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**The role of CSOs in intergovernmental health organisations:
Contributions to global health governance**

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Abstract

There has been growing discussion of how GHG should and could be strengthened, including consideration of the potential role of civil society organisations (CSOs). In recent years, the largely positive view of CSOs has given way to more critical reflection of: (a) the governance of CSOs themselves; (b) the role of CSOs in current GHG; and (c) the transformation potential of CSOs to strengthen GHG in future. This paper considers the role of CSOs in intergovernmental health organisations (IGOs), and maps the specific governance functions carried out by CSOs in four selected health governance instruments which are formally under the auspices of IGOs – the International Code on the Marketing of Breastmilk Substitutes, Framework Convention on Tobacco Control, International Health Regulations and Codex Alimentarius. For each, the paper assesses the effectiveness and appropriateness of CSOs involvement, and draws conclusions about the opportunities and limitations CSOs represent for strengthening GHG.

1.0 Introduction

A wide range of studies of global health governance (GHG) have drawn attention to significant shortfalls in existing institutional arrangements to deal with the challenges posed by a rapidly changing world. Problems such as overlaps or gaps in mandates, undemocratic representation, insufficient transparency and accountability, irrational distribution of resources and, ultimately, lack of effectiveness in meeting global health needs are longstanding concerns (Lee et al. 1996; Buse and Walt 1997; Kickbusch 2005; Lee et al. 2007). The existing configuration of institutions has evolved on a largely ad hoc basis, defined as much by political and economic power, as by health needs and priorities. Overall, there is a sense that the emerging system of GHG is characterised by a considerable degree of dysfunction.

Within this context, there has been growing discussion of how GHG should and could be strengthened, including consideration of the potential role of civil society organisations (CSOs). CSOs have come to play a significant role in health governance at many levels, including the global level, by the early twenty-first century. CSOs are defined by WHO as “the social arena between the state and citizen, and is not part of the state or market (for profit sector)” (Loewenson 2003). Historically focused on health service delivery, notably in low-income countries (Loewenson 2003), CSOs have proliferated over the past fifty years in type, number and range of activities. Alongside this growth has been a largely positive view of their increased role as a response to deficits in health governance. Where governments have failed to deliver basic health services, for example, church-based organisations have filled the gap in many poor countries. Where marginalised or vulnerable populations have been neglected by government policies, CSOs have campaigned on their behalf. Where corporate conduct has adversely affected health, CSOs have raised public awareness and campaigned for

the adoption and enforcement of regulation. In short, there is an assumed enhancement of “good governance” by greater CSO participation.

While CSOs undoubtedly have a key role to play in maintaining necessary “checks and balances” in GHG, increased understanding of the appropriate role for CSOs is needed. In recent years, the largely positive view of CSOs has given way to more critical reflection of: (a) the governance of CSOs themselves; (b) the role of CSOs in current GHG; and (c) the transformation potential of CSOs to strengthen GHG in future. As state and market actors have come under greater scrutiny, so too is there a desire to assess CSOs against principles of “good governance”. As described in the *Human Development Report 2002*,

[W]hen such groups spring from agendas or use tactics that are contrary to democratic values, they can be both civil and “uncivil”. The rise of such groups poses challenges for truly democratic political engagement...many civil society groups recognize that they must be publicly accountable for their actions (UNDP 2002).

Thus, it is increasingly asked what functions CSOs play and are they appropriate? How well are these functions fulfilled? Are CSOs sufficiently accountable and transparent, and to whom? To what extent is there sufficient evaluation of CSO activities? (Gellert 1998; Nelson 2002; DAC 2005).

As a contribution to addressing these set of questions, this paper considers the role of CSOs in intergovernmental health organisations (IGOs), defined as organisations ostensibly concerned with health in which governments comprise the core membership. IGOs directly concerned with health are led by the World Health Organisation (WHO) established in 1948 and today encompassing 192 member states. Other UN bodies, notably the UN Children’s Fund (UNICEF), UN Population Fund (UNFPA) and UN Development Fund (UNDP) all maintain health programmes. Also prominent is the World Bank, governed by ministries of finance, which is now the largest lender for health development. Regional development banks also provide significant funding for such purposes.

A detailed review of the role of CSOs in these wide-ranging IGOs is beyond the scope of this paper. Instead, the paper provides a brief overview of the participation of CSOs in key IGOs concerned with health and, in particular, what contribution they are expected to make to the work of these organisations. Given that the contribution of CSOs varies substantially across organisations and health areas, this paper then draws on a framework by Haas (2003) to map the specific governance functions carried out by CSOs in four selected health governance instruments which are formally under the auspices of IGOs – the International Code on the Marketing of Breastmilk Substitutes, Framework Convention on Tobacco Control, International Health Regulations and Codex Alimentarius. For each, the paper assesses the effectiveness and appropriateness of CSOs involvement, and draws conclusions about the opportunities and limitations CSOs represent for strengthening GHG.

