007 Table 1, reflects a similar conceptualization, although less clearly sequential.

⁵ Laurie Garrett argues that the “whims” of advocates drive the global public health effort (Garrett 2007, 5).

and many actions of the Framework Convention Alliance (FCA) in support of the FCTC, including its Philip Morris boycott. Broad social movements are also prominent, notably the global HIV/AIDS movement, which encompasses numerous individuals living with the disease and thousands of NGOs.

On the other hand, because of the scientific character of health policy, technical advocacy by “epistemic communities” is also common in GHG (Haas 1992). Epistemic communities are networks of individuals in public and private life united by common knowledge and understandings, and often by common norms. They advocate with expertise, technical analysis and ideas. Medical and health experts and associations operate this way, as do CSOs such as MSF, CPTech and Health Action International. For example, CPTech, the Drugs for Neglected Diseases Initiative and many scientists used these techniques to persuade WHO to establish the Committee on Intellectual Property Rights, Innovation and Public Health (CIPIH) and the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property.⁶

GHG also involves hybrid forms of advocacy that draw on both approaches. Examples include the efforts of CSOs like CPTech and HAI on controversial issues such as access to medicines, and certain activities of the FCA – which includes health organizations like the National Cancer Society along with classic NGOs – such as providing technical assistance to FCTC delegates.

Second, WHO and other global health IGOs take important actions to facilitate civil society advocacy, even though WHO’s engagement with civil society is often criticized (McCoy & Hilson 2007, 12). Beyond simply providing a “platform” for CSOs, these IGOs create advocacy partnerships. For example, WHO and UNICEF convened the actors that created IBFAN and with some governments collaborated with the group to advocate for a code. WHO also helped create and support the FCA; collaborated with it to mobilize public support; joined with CSOs to counter industry arguments through the “Don’t Be Duped” campaign; and arranged unusual public hearings. In the Task Force on Child Survival, WHO and other UN agencies joined with the Rockefeller Foundation to advocate for child immunization.

⁶ www.cptech.org/ip/health/who/igwg.html, visited June 1, 2007.

Secretary-General Kofi Annan also characterized as advocacy partnerships a number of UN collaborations with PSFs (often including CSOs as well); some of these address health issues. Examples include the Global Media AIDS Initiative, the Global Alliance for Improved Nutrition (GAIN), and the Global Public-Private Partnership for Handwashing with Soap. Many operational partnerships discussed below also advocate.

Similarly, WHO has helped structure international negotiations to facilitate CSO participation. For example, CIPIH included a range of stakeholders, while even the Intergovernmental Working Group includes CSO observers with opportunities for input. Even more significant, the FCTC negotiations were structured to allow CSOs significant influence. Finally, as discussed below, important GHG institutions such as UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) include CSOs in their policy-making organs, where they participate in negotiating and overseeing implementation of rules and policies.

IV. CSOs as Participants in Vertical Regimes

International regimes are generally viewed as inter-state, supranational organizations. To be sure, states formally create (by treaty) and control (through voting in WHA and similar organs, and through contributions) IGOs like the WHO and World Bank (WB). States must also ratify the rules regimes generate (as with the FCTC) and implement them domestically. Consistent with Liberal theory, however, individual government units and CSOs are essential to the operation of many such institutions. Indeed their role suggests a rethinking of the very nature of international regimes.

While WHO is formally an organization of “states,” for example, in practice it is an association of health ministries.⁷ As a result, the health regime is less supranational than vertical, as the ministries span the international and domestic arenas.⁸ The influence, resources, discourse and skill of the ministries in domestic politics largely determine

⁷ Article 11 of the WHO Constitution requires delegates to be “qualified by their technical competence in the field of health, preferably representing the national health administration...” This may give the organization a somewhat homogeneous substantive and even political outlook on issues, goals and means; the same is true of the broader regime described here.

⁸ In addition, participation of ministries in an organization like WHO creates horizontal linkages among them; to the extent these are developed, WHO becomes the host of a transgovernmental regime. This provides a useful way to think about WHO activities such as framing and disseminating medical policies; it also suggests a potential avenue for strengthening the regime.

whether states authorize new policies or rules, adopt or ratify them, implement or comply with them, and otherwise participate in GHG. Other regimes, of course, rely on different agencies, with different discourses and more or less power and skill. In a positive sense, these domestic differences help explain the success or failure of particular initiatives that provoke political controversy. In a normative sense, they shed light on the benefits and costs to the health regime of the growing role of the WB and other UN agencies: one cannot assess their role solely at the organizational level or on the international plane; one must also judge it in terms of domestic politics.

