GLOBAL DRIVERS FOR NETWORKED GOVERNANCE IN PUBLIC HEALTH

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Health issues, as is often pointed out, are not contained within national boundaries, and the health of Canadians is to a very real extent connected to the global context. Infectious diseases can start in one remote corner of the world and spread across the planet in the matter of days, sometimes less. Even risk factors linked to chronic diseases, such as cardiovascular disease, cancer, and diabetes, are often best understood from a global perspective. The rise in obesity, for example, and the chronic diseases linked to it, is a global phenomenon, albeit one that affects some regions more than others. There is also a governance dimension in this. The forces of fragmentation and disaggregation that have led to a progression from government to governance in public health at the domestic level, has had a similar impact at the global level, although the latter context introduces some distinctive elements.

In this paper, we will review the emergence of Global Health Governance, as distinct from International Health Governance; present three specific cases which illustrate this shift and the consequences for network governance at the national level; and discuss the implications of these developments for public health governance in Canada. Our central proposition is that the increasing number of players at the global level, as well as the more substantive role these players are playing, introduces a new layer of complexity to public health governance on the world stage, and thus, similar to the domestic scene, underlines the need for new mechanisms for network or collaborative – we will use these terms inter-changeably - governance at the global level. Furthermore, not only do these developments at the global level parallel what is taking place within Canada (as well as in other "open" societies), but in fact they have a "splash-back" effect of contributing further to the need to establish network governance mechanisms domestically. We will define network governance as "…a spectrum of structures that involve two or more actors and may include participants from public, private, and nonprofit sectors with varying degrees of interdependence to accomplish goals that otherwise could not be accomplished independently." (Mandell and Steelman, 2003: 202)

The research in this paper is based on a review of documents, as well as interviews with 11 key informants who have been directly involved in global public health affairs as representatives of government or of non-governmental organizations (NGOs). To protect the anonymity of interviewees, we will refer to the interviews which took place by number, as well as by the date on which the interview took place.

<u>Westphalia and beyond</u>

Many scholars trace the basis for international relations, until very recently, with the Peace of Westphalia of 1648. (Fidler, 2004a: 21) Essentially the Peace articulated a world in which independent sovereign states interact "in a condition of anarchy," meaning that the states "do not share or recognize a common, supreme authority." (Fidler, 2004a: 22) Although the Peace was intended to end the Thirty Years'War, it succeeded in establishing a framework for international relations that lasted over 300 years. The Westphalian system of international law rests on the principles of sovereignty, non-intervention, and consent. (Fidler, 2004a: 25)

Broadly speaking, the practical consequence of the Westphalian system has been to establish state-centrism as the model for international relations for three centuries. In the establishment of supra-international institutions, such as the United Nations and its related agencies, care was taken to respect the sovereignty of states, and to reflect that these institutions were being established on the basis of the consent of the member states. The *Charter of the United Nations* (Article 2.1) states clearly that: "The Organization is based on the principle of the sovereign equality of all its members." Furthermore, Article 2.7 states that: " Nothing contained in the present Charter shall authorize the United Nations to intervene in matters which are essentially within the domestic jurisdiction of a state…"

There is nonetheless a strong sense in the literature on international relations that there has been a significant shift over the past half-century. (Commission on Global Governance, 1995) There are now new and stronger players in international processes who expect to have a more direct participation in international affairs than was possible previously. Among others, the role of civil society organizations has increased both in quantitative and in qualitative terms. (Benner *et al*., 2003) In terms of sheer numbers, Rosenau refers to an "organizational explosion" which is of no less consequence than the population explosion the world has seen. (2005: 47). Using similar terms, Salamon says "a veritable 'association revolution' now seems underway at the global level that may constitute as significant a social and political development of the latter twentieth century as the rise of the nation-state was of the latter nineteenth." (1995: 243.) As of 2003, it is estimated that there were 40,000 NGOs operating across borders. (Benner *et al.*, 2003: 18). Benner *et al.* point to the Johannesburg World Summit on Sustainable Development as reflecting "an ongoing transition to a broader notion of networked governance involving not only governments and international organizations but also businesses and nongovernmental organizations." (2003:18) Indeed, the "roster" of civil society organizations involved in international affairs is impressive and includes International NGOs (INGOs); Business-initiated NGOs (BINGOs);Little NGOs (LINGOs), and Labour-Organized NGOs (LONGOs). (Orbinski, 2007: 35) Faith-based organizations can also play a major role, such as when the issue of reproductive rights come to the fore or to help in humanitarian campaigns.

Beyond simply the fact that the non-state participants in international affairs are more numerous, several observers have noted that the role they play has also changed. In the area of health policy, for example, Lee and Goodman have pointed out that the role of non-state actors, "goes beyond efforts directed at the formal processes of government decision-making, in some cases becoming part of the decision-making structure formerly reserved for state actors." (2002: 98)

Does this mean that the scope for nations has been reduced? It is clear that the role of national governments has become more complicated as a result of these developments. The changes in technology and communications that accompanied globalization have led to what one observer has called "rampant fragmentation of norms, ideologies, values, and institutions." (Kettl, 2000: 491) As a consequence, the capacity of governments to shape issues and to manage conflicts related to those issues has been reduced. (Kettl, 2000: 492)

