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Legitimacy and Global Governance in Managing Global Public Health

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Abstract

This dissertation is concerned with health governance on the global level, where over the past fifteen years a number of new organisations have emerged that address major global public health issues. Three examples are the Global Fund to Fight AIDS, Tuberculosis and Malaria, (GFATM), the Global Alliance for Vaccines and Immunisation (GAVI Alliance), and Joint United Nations Programme on HIV/AIDS (UNAIDS), each of which are examined in depth in the dissertation.

These organisations differ significantly from intergovernmental organisations such as the WHO and can be classified as organisations of ‘global governance’. Two basic observations provide the motivation for study. First, the work of each of these organisations can be said to be based on principles that shift away from intergovernmentalism, towards managerialism and cosmopolitanism. Second, despite this break with the conventional model of intergovernmentalism, these organisations are increasing their operational scope in terms of determining rules for action, and gaining funding. The dissertation proceeds to address the question of how GHG Organisations – having moved away from the conventional model of global level governance of intergovernmentalism – come to be accepted as legitimate governing organisations.

Following a historical tracing of the evolution of governance in the area of global health, the dissertation proceeds to provide a basis for examinations into the legitimacy of GHG organisations via a systematic description of what legitimacy entails, the formulation of a conceptualisation of the legitimacy suitable for the global level, and the development of methods suitable for empirically examining the legitimacy of GHG organisations. The second part of the dissertation contains an examination of three GHG organisations and how they have come to experience differing levels of legitimacy amongst stakeholders.

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Abbreviations

ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome
AMC	Advanced Market Commitment
ARV	Antiretroviral (medication)
CCM	Country Coordinating Mechanism
CBO	Community Based Organisation
CIDA	Canadian International Development Agency
CSO	Civil Society Organisation
CVI	Children's Vaccine Initiative
DAC	Development Assistance Committee
DFID	United Kingdom Department for International Development
DOTS	Directly Observed Treatment, Short Course
DTP3	Triple vaccine for diphtheria, and tetanus and pertussis (whooping cough)
ECOSOC	Economic and Social Council of the United Nations
EPI	Expanded Programme on Immunisation
FBO	Faith Based Organisation
FCTC	Framework Convention for Tobacco Control
FHI	Family Health International
G8	Group of Eight (Governments)
GAVI	Global Alliance for Vaccines and Immunisation
GBC	Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHC	Global Health Council
GHG	Global Health Governance
GHP	Global Health Partnership
GNP+	Global Network of People Living with HIV/AIDS
GPA	Global Programme on AIDS
GTT	Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors
GTZ	Organisation for German Technical Cooperation
HAI	Health Action International
Hib	Haemophilus influenzae type b
HIV	Human Immunodeficiency Virus
ICC	Inter-agency Coordinating Committee
ICN	International Council of Nurses
ICW	International Community of Women Living with HIV/AIDS
ILO	International Labour Organization
IFFIm	International Finance Facility for Immunisation
IHAA	International HIV/AIDS Alliance
ISS	Immunisation Services Support
ITN	Insecticide Treated Bednet
IWHC	International Women's Health Coalition
IPPF	International Planned Parenthood Federation

IGO	Intergovernmental Organisation
IUHPE	International Union for Health Promotion and Education
LDC	Least Developed Country
LNHO	League of Nations Health Organisation
M & E	Monitoring and Evaluation
MAP	Multi-country HIV/AIDS Program (World Bank)
MDG	Millennium Development Goal
MINBUZA	Dutch Foreign Ministry
MMV	Medicines for Malaria Venture
MOH	Ministry of Health
MVI	Malaria Vaccines Initiative
NACA	National AIDS Coordinating Authority
NGO	Nongovernmental Organisation
ODA	Overseas Development Assistance
OECD	Organisation for Economic Co-operation and Development
OIHP	Office International d'Hygiène Publique
PAHO	Pan-American Health Organization
PATH	Program for Appropriate Technology in Health
PCB	Programme Coordinating Board of UNAIDS
PEPFAR	United States President's Emergency Plan For AIDS Relief
PF	Partnership Forum of GFATM
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
PPP	Public-private Partnership
PVO	Private Voluntary Organisation
RBM	Roll Back Malaria
STI	Sexually Transmitted Infection
TASO	The AIDS Service Organisation
TB	Tuberculosis
TB Alliance	Global Alliance for Tuberculosis Drug Development
TNC	Transnational Corporation
TRP	Technical Review Panel
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Fund for Children
UNOCD	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WFPHA	World Federation of Public Health Associations
WHO	World Health Organisation
WPF	United Nations World Food Programme
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan

Introduction

Global level approaches to health challenges

One of the most pressing global challenges of the early 21st century is the inequality between health standards in the world's wealthiest countries compared with the world's poorest countries. Life expectancy at birth in the world's most economically advanced states stands at around or above 80 years, while in others, most notably in some of the least developed countries,[1] life expectancy at birth is below 40 years. Furthermore, many of the diseases that contribute to low life expectancy amongst the world's most vulnerable are, to a large extent, rare or absent in wealthy countries. This is because many of the diseases that are most debilitating in the developing world are either preventable or treatable, or can be controlled when there is adequate access to health products and services and good living conditions. They include many preventable and treatable childhood diseases such as whooping cough, tetanus, diphtheria, acute infectious diarrhoea and hepatitis, as well

[1] Least Developed Countries, or LDCs, are categorised by the United Nations as countries exhibiting very low levels of socioeconomic development. There is a special office of the United Nations for a High Representative for the Least Developed Countries assigned to addressing issues specifically relating to their development. In 2008, 50 countries were listed by the UN as LDCs, of which 33 were located in Africa (UN High Representative for LDCs, 2008).

as malaria and tuberculosis. Exacerbated by phenomena associated with globalisation, including the increased movement of people and goods, urbanisation, as well as the global HIV/AIDS pandemic, overcoming these infectious diseases has become a vital and urgent concern requiring action on all levels.

Addressing the enormous challenge of global health is a highly complex project that no one individual, community, group, state or organisation can address alone. A combined effort on many levels is required, from grass-roots community-based health promotion to medical research in highly equipped laboratories to state-run health care systems. To a large extent, however, addressing global health is not only about (new) products, services and education; it also requires cooperation and coordination between different actors, active on different levels in a broad range of sectors. In other words, confronting the challenge of global health is a political undertaking and global health needs to be governed. This means that strategies (and policies) on how to ensure global, equitable access to goods, services and enabling living conditions need to be developed; common principles on which positive outcomes can be ensured need to be formulated; and the rights, roles and responsibilities of various individuals, groups, organisations and states need to be agreed upon and accepted. Each of these steps make up part of the process of governance, defined as "…identifying high potential approaches for solving problems in society; converting these approaches into specific rules for action, overseeing compliance with these rules for action and when appropriate adjusting them to changing environments and conditions" (Rittberger, 2003, pp. 181-182).[2]

Health governance takes place on many levels, in any situation where an overarching individual or group prioritises certain principles, develops health strategies, lays out concrete measures and assigns duties (rules of behaviour) to various individuals or organisations. For example, a community-based health programme that distributes educational material among at-risk groups engages in health governance by developing a strategy about how to go about their work, giving priority to basic principles that underlie health education and assigning rules (in the form of expected behaviour or duties) to various actors, whether they be fund providers, field workers or administrators. At the state level, a Ministry of Health engages in governance when it develops strategies for ensuring the good health of citizens, bases them on

[2] Author's translation. Original in German.

certain principles relating to the consequences of certain health policies and assigns rules (designates duties) to employees, citizens and others to carry out policies.

Along with health governance on community and state levels, health is also governed on the global level. While local and state health governance directly connects with the health of individuals, governance on the global level develops strategies and coordinates action between a large array of actors with a global scope. Following its establishment after the conclusion of World War Two, the World Health Organisation (WHO) became the central organisation engaging in health governance on the global level. Its governance tasks include strategy development, the promotion of good principles for health promotion and care, and the mobilisation of individuals, groups, associations and states to take on certain roles and duties.[3] However there are many more organisations which take on governance roles in health at the global level, including donor states with special global health programmes,[4] UN Specialised Agencies such as UNICEF and the World Bank, consortia of several UN organisations such as the Joint United Nations Programme on HIV/AIDS, and more recently public-private partnerships such as the GAVI Alliance[5] or the Global Fund to Fight AIDS, Tuberculosis and Malaria. All of these organisations engage in health governance on the global level by developing strategies, by basing their work on pertinent principles of how health inequalities can best be addressed, and by creating rules for behaviour, in terms of voicing expectations of, and assigning duties to, various actors on various levels.

This book is concerned with the current status of health governance at the global, rather than community or state levels, although the importance of local, state and regional health governance is recognised. Currently, global health governance (GHG) is experiencing a phase of considerable change spurred on by three key phenomena. First, there is increasing attention being given to health issues in developed as well as developing countries due to the dramatic and disturbing worldwide HIV/AIDS epidemic. Second, there has been a considerable increase in funding for health projects coming out of industrialised countries in recent years.[6]

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[3]There has always been limitations on the dominance of the WHO in determining global health policy and other actors have historically also played a role. See Chapter Two in this dissertation.

[4] For example, the United States President's Emergency Plan for AIDS Relief (PEPFAR), which is a specific programme for addressing HIV/AIDS established and run by the United States government.

[5] Originally, known as the Global Alliance for Vaccines and Immunization, the organisation is now referred to by means of the abbreviated form GAVI Alliance.

[6] Following increasing political attention given to global health at G8 and UN General Assembly meetings, the level of financial aid available specifically for health has increased significantly (Garrett, 2007).

Third, increasingly sophisticated communications and transport technology motivates and allows a wide array of actors, including civil society organisations (CSOs)[7] and business sector actors (both within and outside of the health product and service industries) to voice concern over, and an interest in, the challenge of global health.

These three developments make health governance on the global level particularly dynamic. A wide rage of interested actors (or stakeholders) have recognised health as an urgent matter and there is an inevitable level of contestation amongst these actors as to what type of global health governance organisation is most appropriate for taking on the global challenge of increasing levels of health. Overseeing the collection and dispersion of health resources, finding common ground on health policies, and implementing health projects in the field are difficult tasks. The many individuals and organisations involved in funding, research, product development, education, service delivery and general support for health projects may have differing opinions on what global organisation(s) they consider most appropriate to carry out these tasks.

Some organisations that engage in health governance on the global level as state-based, such as the WHO, some are sponsored by one, or just a few states, such as the G8 or PEPFAR, while others are private, involving either members of civil society or actors from the for-profit business sector.[8] Increasingly, global health governance organisations involve both public and private actors governing together.

It is this last type of organisation – where public and private actors govern together – that has become particularly prominent in recent years. While cooperation to pool resources between public and private actors and achieve common goals is neither new nor particularly controversial, over the past 10 years the health sector has seen the foundation and firm establishment of several organisations that bring public and private actors together in formal decision-making roles. These organisations represent a new phenomenon in health

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[7] Through this dissertation reference will be made to civil society organisations, meaning non-state actors that carry out non-profit activities for the purpose of building a functioning society. Another commonly used term to describe this type of non-state organisation is 'nongovernmental organisations' often abbreviated to NGOs. In some cases this term is used to encompass all non-state actors, whether for-profit or non-profit (Mansbach, 2006, p. 223). In this dissertation the term civil society organisations, abbreviated as CSOs, is used to distinguish specifically those non-state actors that are both non-for-profit and who also promote open debate on issues relevant to civil society such as human rights and justice and do so in a peaceful manner. In quotes the terminology used in the original text has been maintained.
[8] Such as the Global Business Coalition to Fight AIDS, Tuberculosis and Malaria.

governance on the global level and their presence raises many questions about the empirical workings of global governance - and the normative-ethical dilemmas that come with it. In particular, it is the legitimacy of this type of organisation that is a topic for debate, both amongst those working in the health sector, and academic researchers.

For those working in the health sector the question of the legitimacy of public-private global health governance (GHG) organisations is pressing for several reasons. First, some actors have raised doubts as to whether these organisations have the right policy focus, as they are, by nature of their purpose, not designed to perform as broad global health policy organisations but are instead focussed on specific diseases or treatments. Second, doubt has also been expressed about the appropriateness of having private actors involved in the decision-making processes of globally influential organisations. Third, it is unclear whether these organisations truly have a firm basis to ensure their stable continuing support for many years to come, a characteristic which is necessary in light of the long term nature of the most pressing global health issues today.

For academic researchers, and in particular political scientists, the question of legitimacy revolves around philosophical enquiry into the rightfulness of the ability for such organisations to exercise power. It also encompasses a desire to understand how global governance organisations can come to enjoy being accepted as legitimate. Approaching this second question is the central goal of this book. It will be demonstrated that, to a large extent, confronting the challenge of global health is a political undertaking, and optimising such political undertaking requires a thorough understanding of how governing organisations are legitimised.

Chapter One

Legitimacy and global health governance: Trends, challenges and questions

The face of global health is changing, not only in terms of the effects that globalisation is having on the spread of diseases around the world, but also in terms of the way public health is approached, managed and governed on local, regional and global levels. This book is concerned with health governance on the global level, where the World Health Organisation (WHO) arguably remains the central coordinating body for global health. Its work is formally based on the decisions of the World Health Assembly, comprised of over 190 member states, which approves its budget and work programme. This structure by and large follows the standard model of international cooperation found within the UN system, that of intergovernmentalism. While the WHO comprises a wide network of programmes and activities, since its inception in 1948 it has remained an essentially intergovernmental organisation (IGO).

The WHO has always worked in an environment in which it has been surrounded by various actors that are also influential in global health. Examples include states that actively pursue

global health matters, transnational corporations (TNCs) that have an influence over the global flow of health products and services, civil society organisations (CSOs) that are active in global health, and various health research institutes. The WHO has come to engage with all of these types of actors in various programmes and projects and has progressively opened itself to their participation. Yet it has always maintained the same intergovernmental structure at its core. Intergovernmentalism is based on the principle that decision-making based on agreement between the governments of states, each of which exercises control over a certain territory, can maximise the benefits to all citizens within those territories, via representation of their interests (Cronin, 2002). During the latter half of the twentieth century intergovernmentalism was the dominant model of international organisation, and many IGOs gained a high level of political authority over many issues areas, such as development, trade and technical standardisation. Accordingly the WHO maintained the position of the central authority for global health matters.

Over the past half-century, however, the global public health landscape has experienced significant changes. Aspects of globalisation such as the increased mobility of people and goods and improved communication technologies has increased the ability for more actors to become influential in global health, and changed the way that states act to control events within their own territories. Furthermore, more recently, a number of new global organisations have emerged that have taken on major global public health issues, offering new policy approaches and comprising new organisational features that differ significantly from those of IGOs such as the WHO. Two examples are The Global Fund to Fight AIDS, Tuberculosis and Malaria, (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI Alliance), which will both be examined in depth in this book.[9]

[9] It is also possible to distinguish between the intergovernmental model and new organisations of global governance by means of looking at who is involved in decision-making. The early years of the WHO can be classified as executive multilateralism, during which executive officers of states negotiated on behalf of governments. The current WHO structure can be better classified as 'advanced executive multilateralism', because the WHO has opened itself to such an extent that non-state actors are intimately involved in parts of the policy-making process within certain programmes and activities. The GAVI Alliance and GFATM are not multilateral organisations in the sense of purely state-state cooperation. They can be classified as 'inclusive institutions', because they include non-state actors as part of their structure (Rittberger, Huckel, Rieth, & Zimmer, 2008). See Chapter Two for an elaboration on this aspect.

1.1 GHG organisations

These organisations can be classified as organisations of 'global governance', which differ from intergovernmental organisations. Global governance is defined as "…collective efforts to identify, understand, or address worldwide problems that go beyond the capacity of individual states to solve" (ECOSOC, 2006). Such collective efforts can be realised in a wide range of organisational arrangements that may involve both public and private (non-state) actors in policy-making roles, based not only on their ability to represent interests, but their ability to contribute to problem-solving as well. UNAIDS[10], GFATM and the GAVI Alliance are three organisations that fit this model that have emerged in the field of health over the past 15 years. All three are objects of investigation in this book and will be referred to as Global Health Governance organisations, henceforth GHG organisations. While Chapter Two will examine their common attributes in detail, it is necessary at the outset to outline four defining elements to explain this denotation. Fundamentally, GHG organisations: first, engage in governance; second, are primarily health oriented; third, act with a global scope within a global political environment; and fourth, base their work on a variety of principles, and not (just) intergovernmentalism, for example managerialism and cosmopolitanism. These four elements are elaborated below.

Engaging in governance. An organisation that engages in governance does more than simply manage the pooling of resources for the execution of public projects. Governance involves ongoing strategic decision-making as well as policy formation, implementation and monitoring. This involves collectively identifying high-potential approaches for solving common problems, transforming these approaches into binding rules of behaviour, monitoring behaviour and, when necessary, adjusting the rules to changes in external conditions (Rittberger, 2003, pp. 181-182). The GHG organisations addressed in this book all engage in governance according to this definition, whereby 'rules of behaviour' are often not presented as laws and regulations, but as expectations and claims that are put on other actors.

Health orientation. Global governance organisations that are primarily concerned with health operate within a unique political environment. While global governance organisations also exist within other issue-areas (environmental protection being one of the most commonly

[10] Joint United Nations Programme on HIV/AIDS. This organisation may still be classified by some as fitting into the intergovernmental model. However, certain characteristics in its decision-making structure clearly set it apart from other intergovernmental organisations such as the WHO. This will be discussed in depth in Chapter Five.

cited and analysed within political science), in the field of health the strong influence of the medical profession and the long tradition of charitable engagement in health, are two of many factors that shape the realities of governance within this issue-area.

Global scope. GHG organisations address health challenges on a global level by crossing state boundaries and working independently of them. They also address health challenges that are both exacerbated by or ignore state boundaries. This has repercussions for the political environment in which these organisations operate, as well as the types of actors that these organisations must interact with i.e. their 'stakeholders'. Stakeholders are persons or organisational entities with an interest or 'stake' in the outcomes in the area addressed by any one particular GHG organisation. The stakeholders of GHG organisations are diverse and operate on various levels (e.g. local, regional and global); making the political environment in which GHG organisations act highly complex.[11] Just some examples of the wide variety of stakeholders of GHG organisations are health ministries, aid agencies, private donors, community leaders, health-promoting CSOs and field workers.

New working principles. Organisations of global governance differ from their intergovernmental counterparts in terms of the dominant principles on which their work is based. Whereas the decision-making structures of IGOs are based on a dominant principle of interest representation through government appointees, the work of global governance organisations is based on a broader set of principles, encompassing elements of managerialism as well as cosmopolitanism. Managerialism is defined as "… a concern with addressing tangible global challenges with a high emphasis on technology, skills and problem-solving capacity" (Commission on Global Governance, 1995), whereas cosmopolitanism – or more accurately, principles of cosmopolitan democracy – encompass such ideas as the transcendence of individual identities over state borders and interest representation through actors other than states (Held, 1995).

The shift in the basic principles that underlie governance, away from intergovernmentalism to managerialism and cosmopolitanism, has considerable consequences for the way in which GHG organisations operate, and how they can gain and maintain political support in their

[11] Different types of stakeholders, their roles and how they can be identified will be addressed in depth in Chapter Four.

surrounding environment. It is this aspect of GHG organisations that will be the focus of the following investigation.

1.2 Political environment

GHG organisations have gained an increasingly sure footing within the global health landscape in recent years. Two examples are the GAVI Alliance, an organisation founded in 2000 to boost immunisation coverage rates in the world's poorest counties,[12] and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), founded in 2002 as a mechanism to gather and distribute funds to nationally planned health projects. GHG organisations such as these have secured substantial funds from an increasing number of donors, increased their geographical and policy scope and gained an increasingly visible profile amongst a wide variety of stakeholders. At the same time these organisations also have the feature of being so-called 'inclusive institutions', as they grant formal membership to actors from both the public and the private sector (Rittberger, Huckel, Rieth, & Zimmer, 2008, pp. 18-19). This book investigates how organisations with a public-private base that break with conventions of intergovernmentalism have come to be able to establish themselves as major, large scale, influential players in global health with continuing levels of political and financial support.

It is not necessarily unusual from a political science point of view that public and private actors have seen it in their interest to come together to address acute public health problems conjointly. However, four co-existing aspects of the ongoing support for these types of organisations are of particular interest:

First, the institutionalisation of both public and private actors in decision-making within GHG organisations significantly breaks with that which has been accepted by key stakeholders, especially states, in the past. In other words, by putting non-state as well as state actors in formal decision-making roles, these organisations signal a significant shift away from the intergovernmental governance on which international cooperation and global rule-making has been based in the past. Not only states, but other types of actors from the private sector, including civil society actors as well as business sector actors, have formal decision-making roles in some GHG organisations, and, critically, they are involved in ongoing, long-term and strategic decision-making.

[12] The GAVI Alliance focuses on countries with a GNP per capita of less than $US 1000.

Second, despite this break with convention, these organisations are increasing in scope in terms of the extent to which they actively engage in policy-making. GHG organisations appear to have gained the authority to determine overarching strategic directions for solving health challenges, plan the dispersal of resources, formulate policies, and oversee implementation. This is occurring to an extent which is significantly greater than the scope of activities that have been accepted as appropriate for public-private partnerships in the past, which, until the mid-1990s were largely limited to the implementation of specific and small-scale projects.

Third, these organisations have also increased their scope in terms of the number of stakeholders accepting and adopting their policies, recommendations and expectations. This includes an increase in the number of donors, the amount of donated funds and the number of engaged partners contributing to the work of GHG organisations, or aligning themselves with the strategies of GHG organisations. This indicates an increasingly secure acceptance of these organisations as long-term, permanent fixtures in global health.

Fourth, the trends described above are occurring despite the absence of any direct means of coercion (punishment or rewards for (non-acceptance), and despite the fact that key stakeholders such as states have several other options for approaching health challenges that involve less convention-breaking modes of cooperation and/or engagement. For example, other options for states may include contracting out field-work to CSOs, contributing to World Bank administered funds and loans, working with and financing programmes within WHO, cooperating within small-scale public-private partnerships and concentrating on projects managed and coordinated via bilateral aid. These and many other methods to approach global public health do not necessarily require delegating strategic decision-making authority to public-private based GHG organisations. They have been and remain options for the various stakeholders that currently support organisations such as the GAVI Alliance or GFATM. While states and other stakeholders still make use of the options listed above, GHG organisations appear to have become an acceptable, valid option when addressing global health.

Each of these developments signals a significant break with the way that public health has been governed before. They also beg the question as to how the empirical acceptance of these developments and a high level of political support for these types of organisations in

particular become possible. The GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, (mentioned above) will serve as brief examples.

The central decision-making body of the GAVI Alliance and the related GAVI Fund consist of representatives from developing and donor countries as well as vaccine industries, CSOs and others. This composition is quite broad but not unusual in a public-private partnership with such a specific focus. However, the GAVI Alliance is more than just a public-private partnership for the administration of vaccines. It is a large-scale global organisation that presides over a large amount of funds and engages in governance. This includes for example the development of global strategies for addressing childhood cluster diseases, making key decisions about which types of vaccines (and diseases) are given priority over others, and arranging so-called ‘Advanced Market Commitments’. The GAVI Alliance also develops policies that include rules for behaviour, such as requirements for executing vaccine distribution, expectations on health systems regarding sustainability of projects and requests for funds from wealthy states. It also takes steps to monitor rules for behaviour, checking if pledged funds are actually donated, if vaccines are delivered and if immunisation programmes are carried out according to agreed arrangements.

Despite the existence of global immunisation programmes within quite a few aid agencies of developed countries, and long established mechanisms for vaccine access within UN Specialised Agencies,[13] the GAVI Alliance has evolved to become the central organisation for the advancement of vaccine access. It partners with aid agencies as well as UNICEF and the WHO and receives support and acceptance amongst an increasing number of stakeholders. The GAVI Alliance’s funding increased from under US$ 520 million from six donors in 2001 to an accumulative total of US$ 1880 million from 16 major and several minor donors in 2006. In comparison UNICEF received a total of US$ 1688 million in contributions in 2004 for its entire budget and the WHO had a budget of US$ 3300 million for the year 2006/2007 (UNICEF, 2007; World Health Organisation, 2007a). Overall, the GAVI Alliance is a prime example of a GHG organisation that has, over time, increased its scope of governance activities. Despite several other options being open to stakeholders for addressing the problem of vaccine coverage, the GAVI Alliance has come to enjoy a stable financial and political support base.

[13] Such as UNICEF’s and WHO’s Expanded Programme for Immunization.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a further example of a GHG organisation that has increased its scope of activities, taking on more decision-making authority and a central position in global health. As with the GAVI Alliance, GFATM has a public-private base with its central decision-making body comprising developing and developed states, private foundations and representatives from business and affected communities. Like the GAVI Alliance, GFATM operates globally and engages in governance, for example by prioritising certain treatments, (e.g. Directly Observed Treatment, Short-Course (DOTS) strategy against Tuberculosis and the artemisinin-based combination therapies (ACT) to fight malaria), by creating rules for behaviour such as minimum requirements for Country Coordinating Mechanisms, (the country level partnerships that should be in place to oversee the implementation of health projects before funds are dispersed) and determining which states should donate which amounts based on wealth and income.

Although the WHO has its own AIDS programme and several developed countries maintain bilateral AIDS programmes, GFATM has gained a sure footing as the central funding channel for the fight against AIDS, Tuberculosis and Malaria in recent years. For example, the WHO regular budget resources for specific AIDS programmes decreased from $US 17.5 million to US$ 16 million from the years 2004-2005 to 2006-2007 (World Health Organistion, 2005, p. 40). GFATM on the other hand was able to disperse approximately 61 percent of its latest round of funds (for the year 2007), which totalled US$ 106.7 million, to AIDS projects (GFATM, 2008a).

Hence, both the GAVI Alliance and GFATM are examples of GHG organisations with a scope of activities and scale of funding unlike any public-private based organisation in the health sector before. Furthermore, since their founding in 2000 and 2002 respectively, both the public-private nature of their organisational make-up as well as position in the global health landscape has become firmly established. Both organisations appear to have been accepted as valid organisations for the governance of global health.

1.3 Legitimacy as a key factor in global health governance

Global health is an issue-area that has not shied away from new and innovative forms of co-operation and governance in the attempt to achieve health aims. From early state cooperation

with philanthropic programmes to the involvement of CSOs in the negotiations of the Framework Convention for Tobacco Control (FCTC) of 2003[14], global public health has proven to be particularly open to innovative governance forms involving a wide array of actors. There may be several reasons for this. First, there is a relatively undisputed (although poorly executed) aim of providing life free of disease and pain. Second, public health achieves a de-politicised nature by presenting health care as a technical issue, heavily reliant on medical expertise. Third, there is a long history of health care provided by charities, churches or community groups, predating the era of state-run health care in welfare states. Fourth, the promise of observable and measurable results via statistics on mortality, morbidity and access, makes results-oriented action attractive. Finally, there is a history of strong state and inter-agency cooperation in health matters.

Despite these factors and a history of evolving governance within public health, the recent formation and increased acceptance of GHG organisations over the past fifteen years still remains a unique phenomenon in global governance and it deserves closer attention. The observations described above raise the question: How do GHG organisations – having moved away from conventional models of intergovernmentalism – gain and maintain stable political support amongst the key stakeholders in global health?[15]

This is the motivating question guiding this book. It is also a question that contributes to solving a greater puzzle with which scholars of international relations are increasingly occupied (both those within the constructivist school[16] and those following positivist epistemologies seeking to understand changing empirical trends in global governance) namely, how global governance organisations interact with their environment in a way that allows them to exercise political authority.

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[14] See Chapter Two for more information on this convention.

[15] This is a classic example of a 'how is it possible?' question, which aims at finding out how an object of investigation and its surrounding environment hang together to allow for certain phenomena to occur (Wendt, 1999, p. 83). The purpose of structuring the question in this way is to conduct social enquiry for the purpose of simplifying and systematising the complex phenomena described above, allowing for the inference of conclusions based on observed patterns drawn from empirical field research (King, Keohane, & Verba, 1994, pp. 44, 94). This enables the researcher to uncover how interactions between actors play out in relevant real world cases, one purpose of the methodological approach of descriptive inference, which will be applied in this dissertation (see section 1.4 below).

[16] The constructivist school within the discipline of international relations emphasizes the primacy of non-material variables, such as norms, culture, identities and ideas and the socially constructed nature of the interests and identities of various actors in global politics. Many constructivist studies, thus take on subjectivist epistemologies in their research, although positivist methods can also be applied (Barnett & Finnermore, 2004; Finnemore & Sikkink, 1998; Klotz & Lynch, 2007).

There are several theoretical approaches that may explain how GHG organisations have become firmly established actors in the global health environment. Cost-benefit calculations within a means-ends rationality possibly, or even probably play a role. Following this metatheoretical approach, as in the realist and liberal-institutionalist schools of international relations, stakeholders might delegate authority to GHG organisations to minimise their own costs or reap the benefits of pooled resources. Logically, this can explain some of the support for GHG organisations which indeed act as platforms for sharing interests (creating an avenue for cooperation) and pooling resources (increasing the chance of effective and coordinated achievement of goals). Accordingly, extending this idea to the principal-agent theory, GHG organisations can also be seen as the agents of states and other stakeholders (principals) which delegate decision-making authority within a zone of autonomous discretion on the presumption that their own interests will be advanced.[17] Indeed, the rise of GHG organisations can be taken as a progression of advancing modes of cooperative action in an environment dominated by the rationale of *homos economicus*.

There is however, an increasing body of literature based on the idea not of *homos economicus* but of *homos sociologicus* that seeks out a more complete understanding of the interactions between both intergovernmental and global governance organisations and their stakeholders (Risse, 2003, pp. 101-102; Hasenclever, Meyer, & Rittberger, 1997, p. 155). Within this metatheoretical approach, international (global) organisations are seen as having the ability to act independently of the actors that create them. They influence the social environment within which they exist and gain acceptance for their actions based on a logic of appropriateness and exemplary behaviour, including considerations of justice, right process and perceived competence (Barnett & Finnermore, 2004, p. 4). Thus, a global organisation (such as a GHG organisation) gains and maintains political support if there is a perception or assumption amongst its stakeholders that the organisation, its actions and its rules for behaviour are appropriate and worthy of support according to certain norms, values and principles.[18] The extent to which a governance organisation enjoys support based on these perceptions and assumptions is the extent to which it enjoys *legitimacy*. Legitimacy is one of the most promising and increasingly popular concepts now considered to offer a more complete

[17] For an analysis on rational motivations for public and private actors to form cooperative arrangements in the health sector see Edele (2006).

[18] See Suchman for a similar definition, from which this passage has been adapted (Suchman, 1995, p. 576). Finding out which norms, values and principles are prioritised by stakeholders in global health is a key aim of this dissertation.

understanding of the relationship between intergovernmental as well as global governance organisations and their surrounding political environments. It can be used as a tool to conceptualise the normative pull that an organisation has on its addressees to comply with its governance activities including rules of behaviour (Reus-Smit, 2007; Hurd, 1999). When present, legitimacy forms the basis for a 'reservoir of support' for governing organisations that allows them to go about their everyday work, without a constant threat of withdrawal of support from stakeholders who undertake constant means-ends judgements (Easton & Dennis, 1980, p. 338; Easton, 1965, pp. 51-57).

There are four main arguments as to why purely rational-based explanations are unsatisfactory for fully understanding the relationships between GHG organisations and their stakeholders. These arguments advocate an examination of how they come to enjoy being seen as legitimate as an important additional aim of inquiry.

First, while rational choice theories may be able to explain individual stakeholder decisions to fund or support GHG organisations in the short-term, they do not explain the whole picture. They do not consider how underlying principles make a public-private organisation of this scope a valid option for engagement in the first place. A GHG must first be a normatively acceptable option for cooperation, before it can be subject to means-ends considerations.

Second, not all actors that support GHG organisations are resource dependent, nor do GHG organisations always present the most obvious resource efficient option for addressing global health challenges.[19] In these cases sociologically formed preferences based on conceptions of appropriateness may exert an influence on rational considerations (Wendt, 1995, pp. 73-81).

Third, GHG organisations themselves appear to invest considerable resources into ensuring and publicising the legitimacy of their organisational structure and policy outputs. This indicates that stakeholders consider that the legitimacy of GHG organisations is important, and that GHG organisations themselves do not rely on means-ends calculations alone to maintain and retain political support amongst their stakeholders.

Fourth, because legitimacy is based upon values and principles referring to the nature of the governance organisation, any support based on that legitimacy is more stable than support

[19] They do for example act as 'intermediary organisations' for funds, and inevitably carry own costs.

based on cost-benefit calculations (Reus-Smit, 2007, p. 158). Understanding whether, and how global governance organisations come to be accepted as legitimate, will give a better understanding of the long-term robustness of GHG organisations, independent of short term organisational problems or intermittent policy failure (Buchanan & Keohane, 2006, p. 411).

Legitimacy therefore, presents itself as an important factor in understanding the support for GHG organisations and understanding how it comes about is an important subject of inquiry. Yet legitimacy, on the global level, remains largely unexamined, and is therefore contested. A central aim of this book is to uncover whether a 'reservoir of support', based on legitimacy, exists for GHG organisations. Despite its increasing popularity and a number of studies which use legitimacy as an explanatory variable, it remains a contested concept lacking sound explication of what it is based on, or, importantly, who determines what is legitimate or not. In fact, how to go about addressing legitimacy is, conceptually and methodologically, still unclear even for most constructivist scholars. Amongst others, doubts are expressed as to whether legitimacy can even really exist for global level organisations because of the absence of a global *demos* that would grant legitimacy (Dahl, 1989; Dingwerth, 2007; Reus-Smit, 2007).

The aim of this book therefore is twofold:

1. To provide a basis for examining the legitimacy of GHG organisations via the systematic description of what legitimacy entails, the formulation of a conceptualisation of legitimacy suitable for the global level, and the development of methods suitable for empirically examining the legitimacy of GHG organisations – methods which can be replicated for the purpose of analysing the legitimacy of other organisations, either as a variable in causal research or as a basis for research in other issue-areas.

2. To apply the resulting methods in an examination of three GHG organisations in an attempt to find out whether they are considered legitimate amongst stakeholders and what the sources of their legitimacy are. Importantly, the applied research methods will move beyond a normative-prescriptive approach to legitimacy, seeking for the first time to analyse stakeholders' priorities in terms of what constitutes good, appropriate and 'legitimate' governance, and how they view GHG organisations with respect to these priorities.