In domestic government and politics, ministries typically work with and influence other public entities. These can be brought into relationship with the regime, extending its vertical structure, reach and power. In GHG the leading examples are the WHO Collaborating Centers, primarily public laboratories. In addition, ministries typically have close relations with a constellation of interest groups, CSOs and PSFs. Some of these may be mere lobbyists, but many of them share with agency staff not only an interest in their issue area, but also common knowledge, understandings and norms. In short, they form a public-private epistemic community that supports and participates in ministry initiatives. Again, the regime's domestic political influence depends on the power and skill of these actors, which derive from their expertise and commitment. These actors too can be brought into direct relationship with the regime, as private participation has reshaped the infectious disease surveillance system.⁹

In sum, a more accurate picture of an international regime is as a collection of vertical "silos," complex political relationships among actors with common interests and understandings that bridge both the public and private spheres and the international, transnational and domestic arenas.¹⁰ To assess the impact of such a regime, one must consider the full range of participants and arenas. For example, given the range of actors that can be mobilized to support and carry out its initiatives in domestic and international politics, the health regime may be far more influential than the WHO's decision-making power and budget suggest. This is all the more true if subjective influences are taken into

⁹ Regime participation also helps these actors form transnational relationships.

¹⁰ This is a broader version of the observation by Zacher and Keefe (2007, 7) that the WHO is an "organization of organizations."

account: a public-private epistemic community can shape political discourse at all three levels. On other hand, some long-standing weaknesses of the health regime – e.g., its reliance on soft law and (until recently) the narrowness and weakness of the IHR – may not be the result of the policies or (lack of) political will on the part of “states,” but rather of the weakness of the regime’s participants in domestic politics.

V. Domestic Strategies of International Regimes

States, IGOs and regimes are not only targets of advocacy by CSOs and other private actors. They are political actors in their own right, and their influence extends to domestic politics. States and international regimes enlist domestic actors to support their policies, and can strengthen those actors within domestic politics. These effects may be unanticipated, but they also flow from conscious regime strategies.

The best example in GHG is the GFATM. This body has drawn attention because it is structured as a public-private partnership (PPP); I discuss this aspect further below. In Liberal terms, though, equally significant is the strategy of the GFATM to replicate that structure domestically. Based on the principle of political “ownership,” the GFATM requires local CSOs and PSFs to participate in funded programs. Grant proposals must be developed by Country Coordinating Mechanisms (CCMs), multi-stakeholder PPPs; CCMs also supervise funded projects. While the rationale for CCMs is program effectiveness, they also seem to reflect a commitment to norms of social participation.

In material terms, the GFATM uses its financial leverage to empower CSOs; new CSOs will likely form to take advantage of the opportunity. In the subjective terms of Constructivist IR theory, the CCM requirement frames norms of social participation as legitimate international expectations and communicates them to countries and societies. These norms “constitute” new CSOs and “reconstitute” existing ones: understandings of their identities, missions and powers are changed, both within the organizations and in society at large; the CCMs come to embody participatory norms (Barnett & Duval 2005).

In either view, the influence of the GFATM on domestic CSOs clearly extends to the planning and execution of funded projects; and it almost certainly extends to domestic health policy more generally, as GFATM projects are linked to national plans. Finally, as the GFATM helps to create, empower and reconstitute CSOs, they are likely to

participate in broader areas of domestic politics. CCMs alone may not be revolutionary, but over time they could have significant effects. From this perspective the GFATM is far more than pure, technical financing agency it purports to be; it is also a political agency that embodies and promotes social norms and reshapes domestic politics.

The WB follows a similar strategy. Based on the “ownership” principle, it requires that low-income client countries produce Poverty Reduction Strategy Papers (PRSPs) with broad participation by CSOs and PSFs.¹¹ WB also encourages CSOs to participate in funded anti-poverty programs and consults with stakeholders while formulating its own strategies. An even more striking example is the Millennium Campaign, a frankly political effort by which the UN seeks to mobilize domestic CSOs around the globe to demand implementation of the MDGs from their governments. Health advocacy partnerships reflect similar IGO-CSO alliances to bypass states.

VI. CSOs as Protagonists in GHG

A. The Governance Triangle

This section looks at CSOs – and also PSFs and other non-state actors – as direct participants in GHG, independently and as partners of states and IGOs. Sonja Bartsch identifies four common types of private health activity: research and development (R&D); direct services and technical assistance; finance; and advocacy (discussed above) (Bartsch 2007, 15 note 5). I would add the later stages of the policy process – especially monitoring state compliance – an important CSO role little discussed in the papers for this Institute.¹² These are operational rather than policy activities, but as the GFATM example demonstrates, even such activities can embody, develop and communicate values, norms and policies, and have important political and subjective effects.

To depict the roles of the diverse actors concerned with GHG, I use the Governance Triangle – a device Duncan Snidal and I developed to map the public and private institutions that set standards for transnational PSFs in areas such as worker rights and the environment (Abbott & Snidal 2006). A simple version appears as Figure 1.