Yet nation states continue to play a critical role. Member states continue to be the voting members at the World Health Assembly. (*Constitution of the World Health Organization*, Chapter III) Similarly, the ratification of treaties, as will be discussed in relation to the Framework Convention on Tobacco Control, can only be carried out by member states. However, the proliferation of organizations active in global issues, and the networks that have been formed among many of these participants, has meant

that states, while remaining "primary agents" (Weiss, 2005: 73) have had to find space for other parties in the various decision-making processes. As with the domestic scene, in many cases states have become participants within these networks, sometimes in leadership roles, sometimes only as participants. If not as direct participants in networks, states have often had to open a line of communication with them, either formally or informally. The fact that an International NGO (INGO), a Labour Organization NGO (LONGO) or a Business-Initiated NGO (BINGO) will often have a member organization within states makes it even more imperative for states to manage these relationships carefully. Rather than replacing governments, networks involving states and representatives of civil society have become a supplement to state governments as well as to the formally established supra-international organizations, such as the UN and the WHO. (Reinicke 1999-2000: 51; Benner *et al.*, 2003: 21; Scholte, 2002: 337)

Reflecting on changes in the global international scene, former U.N. Secretary-General Kofi Annan said in 2006:

> I believe these global policy networks, capable of bringing together Governments, civil society and the private sector, are the most promising partnerships of our globalizing age. They work for inclusion and reject hierarchy. They help set agendas and frame debates. They develop understanding and disseminate knowledge. (Secretary-General's Opening Address to the fifty-third annual DPI/NGO Conference, 2006)

Boutris Boutris-Ghali, Annan's predecessor, said along similar lines: "The time of absolute and exclusive sovereignty have passed." (cited in Weiss, 2005: 69)

The question now is, what has been put in the place of "absolute and exclusive sovereignty," particularly as it relates to public health?

From International Health Governance (IHG) to Global Health Governance (GHG)

As with many other sectors, and perhaps more so than most, the governance of public health on the global stage has undergone a significant transformation over the past few decades. It has gone from the domain of formal relations between states and formal supra-international organizations, primarily the WHO and its regional entities, to one where many more actors take part. Lee *et al.* refer to a "reterritorialisation" by which "global civil society, virtual communities and cyberspace increasingly defy the logic of territorially defined geography" thus leading to an entirely new set of dynamics. (2005: 6) In the health field, global governance reaches beyond state-centric strategies and involves a broad range of non-state actors, in recognition that governments cannot successfully address global health threats by acting alone. (Fidler 2004b: 800) This applies to both infectious and non-infectious disease threats, since many of the risk factors for chronic diseases such as smoking, unhealthy eating, physical inactivity, and obesity, are a reflection of modern society, rather than of conditions present within the borders of any one particular country. As such, strategies to deal with these issues must often cross state boundaries.

It is difficult to pin-point exactly when the shift from IHG to GHG began in earnest. However, there have been indications from at least the mid-1970s that a progression was taking place. The WHO's

initiative of Health for All, as reflected in *Declaration of Alma Alta* of 1978, represents a significant departure from the Westphalian model in that the focus was directly on the welfare of the individual, rather than looked at through the intermediary of the state. (Fidler, 2004a: 39) In a similar way, the WHO's focus on human rights in relation to the HIV/AIDS pandemic led to a greater role for non-state participants, in particular INGOs, thereby increasing pressure for new governance models globally. (Fidler, 2004a: 40)

In itself, the participation of INGOs in the WHO is not new. They had been allowed to participate for some time in a category called "official relations," a limited form of participation, with state actors still having the predominant roles. Increasingly, however, INGOs began to speak outside the formal constraints of the WHO process, as in the case of the International Baby Food Action Network and the Médecins sans frontières. By 2002, those INGOs participating unofficially were more numerous than those participating through "official relations." (Fidler, 2004a: 52-3)

Aside from increasing the number of players involved in the process, another factor in the shift from IHG to GHG is in the enhanced role of the WHO to become a factor in the internal affairs of member states. Fidler refers to this as a shift from strictly horizontal (relationship between state actors) to vertical global governance. (2004a: 37) Essentially, this means that the WHO becomes more centrally involved in how states deal with public health issues. The member state retains its ability to dismiss the advice offered by the WHO, but there can be significant costs for doing so, as will be discussed below in the context of the SARS crisis. The end result is a multi-layered governance regime, which operates both horizontally and vertically, and in which a number of state and non-state actors participate with the WHO and other supra-international organizations. The results of these interactions are then felt at both domestic and global levels.

To illustrate the transition from IHG to GHG, we have selected three twenty-first century cases: the SARS crisis of 2003; the Framework Convention on Tobacco Control (FCTC) of 2003; and the Global Strategy of Diet, Physical Activity and Health (GS) of 2004. These cases shed light on the much more prominent place of non-state actors in public health governance, as well as on the enhanced role of the WHO. More generally, they are indicative of some emergent forms of networked governance at the global level, as well as on the two-way relationship between network governance at the domestic and global levels.

The SARS case was selected because it represents a prominent infectious disease event on a global level, arguably more intense than the more recent H1N1 pandemic, although the latter caused a greater number of fatalities. The FCTC, and more particularly the process leading up to it, is significant for our purposes because it represents the first (and only) public health treaty, and is therefore a so-far unique mechanism to advance public health. The GS is an example of a major initiative to deal with risk factors related to non-infectious (chronic) diseases. In different ways, each was a "game-changer" in global public health governance.