1.4 Examining legitimacy: finding appropriate methods

There are several ways to approach researching legitimacy in global governance. One approach is to simply try to prove the existence of legitimacy. For example, by means of deductive methodology, researchers may try to seek out instances where other types of reasoning (such as means-ends calculations) cannot possibly explain stakeholder acceptance of a global governance organisation (Hurd, 1999, p. 382). This method takes legitimacy as an independent explanatory variable for the dependent variable – acceptance/compliance. For explaining real world cases, this approach is problematic for two reasons. First, it is highly unlikely that legitimacy is the only factor that determines whether a stakeholder supports a GHG organisation at any one point in time. Seeking out examples where legitimacy plays the only role in the decision to support a GHG organisation would be near impossible and almost certainly an oversimplified depiction of the reality of the interplay between a GHG organisation and its stakeholders (Miyaoka, 2004, p. 11). Second, even if it were possible, in certain cases, to deduce the primacy of legitimacy as the main reason why GHG organisations receive support in specific instances, this method would offer little insight into understanding what legitimacy is based on, how it comes about, or what values underpin legitimacy considerations amongst stakeholders (Steffek, 2003, p. 250).

Faced with these two stumbling blocks, most political science examinations into legitimacy reject deductive causal theorising in favour of a normative-prescriptive approach. Such enquiries are of a philosophical nature and offer valuable insights into how legitimacy might work, what norms, values and principles it might (or even should) be based on, and even go so far as to offer an assessment of the legitimacy of global organisations based on criteria drawn from established philosophical argument (For a good example see Buchanan and Keohane, 2006). However, this approach also has one main weakness. The basis for determining what makes an organisation legitimate or not is inherently drawn from preferences of the researcher/philosopher. The question of who determines what is legitimate, and what stakeholders really think is either disregarded or considered too difficult to scientifically extract.

Both of these approaches – deductive methodology and normative prescription based on philosophical enquiry – are therefore less than promising for a comprehensive understanding of how legitimacy can be conceptualised, or how it actually works on the global level. The enquiry into legitimacy presented in this book therefore adopts a third approach – descriptive

inference by means of empirical analysis. Using qualitative research methods, legitimacy is investigated by supplementing a normative-prescriptive enquiry into *possible* bases for legitimacy (resulting in a proposed conceptualisation of legitimacy suitable for studying it on the global level) with an empirical investigation that systematises data on actual stakeholder perceptions of what constitutes legitimate governance and how they rate GHG organisations in terms of the norms, values and principles which they themselves prioritise. Descriptive inference serves the function of systematically processing and simplifying complex phenomena with the ultimate aim of separating systematic and non-systematic differences (King, Keohane, & Verba, 1994, p. 42). However, it also has an important explanatory function of "…using the facts we know to learn about the facts we do not know" (King, Keohane, & Verba, 1994, p. 46). Research is guided by specific questions that aid this process. The research undertaken in this book is guided by the following main research questions, broken down into three sets of sub-questions:

Main guiding questions: *Are GHG organisations accepted as legitimate amongst key stakeholders in global health? And what makes them legitimate?*

Research Sub-questions:

1. *What different GHG organisations exist and what are their characteristics?*
2. *On what grounds might actors such as donors, addressees and other stakeholders accept GHG organisations as having the right to govern and to make requests to accept and follow their rules for behaviour? (Which properties might make an organisation be seen as legitimate, appropriate or worthy of support? On what norms, values and principles might these considerations be based?)*
3. *Which actors must perceive GHG organisations as legitimate, appropriate, or worthy of support? (i.e. Who are the stakeholders in global health?) What are their positions to the properties identified by answering question 2?*

The first research sub-question is approached by means of a thick description of the historical development and relevant common characteristics of GHG organisations. The second research question is approached by preliminary field research and a philosophical enquiry into how legitimacy may be conceptualised on a global level. The third question is addressed by data collection and systematisation from which conclusions are inferred. Adopting a methodology

of the descriptive inference eliminates the main deficits of purely political-philosophical approaches that largely disregard stakeholder perceptions, or do not incorporate them due to methodological constraints. Furthermore, the investigation explores not merely the existence of legitimacy, but also how it comes about.

Methods of empirical analysis present considerable challenges for any researcher. Recently, Westle and Schneider et al. have addressed these challenges confronting the problematic aspects of empirical research into legitimacy that stem from the studying opinions, views and values, which are notoriously difficult to *identify* (Westle, 2007; Schneider, Nullmeier, & Hurrelmann, 2007). This problem of identifying stakeholder views is exacerbated in research into the legitimacy of governance on the global level, as here the stakeholders' are generally not individuals, but 'conglomerate actors', such as organisations, businesses, CSOs, states, and bureaucracies.

Three main research methods are available for empirical investigations into legitimacy, each of which were applied in the research presented here, stakeholder observation, discourse analysis and survey research. The first method, stakeholder observation, involves systematically recording the acts of support – the concrete actions - that stakeholders undertake in granting support for GHG organisations. Examples include giving funds, attending meetings, or acting in accordance with the policies of, a particular GHG organisation. Such supportive actions may be undertaken due to reasons other than legitimacy. However, without such supportive behaviour, legitimacy will have little meaning. In addition, the absence of supportive behaviour may indicate a lack of legitimacy (Schmitter, 2000). Therefore, the first method of research applied in this book is to document the extent to which GHG organisations receive political support from their stakeholders in the form of supportive behaviour (Gilley, 2006; Schneider, Nullmeier, & Hurrelmann, 2007, p. 129).

The second method, discourse analysis, is applied to study communicative action. Studying public discourse is valuable because "conceptual schemes and worldviews of political actors, and hence the benchmarks used in their legitimacy evaluations, are, to a large extent, shaped by (and expressed within) political discourses" (Hurrelmann, Schneider, & Steffek, 2007, p. 8). Texts in the public domain, – such as strategy papers, annual reports and policies – declare the priorities of stakeholders and their expectations in terms of the norms, values and principles, that they consider should underlie rightful governance. This book uses an analysis

of 90 texts from conglomerate actors representing key stakeholders in global health governance to seek out the underlying values, principles and norms that determine what is considered legitimate – appropriate, rightful – in the eyes of various actors.

Third and finally, the book uses methods of survey research to assess the level of political support for a governing organisation. Stakeholders were asked, first, to express the level of confidence they have in a governing institution, and second, whether this confidence (or lack thereof) is "...grounded in the kinds of normative evaluations that distinguish legitimacy from other kinds of support" (Hurrelmann, Schneider, & Steffek, 2007, p. 7). For this book, public opinion research was undertaken via an administered survey of 185 experts in the field of public health, each affiliated with a key stakeholder. The results of the survey served to complement the accompanying text analysis by recognising that within conglomerate organisations a combination of processes and substantial factors determine which opinions, values and preferences will be portrayed externally and acted upon. Institutionalised rules as well as the opinions and experiences of involved individuals contribute to the development of collective external positions and determine future courses of action. Furthermore, the responses of individual experts offered insights into the underlying values, principles and norms that guide actual preferences, which are often expressed in the public discourse without justification. The expert survey method applied in the research presented here thus differed from general public opinion research in one critical aspect; it did not seek to gauge the average, or representative opinions of a general public. Rather it gathers insights from key stakeholders on the principles, values and beliefs that shape and influence the actions of conglomerate actors.

A triangulation of the three methods described above offers the most complete means for gaining an understanding of how a GHG organisation gains and maintains legitimacy. By comparing and contrasting the results of each of the three applied empirical research analyses it is possible to infer which norms, values and principles are prioritised by stakeholders, and how they rate GHG organisations with respect to those norms, values and principles. With regard to the first method, political behaviour alone does not offer insights into what legitimacy may be based on, but without it, doubts may be raised as to whether an organisation is accepted as legitimate at all. With regard to the second method, analysing texts offers insights into what principles, values and norms underlie certain acts of communicative behaviour, which convey legitimacy beliefs. Finally, with regard to the third method,

surveying influential actors in global health can directly address the norms, values and principles that serve as the basis for legitimacy. The relationships between the three dimensions of empirical legitimacy covered by these methods are summarised in Chapter Four.

1.5 Limits of the study and contents of the dissertation

At the outset it is important to set the limitations of this study. It cannot measure the influence of legitimacy in comparison with other modes of control or reasons for cooperative action, such as rational-choice based interests, or coercion.[20] Rather, it offers a first attempt to gain a more complete understanding of how legitimacy can come about in the instances of three GHG organisations – despite these organisations having broken away from conventional models of intergovernmentalism. Importantly, this dissertation delves into the norms, values and beliefs that underpin acts of legitimation. This is done by organising the dissertation into the following chapters:

Chapter Two reviews how governance structures have evolved within the issue-area of public health over time and answers the first of the dissertation's sub-questions by offering a thick description of the GHG organisations that have become established over the past 15 years. It offers an overview of how to understand global governance as it is currently described in mainstream international relations along with a historical overview of how governance has evolved in international and global health. Finally, it offers a thick description of GHG organisations, looking at their particular features in terms of the extent to which they engage in governance, the principles on which their work is based, and their constitutional make-up.

Chapter Three concentrates on legitimacy as a theoretical and contested concept. It traces the use of the notion of legitimacy throughout the social sciences, lists the different ways in which legitimacy can be approached and most importantly puts forward a definition suitable

[20] Hurd addresses the problem of identifying legitimacy, noting in particular that it has effects that can usually be traceable to more than one cause: "Identifying which mechanism of social control might be operating in a real-world situation is not easy. Doing so requires knowledge of actors' motivations, which may not be clear even to the actors themselves. This difficulty affects not only those trying to study legitimacy, but also anyone trying to distinguish empirically among the various mechanisms. For instance, establishing the proposition that all individual decisions are motivated by self-interest encounters exactly the same methodological problems, which may explain why that proposition, when put forward, is generally only assumed rather than tested" (Hurd, 1999, p. 390).

for use, not only in global health governance research but in global governance research in general. This concept is then developed further by systematically organising the various norms, values and principles of governance that may provide a legitimate basis for a GHG organisation, and matching them with the organisational characteristics of GHG organisations that may be seen to embody these values and principles. This is achieved by looking at aspects of governance 'by' the people and governance 'for' the people. By means of this process, the chapter concludes with proposals as to how legitimacy can be conceptualised on the global level.

Chapter Four introduces the empirical study into the legitimacy of GHG organisations, beginning with an assessment of the political environment in which GHG organisations attempt to engage in governance. It concentrates on the third research sub-question and introduces a systematic identification of stakeholders in global health. It also presents the results of empirical research into stakeholder opinions of what makes up good global health governance, extracted from a discourse analysis as well as survey research.

Chapters Five, Six and Seven are presented as case studies. Three GHG organisations have been selected for a systematic examination of their legitimacy, each for different reasons. The three organisations examined – UNAIDS, the GAVI Alliance and GFATM – are the most prominent and well established examples of GHG organisations today. They have all been founded within a 7 year period around the turn of the 21st century, are the most well financed of the new GHG organisations, and appear to have invested considerable resources in strategies to increase their legitimacy. However, each of these organisations differ in the extent that their work is based on principles related to either intergovernmentalism, managerialism or cosmopolitanism. UNAIDS remains a largely state-based organisation, while the GAVI Alliance and GFATM have highly inclusive structures. Whereas the GAVI Alliance is highly results-based, tending towards a managerial approach, GFATM presents itself as a longer-term project involving wider communities, presenting itself as an organisation attuned to principles of cosmopolitanism. These three organisations therefore stand out as GHG organisations with somewhat contrasting working principles: UNAIDS is a consortium of UN-specialised agencies with a strong public base (private actors do not have voting rights within the central decision-making body); the GAVI Alliance is very results focussed, both in terms of its promises and achievements and GFATM prides itself on its highly developed organisational and decision-making structures, being both highly inclusive

and transparent. The case studies presented in Chapter Five, Six and Seven do not play these aspects against each other in an attempt to find one organisation more or less legitimate than any other,[21] but rather seek to assess whether it is possible for organisations with different working principles to be accepted as legitimate and whether this results from stakeholders prioritising different norms, values and principles in each case.. To address these questions, the possible different bases for each organisation's legitimacy become the focus. The case studies are thus also taken as varying examples to investigate whether the conceptualisation of legitimacy developed in Chapter Three has real world relevance in each different case.

Finally, in keeping with the dual aim of the dissertation, Chapter Eight offers concluding remarks broken down into two sections. The chapter first discusses the usefulness of the undertaken research for further studies into legitimacy in global governance and international relations, and then reviews the results of the empirical project and discusses the replications of the study for global health policy.

At the conclusion of the dissertation, the methods of the empirical research are presented in appendices. Detailed results and their graphical representation are on file with the author.

[21] This is a step which is not undertaken as part of this dissertation. The focus is on identifying the various norms, values and beliefs that underpin legitimacy and making comparisons as to whether these are the same, or different in each case. All three are in-depth case studies of important and complex social phenomena that serve the purpose of systematically describing the real world and inferring from empirical data how a certain phenomenon becomes possible. The importance of this task is described by King, Keohane and Verba as follows: "Case studies are essential for description, and are, therefore, fundamental to social science. It is pointless to seek to explain what we have not described to a reasonable degree of precision" (King, Keohane, & Verba, 1994, p. 42). For an overview of how a measurement may be attempted in future work that builds on the results of this dissertation, see Chapter Eight.

Chapter Two

From international cooperation in health to global health governance: Insights from historical perspectives

Tracing the history of international cooperation and governance of public health at a global level offers valuable insights for both scholars of global governance and those currently active in global health. In the field of public health it is possible to trace an evolution of governance, from early cooperation between states to sophisticated intergovernmental organisations and finally to global health governance (GHG) organisations with a multi-actor membership. Importantly, this history highlights the real differences between the governance structures and working principles of the most recently established GHG organisations and their more traditional counterparts. This chapter reviews how governance structures have developed within the public health issue-area over time and concludes by offering a thick description of the GHG organisations that have increased in prominence since the beginning of the 21st century.

For several reasons public health has been an issue-area where actors of all types and on all levels have been relatively willing to try out and participate in innovative governance forms. Some of the earliest high level cooperative arrangements between states were formed over health matters, and even current trends in the establishment of public-private partnerships and GHG organisations seem to have taken off on a particularly large scale within the public health issue-area.

At what point in history did the critical leap beyond intergovernmentalism, towards global governance organisations take place? By tracing developments in international cooperation and governance in public health over the past 150 years, it will become apparent that GHG organisations – while significantly breaking with conventions of the past in terms of substantial participatory elements, decision-making structures, and working principles – have arisen on the back of a continual trend towards broader non-state actor participation and results-orientation. The relevance of this exercise for the remaining chapters of the dissertation is to show that GHG organisations embody principles of governance that significantly break from what has been accepted as conventional decision-making and policy-making on a global level in the past, but at the same time the steady evolutionary nature of developments in this direction over a considerable time might have increased the ease with which stakeholders have come to accept such new governance forms. This, together with certain external conditions, might help shape and influence the norms, values and principles that stakeholders in global health prioritise when deciding whether or not to support the most recently established GHG organisations.

The chapter will first provide a short overview of how to understand global governance as it is currently described in mainstream international relations is provided. Second, the main body of the chapter will lay out a historical overview of how governance has changed in international and global health. This will serve the purpose of showing how standards of participation in decision-making and bases for the legitimacy of global organisations have evolved over time. Third and finally, the chapter will offer a thick description of GHG organisations.

2.1 Understanding and defining global governance

Global governance is a field of study which emerged in reaction to a large number of non-traditional actors taking on roles of governance due to changes in global contexts and (either related or non-related) changes in the capacity of traditional actors (such as states) to govern (Rittberger, Nettesheim, Huckel, & Göbel, 2008). The study of global governance concerns itself with this new global environment and it looks specifically at the rules, institutions and international organisations emerging within in. It differs from the concept of world government because it does not presume the existence of any one overarching authority. However, it does recognise that between various actors, obligations to abide by certain rules, either formal or informal, do exist that give structure and a degree of certainty to action on the global level. Thakur and Van Langenhove thus define global governance as:

> …cooperative problem-solving arrangements on a global plane. These may be rules (laws, norms, codes of behavior) as well as constituted institutions and practices (formal and informal) to manage collective affairs by a variety of actors (state authorities, intergovernmental organizations, nongovernmental organizations, private sector entities). Global governance thus refers to the complex of formal and informal institutions, mechanisms, relationships, and processes between and among states, markets, citizens, and organizations – both intergovernmental and nongovernmental – through which collective interests are articulated, rights and obligations are established, and differences are mediated (Thakur & Van Langenhove, 2006, p. 224).

Importantly, the nature of global governance is oriented on problem-solving.[22] Rules, institutions, laws, norms and codes of behaviour are not created to offer security and stability within a given territory, (as in the case of government), but rather to solve a particular problem or manage a certain issue-area. Global governance also goes beyond the concept of cooperation between states by recognising the ontological status of states, international bureaucracies, and non-state actors alike.

Global public health is an issue-area which is particularly well suited to demonstrate the emergence and establishment of the complicated web of relationships that make up global governance. Public health is a field of study which examines the 'health of societies' rather than the health of individuals, as in the case of medicine. Global public health has an emphasis on determinants and consequences of health with a global scope (Baum, 2002, p. 7).

[22] This should not be interpreted as a normatively positive evaluation of global governance. The definition of what is a 'problem' and whether global governance structures effectively solve problems are always subject to debate.

A large number of actors engage in collective efforts to identify, understand and address worldwide health problems. Increasingly, they also engage in governance activities, where governance refers to:

> …identifying high potential approaches for solving problems in society; converting these approaches into specific rules for action, overseeing compliance with these rules for action and when appropriate adjusting them to changing environments and conditions (Rittberger, 2003, pp. 181-182).

In sum, global health governance involves solving problems concerning the health of societies in a way that is not linked to territorial control but rather the collective efforts of a variety of actors within institutionalised settings that determine which approach to take, which rules for actions are necessary and how they are best executed. Of course, global health governance must also necessarily entail activities on a 'global' level, which is distinct from governance on regional, national, provincial and local levels, although there are interactions between them (Hein, Bartsch, & Kohlmorgen, 2006, p. 2).

According to Lee, global health governance can be distinguished from international health governance (IHG) (which focuses on health issues across borders and how to protect domestic populations) by three aspects. First, it addresses health-influencing factors that cross, and even ignore, the geographical boundaries of the state. Second, it defines and addresses the determinants of health from a multi-sectoral perspective (e.g. trade, environment, agriculture, education, labour). Third, it involves, both formally and informally, a broad range of actors and interests. While state and non-state actors have long interacted in health governance, the difference here is in the degree of involvement and the nature of their respective roles (Lee, 2004, p. 26; Dodgson, Lee, & Drager, 2002).

The following section will address the extent to which this type of governance has been reached, the concrete organisational forms it takes and the significance of this mode of governance for global health.

2.2 From international cooperation in health to global health governance

While there is a growing body of literature on global health and the organisations that are active in it, most texts on the topic stem from scholars of medicine or public health rather than

scholars of global governance or international relations. For this reason, the transformation from old to new forms of governance are often described in texts in a factual-descriptive manner and therefore their consequences in terms of governance issues and legitimacy are rarely discussed.[23] To understand of the way that global health is governed, it is not enough to merely identify the forms of international cooperation and organisation that have existed in the issue-area of public health over time. Of importance are what kinds of governance these different forms represent, and how they might be categorised for analytical purposes.

For example, according to Loughlin and Berridge the development of international health co-operation is commonly considered in relation to three periods. First, the nineteenth century, characterised in particular by the first international sanitary conferences; second, the inter-war period characterised by the establishment of international organisations such as the League of Nations; and third the post war era, dominated by the history of the World Health Organisation (Lee, Introduction, 2003; Loughlin & Berridge, 2002, pp. 8-9). The dominant organisational forms present in each of these periods can be seen as representing different types of governance and, more precisely, show a continual move away from state-centred international governance to the beginnings of global governance. This was steered not only by states but also autonomously operating international organisations, and non-state actors.

The following work further builds on Loughlin and Berridge by identifying several other developments during these and further eras, from the 1970s onwards. First however, this overview begins with historical developments in international cooperation in global health from the 1850s. By tracing governance structures back this far, it is possible to see a steady evolution in the direction of global governance over a long period of time.

2.2.1 International Sanitary Conferences – early ad hoc multilateralism

Early international cooperation in public health is said to culminate in the international sanitary conference of the 19th century.[24] McKee et al. describe this as a period during which, with a rising speed of trade, "…delays due to quarantine were becoming increasingly costly

[23] The key discussion paper by Kelly Loughlin and Virginia Berridge on the historical dimensions of global health governance makes excellent headway on this topic. However, since its publication in 2002, little more has been written from a perspective that combines historical observation with theories of international relations and governance.

[24] Although some historians refer to the Venetian code of quarantine regulations which were followed by several states as early as 1448.

and unacceptable…" (McKee, Stott, & Garner, 2001, p. 6). The appearance of cholera in Europe acted as a further motivation to find solutions to looming health crises. "With the twin aims of protecting Europe from cholera while facilitating international trade, the first International Sanitary Conference convened in Paris in 1851" (McKee, Stott, & Garner, 2001, p. 7). Loughlin and Berridge also describe the sanitary conferences as having "...emerged as a mechanism for responding to the political and economic threat a new epidemic disease like cholera posed to the European powers" (Loughlin & Berridge, 2002, p. 7). Further conferences took place in 1866, 1874, 1881, 1885, 1892, 1893, 1894, 1897 and 1903 in several European countries as well as Washington DC., USA.

These conferences can be classed as an early form of ad hoc multilateralism. The conferences were certainly international in that they were a platform for different nation-states to negotiate and debate solutions to the threat of infectious diseases to national interests (Aginam, 2005, p. 61). Technocrats and other epistemic communities were given little opportunity to play any authoritative role independent of that of representing the interests of their own states. Loughlin and Berridge for example write that scientific advancements in disease aetiology, such as the work from John Snow in the 1850s and Robert Koch in the 1880s had "…no immediate impact on the conferences that followed these discoveries" (Loughlin & Berridge, 2002, p. 9). The conferences were attended by delegates of various governments of autonomous regions or states and negotiations took place under a specific pretext for a specific purpose[25] (Siddiqi, 1995, p. 5). Delegates in attendance (which included medical experts) specifically represented the interests of their governments. Bargaining for or against certain quarantine measures reflected trade interests of the day, a good example was the British anti-quarantine stance at the Sanitary Conference in Rome (1885) despite the cholera outbreak in Egypt (then occupied by Britain and a major British trading port). However, the agreements that the delegates reached were rarely actually ratified by the governments they represented. Delegates played a type of 'two-level game' but were rarely successful in placing

[25] The states represented at the first conference held in Paris, 1859 were Spain, the Papal States, France, Portugal, Russia, Sardinia, Tuscany, Turkey, Austria, and Greece. (Protocoles de la Conférence sanitaire internationale, 1859)

enough pressure either on their own governments or other delegates to agree to really implement measures for health.[26]

Without a permanent secretariat or membership in a recurring international assembly, decisions at the conferences were usually met by simple majority vote and conventions and regulations emerging from the conferences were rarely ratified. No authority was transferred to any type of formal organisation that was able to take on the role of an agent, in a principle-agent relationship. Trade issues dominated negotiations to such an extent that Loughlin and Berridge write that "it would be inappropriate to think of the Paris meeting as a health conference" (Loughlin & Berridge, 2002, p. 7). The basis for the support of these conferences and the ensuing conventions and regulations should have been built on the principle that upholding common agreements amongst equally recognised sovereigns serves the greatest interest of those sovereigns. As Aginam describes: "Multilateral health diplomacy in the nineteenth century was founded on a state-centric model of internationalism that received normative imprimatur from the seventeenth-century Treaty of Westphalia" (Aginam, 2005, p. 62).

Goodman describes the convention that emerged from the 1903 Sanitary Conference (held in Paris) as the next major step in moving towards more formally established international cooperation that moved beyond ad hoc multilateralism. This conference, which covered aspects of the obligatory notification of epidemic diseases, sanitary measures for the shipping of goods through the Suez and hygiene measures for pilgrim ships, took place after the creation of a standing committee to consolidate previously poorly ratified conventions passed in 1892, 1893, 1894 and 1897 (Goodman, 1971, pp. 23-24). The existence of a standing committee was a crucial step towards coordinating international cooperation. It increased pressure on states to ratify agreements, eased the flow of information and provided a platform facilitating the sharing of knowledge about the interests and benefits of involved states. Following the Conference of 1903, the "idea of an international committee was taken further… when the representatives of 20 governments including Brazil, Persia, Egypt and the US, as-well-as European countries recommended the establishment of an International Office of Public Health" (Loughlin & Berridge, 2002, p. 6)

[26] Here I refer to the two-level game as described by Putnam (1988, pp. 430-36). Diplomats negotiate simultaneously at the domestic and international levels using flexibility or inflexibility of negotiations at either level to gain ground for reaching agreement.

2.2.2 The OIHP and the establishment of permanent institutions for health

The success of the standing committee in improved facilitation of the international sanitary conference should not be underestimated as a key step in the evolution of international cooperation in health towards global health governance. It directly preceded the establishment of the Office International d'Hygiène Publique (OIHP) in 1907 which was "…governed by the authority of the Permanent Committee composed of Delegates technically qualified in the field of health, designated by the Member States" (World Health Organisation, 2008a). The OIHP thus represented an organisation based on principles of intergovernmentalism, but at the same time contained a substantial problem-solving element in its mandate with a focus on expertise and problem-solving capacity. "Responsibilities of the Office were the administration of the international sanitary conventions, the service of epidemiological intelligence and collection and dissemination to Member States of information of general public health importance" (World Health Organisation, 2008a). The OIHP carried out functions such as overseeing epidemiological studies, preparing further conferences and implementing conventions up until 1946. In 1902, the Pan American Sanitary Bureau had also been created. The establishment of this organisation also represented international cooperation based on principles of intergovernmentalism, while containing a strong problem-solving focus. The establishment of permanent organisations served as an avenue to integrate the cooperation between scientists which had been developing throughout the 19th century into organisations formally based on intergovernmentalism.

With the foundation of the League of Nations Health Organisation (LNHO)[27] based in Geneva which did not replace but existed parallel to the OIHP, intergovernmentalism was concreted into a permanent international bureaucracy. The work of the LNHO was based on principles of common respect for agreements amongst states as equals. However, the dynamics of the organisation and its links to corporate philanthropy and a strengthening global biomedical network meant that during this time global health took a strong directional shift towards increasing influence of science in health policy. Dubin describes this as "…leading to the creation of a world-wide public health/biomedical episteme" (Dubin, 1995, p. 72; Loughlin & Berridge, 2002, p. 11).

[27] Founded in 1919 and dissolved in 1946.

This era and the combination of principles of intergovernmentalism and with expert capacity were influenced by a strong link between the League of Nations Health Organisation and the Rockefeller Foundation, from which LNHO drew between a third and a half of its budget at certain times (Weindling, 1995, p. 139). The foundation, a non-state actor, encouraged a problem-solving focus within the LNHO and a strategy shift towards technical activities such as technology transfer and standard setting (i.e. in biological information and epidemiological research methods). Based on principles of scientific universalism, public health became an issue-area in which experts, even those who were not directly representing states, came into positions of authority, effectively exercising bureaucratic authority in the Weberian sense (Loughlin & Berridge, 2002, p. 13). The LNHO made considerable advancements in the gathering of statistics on the state of health of the world's population. It developed programmes on social determinants of health such as how diet, housing and economic conditions affect health, and set standards in areas such as nutrition. In some countries, medical scientists used the authority of the LHNO to put pressure on governments to set or raise minimum standards in welfare provision. The LHNO moved in a direction of autonomy, based partly on a degree of financial independence from states, and on bureaucratic and technocratic authority.

2.2.3 Complex international bureaucracies

The foundation of the World Health Organisation (WHO) in 1948 (and its interim standing committee as of 1946) can be seen as the beginning of yet another era and development towards global health governance. At its establishment, principles associated with intergovernmentalism were securely fastened in the WHO's core structure. However, over time, the WHO itself moved through several eras in which programmes and activities were established that at various times were partly based on principles of scientific universalism, and later managerialism and cosmopolitan governance.

Both the OIHP and the League of Nations Health Organisation were dissolved with the establishment of the WHO, and the Pan American Sanitary Organisation was also incorporated into the WHO's structure taking on the function of the American Regional Office. Key background events from this era include the establishment of state health care systems in many industrialised countries, providing what is considered today to be a core obligation of governments to ensure basic standards of medical health care to all citizens. The increased influence of science during the previous era was accompanied by humanitarian and

human rights movements, creating a range of expectations on the WHO to take on a mandate broader than that of its predecessors.

The work programme of the WHO is formally determined by its member states in sittings of the World Health Assembly (WHA) held in Geneva in May of each year. An Executive Board prepares the programme for the WHA and is made up of technically qualified representatives of governments balanced among the WHO's six regions. In this sense the WHO is, and remains, a strictly intergovernmental organisation. However, as Weiss observed in the early 1980s, within such organisations the international civil service and 'supra-national staff' are "…charged with the day-to-day responsibility for international cooperation" (Weiss, 1982, p. 287). Indeed, over time, the WHO has developed into a complex international bureaucracy, and many members and observers of the organisation find it difficult to conceive the WHO as a single organisation at all. Loughlin and Berridge describe the development of the WHO as different from its predecessors in terms of "…a significant rise in the number of states, the number of intergovernmental organs, specialised agencies and nongovernmental organizations" that participate in its activities (Loughlin & Berridge, 2002, p. 16).

As a complex international bureaucracy, the WHO's legacy in terms of a shift towards global governance over the past fifty years can therefore be best captured by reviewing how interactions between different regions, political blocks, epistemic communities, other UN bodies, states and interest groups have resulted in paradigm conflicts and policy shifts throughout its history. Changes in conceptual approaches to global health within the WHO have reflected different political priorities, power constellations and technical advancements over time, each of which has given impetus to prioritise different working principles. An overview of the broader conceptual and consequent policy programme trends within the WHO are important to understand some key governance developments that followed around the turn of the 21st century.[28]

2.2.3.1 Disease-focused approaches of the 1950s and 1960s

Since its creation, the WHO has been instrumental in disseminating distinctive conceptual approaches to health and has been involved in "…transferring policies or policy cultures from national to international, and back to national levels" (Loughlin & Berridge, 2002, p. 18). Three eras can be identified in which the conceptual approaches of the WHO have differed,

[28] See Table 2.1: Governance eras in the history of the World Health Organisation.

the first spanning the 1950s and 1960s, the second in the 1970s and the third stretching from the 1980s onwards. In each of these eras, the WHO's approaches differ, not only in terms of their substantial focus, but also in terms of the extent to which different principles came to dominate the organisation's work programme.

The first approach in the 1950s and 1960s embodied disease specific programmes such as the Malaria Eradication Programme. This phase of the WHO was plagued by the development of blocs and broader ideological debate during standoffs between East and West, and by serious funding shortages. Concrete programmes therefore took place on a level which was as depoliticised as possible, following principles of scientific universalism, similar to those of its predecessor LNHO. Several of the WHO's most notable successes stem from this period, including 'vertical' disease programmes such as eradication of smallpox. Despite the fact that with the Universal Declaration of Human Rights gave global health a new character within the WHO which distinguished it from the technical nature of its predecessors, most projects in the early phases remained technically-focused.[29]

2.2.3.2 Systems based approaches and the Declaration of Alma Ata

The highly technical nature of the WHO's work was criticised during at the beginning of the second era, which spanned the 1970s. This era has been characterised by Thomas and Weber as a social democracy-based phase of global health (Thomas & Weber, 2004, p. 187). During this time, the WHO went through a major transition following a significant increase in membership of developing countries in the World Health Assembly, (as was the case of the United Nations in general). The balance of power shifted away from previously dominant members. A resulting increased concern with social determinants of health led to a change in strategic direction towards strengthening health systems and in-country projects, rather than fighting specific diseases or treating specific ailments. More states began to voice their demands claiming that technocratic governance based on principles of scientific universalism was flawed if it resulted in work programmes that did not accommodate the needs of the most disadvantaged member states and their citizens. Thomas and Weber note that during this phase with a global push from states of the 'Group of 77' and growing social movements that

[29] In the Universal Declarations of Human Rights it is stated that: "Everyone, without distinction as to economic and social conditions, has the right to the preservation of his health through the highest standards of food, clothing, housing and medical care which the resources of the State and community can provide. The responsibility of the State and community for the health and safety of its people can be fulfilled only by provision of adequate health and social measures"

called for a New International Economic Order, there were greater demands to strengthen UN Agencies as intergovernmental organisations, increase their funding and focus their work on those most in need. The WHO subsequently experienced a significant paradigm shift, culminating in the emergence of the concept of 'Primary Health Care', as laid out in the Declaration of Alma Ata in 1978.

The Declaration of Alma Ata followed a consensus that the World Health Assembly should be the central forum for global health cooperation and the WHO should be the key standard-setting organisation. Health as a human right was a central focus and goals were set to provide needs-based health care focusing on system-wide development and Comprehensive Primary Health Care (PHC) (Magnussen, Ehiri, & Jolly, 2004). Key to this paradigm shift was recognition of the need for community empowerment and equal access to health for all regardless of wealth. There was also a perceived need to build up broader sustainable health systems that did not address one particular disease but had the capacity to treat health problems and relieve social determinants of poor health.

This was defined within the Alma Ata Declaration as:

> …essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination (WHO, 1978).

The declaration also made specific mention of the notion of health as a universal human entitlement and encouraged participatory approaches to securing this entitlement. The era was thus marked by a strengthening of principles of intergovernmentalism, yet at the same time, saw the emergence of new norms and values that would later form the basis for cosmopolitanism in global health governance.

2.2.3.3 Inter-agency conflicts and monetary policy

The third phase, stretching from the 1980s onwards is marked by a shift towards more results-oriented approaches, and the adoption of principles of managerialism. During this era, the health goals of the WHO were "… revised and defined much more narrowly around specific diseases and specific goals of quantifiable scope" (Thomas & Weber, 2004, p. 192). Some observers also associate this era with an alignment of the WHO's work programme with

principles of neoliberalism emerging from the major global financial institutions during the 1980s and 1990s, namely the World Bank, International Monetary Fund and the World Trade Organisation (Ranson et al., 2002; Wamala et al., 2007).[30] Indeed, this era corresponds with a shift in significance of the global financial institutions for the health policy field as the promotion of economic growth through structural adjustment and the liberalisation of trade impacted on the way that health and health systems were managed. This led one commentator to write that: "The role of the market in determining entitlements to health increased while the role of the state decreased. Importantly, the PHC strategy was modified/derailed before it got going" (Thomas & Weber, 2004, p. 193).