¹¹ The sincerity of this requirement has been questioned; Lee 2007, 5.

¹² Bartsh, 20 and McCoy & Hilson 2007, 9, 16, refer to CSOs such as Aidspan and Global Health Watch that monitor WHO and other IGOs, but monitoring state compliance is at least as significant and more frequently addressed in IR.

[Figure 1 about here]

As this Figure demonstrates, the Triangle is formed by three types of actors, each of which may be single or collective: (1) States, groups of states and IGOs; (2) PSFs and business associations; and (3) CSOs and coalitions.¹³ Actors vary widely within each category, and the Triangle will not be useful for issues that turn on their differences. In many respects, however, it gives a clear overall view of the major actors' roles in GHG.

Entries on the Triangle represent specific activities and institutions; entries are placed according to the “shares” the three actor types exercise within them. Placement is not intended to be precise, but to convey an institution's general character.¹⁴

Arrangements close to a vertex are dominated by one actor type: e.g., the FCTC is ratified by and binds states (although it was strongly supported by CSOs against the industry); the Global Business Coalition on HIV/AIDS, TB and Malaria (GBCA) is comprised of PSFs; and MSF members are civil society actors.¹⁵ Institutions away from the vertices involve multiple actors: e.g., the Medicines for Malaria Venture (MMV) includes IGOs and government agencies; industry researchers and financial experts; foundations, academics and other CSOs. In effect, the Triangle includes three “tiers:” public institutions at the top, private activities (of very different kinds) across the bottom, and PPPs in the central region between them.

Figure 2 is a more detailed Triangle that includes entries representing a number of GHG institutions, most of which are discussed below. For clarity, this Triangle is divided into single-actor (#1-3), bilateral (#4-6), and tripartite (#7) zones, representing individual action and varied forms of collaboration.

[Figure 2 about here]

The Governance Triangle is a heuristic device. By mapping activities and institutions, the Triangle makes it easier to observe empirical developments: e.g., which

¹³ Several papers for this Institute refer to the actors in GHG in ways consistent with the Triangle. These include Lee 2007, 2, 4, 11, 16; and Bartsch 2007, 3, 18. McCoy & Hilson 2007, 2, argue that a tripartite framework is inapplicable at the international level because of the absence of a global government, but the Triangle considers how states and IGOs fulfill this role.

¹⁴ At best the placement of entries cannot be precise because of institutional complexity, different actor roles in different aspects of activities, and changes over time. These problems are compounded in the present case by the preliminary nature of the analysis.

¹⁵ The plus sign after MSF indicates that there are many CSOs of its general type.

zones are dense, which are sparse, how the distribution changes over time. It also facilitates comparisons across institutions, within the same or different zones, and assessments of the system as a whole. The following sub-sections first describe arrangements found in each Zone, then analyze some of these important issues.

B. Single-Actor Arrangements

Zone 1 includes a wide range of state actions, national and international. For example, all national public health laws and policies with international implications could be represented in this Zone. So too could all international health policies and norms of IGOs, regional organizations like the EU and other state groupings. In its fullest form, then, Zone 1 would be very dense. Figure 2 only suggests these complexities.

Zone 2 includes independent activities of business firms. Jane Nelson suggests three avenues by which PSFs can influence GHG: core operations, advocacy and policy dialogue, and a broad range of “social investments,” including philanthropy, that draw on a firm’s particular competencies (Nelson 2006). Of these, social investment using firm competencies and a broad definition of core operations seem the most promising.

Firms in the health industry are the most active on both fronts. Most have social responsibility policies: for example, the Johnson & Johnson policy states an aspiration to improve the lives of all affected by HIV/AIDS, a goal “inherent in our responsibility to the global community.”¹⁶ The IFPMA identifies several social contributions made by pharmaceutical firms: primarily developing new drugs and vaccines, but also improving access to drugs, researching diseases, and supporting education and prevention.¹⁷ Such claims are obviously controversial and must be taken with a grain of salt, as competition and the search for profits impede even sincere corporate social responsibility (CSR).

Specific health industry actions (none free of controversy) include ad hoc drug donations (although ethical problems led WHO to issue voluntary guidelines on donations)¹⁸; contributions to emergency relief;¹⁹ and tiered pricing for poor countries (although prices are often negotiated, not truly unilateral, and may maximize profits).