Severe Acute Respiratory Syndrome (SARS)

The SARS story has been told many times, so there is no need to repeat it here. (see for example, Fidler, 2004a and, in Canada, *Campbell Report*, 2005) From a governance perspective, the SARS crisis is particularly significant because it reflected a fundamental turn in the role of non-state actors in

the fight against infectious diseases. (Fidler, 2004b: 801) Two key elements framed the SARS crisis. First, SARS was a global disease, eventually affecting over 25 countries, and reaching every continent except South America and Antarctica. It quickly jumped over national boundaries, greatly assisted by global airline travel. The second factor was that SARS was from the outset a frightening new disease. It was an atypical virus that the medical community had not been seen previously, and did not understand or know how to prevent, treat, or contain. (Interview # 1, July 7, 2010; Interview # 2, October 26, 2010) There was, therefore, a high level of urgency to crack its code before it spread further and put the lives of many more people at risk. According to Fidler, SARS "posed a public health governance challenge the likes of which modern public health had not previously confronted." (Fiddler, 2004a: 6) Although in the end, the number of mortalities associated with SARS was not high, relatively speaking, this could not have been known at the beginning. In the moment, the focus was on the damage that the virus potentially could inflict.

To this was compounded the fact that in the decades preceding the SARS crisis, public health infrastructure in Canada, as in the United States and in many other countries, had been allowed to weaken. In the U.S., the influential Institute of Medicine published a report on the subject whose title, *The Disarray of Public Health,* told the story. (Tilson and Berkowitz, 2006: 900) The state of affairs in Canada was no better. (McMillan and Nagpal, 2007; Lozon and Alikhan, 2007; Mowat and Butler-Jones, 2007) In Ontario, both the *Campbell Report* and the *Walker Report* on the SARS crisis documented in graphic detail the sad state of the public health system in that province. Campbell refers to "a broken system," and identifies, among a long list of serious problems, a lack of provincial public health leadership; a lack of laboratory capacity; poor links between the province and hospitals, physicians and nurses; a confused legal framework, and the lack of a provincial epidemiological expertise. (*Campbell Report*, 2004). For Canada, at least, as well as for many other countries which were affected by it, the SARS crisis served as an unfortunate (in the short-term) but effective "wake-up call." (McMillan and Nagpal, 2007: 63; Lozon and Alikhan, 2007: 53)

How the SARS crisis was handled also had significant reverberations from global health governance perspective. Seen in this way, SARS' greatest impact was admitting non-state actors as direct participants in the surveillance aspect. The foundation for this had been laid some years previous, in 1997. In that year, the World Health Organization agreed to accept infectious disease surveillance reports from non-state sources, and in particular from the Global Alert Outbreak and Response Network (GOARN). The World Health Assembly, the governing body for the WHO, confirmed this approach in 2001, and re-affirmed it again in 2003, in the midst of the SARS crisis.

GOARN is a network of over 120 state and non-state actors, established for the purpose of conducting surveillance on infectious disease threats. Participating organizations include research institutions from member states, networks of laboratories, international humanitarian NGOs, Red Cross and Red Crescent societies and others. The acceptance of data from non-state actors was a major step for the WHO, which, consistent with the Westphalian model, previously accepted data only from member states. (Fidler, 2004a: 133; Interview # 1, July 7, 2010) During the SARS events, 152 experts from institutions in 17 countries were providing real-time information on the progression of the virus. (David Heymann in Foreword, Fidler, 2004a: xiii)

The main impetus for the use of GOARN, and consequently of non-state data, during the SARS events was the situation in China. The WHO had strong reason to believe that the Chinese government was

not reporting accurately the number of active cases of SARS in that country. Combined with the fact that China was the country most affected by SARS, this risked jeopardizing attempts to better understand the virus and to control it. According to David Heymann, former Executive Director of Communicable Diseases at the WHO, GOARN proved to be "a catalyst for the successful containment of SARS." (Foreword, Fidler, 2004a: xiv) From a longer-term perspective, the WHO's decision to use surveillance data from non-states, thereby breaking the stranglehold of member states on the control of surveillance data, set a huge precedent and constituted a major step in the progression from IHG to GHG.

The second aspect of the SARS crisis that suggested an important change in the governance regime was the use of use of travel advisories by the WHO. This came about in steps. On March 12, the WHO issued a global alert to raise awareness about cases of unusual respiratory illnesses. (Fidler, 2004a: 78) This was followed up on March 15 with the issuance of an emergency travel advisory, which reflected an increased concern about a strange new illness, but made no recommendations about restricting travel to any particular locations. It did, however, begin daily postings on the number of reported cases around the world. On April 3, as concern about the disease grew, the WHO issued a travel advisory recommending against non-essential travel to Hong Kong and the Guangdong province of China, because of an infectious disease threat. Never before in its history had the WHO advised against travel to specific geographic regions. (Fidler, 2004a: 90)