During several years from the 1970s onwards, the WHO also faced a frozen budget in real terms, and increasingly, donors moved towards supporting extra-budgetary goal-oriented programmes, thereby expressing a preference for the WHO work to be based on a more managerial style. From the 1980s onwards the WHO began developing 'special' or disease-specific intervention programmes which were intended to "…boost the organisation's routine activities, using international and regional expertise and a project based approach to attack specific diseases or health issues (Godlee, 1995, p. 179). Because these 'special programmes' were reliant on specific purpose funding, a greater focus was placed on capacity to achieve results with a high level of efficiency to prove their value – "By shifting their funds to the special programmes, donors can influence how their money is spent" (Godlee, 1995, pp. 179-180).These special programmes can be seen as an important precursor to public-private partnerships and GHG organisations. "By 1996 such extra-budgetary funds had come to account for over a half of the total WHO budget with more than 80% of these funds coming from 10 donor countries" (Vaughan et al., 1996, p. 253).

[30] Neoliberalism in this sense refers to a set of principles that link free-trade and individual liberty with peace. This is based on a premise that "…democratic society, in which civil liberties are protected and market relations prevail, can have an international analogue in the form of a peaceful global order". Thus, neoliberalism, while recognising the importance of states, does not claim that intergovernmentalism is the only acceptable mode of decision-making on the global level (Burchill, 2005, p. 81).

Table 2.1: Governance eras in the history of the World Health Organisation

Time Frame	Programme Focus	Dominant Working Principles
Inception – late 1960s	Disease elimination; post World War Two recovery	Intergovernmentalism; scientific universalism
1970s	Strengthening of health systems, Primary Health Care	Intergovernmentalism; to a lesser extent cosmopolitanism
1980s onwards	Extra-budgetary programmes	Intergovernmentalism; managerialism

The three WHO eras described above demonstrate an evolution in governance within the WHO from technical disease-focused approaches, across broad health-systems approaches, to project management approaches respectively (see Table 2.1). Understanding the working principles that dominated each of these eras is important for tracing the evolution towards GHG organisations for two reasons. First; it demonstrates the complexity of power relations within the global health issue-area which has become a web of competing interests played not just amongst states but many other actors as well. Second, the second and third eras described above have given rise to two significant changes in health governance: namely an opening up to the participation of civil society organisations (CSOs) (a part of adopting principles of cosmopolitan governance) and the establishment of public-private partnerships for health, (that often base their work, at least in part, on principles of managerialism). The WHO has been closely involved both in developing ways in which CSOs have become active in its activities and in initiating the establishment of public-private partnerships. Each of these changes will be described in more detail below as the key next steps in the evolutionary process towards the formation of GHG organisations.

2.2.4 Opening up to CSOs

Generally, three factors stemming from the more problem-oriented approaches found within the WHO and other international organisations active in the field of health from the 1980s onwards have made the issue-area particularly open to innovative governance forms and the involvement of non-state actors in international institutions.

First, the aim of providing all people with a life free of disease and pain has become relatively undisputed, even if poorly executed. This is partly because the envisaged 'causes' of poor health have been de-politicised and presented on a micro-biological level by medical experts advocating a problem-oriented approach, thus motivating different types of actors to cooperate to combat infectious diseases as a worthwhile cause (Maclean & Maclean, 2007).

Second, within many states, public health has come to involve and even rely on non-state actors for the implementation of health-related services and the provision of health-related goods. This is not necessarily new. Public health projects have a long history of being led by individuals, churches or community groups, before health care was standardised as a public responsibility within welfare states. For example in the 19th century public health actions to clean up American cities were led by civil leaders and women's groups, and in England, the pre World War Two national health service was a mix of public and private actors working together. In many countries, hospital services run by churches and other charitable groups pre-date those run by the state. Even now non-state actors play a large role in the provision of health services in developing countries, even without being part of any public-private partnership or receiving funding from public sources.

Third, results-oriented approaches to global health have come with improvements in data collection methods and analysis which make outputs of global health activities more observable and measurable. The promise, ability and expectation to show results in the form of concrete data has provided further impetus to adopt any means necessary to achieve results, including experimenting with cooperative arrangements and governance forms that break with conventions of the past. As the health sector can rely on epidemiological statistics on mortality and morbidity, the aims, pathways and results of international institutions tend to be treated differently.

These three factors demonstrate the unique relationship that exists between the various actors involved in global health and the unique way in which health politics is influenced by changes in medical and public health sciences. Along these lines, it is possible to observe that, since the inception of the WHO, civil society organisations have increased in presence, scope and number in the health sector. Echoing Article 71 of the UN Charter, Article 71 of the World Health Organisation states that "…the WHO may make suitable arrangements for consultation and cooperation with nongovernmental organizations (NGOs) in carrying out its international

health work" (World Health Organisation, 2007b). Five key developments indicate a progressive opening to CSOs on behalf of the WHO and an increasing importance in their role in global health in general. Nevertheless, it should be noted from the outset that on no occasion has the WHO implied the further development of the status of CSOs to a level equal to states.

The first key development was the WHO's introduction of a system of categorisation for CSOs, similar to that of the United Nations Economic and Social Council (ECOSOC). As early as the first World Health Assembly, ten international CSOs were in attendance with observer status. Slightly differing from the ECOSOC three tiered status system, the WHO distinguishes only between formal and informal relations with CSOs. In 2008 there were 186 CSOs with official formal relationship status (World Health Organisation, 2008b). CSOs are further assisted in developing relationships with specific WHO departments through the WHO Civil Society Initiative, which is responsible for the administration of formal relations. There are offices of the Civil Society Initiative in each of the WHO regional offices (World Health Organisation, 2008b).

The second key development was the increase in influence of CSOs in agenda-setting. One of the main self-proclaimed functions of many CSOs in the health sector is to offer a voice for, and champion the causes of those who are under-represented on the global level. They engage in agenda-setting by using formal and informal channels to lobby the WHO's member states and also by developing pragmatic strategies for tackling global health problems that appear attractive to those in power and/or appeal to the social conscience of others. The most cited path-breaking example is the work of CSOs leading to the Convention on the Marketing of Breast Milk, a prime example of the increasing prominence and strategic power that CSOs gained in health and indeed in several other issue-areas from the 1970s onwards (Rowson, 2005, p. 198).

The third key development has been the inclusion of CSOs in health policy development on the global level, as formally recognised and influential partners. The prime example to be given here is the policy development process leading to the Framework Convention on

Tobacco Control.[31] This can be seen as an extension of the existing formal ties already awarded to CSOs under consultation. During the treaty development process the International Nongovernmental Coalition Against Tobacco was represented in the Policy Strategy Advisory Committee, and the WHO also developed partnerships with civil society to raise awareness for anti-tobacco campaigns. The Framework Convention on Tobacco Control development process also involved public hearings, at which CSOs were particularly active (Yach et al., 2007, p. 55).

The fourth key development is the formal recognition of CSOs in the new International Health Regulations (IHR), which came into force in 2005.[32] The new IHR allow for the first time allow non-government sources as valid providers of information for global epidemiological surveillance of infection diseases. This is a significant development in the history of the WHO, because disease reporting (one of the most basic functions of the WHO) was previously voluntary and considered a practice that only states could appropriately carry out.

The final key development is the institutionalisation of CSOs as members within certain projects and programmes with extended rights in policy-making and strategy formulation. This is possibly the most significant of all the key developments listed above. Formally including CSOs as a fixed feature of decision-making bodies within an organisation, indicates a shift away from the principles of intergovernmentalism towards one of the key components of cosmopolitan governance. This suggests that individuals, not states, are the prime objects of concern of global politics, and that their interests can (and should) be represented in global institutions through various political communities (not only states). One example of an organisation where CSO involvement is institutionalised is UNAIDS, an organisation in the form of a consortium of several UN bodies, including the WHO. This organisation will be addressed in depth in the analytical part of this dissertation. Here, however, it is important to

[31] The Framework Convention for Tobacco Control is a global health treaty that lays out core demand reduction provisions covering pricing, taxation and other non-monetary measures for reducing the demand for tobacco. For an outline of the involvement of NGOs in the treaty preparation process see Yach et al. (2007, pp. 57-59)

[32] In 1951 the International Sanitary Regulations were adopted to address sanitary, quarantine and reporting measures to prevent the geographical spread of four diseases; cholera, plague, yellow fever and smallpox. The regulations were later renamed the International Health Regulations (IHR) in 1969, and updated in 1981, when the eradicated smallpox was removed from the list of diseases for which reporting by states was compulsory. In 2005 the International Health Regulations were revised and strengthened in the wake of SARS pandemic and the new IHR now constitutes a landmark legal framework for the management of acute global public health risks (Fidler, 2004; Fidler & Gostin, 2006; Leung & Ooi, 2003).

note that within UNAIDS, CSOs – specifically associations of people living with HIV/AIDS, have a permanent seat on the UNAIDS Programme Board, allowing – and indeed requiring – CSOs to play a role in the central decision-making processes of the organisation and the most intimate processes of governance. UNAIDS can thus be seen as an example of a significant leap towards GHG organisations. Indeed, as will be outlined below, UNAIDS displays many of the characteristics that allow it to be classified as a GHG organisation.

These five developments in the history of the WHO and WHO-related organisations reflect just some of the ways in which CSOs have come not only to play a prominent role in global health over the past half-century, but also show that they have come to enjoy a new ontological status in global health governance (Buse & Waxman, 2001, pp. 748-749).

2.2.5 Public-private partnerships

Several other key developments from the 1970s onwards that changed the global health landscape gave rise to yet another type of organisation that can be seen as a stepping stone towards GHG organisations: so called public-private partnerships. In such partnerships it is possible to observe a distinct trend moving away from purely state to multi-actor governance, involving international organisations, civil society organisations and even business sector actors.[33] Much confusion still exists over the exact definition of public-private partnerships, their composition and the extent to which they really offer something new for public health practice (Malena, 2004, pp. 2-4). However, the significance of public-private partnerships becomes apparent when distinguishing them from other modes of cooperation found within the public health sector.

The external conditions contributing to the rise of public-private partnerships can be characterised as stemming three trends: first, a decline in the capacity of states and state based organisations to effectively manage issues of global public health, second, competition (and in some cases conflict) between international organisations, [34] and third, an increasing awareness

[33] Here, and in the remainder of this dissertation the term 'business sector actors' will be used to refer to private, for-profit enterprises. Many authors used the term multi- or transnational corporations (M- or TNCs) to denote the same. The term 'business sector actors' is chosen because it is a more generic term, referring not only to corporations with global activities, but also small-scale for-profit actors of a variety of legal forms.

[34] Examples are the conflicts between structural adjustment programmes and investment in health, between intellectual property rights and access to medicines and the debate between the WHO and UNICEF over comprehensive vs. selective health care (Basch, 1999, p. 216; Beigbeder, 2002, p. 61).

of the effect that trade and trade organisations have had on health policy and health outcomes. This, along with the changes in technologies and assessment methods used in the area of public health described above, led to the perceived need for innovative governance forms (Price-Smith, 2002). Buse and Walt suggest that this perceived need was strengthened by ideological shifts towards neo-corporatism, growing disillusionment with the UN and its agencies (and chronic funding shortages within those agencies) and recognition that "…emerging health problems require a range of responses beyond the capacity of either public or private sectors working independently" (Buse & Walt, 2000a, pp. 550-551).

In reaction to these changes and problems, alternative organisational forms emerged that engage both public actors (states and state-based organisations) and private actors (CSOs and business sector actors) in high-level decision-making (i.e. decision-making with wide implications and reach) (Kickbusch, 2005). The governance forms are most commonly described as public-private partnerships, they are also referred to as public policy networks, multi-sector networks, and multi-stakeholder partnerships (Witte, Reinicke, & Benner, 2000; Malena, 2004).

Public health has seen the rapid adoption of public-private partnerships, with over 80 such partnerships with a global focus listed on the International Public-Private Partnerships for Health database, and probably many more which operate locally.[35] With this sudden and massive presence, it is not surprising that public-private partnerships have been the focus of much attention, both welcomed for the opportunities they bring, as well as criticised for the power they 'lend' to private actors (Richter, 2004, pp. 43-48; Zammit, 2003; Sridhar, 2003; Carlson, 2004; Bartsch, 2002, pp. 449-450).

This parallel scepticism and optimism stems in part from the vague nature of public-private partnerships and confusion over what they entail and what principles underlie their work. Public-private partnerships appear to come in all shapes and sizes, some hardly differing at all from CSOs, which were similarly scrutinised in scholarly debate in the 1990s, and others entailing seemingly little more than states 'contracting out' operations to private business. By definition of the UN Secretary General's office, public-private partnerships are "…voluntary and collaborative relationships between various parties, both state and non-state, in which all

[35] The International Public-Private Partnerships for Health database is not longer operational. However, archives are available online at www.ippph.org.

participants agree to work together to achieve a common purpose or undertake a specific task" (Malena, 2004). The UK Department of International Developments Global Health Partnerships Project offers a definition along a similar vein as '…a collaborative relationship among multiple organisations in which risks and benefits are shared in pursuit of a shared goal (Carlson, 2004, p. 5). These definitions however, leave room for confusion in terms of the roles the 'various parties' should play, or how these 'collaborative relationships' differ from any other contractual relationship between state and non-state actors that have existed in the past (Widdus, 2003, p. 235; Börzel & Risse, 2005; Lindner & Rosenau, p. 5). Furthermore, while there has been significant research classifying different types of partnerships according to aims and function, degree of formalisation, the types of actors involved, and scope of activities, (Brühl & Liese, 2004, pp. 164-168; Buse & Walt, 2000a, pp. 704-708; Huckel, Rieth, & Zimmer, 2007) relatively little notice is taken of exactly how decisions are made within public-private partnerships.[36]

A preliminary qualitative overview of public-private partnerships for health found that five important aspects which vary from partnership to partnership: 1) the extent to which strategic or operational decision-making is necessary; 2) whether decision-making is regulated within a body such as a Board of Directors, or undertaken ad hoc within meetings between partners; 3) the extent to which all partners are involved in high level decision-making, or only in operations; 4) whether decision-making is carried out by partners, representatives or by panels of experts; and 5) whether deliberate measures are taken to involve persons or regions affected by the target diseases (Huckel, 2005).

Thus, it is not possible to speak of all public-private partnerships as being the same in terms of who participates in decision-making and to what degree joint decision-making takes place. This has consequences for current debates over the appropriateness of public-private partnerships in determining health policy. What is evident however, is that increasingly actors from both public and private sectors do work together in organised environments that externally present themselves as complying with certain conventions and working according to certain principles. These principles suppose it is both possible and desirable that public and

[36] The World Bank defines a PPP as the spectrum of possible relationships between public and private players for the cooperative provision of infrastructure and/or services. They go on to write that a distinguishing feature of this is the development of a shared governance structure. However, this may or may not always be the case (World Bank, 2003, p. 5).

private actors should jointly contribute to the production of public goods due to the ability to produce certain results and effectively manage certain problems.

There are four indicators that demonstrate the extent to which these conventions have come to carry weight in global health governance: first; the sheer number of public-private partnerships that have been established; second, the scope of these partnerships, in terms of geographic reach, their types of activities, and acquired resources; third, the level of organisational sophistication of the partnerships; and fourth, the level of acceptance that they now appear to enjoy (Huckel Schneider, 2008 forth.).

For example, in terms of *quantity* there has been a rapid formation of a large number of PPPs over the past 10 – 15 years can be asserted. In 2003 Roy Widdus reported on over 50 PPPs operating internationally (Widdus, 2003), a number which increased to 80 by 2005. Most of the partnerships listed were formed after 1995. There are many more PPPs which operate locally and regionally and as yet there is no central data source that comes close to listing them all.

In terms of *scope*, PPPs now approach an astounding range of activities and goals, such as product donation and development (e.g. the Mectizan Donation Program, founded in 1987 and the International AIDS Vaccine Initiative established in 1996) and pressing issues such as education resources, (e.g. The Health Communication Partnership founded in 2004) and health workers shortages (The Global Health Workforce Alliance, founded in 2006). PPPs have also widened their geographical scope. Whereas 'international' partnerships in the 1980s and early 1990s involved mainly service provision in developed countries, or global coordination services, today PPPs, both global and local, are active in almost every country on the globe. PPPs also have increasing levels of resources at their disposal. This can be most clearly seen in terms of financial resources, but also in terms of the number of expert staff they employ as well as the social and reputation resources they have gained.

In terms of increasing *sophistication*, many PPPs within the health sector have and are undergoing changes in terms of their organisational structure and rules for decision-making. This has come about as many PPPs have transformed from pilot projects to long-term strategy forming organisations.

Finally, PPPs seem to be gaining increasing levels of *acceptance* as vital, stable and even taken-for-granted organisations within the global health architecture. The United Nations explicitly promotes closer ties with the business sector to increase effectiveness and efficiency and in 1993, the World Health Assembly called on the WHO to "…mobilize and encourage the support of all partners in health development, including nongovernmental organizations and institutions in the private sector, in the implementation of national strategies for health for all" (World Health Organisation, 1993). The WHO 2002 Report on Communicable Diseases describes PPPs as contributing to the strengthening of health services and systems, (World Health Organisation, 2003, p. 31). At national levels, a growing number of development agencies and finance ministries have officially promoted the use of public-private partnerships as a strategy for global health in white papers (see Appendix II).

Together, these four elements, (quantity, scope, sophistication and acceptance) indicate that PPPs have become a prominent if not dominant strategy for addressing deficiencies and problems in global health.

However, PPPs have not only become a prominent feature of the global public health landscape, they have also become the topic of debate and criticism. This is because they embody working principles that have broken away from principles of intergovernmentalism to such an extent, that other principles have come to dominate, such as managerialism and (to a lesser extent) cosmopolitan governance. This has sparked a debate over the extent to which this is, and should be considered appropriate, in global public health. With public-private partnerships involving not only CSOs but also business actors and philanthropist foundations in decision-making roles, questions of legitimacy have arisen, along with debates over whether it is desirable, proper or appropriate for for-profit actors to be involved in policy-making. Of particular concern is the possibility of instances arising where the goals of profit making business sector actors' accountability towards its shareholders will be considered more important than the health goals that drive the formation of PPPs in the first place (Reid & Pearse, 2003; Carlson, 2004, pp. 11-16; Hancock, 1998, p. 193)[37] The key question thus arises as to whether organisations such as PPPs, that embody working principles of managerialism can rely on acceptance of their working principles to ensure support from key stakeholders in global health, or, in other words, to ensure their legitimacy.

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[37]One example is the protection of patents conflicting with programmes to increase access to affordable medicines (Buse & Walt, 2000b).

2.3 GHG organisations

Following the extensive look at the history of international cooperation in health and global health governance above, the following section proceeds to describe the latest trend in global health governance that has emerged over the past 15 years – namely the establishment of GHG organisations (as briefly introduced in Chapter One).

Fidler describes global health governance as a part of "post-Westphalianism [that] involves a new process that seeks to achieve new substantive objectives – global public goods for health" (Fidler, 2005, p. 174). He goes on to state that new post-Westphalian strategy differs from that laid out in the preamble of the WHO Constitution and pursued by the WHO during the 20th century in that it attempts to integrate non-state actors into public health governance. This includes the establishment of PPPs for health and the WHO's use of non-governmental actors as sources of information for global epidemiological surveillance. It also differs by "…activating, energizing and involving non-state actors in creating and implementing new governance regimes" (Fidler, 2005, p. 174).

Several organisations founded around the turn of the century take this final step towards genuine inclusion of non-state actors as equal institutionalised partners in decision-making. These organisations, classified as GHG organisations, can be defined according to the four key elements introduced in Chapter One (their ability to engage in governance, their focus on health, their global scope, and the variety in their working principles that advance beyond intergovernmentalism). However, they also have several other characteristics in common; the most important of these is their highly inclusive central decision-making structures. In fact, GHG organisations fit the requirements of what are called 'inclusive institutions'. "An inclusive institution allows for memberships of both public sector and private sector actors and endows these members with rights in the policy-making process" (Rittberger, Huckel, Rieth, & Zimmer, 2008, p. 26). Several other features are also found to be common amongst GHG organisations. For example, in terms of the monitoring function of their governance activities, they rely on mechanisms of managerial follow-up, they have a focus on one or a few diseases or prevention strategies, they have flexible evolving and increasingly sophisticated organisational structures, and they appear to spend time investing in legitimation strategies. UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI Alliance) serve as prime examples of GHG organisations that have these features in common, although in each

organisation they are manifested differently.[38] These features and examples from each of these organisations are summarised in Table 2.2, and are elaborated below.

2.3.1 Inclusive decision-making structures

GHG organisations all have the common feature of having inclusive decision-making structures that give states as well as non-state actors' rights in decision-making processes. This feature can be directly linked to the fact that the working principles of GHG organisations are not (predominantly) based on intergovernmentalism. Even the central decision-making body of UNAIDS (a GHG organisation located firmly within the United Nations system) displays this feature.

The central decision-making body of UNAIDS is its Programme Coordinating Board (PCB) which was briefly introduced above. The PCB decides on all programmatic issues concerning policy, finance, monitoring and evaluation. Membership is made up of 22 states and five CSOs, as well as ten co-sponsoring UN organisations. While the 10 UN co-sponsoring organisations all have renewable seats, state and CSO representatives rotate every two years and are elected through the regulated process of nomination, review and voting. CSOs are not granted voting rights, but are assured a place in the PCB, bringing CSOs both rights and responsibilities as full political actors and delegates of a valid political community. This makes UNAIDS both an inclusive institution and one whose work is based on a combination of principles, intergovernmentalism, and cosmopolitan governance.

The central decision-making structures of GFATM and GAVI exhibit even higher levels of inclusiveness. The Foundation Board of GFATM is the supreme governing body and has the power to determine eligibility criteria for projects and make funding decisions. The twenty voting members consist of seven representatives from developing states, eight representatives from donor-states, and five non-state representatives (one representing developing country CSOs, one representing developed country CSOs, one representing the private sector, one representing communities of people living with the diseases[39], and one representing private foundations). There are also four non-voting members representing UNAIDS, WHO, World Bank, and a Swiss citizen as required by law. This highly inclusive composition is justified by

[38] There are a range of other GHG organisations that could also be taken as examples such as Roll Back Malaria, the Stop TB Partnership, and the Global Alliance for Improved Nutrition.
[39] This representative was originally intended to be a non-voting member (GFATM, 2007c).

principles of intergovernmentalism, cosmopolitan governance and managerialism. States representing their respective territories still comprise the majority of seats on the board. Yet some actors are present that contribute expertise. Others, such as the CSO representative for communities living with the diseases, act as delegates for a cosmopolitan political community.

Table 2.2: Common features of global health governance organisations

GHG Organisational Feature	Examples from UNAIDS	Examples from GFATM	Examples from GAVI Alliance
Dominant Working Principles	Intergovernmentalism; some cosmopolitan governance.	Balance between intergovernmentalism, cosmopolitan governance and managerialism	Strong managerialism component; some cosmopolitan governance and intergovernmentalism.
Inclusive decision-making structures	PCB composed of state delegations and delegates from Associations of People Living with HIV/AIDS, balanced between geographical regions.	Members of the Foundation Board represent donor and recipient states, business sectors actors and non-governmental actors	Members on the Alliance Board represent states, business actors and CSOs with particular relevance to the goals of GAVI
Active managerial follow-up	Co-sponsoring members of UNAIDS provide expertise and technical assistance.	WHO and Global Fund offices in developing countries work with stakeholders.	Coordinating Committee oversees disbursement and use of funds
Narrow focus	Focus on HIV/AIDS and related health aspects	Main focus on HIV/AIDS, Tuberculosis and Malaria	Focus on diseases preventable through immunisation
Organisational sophistication	PCB guides a secretariat and Regional Support Teams	Foundation Board supplemented by the Partnership Forum, the Foundation Board, the Secretariat, and the Technical Review Panel.	Governance structure entails complex linkages between a GAVI Foundation Board, Alliance Board, Fund Board, Affiliates Board and the Board of the IFFI. Various committees support Alliance Board.
Investment in legitimation strategies	Publishes records of PCB meetings, emphasises effects and efficiency on its website and in publications.	Publishes reports on effectiveness and outcomes, focuses on its transparency, publicises inclusive nature of its decision-making Board.	Releases regular updates on its progress, emphasises the inclusiveness of its Board on its website

Membership on the Board of the GAVI Alliance is very broad-based. Twelve rotating members represent: developing country governments, industrialised country governments, a technical health institute, the industrialised country vaccine industry, the developing country vaccine industry, non-government organisations, and a research institute. There are four renewable members: the Bill and Melinda Gates foundation, UNICEF, The World Bank Group, and the WHO. Originally the rotating members sat for a term of two years, and this has now been changed to three years. As with GFATM, the GAVI Alliance Board is

comprised mostly of states, allowing the organisation to work, at least in part, with principles of intergovernmentalism. However, the decision-making structures in the GAVI Alliance also have a high leaning towards expertise and capacity building actors, enabling the organisation to base its work on principles of managerialism.

2.3.2 Active managerial follow-up

By definition, GHG organisations engage in governance. This entails not only policy-making, but also ensuring the successful execution of policies and the compliance of others required to make them a success. There are two broad means by which governing organisations do this. The first is by means of 'authoritative dispute settlement', where a central body has the power to impose sanctions on any one actor that is not complying with its rules, similar to law enforcement mechanisms within states. GHG organisations do not have, nor do they seek it. The second is by means of 'active management', which involves becoming more intimately involved with the processes of the operational follow-up of its policies, making sure that any non-compliance is not due to incomprehensible policies or a lack of capacity to work in compliance with them (Brühl & Rittberger, 2001, pp. 23-24; Rittberger, Huckel, Rieth, & Zimmer, 2008, p. 40). The problem-solving focus of GHG organisations generally leads to them having a strong level of active managerial follow-up. In the case of UNAIDS, for example, the co-sponsoring UN agencies and programmes provide expertise and technical assistance to assist stakeholders in complying with UNAIDS recommendations and raise levels of knowledge and understanding for the research and scientific evidence on which they are based. In the case of GFATM, the organisation utilises WHO and Global Fund offices in developing countries to assist with meeting GFATM requirements. GFATM also conducts meetings in various regions of the world to promote knowledge and understanding of policies. The GAVI Alliance also invests time and resources in a comprehensive active managerial follow-up: health systems are strengthened to assure GAVI projects can be successfully carried out. A coordinating committee oversee disbursement and use of funds, ensuring that policies do not fail due to mismanagement.

2.3.3 Narrow, disease-oriented focus

Another distinguishing feature of GHG organisations is their narrow focus on one or just a few health topics. Unlike the WHO, which has a broad mandate to cover all aspects of global health, and in contrast to states, which are organisations that fulfil broad functions covering almost all areas of political life within a given territory, GHG organisations have the

characteristic that their work concentrates on a specific global health problem or challenge. This characteristic can be seen as a consequence of the political environment in which they were created. During the 1990s and early 2000s, several pressing health problems gained a great deal of attention globally, and previously-established programmes for addressing were criticised. For example, UNAIDS is an organisation with a focus on alleviating the HIV/AIDS epidemic and founded as a replacement for the WHO Global Programme on AIDS (GPA). Calls for the establishment of the GAVI Alliance emerged after immunisation coverage rates dropped dramatically in some countries in the beginning of the 1990s, and the effectiveness of the Expanded Programmes for Immunisation (run by the WHO and UNICEF) were called into question. Similarly, calls for the formation of GFATM arose out of serious shortfalls for the funding of AIDS programmes.

There are two possible consequences of this narrow focus. The first follows criticism that GHG organisations might hinder the building up of strong, all-encompassing health systems if they contribute an over-proportional amount of resources to one or just a few diseases. Arguments in this direction suggest that because GHG organisations have a narrow focus, they are not flexible enough to be responsive to changing needs and changing priorities in global health (Richter, 2004). The second consequence of a narrow disease focus is a strong emphasis on achieving results. GHG organisations are in a situation where they can invest their resources on achieving the results for which they were created, and feel obliged to do so, with the respect to their founding histories.

2.3.4 Organisational sophistication

GHG organisations can be distinguished from other, more basic public-private partnerships for health by the level of sophistication displayed in their organisational structures. Decision-making bodies are highly formalised as are consulting committees and the relationships between executive boards and their ever growing secretariats. This means that GHG organisations are designed as true governing organisations and not merely ad hoc operational programmes. Some GHG organisations, like those presented as case studies in this dissertation have been operating for between five and 15 years, and within this timeframe their organisational structures have become increasingly complex. This is partly due to the increase in size of these organisations and the necessity to build up larger secretariats in order to have enough personnel resources to carry out their work. However, it is also a response to demands to provide more stable, predictable and formalised decision-making structures. For

example, in 1999 UNAIDS introduced formal rules for the election of civil society representatives to its Programme Coordinating Board, and in 2007 requirements and rights of civil society representatives were revised following an internal review (UNAIDS, 1999a; UNAIDS, 2006a; UNAIDS, 2007a). Within GFATM, the executive board is now supplemented by a partnership forum, and technical review panel. The GAVI Alliance seems to have developed the most complex structure of all. Unlike in early years, it is now actually quite difficult to comprehend who is responsible for what decisions within the organisation. The governance structure is made up of complex linkages between a several management boards. Other GHG organisations have also undergone considerable change. For example Roll Back Malaria, which has evolved from a WHO-led partnership to a GHG organisation, with the introduction of an inclusive board of directors in 2002 (Huckel, Rieth, & Zimmer, 2007, p. 141).

2.3.5 Engaging in legitimation strategies

A final common feature of GHG organisations is manifested in the way in which they interact with other actors in their political environment. GHG organisations appear to invest both time and resources in presenting themselves (their policies, their effects and their organisational traits) in a positive way to other actors in global health. GFTAM, the GAVI Alliance and UNAIDS all release publications, in the form of websites, fact sheets and reports that address and explain to their stakeholders why they are organisations particularly worthy of support. These activities can be interpreted as part of a legitimation strategy on behalf of these organisations. For example, several publications of GHG Organisations contain features reminiscent of corporate advertising. The main website of the GAVI Alliance boldly presents the organisation as incorporating 'innovative funding', 'innovative partnership' and 'innovative technologies' (GAVI Alliance, 2008a). The GAVI Alliance also regularly release performance reports and video material designed to educate stakeholders about its policies. GFATM frequently releases publications designed to educate stakeholders about policies and publicise its successes. It also has a highly comprehensive website, on which a large amount of information can be accessed, including all governance and funding policies, and biographies of each delegate that sits on the Foundation Board. The website of UNAIDS also contains links to documents which lists the names and contact details of attendees of its Programme Coordinating Board meetings. A useful contrast to this type of outwards presentation are the websites of the WHO or UNICEF. Their opening websites and publications are usually presented in an unadorned format with a focus on issues and

challenges. This common feature of GHG organisations is particularly interesting because it suggests that they deliberately seek to build up support amongst stakeholders by emphasising certain traits – which they consider make their organisations worthy of support.

2.4 Conclusions

GHG organisations represent a significant development on the global health landscape. They are unique in the extent to which they break with conventions in the past, yet this is not likely to come as a complete shock to the stakeholders in global health. The historical perspective outlined in this chapter shows that non-state actor involvement has long been present in global health. Also, at various times, major health organisations (including the World Health Organisation) have partly based their work on principles other than intergovernmentalism. Indeed, the historical perspective shows that only during a short period in the 1970s was there a balance between states, regardless of their financial influence that gave power to the World Health Assembly as a parliamentary-like body that shaped the strategic direction of global health. Directly preceding this era, scientific universalism was a strong working principle, and following this era, extra-budgetary programmes of the WHO already began moving towards principles of managerialism, based on outcomes and efficiency. GHG organisations, whose work is based on a mix of intergovernmentalism, managerialism and cosmopolitanism, can therefore be seen as product of a long and steady evolution.

Yet, the extent to which intergovernmentalism has had to give way to alternative working principles has reached a new level within GHG organisations, and they display a range of common features that distinguish them from IGOs. The key questions of this dissertation therefore still remain open: How do GHG organisations – having broken away from conventional models of intergovernmentalism – gain stable political support amongst the key stakeholders in global health? What makes a GHG organisation legitimate and how do GHG organisations come to be accepted as legitimate amongst key stakeholders in global health?

The following chapter will proceed to find answers to these questions by addressing legitimacy as a concept: looking at what it is, and what the legitimacy of a GHG organisation might be based on, not only in terms of working principles, but what substantial and operational elements of a GHG organisation can be used as indicators of legitimate governance.

Chapter Three

Legitimacy in global health governance

Global health governance organisations appear to have become accepted as valid, even desired, organisations with which to engage on the global level. As described in Chapter One, they have widened the scope of their policy field, have gained increasing levels of funding, and have found that an increasing number of actors are willing to act in accordance with their policies. GHG organisations also deliberately seek out support from their stakeholders by publicly highlighting certain organisational features, as described in Chapter Two. This indicates that GHG organisations are aware that the support they receive from their stakeholders needs to be robust, stable and predictable. They seek broad 'diffuse', support rather than narrow 'specific' support from other actors in their political environment (Westle, 2007 p. 95).

In politics, diffuse support "…refers to the evaluation of what an object is or represents – to the general meaning it has..." (Easton, 1965, p. 437). For GHG organisations, this means support based on organisational features and working principles, rather than support for each and every activity undertaken. In other words, GHG organisations desire, and require, a 'reservoir of support' that allows them to go about their everyday activities, without threat of

active disapproval in the case of intermittent failures (Easton & Dennis, 1980, p. 338; Easton, 1965, pp. 51-57). The existence of this reservoir of support relies on judgements on behalf of stakeholders that there is something essentially rightful about a particular GHG organisation, that it ought to be given the opportunity to create and carry out its policies, and that it should receive active support in doing so. This perception can be conceptualised in terms of the legitimacy of a GHG organisation; a concept that essentially ties the pragmatic needs of a governing organisation – to obtain diffuse support – with the normative judgements of its stakeholders.

This mix of normative considerations and empirical effects makes the concept of legitimacy complex. However, understanding legitimacy is essential for answering the motivating question of this dissertation: how do GHG organisations – having moved away from conventional models of intergovernmentalism – gain and maintain stable political support amongst the key stakeholders in global health?

This chapter is devoted to the concept of legitimacy and its relevance for global governance (and global health governance in particular). It begins with a clarification of the concept itself, and reviews some of the debates that are currently being waged in global governance studies over the extent to which legitimacy can exist beyond the level of the state. The chapter then proceeds to address how legitimacy can be conceptualised on the global level in the health policy field and the question of which features of GHG organisations might make them appear legitimate (or not) in the eyes of their stakeholders. At the conclusion the chapter, the information is brought together and a proposal made as to how legitimacy can be conceptualised on the global level.