2.0 CSO engagement by the WHO and World Bank

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

Margaret Chan, Message from the Director General
World Health Day, 2007

From the mid 1990s, there has been support in a wide range of IGOs for enhancing the role of CSOs. The Development Assistance Committee of the OECD (2005), for example, argues that civil society “can play a crucial role in preventing violent conflict and in building peace”. UNAIDS (2006: 202) describes CSOs as being “at the forefront of prevention, care and support programmes, particularly among the most vulnerable and hard-to-reach populations.”

In WHO, a Civil Society Initiative (CSI) was launched in 2001

to undertake a review of both official and informal relations between WHO and Civil Society Organisations (CSOs); to develop a renewed policy for more effective collaboration, information exchange and dialogue with CSOs and improve the support offered by WHO to Member States in their work with NGOs and CSOs (Lanord 2002).

Critics of WHO pointed to the organisation’s traditional emphasis on ministries of health, while formal relations with non-state (civil society and market-based) institutions were limited. The increased prominence of public-private partnerships in WHO also brought concerns of undue influence by corporate actors (Raghavan 2001; Lee and Buse 2006), leading the organisation to find ways of rebalancing representation among state, market and civil society actors. An inventory of relations found 482 “relationships” between NGOs and WHO headquarters, of which 56% were “official relations” (WHO 2002a). Under Director-General Brundtland, the review was intended to pave the way for more diverse institutional representation in WHO activities through, for example, reforming the process of granting official relations status and enhancing informal participation. The rationale for this change was described as follows:

The engagement with civil society profoundly affects the ways in which international organizations understand and respond to the needs of people all over the world. Concepts about poverty, equity, justice, security, rights and responsibilities take on new meaning. Exposure to the complexities of cultures and communities hone critical thinking and sensitivity. Assumptions are challenged, power is redefined, change is initiated (WHO 2002b).

Brundtland’s departure in 2003, however, saw the CSI largely shelved and little progress was made to enhance the role of CSOs under her successor, J.W. Lee. Upon her election as the new Director-General, Margaret Chan identified “partnerships” as one of her six priorities, and spoke of “strengthening relationships with civil society and the private sector, and creating greater alignment between partnerships”. Whether these broadly defined and often recited commitments will be translated into actual policy changes in how WHO works with CSOs remains unclear. Many CSOs continue to

lament the difficulties of working with WHO, the closed nature of its activities, and blind romance with public-private partnerships (Reid and Pearse 2003).

The World Bank has similarly sought to enhance the role of CSOs in health development. The Participation and Civic Engagement Group of the Social Development Department “promotes the participation of people and their organizations to influence institutions, policies and processes for equitable and sustainable development” (World Bank 2007). In this context, the Bank has sought to strengthen CSOs as a component of conditionalities to improve “good governance”. While the validity of such an approach is worthy of critical analysis, the separate issue of CSOs’ participation in the World Bank’s own work appears so far to be a more difficult pill to swallow. For similar reasons to WHO, and indeed as the target of even fiercer criticism of its internal governance, the Bank has sought to enhance its relations with CSOs. Under President James Wolfensohn, a review of the Bank’s relations with CSOs was undertaken which proposed “options for promoting more effective civic engagement in Bank-supported activities and managing associated risks in the future” (World Bank 2005). The report recognised “growing internal and external demands on the Bank to demonstrate greater corporate social responsibility and accountability for its own actions.”

In this spirit, a World Bank-Civil Society Global Policy Forum was held in 2005 “to assess the PRSP [Poverty Reduction Strategy Paper] process and discuss the way forward for Bank – civil society engagement at the global level.”¹ Among the recommendations put forth was the need to “deepen the quality of civil society participation as there is a widespread sense that CSO input is not reflected in the final versions of the PRSP”. From the perspective of CSOs, there is considerable ambiguity towards closer engagement. Short of dismantling the Bank and IMF altogether, which many CSOs advocate, on the one hand, some see recent initiatives as hard won opportunities for changing the organisation from within. Others, however, remain sceptical of the Bank’s true colours, seeing CSO engagement as a way of co-option to make fundamentally neoliberal-based policies more palatable (Naidoo 2003; Tleane 2004; Bond 2007). Boycotts of the Bank by CSOs, such as the boycott of the International Finance Corporation (IFC) review of its environmental and social policies in 2004, in protest at the lack of time, transparency and relevant background documents provided (Friends of the Earth 2004), reflect the at best uneasy truce that remains between the Bank and civil society.

Overall, while major IGOs concerned with GHG accept the importance of CSOs to their work, CSO participation has been encouraged largely to implement the in-country programmes and activities of these organisations. There has been less scope for involvement in formal policy making by IGOs that influence what the nature of such activities should be. In this sense, engagement between IGOs and CSOs to date has been on limited terms with limited effect.