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¹⁷ www.responsiblepractice.com/english/insight/ifpma/

¹⁸ http://whqlibdoc.who.int/hq/1999/WHO_EDM_PAR_99.4.pdf

¹⁹ E.g., http://www.pfizer.com/pfizer/are/mn_tsunami_qa.jsp

Most interesting are systematic drug donation programs. Many such programs are PPPs, but some appear, at least initially, to be largely PSF undertakings, which may evolve into PPPs as they become more complex. Examples include Pfizer's donation program for Diflucan (shown on Figure 2) and Boehringer Ingelheim's program for Viramune.²⁰

Outside the health industry, corporate activities in support of GHG appear more limited than in other areas of CSR. According to Business for Social Responsibility, the most common activities are health and wellness programs for employees, and sometimes families or local communities. For example, Chevron provides AIDS testing and treatment for employees and their families in Africa, plus education for communities.²¹ IBM offers broader, more interesting examples of what a non-health firm can contribute based on its competencies: it makes available for cancer research the World Community Grid of collaborative computing,²² and recently donated advanced epidemiology software for use by public health agencies.²³ The GBCA helps firms develop AIDS strategies that use their competencies in innovative ways.²⁴

Zone 3 includes independent CSO activities. This area is dense and diverse. Considering only activities identified in the papers for this Institute, *Zone 3* includes health experts and NGOs that communicate information on infectious disease outbreaks, e.g., through ProMED; MSF, CARE, the Red Cross and many other CSOs that provide direct health services in developing countries; NGOs like Rotary that mobilize volunteers and private contributions; CSOs that provide technical assistance on policy issues; organizations that engage in public education; and private foundations that provide unprecedented financial support for global health, such as the Rockefeller and Gates Foundations. In addition, it is important to note the independent monitoring activities of CSOs. For example, now that the FCTC has entered into force, the FCA has explicitly taken on the mission of acting as "watchdog" for implementation and compliance.²⁵

²⁰ See Pefile, ***, www.globalforumhealth.org/filesupld/ippph/Donations.pdf

²¹ www.chevron.com/social_responsibility/hiv_aids/

²² http://www.ibm.com/ibm/ibmgives/news/help_defeat_cancer.shtml

²³ http://www.nytimes.com/reuters/technology/tech-ibm-diseases.html?_r=1&oref=slogin;

http://domino.research.ibm.com/comm/research_projects.nsf/pages/stem.index.html?Open&printable

²⁴ www.businessfightsaids.org

²⁵ www.fctc.org

B. Bilateral Arrangements

Zone 4 includes arrangements between states and/or IGOs and PSFs. Such partnerships became a UN priority under Secretary-General Annan, leading to a “fundamental shift” in UN-business relations (UN General Assembly 2000).

For some time WHO and other IGOs have implemented “push” mechanisms (e.g., mobilizing and channeling funds) and “pull” mechanisms (e.g., funding public programs that commit to buy drugs) to encourage R&D on neglected disease treatments (Bull & McNeill 2007, 67). Many of these involve direct collaboration with PSFs. The Special Programme for Research and Training in Tropical Diseases (TDR) – sponsored by WHO, UNICEF, UNDP and WB – “selects, guides, funds and develops research done by others;” it has entered into partnerships with PSFs as well as other actors.

Zone 4 includes certain drug donation programs established, initially or on a continuing basis, as bilateral PPPs between a PSF and an IGO or government. For example, WHO had for some years purchased MDT for leprosy from Novartis, with foundation support. When that funding expired, Novartis and WHO negotiated a memorandum of understanding whereby the firm would donate MDT for six years (since extended) and fund distribution costs.²⁶ WHO later created GAEL (*Zone 7*), a broad PPP in which Novartis now participates, to coordinate its MDT strategy.²⁷ Aventis’ donations of sleeping sickness drugs were initiated under a similar MOU and distributed through WHO.²⁸ Finally, Dodgson, Lee & Drager (2002) describe how the WHO Tobacco Free Initiative worked with drug companies to develop nicotine replacements.

Zone 5 includes bilateral arrangements between states and/or IGOs and CSOs. The oft-criticized CSO accreditation system of the WHO, its Civil Society Initiative and their proposed reforms are relevant here but addressed by other papers (McCoy & Hilson 2007). In a 2002 report, WHO described several specific CSO collaborations over the

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http://www.novartisfoundation.com/en/projects/access_health/leprosy/multidrug_therapy/mdt_donation.htm

²⁷ http://www.novartisfoundation.com/en/projects/access_health/leprosy/multidrug_therapy/about_global_alliance.htm

²⁸ http://www.ohchr.org/english/issues/development/docs/WHO_4.pdf

prior decade.²⁹ Examples include Out of the Shadows, a collaboration with CSOs to combat the stigma of leprosy; the Somalia Aid Coordination Body, in which NGOs helped WHO provide health outreach services in that war-torn country; the Guinea worm eradication program in southern Sudan during its civil strife; and the reconstruction of the Cambodian health system.

UNAIDS is primarily a consortium of UN agencies with state participation, but its Coordinating Board also includes representatives of five CSOs including organizations of persons living with HIV/AIDS. The Global Polio Eradication Initiative is a massive PPP based on collaboration among IGOs, the US CDC, and Rotary International. The WHA's call to eradicate polio in 1988 came after the success of Rotary's first fundraising campaign. The Task Force on Child Survival and Development, discussed above, began as a Zone 5 collaboration advocating immunization; it has gone on to facilitate diverse health PPPs. The WB also works with CSOs in most of its projects.