3.1 Legitimacy, a contested concept

Legitimacy is a contested and complex concept because it is both a basis on which power can be executed, and it is also "…ultimately grounded in intersubjective meanings, normative structures, and social institutions" (Reus-Smit, 2007, p. 167; Habermas, 1973, p. 46). Luck has described legitimacy by saying that: "Everyone wants to have it, but there is little agreement on where it comes from, what it looks like, or how more of it can be acquired" (Luck, 2002, p. 47). In seeking diffuse support from their stakeholders, GHG organisations engage in a normative process "…seeking to justify their identities, interests, practices, or

institutional designs" (Reus-Smit, 2007, p. 159). Understanding legitimacy therefore requires bringing essentially normative concepts into a framework where their empirical effects can be observed" (Zelditch, 2001, p. 34).

Legitimacy has long been a debated concept in political philosophy; and has remained an arguable term which is difficult to define and even more difficult to measure. Unlike power or coercion, which are concepts based at least partially on control over material resources, legitimacy is an essentially normative concept of ideas and perceptions (Frank, 1990). Furthermore, as alluded to by Schmitter, on the global level legitimacy is also usually only discussed when it is absent, or under threat:

> Only when a regime or arrangement is being manifestly challenged by its citizens/subjects/victims/beneficiaries do political scientists tend to invoke lack of legitimacy as a cause for the crisis. When it is functioning well, legitimacy recedes into the background and persons seem to take for granted that the actions of their authorities are "proper," "normal" or "justified" (Schmitter, 2000 p. 1).

GHG organisations have emerged at a time when there has been much public debate over legitimacy on the global level. There has been talk of legitimacy crises amongst international institutions, most notably the international financial institutions such as the World Bank, the World Trade Organisation and the International Monetary Fund, but also the United Nations system as a whole. The related debates are often waged with little clarification of what legitimacy means in terms of these organisations and are sometimes accompanied by claims that legitimate governance cannot exist at all on a level above that of the state (Dahl, 1989; Buchanan, 2002).

The first part of this chapter, (section 3.2) will develop the premise that legitimacy can exist on the global level – but must be conceptualised differently from legitimacy on the state level. To understand how GHG organisations gain and maintain legitimacy, it is necessary to view legitimacy as being based on more than just democracy, rule of law or power over a given territory. On the global level, legitimacy needs to be re-conceptualised in such a way as to make it suitable for understanding the heterarchical nature of the global-level policy-making processes that exist today.[40] Such a re-conceptualisation of legitimacy encompasses two elements: First – redefining the sources of legitimacy so that they are based on principles that

[40] See Rittberger et al. (2008, pp. 42-45).

go beyond democratic consent. Second – redefining the relationships that exist between global institutions and their surrounding environments as social relationships between actors in a heterarcically organised world society, rather than relationships between superiors and subordinates.

Before beginning with a re-conceptualisation of legitimacy suitable for the global level, it is first necessary to clarify the way in which the concept of legitimacy is to be approached. Two vital distinctions need to be made, first, whether legitimacy will be approached from an empirical-analytical or normative-prescriptive perspective (i.e. which epistemological approach will be taken); and second, whether it is the legitimacy of rules, or of the rule-makers that is to be examined (i.e. what will be the object of the approach).

3.1.1 Empirical-analytical vs. normative-prescriptive approaches

The distinction between normative-prescriptive approaches and empirical-analytical approaches to legitimacy is an important one. Normative-prescriptive approaches involve stating whether certain rules and makers of rules are fair or appropriate; the writer places their own perspective at the centre of the interpretation of whether or not a governing organisation is legitimate. These approaches may draw on established concepts of justice in justifying their arguments, but ultimately, they are attempt to *prescribe* which governing organisations and rules ought to be obeyed and which moral judgements should be made.[41]

The alternative is an empirical-analytical approach to legitimacy. This involves researching whether a rule, or rule-maker, is taken as legitimate or not (Steffek, 2003, pp. 249-251) in an attempt to *observe* legitimacy in the real world. This approach follows the definition of legitimacy put forward by Max Weber who took legitimacy as being the same as *Legitimitätsglaube*, i.e. legitimacy can be defined by its own acceptance or success in holding political stability (Weber, 1968, p. 213). According to this approach a stakeholder believing

[41] A good example is the 'complex standard for legitimacy' developed by Buchanan and Keohane. In it they emphasise six main points. First, a complex standard of legitimacy "…must provide a reasonable public basis for coordinated support for the institutions in question, on the basis of moral reasons that are widely accessible in spite of persistence of significant moral disagreement – in particular, about the requirements of justice" (Buchanan & Keohane, 2006, p. 417). Second, "…it must not confuse legitimacy with justice but nonetheless must not allow that extremely unjust institutions are legitimate" (Buchanan & Keohane, 2006, p. 417). Third, "…it must take the ongoing consent of democratic states as a presumptive necessary condition, though not a sufficient condition, for legitimacy" (Buchanan & Keohane, 2006, p. 417). Fourth, "…it should … promote the key values that underlie demands for democracy". Fifth, "…it must properly reflect the dynamic character of global governance institutions: the fact that not only the means they employ, but even their goals, may and ought to change over time. And finally, it must address the problem of "…bureaucratic discretion and the tendency of democratic states to disregard the legitimate interests of foreigners" (Buchanan & Keohane, 2006, p. 418).

that a rule or organisation is legitimate is what makes it legitimate (Hegtvedt & Johnson, 2000; Crandall & Beasley, 2001).[42]

The normative-prescriptive approach ignores the opinions that different stakeholders have when granting legitimacy. This makes the prescriptive approach a lot less demanding in terms of research, but limits its relevance in explaining reality. In taking an empirical approach "...the social scientist examines which criteria of acceptability are used by real-world actors – for instance, citizens or political elites – and how these actors use them to assess the existing political institutions" (Hurrelmann, et al., 2007 p. 7). Choosing to take an empirical approach to legitimacy does not mean denying the normative elements of legitimacy – legitimacy, even approached from an empirical science point of view, is still concerned with norms, values and principles. However, the empirical analytical approach recognises that political actors can both make judgements about legitimate governance, as well as observe the judgements of others about the legitimate governance, and distinguishes between the two activities (Hurrelmann, et al., 2007 p. 4).

It is also important to be aware of tensions between the two approaches. Empirical approaches view legitimacy as something subjective that lies in the eye of the beholder: it is the opinions and perceptions of each and every stakeholder that matters. If a particular stakeholder bases its legitimacy judgements on democracy, then that defines what makes an organisation legitimate for them. If another makes its legitimacy judgements based on the belief that a leader is a representative of a divine god, then that is what defines legitimacy for that actor. Normative-prescriptive approaches on the other hand emphasise certain norms, values and principles and argue for or against them as a universal basis for legitimacy (Beisheim & Dingwerth, 2008, p. 9).

The conceptualisation of legitimacy presented below, should be viewed with the empirical-analytical approach to legitimacy in mind. While certain elements are differentiated that might provide a basis for the legitimacy of GHG organisations, they are not intended as a list of

[42]More accurately however, an organisation is not considered legitimate by stakeholders simply because they believe in its legitimacy, but because its legitimacy can be justified in terms of their beliefs (Beetham & Lord, 1998). This clarification is vital because studies that take legitimacy to be only a belief of stakeholders in the rightfulness of a governing organisation fail to see that stakeholders already have values, norms and beliefs in the first place, and then judge GHG organisations based on them (Seabrooke, 2002, p. 22).

universal principles that are ranked in order of importance. Even an empirical-analytical approach to legitimacy will inevitably require the researcher to firstly undertake some kind of philosophical enquiry into what norms, values and principles might serve as a basis for the legitimacy of a governing organisation. However, the crucial difference is that the empirical analytical approach does not allow the researcher to prioritise certain norms, values and principles over others on his or her own accord. Instead, it must always be kept in mind that different stakeholders might prioritise certain principles over others, and discard some norms, values and principles altogether.

Several authors begin with the aim to take an empirical-analytical approach recognising legitimacy as an empirical fact, but then proceed to identify properties of an organisation which may provide the sources of legitimacy without referring to the ways in which stakeholders perceive the importance of these properties (e.g. Junne, 2001; Slaughter, 2004). This usually comes with the realisation that identifying the relevant stakeholders of a global governance organisation is a deceivingly difficult task (Gelpi, 2003, p. 9). While it is possible to take an empirical approach to legitimacy simply by discussing the properties that *might* provide the source of legitimacy in the eyes of stakeholders, without actually identifying the opinions of the stakeholders themselves this always needs to be qualified as an incomplete analysis of legitimacy. The remainder of this chapter elaborates on the empirical-analytical approach to legitimacy and takes the first step in the empirical-analytical process, identifying organisational features of GHG organisations that *might* provide the source of legitimacy in the eyes of their stakeholders. The opinions of stakeholders in terms of how they regard these possible sources of legitimacy are the object of investigation in the following chapters.

3.1.2 Rule-makers and rules

It might be argued that, whether taking a philosophical-prescriptive, or an empirical-analytical approach to legitimacy, there are two different ways to approach legitimacy in terms of the objects of investigation: First, the legitimacy of governing organisations; and second the legitimacy of the products of governing organisations – which can be broadly described as their ‘rules’. In actual fact, these two levels are inseparable. Of interest here is the legitimacy of governing organisations – specifically GHG organisations, but what is really sought is how GHG organisations come to be accepted appropriate organisations to lay down ‘rules’. Alternatively, if the object of interest were to be the ‘rules’ of a GHG organisation, what would then be sought is whether they stem from a legitimate source, i.e. from a legitimate

governing organisation. When a stakeholder or prescribing author make judgements on the legitimacy of a rule, the origins of the rule are inevitably incorporated into this judgement.

It is, however, difficult to talk of rules in the context of GHG organisations. As explained above, GHG organisations operate in a global political environment that resembles a heterarchical world society, rather than a hierarchical world government. The idea of rules, rule makers and rule takers in the context of global health governance will be addressed further in section 3.3.

3.2 Legitimacy – from government to governance

3.2.1 The legitimacy of state governments

Common definitions of legitimacy refer to some kind of lawful rule; such as 'conforming to the law or to rules' (Oxford English Dictionary, 1989). A definition based on legal status alone, however, is oversimplified and definitely too narrow for the global political context. These definitions are made for, and influenced by, the political realities of liberal democratic states, in which governments make laws based on accepted norms of democratic process and common purpose. This conceptualisation of legitimacy based on democratic rule has been framed by early Greek thought and the idea of consent through the *demos* (Zelditch, 2001, p. 34). Where a *democracy* exists, the minority accepts the will of the majority, because they identify with the whole. Laws that emerge from democratic processes induce voluntary compliance amongst citizens, even if they do not offer any direct immediate gains (Huckel, Reusch, & Scholtes, 2005). A democratically elected government is seen to be legitimate because the law makers – superiors – are accountable to citizens – subordinates – who have the power to vote them out of government. Citizens are not only involved in the inputs of the law making process, they are able keep a check on the outputs of the process; "… (t)his implies a congruence between the rulers and the ruled through mechanisms of representation" (Risse, 2006, p. 185).

Although many states do not have democratic systems, democracy has become the most widely accepted standard for the legitimation of state power. In liberal democracies, a government has power over a given territory and a definitive number of citizens belonging to that territory. Those citizens choose delegates to represent their best interests in the central decision-making forum of government. Both the choice of delegates and the decision-making

procedures for making laws are based on a majority voting systems whereby a minority will accept the will of the majority.

However, this system only functions in the presence of a particular social environment. It can be argued that it is not the democratic process as such that makes a government legitimate, but rather the fact that it functions within a social system which allows it to be accepted as legitimate. The social system consists of open and free debate over political issues, constitutional rights that protect liberty, and a socialisation of citizens from a young age that trains them to accept majority decisions and obey laws created through the system. The *demos* is a vital part of this social system; it consists of the citizens of the state who share a particular identity, political experience and have a common stake in the well being of the state.

Just as democracy has come to be the "gold standard" for legitimising the state, there have been calls that if there are going to be legitimate institutions of the global level, then they also need to meet similar standards of democratic legitimacy. Such calls are usually accompanied by arguments pointing to the increasing pervasiveness of global institutions on the lives of individuals all over the world. If all people are affected by global institutions, and states no longer have the capacity to protect citizens from any possible negative effects that might stem from the policies of global institutions, then all people should have an equal say in the decision-making process. This view can be labelled the "global democracy" view.

However, when taking in the importance of the *demos* for democratic legitimacy, it becomes apparent how difficult it would be to transfer this model to the global level. Not only is there an absence of any central decision-making authority, but, as yet, a global *demos* remains elusive (Scholte, 2002; Hirst, 2000; Grant & Keohane, 2005). On the global level it is difficult to identify any shared political history amongst all citizens, it is difficult to pursue open and accessible debates over political issues amongst citizens, and a sense of common identity and solidarity amongst all global citizens required to sustain a legitimate superior-subordinate relationship remains a challenge (Buchanan & Keohane, 2006, p. 416).

3.2.2 The legitimacy of IGOs

Intergovernmental organisations represent the closest attempt to transfer the idea of democratic consent to the global level. Their legitimacy is said to rest on state consent, with each state representing the interests of their citizens, similar to delegates representing their

constituencies in liberal democracies. The gradual process of constitutionalisation should affirm the strength of IGOs to create laws which states have the obligation to abide by, with IGOs taking on the position of the superior and states – and therefore, by de facto, their citizens – the position of the subordinate.[43] Recently however, intergovernmentalism is said to have come to suffer from a crisis of legitimacy, leading some scholars to argue that attempts to transfer democratic legitimacy to the global level are neither practical nor desirable. For example, according to Buchanan and Keohane there is an:

> ...increasingly discredited conception of legitimacy that conflates legitimacy with international legality understood as state consent, on the one hand, and the unrealistic view that legitimacy for these institutions requires the same democratic standards that are now applied to states, on the other (Buchanan & Keohane, 2006, p. 406).

As discussed in the previous chapter, GHG organisations are a product of changes and developments closely linked to processes of globalisation. Likewise, processes of globalisation have had a profound effect on competing standards of legitimacy on which global institutions such as IGOs and GHG organisations may be judged (Keohane & Nye, 2001).

The legitimacy deficits of global institutions have been debated in International Relations and Global Governance studies for quite some time. More recently it has become an issue receiving mainstream attention worldwide. At meetings of international financial institutions over the past ten years, there have been large scale protests involving various groups of concerned individuals from all over the world, with varying interests, identities and political experiences. They have all voiced dissatisfaction with the way that these particular IGOs are organised, the extent to which decision-making is separated from the citizens, and the power imbalances they appear to compound (Zürn, 2004, p. 261). While globalisation has, on the one hand, strengthened the need for greater cooperation and decision-making on the global level (because of the increasing number of global challenges that states are not able to address alone) on the other hand it has made it increasingly difficult for intergovernmental organisations to make and execute policies free from scrutiny and criticism. It seems that intergovernmental organisations based on principles of multilateralism (which, to a certain degree were designed to replicate the democratic legitimacy of the state) are suffering from

[43] The constitutionalisation of intergovernmentalism has most commonly been discussed with reference to the WTO (Dunoff, 2008).

legitimacy deficits. At the very least they are coming under a level of scrutiny that goes beyond criticism of intermittent failures and attacks the very nature of intergovernmentalism as a valid working principle.

In the policy field of global health, the legitimacy deficits of IGOs have not been highlighted in the same dramatic way as has been the case with the international financial institutions. Nevertheless, the level of scrutiny that IGOs working in this issue-area have been exposed to has also dramatically increased. Like other IGOs, the WHO has been exposed to debates over its legitimacy on a much broader scale than ever before. Generally, there are four main elements of globalisation which can be seen to contribute to an increasing level of scrutiny of the WHO in terms of its legitimacy, as summarised in Table 3.1, (adapted from Junne 2001, p. 211).

The first element is the reach and effect of global idea networks. Global idea networks allow for the spread of ideas such as human rights, and knowledge about fair access to goods and services. They also forge new identities. Such networks might be comprised of professional associations, civil society organisations, or linkages between individuals that meet at various conferences, meetings or via electronic communication as part of their work, voluntary or social activities. Information sharing via global networks has led to an increasing number of people having the opportunity to learn and understand how decisions are made within IGOs and who has control over what outcomes. The legitimacy of IGOs, including the WHO is therefore coming under scrutiny, as they have had to keep pace with the sharing of ideas in terms of what constitutes good governance as well as an increasing variety of expectations in terms of what good governance should deliver.

The second element is the intensity of global flows. Processes of globalisation involve a sharp rise in the amount of goods and services crossing state borders, increasing the complexity of global challenges which affect different groups in very different ways. IGOs have come under scrutiny in the terms of the capacity they have to recognise these complexities, respond to them, and integrate the concerns of affected groups and individuals into their organisations (Junne, 2001, p. 195).

The third element is the speed of global information flows. Communication technologies including the mass media have increased the speed with which new information is spread

throughout the world. This has increased pressure on IGOs to respond to perceived injustices faster, and the WHO has been increasingly judged on its capacity to do so. Rapid responses to global challenges are eased by having a small number of persons in control of central decision-making, but at the same time this limits the possibilities for ensuring broad representation. The legitimacy of IGOs thus comes under scrutiny in terms of ability to act with speed, which can contradict the working principle of intergovernmentalism (Junne, 2001, p. 195).

The fourth element is the impact of local and global action. Globalisation is seen to have increased the impacts that decisions made on global, state and local levels have on others around the world (Junne, 2001, p. 196). IGOs are coming under scrutiny for their ability to control these impacts and, at the least, not to make decisions that impact negatively in the welfare of citizens throughout the world.

Table 3.1: How globalisation affects governance institutions

Aspect of Globalisation	Demands on global level institutions
Reach of global networks	Meet standards of governance
Intensity of goods and services transfer	Capture and respond to complex problems
Speed of global information flows	React quickly to global challenges
The impact of local and global action	Control negative impacts and protect citizens

Intergovernmental organisations have had varying success in coping with the four challenges outlined above. Globalisation has created a demand for more governance, but at the same time it has made it more difficult for intergovernmental organisations to respond to demands from increasingly organised citizens within a global civil society, and address global problems in light of increasing reach, intensity, speed and impact of global processes (Junne, 2001, p. 211)[44]. It is evident, however, that the scrutiny placed on IGOs, including WHO, relates to more than their ability to replicate state democracy on the global level. IGOs are under increasing pressure to meet standards of governance that relate to performance, efficiency and

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[44] Or, in the words of Michael Zürn: "The constantly growing intrusiveness of international institutions highlights the democratic deficits and generates resistance, which in turn undermines the effectiveness of these institutions. … The more intrusive these international institutions become, the more justified and intense the demands will be for their democratization. Without an improvement of the legitimacy of decision-making processes, i.e. the incorporation of affected societal actors into the decision-making process, there is a danger that the effectiveness of international institutions will weaken" (Zürn 2004: 286). See also Krasner (1993).

the recognition of new identities and interest groups. IGOs are also faced with the reality that they do not act as superiors to an audience of subordinate states – instead they govern in a political environment made up of various actors of a world society. There is therefore urgent need to re-conceptualise legitimacy in a way that moves beyond the ideas of replicated democracy through a system of state consent and constitutionalisation (Junne, 2001, p. 211).

Ian Clark has addressed how two different sets of overarching principles might form the basis for legitimacy on the global level (Clark, 2007, p. 198; Buzan, 2004). First, principles associated with a world society, marked by consent, representation, accountability, transparency and responsibility for outcomes; and second, principles associated with international society, focusing on legality, morality and constitutionality (Clark, 2007, pp. 207-208). Demands for better representation of different interests, and a higher capacity to control negative effects of globalisation are criticisms that suggest that IGOs should embody working principles more closely related to principles associated with a world society. Legitimacy at the global level might therefore be better assessed by taking a concept that focuses on representation, accountability, transparency, and responsibility outcomes. This becomes even more necessary, when taking a closer look at the nature of the relationships between IGOs and the actors in their political environment.

The legitimacy of IGOs is normally conceptualised in terms of a justification for the power that they have over subordinates, i.e. states and their citizens. This conceptualisation of legitimacy relationships appears to have been adopted on the global level to replicate legitimacy on the state level, where the government is in the position of the superior, and the citizens are subordinates. It is the replication of this model however, which was been particularly problematic for conceptualising legitimacy on the global level. As noted above, there is no central global government. Instead, global politics today resembles a system that can be best described as a heterarchy, rather than a system of hierarchy. For example, it can be argued that IGOs as well as global governance organisations that rely on voluntary compliance, for example the WHO, and GHG organisations such as the GAVI Alliance and GFATM, do not even need to be legitimised, if legitimacy is conceptualised as a justification for power. They cannot force any subordinates to comply with their rules. However, it is precisely the voluntary nature of cooperation on the global level that makes legitimacy so important for these organisations (Rosenau, 2002, p. 308). Without legitimacy, they could not expect any of their stakeholders to align their actions with their policies. Therefore, legitimacy

on the global level needs to be re-conceptualised to take into account the types of relationships that IGOs and global governance organisations have with their stakeholders.

Global governance studies generally draw on Weber's threefold distinction of why one actor might comply with the will of another (Weber, 1968). First, coercion, based on rewards or sanctions, second, incentives based on actors self interests, and third, authority, based on ideas and legitimacy (Hasenclever, Meyer, & Rittberger, 1997; Hurd, 1999). On the global level, coercion is largely absent, although there are coercive mechanisms that have been introduced in the international financial institutions, such as trade embargoes. Overall IGOs rely on coercion to a very small extent only. This is especially the case in the global health policy field, with reference to the WHO and GHG organisations. As there is no central government, there is also no coercion pull that stems from rule-making that has taken place in the 'shadow of hierarchy' (Jachenfuchs, 2003, pp. 505-506). Compliance therefore relies on the motivations of stakeholders to do so (Beisheim & Dingwerth, 2008, p. 9). Coercion, self-interest and legitimacy are related in complex ways, and each reason for compliance is rarely found isolated from the other two. Hurd suggests that they are even probably related to each other in a patterned, systematic fashion. For example, compliance stemming from coercion or self interest, if sustained long enough, will develop certain actions as normatively righteous (Hurd, 1999, p. 389; James, 2000, p. 17).

When individual citizens, and groups of stakeholders become aware of the extent to which global institutions impact on their lives they become more demanding of these institutions in terms of requiring that they provide good governance. They expect global institutions to be legitimate, and this normally entails having their interests represented in the global organisations, or at least looked after. State consent and constitutionalism as a working principle has, for many, proven inadequate for fulfilling these demands (Zürn, 2004, p. 275).

In sum, legitimacy is a complex phenomenon at the level of the state, when it encompasses the relationships between national governments and citizens. The constituency of a global governance organisation is much more diverse than the constituency of a state. It varies in terms of the cultures, places, education, and value systems represented, and therefore, it is not possible to speak of a *demos* that will approve of an overarching superior power. The members of the global constituency do not share the same historical experiences, or have similar political traditions. Conceptualising the legitimacy of global governance organisations

in terms of the extent to which they replicate the superior-subordinate relationships within democratic states therefore, is bound to result in an assessment that they suffer from a lack of legitimacy (Junne, 2001, p. 191).

However, GHG organisations do appear to have gained and maintained diffuse support from other actors in their political environment. They are not subordinates, but can be classified as 'stakeholders'. If global politics is to be viewed as interactions between actors within a diverse global society consisting not only of states, but other actors as well, it is necessary to find an appropriate way of looking at how legitimacy works within such a society. In order to find a definition of legitimacy suitable for GHG organisations it is first necessary to ascertain a definition of legitimacy that can be used on social relationships between actors that have various roles and various degrees of power.

3.3 Legitimacy on the global level

In this section the premise developed above, namely that that legitimacy can exist on the global level – but must be conceptualised differently from legitimacy on the state level – will be taken into account in a re-conceptualisation of legitimacy suitable for assessing the level of diffuse support that GHG organisations enjoy. It takes into account the finding that on the global level legitimacy must be conceptualised to encompass more than just the acceptance of rules in subordinate-superior relationships and to allow for the heterarchy of relationships that exist in global politics.

3.3.1 Legitimacy in social relationships

Global governance can be seen as the process of governance in a social realm that is marked by an absence of an overarching government, or rule enforcing institution. GHG organisations are typical of the type of global institutions that make up heterarchical rather than hierarchical governance.

> The peculiarities of a heterarchical world order consists, *inter alia*, in the horizontal generation and implementation of norms and rules – which is not bound to a vertical top-down policy process (Rittberger, 2008, p. 16).

Thus the political realm in which GHG organisations are active can be likened to a series of relationships between various actors, peers, interest groups and communities within a larger world society, rather than strict hierarchical relationship that exists between the governments

of states and their citizens (Rittberger, Huckel, Rieth, & Zimmer, 2008, p. 52). An alternative model to one containing a superior and a subordinate, is one containing a governing organisation and those affected by the policies of the governing organisation. This can be called the stakeholder model (Huckel, Reusch, & Scholtes, 2005). GHG organisations do not have a set number of ‘citizens’ or a territorial jurisdiction, nor do they have states and citizens as subordinates like IGOs do. They do however, have actors in their political environment which have a particular stake in the organisations activities. Exactly who these stakeholders are will be the main topic of the following chapter; however, some illustrative examples include fund donors, people living with diseases that GHG organisations aim to address, and associations of professionals working in the medical field. Legitimacy becomes an issue as part of the relationship between a GHG organisation and these stakeholders.

According to Kelman, legitimacy at its most basic level exists within any kind of social relationship and "…refers to the *moral basis* for interaction" between any two actors within a society (Kelman, 2001, p. 55). Legitimacy is then the "... issue that arises in an interaction or relationship between two individuals, or between one or more individuals and a group, organisation, or larger social system, in which one party makes a certain claim, which the other may accept or reject. Acceptance or rejection depends on whether that claim is seen as just or rightful" (Kelman, 2001, p. 55). Therefore on the most basic level legitimacy is defined as the obligation to accept a claim made by one actor, because it is seen as just or appropriate by the other actor at which the claim is addressed, because it concurs with norms, values and principles on which the relationship is based.

In politics, claims might come in the form of requirements, requests, rules or laws. States, for example, make laws. GHG organisations make claims in the forms of policies that encompass requests for their stakeholders to take certain actions - such as provide funds, carry out field operations following certain methods, provide information and so on. Without legitimacy, GHG organisations could ensure acceptance of its claims by offering incentives, but incentives only build up specific, rather than diffuse support. To gain a reservoir of diffuse support, GHG organisations need to have a relationship with their stakeholders based on mutual recognition of certain norms, values and principles that can provide the basis for legitimacy, thus creating a sense amongst the stakeholders that it is appropriate and rightful for GHG organisations to make the claims that they do (Zelditch, 2001, p. 37). The question

then arises, as to how relationships come to exist, in which one party feels obliged to accept the claims – laws, or request for actions, from another?

Legitimacy leads to support by providing a moral reason for one actor to accept the claims of another. If an actor believes that it is legitimate for a GHG organisation to make its claims then they will comply with them, not because of fear of sanction, or by calculating the gains from following the rule, but because they feel that it was appropriate for the organisation to make such a claim and they therefore ought to comply. Importantly, the norms, values and principles that stakeholders refer to in judging whether a GHG organisation is rightful in making the policies that it does might be multiple and varied. They do not necessary have to be principles of democratic delegation, or state consent. Increasingly scholars of political science have recognised that legitimacy has many sources, (or may be based on many different features of an organisation. Several authors have thus proceeded to give different names to different 'legitimacies' (Coicaud, 2001a, pp. 523-533).

3.3.2 A definition of legitimacy in global governance

For studies of global (health) governance therefore, legitimacy is best defined as – a generalized perception or assumption on behalf of relevant stakeholders that an entity and its claims are desirable, proper, or appropriate based on their normative judgements (adapted from Suchman (1995, p. 574)). Similarly, Thomas Franck defines legitimacy as "a property of a rule or rule-making institution which itself exerts a pull toward compliance on those addressed normatively because those addressed believe that the rule or institution has come into being and operates in accordance with generally accepted principles of right process" (Frank, 1990, p. 24).

To understand the legitimacy of GHG organisations then, it is important to find out: first, what social norms, values and principles good global health governance might be based on, and second, which properties of a GHG organisation a stakeholder might interpret as the manifestation of desirable, proper and appropriate norms, values and principles.

3.3.3 Good governance – 'by' and 'for' the people

Increasingly scholars of political science have recognised that stakeholders may judge the legitimacy of governing organisations on a variety of norms, values and principles. Clark has suggested that currently a search for new agreed principles to regulate contemporary systems

is underway (Clark, 2007, p. 194), while Koppell has found that global governance organisations sometimes specifically violate some established norms to advance others as demanded by stakeholders (Koppell, 2008, p. 178). Governance, on all levels, may be based on different things according to different stakeholders, whether they are citizens or otherwise. Junne for example distinguishes five different possible sources of legitimacy; first, justice – where a governing organisation is regarded as legitimate because its policies are based on accepted norms and values; second, correct procedure, where a governing organisation can be judged as legitimate based on the processes by which it has been formed; third, representation – where a governing organisation is seen as legitimate if it represents all affected peoples fairly; fourth, effectiveness, where a governing organisation is regarded as legitimate if it is seen as having the capacity to achieve certain desired results; and fifth, charisma, where a governing organisation is considered legitimate if people identify emotionally with its leaders or overall image (Junne, 2001, p. 191). Dingwerth also offers a list of four possible criteria, including open avenues of participation, inclusion of a range of actors in decision-making, democratic control, and discursive procedures in decision-making (Dingwerth, 2007).

A governing organisation may be seen as legitimate according to one of these criteria, but illegitimate according to another. Different stakeholders have different ideas of what criteria are most important for making a governing organisation legitimate. The more varied the stakeholders, the more likely it is that a governing organisation will need to cover all of these criteria to be seen as legitimate amongst all of it stakeholders. This has been described by Junne as the 'volatility' of legitimacy (Junne, 2001, p. 191).

To purposefully conceptualise legitimacy in order to make an assessment of the legitimacy of a GHG organisation, it is necessary to systemise the variety of criteria on which stakeholders might judge GHG organisations. In his seminal work on the legitimacy of the European Union, Fritz Scharpf distinguished between two dimensions of legitimacy and therefore two groups of norms and principles that can provide a basis for legitimacy. He states that legitimacy is made up of two complementary yet distinct elements; the first is legitimacy based on good governance 'by' the people, (also referred to as input-oriented legitimacy) and the second based on good governance 'for' the people (also referred to as output-oriented legitimacy) (Scharpf, 1999, pp. 14-15). Over the past few years new categorisations adding to, or re-shuffling this model have been presented making considerable progress in differentiating different aspects of legitimacy that Scharpf neglects or fails to distinguish clearly. Zürn for

example emphasises a source of legitimacy that comes through right processes, called throughput legitimacy (Zürn, 2004, p. 270). Others have sought ways to differentiate output oriented legitimacy in terms of how to measure effectiveness along the lines of outputs, outcomes and impacts (Easton, 1965); or substantive and procedural aspects of legitimacy (Barnett & Finnermore, 2004, pp. 167-168). Others have adopted approaches in which democratic representation is re-packaged for global governance as accountable representation (Keohane & Nye, 2003, p. 387). All of these advancements are important and refer to real grounds for legitimacy. However, Scharpf's important distinction has become lost in many other attempts to operationalise legitimacy, especially in those cases where governance 'by' the people is interpreted simply as 'inputs' and governance 'for' the people interpreted as simply 'outputs'. The real difference between the two dimensions of legitimacy in Scharpf's dichotomy is not at what stage of the governance process they come into play, but rather the principles that they embody – and it is this distinction which provides a particularly fruitful basis for answering the two key questions: What social norms, values and principles might good global health governance be based on? Which properties of a GHG organisation might stakeholders interpret as the manifestation of desirable, proper and appropriate norms, values and principles?

Input-oriented legitimacy refers to governance which reflects the will of the people. Governance organisations that base themselves on this principle might ensure that the will of the people is upheld in either the early (input) phases of the policy-making process e.g. by involving people's delegates in agenda-setting and decision-making. They may also ensure that the will of the people is heard by creating mechanisms through which the people can watch, monitor, criticise and reject the organisation's policies, or demand to have them amended, at later stages of the policy-making process, i.e. at the stages of implementation, or monitoring and evaluation. Having highly transparent decision-making procedures is one example of a mechanism to ensure that their governance reflects the will of the people. Therefore, using the phrase *'governance 'by' the people'* is a more precise terminology to use when referring to this dimension of governance than simply 'input legitimacy'.

A similar argument applies to output-oriented legitimacy, which, according to Scharpf, is based on the ability to provide good *governance 'for' the people*, or, the ability to provide solutions to problems that require collective action (Scharpf, 1999, p. 20). Stakeholders may well make judgements on the ability of an organisation to provide good governance 'for' the

people based on their outputs, e.g. the effectiveness of their policies; but certain inputs into the policy-making process at the stage of agenda-setting and decision-making may also reflect, and be justified on the basis of, providing good governance 'for' the people. The presence of technical experts in decision-making bodies of GHG organisations is a case in point. Experts give inputs into the governance process, but any judgements on whether their presence contributes to the legitimacy of the organisation relates to whether they increase the capacity of the organisation to contribute to good governance 'for' the people.

Table 3.2 shows how both inputs and outputs of global governance organisations may reflect either legitimacy based on principles of good governance 'by' or 'for' the people. An conceptualisation of legitimacy therefore needs to follow along the lines of the principles, norms and values that might provide the basis for legitimacy judgements, rather than the phases of policy-making.

Table 3.2: Dimensions of legitimacy in the policy-making process

Dimension of Legitimacy / Policy-making phases	Governance 'by' the people	Governance 'for' the people
Agenda-setting and decision-making	Elected delegates	Expert knowledge
Implementation and Monitoring	Field operations and results open to external scrutiny	Effective policies

3.4 Bases for legitimacy of global governance organisations

This section takes the first step in an analysis of the legitimacy of GHG organisations, which involves identifying the properties of GHG organisations that may prove to be sources for their legitimacy.[45] Each of the properties refers to certain values, beliefs or norms that stakeholders may hold when judging a GHG organisation as legitimate – or not – and can be related to either the dimension of legitimacy based on governance 'by' the people or governance 'for' the people as described above. At this stage the actual opinions of stakeholders are left aside, and GHG organisations are discussed in a general sense in relation

[45] Koremenos, Lipson and Snidal also describe how the design of international institutions also have an affect the way that stakeholders respond to them (Koremenos, Lipson, & Snidal, 2001).

to those features they have in common, rather than the features that sets one GHG organisation apart from another. However, at all times it should be kept in mind, that it is not the author's opinions towards these properties which count, but rather how they will be considered by the stakeholders that are introduced in the following chapter. Thus, the aspects listed here are *possible* grounds on which a particular stakeholder might consider a GHG organisation to be legitimate.