The April 3 travel advisory was followed by a travel advisory on April 23, extending the recommendations against non-essential travel to Beijing and Shanxi province in China, and Toronto, in Canada. What is particularly note-worthy is that this action was done outside the formal role and mandate of the WHO. Furthermore, the WHO took these steps without the approval of the WHA, which only approved the actions of the WHO after the fact. (Interview #2, October 26, 2010; Fidler, 2004a: 142) What it meant was that the WHO was taking it upon itself to appeal directly to populations around the world. Member states were neither consulted nor even advised before the travel advisories were issued. In some cases, this led to significant tensions between the WHO and particular countries that were included in the travel advisories. Canada, for one, was quite incensed and publicly objected to being targeted. Ontario, the jurisdiction most affected in Canada by SARS, was particularly vociferous in its objections and the Minister of Health at the time travelled to Geneva to express his concerns in person. These actions may have had an effect in leading the WHO to lift its travel advisories against Canada six days later. Interestingly, those countries which were targeted in WHO's travel advisories, such as Canada and China, questioned the data on which the WHO had based its advisories, but did not question the authority or mandate of the WHO in making them. (Interview #2, October 26, 2010; Fidler, 2004a: 142-3) The lack of objection from these countries essentially legitimized the WHO's actions. The act of effectively by-passing member states and speaking directly to populations around the world reflected a new role that the WHO had defined for itself. Many of these new powers, including the ability to use data from non-state sources, were subsequently codified in the revised International Health Regulations that were approved in 2005 and became binding in international law in 2007. (Wilson *et al.*, 2008: 44-5)

In the end, the non-state organizations which became directly involved in the SARS events for the purpose of providing epidemiological data were not many, and were quite specialized. Since SARS turned out to be mostly a hospital-based virus, and did not reach the broader community to a significant extent, there was no need for a broader segment of civil society to become involved.

Nonetheless, these events constituted an important precedent and signalled a bold new direction for the WHO, with implications for member states and for newly-empowered non-state actors. As Fidler says, "SARS outbreak confirms a transition from old to new forms of public health governance…" (2004a: 7)

In terms of the impact these global developments have had national governments, two points can be made. First, seeing the WHO accept data from non-state sources within China seemed to motivate the Chinese government to reverse itself and begin to report accurately the progression of the virus within China. (Fidler, 2004a: 117) It seems reasonable to conclude that the threat of being circumvented by other actors pressured the Chinese government into becoming more transparent and playing a more collaborative role on the world stage. Second, the threat of the imposition of travel advisories, and the negative consequences these can have on a country's economy, provides a strong incentive for member states to work closely with the WHO to contain infectious disease that have the potential to spread globally. Rather than seeing these diseases as "national" or local problems, states are now more likely to see them in a global context and to find strategies to contain them that involve the WHO and others that form part of the global community. The fact that the revised International Health Regulations have now codified a stronger role for the WHO suggests these developments will continue in the future.

Framework Convention on Tobacco Control (FCTC)

The FCTC represents the first, and so far the only, treaty in the area of public health. Interestingly, the treaty was adopted by the World Health Assembly in May, 2003, at about the time that the SARS crisis was at its peak. The FCTC was notable for the extent to which it allowed, and in fact, encouraged, non-state actors to participate in the process. However, it led to quite a polarized debate, with most states and INGOs on one side, and large tobacco companies and tobacco producers, on the other. Because of the broad base of stake-holders involved in the process, the WHO was challenged to construct the appropriate platforms to accommodate the participation of all those who had an interest in the issue. Its success in doing so could well prove to be a turning point for the organization. (Taylor, 2002) The FCTC also provides an interesting case of how global processes can "splash back" and trigger further policy fragmentation and disaggregation on the domestic front.

Background on the FCTC

Article 19 (2) of the WHO's constitution gives that body powers to protect and promote international public health, including the power to make treaties. (WHO, 2009: 2) However, no serious attempt to use the treaty-making powers had been attempted until the 1990s when Dr. Ruth Roemer of the United States started on a campaign to use international legal instruments to curb the use of tobacco. (WHO, 2009: 2) The process was a slow one, and followed many stages. After a number of steps were taken in 1995 and 1996 to build support for the idea, in May of 1996, the World Health Assembly gave the WHO the mandate to draft a convention. (WHO, 2009: 5) After a period a relative inactivity, the idea was seized by Dr. Gro Harlem Brundtland, then the new Director-General of the WHO, who in 1998 established the Tobacco Free Initiative (TFI) as a special cabinet project. The following year, the WHA established a working group to prepare the draft elements of the treaty. The 2000 meeting of the WHA accepted the provisional texts, and called on the Intergovernmental Negotiating Body (INB) to start the negotiations on the convention.

The negotiating process took 2.5 years. During this period, the INB met six times. In between the INB meetings, several consultation sessions were held in many of the WHO regions and sub-regions. On May 21, 2003, the WHA unanimously adopted the FCTC, eight years after the initial resolution to begin the process.

The FCTC contains both demand-side and supply-side provisions. To reduce demand, it includes provisions relating to exposure to tobacco smoke; regulation of the contents of tobacco products and tobacco product disclosures; packaging and labelling of tobacco products; limitations on tobacco advertising, promotion and sponsorship; and other measures. To reduce the supply of tobacco, provisions cover illicit trade; sales to minors; and support for economically viable alternative activities. (WHO, 2009: 28)

FCTC through a global governance lens

From a global governance perspective, what is particularly note-worthy about the FCTC is the inclusive process that was followed to lead up to it, which, like SARS, followed a distinctly post-Westphalian path. From the beginning, it was clear that participation in this process would not be restricted to member states. Dr. Ruth Roemer was a law professor who had not been part of the WHO bureaucracy. Moreover, a number of NGO stakeholders, beginning with the American Public Health Association, were quick to mobilize and saw a role for themselves in the public debate. In response, tobacco companies – the major ones of which are Philip Morris, British American Tobacco and Japan Tobacco International - also mobilized quickly with a view to either de-rail the treaty or to weaken its provisions. (Collin, 2004: 94; Mamudu *et al.*, 2008)

