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Annotated Bibliography on Civil Society And Health

Civil society influence on global health policy

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This paper is part an annotated bibliography which is presented in a searchable web format on the WHO site (<http://www.who.int/en/>) and the TARSC site (<http://www.tarsc.org>). There you can view and download the following **theme papers** highlighting research findings and issues arising from the literature.

- 1 Overview of issues from the bibliography on civil Society and health
- 2.Civil society-state interactions in national health systems
- 3.Civil society contributions to pro-poor health equity policies.
- 4.Civil society influence on global health policy;

You can also view and search a data base on the **articles** on research within the last three theme areas: An abstract is provided on each of the articles reviewed

Civil society influence on global health policy

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The involvement of civil society organisations (CSOs) in health brings new institutional, technical, political and financial resources to health. How best can these resources be marshalled towards local, national and international health goals? Policies and programmes that seek to engage and utilise the resources within civil society for health need to be informed by evidence and experience of good practice.

Collaboration with CSOs is not new for WHO, and interaction, consultation and co-operation with CSOs are encouraged by its Constitution. The growth of the scale and policy influence of CSOs, the relevance of civil society to WHO's strategic agenda for health and to the attainment of global and national health goals, and the increased formal interaction with CSOs within the UN system have, amongst other factors, stimulated a review of civil society roles in health within and beyond the WHO. If policy shifts in relations with CSOs are to be sustainable and relevant, they need to be backed by evidence and supported by dialogue. Towards this aim, the WHO Civil Society Initiative and Training and Research Support Centre (TARSC) have collaborated in work to gather evidence from research on key areas of civil society engagement in health, to identify the knowledge emerging from current research in these areas and the issues informing future research on civil society and health.

An overview of the methods used to select the research papers, definitions of civil society, overall findings and research issues arising is provided in the first paper in this annotated bibliography.

This is the fourth paper in the series and presents the evidence from studies of civic influence on global health policies.

CSOs have become increasingly influential in global policy processes. The UN draws information and expertise from CSOs and increasingly integrates CSO inputs and collaboration in UN processes. In relation to global health policy, CSOs have intervened around trade agreements; drug prices and treatment access; tobacco control; patient rights; promotion of breastfeeding and control of infant formula; rights of people with HIV/AIDS, and primary health care. Civil society visibility and influence in health policy has grown, with the growth in capacity and increasingly widely connected networks of civil society, supported by an expansion in access to information and increased concerted action.

This paper reviews literature on CSO influence on global health policy. Whilst this paper followed the search criteria used in other papers – viz publicly accessible or published research on the theme area – it also included review

¹ The views expressed in this paper are those of the author and do not necessarily reflect the views of the World Health Organisation.

and position papers on global policies from CSOs and descriptions of global policy processes, given the nature of the theme, the paucity of traditional research and the wider use of social science and content analysis in this area. This paper discusses the findings on how civil society is intervening in global policy processes, from what sections of civil society, through what processes, using what evidence and with what impact. The overview discusses the knowledge gained and the knowledge gaps in our understanding of civil society influences on global health policy processes.

4.1 Globalisation – new policy issues, new policy actors

Global processes have raised new policy issues. Globalisation is associated with a spectacular growth in the transnational movement of capital, goods and services, a rise in transnational corporations, and a massive increase in information flow and technology development. Policy concerns have emerged from both the positive and negative effects of these changes, including on household productive capacities and poverty and access to social services (Development Gap 1995).

New health policy concerns have arisen from intensified transborder health risks and widened social and economic inequalities within and between nations. These health concerns also arise from the population movements, liberalised trade and environmental effects associated with globalisation (Dodgson et al 2002; Frenk et al 2002; Vieira 1993; SID et al 1999; Lee and Dodgson 2000). Health policy processes have been affected by the growth in global telecommunications and information networks. These have helped to shape global information and build shared frameworks on policy issues, such as in the rights frameworks underlying global conventions and an international justice system, or in agreed areas of corporate social responsibility (Koh 2000; Sheehan 2000). Such inclusive global trends are counterbalanced by social disintegration and marginalisation within communities brought about by widening inequality and poverty, distancing households and communities from state and civil society institutions (Development Gap 1995).