3.0 Functions of global health governance

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<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/CSO/0,.contentMDK:20327929~pagePK:220503~piPK:220476~theSitePK:228717,00.html>

In his assessment of global environmental governance, Haas (2003) describes “two new geopolitical realities that challenge the old geographical principles of national sovereignty.” The first is the complexity of a globalising world “whose management requires more holistic or comprehensive policies”. The second is “the proliferation of new political actors and the diffusion of political authority over major governance functions.” These new actors include CSOs, transnational corporations, organized transnational scientific networks (epistemic communities), global policy networks and selected international institutions capable of exercising discretionary behaviour independently of their dominant member states (e.g. World Bank, European Commission).

In an effort to map the actual division of labour among these institutional actors, in order to evaluate how they performance and to determine any comparative advantages, Haas identifies twelve governance functions (Table 1). Some functions are performed formally, that is, “by the direct commitment by somebody to a clear actor to perform the designated function or functions”. Others are carried out informally, in that, “the functions may be observed but are not the consequence of intended action by those contracting some set of activities to be performed by the relevant actors.”

Applied to specific examples of global health governance, can different institutional actors be mapped by function to identify an appropriate division of labour and, specifically, assess the contribution of CSOs?

Table1. Matrix of Functions

Function	Formal/direct	Informal/indirect
Issue linkage	<ul style="list-style-type: none"> • By inter-governmental negotiations • By new information provided by epistemic communities • Through financial mechanisms (GEF) • By IOs (GEO/WEO) 	<ul style="list-style-type: none"> • By scientists • By business/industry
Agenda setting	<ul style="list-style-type: none"> • By IOs and member states • By scientists 	<ul style="list-style-type: none"> • By NGOs • By media • By scientists
Developing usable knowledge	<ul style="list-style-type: none"> • By scientists 	<ul style="list-style-type: none"> • By scientists • By NGOs • By business/industry
Monitoring	<ul style="list-style-type: none"> • By IOs • By committees nominated by MEA secretariat • By MEA signatory governments 	<ul style="list-style-type: none"> • By NGOs (particularly in developing countries) • By Scientists
Rule making	<ul style="list-style-type: none"> • Negotiations by national governments • By NGOs (principled standards) 	<ul style="list-style-type: none"> • By Business/Industry (de facto standards) • By NGOs (principled standards)
Norm development	<ul style="list-style-type: none"> • Epistemic communities 	<ul style="list-style-type: none"> • By NGOs (equity & environmental preservation) • By Business/Industry (efficiency)
Policy Verification	<ul style="list-style-type: none"> • Governments 	<ul style="list-style-type: none"> • NGOs • IOs
Enforcement	<ul style="list-style-type: none"> • (Hard) Law • WTO and MEA rules 	<ul style="list-style-type: none"> • NGO campaigns
Capacity building (tech transfer)	<ul style="list-style-type: none"> • Official technical assistance (national and local government) • Business/Industry • Science community (education/training) 	<ul style="list-style-type: none"> • Business/Industry (joint venture)
Capacity building (organizational skills)	<ul style="list-style-type: none"> • By IOs • By NGOs • Science community (education/training) 	<ul style="list-style-type: none"> • By Business/Industry
Promote vertical linkage	<ul style="list-style-type: none"> • IOs • National and Local Governments 	<ul style="list-style-type: none"> • NGO • Scientific community
Financing	<ul style="list-style-type: none"> • Government (ODA) • Regional Development Banks • Multilateral bodies 	<ul style="list-style-type: none"> • By Business/Industry

Source: Haas P.M. (2003), "Is there a Global Governance Deficit and What Should be Done About It?" Ecologic, Institute for International and European Environmental Policy.

3.0 The role of CSOs in selected GHG instruments

3.1 *International Code on the Marketing of Breastmilk Substitutes*

Adopted in May 1981 by WHO member states (WHA Resolution 34.22), following years of concern about the general decline in breastfeeding in many parts of the world, the International Code of Marketing of Breastmilk Substitutes represented the culmination of a prominent global health promotion campaign by WHO, the United Nations Children's Fund (UNICEF) and CSOs led by the International Baby Food Action Network (IBFAN). The Code was highly successful at drawing worldwide public attention to the health consequences of the marketing practices of infant formula manufacturers, with CSOs mounting a successful boycott of the food manufacturer, Nestlé.

The Code was prepared by WHO and UNICEF after a process of consultation with governments, the infant feeding industry, professional associations and CSOs. As an internationally adopted and endorsed basic minimum requirement to protect healthy practices in respect of infant and young child feeding, it was the first health document of its kind. It is less binding than a treaty or a convention, serving as an international recommendation to regulate the marketing of breastmilk substitutes. Follow up resolutions by the World Health Assembly have reinforced or extended specific provisions. There have been efforts to incorporate the Code into provisions under the Food and Agriculture Organization (FAO), Codex Alimentarius, World Trade Organization (WTO) and other relevant international forums in the form of nutritional guidelines and trading principles.

Implementation of the Code over the past twenty-five years has met with mixed success. The Code was adopted by national health systems around the world, and corporations were made acutely aware of the power of consumer action. At the same time, it remains largely a voluntary code, and CSOs argue that some of its definitions and articles remain open to interpretation. For example, amid a renewed Nestlé boycott, CSOs accuse the company of using a corporate social responsibility initiative (i.e. ombudsman scheme) to placate public concerns. Violations in many low- and middle-income countries have been regularly reported (Taylor, 1998). CSO-led monitoring reports that 4000 babies continue to die each day from unsafe bottle feeding (International Baby Food Action Network, 2004). There remain almost no formal means of enforcement beyond public censure.