Underscoring the inclusive nature of this process, the WHO conducted public hearings on the Convention in 2000. This was the *first time* in WHO's history that such hearings had been held. (Collin, 2004: 93) 144 organizations testified in these hearings, including tobacco control NGOs as well as tobacco companies and tobacco producers. In addition, 500 written submissions were received. Beyond this, the WHO accelerated the process by which International NGOs could enter into "official relations." (Collin, 2004: 93) To underscore the point, one of the Guiding Principles (Article 4, no.7) of the FCTC states: "The participation of civil society is essential in achieving the objective of the Convention and its protocols." (cited in Mamudu and Glantz, 2009: 164)

Perhaps the most significant element to illustrate the post-Westphalian nature of the process is the establishment by the WHO of the Framework Convention Alliance (FCA), which Keck and Selkirk have called a "transnational advocacy network framework." (cited in Mamudu and Glantz, 2009: 151) Rather than simply advocating for the Convention, however, the FCA had a place in the actual development of the instrument, and played a major role in influencing the member state actors in the process. (Mamudu and Glantz, 2009: 151) The WHO was the catalyst for the creation of the FCA by giving a grant to Action on Smoking and Health, a U.K. based NGO, to explore how to involve civil society in the negotiations. (Mamudu and Glantz, 2009: 152) What emerged was a loose coalition of NGOs that expanded considerably in the course of the process, going from 72 in 2000 to 306 organizations from 98 countries in 2008. (Mamudu and Glantz, 2009: 153) Although the FCA did not have "official relations" status, it used its observer position to address the formal meetings, make

proposals, and comment on the proposals of others, in addition to engaging in active lobbying in the corridors. As an example of its influence, at each INB the FCA provided the delegates with side by side analyses of the draft texts, accompanied by suggested alternative wording and accompanying rationale. These came to be viewed quite positively, and came to be relied upon by many of the delegates. (Wilkenfeld, 2005: 22) So effective were these that they caused the states opposing the Convention, principally the U.S., to complain to the WHO about the influence the FCA was having. (Mamudu and Glantz, 2009: 156.) Another powerful tactic was the use of the *Alliance Bulletin*, an internet-based communications product that came out on a daily basis, and which proved to be quite influencial in framing the debate around the Convention. (Mamudu and Glanz, 2009: 154) Although the FCA was effectively excluded from the final INB, it continued to participate indirectly by maintaining its relationships with sympathetic delegations, and continuing to provide them with draft texts and rationales. (Wilkenfeld, 2005: 30)

The FCTC process, then, was quite a radical departure from the state-centric approach of the Westphalian model. In the end, the process became closed, and only member states had a vote on approval and ratification. However, the processes leading up to those decision points included hundreds of stake-holders who were directly and substantively involved in developing the Convention. Moreover, because tobacco control issues, like public health issues generally, touch on many other sectors, the FCTC process broadened the constituency of organizations typically involved in health issues to include actors from other areas, such as economics, law, trade, education, and environment. (Collin *et al.,* 2004: 261).

A second point to be stressed is the impact of the Convention on the domestic scene in many countries. Tobacco consumption, as a global issue, needs a global response, which is what the Convention seeks to provide. (Collin *et al.,*2004: 267) At the same time, however, the FCTC process added another layer of complexity within many of the countries that were involved in that it helped to mobilize a number of NGOs - examples in Canada include the Physicians for a Smoke-Free Canada, and the Heart and Stroke Foundation of Canada - to become involved in the issue at the domestic level, and to attempt to influence the positions taken by their respective national governments at the global level. (Interview # 3, June 24, 2010) The result was that a global issue became a domestic one. (Mamudu and Glantz, 2009: 154)

Again, the FCA was a significant contributing factor in this. An important part of the FCA tactics in countering the positions of those states who were opposing the Convention was to inform the public of their government's positions, using their member organizations as conduits, and to help local organizations lobby those governments to support the convention. (Mamudu and Glantz, 2009: 161) In the U.S., for example, NGOs such as the American Lung Association, the American Cancer Society, the American Lung Association, and the Campaign for Tobacco-Free Kids, among many others, all took a strong interest in the Convention, and exerted pressure on the U.S. Government to change its anti-Convention position or, if it was unwilling to do so, at least to withdraw from the FCTC negotiations so as not to impede the development of the Convention. (Wilkenfeld, 2005: 31) The U.S. government then found itself between deeply opposing interests, with large tobacco companies on one side and a broad constituency of NGOs on the other. The U.S. eventually voted in favour of approving the Convention when it saw that its position of resistance had almost no support from other countries. To date, however, it has yet to ratify the Convention. The Japanese government was in a similar position, with the Japanese Medical Association and other NGOs strongly pressing the

government to reverse its opposition to the Convention, and the Japanese Tobacco Inc., and its supporters pressing in the opposite direction. (Mamudu and Glanz, 2009: 161) (This is a particularly tangled situation, as the Japanese Finance Ministry owned about half the firm.) Of course, the implementation phase of the FCTC also impacted the relations at the domestic level as governments around the world have had to introduce or modify tobacco control measures and often to increase regulation. (Collin, 2004: 95)