Zone 6 includes private institutions that bring together business and civil society. These are not PPPs, but often involve diverse stakeholders. In some areas, like the private standard-setting Snidal and I are studying, Zone 6 schemes such as the Global Reporting Initiative, Fairtrade Labeling Organization and Social Accountability International are among the most complex and prominent global institutions; since these schemes address issues such as pollution, working conditions and child labor, they have significant health implications, although they are not framed as health initiatives. Figure 2 includes one example of an environmental collaboration, the recent Coca-Cola – WWF partnership to protect freshwater resources.³⁰

To my knowledge, however, the field of global health itself includes few collaborations of this kind. Figure 2 includes one example, the International Trachoma Initiative. ITI was founded by the Edna McConnell Clark Foundation and Pfizer to facilitate donations of Zithromax for use as part of the WHO's SAFE trachoma strategy.³¹ Further collaborations like this could be highly fruitful for GHG.

²⁹ <http://www.who.int/civilsociety/documents/en/CSICaseStudyE.pdf>

³⁰ www.worldwildlife.org/water/cocacola

³¹ <http://www.trachoma.org/pdf/trachomagold.pdf>

C. Tripartite Arrangements

Zone 7 includes tripartite collaborations: PPPs that involve both CSOs and PSFs. High transactions costs impede the creation of tripartite arrangements, and they face strong centrifugal forces stemming from the diverse interests represented. For example, CIPIH nearly split apart because of conflicts between CSOs and PSFs backed by the United States. Thus the prevalence of tripartite GHG schemes is one of the most striking features of the Triangle. I consider three main categories of partnerships here.

First, several *drug access arrangements* involve tripartite collaboration. In 1987, Merck announced it would donate Mectizan (ivermectin) for river blindness to all and for as long as needed; it initially administered the program itself with expert advisors.³² But Merck soon involved WHO, UNICEF and WB; national health agencies; and NGOs; it created a Secretariat for the program housed in the Task Force for Child Survival.³³ In Africa, another tripartite PPP administers the river blindness program.³⁴

Similarly, in 1998 GlaxoSmithKline announced it would donate albendazole to every country that needed it, working with WHO and recipient governments, until lymphatic filariasis (LF) was eliminated.³⁵ WHO then launched its Global Programme to Eliminate LF,³⁶ and the tripartite Global Alliance to Eliminate LF was created to support the program.³⁷ Merck extended its Mectizan donation program to LF and also works with the Global Alliance. Finally, although the Clark Foundation and Pfizer alone founded the International Trachoma Initiative, it soon began to work with UNICEF and WHO, governments, CSOs such as the Carter Center and a range of donors. In 1997, WHO initiated the tripartite Alliance for the Global Elimination of Blinding Trachoma.³⁸

Second, some *drug development partnerships* are tripartite. The MMV arose out of discussions between WHO and IFPMA; other early participants included Rockefeller, WB, the Swiss development agency and the Global Forum for Health Research. MMV

³² Drug donation schemes are typically initiated by firms. Buse & Walt 2000a, 700.

³³ http://www.merck.com/cr/enabling_access/developing_world/mectizan/

³⁴ <http://www.apoc.bf/en/>

³⁵ <http://www.filariasis.org/resources/gsk.htm>

³⁶ http://www.who.int/lymphatic_filariasis/policy/en/

³⁷ <http://www.filariasis.org/>

³⁸ <http://www.who.int/mediacentre/news/notes/2006/np09/en/index.html>

was founded in 1999 as a tripartite PPP. Its board includes experts in health, management and finance; advisory bodies include industry and academic representatives. Donors include public agencies, foundations and PSFs. MMV manages a portfolio of drug candidates; actual development work is done by PSF and academic partners.³⁹

The International AIDS Vaccine Institute is a non-profit PPP. The impetus for its 1996 formation came from the Rockefeller Foundation. IAVI carries out most drug development work through scientists at PSFs; they collaborate with local public agencies and CSO for clinical trials. IAVI also collaborates on education, capacity building and similar activities with public agencies, NGOs and community groups. Its Board is tripartite, and like MMV receives support from public agencies, foundations and PSFs.⁴⁰

Finally, GHG includes broad, *multifaceted tripartite partnerships*. The most prominent may be the GAVI Alliance (Bull & McNeill 2007, 76). GAVI participants include WHO, UNICEF and WB; national governments; the Gates Foundation, NGOs and public health institutes; and PSFs in the vaccine industry. Its Board reserves seats for all these constituencies, with separate positions for Northern and Southern governments and firms. Country programs involve further collaborations. The parallel GAVI Fund is supported by the Gates Foundation and governments.