A mapping of governance functions surrounding the Code (Table 2) confirms that the role of CSOs has been critical to the successful adoption of the Code, initially drawing attention to the problem, raising public awareness and campaigning fiercely in relevant IGOs for governments to take action. CSOs were also critical to mobilizing evidence to support international action. However, the status of the adopted Code, as a nonbinding recommendation, has undermined its longer term effectiveness. While the Code sets out measures for its implementation, monitoring and enforcement by WHO, governments, business/industry and CSOs, in practice, it does not formally allocate the authority or resources to ensure compliance. Without "teeth" and the means of implementing its provisions, these responsibilities have fallen heavily on CSOs. For example, the Code states that national governments "individually, and collectively through the World Health Organisation...The manufacturers and distributors...nongovernmental organisations...should collaborate with governments to this end" (Article 11.1). In reality, the burden of monitoring has fallen heavily on CSOs which have limited capacity to maintain a worldwide effort. This example suggests that

effective regulation of powerful and well-resourced TNCs cannot rely solely on nonbinding codes to achieve change. Certain governance functions require a formal role by governments, backed by authority and resources.

Table 2: Functions in the global governance of breastmilk substitutes

Function	Formal/Direct	Informal/Indirect
issue linkage	<ul style="list-style-type: none"> by CSOs (drawing attention to link between health problems and marketing practices) 	<ul style="list-style-type: none"> by health workers (reporting of infant and child health problems)
agenda setting	<ul style="list-style-type: none"> by CSOs and health professionals (campaigning for regulation) 	
developing usable knowledge	<ul style="list-style-type: none"> by IGOs (WHO development of evidence base) by CSOs (contribution of evidence from different countries) 	<ul style="list-style-type: none"> by scientists (research on infant feeding practices and health)
monitoring	<ul style="list-style-type: none"> by CSOs (i.e. <i>Breaking the Rules, Stretching the Rules</i> and <i>Look What They're Doing</i> reports) by business/industry (i.e. monitoring own marketing practices) 	
rule making	<ul style="list-style-type: none"> by IGOs (WHO and UNICEF adoption of Code) by other IGOs (FAO, WTO and Codex Alimentarius) by national governments (adoption of code into domestic law) 	<ul style="list-style-type: none"> by business/industry (bringing legal action challenging interpretation of Code's requirements)
norm development	<ul style="list-style-type: none"> by IGOs (WHO adoption of follow up resolutions) 	<ul style="list-style-type: none"> by business/industry (CSR initiatives and legal action challenging reported violations) by CSOs (drawing public attention to Code and violations, promoting breastfeeding)
policy verification	<ul style="list-style-type: none"> by national governments (reporting progress to WHO) by CSOs (periodic reports on state of the code by country and company) by health workers (e.g. reporting violations to government officials) 	
enforcement	<ul style="list-style-type: none"> by national governments (e.g. adoption and enforcement of penalties under domestic law) 	<ul style="list-style-type: none"> by CSOs through public approbation (e.g. consumer boycott) by health workers and individuals (e.g. complaints to

		manufacturers)
capacity building (technology transfer)	<ul style="list-style-type: none"> • by national governments (i.e. providing information on infant feeding) • by CSOs (International Code Documentation Centre) • by business/industry (only if strictly approved by government) 	
capacity building (organizational skills)	<ul style="list-style-type: none"> • by CSOs 	
promote vertical integration		
financing	<ul style="list-style-type: none"> • by national governments (i.e. allocation of resources for implementing Code) 	

3.2 Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control (FCTC) was adopted in 2003, as the world's first international health treaty, and entered into force in February 2005. As of 30 April 2007, 168 countries have signed the agreement, of which 147 have formally ratified. While negotiation of the FCTC was ostensibly an intergovernmental process, it is widely recognised that CSOs played a critical role throughout (Collin et al. 2004).

The initiation of the FCTC process recognised from the beginning the importance of CSOs. World Health Resolution (WHA) resolution 52.18 (May 1999) established two bodies to draft the convention: the Technical Working Group to prepare the proposed draft elements; and the Intergovernmental Negotiating Body (INB) to draft and negotiate the agreement and possible related protocols. Participation in both bodies was open to all member states, regional integration organisations, and observers including CSOs. In Resolution 53.16 (May 2000), the ING was called upon "to examine the question of extended participation by nongovernmental organisations as observers" in FCTC negotiations. A report on NGO participation was presented to the Executive Board in January 2001, and two organisations (International Nongovernmental Coalition Against Tobacco and Infact) were admitted into official relations with WHO for this purpose. Accreditation of CSOs was facilitated by WHO which recognised the importance of their support, not only in supporting the negotiation process, but the subsequent signing, ratification and implementation of the FCTC within member states. In addition, prior to the ING's first of six sessions, public hearings were convened by the Director-General in 2000 "to provide a forum for the public health community, the tobacco industry and farmers' groups to submit their case" (WHO 2003). Finally, the WHO Tobacco Free Initiative (TFI) held regional pre-negotiation consultative meetings