In Canada, the domestic and global dimensions of process leading up to the Convention were closely intertwined. In this case, the Canadian Government, led by Health Canada, was a leading proponent of the FCTC from the outset. Rather than trying to play the role of "honest broker" between the NGO community and the tobacco industry, the government took an active role in building a constituency of support for the initiative. One government informant recounted how, using Canadian NGOs as intermediaries, the Canadian government directed financial support to NGOs in strategically placed countries as a way of encouraging the support of these NGO communities. This informant also indicated that Health Canada worked closely with Canadian NGOs to gain intelligence from their networks about the positions and strategies of international NGOs on the various issues under negotiation. (Interview # 4, October 7, 2010; see also Lencucha *et al.*, 2010: 83)

As a global leader in the fight against tobacco consumption, Canada did not experience sharp new divisions as a result of the FCTC. In a large measure, the provisions contained in the Convention reflected steps that had already been taken in Canada as a result of 3 or 4 decades of tobacco cessation activities. (Interview #4, October 7, 2010) The large multi-national cigarette companies preferred to target countries, often developing countries, they believed would be more sympathetic to their interests or could be influenced to be so. (Mamudu *et al., 2008:* 1696) Still, opposition to the Convention did manifest itself in Canada. The tobacco industry was invited to consultations on the issue held by Health Canada, and used the occasions to advocate alternative approaches. Representatives of the tobacco growers also played a fairly active role. (Interview #4, October, 7, 2010) Finally, the large tobacco companies sought to influence public opinion, including in Canada, by supporting individuals or groups willing to critique *Curbing the Epidemic: Governments and the Economics of Tobacco Control (CTE),* the World Bank's pivotal study on the economics of tobacco control. One such individual was Pierre Lemieux of the Economics and Liberty Research Group at the Université du Quebec who, according to Mamadu *et al.,* was commissioned by the Philip Morris company to write articles for publication in the context of a coordinated campaign against the CTE. (2008: 1695)

What can be taken from the FCTC experience is that global processes can lead to further policy fragmentation at the domestic level, thus reinforcing the need to find appropriate mechanisms to deal with these challenges both domestically and globally. "Wicked problems" at the national level are not resolved by transferring them to the global level. In fact, issues dealt with globally can often make domestic problems that much more wicked.

Global Strategy for Diet, Physical Activity and Health (GS)

The third case revealing a recent shift from IHG to GHG is the Global Strategy for Diet, Physical Activity and Health. The GS, which was approved by the World Health Assembly in May, 2004, was initiated as a result of concern about the increase in the incidence of non-communicable disease, or chronic diseases, particularly in low-income countries. A resolution on the issue was first passed in

2000. The 2002 World Health Report reinforced concern around the issue by revealing common risk factors of many chronic diseases, such as cancer, cardio-vascular disease, diabetes, and many others. The common risk factors identified – unhealthy eating, physical inactivity, and tobacco use – showed that many of these diseases were preventable. (Norum, 2005: 83) In that year, it was decided to develop a global strategy to lower the incidence of chronic disease and to submit this to the World Health Assembly meeting in 2004. At its core, therefore, the GS was a chronic disease prevention strategy.

The GS process

The GS did not attract the same level of attention, in Canada or abroad, as the FCTC. Comparing the dimensions of the two, one key informant referred to the FCTC as the "pumpkin", whereas the GS was the "orange." (Interview # 4, October 7, 2010) Unlike the FCTC, it was not a treaty or formal convention, and therefore it had no status in international law. Consequently, there were no enforcement mechanisms; it was meant to persuade, not compel, the actions of member states. Nevertheless, the process leading to the GS resembles in many respects that for the FCTC. In both cases, there was a battle between public health advocates and the corporate sector, albeit at different levels of intensity. As with the FCTC, the debate around the GS was not confined to the international sector with a supra-international agency, in this case, the WHO, attempting to find a consensus. In fact, it was played out on a much broader canvas. The WHO document detailing the process followed for the GS reveals a commitment to a broad level of stakeholder involvement from the outset. In this vein, there were four tracts to the consultation phase: consultations with member states, which were carried out by the six WHO regions; consultations with UN agencies, including the Food and Agriculture Organization (FAO), the World Bank, the World Trade Organization and many others; consultations with civil society organizations, including not-for-profit organizations and professional organizations in the area of health, physical activity, and nutrition; and consultations with the private sector, including the food, non-alcoholic beverage, sport, and advertising industries.

In reality, the process was far from being a level playing field. The food industry, particularly the sugar industry and the manufacturers of confectionary goods, organized strong lobbies to pressure supra-international organizations such as the WHO, the WTO, and the FAO, as well as the governments of many states where these industries had a strong presence, in particular the United States. On the other hand, NGOs concerned about public health had a much more difficult time being heard. One observer, frustrated with the influence the corporate sector was able to exert, complained that the INGOs were being treated, "not so much as partners as peons." (Cannon, 2004: 377)

Nevertheless, what is significant for our purposes, is the WHO's recognition that in order for the GS to be effective and legitimate, it (the WHO) needed to reach beyond member states. Writing on behalf of the WHO, Amalia Waxman says that : "One of the strategy's most important conclusions is that reducing the burden of NCDs requires a multi-sectoral, multi-stakeholder approach." (Waxman, 2005: 164.) While the responsibility for implementation of the GS rests primarily with states (Tukuitonga and Keller, 2005: 122), Waxman argues that this is not sufficient "in an increasingly globalized and interdependent world," and that the GS's goals "can only be met through decisive and coherent action by countries, sustained political commitment, and broader, multi-level involvement with all relevant stakeholders worldwide." (Waxman, 2005: 166)