This complex and contradictory environment is giving rise to new issues, processes and actors in health policy at the global level. It poses a particular challenge for the protection of public health goals (SID et al 1999). National governments face political and practical constraints in addressing health risks arising from beyond national boundaries. This has brought into focus the role and impact on health governance of intergovernmental institutions, transnational business and civil society actors that cross national boundaries, such as social movements (Frenk et al 2002; Hong 2000). As noted in the first paper, while some CSOs are organised internationally, in that they operate in more than one country or network across more than one country, there are CSOs, such as the People's Health Assembly, which now seek to transcend national boundaries and establish a civic presence at global level.

4.2 Global health policy development – new forms of governance?

Policy development processes are neither linear, simple nor always coherent. They often involve the concerted action of multiple agencies with differing interests and are generally influenced by a wide range of factors, not all of which are within the public domain. This complicates efforts to trace the influence and role of civil society in global health policy. In reviewing the literature, it is apparent that while there is a lot written on policy issues and concerns, there is less on policy processes and very little published work that directly analyses the relationship between processes, actors and inputs in relation to specific policy outcomes.

Global health policy development is located within systems of global health governance. Health governance is defined as the 'actions and means adopted by society to organise itself in the promotion and protection of the health of its population' (Loughlin, Berridge 2002). According to the UN, *good* governance refers to mechanisms that are appropriate, representative, compliant with rule of law, participatory, accountable and transparent (UNDP 1997). The literature indicates that international health governance has shifted over the twentieth century from single issue concerns and support of national standard setting towards dealing with cross border spill overs and externalities of national actions, bringing in new rules, systems and competencies in international public health regulation and giving greater profile to non state actors in health (Loughlin, Berridge 2002; Khor 2002; Kickbusch 2000; Lee and Dodgson 2000).

There are a number of arguments made for giving *civil society* greater profile within global policy making:

- While intergovernmentalism reflects the overlapping interests of member states, *transnationalism* is argued to reflect a common good that transcends the individual interests of member states and thus involves other spheres of society, including civil society (Cronin 2001).
- Global public policy is argued to depend for its coherence on two forms of subsidiarity: *vertical* – thinking globally, acting locally ; and *horizontal* – widening the mix of public and private actors involved, including civil society (Kaul undated; Kickbusch 2000).
- Civil society is argued to be a force for more humane governance and more human centred development and thus a counter to powerful private for profit interests within current processes of globalisation. CSOs are argued to reinforce the public interest roles of states and balance the growing influence of markets (Edwards undated; Dodgson, Lee and Drager 2002; Labonte 1998).
- The growth in CSO service provision and increased pressure from CSOs for greater access to policy making have raised the profile of civil society participation in policy development (Weiss TG 1999; Stanley Foundation 1999).

This theoretical basis for increased CSO participation in global health policy can be tested against the extent to which such CSO participation is realised in practice, at least as reported in the literature. This is explored below in terms of

- The areas of health policy that currently attract CSO attention and with what impact.
- How civil society organisations (CSOs) participate, through what processes.
- What interests are served in such civic influence.
- Which factors affect such CSO participation and influence.

4.3 Areas of CSO intervention in global health policy

CSOs have intervened in global health policy in a number of ways. These include interventions to legitimise policies, mobilise constituencies, resources and actions around policies and to monitor their implementation. CSOs have contributed technical expertise to policy development. They have made global and international policy processes more publicly accessible through disseminating information on them, and thus helped to widen public accountability around these policies (Turmen 1999; Sheehan 2000). CSOs have intervened in global policies related to women's health, ethical standards in humanitarian relief, tobacco control, food quality and safety, pharmaceuticals and access to treatment for HIV/AIDS (Randell et al 1997; Dodgson, Lee and Drager 2002; Gostelow 1999). While CSO involvement in international policy dates back to the nineteenth century antislavery movements, there is evidence of a growth in the scale, numbers and cross border networking and communication of the CSOs involved, with a greater focus on transnational issues (Weiss 1999; Rice and Ritchie 1995; Naidoo and Heinrich 2000).