The influence of CSOs was enhanced significantly by the formation of the Framework Convention Alliance (FCA) comprised of more than 250 organizations representing over 90 countries. The FCA includes organizations working at the local or national levels, as well as existing coalitions and alliances working at national, regional, and international levels. The vision of the FCA is a world free of death and disease caused by tobacco. Its mission is to promote and support a global network for co-ordinated international campaigning against tobacco; developing tobacco control

capacity, particularly in developing countries; and carrying out effectively the watchdog function for the Framework Convention on Tobacco Control. It was created to support the development, ratification, and implementation of WHO's FCTC. It was formed out of the need for improved communication among groups already engaged in work around the FCTC process, and the need for a more systematic outreach to CSOs not yet engaged in the process, particularly in low and middle-income countries (LMICs), which could both benefit from and contribute to the creation of an effective FCTC (Collin et al. 2004).

Organised around the FCA, during the negotiation process, CSOs were permitted to submit statements following each negotiation session. While not entirely satisfying, it was an advance on the usual format of UN negotiations largely restricted to member states. The views of CSOs were deemed especially important to counter efforts by some governments, notably the US, Germany and Japan, to weaken tobacco control measures within the treaty. For example the Japanese government, which owns half of Japan Tobacco International, successfully argued for extensive optional language (e.g. "appropriate measures") that seriously weakened the FCTC (Assunta and Chapman 2006). CSOs, in turn, presented briefings on specific issues between negotiation sessions, as well as lobbied delegates. While these efforts were critical for catalysing many governments into regional coalitions, notably in Africa and Asia, they did not wholly counter those governments opposed to stronger tobacco control measures.

Since the adoption of the treaty, the FCA and CSOs in general have continued to serve as a coordinating body for supporting the signing and ratification of the treaty. For example, in central and eastern Europe, and the former Soviet Union, Malinowska-Sempruch et al. (2006) find that CSOs have led efforts to identify direct and indirect health consequences of tobacco use. The FCA has also helped disseminate information about implementation of the FCTC, notably in LMICs (FCA 2006).

Mapping the governance functions for global tobacco control, one can observe that WHO initiated the FCTC negotiation process alongside efforts to build and broaden support and participation by CSOs across the world. It was recognised that the negotiations would be opposed by a powerful industry, with the capacity to undermine the process through its influence of key governments. The prominent presence of CSOs at the ING negotiations, in the form of the submission of statements as observers, hosting of informal briefing sessions on key topics between negotiation sessions, and lobbying of delegates, served to rebalance public health and industry influence. Negotiation on key parts of the text, such as trade and marketing restrictions, remained weaker than public health advocates had hoped, but the overall treaty proved stronger than at times expected. CSOs publicised the positions of intransigent governments, communicated worldwide through the internet as negotiations unfolded, enhancing the transparency of the process.

Like the International Code on the Marketing of Breastmilk Substitutes, how the FCTC is translated into policy changes which strengthen tobacco control is the key challenge. To date, the FCA has played an active role lobbying governments to sign and ratify the treaty. Progress on adopting the comprehensive tobacco control measures required under the FCTC has been slower but comparatively better than for the Code. Once again, however, compliance is limited by the lack of punitive measures for non-compliance. Although the FCTC is a legally binding treaty, there are no formal measures available to WHO to sanction states parties which fail to fulfil their obligations.

Resource constraints have also been a major problem especially for LMICs. Funding for tobacco control in all countries remains disproportionately low, relative to the disease burden caused. Increased recognition of the public health impact of non-communicable diseases has resulted in increased attention in recent years. Funding for tobacco control research, especially in relation to LMICs, has remained scarce despite the predicted 7 million deaths from tobacco annually by 2030 (Lando et al. 2005).