The WHO's advocacy role in the GS

Another note-worthy aspect is the role the WHO gave itself in the GS process. The organization saw itself as far more than a facilitator, mediator, or catalyst for member states. Rather it positioned itself as an advocate in the quest for improved public health and a leader in the process of achieving better health outcomes. In this context, the WHO process document deserves to be quoted at length:

> Countries and their peoples must be alerted to the health problems caused by unhealthy diets and physical inactivity, of the devastating social and economic outcomes of chronic conditions resulting from these risk factors and to the proven prevention interventions. The involvement of different stakeholders will allow an opportunity to ensure that this information is adequately provided to decision-makers, the public, and above all, the participants of the process. Communication of this information, therefore, will be an essential facet in the process leading to a strategy document. *WHO will address this need to inform, convince and mobilize stakeholders continuously in the course of the development of the Strategy.*" (WHO, 2003: 2 – emphasis added)

This role as an advocate for public health, therefore, compels the WHO to reach beyond the member states to engage a broader public so that the needed reforms can be achieved and successfully implemented. The WHO's self-defined role to "convince and mobilize stakeholders" is clearly far beyond a Westphalian conception of international relations.

The debate over the GS also had reverberations at the national state level. As mentioned earlier, there is clear evidence of a strong lobbying campaign by parts of the corporate sector on member states. The argument advanced was that governments should not be intruding on the personal life-style choices of their citizens. Fears were also raised about the damage that could be caused to the economies particularly of sugar producing countries. In the U.S., the Sugar Association and the confectionery industry wrote to U.S. Secretary of Health, Tommy Thompson, to demand that the U.S. withdraw its financial support to the WHO if that organization persisted with the GS. (Norum, 2005: 85) Similar letters were sent by the Corn Refiners' Association, International Dairy Foods Association, National Corn Growers' Association, Snack Food Association, Sugar Association, Wheat Foods Council and US Council of International Business. In the end, the office of the U.S. Secretary of Health wrote to the WHO to seek to stall the development of the GS. (Norum, 2005: 85)

Industry organizations were also active among the G77, a loose coalition of low and middle income countries, essentially advancing the argument that the GS would damage the economic development of many of those countries. (Norum, 2005: 85) That arguments made by these organizations were taken by the G77 countries to the WHO Executive Board at their meeting in January, 2004, and to the FAO Committee of Agriculture meeting in February of that year, is evidence of the influence they exerted on these countries.

While these actions were taking place, the public health organizations in the U.S were working hard in support of making the GS as strong as possible. The American Cancer Society, for example, wrote to Dr. Lee Jong-Wook, Director General of the WHO, to express their support for the Strategy. Furthermore, a group of U.S. Senators wrote to Tommy Thompson to express their support for the GS and the principles it reflected. (Margetts, 2004: 362)

As mentioned, the debate in Canada around the GS was not as divisive as was the case in the U.S. The stakes were clearly not as high as was the case with the FCTC. Partially for that reason, and because their resources were limited, major public health NGOs, such as the Canadian Cancer Society and the Heart and Stroke Foundation, focussed most of their energies on the FCTC. (Interview # 5, September 8, 2010) Some professional associations, such as the Dieticians of Canada, took a more active interest in the GS, as well as the Canadian chapter of the Centre for Science in the Public Interest (Interview #6, September, 22, 2010). On the other side, industry representatives, such as the Canadian Sugar Institute and the Salt Institute, pressed their cases in the opposite direction and sought meetings with federal ministers with a view to either stopping the provisions of the GS or at least weakening its wording. (Interview #6, September 22, 2010)

Conclusion – Where to from here?

What conclusions can we draw from these three case studies? From the global governance perspective, it is clear that the number and the range of participants that are involved in global processes have increased dramatically. In each of the cases reviewed, we saw that processes related to public health at the global level are no longer restricted to nation states, with supra-international institutions such as the WHO playing a coordinating role. In the cases of the GS and the FCTC, direct and strategic involvement from NGOs and the corporate sector was clearly in evidence. This was somewhat less the case with the SARS crisis, because it was not an issue which lent itself to broad societal involvement. Even here, however, the involvement of non-state parties in the collection of vital surveillance data constituted a fundamental break from the past. What's more, in its use of travel advisories, the WHO spoke over the heads of member states to speak directly to the travelling public, thus signalling a new role for itself.

In both the FCTC and GS cases, the WHO dealt directly and intensively with INGOs and BINGOs. The involvement of these parties went beyond simple consultation. Rather, they were substantively involved in the development of the instruments in question. Overall, these cases saw the emergence of governance mechanisms and processes that are more suited to a broader and more diverse community of participants, in other words, that reflect the transition to more collaborative forms of governance. This tends to confirm Anne-Marie Slaughter's observation that "public and private actors are coming together to develop new ways of decision-making under conditions of complexity." (2004: 194)

Unfortunately, there does not appear to be a pre-established road-map to follow. From all appearances, the new processes and mechanisms are *ad hoc* constructions, suited to the exigencies of the particular case in question. In many ways, public health practitioners are having to re-invent the rules of the game while it is in play. Networks are being formed, but there is not yet a consistent pattern of network-building; rather, these develop differently according to different circumstances and conditions (Reinicke and Deng, 2000: 4-5) In the same 2006 speech cited earlier, Kofi Annan pointed said: "The United Nations involvement with […] networks has been extensive. We must now move forward, from largely unplanned interaction towards a more systematic approach – while maintaining the flexibility that is one of civil society's greatest assets."