The baby milk controversy was one of the first health issues to mobilise international civil society networks. CSO intervention was fuelled by public health practitioners moving the issue into the public domain, and by Nestlé's legal suit against professional/civic lobbies. Referral of the issue to the UN opened up active industry and civic lobbies. CSOs like IBFAN, Oxfam and War on Want played an important role in: negotiating the drafting of the code on breastmilk substitutes; informing the public on the code; supporting government regulatory action; and monitoring and publicising violations of the code. While largely reactive in its early phase, the experience and learning built around intervention on this issue is reported to have provided useful models for future civic engagement in global policy (Chapman 1999; IBFAN undated; Singh undated).

The WHO Framework Convention for Tobacco Control exemplifies a more recent civic engagement. CSOs contributed evidence, public information and advocacy to the process. National and international networks of healthcare professionals and other CSOs were identified as critical to counteract the political power of industry interests, confronted by regulation of tobacco. Research papers indicate high levels of industry investment in challenging

scientific evidence, advertising, public information campaigns and both direct and indirect funding of research. CSOs produced counter-evidence and public interest lobbies, identified as 'essential' in negotiating public health regulation of corporate interests (Mindell 2001; Yach et al 2000; Capdevila 2001; Yach et al 2000; Bond 1999).

Global tobacco control policies have been strengthened by CSO networks at global level, supporting policy implementation at local level. CSOs campaigned in favour of Thailand's resistance to US efforts to use the World Trade Organisation (WTO) to force access by US cigarette multinationals to Thai markets. CSOs also provided public lobbies in support of the South African government in its conflict with industry over its tobacco regulation policies. In these cases international CSOs galvanised public and institutional support for the governments; provided technical information to governments and built public lobbies around their positions through public information campaigns (Dale 2001; van Walbeek 2001). National CSOs have formed pressure and watchdog groupings to give relevance to and ensure implementation of global policies, and to feed concerns relevant to global policy (Chapman 1998).

Another area that has attracted CSO attention at global level is that of pharmaceuticals and treatment access. Health Action International (HAI), an international coalition of about 150 NGOs from over 70 countries, has been prominent in influencing policies on treatment access and pharmaceutical pricing (Raghavan 2001). HAI has blended public information and advocacy with technical inputs, supported by HAI implemented research on issues such as private sector drug pricing (HAI 2001b). Oxfam GB and Medecin sans Frontiers have made a similar range of inputs around the World Trade Organisation Agreement on Trade-Related Aspects of Intellectual Property rights (TRIPS) (Oxfam 2001, 2001b).

The issues attracting CSO attention noted above – baby foods, pharmaceuticals, tobacco – are all health policy issues that derive from corporate practice. CSO intervention has largely been focused on balancing corporate interests in policy making, with the positive effect of strengthening the public accountability of business and government and of strengthening southern government lobbies for public health measures, such as the African states lobby on the Framework Convention on Tobacco Control. This effect is observed to be essential for public health at a time when market reforms have made governments less willing to confront big business, or more vulnerable to business pressures (FCA 2001).

CSO concerns around business interests in global policy have led to wider focus amongst CSOs on the nature of WHO relations with the private sector. HAI, Oxfam and People's Health Assembly have called for greater involvement by southern governments and CSOs in decisions on public-private partnerships in WHO, and in monitoring and evaluating WHO work with commercial enterprises, to see if equitable and sustainable health outcomes are achieved (Raghavan 2001, 2001b). HAI, Save the Children Fund, AFRICASO and Oxfam have also intervened around intergovernmental

institutions or public-private partnerships, such as the Global Health Fund, seeking CSO involvement in its decision-making for transparency and accountability, and raising policy concerns that the fund not divert attention from more substantive policy issues of drug pricing and health service infrastructures (HAI 2000; Sen 2002; SCF(UK) 2001; Machipisa 2001).

Together with these interventions around corporate and market forces in health, CSOs have also intervened on behalf of particular public interests in health, or around wider support of the public health sector. There is evidence from the literature of CSO intervention at international level in support of primary health care, equity in health and state health services. CSOs have lobbied for the rights of communities with specific health needs, including consumer lobbies, people with disability, people living with HIV/AIDS. CSO information outreach, research, advocacy and legal action at both national and global level have given visibility to the experience of vulnerable groups and raised important ethical and equity issues around public services for such groups (UNAIDS 1998; Devraj 2001; Hakkinen and Ollila E 2000).