Roy Widdus calls Roll Back Malaria a public sector program with PSF participation (Widdus 2001); it is placed high in Zone 7. RBM was created in 1998 by WHO, UNICEF, WB and UNDP. It was intended to bring consistency to the malaria control activities of diverse actors and to raise the political profile of the disease (Buse & Walt 2000a, 702). As a result, RBM includes a broad range of loosely coordinated partners, including donor and malaria-endemic states; bilateral and multilateral development agencies; research institutes, foundations and NGOs; and PSFs.⁴¹

As noted above, the GFATM was designed as a multi-stakeholder PPP. Its Board includes seats for representatives of all three sectors, although the private sector has only one seat. The Fund receives the great majority of its funding from governments, with some from the Gates Foundation and other foundations.

³⁹ http://mmv.org/rubrique.php3?id_rubrique=11

⁴⁰ <http://www.iavi.org/viewpage.cfm?aid=24>

⁴¹ <http://www.rollbackmalaria.org/>

D. Interpreting the Triangle

Having placed a number of GHG arrangements on the Triangle, what patterns can we observe? In general, the profusion and diversity of governance arrangements for global health are notable; in both respects the field is atypical if not unique. The Triangle demonstrates clearly that GHG now includes a wide range of institutional innovations, and these suggest important possibilities for institutional design (as well as associated problems) in many other areas of international cooperation.

More specifically, consider the three tiers of the Triangle identified above. The top (purely public) tier is quite dense, but mainly because of numerous national public health laws and WHO medical policies; I will not consider that area further. The bottom (purely private) tier is relatively sparse, except for the large number of significant CSO advocacy and service organizations in Zone 3. The central (public-private) tier is remarkably dense, across Zones 4, 5 and 7. This distribution raises important issues.

Two areas in the bottom tier – Zones 2 and 6 – contain fewer arrangements than I at least would have expected. In Zone 2, as mentioned above, most major health industry firms engage in various forms of (generally controversial) CSR; some initiatives have led to complex GHG institutions, as with the Merck Mectizan and Novartis MDT programs. Outside the health industry, however, the initial impression is that global health is not yet a prominent part of firms' CSR initiatives, unlike worker rights and environmental protection (which do have health implications). Non-health firm CSR is thus a largely untapped resource for GHG. Given the potential demonstrated by the IBM examples and the GBCA, this could be an important area to promote. A number of proposals along this line have recently been advanced (Nelson 2006). In Zone 6, collaboration between CSOs and business also appears quite limited, perhaps owing to the limited CSR activity on the part of business. This too could be a valuable area to promote.

Two areas in the central tier – Zones 5 and 7 – include more arrangements than expected. Zone 5 features a number of IGO-CSO programs, whereas business resists such relationships in most areas. One explanation might be that these arrangements are seen as operational, not as policy oriented; but again, even operational activities often embody, develop and promote policies and norms, and can even modify domestic politics. In short,

these schemes may be more influential than even their potential opponents realize. Zone 7 features a surprisingly large number of tripartite institutions, normally quite difficult to form and hold together. These include prominent drug development and access programs that are often regarded as business-centric and may have originated in Zones 2 or 4.

What explains the notable level of collaboration across the central tier of the Triangle? Two factors seem most significant. The first is the need for institutions to deploy particular competencies to achieve desired results: actors possess different strengths, and partnerships typically aim to assemble complementary attributes among their participants (Zacher & Keefe 2007, 17; Widdus 2001; Buse & Walt 2000b).

Snidal and I have suggested four competencies that seem relevant to GHG (Abbott & Snidal 2006). *Expertise* is crucial; partnerships like MMV, GAVI and GAEL combine PSF expertise in drug production, management and finance, CSO expertise in local mores and distribution, and IGO expertise in administration and international politics. *Operational capacity* includes a range of practical abilities, especially important in operational arrangements. PSFs have unique capacities in drug development and production, strong internal authority and organization, and often great financial resources; CSOs have the ability to operate in remote locations, interact with local communities and engage in public appeals; states and/or IGOs have financial and administrative resources, authority to adopt binding rules, international reach and strong communication abilities. (Clearly there are major variations in all these areas.)

Representativeness is closely related to accountability; both are important to the legitimacy of an actor's role in governance (Bartsch 2007; McCoy & Hilson 2007). Democratic states are generally quite representative; multilateral IGOs are representative of states and democratically representative to some extent on a derivative basis, but are widely criticized for their democratic deficits. CSOs vary widely, but often organize their activities so they speak for members, contributors, beneficiaries and other stakeholders; some CSOs, however, reject representativeness, arguing that they speak for a mission or value, not for particular individuals. *Independence* (from the target of an action or policy) is particularly important in activities such as advocacy and monitoring; most CSOs are

highly independent; states and IGOs are fairly independent, although sometimes unduly influenced by powerful interest groups; while PSFs are the least independent.