Table 3: Functions in the global governance of tobacco control

Function	Formal/Direct	Informal/Indirect
issue linkage	<ul style="list-style-type: none"> By IGOs (WHO Tobacco Free Initiative) 	<ul style="list-style-type: none"> By scientists (smoking and health research)
agenda setting	<ul style="list-style-type: none"> By IGOs (FCTC Working Group and ING) By national governments 	<ul style="list-style-type: none"> By CSOs as observers in FCTC Working Group and ING) By business/industry lobbying policy makers
developing usable knowledge	<ul style="list-style-type: none"> By IGOs (WHO TFI surveillance surveys; World Bank, FAO) National governments (CDC youth survey) 	<ul style="list-style-type: none"> By scientists (smoking and health research) By business/industry (industry funded research) By legal action (discovery of internal industry documents)
monitoring	<ul style="list-style-type: none"> By IGO (national reports to WHO FCTC Interim Secretariat) 	<ul style="list-style-type: none"> By CSOs (FCA reporting lack of compliance by governments and violations by industry)
rule making	<ul style="list-style-type: none"> By IGOs (WHO member states;) By national governments (adoption of national legislation) 	<ul style="list-style-type: none"> By CSOs (as observers at ING sessions) By legal systems (litigation against tobacco industry)
norm development	<ul style="list-style-type: none"> By IGOs (WHO TFI awareness building among member states) By national governments (support of tobacco control programmes) By health workers (public education) 	<ul style="list-style-type: none"> By CSOs By business/industry (e.g. CSR initiatives)
policy verification	<ul style="list-style-type: none"> By IGO (WHO FCTC Interim Secretariat national reporting; Global Information System on Tobacco Control) 	<ul style="list-style-type: none"> By CSOs (scrutiny of industry CSR initiatives against practices)
enforcement	<ul style="list-style-type: none"> By IGO (WHO FCTC Interim Secretariat) 	<ul style="list-style-type: none"> By CSOs (campaigning and exertion of public pressure)
capacity building (technology transfer)	<ul style="list-style-type: none"> By WHO FCTC Interim Secretariat (technical assistance to member states) 	<ul style="list-style-type: none"> By CSOs (RITC; Fogarty International Centre; Rockefeller Foundation; Globalink)
capacity building	<ul style="list-style-type: none"> By WHO FCTC Interim 	<ul style="list-style-type: none"> By CSOs (RITC;

(organisational skills)	Secretariat (technical assistance to member states)	Bloomberg Global Tobacco Initiative)
promote vertical integration		
financing	<ul style="list-style-type: none"> By CSOs (e.g. Bloomberg Global Tobacco Initiative, Rockefeller Foundation Trading Tobacco Initiative) 	<ul style="list-style-type: none"> By research funding bodies (e.g. Fogarty, NIH)

3.3 International Health Regulations (2005)

The International Health Regulations were established in the nineteenth century, as the International Sanitary Regulations, to govern the sanitary conditions required by all forms of transport for preventing the international spread of disease. The agreement of the IHR was ostensibly driven by the desire to facilitate growing trade relations (Fidler 2005a). Limited to a few selected diseases and functions, the IHR has been subject to periodic revision. Economic globalization, with its intensified flows of trade and incorporation of almost all countries into the world trading system, led to a fundamental review of the IHR in the late 1990s. This proved an initially protracted process because of a lack of political will and resources. The SARS outbreak and prospects of an influenza pandemic, however, lent a greater sense of urgency to the process among high-income countries. The revised regulations were unanimously adopted on 23 May 2005 by the WHA, to enter into force in June 2007.² The broadened purpose and scope of the IHR (2005) are to “prevent, protect against, control and provide a public health response to the international spread of disease and which avoid unnecessary interference with international traffic and trade”.

The provisions adopted within the IHR (2005) provide a good example of efforts to enhance GHG through, *inter alia*, broadening CSO participation. Perhaps the most significant achievement of the revised IHR (2005) is its capacity to draw on a far wider range of information sources beyond national health systems of member states. In the past, a key limitation of surveillance, monitoring and reporting efforts was the dependence on governmental sources of data which, if not forthcoming or inaccurate, could not be effectively questioned. The narrow scope of the IHR also meant that governments were obligated to disclose information on only three diseases (yellow fever, cholera, plague). The IHR (2005) states that, while national IHR Focal Points will liaise with WHO IHR Contact Points, WHO “may take into account reports from sources other than notifications or consultations and shall assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring” (Article 9(1)).

The institutional structure emerging is what WHO calls a “network of networks” whereby surveillance is undertaken through a loose network that links parts of national health care systems with the media, health organisations, laboratories, and institutions focusing on particular disease conditions. These individual networks are increasingly

² All Member States of WHO will become States Parties to the IHR (2005) except for any that reject the Regulations before 15 December 2006. States not Members of WHO may become States Parties to the IHR (2005) by notifying the Director-General of WHO of their acceptance.

linked across countries, regions, and globally, through governments, centres of excellence (e.g. US Centers for Disease Control, Pasteur Institutes), WHO offices, military networks (e.g. US Department of Defence Global Emerging Infectious Disease System) and internet discussion sites such as Promed (<http://www.promedmail.org>) and Epi-X (<http://www.cdc.gov/epix>). In 1997, WHO initiated the Global Outbreak Alert and Response Network which was formally adopted by WHO member states in 2000. The network has more than 120 partners around the world, and identifies and responds to more than 50 outbreaks in developing countries each year (Heymann and Rodier 2004).