4.4 Impacts of CSO intervention in global health policy

The impact of such civic policy intervention is not easy to assess. It can be inferred from the outcomes observed in global health policies: the passing of treaties and codes to ban landmines, to control tobacco and breastmilk substitutes, the amendment or rejection of particular trade agreements, reductions achieved in drug prices and other changes in policy. Making more than an anecdotal link between civic contributions and specific global health policy outcomes calls for research designed specifically to address this question. Such research is sparse.

It is also important to differentiate between changes in policy development and changes in policy implementation. Research in Latin America suggests, for example, that legal actions by CSOs on rights of special groups have been more useful in raising their visibility and policy recognition than in achieving real changes on the ground. This is attributed to the inability or unwillingness of states to implement such legal decisions (UNAIDS 1998; Devraj 2001; Hakkinen and Ollila E 2000).

There are more studies showing an impact from CSOs on policy *processes*. A number of studies show a shift from CSOs as ‘outsiders’ raising policy issues to ‘informed insiders’ involved in policy processes. This is asserted to have been achieved through CSO networking with sympathetic governments and members of international secretariats. It is reported to have yielded benefits for all players within policy processes through reducing conflict, facilitating communication and bringing new expertise into policy processes (Weiss 1999; Koh 2000; Gellert 1996; Coulby 2001). UN agencies have reported benefits from CSO engagement and alliances in terms of community support of new initiatives, shared values, knowledge and expertise, increased resource mobilisation and increased policy accountability (Gates Foundation 2001; Haines 1997; Nelson 2002; Ibrahim 1998).

This gain from CSO involvement in policy processes is reported in the literature to derive from CSOs contributing skills, leadership and constituencies to back policy changes and disseminating social innovation. CSOs have made policy development more transparent through public information outreach, have monitored policy implementation and have mobilised resources to act on public problems (Gellert 1996; Mann 1995; Aghi 2001; Greenhill 2002; Breman and Shelton 2001). In some cases the civic intervention on the policy process was decisive, such as in the Multilateral agreement on Investment and the International Treaty for the Ban on Landmines, discussed further below.

4.5 Factors influencing CSO engagement at global level

Despite the greater evidence of CSO impact on policy processes, there is little documentation of the forms of CSO engagement in global health policy, or analysis of the factors influencing these impacts. The available evidence suggests that the influence of CSOs on global health policy is determined primarily by the characteristics of the CSOs and of the policy processes, with the specific policy evidence playing a lesser role. This would need to be tested through further research.

Characteristics of the CSOs

The impact of CSO influence on global health policy processes and outcomes appears to be associated with the visibility, scale and resource (technical, financial, social) contribution of CSOs, and the extent to which they reinforce state public interest lobbies. This is found particularly in the extent to which CSOs work in coalitions, have pooled and adequate resources, project strong leadership and co-ordinate lobbying on a focused policy target. CSOs that have built proactive links with sympathetic states and UN agencies have been effective in achieving policy impact. CSO coalitions that have been inclusive, proactive and flexible have been able to respond better to changing conditions influencing policy processes (Gates Foundation 2001; Krut 1997; Koh 2000; Gellert 1998; Deacon et al 2000; Chapman 1999; Korten 1990; Hong 2001; Development Gap 1995; London School of Economics and Political Science 2001).

Coalition building is thus a commonly reported vehicle for increasing influence. Networking between CSOs whose individual resources and status make them unlikely challengers of government and business is observed to create new and more powerful institutions (Korten 1990). Such networks are often centred around a focal individual or organisation that catalyses and coordinates the networks and that mobilises resources and network members. Information access and electronic communication is reported to have facilitated coalition building (Brown et al 2000; Bernal et al 1999). This widening of CSO networks around global policy was publicly evident at the Seattle WTO meeting, for example, where 1300 CSOs were involved. The relationship between size and policy impact may however not be linear. Huge global movements such as the Seattle movement, often 'coalitions of coalitions', are not homogenous and cover a wide spectrum of political ideologies and policy positions, from radical to reformist. This is noted to weaken their policy impact compared to somewhat smaller, more focused coalitions (Barry 2001; Brown et al 2000).