The second factor explaining collaboration is power. Clearly certain actors – major states, rich and influential PSFs – have multiple sources of power that extend far beyond GHG. I would make a different point: the competencies just discussed are sources of power as well as mere abilities. Major states and PSFs have power because of their resources, authority, capacities and knowledge; other actors also have power because of their particular competencies: experts and epistemic communities because of their expertise; CSOs because of their independence, representativeness and legitimacy, expertise and on-the-ground capacities; and IGOs because of their expertise, political and administrative capacities, independence and multilateral representative character.

If an actor has sufficient competencies by itself to engage in some governance activity, that actor has what Snidal and I call “go-it-alone power.” In CSR, for example, PSFs have the expertise and operational capacity to adopt and implement codes of conduct on range of issues; they lack the independence and representativeness to make those codes fully legitimate, but the public generally accords them some legitimacy, and they create some social benefits. In GHG, go-it-alone power seems more limited than one might expect. PSFs, especially in the health sector, do adopt codes of conduct on health issues, but in more concrete areas of activity they quickly feel the need to create or join partnerships, as Merck did with Mectizan and Novartis did with MDT. IGOs have all the competencies needed to adopt rules and policies (if not to enforce them), but create partnerships for many other governance tasks. CSOs have the expertise, operational capacity, independence and representativeness to advocate for health policies and are typically considered quite legitimate and effective in doing so; they can also deliver on-the-ground health services. But they lack business capacities and resources, and so rely on partnerships in areas such as drug supply and development.

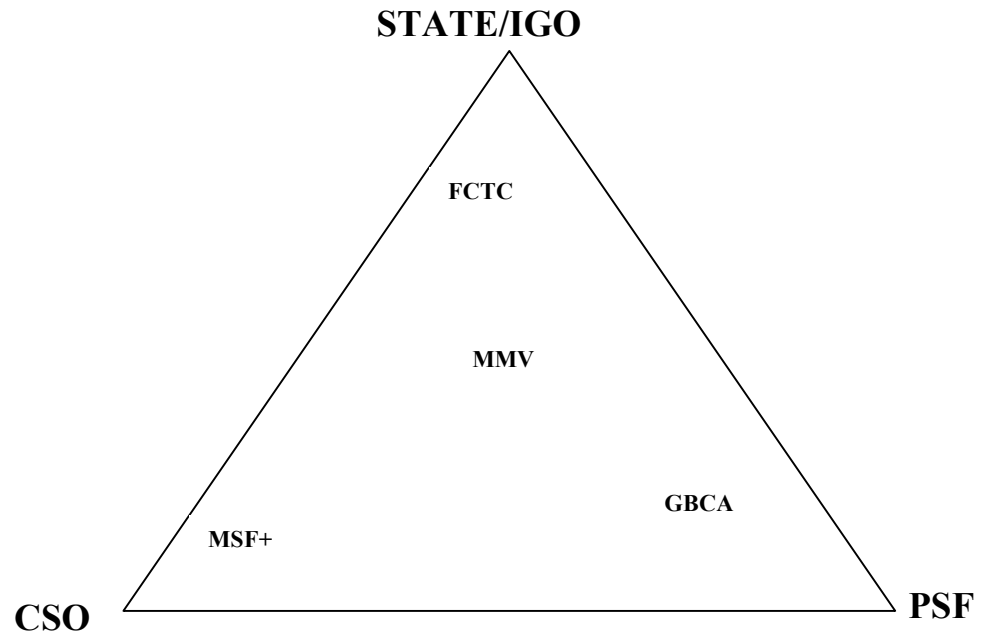
At the same time, these competencies create what Snidal and I call “inclusion power:” when an actor has inclusion power, it is difficult to create an effective and legitimate institution without including it (Abbott & Snidal 2007). Clearly, for example, one cannot create an effective drug development or donation program without

pharmaceutical firms, because of their essential expertise and operational capacity. Judging from the Triangle, however one can rarely create an effective and legitimate program of either sort without also including CSOs and/or IGOs, because of their unique expertise and operational capacity (quite different from those of firms), as well as their independence, representativeness and legitimacy. The proliferation of Zone 7 institutions and the evolution of arrangements like the Merck and Novartis donation programs from Zones 2 and 4 to Zone 7 provide evidence that inclusion power is widespread in global health. Both points suggest that the level of collaboration in GHG seen on the Triangle is likely to be long-lasting and pervasive.