3.4.1 Sources of legitimacy

Below, diverse literature from the discipline of global governance studies described above, as well as initial empirical observations on how GHG organisations attempt to go about increasing the level of diffuse support from their stakeholders have been used to break the two main dimensions of legitimacy (governance 'by' the people and 'for' the people) down into nine sub-components. Each of these sub-components refers to a value, norm or principle that, when upheld could strengthen the extent to which a GHG organisation is seen to provide legitimate governance 'by' or 'for' the people. Each sub-component will be discussed in terms of the following aspects; first: the specific value, principle or norm the sub-component refers to; second, what probing questions a stakeholder might need to ask of a GHG organisation, if they consider this sub-component to be an important basis for legitimacy; and third, what substantial features of a GHG organisation might indicate the manifestation of the sub-component as an existent organisational feature. These aspects are summarised in Table 3.3, at the conclusion of this section.

3.4.2 Manifestations of legitimate governance 'by' the people

Legitimate governance 'by' the people is manifested in the extent to which stakeholders come to believe that they have the ability to influence decision-making and scrutinise the results of GHG organisations. This can be manifested in four different ways. The first two refer to direct inputs into the decision-making processes. The third refers to how decision-making processes are regulated to ensure that decisions reflect the will of the people. The fourth refers to modes of external – or indirect – participation and the possibilities of stakeholders to express their will through criticism and by demanding change.

3.4.2.1 Public governance - state delegation

The first sub-component of legitimate governance 'by' the people can be described as public governance, expressed through representation of citizen's interests via state delegates. Despite

the fact that it is highly disputed whether democratic governance can exist on the global level the delegation of citizens interests through state representation is still cited as an (if not the most) important basis for the legitimacy of global governance organisations (Buchanan & Keohane, 2006). The principles that lie behind this component have been described in detail above; in short, citizens' interests are represented on the global level by their state governments, who act to ensure the well being of the citizens within their territory of control. If those governments are democratically elected they must act in the best interest of their citizens or face the possibility of being voted out of government. Stakeholders that might prioritise this component may also argue that, even though many state governments are not democratically elected, delegation through states still provides the most comprehensive way to ensure that the interests of as many individuals as possible are represented at the global level. Mutual recognition of state sovereignty will mean that all states must be granted equal rights in the decision-making process, and this in turn ensures that all citizens, regardless of material power or other resources are, at least to some extent, represented in public governance via state delegates. Thus legitimate governance 'by' the people is more likely to be ensured.

GHG organisations have the common feature that state delegates are represented in decision-making bodies. For stakeholders that prioritise this sub-component of legitimate governance 'by' the people it is important to ask – Which states are represented? And do they have the role of acting in the best interests of their citizens?

The extent to which this component suffices as an adequate basis for legitimate governance 'by' the people can be disputed. There are several degrees of separation that exist between citizens and global level decision-making that takes place between state delegates. In the case of global health governance, it is questionable whether the representation of state interests always matches with the needs of those most affected by the decisions made within GHG organisations i.e. the stakeholders. In response, additional sub-components of legitimate governance 'by' the people might be seen as necessary additions to state delegation, or even be prioritised over state delegation when assessing a GHG organisation's legitimacy.

3.4.2.2 Participatory governance - stakeholder representation

The second sub-component of legitimate governance 'by' the people builds on an alternative model of democracy, namely cosmopolitan democracy, or participatory democracy (Held,

1995). The underlying principle is that individuals, (especially those directly affected by a governing institution) should have their interests represented in decision-making processes on the global level, and that these interests can be represented by more than one political community. Thus, a GHG organisation that has certain stakeholders – defined by who is affected most by the policies it makes – could include certain actors in its decision-making processes that adequately represent these stakeholders, even if they are not states. For example, this inclusion of a civil society organisation that represents the interests of people living with a disease that is targeted by a GHG organisation in decision-making would be seen as a valid manifestation of participatory governance.

However, for stakeholders that give priority to this sub-component of legitimate governance 'by' the people, complex judgements need to be made regarding which stakeholders need to be represented and which actors are best equipped to do so. For stakeholders prioritising this sub-component of legitimacy 'by' the people, it is therefore important to ask the questions: Who is involved in decision-making? Whose interests are represented by those involved in decision-making?

Conclusions drawn from answering such questions might be mixed. In particular, the inclusion of business sector actors in decision-making for the purpose of representing the interests of profit-makers might be controversial. Although their inclusion may well fit with the principles of cosmopolitan democracy (they are after all stakeholders by definition), granting them decision-making rights might also be seen as granting extra power to actors that already have considerable resource advantages. Therefore, for some stakeholders, legitimate governance 'by' the people will also need to contain a component that regulates how decisions are made and how the relationships between stakeholders and their representatives are managed in decision-making processes.

3.4.2.3 Fair processes

The third sub-component of legitimate governance 'by' the people addresses questions such as: How do the persons that are meant to represent the interests of stakeholders come to have this representative role? How are power differentials between represented groups balanced out? How is decision-making organised to ensure that decisions reflect the will of as many represented individuals as possible?

Decision-making processes within GHG organisations influence the extent to which policy outcomes reflect the will of the people. Therefore, governing organisations that are seen to make decisions according to fair and right processes might be more likely to be accepted by stakeholders as legitimate. The principle that underlies this sub-component is that consistent and fair decision-making rules will ensure that no one actor can dominate over others, and thereby effectively diminish their ability to represent the will of the people. The extent to which a GHG organisation embodies right processes may be judged at all stages of the decision-making process, such as the way that the board representatives are chosen, the rules that must be followed during discussions, the extent the voting procedures are followed in decision-making boards and the measures taken to ensure that all representatives are equipped to discuss and debate decisions on an equal footing.

Intergovernmental organisations have been criticised for being structured in such a way that they encourage specific styles of decision-making, oriented towards 'posturing'. This type of decision-making has been criticised for giving advantages to certain actors and alienating others (Junne, 2001, p. 201). Decision-making procedures that are formalised and regulated in such a way that various stakeholders can come together and develop a common approach to a certain challenge, without the need to 'posture' can therefore be seen as a desirable organisational feature that signifies right process (Junne, 2001, p. 215). Stakeholders that give priority to this sub-component of legitimate governance 'by' the people are particularly interested in the institutional design of GHG organisations.

3.4.2.4 Indirect participation – via transparency and accountability

The fourth sub-component of legitimate governance 'by' the people rests upon principles of indirect participation. Stakeholders that have the opportunity, and ability, to scrutinise a GHG organisation, its decisions and its policies, and forcefully disapprove of decisions that do not reflect their will, are also able to participate in its governance – albeit indirectly. This process of indirect participation is manifested in the ability of stakeholders to hold a GHG organisation to account. For stakeholders that prioritise accountability, two features of a GHG organisation are of importance; first, the extent to which they are transparent, and second, the extent to which they are responsive to external scrutiny.

Transparency has become an important feature of GHG organisations, in particular through their use of electronic media. With the advent of the internet, and increasing access to it

throughout the world, it has become easier for GHG organisations to grant access to information and internal documents. Transparency, however, involves more than simply giving access to information to those that seek it; to be able to hold a GHG organisation to account, stakeholders require access to information that is relevant, comprehensible and accessible, even for stakeholders with limited time and resources (Curtin & Maijer, 2006).

Accountability refers to the ability of stakeholders to incur costs on an organisation that does not act in a way that reflects the will of the people. It can be seen as a retrospective element of governance (Grant & Keohane, 2005). While stakeholders do not have the ability to hold a GHG organisation to account in the same way that citizens in democratic states can hold a government to account, the accountability of a GHG organisation may be ensured on two levels, either by ensuring the ability of stakeholders to incur costs on the GHG organisation itself, or by ensuring the ability of stakeholders to incur costs on the representatives that are involved in the organisations decision-making procedures.

On the level of the representatives, accountability varies according to the type of actor and the processes by which they come to sit on a decision-making board. A high level of accountability would be indicated by representatives risking losing their position on the Board of a GHG organisation if they did not adequately represent the organisations stakeholders.

On the level of the GHG organisation itself, the way in which the organisation responds to external scrutiny determines whether stakeholders are able to incur costs on the organisation. If stakeholders are granted access to the organisation, via meetings or direct correspondence, and if there are platforms available in which stakeholders can engage in open, honest and public debate over criticisms and shortcomings of the organisation, then stakeholders will have an increased ability to influence the external and internal environment of the organisation.

The key questions to be asked by stakeholders prioritising this sub-component of legitimate governance ‘by’ the people are therefore: How can stakeholders express disapproval of decisions? Is the organisation responsive to criticism? What information about the organisation is available?

Looking at the combined effect of each of these four components, one might predict that if the decision-makers are representative of their constituencies and can be held accountable for their actions then it would be expected that they increase the legitimacy of an organisation in the eyes of most stakeholders. Importantly on a global level, if the decision-makers are seen to contribute to a widening of the number of interests represented within the organisation (as possibly CSOs do), they might also contribute to heightening the perceived legitimacy of an organisation. On the other hand, if decision-makers are not representative of a stakeholder group or constituency and do not suffer negative consequences for making bad decisions, (are not accountable), then it might be expected that the legitimacy of the GHG organisation would be lowered. Whether or not this is the case can only be drawn from empirical studies that can infer conclusions as to the priorities of stakeholders and their positions to the above sub-components

3.4.3 Manifestations of legitimate governance 'for' the people

The dimension of legitimate governance 'for' the people entails sub-components that refer to what a governing organisation achieves or is seen to have the potential to achieve, and whether or not these achievements are interpreted by stakeholders as being beneficial. If the legitimacy of a GHG organisation is to rest on features that reflect legitimate governance 'for' the people, then it must be seen to have the capacity to solve the problems that its stakeholders consider most pressing, in a way that is considered appropriate, and to a satisfactory level of effect. This dimension can be manifested in five ways; first, when aims of the organisation correspond with solving the problems that stakeholders feel need to be addressed; second, when the organisation is seen to have a high problem-solving capacity; third, when stakeholders agree with the overarching approach it takes to solve problems; fourth, when the effects of the organisation match the outcomes that stakeholders want to see the organisation achieve; and fifth, when the organisation goes about its work in a competent and efficient manner.

3.4.3.1 Right Purpose

The first sub-component of governance 'for' the people refers to the aims of the organisation. A GHG organisation will be seen as providing legitimate governance 'for' the people if it aims at solving problems that the stakeholders agree need to be approached on the global level and by a specific organisation. For example, a GHG organisation that aims to provide antiretroviral drugs to people living with AIDS should be seen as legitimate in the eyes of

stakeholders that view this aim as important and in need of global policy guidance. The values that guide stakeholders' judgements as to what aims are appropriate or not vary greatly depending on the stakeholder. They might for example value the idea of a universal right to health and consider existing organisations incapable of achieving access to this right. The guiding principle that would lead a stakeholder to prioritise this sub-component is that problems that cannot be solved on local or state levels or in existing intergovernmental arrangements should therefore be governed by specific organisations on a global level. The key questions to be asked by stakeholders that prioritise this sub-component are therefore: What does the organisation aim to do 'for' the people? Is it necessary, and desirable for a global organisation to take on this task?

3.4.3.2 Problem-solving capacity

A key aspect of legitimate governance 'for' the people is the perception on behalf of stakeholders that the organisation has the capacity to effectively solve problems and benefit stakeholders. This sub-component might therefore be of particular importance for GHG organisations that tackle long term problems and cannot prove their effectiveness in terms of the complete dissolution of a problem. Stakeholders that prioritise this component seek to judge whether a GHG organisation provides legitimate governance 'for' the people by looking for indicators that the organisation has a high potential problem-solving capacity. In the health policy field this sub-component might be considered particularly important for those stakeholders that believe that the main hindrance to achieving high levels of health is the inadequate and improper application of scientific knowledge, medical technologies and project management. The extent to which a GHG organisation incorporates and utilises experts thus becomes an indicator for an organisation's problem-solving capacity. For example, legitimacy might be based on the principle that experts who understand best the cause-effect relationships that lead to effective solutions to global health challenges should be involved in decision-making. If there is a consensus amongst a group of 'experts' with this type of knowledge, then this becomes authoritative knowledge (Goldstein & Keohane, 1993, p. 10; Wolf, 2006, p. 200). Legitimacy based on this type of knowledge can also be termed scientific legitimacy.

Stakeholders that give priority to this sub-component may prioritise it over all other sub-components, or might see it as complimentary to others. Prioritising only this sub-component supposes that experts can make appropriate judgements of the desirability of the effects that

they know certain policies will have (Miyaoka, 2004, p. 12). While it is not really possible for scientific theories to result in knowledge about what is ethically desirable, science holds such prestigious status in global governance, and global health governance in particular, that it might be taken as a source of legitimacy for many stakeholders regardless. It compounds in cases where a governing organisation constitutes being "an authority" rather than "in authority". (Beetham, 1991, p. 73; Wolf, 2006, p. 217).

Stakeholders might also judge the problem-solving capacity of an organisation based on other aspects that indicate the potential for the organisation to successfully carry out its policies. This includes the perceived 'expert' capacity of secretariat staff and field workers as well as the network of implementing partners it works with. The questions that might be asked by stakeholders that prioritise this component might therefore be: Is decision-making based on scientific evidence? Does the organisation comprise an expert base? Does the organisation have good relationships with the necessary actors to carry out its policies? Does the organisation employ competent staff?

Right approach

The third sub-component of legitimate government 'for' the people refers to the general problem-solving approach adopted by a governing organisation. This sub-component is particularly relevant for GHG organisations, because there has been a long running debate in the health policy field about which approach is most appropriate for confronting global health challenges.

Stakeholders that prioritise having the right problem-solving approach when judging whether or not to support a GHG organisation do not make judgements based on the merit of individual policy decisions; rather, they base their judgements on beliefs about rightfulness of certain overarching approaches. This is important because if the aims of an organisation are seen as legitimate, but the organisation goes about achieving them in an inappropriate manner the organisation might lose legitimacy.

In the global health policy field there are two main competing sets of approaches for achieving health aims. The first can be broadly labelled 'Selective Primary Health Care', which targets specific diseases or problems with the aim of alleviating their effects so that they do not burden health care systems (Cueto, 2004; Walsh & Warren, 1979). The second is

'Comprehensive Primary Health Care' which approaches global health by focussing on health systems and building a broad base for long term sustainable health care capable of tackling existing health problems and preventing new health problems (Magnussen, Ehiri, & Jolly, 2004).

The central questions asked by stakeholders that prioritise right approach are therefore: How does the organisation go about achieving its aims? Does the approach embody principles that promise achieving desired effects?

3.4.3.4 Effectiveness and Efficacy

The fourth sub-component of legitimate governance 'for' the people can be summarised as having the right effects. Judgements made in reference to this sub-component are based on the argument that if an organisation is successful in solving the problems which it was created to tackle, then it provides good governance 'for' the people. For stakeholders that prioritise this sub-component they will seek to judge the effectiveness of the organisation when judging whether to support it. Assessing effectiveness however is a difficult task, especially with respect to GHG organisations, all of which are still relatively young organisations, and most of which take on long term health challenges. The problem of measuring effectiveness is, in fact, a challenging academic endeavour whenever *ex post* assessments are not possible. This is further complicated in the health policy field by the large number of actors that address the same challenge, whether they be states, intergovernmental organisations, CSOs or GHG organisations. Specifying exactly which actor is responsible for reducing the prevalence of a certain disease and to what degree is an extremely complex if not impossible task.

Therefore, stakeholders that prioritise this sub-component might make judgements about the effectiveness of an organisation based on intermittent or early successes. An assessment of the legitimacy of an organisation might be simplified by assessing whether certain goals have been reached. Such goals can be summarised as comprising the outputs, outcomes and impacts – of a governing organisation (Easton, 1965; Young & Levy, 1999), where outputs refer to the early stages of problem-solving entailing the norms, rules and actions that are set in motion by the organisation. Outcomes refer to changes in behaviour in response to the initial rules and actions. Impacts refer to actual effects on the problems at hand and can be further divided into procedural indicators of success, for example, the distribution of mosquito

nets, and absolute successes, such as the eradication of a disease, an increase in life expectancy, or a reduction in infection rates.

Effectiveness alone is not a criterion for legitimate governance 'for' the people. What is really sought is efficacy; which is a judgement made about an organisation, related to effectiveness, but with a crucial difference. The capacity of a governing organisation to achieve its aims and produce outcomes will only become efficacious in the eyes of its stakeholders, if it produces effects which are considered desirable, and appropriate (Reus-Smit, 2007, p. 165). The key questions to be asked by stakeholders that prioritise this sub-component therefore are: What effect did the organisation have on the actions of other actors in the policy field? What procedural indicators of success are there? What impact has the organisation had? Are these effects desirable?

3.2.3.5 Organisational efficiency

A final sub-component of legitimate governance 'for' the people concerns the ability of the organisation to go about its work in a competent and efficient manner. Stakeholders that look at this aspect when deciding whether or not a GHG organisation is worthy of support make judgements over whether the organisation is structured in such a way that resources are used appropriately. For example, a large and costly secretariat could detract from the legitimacy of an organisation in the eyes of some stakeholders.

The principles that underlie this sub-component relate to organisational efficiency along the lines of 'new public management' (Geri, 2001; Anheier & Themudo, 2008)[46]. This entails not only keeping overhead costs to a minimum, but also ensuring that organisational structures are not cumbersome and do not become tied up in red tape. An efficient organisation is structured in such a way that all staff members are aware of overarching goals and go about their work with achieving these goals in mind. Staff spend a minimum amount of time with bureaucratic and routine procedures and dedicate more time to tasks that lead to outcomes. (Junne, 2001, p. 212). The key questions to be asked by stakeholders that prioritise this sub-component of legitimate governance 'for' the people is therefore: Does the organisation work

[46] 'New public management' is a set of reforms undertaken within government departments in several countries, primarily in the 1990s. The intent of the reforms was "… to improve governmental efficiency by moving government administration from its stodgy bureaucratic roots to a nimble entrepreneurial future (Geri, 2001, p. 445). Elements of new public management include decentralization of organisational structures, reducing budgets and staff numbers, creating competitive relationships between agencies and departments and the use of performance contracts

in a lean and efficient manner? Does the organisational structure allow the organisation to produce the best possible outcomes that benefit its stakeholders?

In sum, stakeholders or normative-prescriptive researchers might choose to make judgements about whether a GHG organisation is legitimate or not by posing certain relevant questions addressing whether there is evidence that a governing organisation embodies the specific values, norms and principles that they themselves prioritise. These questions are summarised in Table 3.3. Such judgements may therefore be based on a variety of norms and principles, aligned with either the governance 'for' the people, or the governance 'by' the people, dimension of legitimacy.

Table 3.3: Conceptualisation of Legitimacy Part 1: Bases for the legitimacy of global governance organisations

Dimension Of Legitimacy	Sub-component	Questions that may be posed by stakeholders
'by' the people	***Public governance***	Are those involved in decision-making representatives of citizens and/or sovereign states? Which states are represented? And do they have the role of acting in the best interests of their citizens?
	Participatory governance	Who is involved in decision-making? Whose interests are represented by those involved in decision-making?
	Fair processes	How do the persons that are meant to represent the interests of stakeholders come to have this representative role? How are power differentials between represented groups balanced out? How is decision-making formalised and organised?
	Indirect participation	How can stakeholders express disapproval of decisions? Is the organisation responsive to criticism? Is the organisation transparent? Do stakeholders have access to documentation and comprehensive information?
'for' the people	***Right Purpose***	What does the organisation aim to do 'for' the people? Is it necessary, and desirable for a global organisation to take on this task?
	Problem-solving capacity	Is decision-making based on scientific evidence? Does the organisation comprise an expert base? Does the organisation employ competent staff and consult and partner with necessary experts?
	Right approach	How does the organisation go about achieving its aims? Does the approach embody principles that promise achieving desired effects?
	Effectiveness and efficacy	What effect did the organisation have on the actions on other actors in the policy field? What procedural indicators of success are there? What impact has the organisation had? Are these effects desirable?
	Organisational efficiency	Does the organisation work in a lean and efficient manner? Does the organisational structure allow the organisation to produce outcomes that benefit its stakeholders?

3.5 Legitimacy – between global governance organisations and stakeholders

This chapter has focused on legitimacy, defined as a perception or assumption on behalf of relevant stakeholders that an entity and its actions are desirable, proper, or appropriate according to stakeholders' values and beliefs. Importantly, after defining legitimacy in this way – as a component of a social relationship between a governing organisation and its stakeholders –legitimacy was conceptualised on the global level by means of two inter-related aspects.

First, while on the global level the absence of a clear demos may limit the possibility of a minority accepting the will of the majority based on collective identity, legitimacy can still exist on a global level because a range of other norms, values and principles underlie the work of global governance organisations. Two different dimensions and nine-sub-components of legitimacy can be identified, each of which refer to specific principles, values and norms that can underpin legitimacy considerations. Following this, the proposition is put forward that on the global level, legitimacy will based on both aspects of governance 'by' and 'for' the people as summarised in Table 3.3.

Second, as described in section 3.4 above, because global governance organisations can be viewed as operating within a system of heterarchical, rather than hierarchical governance, legitimacy on the global level can be understood as an "... issue that arises in an interaction or relationship between two individuals, or between one or more individuals and a group, organisation, or larger social system in which one party makes a certain claim, which the other may accept or reject." (Kelman, 2001, p. 55). In global governance, legitimacy comes about as part of a relationship between a global governance organisation (A) and its stakeholders (B). As it is the stakeholders of a GHG organisation that hold the power to grant or withhold legitimacy, the nine sub-components of legitimate governance outlined above lie in the eye of the beholder. It is therefore proposed that organisations that engage in global governance, such as GHG organisations, will come to enjoy legitimacy in instances where relevant stakeholders perceive that there is a congruence between the norms, values and

principles conveyed through the characteristics of the organisation and their own normative priorities, as shown in Diagram 3.1.

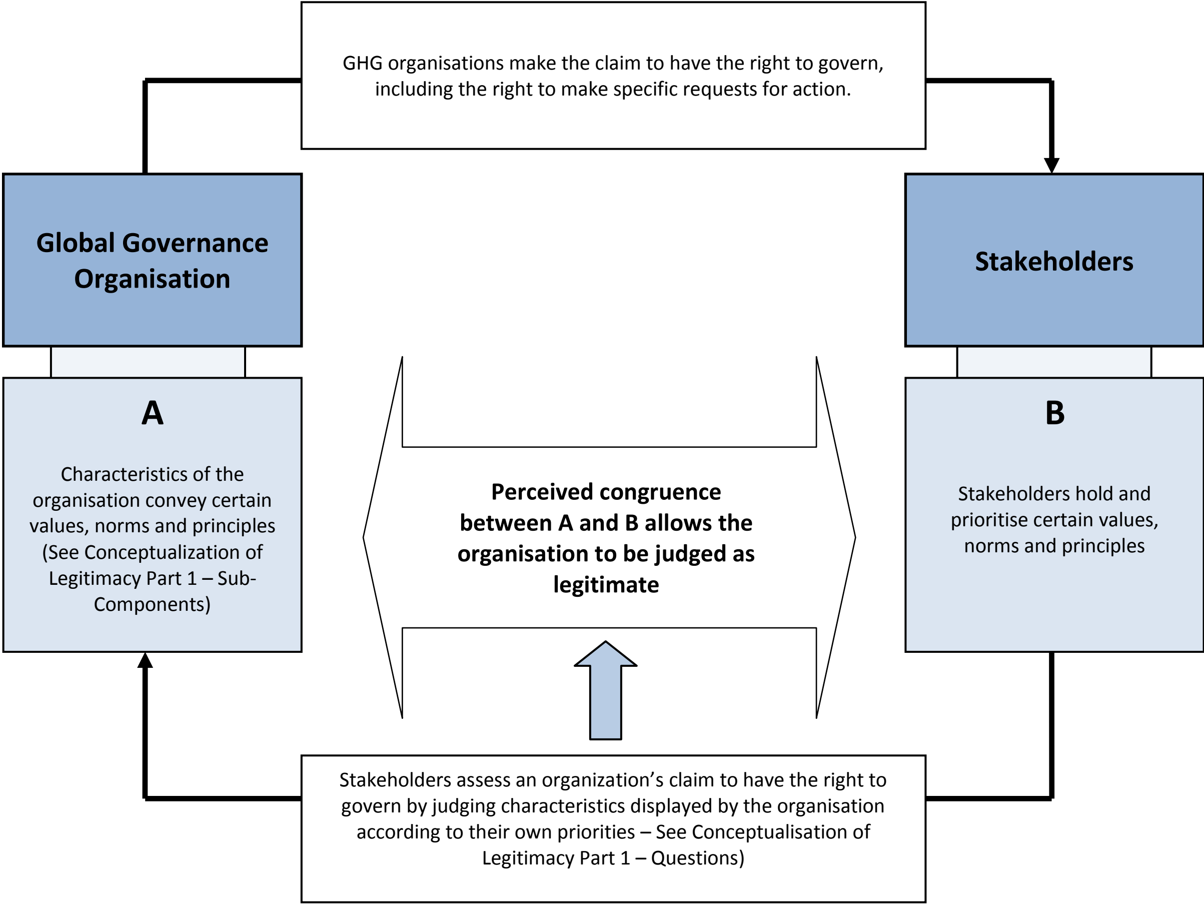

Diagram 3.1: Conceptualisation of Legitimacy Part 2: Relationships between global governance organisations and stakeholders

Now that a conceptualisation of legitimacy suitable for the global level has been proposed, the following chapter proceeds to the important task of developing methods to gather evidence from the real world that allows us to infer whether it is accurate to conceptualise legitimacy in this way. Importantly, three questions remain open: First, how can the stakeholders that are most relevant for granting legitimacy to GHG organisations be identified? Second, what values, principles and beliefs do the identified stakeholders actually prioritise when deciding whether or not to support a GHG organisation? i.e. what sub-components identified in the conceptualisation do they prioritise, if any? Third, how do they rate GHG organisations in terms of these sub-components? The following chapter returns to the specific policy field of global public health in conducting an empirical examination of, whether, and how GHG organisations have come to be accepted as legitimate global governance organisations.

Chapter Four

Stakeholders in Global Health Governance

Throughout this dissertation, frequent mention has been made of the political environment in which GHG organisations and their stakeholders operate. It has been shown that GHG organisations interact with a variety of political actors, and seek out, and rely on their diffuse support to enable them carry out their governance activities with a certain level of stability, and security.

But who are the actors that occupy the political environments of GHG organisations? In global governance studies, there is often talk about different actors, their roles and different organisational types, however there are few methods available for systematically assessing who the stakeholders of any one global governance organisation might be, how important they are, and, critically what features of a global governance organisation justifies them being granted legitimacy. Simply trying to name all stakeholders, or focus on the most vocal stakeholders, is both difficult and prone to provide an unbalanced picture of the role that stakeholders play. Instead, the method of a stakeholder analysis should be used.

This chapter addresses the third set of sub-questions of the dissertation as laid out in Chapter One and to consider the proposals set out in Chapter Three alongside empirical evidence: *How can stakeholders in global health be identified? Which actors must perceive GHG organisations as legitimate, appropriate, and worthy of support? What are their positions to the properties identified in the conceptualisation of legitimacy laid out in Chapter Three – i.e. do they give priority to both aspects of governance 'by' and 'for' the people when making judgements about global governance organisations?*

This chapter begins by introducing the concept of a stakeholder analysis – a method for finding and systematising stakeholders in management studies, and illustrates how this method can be applied in the field of global health. While each and every different GHG organisation might have a slightly different set of stakeholders, it is possible to categorise stakeholders that are particularly important for GHG organisations generally. The chapter then goes on to describe three ways in which researchers are able to gather stakeholders views on the legitimacy of GHG organisations, as were briefly introduced in Chapter One; stakeholder observation, discourse analyses, and survey research. These three methods will then be applied in an analysis of the legitimacy of GHG organisations; the first, observing the nature of the relationships between GHG organisations and their stakeholders (i.e. systematically analysing the 'claims' the GHG organisations make regarding what they would like stakeholders to do); the second, extracting stakeholders views and opinions on sub-components and legitimacy via text analyses; and the third; assessing stakeholders' opinions via a stakeholder survey questionnaire.

4.1 Why are stakeholders vital for legitimacy?

Two proposals regarding the conceptualisation of legitimacy of GHG organisations were developed in the previous chapter. First: that legitimacy can exist on a global level, although it differs from legitimacy on the state level. Crucial here is seminal work on legitimacy from Fritz Scharpf (1999) who, in writing in the European Union context, distinguished between legitimacy based on governance 'by' the people, and legitimacy based on governance 'for' the people. The legitimacy of GHG organisations may be based on principles related to either of these types of governance. Second: the legitimacy of a GHG organisation created as part of a relationship between the GHG organisation and its relevant, concerned and affected audiences i.e. its stakeholders. This means that both the characteristics of the organisations, their inputs

and outputs etc, in conjunction with the perceptions of the stakeholders which surround the organisation determine whether the organisations is accepted as legitimate or not. In this chapter, these proposals will be addressed by means of gathering relevant empirical evidence with the aim of inferring their relevance for viewing real world cases.

The breakdown of legitimacy into the two dimensions – governance 'by' and 'for' the people developed in the previous chapter (see Table 3.3) suggested which features of a GHG organisation might prove to be sources of its legitimacy. At this stage, no objective assessment of the sources has been made and there are few differences between what was achieved in the previous chapter and a purely normative-prescriptive approach to legitimacy. The crucial part of an empirical-analytical approach to legitimacy comes with an assessment of the perceptions of stakeholders. While normative-prescriptive approaches would assess each of the nine sub-components identified according to the researchers own values, beliefs and norms or established philosophical works on values and norms, here, the choice is to proceed with a empirical analysis of GHG organisations by asking; which actors must perceive GHG organisations as legitimate (or not)? And what opinions do they hold? From the gathered evidence, conclusions will be inferred as to whether legitimacy really can be based on aspects of both governance 'by' and 'for' the people.

As noted above, very few scholars, even amongst those who recognise that it is the opinion of stakeholders that counts, actually proceed to identify stakeholders and seek out their perceptions. This is because it is a difficult task to achieve, even in relation to small organisations, let alone organisations of global governance. Accepting that it is possible for different actors to have different opinions about whether certain organisations are legitimate or not, makes the problem of legitimacy appear infinitely complex. Something that is subjective, or lies in the eye of the beholder, is an extremely difficult endeavour for political science to grab a hold of (Clark, 2005, p. 215). However, the fact that legitimacy itself cannot be equated with any specific normative arguments makes the endeavour a necessary one to follow. The challenge therefore is to be able to systematise stakeholders, and their opinions, to a level that is scientifically useful. Methods from public policy and management studies, that are aimed specifically at the identification, ranking and surveying of stakeholders of certain projects and reforms, i.e. the methods of stakeholder analysis, will be applied in a first attempt to systematise the difficult endeavour on a global level, beginning with the problem of how to recognise stakeholders.

4.2 Who are stakeholders in global health governance?

Varvasovsky and Brugh define a stakeholder analysis as "...an approach, a tool or set of tools for generating knowledge about actors, individuals and organizations – so as to understand their behaviour, intentions, inter-relations and interests..." (Varvasovszky & Brugha, 2000).[47] The first step of a stakeholder analysis, (after identifying the questions to be answered as the aim of the analysis) is to identify the stakeholders. Stakeholders can be defined as

> …actors who have an interest in the issue under consideration, who are affected by the issue, or who – because of their position – have or could have an active or passive influence on the decision-making and implementation processes. They can include individuals, organizations, different individuals within an organization, and networks of individual and/or organizations i.e. alliance groups (Varvasovszky & Brugha, 2000, p. 341).

The identification of the stakeholders of any one GHG organisation therefore requires careful consideration of who is affected by the organisation, who has an interest in its policies, and who can exert an influence over the organisation (Schmeer, 1999, pp. 7-8). The stakeholders of three specific GHG organisations and their perceptions of legitimacy will be addressed in chapters 5, 6 and 7 respectively. Here, a preliminary examination of stakeholders in global health governance in general will be made. This is possible because the political environments in which all GHG organisations operate overlap, due to the specific nature of the global health policy-field. Differences in stakeholders between specific GHG organisations are therefore relatively minor.

In the first instance it is obvious that people at risk of poor health or living with disease are affected by the work GHG organisations, as are people working in the field of global health, such as doctors, nurses, carers and other health professionals. Importantly, because stakeholders can also be organisations, and not just individuals, it is possible to consider associations of health workers, and patient interest organisations as stakeholders. In the second instance GHG organisations work most closely with states and policy makers in states. Therefore, states with populations that have poor health, or are at risk of poor health might be considered stakeholders as well. Looking at which stakeholders might influence GHG organisation's governance as donors, states, or more specifically states that grant overseas

[47] In management and policy planning, stakeholder analyses serve the primary purpose of identifying which stakeholders are the key for ensuring the successful functioning of an organisation or project. Here, no attempt is made to try to optimise the success of a GHG organisation; the stakeholder analysis serves the purpose of empirically analysing the extent to which GHG organisations enjoy legitimacy amongst a wide range of stakeholders.

development assistance (ODA), and more specifically again, states that grant ODA specifically to health projects can be identified as stakeholders. Non-state donors also influence GHG organisations and can be identified as stakeholders, as may academic and research organisations that preside over evidence and knowledge that may influence GHG organisations.

This short listing provides a first indication of how easily the identification of stakeholders can become an overwhelming task without some kind of systematisation and categorisation of stakeholders. For analytical purposes, it is important not just to identify stakeholders and list them, it is also necessary to distinguish between stakeholders, which can be done along various lines. The two main ways are to first; list stakeholders by level of importance or proximity to a GHG organisation, i.e. by the extent to which they are influenced by a GHG organisation's decisions or second; listing stakeholders according to their organisational type. Combining both of these methods gives the most comprehensive categorisation of stakeholders.

4.2.1 Ranking stakeholders

The global health policy field is earmarked by a broad yet distinct range of stakeholders that are either involved directly in health policy, are affected by it, or consider addressing health challenges to be one of their main concerns. Furthermore, for every stakeholder that is directly involved or concerned with, or affected by health policy, there is a further range of actors that are in turn affected by the actions of these stakeholders, which themselves become stakeholders. One could in fact argue that all citizens, globally, are in some way affected, or concerned with GHG organisations – but not to equal degrees.