Overall, governmental institutions remain central to the global governance of infectious disease surveillance, acting as the key institutional nodes within various networks for surveillance, monitoring, reporting and response. Governmental mechanisms also remain critical for building capacity. The revised mandate it gives to Member States and WHO has expanded their respective roles and responsibilities. In particular, States Parties to the IHR (2005) are required to develop, strengthen and maintain core surveillance and response capacities to detect, assess, notify and report public health events to WHO and respond to public health risks and public health emergencies. WHO, in turn, is to collaborate with States Parties to evaluate their public health capacities, facilitate technical cooperation, logistical support and the mobilization of financial resources for building capacity in surveillance and response. States Parties and WHO are now developing plans for implementing IHR (2005). To date, CSOs play a supplemental albeit critical role - filling information gaps or confirming reports – in a timely manner to enable government institutions to respond. In this way, disease surveillance has become a more open process, allowing information to flow in a more open and transparency manner.

Table 4: Functions in the global infectious disease surveillance through the International Health Regulations

Function	Formal/Direct	Informal/Indirect
issue linkage	<ul style="list-style-type: none"> By national governments (reporting of disease outbreaks) By IGOs (WHO EPR outbreak reporting) 	<ul style="list-style-type: none"> By health workers (reporting of disease outbreaks) By business/industry (economic losses incurred as a result of infectious disease threats or responses)
agenda setting	<ul style="list-style-type: none"> By national governments (need for improved surveillance systems) By IGOs (WHO EPR) 	
developing usable knowledge	<ul style="list-style-type: none"> By national governments (national public health systems) By IGOs (WHO EPR development of standards of reporting; coordination and dissemination of data) 	<ul style="list-style-type: none"> By CSOs (ProMed, disease monitoring and reporting networks)
monitoring		<ul style="list-style-type: none"> By CSOs (through ongoing reporting of outbreaks)
rule making	<ul style="list-style-type: none"> By IGOs (WHO member states) 	<ul style="list-style-type: none"> By research institutions

	<ul style="list-style-type: none"> revise IHR) By national governments (adoption of national legislation and surveillance systems) 	
norm development	<ul style="list-style-type: none"> By IGOs (WHO standards setting, nomenclature) 	
policy verification	<ul style="list-style-type: none"> By national governments (ministries of health) By IGOs (WHO EPR) 	<ul style="list-style-type: none"> By CSOs (disease monitoring and reporting networks) By mass media
enforcement	<ul style="list-style-type: none"> By IGOs (WHO EPR issuance of travel advisories and restrictions) 	
capacity building (technology transfer)	<ul style="list-style-type: none"> By IGOs (WHO Office for National Epidemic Preparedness and Response) By national governments (aid to build surveillance capacity in LMICs) 	<ul style="list-style-type: none"> By research institutions (training of health workers/epidemiologists)
capacity building (organisational skills)	<ul style="list-style-type: none"> By national governments (aid to build surveillance capacity in LMICs) By IGOs (WHO Office for National Epidemic Preparedness and Response) 	
promote vertical integration	<ul style="list-style-type: none"> By governments and IGOs (building of national, regional and global networks) 	
financing	<ul style="list-style-type: none"> By national governments (health sector aid) 	

3.4 Codex Alimentarius

The *Codex Alimentarius* - a collection of 250 or so standards, codes of practice, guidelines and other recommendations - was created in 1963 by the FAO and WHO to be “the single most important international reference point for developments associated with food standards” (FAO/WHO 2005: 1-2). The Codex is governed by the Codex Alimentarius Commission (CAC), comprised of 172 member states, which meets in plenary every two years (alternately in Rome and Geneva). Total participation numbers around 600 delegates. National delegations are led by senior officials appointed by their governments. Delegations may, and often do, include representatives of industry, consumers’ organizations and academic institutes. Countries that are not yet members of the Commission sometimes attend in an observer capacity. A number of IGOs and international NGOs also attend in an observer capacity. Although “observers”, the tradition of the CAC allows such organisations to put forward their points of view at every stage except in the final decision, which is the exclusive prerogative of member states. To facilitate continuous contact with member countries, the CAC, in collaboration with national governments, has established country *Codex Contact Points* and many member countries have *National Codex Committees* to coordinate activities nationally.

Criticism has been raised about the extent to which the food industry is represented within the CAC, and thus the balance achieved between the goals of for-

profit trade and consumer protection. According to the report, *Cracking the Codex* (Avery et al. 1993), 81% of non-governmental participants on national delegations came from industry between 1989 and 1991, while only 1% represented public interest groups. The study examined participation on all Codex committees which met between 1989 and 1991, finding that industry representatives accounted for 26% of all participants on these committees. Industry participation increased on committees dealing with particularly controversial issues. For example, one-third of the 387 participants in the two meetings of the Committee on Pesticide Residues were industry representatives, and 86 of these participants represented specific agrochemical and food companies; only three participants at these meetings represented public interest groups. Forty-one percent of the participants in the two meetings of the Codex Committee on Food Additives and Contaminants were food industry representatives. On the Codex Committee for Nutrition and Special Dietary Uses, 47% of participants represented industry.

This imbalance in the representation of industry and consumer interests has led to criticisms that this results in food standards which favour trade over consumer protection. Many Codex standards are lower than national ones, allowing, for example, residues of some of the most hazardous pesticides in the world. Residues of these pesticides are banned or strictly limited in many countries of the world. Lang writes, "With an increased role for Codex, nations will effectively hand a great deal of control over the regulation of food safety and quality to global trade and corporate interests" (as quoted in Avery et al. 1995).