VII. Conclusion

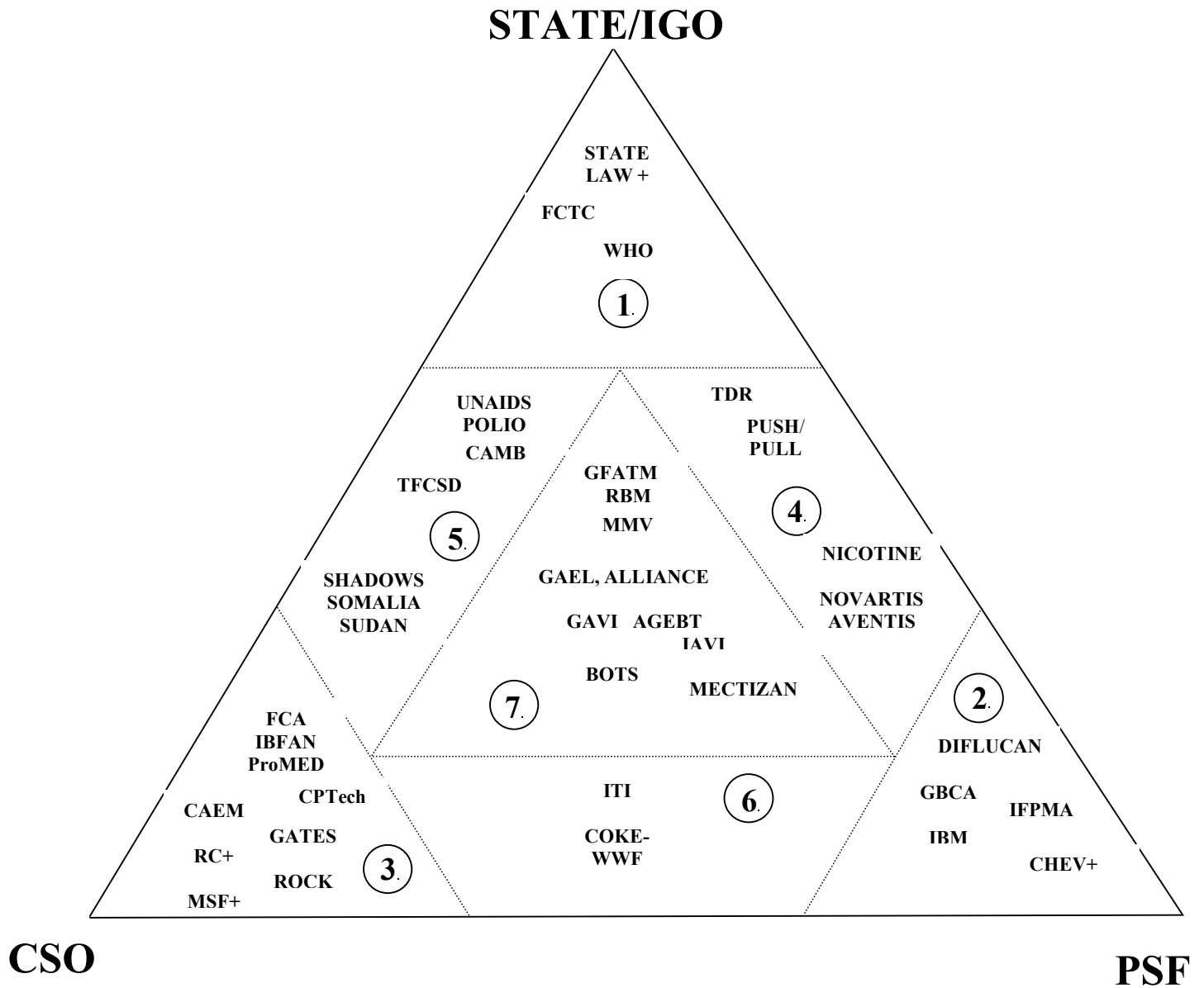
Liberal theory suggests that, to understand international relations, it is essential to look at the activities of CSOs, PSFs and other non-state individuals and groups, in both domestic and transnational politics. This admonition applies with particular force to GHG, even though recent innovations there go well beyond the models and analyses of most Liberal scholars.

In this rapidly evolving area of international governance, CSOs are among the leading “proponents” of global health policy, often joining states and IGOs in advocacy partnerships. Health experts, CSOs and other private actors play increasingly prominent policy and operational roles within the inter-state WHO and the broader “vertical” regime associated with it. IGOs like the GFATM and WHO actively seek to mobilize domestic civil society, with potentially significant political effects. As the Governance Triangle demonstrates, CSOs, PSFs and other non-state actors are now among the most active “protagonists” in GHG, acting on their own and in complex public-private and multi-stakeholder partnerships to create governance institutions and global health programs. In these respects, GHG can serve as a model of innovation for political actors in other fields and for scholars of governance alike.



The Governance Triangle: Global Health

Figure 1



**THE GOVERNANCE TRIANGLE:
GLOBAL HEALTH**

Figure 2

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