One of the very few studies into legitimacy which has proceeded to the point of critically examining the importance of the role of various stakeholders is that of Benjamin Cashore, who has studied the role of non-traditional governance forms in the logging industry (Cashore, 2002). Cashore explains that the stakeholder can be differentiated in two ways.

First, different stakeholders can hold different core values and beliefs and therefore prioritise different sub-components of legitimacy (as laid out in Chapter Three). For example, a health focused civil society organisation might prioritise the indirect participation via transparency, and participatory democracy. A state with high disease prevalence might prioritise the sub-component of right approach. A donor-state might prioritise the sub-component of impact.

Second, stakeholders vary in the density of interactions that they have with GHG organisations. A civil society organisation that focuses specifically on global health might have a higher density of interaction with a GHG organisation, than a multi-issue CSO.

Cashore differentiates between a governance organisation's immediate audience as 'tier I' and general audience as 'tier II' (Cashore, 2002, p. 511). 'Tier I' actors have a direct interest in the policies and procedures of the organisations they legitimate whereas 'tier II' actors are less directly influenced by the policies, but have an equally important role in granting legitimacy (Cashore, 2002, p. 511). In global health governance, it is also possible to distinguish between stakeholders according to their level of interest in a GHG organisations policies and procedures, and the extent to which they can influence GHG organisations.

Diagram 4.1 gives a graphic representation of how various stakeholders in global health described above might be placed in order of distance from a GHG organisation, in terms of the extent to which they are either affected by a GHG organisation's decisions, or influence a GHG organisations governance. Stakeholders placed close to the inner-circle have a very direct stake in a GHG organisation and its decisions. These include aid agencies that provide funding for GHG organisations and have a desire to see the goals of GHG organisations reached, either as a justification for their own engagement, or because they have prioritised these goals themselves and chosen a GHG organisation as a best way to address them. Organisations set up to represent patients, or people affected by diseases are also intimately affected by the work of GHG organisations, as are the manufacturers of the products that GHG organisations aim to distribute, promote, or, in some cases discourage. Finally health and finance ministries in the states that are addressed by GHG organisations will also be directly affected, especially when GHG organisations request changes in their policies or actions.

Somewhat further out from the inner circle are stakeholders that will be affected by GHG organisations in an indirect way, but are still to be classified as stakeholders because they have an interest in the goals and operations of GHG organisations. For example a business with a high number of staff that are at high risk of poor health, is a stakeholder that will be affected by the success or failure of a GHG organisation. Consumers are placed at quite a distance away from the inner circle, they are not directly affected by the GHG organisations, but are affected by the actions of others stakeholder that are positioned in close proximity to

the GHG organisation. Importantly, they might steer the actions of the business sector in their financial ability or desire to offer support to GHG organisations.

These three layers can be distinguished along similar lines of the 'tier I' and 'tier II' system introduced by Cashore. The stakeholders placed closest to the centre of the circle are directly addressed by GHG organisations' policies and the relevant GHG organisations will be directly affected if support from these stakeholders is withdrawn. They can be labelled *primary stakeholders*. Actors placed at a medium distance from the centre, are affected by GHG organisations, but they have limited capacity to affect GHG organisations if they withdraw support from them – they can be labelled *secondary stakeholders*. Stakeholders placed furthest away from the inner circle carry an important role in global health despite the distance between them and GHG organisations. These stakeholders influence other actors, such as primary and secondary stakeholders, and shape their preferences and attitudes towards GHG organisations as well as their ability to influence them. These actors can be labelled *tertiary* stakeholders.

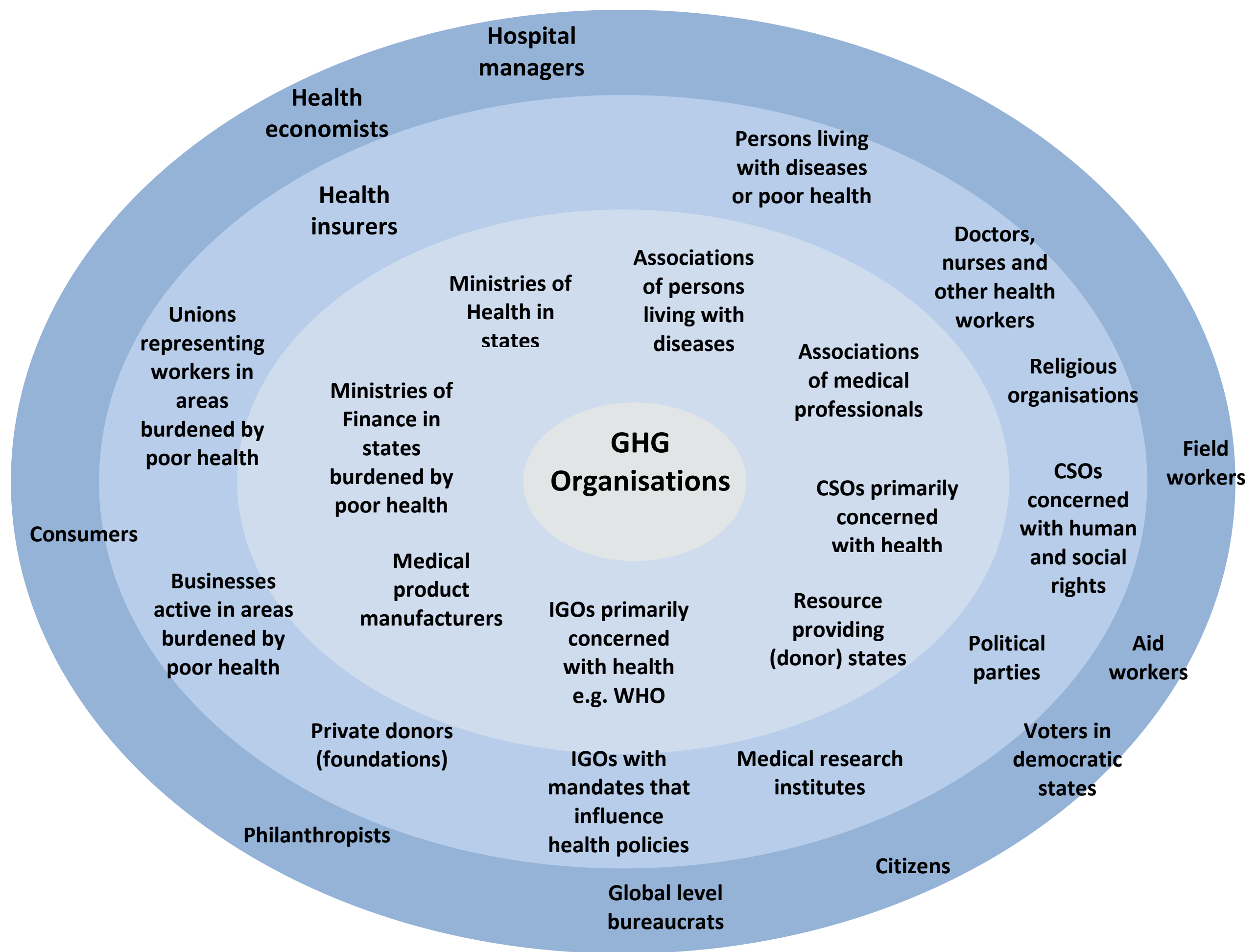

Diagram 4.1: Stakeholders of GHG organisations

Another important feature of Diagram 4.1 is that it shows that the stakeholders that are positioned close to the GHG organisation in the centre are all organisations themselves. On the global level, primary stakeholders are, for the most part organisations or 'conglomerate actors' i.e. organisations that present themselves outwardly as a unit, despite being made up of many individual parts. Individuals, such as voters or employees in government departments are also stakeholders, but their direct influence on GHG organisations, as well as the ways that they are affected by the policies of GHG organisations are normally channelled through the actions of conglomerate actors. They are therefore more likely to be tertiary stakeholders. Some stakeholders also straddle the lines between primary and secondary, or secondary and primary stakeholders.

4.2.2 Classification of stakeholders

A closer look at Diagram 4.1 shows that several stakeholders are similar according to their main aims and functions, and the way in which they are affected by GHG organisations. Some of the actors are public, in that they function as organs of, or cooperative organisations of, states and their citizens. Other stakeholders in the figure exist independently of states, and therefore have structures, aims and purposes that are not related to citizens, but rather specific interests or interest groups. For analytical purposes four distinct types of stakeholders can be identified that are active in global health governance. With a few exceptions, almost all stakeholders in global health governance can be categorised along these lines, when each group is divided into further sub-categories according to the relationship they have with GHG organisations i.e. whether they are affected more by the operational policies of GHG organisations, or the funding policies of GHG organisations, and to what extent. In this section the four types of stakeholders are introduced, followed by further classification of the stakeholders that make up these groups

The first category of stakeholders is made up of states, and the organs of states. States can be classified as public actors because they act with the primary purpose of fulfilling functions such as ensuring security over a certain territory, rule of law within that territory, the welfare of citizens within that territory and a sense of community amongst those citizens. Within states, sub-organisational structures are formed to ensure the successful functioning of the state, in the form of ministries and departments. These organs, while often acting with a certain degree of independence when it comes to policy choice are inseparable from the state and can therefore be seen as public actors.

In the health policy field it is useful to distinguish between states in terms of their role in global public health. This also helps distinguish which state organs represent the most important stakeholders in public health. In global health, states can generally be categorised according to two defining elements 1) the level to which the state is burdened by poor health or at risk of becoming burdened by poor health; and 2) contribution the state makes in providing overseas development dedicated to health projects, both in terms of financial development assistance, and knowledge and expertise. For example, a state with a high prevalence of childhood diseases will be affected by the operational policies of a GHG organisation that targets childhood diseases and prescribes courses of action for increasing immunisation rates or increasing childhood nutrition. Examples in this case are the states of

Guinea, Guinea-Bissau, Niger and Somali, all of which had death rates from childhood cluster diseases of over 80 per 100,000 population in 2004, according to WHO estimates (World Health Organisation, 2006).[48] In particular, the Ministry of Health of the state will be an important stakeholder as an organ of the respective state, but also, due to the need to ensure resources, the Ministry of Finance (or equivalent) will also be a primary stakeholder. A state with very low levels of childhood diseases will not be affected by the operational policies of the same GHG organisation; however, if that state has the capacity to provide ODA, the GHG organisation may request funding from it in order to be able to carry out its operational policies. States such as France, Germany, Japan, the United States and the United Kingdom each contributed over US$ 10,000 million to overseas aid in 2006 (OECD, 2007). In these cases, the Ministry for Development and Cooperation or equivalent in each respective state would represent a key stakeholder for the GHG organisation. In terms of gathering other resources such as knowledge of new or promising medicines or strategies to reduce childhood disease prevalence, other state organs, such as research institutes might also become key stakeholders. A GHG organisation that focuses on a different aspect of global health, such as a specific disease or condition will have slightly different states as primary stakeholders, depending on which states have a particular high prevalence of the disease in question and which states have the resources and technologies to contribute to fighting the disease. Finally, the governments in power in those states can also be seen as stakeholders. The political party in power may therefore be seen as a secondary stakeholder.

The second category of stakeholders relevant for global health governance is made up of intergovernmental organisations. IGOs are also public actors in that they act as organisations with the purpose of maximising the benefits to states and their citizens through modes of cooperative action. In the health policy field the WHO remains the IGO with the highest stake in global health governance, and is therefore always a key stakeholder of GHG organisations. It is also a conglomerate actor which is the most difficult to view and analyse as a unit. Other IGOs may also be seen as having health as (or one of) its primary areas of activity. Of particular note here is UNICEF and the United Nations Food and Agricultural Organisation, (FAO), but also the World Bank, which has directly addressed health in many of its policies over the past 15 years. Other IGOs might be seen as secondary stakeholders. They might not address health as a primary policy issue-area, but the extent to which they integrate health into

[48] Childhood cluster diseases include Pertussis, Poliomyelitis, Diphtheria, Measles, and Tetanus. The rates cited are age-standardised rates.

their work can have significant impact on GHG organisations, especially in the case of possible regime conflicts. The policies of the World Trade Organisation, for example in relation to intellectual property rights is a prime example, but also policies on development, human rights, cultural rights from various UN Specialised Agencies have an impact of health.

The third main type of stakeholder that can be identified as a distinct group is made up of business sector actors. Stakeholders that fit into this category are marked by their private and profit-making status, which makes them distinct from public actors. Stakeholders in this category act with the primary purpose of producing goods and/or services that can be bought and sold in the market. This focus can also mean that, even though the products and services they produce, and the way they produce them might be aimed at increasing levels of good health and reducing levels of poor health, by definition their primary focus must remain benefiting the business owners, which are in many cases shareholders.

In the health policy field it is possible to distinguish between different business sector actors by the way they are affected by health policy on the global level, and the extent to which the actors themselves affect the health of populations. Some business actors are directly involved in the health sector as manufacturers of medical or hygiene products, for example the pharmaceutical product manufacturers Merck & Co. and Bayer Chemicals; and the hygiene product companies Johnson & Johnson and Procter & Gamble. They are known to be important stakeholders of GHG organisations. Other businesses sector actors might not be directly involved in health product manufacturing or health care delivery, but might be operational in areas that are affected by high levels of disease prevalence. Examples include the car manufacturer Mercedes, with operations in Southern Africa, or businesses involved in extractive industries in developing countries, such as Exxon Mobil and Total. Their business operations might be affected by GHG operational policies. Yet another sub-category of business sector actors is made up of those businesses that are hardly affected at all by the policies of GHG actors, but may choose to become involved in GHG organisations, or publicly express their support for them as part of corporate social responsibility activities. For example there are numerous businesses that have become members of the Global Business Coalition to Fight AIDS, Tuberculosis and Malaria (GBC), an organisation for coordinating the support of for-profit actors for global health at the global level. Some businesses that are members barely have direct relationships to global health policy, such as Deutsche Bank, or Standard Chartered, both of which are involved in the financial services industry. Others are

involved in the manufacture of products which are health related, such as Heineken N.V., a producer of alcoholic beverages. Finally, organisations designed to represent the interests of businesses are also to be categorised as business sector actors, because their focus is also in trade of goods and services and profit making. Examples include think-tanks such as the pharmaceutical industry sponsored International Alliance of Patients' Organizations, the International Chamber of Commerce and the International Federation of Pharmaceutical Manufacturers Associations.

The fourth type of stakeholder that can be identified is civil society organisations. This type of organisation is the broadest and most difficult to define. A thin definition is that all actors that are neither public, nor for-profit can be categorised as belonging to this group. Thus CSOs are non-state, non-for-profit actors. However, it is generally accepted that criminal organisations, such as terrorist groups, should not be considered civil society actors, despite being both non-state and non-for-profit (Anheier & Themudo, 2008, p. 141). A further defining characteristic of civil society organisations is therefore that they contribute to the development and maintenance of (global) civil society, a political space in which individuals may pursue social and political activities, and create and promote common values in areas such as human rights and justice in a peaceful manner. CSOs may either be influenced by the policies of GHG organisations, or may have the power to influence GHG organisation. This power might be based on material resources that they can contribute to GHG organisations, but is more likely to be in the form of soft power, i.e. power based on knowledge and reputational resources, such as local information, access to target groups, or expertise.

It is important and necessary to differentiate between the many types of civil society organisations that exist, especially in the global health policy field. Many are intimately intertwined with states, and others with business sector actors; they also vary considerably in terms of size, scope, goals, legal status and funding sources. For global health governance, the following eight sub-classifications can be made.

First, (International) CSOs that promote health as their main goal or one of their main goals via lobbying, advocacy work and public awareness campaigns. Examples include Oxfam, the International Planned Parenthood Federation (IPPF), Health Action International, Médecins Sans Frontières and the International Union for Health Promotion and Education. CSOs with an international scope of activities will sometimes be made up of smaller local branches,

which might be considered secondary stakeholders, and have large numbers of staff and advisors, which may be seen as tertiary stakeholders.

Second, CSOs that coordinate and implement disaster relief, including medical care, e.g. The International Red Cross and Red Crescent, and Medicus Mundi International.

Third, CSOs that engage in grass-roots work often implementing projects with a high degree of contact with citizens and individuals, examples here include The AIDS Support Organisation (TASO) which is active in Uganda or the Thai AIDS Treatment Action group (TTAG).

Fourth, CSOs (local, regional and global) that act as a coordinator of activities between other CSOs, or a platform for exchange, also known as umbrella groups. For example the People's Health Forum.

Fifth, CSOs in the form of charities and foundations that aim to provide private funding for health projects. Examples of foundations include the Bill and Melinda Gates Foundation and the Rockefeller Foundation, while examples of private funds include the Save the Children Fund.

Sixth, CSOs that do not have health as their main focus of activities, but promote values and policies that influence health. These might include environmentally focused CSOs such as Greenpeace; CSOs that aim to combat poverty and its consequences, such as World Vision, or human rights related CSOs such as Human Rights Watch. These types of CSOs will generally be secondary rather than primary stakeholders.

Seventh, CSOs with the primary goal of representing and increasing the power of people living with diseases or poor health. There are a large number of CSOs that act in this capacity, especially with regards to people living with HIV/AIDS for example the International Community of Women Living with HIV/AIDS (ICW) and the Global Network of People living with HIV/AIDS (GNP+).

Eighth, CSOs that act to represent the interests of workers and professional groups involved in health. These may be in the form of Unions or professional associations. Prominent examples include the International Council of Nurses and the International Society of Doctors for the Environment.

The fact that so many different sub-categories of CSOs can be made highlights the difficulty in labelling CSOs as a unit at all. Furthermore, several CSOs might be labelled under several of these categories, because their work entails several types of activities. In other instances some of the CSOs given as examples above are not classified as CSOs at all by some analysts. For example, some philanthropist foundations that are connected with a particular business might be classified by some as a type of business sector actor, arguing that the aims and scope of activities of such foundations are inseparable from the profit-making activities of the business from which they receive funding. Similar arguments can be applied to associations of medical professionals. Other scholars have classified CSOs that are primarily state funded as a type of state organ. Still, it is possible to identify two key similarities amongst all of these actors, which makes it useful to group them together when analysing the legitimacy of GHG organisations. First, they are content driven actors, addressing problems and specific solutions they hold to be most promising. Second, as parts of a global civil society, they embody the type of actor that reflects a global society, rather than a society of states.

4.2.3 Dynamic stakeholders

Two exceptions to the above four stakeholder types are important for a stakeholder analysis in global health. These exceptions occur because of the dynamic nature of governance on the global level, creating at least two new types of stakeholders.

First, as noted in the previous section, individuals are also stakeholders of GHG organisations, however, they have a limited ability to affect GHG organisations and are more often in the position to influence primary and secondary stakeholders in the form of conglomerate actors. It is especially the tertiary and individual stakeholders that tend to transcend these four broad types of stakeholders. For example individuals, that present themselves as experts, may act as policy advisors to one or more key stakeholder of different types.

Second, some conglomerate organisations cannot be categorised as strictly state, or non-state stakeholders because they might be made up of parts from different stakeholder types. Public-private partnerships are the main example to be cited here, being organisations that have both the characteristics of state as well as non-state stakeholders. GHG organisations, which represent particularly advanced forms of public-private partnerships, can also be classified along these lines. A GHG organisation may well be a key stakeholder of another GHG organisation, UNAIDS and GFATM for example are key stakeholders of each other.

Stakeholders of GHG organisations can thus be classified along both organisational type (including sub-categories) as well as their distance from the GHG organisation in terms of the extent to which they are influenced by policies or exert influence on GHG organisations. In Table 4.1 both of these classifications are laid out, along with concrete examples.

The first step of a stakeholder analysis, the results of which are presented in Table 4.1 involves identifying and categorising the main actors in the political environment surrounding a particular organisation for the purpose of identifying with whom the organisation enters into relationships, and who makes judgements about whether the organisation is legitimate or not. The remainder of this chapter will focus on *primary* stakeholders in global health governance and on identifying some of the norms, values and beliefs that they hold and might base legitimacy judgements on. At this stage the analysis will focus on whether primary stakeholders appear to be influenced by, and prioritise, any particular norms, values or beliefs in their political behaviours, their communicative actions, and how they respond to direct questioning on aspects of legitimacy. Initially, stakeholders' views on the legitimacy of any one particular GHG organisation will not be examined. This will be the topic of investigation in the following three case study chapters.

Table 4.1: Stakeholders in global health governance by organisational type

Stakeholder Type	Sub-category	Examples of primary stakeholders	Examples of secondary stakeholders	Examples of tertiary stakeholders
States	**States burdened by poor health**	Ministries of Health and Ministries of Finance	Political parties in government	Staff members and department advisors; Citizens and voters
	Resource providing (donor) states	Ministries of Development and Cooperation		
IGOs		WHO and its departments; UNICEF; World Food Programme and other health related IGOs	UNDP, International Monetary Fund	Global level bureaucrats and advisors
Business Sector Actors	**Health product manufacturers and service providers**	Pharmaceutical and medical equipment industry, e.g. Aventis; Merck & Co. Hygiene and nutrition industry e.g. Procter and Gamble; Nestle.	Suppliers and clients of health product manufacturers and service providers	Staff members
	Business affected by global health challenges	Businesses active in states burdened by poor health e.g. Daimler in Southern Africa, Shell in Nigeria.	Suppliers and clients of businesses affected by global health challenges, Union and staff representatives	Employees and their families
	Business involved in health as part of CSR activities	Members of the GBC, e.g. Standard Chartered. Businesses active in the World Economic Forum's Global Health Initiative.		Staff members and advisors
	Industry lobby associations	Intellectual Property Committee		Staff members and advisors
Civil Society Organisations	**Health focused CSOs**	Oxfam, IPPF, Health Action International, Médecins Sans Frontières		Staff members, field workers
	Disaster-relief CSOs	International Red Cross and Red Crescent		
	Grass-roots CSOs	The AIDS Support Organisation		
	Umbrella groups	People's Health Forum		Staff members and advisors
	Charities and foundations	Bill and Melinda Gates Foundation, Save the Children Fund		
	CSOs focusing on related issue-areas		Greenpeace, Human Rights Watch	
	Associations of people living with diseases	International Community of Women Living with HIV/AIDS (ICW), the Global Network of People living with HIV/AIDS (GNP+)	Local organisation branches; discussion groups	Person's living with poor health or targeted diseases
	Medical professional associations	International Council of Nurses.		Doctors, nurses and medical professionals
Dynamic Stakeholders	**Public-private partnerships (PPPs)**	Health focused partnerships e.g. Global Alliance for Improved Nutrition	PPPs from related policy fields e.g. water supply partnerships	
	Health policy elites	Global health consultants e.g. Kickbusch Health Consult; Transient staff members		

4.3 Analysing stakeholders' positions

As proposed in Chapter Three, legitimacy is a quality that stakeholders may ascribe to a GHG organisation if it considers it to represent legitimate global health governance. When stakeholders make such judgements, they do so with reference to their own values, beliefs, preferences and priorities that specify what a GHG organisation should do and which organisational features are desirable (Reus-Smit, 2007, p. 163). These values, norms and

opinions may be related to principles that underpin governance 'by' or governance 'for' the people.

Once it has been made clear who the stakeholders of GHG organisations are, the next step in an examination of legitimacy is to seek out the norms, values and beliefs that these stakeholders prioritise when making judgements about whether a GHG organisation is worthy of diffuse support and to be considered legitimate. This involves surveying stakeholders' positions towards GHG organisations, to draw out answers to two pertinent questions. First, which of the two dimensions and nine sub-components of legitimate governance do stakeholders consider to be important? Second, how do stakeholders rate GHG organisations in relation to the sub-components of legitimacy that they consider to be most important? The remainder of this chapter seeks out answers to the first of these two questions. The following three case study chapters then go on to relate to the aspects that stakeholders prioritise when judging specific GHG organisations.

While stakeholder analyses in public policy and management go on to assess the importance of stakeholders based on certain traits, such as whether they are internal or external stakeholders, and the level of resources at each stakeholder's disposal, what is sought here is the subjective opinions, feelings and preferences of stakeholders. This makes analysis difficult because it involves trying to observe empirical facts which are not directly replicated in any natural data sources. Therefore, it is necessary to apply methods that allow the researcher to infer conclusions about the subjective norms, values, beliefs and preferences of stakeholders through an understanding of how these values are formed, and how they may be projected externally.

Legitimacy has both an attitudinal and a behavioural component. Stakeholders that accept a GHG organisation as legitimate hold attitudes that are positive towards the organisation in terms of whether or not it is appropriate, rightful and worthy of support. In essence, this attitude or *Legitimitätsglaube*, on behalf of stakeholders is what makes an organisation legitimate. Stakeholders are then likely to act upon this positive attitude, provided other constraints – such as fear of consequences from other actors – do not hinder them (Schneider, Nullmeier, & Hurrelmann, 2007, p. 126). While it is not possible to directly observe attitudes, the values, beliefs and preferences of actors in global governance may be manifested in three types of observable action; the first is political behaviour, i.e. whether stakeholders act in such

a way that indicates a positive, supportive relationship with GHG organisations. The second type of observable action is communicative action, where actors make direct and indirect references to certain values, beliefs and norms when either judging the political behaviours of others, or justifying their own political behaviours while in the process of engaging in public discourse. The third type of observable action is direct expression of opinions, in other words, specifically stating what values, beliefs and norms are important to a stakeholder (Schneider, Nullmeier, & Hurrelmann, 2007, p. 132). Each of these types of actions are linked. Attitudes expressed in public communication can influence the norms, values and beliefs that may ultimately be expressed in the direct expression of opinions. In turn, values and norms held by stakeholders influence political actions, as does communicative action. Political acts that require justification or are commented on can shape the way that a stakeholder communicates, and thus influences the types of norms, values and beliefs they refer to in communicative action. What is important for an empirical analysis of legitimacy however, is that each of these types of action offer insight into the extent to which stakeholders hold the attitude that they consider a governing organisation to be legitimate, and in some cases, what norms, values and principles they refer to in justifying this attitude.

Each of these types of action can be observed on the basis of empirical data, from which, when organised systematically, inferences can be made as to the attitudes, the values, beliefs and preferences of actors. However, a different method for extracting data needs to be applied in each case. The method of observation is the most appropriate for collecting information on political behaviour. Communicative action can be analysed by means of discourse analysis. In the analysis below, the communicative action expressed in formal published texts of stakeholders belonging to each stakeholder type was analysed for references to specific norms, values, beliefs and principles. Finally, the direct expression of opinions can be sought out by means of direct questioning, either via administered questionnaires or by interviewing. Here, tertiary stakeholders are asked questions to find out their attitudes, and the extent to which these tertiary actors are affiliated with, are part of, or influence primary actors is taken into account. The relationships between the three dimensions of empirical legitimacy covered by these methods are summarised in Diagram 4.2: (adapted from Schneider, Nullmeier and Hurrelman (2007, p. 132).

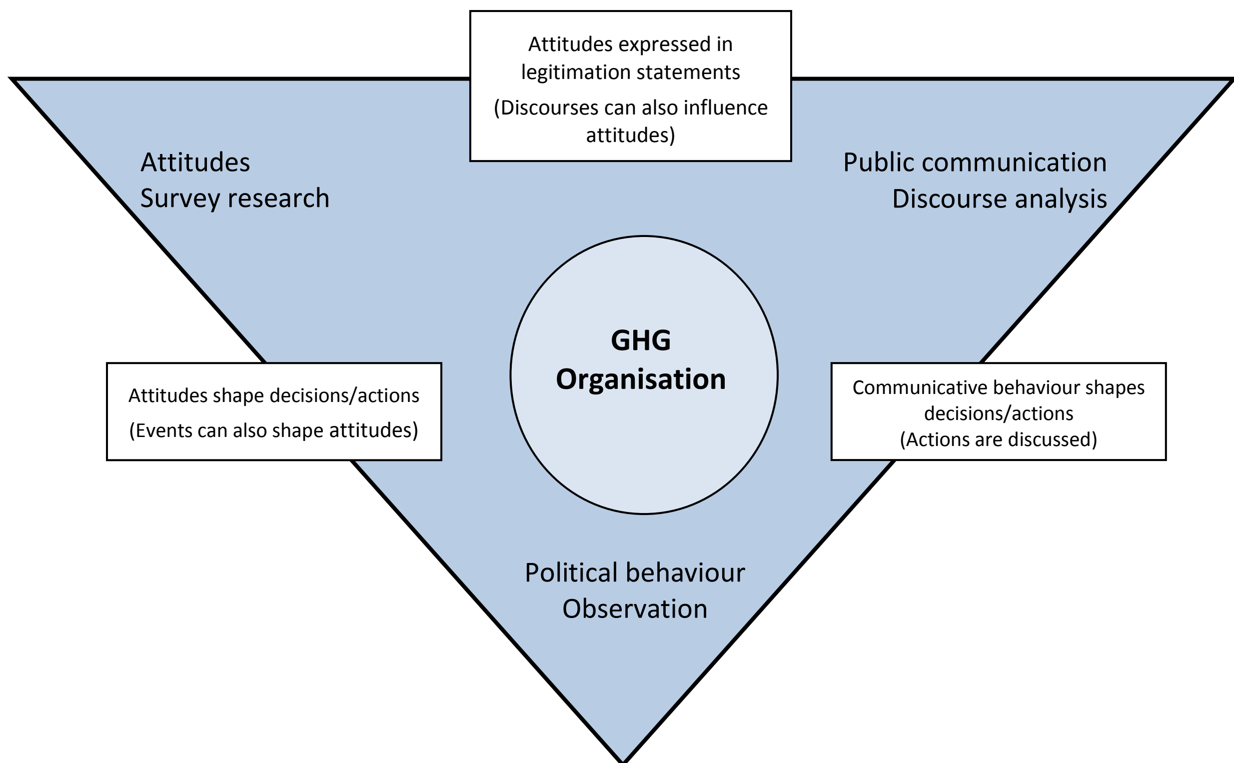

Diagram 4.2: Observing empirical legitimacy

The exhaustive list of classification of stakeholders presented in the above section highlights the need for selectivity when surveying stakeholders. The following three sections concentrate on primary stakeholders, which, in some cases have been narrowed down to just a few stakeholder groups.

4.4 Claims and behaviours of GHG organisations and their stakeholders

Observing the nature of relationships between GHG organisations and their stakeholders is one method by which it may be possible to infer whether global health governance organisations may be seen as legitimate, or not, by their stakeholders. This method has strengths in terms of analytical rigour, because it relies on data that can be collected without any direct interference on behalf of the researcher. It also involves observing situations where legitimacy is present to such an extent, that a GHG organisation becomes accepted as a valid actor in global health governance, or situations where legitimacy has been placed in doubt to such an extent that it becomes subject to rejection. In applying this method, political behaviour that indicates support for and acceptance of GHG organisations, is interpreted as a sign that the organisation is accepted is likely to be accepted as legitimate, at least to the

extent that it is accepted as a valid option for political cooperation, while political acts that withdraw support from a GHG organisation, or in some way protest against it, are interpreted as a sign of rejection, or that the organisation is rated as having a low level of legitimacy. Despite these strengths, observation of political action can be considered an incomplete method for drawing inferences about legitimacy. This is because political actions may well indicate manifestations of beliefs, values and norms that provide the basis for an organisation's legitimacy, but they might also be traceable back to other motivational factors, such as coercion, or rational action based on short-term means-ends calculations (Norris, Walgrave, & van Aelst, 2006). Furthermore, while it is useful for making inferences about the extent that legitimacy is present, it cannot show what values, beliefs or norms form the basis for legitimacy or lack of legitimacy. Therefore, this method is only of value for an analysis of legitimacy if used in conjunction with other methods aimed specifically at inferring which values, beliefs and principles stakeholders behold and prioritise, such as text analysis and the surveying of stakeholders opinion via direct questioning.

Therefore, the following section aims to provide an overview of the relationships between GHG organisations and their stakeholders for the purpose of comparison with those shown in the results of analyses using the other two methods. This will be done by reviewing the types of 'claims' that GHG organisations make concerning how they would like their stakeholders to act, and the responses of stakeholders to these claims in terms of their political behaviour and the general levels of active support they then lend to GHG organisations. Sample 'claims' made by GHG organisations about what type of action they would like to see from their stakeholders will be compared with the political acts of stakeholders in response to these claims.

4.4.1 GHG organisations and their relationships with states

How have states reacted to the trend towards the formation of GHG organisations and their increase in numbers and scope? How can the relationship between GHG organisations and the states, which are their stakeholders, be best described? Both states that have the capacity to contribute resources to global health governance organisations as well as states that are burdened by disease and poor health are important stakeholders and their political actions of acceptance or rejection of GHG organisations will offer initial indicators of whether GHG organisations enjoy a level of diffuse support that could be based on legitimacy.

4.4.1.1 Donor states

Currently there are 22 member states of the OECD development assistance committee (OECD-DAC).[49] All of these states aim to provide overseas development assistance (ODA), with a range from 0.17 % to 0.89 % of their gross domestic product (GDP). Combined ODA from these states totalled US$ 103 940 million in 2006 (OECD, 2007), thus, they represent a group of states that have the potential to contribute resources to GHG organisations. They are also states that are presented with various options regarding how they disperse ODA. For example, OECD-DAC member states are requested to provide the highest levels of core assessed contributions to the WHO and to other IGOs. The 'claims' that GHG organisations make concerning desired political behaviour on behalf of these states is that they should channel development assistance funding designated to health through their organisations. Thus, support for GHG organisations in the form of channelling ODA funds directly to GHG organisations can be interpreted as a sign of support. If, however, these states are reluctant to provide funding for GHG organisations choosing instead to fund IGOs – such as the WHO, or the World Bank Global AIDS programme – or to channel their ODA though bilateral programmes, this might indicate a weak level of support for GHG organisations.

By comparing the ratio of funding to address HIV/AIDS channelled through GFATM, UNAIDS or bilateral programmes, it becomes evident that some states have chosen to support GHG organisations more than others. For example, of a total of $US 738 million in aid for HIV/AIDS projects from the United Kingdom, 87 cents from each dollar was channelled through bilateral programmes[50]. Other states with similar ratios were the United States (80 cents in every dollar) Ireland (77 cents in every dollar) and the Netherlands (76 cents in every dollar). In contrast, other OECD-DAC members channelled a higher percentage of HIV/AIDS targeted aid through GFATM and UNAIDS than through bilateral programmes, for example France (81 cents channelled through GFATM and UNAIDS for every 18 cents through bilateral programmes); Japan (74 cents channelled through GFATM and UNAIDS for every 26 cents through bilateral programmes) and Italy, (93 cents channelled through GFATM for every 7 cents though bilateral programmes). However, it seems that, in some cases bilateral aid is still preferred over GHG organisations.