The internet has played a significant role in CSO coalition building and information flow. Internet publication by a CSO ('Public Citizen') of the Multilateral Agreement on Investment (MAI) in 1997, a document that until then had been discussed behind closed doors in the OECD, triggered a response from 700 organisations in 60 countries. The internet was used to inform, network, build lobbies and shape public discourse on the MAI contributing to its rejection. Analysis of the MAI case study highlighted that while the internet facilitated wide information flow, it also enabled poorly reasoned, non-peer reviewed material to be published, potentially confusing CSO positions (Koh 2001; Warkentin and Mingst 2000).

CSO roles in service provision are noted in some studies to enhance policy influence and support policy alliances. In the CSO campaign on the International Convention to Ban Landmines (ICBL) CSOs providing relief for victims of landmines built a network of supportive states that was used to lever commitment from more influential states, from UN institutions and from influential leaders. The CSOs provided a mix of technical, policy and operational information to support the campaign. Such CSO influence on policy through service roles has also been noted in the Children's Vaccine Initiative (CVI) work on policy conflict between public-private sectors on vaccine policies. CSO involvement in programmes and services is noted in a number of studies to provide the organisations involved additional credibility and legitimacy to contribute to health policy, while CSOs can bring programme resources that give them policy leverage (Weiss 1999; Willetts 2000; Muraskin 2000; Gates Foundation 2001; Hardon 2001; Fleck 2002).

These factors would appear to give weight to larger, better resourced CSOs in the North, with greater access to funding and power, than to those in the south. Some reviews of global health policy have critiqued the corporatist inclusion of CSOs in policy processes, without being thorough about the nature of the CSOs involved. Large 'consulting' organisations are lumped with membership groups, paying inadequate attention to people covered, accountability mechanisms, mandate or competencies and giving a disproportionate role to well organised, internet-linked and often northern-based CSOs in global health policy. This is suggested to reinforce more liberalised approaches to health, to block a more fundamental, southern hemisphere based and critical understanding of the roots of social crises and to provide little challenge to status quo (Deacon 1999; Deacon et al 2000; Ottaway 2001; Paul 1996; Paul 1996b). Companies have also 'muddied the pitch' by setting up their own business funded CSOs. Hong (2000) reports evidence of tobacco companies setting up ostensibly independent surrogates to attack the credibility of international health organisations, misrepresent research, dilute regulatory standards, divert resources and advocate that tobacco is not a concern for poor countries.

A number of studies note the disadvantage and exclusion faced by southern CSOs in access to both CSO and UN processes. This bias in inclusion would need to be more systematically researched for its impact on CSO contributions to both policy process and policy content. At least one paper notes the breakaway of southern CSOs from a global network (Jubilee 2000) due to unresolved differences in positions north and south on the debt issue (Naidoo and Heinrich 2000; Buse and Walt 2000; UNAIDS 1998; Deacon et al 2000).

Characteristics of the policy process

There are also potentials for and barriers to accessing policy development at national and international level that influence the nature and effectiveness of CSO policy engagement. At national level, CSOs are reported from policy analysis to face constraints both from government unwillingness to recognise or incorporate civic lobbies and from inflexible constraints in policy processes posed by international finance institutions (Development Gap 1995).

The international commitment to CSO involvement in global policy is reported to be growing, borne out by policy analysis of major UN processes (Fidler 2001; Bigg 1997; Willetts 2000). Studies indicate, however, that the practical commitment within UN staff has been slower, with many not convinced of CSO roles, particularly in relation to the normative and advocacy roles that are relevant to policy (Ibrahim 1998; Bigg 1997; Willetts 2000; Stanley Foundation 1999). UN processes have been observed to create barriers for CSOs, to be inaccessible to poor civil society groups, with gaps between consultation and real influence that can compromise CSOs. The 'corridor discussions' and informal contacts that are part of UN policy negotiations are reported to undermine the more formal ways in which CSOs organise their policy interventions in global health policy (Rice and Ritchie 1995; Coulby 2001; Civicus 1998). Bureaucratic rules of engagement, international agency criteria for selection of CSOs, the manner of agenda setting and procedures

for policy development are argued to carry the risk of filtering out more representative and less compliant CSOs, of excluding certain evidence and expertise, of reducing CSO influence and of reducing policy acceptance (Rice and Ritchie 1995; Ottaway 2001; Deacon et al 2000). Hence for example World Bank poverty reduction strategy development processes have drawn criticism from CSOs for being inaccessible, and for the limited manner in which they draw CSO input and accommodate the deeper structural critiques of poverty emanating from CSOs (Nelson 2002; Kebede 2002).