For the CAC to be an effective governance mechanism, that ensures food safety within an increasingly globalised food production system, an improved system of representation and participation by a broader range of stakeholders, notably groups representing consumer interests, should be considered. This is especially relevant given the enhanced role of Codex in trade liberalisation, and growing evidence of the links between weak global food regulation and nutrition-related health problems.³ At present, CSOs representing consumer interests are not as well represented as business and industry interests, and occupy a largely informal/indirect role in governance functions.

Table 5: Functions in the global governance of food standards through the Codex Alimentarius

Function	Formal/Direct	Informal/Indirect
issue linkage	<ul style="list-style-type: none"> • By national governments • By business/industry 	<ul style="list-style-type: none"> • By business/industry • By CSOs (consumer groups drawing attention to food safety issues) • By health workers (reporting of foodborne diseases)
agenda setting	<ul style="list-style-type: none"> • By national governments • By business/industry • By IGOs (WHO, FAO and WTO) 	<ul style="list-style-type: none"> • By CSOs (consumer groups) • By mass media (reporting on food related)

³ Hawkes C, Chopra M, Friel S, Thow AM. (2007), "Globalization, food and nutrition transitions," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

		issues)
developing usable knowledge	<ul style="list-style-type: none"> • By IGO (CAC expert committees) • By business/industry (support for industry funded research) 	<ul style="list-style-type: none"> • By research institutions (research on food safety and nutrition issues)
monitoring	<ul style="list-style-type: none"> • By national governments (food standards authorities) 	<ul style="list-style-type: none"> • By CSOs (consumer groups)
rule making	<ul style="list-style-type: none"> • By IGOs (Codex sub and coordinating committees draft regulations) • By national governments • By business/industry (representation on national delegations and consultation as “interested parties”) 	<ul style="list-style-type: none"> • By CSOs (consumer group proposals on food safety, labelling etc.)
norm development	<ul style="list-style-type: none"> • By IGOs (WTO SPS and TBT on food harmonisation) • By business/industry (representation on technical and standard setting bodies) 	<ul style="list-style-type: none"> • By business/industry (marketing of food products)
policy verification	<ul style="list-style-type: none"> • By national governments • By IGOs (WHO, FAO and WTO) 	<ul style="list-style-type: none"> • By CSOs (consumer groups)
enforcement	<ul style="list-style-type: none"> • By national governments (customs checks; legal action against violations) 	
capacity building (technology transfer)	<ul style="list-style-type: none"> • By IGOs (WHO and FAO support to member states to build technical and administrative infrastructure to implement Codex) • By IGO (WTO Standards and Trade Development Facility) 	
capacity building (organisational skills)	<ul style="list-style-type: none"> • By IGOs (as above) 	
promote vertical integration		
financing	<ul style="list-style-type: none"> • By national governments (inspection and enforcement) • By business/industry (production costs to comply with regulations) • By IGO (WHO/FAO Trust Fund to participate in Codex) 	

4.0 Conclusions: The role of CSOs in strengthening global health governance

A recent review of GHG, as an influence on the social determinants of health (Lee et al. 2007), concludes that “[t]he past two to three decades has brought a period of transition from international to global governance including health governance. Societies around the world are faced with the challenge of finding more effective means of collectively addressing issues of global relevance.” The review found that, to date, this challenge has been far from met. There is a need for the overall structure of global

governance to be fundamentally reviewed, in the context of the needs, priorities and political culture of the early 21st century.

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

What lessons can we draw from these diverse examples for the strengthening of GHG? First, there remains considerable variation in the functions performed by CSOs in GHG. The examples suggest that CSOs need not necessarily be confined to agenda setting, advocacy and watchdog roles, but could be formally integrated into governance mechanisms which have traditionally been open to states alone. This is especially important where powerful vested interests seek to limit the scope of GHG.

Second, while formal participation in GHG functions by CSOs remains limited, negotiation of the FCTC suggests that informal participation can be highly effective. Governments will continue to fulfil the formal functions of rule making and enforcement, but can broaden the scope for inputs by CSOs to enhance policy making.

Third, despite a more institutionally crowded playing field, GHG remains far from pluralist in a true sense. GHG, like global governance as a whole, has been characterised by greater, rather than lesser, concentration of power in fewer hands (Lee et al. 2007). In some cases, increased CSO participation in IGOs can enhance the scope of interests represented. In food standards setting, corporate actors remain far more prominent, prompting concerns about the representativeness of decision making. At the same time, CSOs can themselves be elitist, and their membership must also be critically assessed and balanced.

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

Finally, Haas (2003) argues that decentralised governance (or multi-level governance) should structure reform of global environmental institutions whereby effective governance rests on the performance of multiple functions performed by a range of institutional actors including CSOs. This model could be applied to further reflection on the reform of GHG. More detailed understanding of the roles of state, market and civil society actors is needed in terms of specific functions, and across different types of GHG instruments.

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