The challenge Annan presents is not a trivial one. Global networks are not a panacea. As many observers have noted, networks come with a significant level of risk. (see, for example, Huxham and

Vangen, 2005; Koppenjan and Klijn, 2004; Goldsmith and Eggers, 2004) Risks that pertain more directly to the global context include: large numbers of participants raising questions about manageability and transaction costs; the possibility of creating or accentuating existing unequal access and power, particularly affecting low income countries; encouraging "lowest common denominator" solutions as a function of the need for compromise; and polarized views that cannot be reconciled, leading to paralysis. (Benner *et al.,*2003: 21) Several authors have pointed to the need for new skill-sets and mechanisms for global networks to succeed. (Kickbusch, 2004: 230; Benner *et al.,* 2003; Slaughter, 2004) Since the "hard power" of international legal instruments has now has been at least partially displaced by "soft power" of guidelines, best practices, and principles, which are more typical of policy networks (Slaughter, 2004: 178), participants need to become more skilled at "leading from behind," (Reinicke, 1999-2000: 54), that is of influencing rather than commanding.

On the other hand, global networks provide an enormous opportunity to bridge policy differences and to achieve outcomes that reflect the interests and concerns of a broader cross-section of stake-holders. Used well, they can harness "the positive power of conflict." (Slaughter, 2004: 195) Reinicke and Deng speak to the potential of global policy networks in saying that "using them [global networks] wisely will no doubt improve our ability to cope with the difficult challenges posed by rapid global liberalization, technological change, and the complexity these trends have brought to our lives." (2000: 5) Networks are well positioned through the "strength of weak ties" – to apply Granovetter's concept to the global environment – "to take maximum advantage of the tensions and differences among disparate groups."(Reinicke, 1999-2000: 55) Ultimately, global networks are a part of the new reality that has transformed the global scene in public health, as well as in many other policy sectors. After SARS, the FCTC, and the GS, there is no going back to the ways of Westphalian public health. (Witte *et al.,* 2003: 185; Weiss, 2005: 81) What remains to be determined is how the new game will be played.

These global trends inevitably impact public health within Canada. Exactly how they do so leads to our second broad observation, which is that the changes taking place at the global level contribute to policy fragmentation within Canada, thereby adding a further level of complexity to how public health issues are managed domestically. What the examples above suggest is that the domestic environment has been altered as a result of the general pattern in the direction of global health governance. National governments must now contend with a broader number of players, in particular from civil society, who have the sophistication, knowledge, and the opportunity to participate in global processes and to bring these battles back to the domestic stage. An organization which becomes involved in a global process will often see itself as a "player" on the domestic scene as well and will tend to intervene with the domestic government with a greater level of confidence and legitimacy. (Interview # 5, September 8, 2010) What is more, a national government dismisses these players at its own risk. Both the FCTC and the GS provide examples of NGOs, in this case mostly the U.S., strategizing with foreign governments and international NGOs against the positions taken by their own governments, because they could not get what they considered a sympathetic hearing from that government. (Collin, 2004; Cannon, 2004; Norum, 2005; Wilkenfeld, 2005) Even when the relationships are more positive, such as that between Health Canada and the NGOs it funded to allow them to participate in the FCTC process, there were occasions when the NGOs publicly criticized the government and took positions that the Department considered extreme and unhelpful. (Lencucha *et al.,*2010: 79; Interview #4, October 7, 2010)

Globalization, then, can trigger a range of responses at domestic level. Domestic organizations can counter indifference or opposition from their respective national governments by operating at the global level to achieve their objectives, (Rosenau, 1995: 63) just as states can receive sharply differing reactions from domestic stake-holders as a result of positions they take on the global stage. The end result, for Canada as well as other member states of the WHO, is that there are more players involved in the process whose interests have to be reconciled, thus making it increasingly challenging and complex to achieve some reasonable level of national consensus about policy directions.

One can legitimately raise the question about whether it is the disaggregation at the domestic level that leads to disaggregation at the global level, or if the reverse is true. It would probably be very difficult to establish as a general rule which way the arrow points; most likely, this would depend on the specific circumstances in each case. At the very least, it can be said that the two are mutually re-inforcing. The more general point is that these changing circumstances present real changes from a governance perspective that call for new governance mechanisms, both globally and domestically.

Whether looked at through the global lens or from the domestic perspective, a key question is how to deal with these trends in a way which offers the most positive outcomes from the perspective of democracy, equity, fairness, transparency and effectiveness. What some authors have called the current state of “laissez-faire” (Witte *et al.,* 14) needs to be improved. More rigorous and appropriate accountability measures and useful evaluations need to be developed and applied. Weiss is quite right in suggesting that we need to think about ways “to pool the collective strengths and avoid the collective weaknesses of governments, intergovernmental organizations, NGOs and global civil society.” (Weiss, 2005: 83) The question remains, how to do this most effectively?

Where this leads in the end is not known or perhaps even knowable at this stage. Certainly there will be many concrete achievements as well as false starts. As Rosenau suggests: “All one can conclude with confidence is that in the twenty-first century the paths to governance will lead in many directions, some that will emerge into sunlit clearings and others that will descend into dense jungles.” (Rosenau, 1995: 64) Research, particularly involving case studies, and policy learnings gained through direct involvement in governance, will hopefully lead practitioners to more “sunlit clearings” than “dense jungles.”

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