This evidence of both national distrust and global barriers is still anecdotal, and would need to be further explored for the extent to which it systematically marginalises southern CSO input in global health policy processes.

Strength of evidence for policy

There is less documentation in the literature of CSO impacts on global health policies based on the strength of the evidence presented. The growth in CSO numbers and involvement in the UN is reported to be poorly correlated with the quality of social policy research or of service delivery. CSO inputs to policy derive from a mix of evidence, normative and theoretical arguments, with information on the internet playing an important role in shaping them (Weiss 1999; Breman and Shelton 2001; Turmen 1999; Sheehan 2000). Either because less attention has been given to this or because it is less critical, the literature suggests that the evidence presented by CSOs is a lesser determinant of successful intervention in global health policy than the consistency and scale of political force commanded through networking, alliances, linkages and advocacy. This too would need to be further investigated.

4.6 Conclusions and research issues

The literature indicates that CSOs intervene in, and have some influence on global health policy. Tracing this influence is complicated, however, both by the complex nature of policy processes and by the relatively sparse research that specifically addresses this issue. The available studies are largely descriptive and few specifically set out to map the impact of CSO influence in global health policy. The research papers and reviews of policy processes included in this overview do however identify a number of features of current civil society engagement in global health policy that could usefully be subject to more direct analytic research.

The risks, opportunities and health policy challenges associated with globalisation have motivated and given profile to new policy actors and processes. The literature shows that CSO engagement in global health policy clusters in areas related to regulation of corporate health risks (tobacco, breastmilk substitutes), promotion of public health systems and promotion of the health rights and needs of vulnerable groups. CSOs have strengthened public interest lobbies in these areas, reinforcing states and making a valuable and sometimes essential contribution to successful policy outcomes.

CSO contribute evidence, information exchange, technical expertise, public lobbies and resources to global health policy processes, enhancing the public accountability of policy processes. The studies in this review point to CSO influence largely coming from the strength, visibility and resource base of CSO coalitions, supported by information access and exchange. There is some, but less, evidence of CSO influence through the credibility obtained from service roles, and from the technical evidence presented.

Within these general trends there are some contradictions. A number of research papers have critiqued the current 'corporatist' inclusion of CSOs in policy processes for giving a disproportionate role to well organised northern-based CSOs, with greater linkages to funders, northern and international policy actors and to the internet. This produces a bias against southern hemisphere CSOs, and against the more critical analysis and challenge that they bring to the health and social policy.

This bias within CSOs and their networks is reinforced by characteristics of the policy processes, with barriers arising from formal procedures as well as from non transparent informal processes, and from the attitudes towards CSOs held by state and UN personnel. While the internet has played a critical role in information access, exchange and public dissemination, there is some critique of the use of poorly researched, non- peer reviewed material and the dominance of information inputs from better funded CSO networks.

The current research thus leaves a number of questions unanswered.

There is little systematic documentation of the nature of CSOs involved in global health policy and of how they organise their internal accountability and representation. The specific forms and processes of CSO engagement in health policy are also poorly mapped, and the relationship between civic contributions and global health policy outcomes poorly analysed.

The role of information technology, particularly the internet, is frequently noted as instrumental in informing, networking, and disseminating positions of civil society policy alliances. What is not clear is the extent to which the internet has influenced the form and content of CSO positions in key areas of global health policy, through what sites and evidence, and the options this implies for the UN and others seeking to inform civil society lobbies.

The largely descriptive research to date provides general insights, but leaves largely unanswered the analysis of the determinants of effective outcomes of CSO intervention in global health policy. Most importantly, the literature signals a need for research to explore further the differential access by different types of CSOs to policy processes and its impact on policy interests and outcomes. In particular, evidence of the differential access to global health policy processes between CSOs (largely northern) that comment greater access to processes, power and resources compared to those without (largely southern) needs to be further explored. This raises research questions in terms of the impact on gender, economic and political equity in CSO participation in health policy and on global health policy outcomes.

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