[49] OECD-DAC members states in 2006 were Australia, Austria, Belgium, Canada, Finland, France, Denmark, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, and the United States.

[50] For the year 2005.

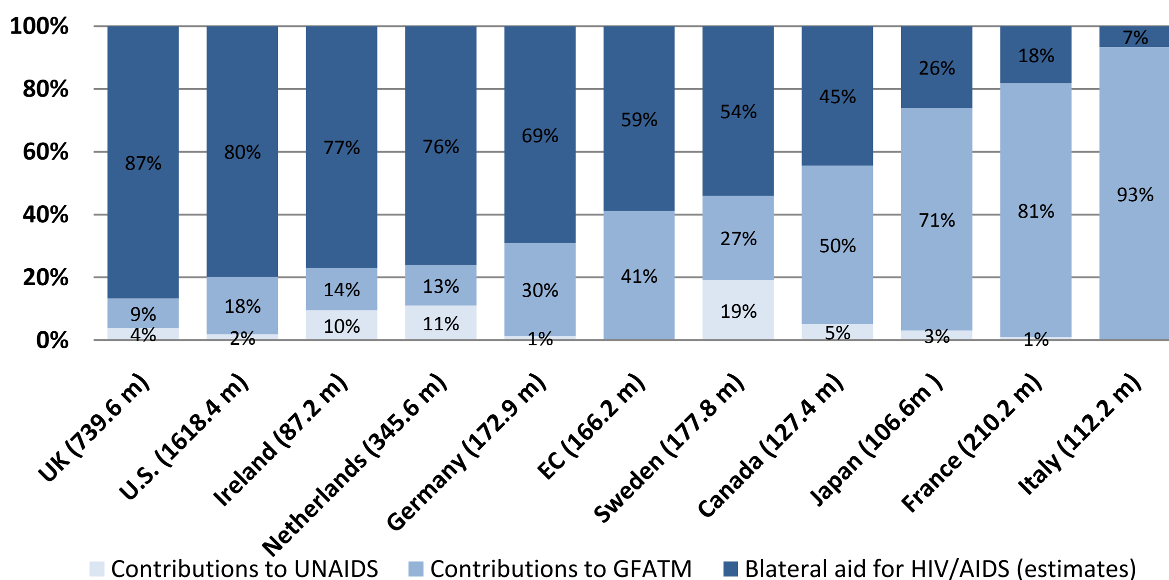

Diagram 4.3: HIV/AIDS aid funding channels from selected OECD-DAC members 2006[51]

The extent to which states within this group have begun to contribute funding to GHG organisations suggests an acceptance of GHG organisations as valid governance actors. All of the 22 members of the OECD-DAC contribute to the funding of GHG organisations, as have many other states that are not part of the DAC. For example, all OECD-DAC member states, with the exception of Austria contribute funds to GFATM. Furthermore, almost all of these donors have steadily increased pledges since this organisation's inception in 2002 (see Chapter Seven). Fourteen of the 22 OECD-DAC member states contribute funds to the GAVI Alliance and all DAC members with the exception of Austria, Greece and Portugal made direct contributions to UNAIDS in the year 2007. Political action on behalf of OECD-DAC member states thus suggests that GHG organisation are accepted as legitimate, although they may not necessarily be the preferred organisations for addressing global health, especially in comparison to bilateral programmes, amongst some states.

4.4.1.2 States burdened by poor health

A large number of states that are burdened by poor health have engaged with GHG organisations. In all, 136 countries have fulfilled the requirements for grants from GFATM,

[51] Bilateral aid refers to actual disbursements and includes funding channelled through specific UN programmes but earmarked for specific AIDS projects, minus contributions made to UNAIDS. Bilateral aid data was gathered from the Kaiser Family Foundation/UNAIDS study on HIV/AIDS funding from 2007 (UNAIDS & Kaiser Family Foundation, 2007). The sources used in this study included OECD data and data solicited directly from governments. The data also referred to the 2006 financial year of the donors, which varied from state to state. Data on contributions to the GFATM were sourced from GFATM donor contribution tables, and adjusted to AIDS share (58%) (GFATM, 2008b). Data on contributions to UNAIDS were sourced from the UNAIDS total contributions tables, and include core as well as extra budgetary contributions (UNAIDS, 2007f).

and the GAVI Alliance had approved financial support for 75 applicant countries. The extent to which states with high levels of disease align their own domestic health policies with those of GHG organisations offers an indicator of the extent to which they are willing to accept the GHG organisation as legitimate. The 'claims' that GHG organisations make concerning the political behaviour of these types of states is that they should follow certain policy preferences of GHG organisations and align state health policy with them. When observing political behaviour, it is therefore useful to observe the extent to which certain priorities of GHG organisations are also adopted on the state policy level. Three examples of policy preferences common to GHG organisations are: 1) that states invest more of their own resources in health; 2) that states recognise and engage with CSOs on state and local levels and 3) that states set up monitoring and evaluation (M & E) procedures to assist in progress reporting.[52]

The extent to which states burdened by disease have adopted policies aligned with the three GHG policy preferences outlined above can be described as mixed. There has been a clear trend towards greater government spending on health, in particular in areas such as HIV/AIDS which are addressed by GHG organisations (see Diagram 4.4). Over the past 15 years domestic spending on HIV/AIDS in low and middle-income countries has risen to around one third of all money dedicated globally to addressing HIV/AIDS (UNAIDS & Kaiser Family Foundation, 2007; UNAIDS, 2008a).

[52] In assessing the level to which epidemic and at-risk states have aligned their policies with those of GHG organisations, it is important to note that these states have fewer options open to them when it comes to deciding between implementing partners and funding sources. Often it is a matter of obtaining as many funding sources as possible. Dissatisfaction with a GHG organisation is therefore more likely to be expressed during direct questioning or in public communication, rather than in political action. Thus, minimal levels of compliance – just satisfactory to ensure funding – might actually indicate that a state is not basing its decision to align its policies with those of GHG organisations on its legitimacy, but rather on potential material benefits. On the other hand, significant changes in policy, that go beyond minimum requirements to secure funding will indicate a willingness to accept 'claims' based on other factors.

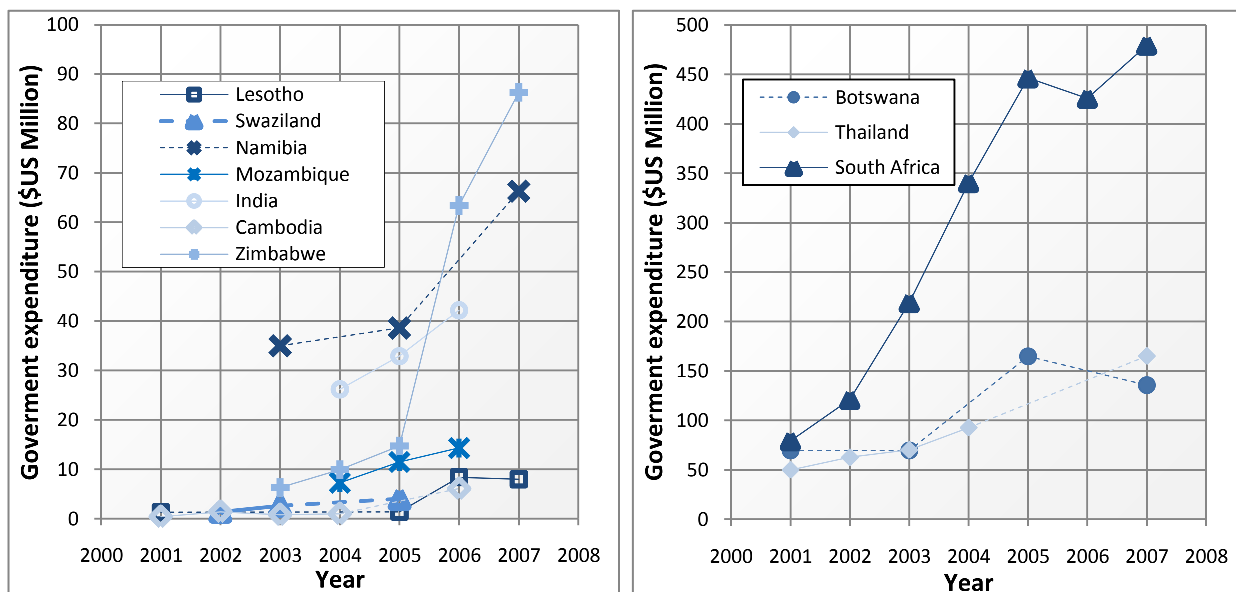

Diagram 4.4: Domestic Spending on HIV/AIDS in Africa and Asian states with highest HIV prevalence rates[53]

States with the highest levels of HIV prevalence in Africa and Asia have all increased domestic spending on HIV/AIDS between the years 2001 and 2007, with the exception of Zambia, which slightly decreased domestic spending between 2005 and 2007 when viewed in US dollar equivalents. South Africa increased domestic spending on HIV/AIDS from $US 79.5 million in 2001 to just under $US 480 million in 2007. Swaziland the state with the highest prevalence rate of HIV/AIDS in 2006 increased its spending on HIV/AIDS from $US 2.4 to $US 4 million between 2003 and 2005 and Botswana, the state with the world's second highest HIV prevalence rates in 2006 increased its domestic spending from $US 69.8 to $US 135.6 million between 2001 and 2007. In Asia there have also been steady increases in government spending, for example in India, which increased government spending from $US 26.2 million in 2004 to $US 42.2 million in 2006, and in Thailand, which increased government spending from $US 50 million in 2001 to $US 92.8 million in 2004.

[53] Data for the years 2001-2003 taken from the 2006 Report on the Global AIDS epidemic (UNAIDS, 2006b, pp. 545-548). Data for 2004-2007 taken from 2007 Country Progress Reports submitted to the UN General Assembly Special Session on HIV/AIDS 2008. South African data is not shown beyond 2003, as spending as of that year was already above $US 300 million. Data was not available for all years; in instances of gaps in the data of over a year points are connected with a dotted line. African states shown all had prevalence rates above 15% in 2006, Asian states shown all had prevalence rates above 0.9 % in 2006 (UNAIDS, 2006b). Although Myanmar had a prevalence rate of 1.3% in 2006, it has been omitted as no data was available.

Acceptance and integration of CSOs into state health infrastructures and decision-making has increased over the past 15 years, despite many states being reluctant to work with CSOs in the past. It is however, difficult to assess the real extent to which CSOs have become integrated in health decision-making. GFATM has set a target that 40% of members of the Country Coordinating Mechanisms (CCMs) that are to be established in order to be eligible for grants should be civil society organisations. In 2005 a study conducted by the International Planned Parenthood Federation (IPPF) and the Organisation for German Technical Cooperation (GTZ) found that only a handful of GFATM recipients had reached this target. Furthermore, about 40% of states that received funds from GFATM had no representatives of people living with HIV/AIDS integrated into their CCMs (IPPF & GTZ, 2005). However, of 37 states surveyed, 21 did include International CSOs in their CCMs, and the same number included associations of people living with the three targeted diseases. Nineteen states also included nongovernmental faith based organisations in their CCMs. A survey amongst IPPF member associations that were involved in CCMs showed that a large percentage (43%) were directly asked to join by other state bodies, while 23% nominated or applied themselves (IPPF & GTZ, 2005, p. 18).

Of the eleven states with high HIV/AIDS prevalence rates surveyed for their HIV/AIDS domestic spending in Diagram 4.4 all reported on the state of monitoring and evaluation activities, and engagement with civil society in country update reports submitted to the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) covering the years, 2003, 2005 and 2007.[54]

Over the time period between 2005 and 2007, CSOs in all states reported an improvement in the efforts of the states in which they are active to increase civil society participation (see Table 4.2). Civil society participation has increased most significantly at the level of national strategic planning. In Lesotho civil society rates civil society participation in this process as zero out of ten in 2005, but with eight out of ten in 2007. Comments made by CSOs in the reports show a mixed picture in terms of the extent to which civil society engagement has improved in other parts of the policy process. CSOs are increasingly recognised as important for implementation, but in almost all countries they struggle to access adequate financial and technical support for their work. Furthermore, the number and type of CSOs that have access

[54] Which were then submitted to the UNGASS sessions in 2004, 2006 and 2008 respectively.

to the policy-making process is often not representative of the diversity of CSOs active in the country.

Table 4.2: Civil society participation indicators in Africa and Asian states with high HIV prevalence rates[56]

Indicator (max. 10 points) / Country	To what extent have CSO representatives been included in planning and budgeting of the national strategic plan?		To what extent is civil society able to access adequate financial support?		CSO ratings of state efforts to increase civil society participation?			Comments
	2005	2007	2005	2007	2003	2005	2007	
Botswana	7	8	4	4	5	5	7	Civil society formally involved in national planning, but CSOs have stated that bureaucracy and lack of funding hinders full and meaningful involvement.
Lesotho	0	8	8	6	2	4	7	Civil society not mentioned in the 2005 country progress report, but frequently in the 2007 report.
Swaziland	n/a	8	6	4	n/a	4	4	Civil society only mentioned as a recipient of training on the 2005 report. 2007 report emphasises the involvement of civil society in several processes "However, participation in non Global Fund driven activities is limited" (Comment from a CSO)
Namibia[55]	6	Qualitative comments only (positive)	"inadequate"	"inadequate"	7	7	Progress since 2005	Civil Society involved in planning stages (including M&E plan) since the early 2000s. "However…there is neither adequate financial nor technical support of civil society to implement its HIV activities" (Comments report composer).
India	5	10	4	2	2	2	5	Engagement with civil society increased with the third national plan, in 2006, by means of e-forums and participatory design.

Comparable data from five states shows that M & E systems have been developed rapidly since the year 2000, (see Table 4.3). For example, India and Lesotho both developed national M & E plans in the year 2005 and have since expanded their infrastructure to include a specific M & E department employing eight and seven full time staff respectively. Other states, such as Botswana, Swaziland and Namibia, all states with very high HIV prevalence rates, have developed M & E plans since the year 2000. However, M & E plans in all of these

[55] The 2007 Country Progress Report from Namibia contained some qualitative comments in the place of ratings. For example in response to the question "To what extent have CSO representatives been included in planning and budgeting of the national strategic plan?", it was simply stated that "Civil society has been involved in all levels of policy formulation".

[56] Source: UNGASS Country Progress Reports for the years 2005 and 2007. All data taken from the 2007 reports, apart from for the year 2003, which was taken from the 2005 report. The country progress report from Namibia used qualitative rather than quantitative indicators, which have been entered here as formulated in the report.

states still face considerable challenges, most commonly in terms of data gathering, and the dispersal of information to relevant sources and the general public.

Table 4.3: Monitoring and evaluation indicators in Africa and Asian states with high HIV prevalence rates[57]

Indicator / Country	Does the country have a national M&E plan?		How many full time staff are employed in the M&E department or unit?		Government's own rating of M&E efforts (out of 10)			Comments
	2005	2007	2005	2007	2003	2005	2007	
Botswana	Yes	Yes	≤1	7	4	5	7	An M & E system was developed in 2001. An electronic database was established in 2006. Remaining challenges include transparency and results distribution.
Lesotho	No	Yes	1	7	3	3	5	An M & E plan was developed in 2005 in an established M&E unit. Several challenges remain for the M&E plan including limited data and poor coordination.
Swaziland	Yes	Yes	≤1	4	n/a	4	7	An M & E office was opened in 2003 and an M&E plan became operational in 2006. The Country Progress Report noted challenges including incompleteness of data, poor quality of data and problems with timely reporting and dissemination of reports for use in planning.
Namibia	Yes	Yes	4	6	5	7	Progress since 2005	A first M & E plan became operational in 2004 which was revised in 2006 to include an integral action plan with other partners. Sources send data irregularly. Results are not widely shared.
India	No	Yes	1	8	4	6	n/a	The M & E system was being developed in 2005, with a full time staff member employed since 2002 for its coordination. The system is said to be improving, but it still faces challenges such as limited data from the private sector and staff shortages. Ambitious plans are in place to combine M & E with operational research into a Strategic Management Information Unit.

UNGASS reports from these five countries also indicate a general trend towards greater engagement with civil society, although the extent of progress seems to be less linear than is the case with the building up of M & E systems. Each UNGASS country progress report includes the opinions of civil society organisations regarding the extent to which civil society is integrated into HIV governance.[58]

[57] Source: UNGASS Country Progress Reports for the years 2005 and 2007. All data taken from the 2007 reports, apart from data for the year 2003, which were taken from the 2005 reports (UNAIDS, 2006c).

[58] These opinions are gathered via the national policy composite index questionnaire and are expected to be presented in a specific section in each country progress report.

Overall, it appears that states burdened by poor health are responding to certain claims made by GHG organisations, such as, that they should increase funding on health, that they should increase engagement with civil society and that they should develop better oversight of their health governance through monitoring and evaluation infrastructure. However, caution needs to be taken before concluding that these results indicate a relationship between GHG organisations and their stakeholders who are states burdened by poor health is marked by a particularly high degree of legitimacy. This is because the claims made by GHG organisations in terms of these three areas are also claims made by other actors in global health, including IGOs and states that offer bilateral aid to states burdened by poor health. It is not possible to definitively conclude, whether the behavioural patterns of these stakeholders are directly traceable to the claims of GHG organisations. However, one factor that does indicate that the legitimacy of GHG organisations may be playing a role is the time period in which these changes are taking place. Health funding, especially on HIV/AIDS has increased in these states since the mid 1990s and more so since the year 2002, the same period during which GHG organisations that focus on HIV/AIDS such as UNAIDS and GFATM were formed. Their standing and the strength of their claims in the eyes of these states might therefore be a factor motivating rapid behavioural changes.

4.4.2 GHG organisations and their relationships with IGOs

GHG organisations represent a significant break with governance conventions of the past that were based on intergovernmentalism. However, IGOs remain important stakeholders for GHG organisations due the level of support they receive from them. This is because GHG organisations often rely on IGOs, their resources, their expertise and their access to states and other operational partners to oversee the implementation of their policies. If an IGO acts in a way that assists a GHG organisation to implement their policies, this may indicate support for the GHG organisation and the collective attitude within the IGO that it is legitimate. Thus, GHG organisations seek a relationship with IGOs in which they can make certain claims that IGOs should choose to support them by offering types of assistance that GHG organisations themselves cannot or are not intended to provide. The World Health Organisation, UNICEF and the World Bank, as IGOs with the highest influence in the health policy field, remain important IGO stakeholders for GHG organisations. To what extent do these organisations have positive relationships with GHG organisations? And to what extent do they act in a way that is supportive of GHG organisations?

It is notable that the WHO, World Bank and UNICEF are active as non-voting board members in GHG organisations such as the GAVI Alliance, GFATM and UNAIDS. UNICEF even hosts the GAVI Alliance in its offices in Geneva. Formally, there is a high level of support offered to each of these three GHG organisations within IGOs. The WHO has acted in support of GHG organisations and public-private partnerships over the past 15 years. It was a founding partner of GFATM, UNAIDS and the GAVI Alliance and hosts a number of other public-private partnerships with diverse executive boards, such as Roll Back Malaria and the Stop TB Alliance. The WHO has established assistance programmes for states applying for funding from GFATM and has also worked in close collaboration with the GAVI Alliance in setting up immunisation days.

However, while there is overall support for GHG organisations on behalf of IGOs, IGOs, such as the World Health Organisation, are such large entities that it is difficult to assess a collective stance for the whole organisation. The activities of some departments or sub-sections of the WHO and the World Bank indicate a slight distancing from GHG organisations. For example, although WHO's AIDS programme was formally disbanded with the establishment of UNAIDS in 1995, more recently the WHO has re-opened a department for HIV/AIDS which has taken on the tasks of country support and drug and diagnostic procurement amongst others. Furthermore, the World Bank opened a Global AIDS program in 2002, consolidating several existing funding projects into a single program and acts as a financing mechanism, just as the GFATM aims to be. While the tasks of these programmes within WHO and World Bank may be seen as complimentary to GHG organisations, several activities and aims overlap with the functions of GHG organisations active in the area of HIV/AIDS such as GFATM and UNAIDS. The operational aims of the four organisations presented in Table 4.4 are sometimes conducted in partnership with one another, but also sometimes overlap or even compete. In 2005 the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (GTT) found that GHG organisations and IGOs often overlap in their work and fail to communicate with each other adequately (GTT, 2005). For example, with reference to the financing of HIV/AIDS programmes, it was found that:

> The Global Fund and the World Bank increasingly seem to finance the same types of goods and activities in the same countries, without any clear sense of their respective comparative advantages or complementarity with the other. Continued progress on a clearer division of labour between the two will require careful review of each organization's comparative advantages (e.g.,

the demand-driven, performance-based approach of the Global Fund and the longer time-horizon and experience in infrastructure and health-systems development of the World Bank financing). Further, communications between the two has been sub-optimal, meaning that potential synergies have often not been released (GTT, 2005, p. 15).

Table 4.4: Operational aims of GHG organisations and IGOs in the policy field HIV/AIDS[59]

Organisation / Operational Aims	UNAIDS (est. 1995)	GFATM (est. 2002)	World Bank Global AIDS Program (est. 2002)	WHO HIV/AIDS Department (est. 2004)
Financing	-	Grants distributed through "Principle Recipients"; performance based funding	Loans and credits for national and regional programmes; grants distributed to governments of poorest countries.	-
Policy Development and Implementation	Articulation of the broad principles and standards that should inform national (state and local) policies;	Support programs that reflect national ownership. Pursue an integrated and balanced approach to prevention and treatment	Develop new approaches; assistance for strategic analysis, policy advice, technical expertise.	Policy development and normative and technical guidance to help countries scale up HIV/AIDS interventions in the health sector.
Country Support	Knowledge sharing and best practices	-	Knowledge sharing and best practices; build M & E capacity at state level	Capacity building and training for health workers; technical support
Medicines and Diagnostics	-	Procurement of commodities and drugs, (about half of all GFATM expenditures)	Procurement of medicines and purchasing agreements, procurement technical guidance	Securing an adequate supply of HIV medicines, diagnostics, and other tools.
Monitoring and Evaluation	Monitoring the status of the HIV/AIDS epidemic, publication of reports. Requests that each state produce progress reports.	Evaluate proposals and outcomes through independent review processes; use of performance based funding. Requests that each country produce project update reports.	M & E activities coordinated through the World Bank Independent Evaluation Office (IEO)	Monitoring the global spread of HIV/AIDS and the availability of treatment and prevention services.
Advocacy	Improving access to information and developing a body of knowledge on the epidemic	Raising Awareness	Regional strategy development, raising awareness	Raising awareness, dissemination of epidemic data

The GTT also found that although UNAIDS is meant to coordinate the HIV/AIDS budgets of all its cosponsoring UN Agencies within the one Unified Budget, only a small percentage of the HIV/AIDS expenditure from those UN Agencies is actually coordinated within UNAIDS (GTT, 2005, p. 14).

[59] Source: websites of GFATM, UNAIDS and the GAVI Alliance.

Overall, the level of support for GHG organisations amongst IGOs is high, although IGOs have been reluctant to hand over all of their activities to GHG organisations, even when they claim to be the right alternative.

4.4.3 GHG organisations and their relationships with business sector actors

Of all the relationships that GHG organisations build with their various stakeholders, it is their relationships with business sector actors which appear to be the most ambiguous. Often it is not clear what types of claims GHG organisations make in terms of what behaviours they expect from business sector actors. On the one side, business sector actors might be seen as a possible source of funding, although, compared to donor states, they have considerably less financial resources at their disposal to contribute to GHG organisations. Another claim that GHG organisations make on business sector actors, (in particular those involved in medical product manufacturing) is that they should be willing to sell their products at a reduced cost, if there are large numbers of people in need who are unable to afford them. On the other side GHG organisations appear to tread cautiously in making 'claims' that business sector actors should behave in a certain way. For example, GHG organisations have not been very vocal in requesting the lifting of patents on essential medicines and they have refrained from criticising business sector actors for contributing relatively little funding.

As is the case with IGOs, business sector actors are closely engaged with GHG organisations at the central decision-making level, with seats on the board of GFATM and the GAVI Alliance, and by working in partnership with UNAIDS at the project level. However, when it comes to aligning their own business practices with the requests of GHG organisations the real nature of the relationships between GHG organisations and their business sector actor stakeholders is less clear.

Examples of supportive stakeholder responses to each of the types of 'claims' are listed in Table 4.5. In terms of providing funds to the budgets of GHG organisations, business sector actors have responded, but only minimally, providing less than 1% of funds to UNAIDS and GFATM, and none at all to the GAVI Alliance. The Product Red campaign, established in 2005 has contributed a greater amount of funding for GHG organisations. With regard to providing medicines at reduced costs, several pharmaceutical companies have entered into pricing agreements with GHG organisations (as they have with the World Bank and WHO also), however, there has been criticism that these pricing agreements have been inadequate to

ensure a secure supply of medicines for those most in need (Hardon & Blume, 2005). Business sector actors have begun to publicise their own contributions to global health and are thus also beginning to increase awareness of the diseases, but this is also still limited.

Table 4.5: Business sector actor responses to GHG organisations' claims

Business Actor Sub-category	Example 'claims' made by GHG organisations. Business sectors actors should:	Stakeholder responses
Health product manufacturers and service providers	Provide funding for GHG organisations; contribute medical products at a reduced cost; conduct research into technologies for neglected diseases	Small donations to GHG organisations; Pricing Agreements such as the Mectizan Donation Program, Medicines for Malaria Venture,
Business affected by global health challenges	Establish health programmes in work places.	Workplace programmes have been established, but are still exceptional. E.g. Daimler Chrysler workplace HIV testing and family support.
Businesses involved in health as part of CSR activities	Provide funding for GHG organisations; contribute to awareness raising.	Campaign Product Red partners contributed $67.6 million (or <1 % of all funding) to GFATM to date.
Industry lobby associations	Refrain from promoting industry interests that restrict access to medicines and services.	Lobby associations continue to advocate strict patent laws.

Overall, the relationship between GHG organisations and business sector actors appears to be marked by relatively few claims for change of behaviour, but these few claims have been met with highly publicised positive responses.

4.4.4 GHG organisations and their relationships with CSOs

As shown in section 4.2.2 civil society organisations are diverse in their function, size, and involvement in the health policy field. Accordingly, the relationships between GHG organisations and different types of CSOs vary, as do the types of 'claims' they make regarding expected behaviours from CSOs. For example, GHG organisations request that charities and foundations provide funding; that Associations of People Living with Diseases coordinate their work with other like-minded CSOs, and that health oriented CSOs enter into implementing partnerships. Such 'claims' are made on local, regional and global levels.

On the global level one of the distinguishing features of GHG organisations is the extent to which they integrate CSOs into central decision-making structures. In doing so, they not only act to enable a greater voice for CSOs, but make 'claims' that CSOs should act as appropriate representatives of their relevant constituencies, comply with set procedures and standards when fulfilling their decision-making role, and importantly work to coordinate the work of

CSOs so that their collective aims and strategies can be articulated to governments and global level organisations. UNAIDS, GFATM and the GAVI Alliance all have guidelines or statutes in their governing documents that specify expectations on CSO delegates, as laid out in Table 4.6. The way in which CSOs respond to these expectations can be used as one indicator for the type of relationship that GHG organisations have been able to build up with CSOs, and an indicator of the extent to which CSOs act in a way that indicates support for GHG organisations.

Table 4.6: Expectations on CSO delegates on decision-making boards[60]

Organisation / Expectations	UNAIDS PCB Members	GFATM Board Members	The GAVI Alliance Alliance Board Members
Qualifications	• Min 3 years active involvement with HIV work • Connections with national and regional/global networks • English language proficiency in writing and public speaking • Easy and regular access to the internet and email • Ability to work strategically in a group with diverse people	• Understanding of GFATM's work • Knowledge of civil society and PLWHA issues • Minimum 3 years experience in CSO work with relevant diseases • Access to telephone, fax, computer and email • Teamwork, diplomacy, strategy skills and gender sensitivity • English language proficiency • Links to a facilitating organisation	• Experience in children's health and immunisation • Demonstrated partnerships • Ability to represent concerns, issues and ideas to the GAVI Board. • Sensitive to the concerns of CSOs • Ability to work with large number of partners from different sectors • Demonstrated record of networking and outreach with CSOs on all levels.
Commitments	• Adequate office space / supplies • Freed up from regular duties for up to 10 hours per work week PCB meetings and UNAIDS tasks • Attend all semi-annual meetings as well as external meetings, e.g. UNGASS and GTT Actively participate in chairing ad hoc Working Groups • Actively participate in 1 hours conference calls (average 2 per month), usually held at 14:00 Geneva time.	• Up to 25% of working time for GFATM related duties • Participate fully in all meetings of the Board (study all relevant documents; provide input in the decision-making process) • Participate in teleconferences and keep contact with other Board members and CSOs • Advocate for the participation of CSOs in the design, implementation and evaluation of all policies and programmes	• At least one full time staff member to be dedicated to CSO liaison activities • Attend all meetings • Raise funds for CSO activities in immunisation and work to strengthen CSO participation • Facilitate greater cooperation and understanding between CSOs and governments. • Maintain contact with CSOs to keep them informed and engaged in GAVI activities and act as a liaison between GAVI and CSOs
Formal role	• One 2 year term of office, with possible one year extension • Right to speak at PCB meetings, but no formal voting role. • Termination possible in case of conflict of interest, on non-fulfilment of commitments.	• One 18 month term as alternate Board Member and one 18 Month term as Board Member • Full voting rights. • Termination possible if member unable to perform tasks	• 3 year terms in office with maximum two consecutive terms. • Decisions normally met by consensus, but should a vote be required each member has one vote.

[60] Sources: Terms of References of the UNAIDS PCB NGO Delegation (UNAIDS, 2007c); The Communities Living with HIV, TB and Affected by Malaria Delegation Constitution and By-laws (GFATM, 2007d) and the GAVI Alliance website.

In general CSOs, or at least those that make it to the level of representing their communities on the global level, appear to have embraced the expectations placed upon them. There have been no instances of a PCB delegates having their position terminated prematurely from a decision-making Boards of GHG organisations. However, on several occasions CSO delegations have remained vacant for extended periods of time on the boards of all three GHG organisations mentioned in Table 4.6. In particular, CSO delegations on the GAVI Board have actually experienced very little rotation since the organisation's inception, with the CSO delegate there being fulfilled by representatives from just three organisations over the past 8 years. In the year 2004, just 10 CSOs applied for a position on the Board. In 2007 a review of civil society participation on the UNAIDS Board, conducted by the CSO Board delegations, found that participation had been inconsistent and that there was "a need to strengthen and institutionalise participation" (UNAIDS, 2007b, p. 3). Amongst other aspects, civil society recommended increasing the number of seats for civil society on the PCB Board, providing voting rights for PCB delegates, allowing CSOs to hold Chair and Vice-Chair positions, and removing the formal requirement that the PCB gives formal approval to delegates.

In contrast a large number of CSOs are active at GFATM and CSOs have already held chair and co-chair positions on the Board. Furthermore, CSO delegations are also involved with the Fund Board via Core and Support Delegations that work with the Board members.

A general overview of the relationships between GHG organisations and their stakeholders indicate a positive attitude towards global health governance organisations, although in several instances, there are signs that some stakeholders hold back from offering full support for GHG organisations. However, it is difficult to discern the reasons for these political actions simply by observing claims and reactions to claims alone, i.e. political acts say little about whether the good supportive relationships that GHG organisations appear to have with their stakeholders are a result of their perceived legitimacy, or due to other factors. To make leeway into this question, it is necessary to look at other ways by which stakeholders express their views, opinions and attitudes towards global health governance and GHG organisations in particular. In the following sections this will be done, first, by analysing public communication of stakeholders, with regards to the sub-components of legitimacy drawn up in Chapter Three; and second, via direct questioning of stakeholder opinions in an administered questionnaire. In the following sections the focus is not on specific 'claims' that GHG organisations make, but rather on the types of values, opinions and beliefs that

stakeholders in global health governance prioritise, in their own work, as well as when judging others.

4.5 Stakeholder values in public communication

While the relationships between GHG organisations and their stakeholders can, to a certain extent be assessed by analysing the 'claims' that GHG organisations make and their stakeholders' reactions to them in terms of political acts and certain behaviours, documenting these claims and behaviours provides little insight into the values, norms and beliefs that underlie the legitimacy (or lack of legitimacy) of GHG organisations. While the previous section concluded that there appears to be general support for GHG organisations, varying somewhat between individual stakeholders, the question remains open as to what norms, values and beliefs are important for stakeholders when deciding how to react to the claims of GHG organisations. To supplement the observational method, it is therefore important to look at further ways by which stakeholders might demonstrate approval or disapproval of GHG organisations, and how they justify their positions.

Stakeholders may express their preferences in terms of what they consider constitutes legitimate governance communicatively. Reus-Smit has summarised the importance of public communication, not only as a data source for observing legitimacy, but also in the way it actively contributes to creating legitimacy:

> Ascribing legitimacy is ... inextricably linked to, and developed upon, social communication. Actors establish their legitimacy, and the legitimacy of their actions, through the rhetorical construction of self-images and the public justification of priorities and practices, and other actors contest or endorse these representations through similar rhetorical processes. Establishing and maintaining legitimacy is thus a discursive phenomenon… (Reus-Smit, 2007, p. 163).

Stakeholders' communicative acts might contain the expression of satisfaction or dissatisfaction with its own actions or those of other organisations in public speeches or in published reports or statements. Such documents are thus important sources of information for studies into legitimacy "…because norms by definition embody a quality of 'oughtness' and shared moral assessment, norms prompt justifications for action and leave an extensive trail of communication among actors that we can study" (Finnemore & Sikkink, 1998, p. 892). GHG organisations have been subject to attention from various stakeholders, and individual

commentators that have expressed support, disapproval, and often scepticism and caution in communicative acts, such as commentaries in newspapers and journals, and working papers.

In particular, several CSOs have released critical texts (HAI Europe, 2001; Oxfam, 2001). However, the extent to which specific commentaries on GHG organisations reflect the general positions of stakeholders can be doubted. To gain insight into the values, norms and beliefs that influence stakeholder behaviour, it is therefore preferable to analyse texts that represent the formal positions of a stakeholder (usually conglomerate actors) as a unit when addressing global public health in general. States, non-governmental organisations and business actors alike publish texts – such as strategy papers, annual reports and policies – to declare their priorities and expectations in terms of their underlying principles and values, and understandings of what they consider to be legitimate practice. Published texts also form part of a global political discourse and are therefore a useful resource for an initial analysis aimed at answering the question: *In the opinion of stakeholders, what provides the basis for a legitimate global health governance organisation?*

Legitimating (or de-legitimating) statements in communicative acts can be identified as containing three elements (Schneider, Nullmeier, & Hurrelmann, 2007, p. 135):

First: a reference to an object of legitimation (e.g. a GHG organisation, a WHO department, a CSO);

Second: an evaluation of the object of legitimation (e.g. is good, is innovative, is a disgrace, should be disbanded, should be promoted);

Third: a pattern of legitimation containing references to values, norms, or principles e.g. due to its effectiveness, because the people have no say, for the reason that it is secretive.

Often, stakeholders use patterns of legitimation in texts to refer to processes, aims, objectives and goals that a stakeholder itself uses or intends to work towards and seeks to justify and prioritise. Thus, it is also important to seek out patterns of legitimation in the broader text, and not only in distinct legitimating statements referring to GHG organisations.

In the following section the results of an analysis of 90 sample texts from various stakeholders are presented.[61] It was possible to discern distinct differences in the way certain stakeholders

[61] A summary of the methodology used is found in Appendix II. Complete results are on file with author. In the text analysis and the survey questionnaire, discussed below, the views and opinions of stakeholders that belonged to the groups, states, business sector actors and CSOs were sought out. Intergovernmental

referred to values, norms, beliefs and preferences in terms of what constituted good global health governance. In the following section the two dimensions of legitimacy – governance 'by' and 'for' the people – and its sub-components are discussed in terms of the extent to which they were referred to in patterns of legitimation in texts from each stakeholder group. At this stage the extent to which specific GHG organisations were referred to as objects of legitimation and the evaluation statements are not presented as part of the analysis, this will be addressed in the case study chapters.

In the text analysis stakeholders were divided into four stakeholder groups comprising: first, states with significant resources to contribute to GHG organisations, sampled as OECD-DAC member states that contributed over $US10,000 million, or over 0.5% of Gross National Income to overseas aid in 2006. Second, states burdened by poor health, sampled according to death rates from childhood cluster diseases and HIV/AIDS prevalence rates. Third, CSOs that are listed as having consultative status with the WHO and/or have particular policy relevance for global health (including charitable foundations). Fourth, business sector actors listed as members of the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC). From each of the stakeholders that qualified for the sample, texts were selected that reflected the formal outward positions of the stakeholders and covered the stakeholder's policies, strategies, aims and evaluations of own health related activities and with respect to their surrounding environments. All texts were published between 2005 and 2007, although documents published immediately prior, but relevant for the years 2005-2007 were also included if no up-to-date alternative for the specified time frame was available.

The texts were analysed using a combination of qualitative and quantitative assessment methods. Each text was reviewed qualitatively for any legitimation statements, and the objects of legitimation, evaluations and patterns of legitimation were noted. Particular 'word clusters' and references to 'key concepts' were noted that indicate references to good governance 'by' and 'for' the people as well as other values and principles, such as leadership. The use, significance and meaning of these word clusters were qualitatively reviewed in a summary of the texts. Any references to the case study organisations were also sought out and analysed in terms of the way they were portrayed in the text. The frequencies of use of the most

organisations were not included in the research. IGOs are, however, important stakeholders of GHG organisations. Drawing out the opinions of values of such stakeholders will be an important task for future research, however because they are large and diverse organisations this will require a much more complex research programme and methodology.

significant ‘key concepts’ and ‘word clusters’ indicating values, beliefs and principles relating to governance ‘by’ the people and governance ‘for’ the people were then collaborated to allow for comparisons between texts, and stakeholder groups. Frequent and qualitatively strong references to specific sub-components of legitimate governance ‘by’ and ‘for’ the people were taken as indicating that the particular sub-component was important for the stakeholder making the statement. Key concepts and word clusters relating to specific sub-components of legitimacy will be addressed in specific sections below, and are documented in Appendix II.

4.5.1 Stakeholders on legitimate governance ‘by’ the people

Very few of the texts analysed contained specific use of the words legitimacy or legitimation. Instead, other patterns were used to justify statements evaluating objects of legitimation. There was however, considerable use of the term ‘governance’ and the pattern ‘good governance’ in the texts, and there were frequent use of lists to summarise what good governance should entail. In this section, patterns referring to each of the sub-components of legitimate governance ‘by’ the people are discussed.

4.5.1.1 Public governance

Patterns of legitimation referring to public governance used in the texts contained words such as ‘democracy’ ‘representation of the people’; and ‘UN sanctioned mandate’. The stakeholder groups that were most likely to make references to this sub-component of legitimacy were the OECD-DAC member states and states burdened by poor health (hence referred to as epidemic and at-risk states). However, within the OECD-DAC member state stakeholder groups, some texts did not make any references to public governance within legitimation statements at all. Overall, the texts contained relatively few legitimation statements that are referring purely to public governance and democracy. This was especially the case amongst texts that addressed health issues. Within the stakeholder group of OECD-DAC member states, the texts that contained the most legitimation patterns with reference to public governance were texts that covered general development issues, including health, rather than texts that covered health exclusively. Most notably, legitimation statements that contained patterns referring to public governance often also contained patterns referring to participatory governance. The following excerpt from a text from the OECD-DAC member state is a particularly good example of such a statement.

> An international order is only accepted if it is based on participatory discussion and cooperation among member states, as is the case in the UN ... Although originally the work of the UN was based almost exclusively on contacts between governments, in recent years civil society and the private sector have been involved in its activities to an increasing extent. This has the express support of the German government (German Federal Ministry for Economic Cooperation and Development, 2005, p. 188).

Other texts that put a particularly high emphasis on public governance stemmed from the Governments of the US, Norway, Ireland, the UK, and France. The only other texts in other stakeholder groups that contained similar patterns of legitimation based on public governance were texts from the governments of Mozambique and Lesotho and the business sector actor Sanofi. These texts were exceptional with their respective stakeholder groups, but were similar to texts in the OECD-DAC stakeholder groups in that they combined legitimation patterns referring to public governance with those referring to participatory governance. In some instances there was also no clear difference between the two, as in the following excerpt from a text from the Government of Mozambique:

> The United Nations should increasingly become the privileged centre for international regulation, peace consolidation and world security. Thus, it is essential to deepen democracy within its institutions and multilateral organisations, to intensify dialogue and ensure international equilibrium (Mozambique Committee of Counsellors, 2003, p. 111).

4.5.1.2 Participatory governance

Overall, legitimation statements found in the texts included patterns referring to participatory governance far more frequently than public governance. Words relating to 'participation', 'involvement' and 'inclusion' were mentioned often in the texts in all stakeholder groups, often in relation to including civil society and non-state actors in decision-making.

It was clearly discernable that several CSOs had put the highest emphasis on this aspect of health governance in their texts. Examples of CSOs that frequently mentioned participatory governance in their texts were Family Health International, Health Action International, the International Council of Nurses, the IHAA, the IUHPE and the AIDS Service Organisation. The text from the International Planned Parenthood Federation contained by far the most legitimation statements with patterns referring to participatory governance. In the text it is explicitly stated that it is a strategy of the organisation to:

> ...promote active stakeholder participation in identifying barriers and developing, implementing and evaluating strategies to remove these barriers (IPPF, 2005, p. 15)

It is also stated that:

> We value diversity and especially emphasize the participation of young people and people living with HIV/AIDS in our governance and in our programme (IPPF, 2005, p. 3).

In contrast, the texts from the Bill and Melinda Gates Foundation, the Global Health Council and PATH contained relatively few references to participatory governance (although still more than they did references to public governance). These three CSOs can be classified as a charitable foundation and research oriented organisations respectively. Thus, a strong split amongst CSOs became evident in terms of the aspects of good governance that they emphasise.

The vast majority of texts from other stakeholder groups emphasised participatory governance in a similar way to the IPPF. The text from the Government of Mozambique, as well as one text from the Government of Pakistan contained very frequent use of terms related to participation, for example:

> Agenda 2025 looked at participation as the key element for the whole process. This was particularly important for obtaining legitimacy and empowerment for the exercise (Mozambique Committee of Counsellors, 2003, p. 18).

> Because of the need to bring all of these key players into partnership in the response to the epidemic, it is essential that they have actively participated in the formulation of the nation's Strategic Framework. The participation of a wide range of partners will lead to enhanced feelings of ownership, will facilitate the development of an expanded response, and will help in resource mobilization (Pakistan Ministry of Health, 2007, p. 5).

Another analysis method to assess the value that stakeholders placed on participatory governance is by looking at the way stakeholders refer to the inclusion of CSOs in governance processes in their texts, both in terms of the number of times references were made to CSO inclusion, and whether these references portrayed CSO inclusion as desirable in a qualitative sense.

There were considerable differences between the analysed texts in terms of the number of times they referred to civil society and CSOs, and how their participation in governance was valued. However, overall, civil society and CSOs were addressed frequently and in general a willingness to open up policy-making processes to CSOs was evident. Qualitatively, texts from the governments of OECD-DAC states rated civil society participation positively and

directly encouraged their involvement in governance processes. For example one text from the Government of the United States said of CSOs that:

> ...(t)heir reach, authority, and legitimacy identify them as crucial partners in the fight against HIV/AIDS (United States Global AIDS Coordinator, 2004, p. 9)

The following quotes from other OECD-DAC governments are typical examples of positive references to civil society involvement in participatory governance:

> France's aid should continue to support the principle of multi-partnerships, involving States and local authorities, the private sector – both internationally and locally –, decentralised cooperation, NGOs and user associations (France Ministry of Foreign Affairs, 2006, p. 23).

> As well as national NGOs, self-help organisations and traditional care structures at local level should contribute to health planning (German Federal Ministry for Economic Cooperation and Development, 2007, p. 11).

> Compositions of governing boards (should) reflect their overall goals, including (but not limited to) representatives of multilateral UN agencies, major donors, recipient governments and civil society (Irish Aid, 2007a, p. 18).

An exception within this stakeholder group was the Government of Japan. Texts from this stakeholder indicated that CSOs were considered important sources of expertise, but did not indicate that they should be involved in governance for the purpose of increasing participatory governance. For example, one text from the government of Japan included the statement that: "Cooperation with NGOs and civil societies pertaining to health will be strengthened with a view towards achieving MDGs" (Japan Government, 2005). This suggested that CSOs may be considered useful or necessary for effectiveness, but should not be included for the sake of participatory governance. Overall, however, the text analysis indicated that stakeholders within the group of OECD-DAC member states generally put a high value on civil society involvement in participatory governance.

Quantitatively, texts from the stakeholder group of epidemic and at-risk states, contained frequent mentions of civil society, including their involvement in processes of governance such as strategy development, for example in the following statement from the Government of Nigeria.

> NGO, private sector and most recently, the public sector, have worked towards the development of a HIV and AIDS workplace policy (Nigerian National Action Committee on AIDS, 2005, p. 15).

Several of the texts also included statements that gave a high value to civil society inclusion, or introduced national programmes with specific mention of their inclusiveness.

> People with HIV and their carers are not just recipients of social support services; they are also part of the solution. Their efforts, experiences and insight are valuable in all aspects of the national response, from policy development to programme planning, implementation, monitoring, and evaluation (Cambodian National AIDS Authority, 2006, p. 11).

However, when assessed for the value placed on this involvement a high level of scepticism became evident. For example one text from the Government of Sierra Leone addressed difficulties in working with CSOs such as staff poaching and stated that:

> ...all NGOs operating in the health field will be required to provide annual reports to government on their activities and financial arrangements (Sierra Leone Ministry of Health and Sanitation, 2002, p. 6).

Overall, the texts indicated that some stakeholders in the group of states burdened by poor health considered CSOs participation in governance to be important, while most only discussed CSO participation in terms of implementation.

Several texts from stakeholders in the group of CSOs did not contain terms such as 'NGO', 'CSO' or 'civil society'. In particular those CSOs that classified themselves as foundations, research organisations or professional interest groups avoided these terms altogether and also contained no evaluative statements about the inclusion of CSOs as a part of participatory governance. In contrast, several CSOs including Family Health International, Health Action International, the International HIV/AIDS Alliance, the International Planned Parents Federation and The AIDS Service Organisation made frequent mention of civil society and civil society participation in governance in their texts. These texts explicitly encouraged greater CSO involvement in governance processes, on all levels. The texts also often expanded on the goal for more participatory governance including CSOs by elaborating on why it is important:

> Programs that involve PLWHA [People Living With HIV/AIDS] are known to be more responsive to their needs, while personal testimonies by PLWHA are known to have a profound

> influence on the risk perception of members of the public about HIV/AIDS (The AIDS Support Organisation, 2002, p. 10).

> By enabling stakeholders to participate in local, regional, and international technical meetings, FHI contributed to the sustainability of programming well beyond the end of the IMPACT project (Family Health International, 2007, p. 61).

Stakeholders within the CSO group thus differed considerably in the extent to which they demonstrated giving a high importance to participatory governance through the inclusion of CSOs. Far fewer differences could be discerned amongst stakeholders in the group of business sector actors, as almost no texts from this stakeholder groups made frequent mentions of civil society, although all of the texts did mention civil society at least once. Usually references are made to civil society in terms of being implementing partners in specific projects or in lists of stakeholders. For example, Becton, Dickinson and Company, wrote of the maternal and neonatal tetanus project with which it is involved in it's text, and mentioned the inclusive nature of the project.

> Additionally, a coalition of bilateral and multilateral organizations, non-governmental organizations (NGOs) and others who support the goals of eliminating MNT and promoting safe injections play a role in this public-private partnership (Becton, Dickinson and Company, 2006).

However, in strong contrast to most of the texts from OECD-DAC member states and from certain CSOs, very few references are made to CSO involvement primarily for the purpose of participatory governance.

Overall, references to the participatory governance sub-component of legitimate governance 'by' the people can be said to dominate the governance discourse in global health during the time period examined. Nevertheless, although a high number of references to participatory governance made specific note of civil society organisations, the inclusion of state bodies was also considered an important part of participatory governance.

4.5.1.3 Fair processes

When stakeholders include patterns referring to the sub-component of fair process in their general texts and legitimating statements, they normally do so by referring to ways in which they consider policy-making and decision-making is, or should be, conducted, either within their own organisation or within other organisations. References to the need to 'debate', 'discuss', and 'deliberate' were frequently found in the texts included in the analysis,

however, references to systems of voting were hardly found in the texts at all. Qualitatively, it was a text from the Government of Sweden that put the strongest focus on deliberation and discussion. Joint discussion and detailed discussions are portrayed in a positive light. This text often referred to the benefits of discussions and important topics were said to have been discussed often and should be discussed further. Results and clarifications were said to have come about through intensive deliberations and debates.

> The international community has responded by taking up HIV/AIDS in political deliberations at the highest level (Special Session of the United Nations General Assembly, UN Security Council deliberations, G8 meetings etc.) and providing substantially increased funding (notably through the Global Fund to fight AIDS, TB and Malaria and increased bilateral-multilateral funding) (Swedish International Development Cooperation Agency, 2005, p. 5).

Stakeholders also made references to the sub-component of fair process by specifically mentioning the balance of representation between developing and developed states in specific GHG organisations, for example GFATM. Such statements were however rare, and mainly found within texts from OECD-DAC member states.

> The strength of this new funding instrument compared with other bi- and multilateral organisations is that all relevant actors (donor and recipient countries, representatives of affected persons, non-governmental organisations from North and South, private foundations and the private sector) determine, in a joint process, strategies to provide support for countries requiring assistance in combating HIV/AIDS, tuberculosis and malaria (German Federal Ministry for Economic Cooperation and Development, 2007, p. 23).

In texts from CSOs reference was also frequently made to this sub-component by stressing the importance of assisting access for small NGOs and weaker states in decision-making processes. Overall, there were more references made to fair processes than to public governance, but less than to participatory governance. There was no clear pattern within any one stakeholder group of the use of words relating to fair processes in legitimating statements, however, texts from business sector actors tended to use words such as ‘deliberation’ and ‘debating’ considerably less, than stakeholders in other groups. Texts from the governments of Sweden, Luxembourg, Ireland, as well as from certain CSOs such as the International Community of Women Living with HIV/AIDS (ICW) and the WFPHA all included a high number of references to fair process.

Amongst other stakeholder groups, there was mention of right processes in most texts, but rarely were they used in legitimating statements. Specific debates and discussions were often

described positively, but the principle of debating was rarely a specific goal or aim. Business sector actors however often referred to process of debate as an avenue through which they seek participation in governance processes.

Overall, stakeholders in all groups frequently made mention of processes such as debating and deliberation and specific balances between actors in decision-making processes when describing governance activities. However, they rarely highlighted them as being particularly important. Exceptions were CSOs that made specific references to the need to assist resource weak actors to gain greater access to decision-making and OECD-DAC member states that referred directly to processes of GHG organisations when introducing them.

4.5.1.4 Indirect participation

Indirect participation via the ability to oversee activities and hold organisations to account was given much attention some texts, and virtually none in others. For example, by comparing the frequency with which the concept of transparency was mentioned in the texts, it becomes apparent that business sector actors put a high priority on this aspect.

> Public policy is also important. In our view, the most effective policies will promote global participation and maximize the use of markets, as well as promote transparency, minimize complexity, and provide flexibility (ExxonMobil, 2007, p. 3).

> Some stakeholders have different views on how to achieve healthcare goals. Our challenge is to build on areas of agreement and find common ground. To achieve this, we seek to constantly improve our communications and transparency, to listen and respond better to stakeholders, and to learn from them (Pfizer, 2007, p. 10).

It is notable, however, that several texts from stakeholders within the group of business sector actors made no, or only one or two, mentions of transparency.

Most texts from stakeholders within the group of CSOs did not mention transparency in their texts. Two exceptions were ActionAid and the International Union for Health Promotion and Education, which mentioned transparency in terms of their own activities and role within partnerships.

> The values that we promote in all our partnerships - accountability, transparency and solidarity with the poor – must be practiced consistently (ActionAid International, 2006, p. 13).

Almost two thirds of the texts from the group of epidemic and at-risk states mentioned transparency in their texts, and qualitatively, these mentions both condemned lack of transparency (for example labelling lack of transparency as a cause for failed development), and promoted more transparency.

> Transparent governance systems allow direct access to a wider range of information, are characterised by clear procedures in decision-making, have open communication channels between citizens and civil servants. Such systems enable citizens to scrutinise and evaluate all aspects of governmental action, to expose cases of misconduct and to protect their rights (Mozambique Committee of Counsellors, 2003, p. 114).

> The MOHSW [Ministry of Health] will adhere to the principles of transparency, accountability, predictability and fairness (Swaziland Ministry of Health and Social Welfare, 2007, p. 11).

Several member states of the OECD-DAC put a high focus on transparency in their texts, including France, Germany, the UK, the US, Ireland and Japan. Frequent mentions of transparency in these texts were coupled with direct calls for greater transparency in global level decision-making and that transparency is an important element of governance on the global level.

> It is important for information on ODA policy, implementation, and evaluation to be disclosed widely and promptly to ensure the sufficient transparency, and for it to be publicized actively (Japan Ministry of Foreign Affairs, 2003, p. 7).

> Governance issues that are common to both types of GHP [Global Health Partnership] at the global level include: ensuring effective representation of key stakeholders on governing boards, defining clear roles and responsibilities for all partners; and having systems in place to ensure accountability, transparency and performance monitoring (Irish Aid, 2007a, p. 28).

Seven of the twenty texts from CSOs made specific mentions of transparency. Texts from stakeholders in this group however, were more likely to refer to accountability in stressing the importance of indirect participation. For example, the texts from Oxfam and the International Community of Women Living with HIV/AIDS, included statements that organisations, including their own, must be able to be held accountable.

> Changing unfair global rules is essential, but national governments have the biggest direct impact on the lives of their citizens. Citizens must be able to hold governments to account for providing essential services, such as education, health and water (Oxfam International, 2007, p. 4).

> ICW must be accountable to our members for our actions, use of funds, and for fulfilling any of our legal obligations (International Community of Women Living with HIV/AIDS, 2003, p. 1).

Echoing the results of the text analysis with regard to other sub-components of legitimate governance 'by' the people, considerable differences were discernable between CSOs that presented themselves as professional associations, research organisations and charities on the one hand, and social interest CSOs on the other. The texts from the Bill and Melinda Gates Foundation, The Global Health Council, the Global Forum for Health Research and the Rockefeller Foundation did not include any mentions of accountability or transparency.

In texts from OECD-DAC member states and epidemic and at-risk states, accountability and transparency were often mentioned together. Several texts contained no, or very few mentions of either. These included texts from the Netherlands, Sweden and Norway, despite the fact that all of these texts included statements specifically mentioning good governance and other aspects of legitimate governance 'by' the people such as participation and civil society involvement. Qualitatively, the text analysis showed that amongst stakeholders that mentioned transparency and accountability in their texts, these two aspects carry a high weight.

4.5.2 Stakeholders on good governance 'for' the people.

4.5.2.1 Right Purpose

All of the texts in the text analysis included detailed outlines of stakeholders' own aims and purpose. However, non-state actors were more likely to emphasise their own aims and purpose by mentioning them at the beginning of their texts. Texts from states, both OECD-DAC member states and epidemic and at-risk states often began with outlining a particular problem, challenge or development and made mention of the particular purpose of state bodies later in the text. Overall, presenting the purpose of one's organisation, state, department or business was used as a mode of self-presentation.

> The aim of German development policy is to help reduce world poverty, build peace and achieve justice in globalisation (German Federal Ministry for Economic Cooperation and Development, 2005, p. 9).

> The International Women's Health Coalition (IWHC) generates health and population policies, programs, and funding that promote and protect the sexual and reproductive rights and health of

> girls and women worldwide, particularly in Africa, Asia, and Latin America (International Women's Health Coalition, 2007, p. 2).

With regard to other organisations, a brief examination of the way in which the purpose of GHG organisations was addressed in the texts shows that it is also common to introduce GHG organisations by means of their purpose.

Of the 90 texts included in the analysis 38 included one or more direct mentions of the Global Fund to Fight AIDS, Tuberculosis and Malaria, a small percentage of contained explicit descriptions of the purpose of GFATM. Mostly, texts from OECD-DAC member states made a point of mentioning the purpose of GHG organisations.

> The Global Fund is a financial instrument that raises, manages and distributes additional funds to combat the developing world’s three deadliest diseases (France Ministry of Foreign Affairs, 2006, p. 26).

> The Fund, which began work in 2002, supports needy countries worldwide in their efforts to combat HIV/AIDS, tuberculosis and malaria (German Federal Ministry for Economic Cooperation and Development, 2005, p. 44).

> The Global Fund to Fight AIDS, Tuberculosis and Malaria was established in 2002 as a foundation outside the United Nations system in order to mobilise and distribute additional resources in the fight against three infectious diseases, AIDS, tuberculosis and malaria, according to need (German Federal Ministry for Economic Cooperation and Development, 2007, p. 23).

> Global Fund as the embodiment of a new way of doing business, bringing together diverse partners, including the public and private sectors, donors and recipients, and NGOs and affected communities, to quickly and effectively mobilize resources for combating HIV/AIDS and the other two diseases (United States Global AIDS Coordinator, 2004, p. 59).

Sixteen of the analysed texts specifically mentioned the GAVI Alliance, and three of the texts introduced that organisation by means of its purpose, or mentioned its aims.

> GAVI was formed to harness the strengths and experience of the WHO, UNICEF, recipient countries, donors and industry in saving children's lives through immunization (Netherlands Ministry of Foreign Affairs, 2007).

> … GAVI will aim to further strengthen the health systems as a basis for immunisation and other health interventions as well as support the introduction of new vaccines that will become available in the next few years (most probably rotavirus and pneumococcal vaccines) (Swedish International Development Cooperation Agency, 2007, p. 124).

> GAVI aims to get lifesaving vaccines to children in the developing world (Bill & Melinda Gates Foundation, 2007, p. 20).

The following is an example of a similar introduction to UNAIDS.

> Its mission includes developing effective and efficient HIV/AIDS control strategies, raising awareness of the causes and impacts of the pandemic, collecting and publishing epidemiological data, evaluating interventions, and mobilising the requisite resources at national and global level (German Federal Ministry for Economic Cooperation and Development, 2007, p. 24).

Overall, although a few texts made point of mentioning the purpose and aims of GHG organisations, most were actually introduced and assessed by means of other sub-components of legitimate governance 'by' and 'for' the people, such as their inclusive, participatory structures or their effectiveness (see Chapters Five, Six and Seven).

4.5.2.2 Problem-solving capacity

Stakeholders gave a high value to the sub-component 'problem-solving capacity' by two means: first, by mentioning and positively rating the inclusion of experts into policy-making processes; and second, by introducing or assessing organisations in terms of their management potential.

The importance of experts and expertise was mentioned in almost all of the texts in the analysis, most of all within the stakeholder group of OECD-DAC member states, some of which had quite a high focus on this sub-component of legitimate governance 'for' the people. One text, from the Government of Norway, contained by far the most frequent use of words in this cluster. This can partly be explained by the text's focus on environmental policy. However, in this text references were also made to the importance of expertise for good governance, for example when stating that high standards in policy require:

> A high level of technical expertise and sufficient capacity (Norwegian Ministry of Foreign Affiars, 2006, p. 13).

Texts from Ireland, Japan and Sweden also included frequent positive references to expertise in relation to governance.

> In particular, Japan will enhance collaboration with international organizations that possess expertise and political neutrality, and will endeavor to ensure that Japan's policies are reflected

> appropriately in the management of those organizations (Japan Ministry of Foreign Affairs, 2003, p. 3).

> We believe that a multilateral approach offers important opportunities and advantages for advancing U.S. foreign policy and assistance priorities, including significant cost sharing, leverage, legitimacy, access, expertise, and coordination (United States Department of State & USAID, 2007, p. 57).

Some texts rarely specifically used words such as ‘experts’ or ‘expertise’ but still had a qualitatively high emphasis on this sub-component. For example, the text from the Bill and Melinda Gates Foundation stated that policy-making is a:

> ...rigorous process that includes identifying a problem, scoping the landscape for what has already been tried, and creating the approach that will have the most impact. At every step in the process, we work with partners and experts (Bill & Melinda Gates Foundation, 2007, p. 4).

Several other CSOs also included frequent mentions of expertise in their texts, including the International Council of Nurses, the International Union for Health Promotion and Education, PATH and the Rockefeller Foundation. Frequent mentions of expertise were also found in several texts from epidemic and at-risk states, although the emphasis amongst this stakeholder group was weaker than the other three.

> Worldwide, we increased our staff by nearly 100 people, to a total of 546—adding experts in almost every important health area on which we focus (PATH, 2007, p. 27).

> Over the last years the IUHPE has strengthened its reputation as a source of expert policy advice on a range of global health issues. Thanks to the expert knowledge, skills and commitment of individual members, institutional partners and staff, the IUHPE has contributed significantly to policy development (International Union for Health Promotion and Education, 2007, p. 25).

Management skills were mentioned in quite a few texts in each stakeholder group, but especially in business sector actors and OECD-DAC member states. For example, one text from the Government of Ireland names “Management Strength” as one criterion for Irish Aid support to UN Agencies (Irish Aid, 2007b, p.24). Several texts, notably from Germany, the UK and the USA made a few mentions of the potential of various organisations including mentions of the potential of GFATM and global health partnerships in general.

> Effective coordination and institutional management is at the center of an effective national response to the epidemic (Nigerian National Action Committee on AIDS, 2005, p. 7).

> The Fund has the potential to revolutionize the provision of assistance, and the United States is committed to the fulfillment of this vision and the Fund's full potential (United States Global AIDS Coordinator, 2004, p. 59).

> Since the late 1990s, there has been a rapid proliferation of Global Health Partnerships (GHPs) and other global initiatives, which are now seen as potentially powerful mechanisms to increase funding for health and to intensify global efforts towards the poverty, health and HIV Millennium Development Goals (MDGs) (Irish Aid, 2007a, p. 8).

Some texts from epidemic and at-risk states also made mention of the potential of civil society organisations.

> The potential of private sector, including both for-profit and not-for-profit providers, will be harnessed to complement the provision of publicly funded services (Cambodia Ministry of Health, 2002, p. 19).

> Civil society has enormous potential to assist with the fight against HIV and AIDS and needs to be further enabled to address the growing needs of the National Response (Botswana National AIDS Coordinating Agency, 2003, p. 70).

Overall, problem-solving capacity was often referred to in texts from each stakeholder group. The group of business sector actors appears to be the stakeholder group most consistently giving this sub-component of legitimate governance a high priority. Several states, such as Ireland, Japan, Germany, Norway, and the USA also appear to consider this aspect important, as did several CSOs with scientific areas of work, such as PATH, the Rockefeller Foundation, the International Union for Health Promotion Education and the Global Health Council.

4.5.2.3 Right approach

In placing value on this policy element, many texts made use of the concept of 'appropriateness'. This was especially the case amongst texts from epidemic and at-risk states. Although the term was often used, rarely were the appropriate policies for a particular country, population segment or region explicitly stated. This seemed to be left open to interpretation.

In the global health policy field, debate has long been waged over the best approach for addressing health problems within epidemic and at-risk states. Two general approaches can be defined, the first labelled selective, project-based, or vertical strategies and the second labelled comprehensive or horizontal strategies. The rationale behind the selective health care approach is based on the principle that it is more efficient and effective to invest in blanket

programmes to treat, alleviate and even eliminate specific diseases that cause the greatest levels of burden. By concentrating funds and efforts on the diseases that cause the highest level of burden first, the population will be provided with a necessary reprieve to build a stronger health care system in the future. Comprehensive approaches are based on the principle that building up strong health care systems will increase overall population health. This involves training health workers and opening hospitals as well as mobile medical stations that give a highest percentage of the population access to medical professionals. The aim is to concentrate funds and efforts on building medical services with the capacity to treat as many people with as many conditions as possible.

Principles aligning with the comprehensive, or horizontal approach were embodied in the Primary Health Care approach, laid out in the declaration of Alma-Ata in 1979. Stakeholders that prioritised this aspect of legitimate global health governance did so by frequently mentioning Primary Health Care in their texts and by giving it a high priority, or by criticising vertical approaches directly.

> ...recent international agencies' initiatives on HIV and AIDS have tended more towards heavy utilisation of a project approach. While a project modality may in some cases be useful for rapidly initiating activities, it is likely to militate against longer-term sustainability by entrenching the vertical nature of the response to HIV and AIDS, barricading it off from broader developmental efforts in a manner that is ultimately counterproductive (Zambia National HIV/AIDS Council, 2006, p. 46).

One of the clearest differences between stakeholder groups is to be found in the number of times reference was made to Primary Health Care (PHC). Almost all states in the stakeholder group of epidemic and at-risk states made frequent mention of PHC and put a high value on this subject in their texts. The texts also included legitimating patterns that declared its importance as a right approach. For example one text from the Government of Lesotho described Primary Health Care as an:

> integrated strategy... to provide basic and accessible services through community-based health workers and health centres…. By and large, the PHC approach...was successful. (Lesotho, Kingdom of, 2004, p. 70).

> Strengthened primary care is necessary for appropriate follow up and support (Guyana Ministry of Health, 2003, p. 32).

> Trained Lady Health Workers will be utilized to cover the un-served population at the primary level. This would ensure family planning and primary health care services at the doorstep of the population through an integrated community-based approach (Pakistan Ministry of Health, 2001, p. 5)

> There is a strong history of Primary Health Care within the health sector of Sierra Leone. The Government remains committed to this approach (Sierra Leone Ministry of Health and Sanitation, 2002).

> …the local and international initiatives, for which Sudan is signatory are valid, including the convention on child health (1990), millennium summit and the MDGs, and the primary health care approach and its recent development (Sudan Federal Ministry of Health, 2006, p. 2).

It is noticeable that amongst the texts from the other three stakeholder groups, very few contained any mentions of the Primary Health Care approach at all, with the exception of texts from Germany, Ireland, Sweden, the UK and the CSO Save the Children.

> Irish Aid will: Support strategies to achieve universal coverage of essential promotive, preventive and curative health services, based on a primary health care approach (Irish Aid, 2007b, p. 20).

Right approach, both in terms of adjusting policies to local specifications, and adopting Primary Health Care appears to be an important aspect for certain stakeholders, in particular those representing epidemic and at-risk states, as well as a few key OECD-DAC member states. These stakeholders put priority on Primary Health Care as a right approach, and advocate taking this approach at state level and on the global level. GHG organisations, such as GFATM, UNAIDS and the GAVI Alliance however, can mainly be classified as following a selective, or vertical approach to global health. They each address, one, or a few specific diseases or technologies. Although each of these GHG organisations have also incorporated elements of the PHC approach into their policies, such as strengthening health systems, their approaches are more likely to be aligned with stakeholders that prioritise vertical approaches. Stakeholders tended to express their preference for such an approach by means of emphasising evidence-based medicine or the use of proven technologies and medical knowledge in as many situations as possible to even out inconsistencies in treatment practices. While evidence-based approaches were not mentioned nearly as often as Primary Health Care it was mentioned several times in some texts from epidemic and at-risk states as well as a few texts from OECD-DAC member states, in particular one text from the United States. Thus, amongst public actors, while different stakeholders might be seen to prioritise different or

even multiple strategies the overall approach is considered important. CSOs and business actors appeared to make very little reference to approach in their texts.

> As an international community, donors should commit to promoting best practices and evidence-based interventions and adhere to high standards for resource allocation and management (United States Global AIDS Coordinator, 2004, p. 58).

> The core strategies are built on past and emerging evidence based practices and are best indicative of a core approach to achieving the strategic objective but are not meant to be exclusive of new strategies or to stifle innovation (Zambia National HIV/AIDS Council, 2006, p. 18).

4.5.2.4 Effectiveness and efficacy

Legitimation patterns containing references to effectiveness were found frequently throughout almost all of the texts. Almost all of the texts that were analysed frequently used words such as 'impact' and 'success' as well as 'output' and 'outcome' in various contexts. Specific use of words meaning 'effective' or appraising 'effectiveness' were also very common. Along with participatory governance, this was the most frequently used legitimating pattern. The highest focus of effectiveness was in texts from OECD-DAC member states, followed by texts from epidemic and at-risk states. Some CSOs barely put a focus on effectiveness at all in their texts, although most still presented goal achievement as an ultimate aim. As the direct quantitative comparison in Diagram 4.5 shows, texts from the governments of Germany, Ireland, Japan, Norway, the UK and the United States put a particularly high emphasis on this sub-component of good governance 'for' the people. The governments of France and Sweden were the only two in this group that put considerably less emphasis on effectiveness than the other texts, although even in these cases, legitimating patterns contained references to effectiveness more often than to any other sub-component of legitimacy, other than participatory governance.

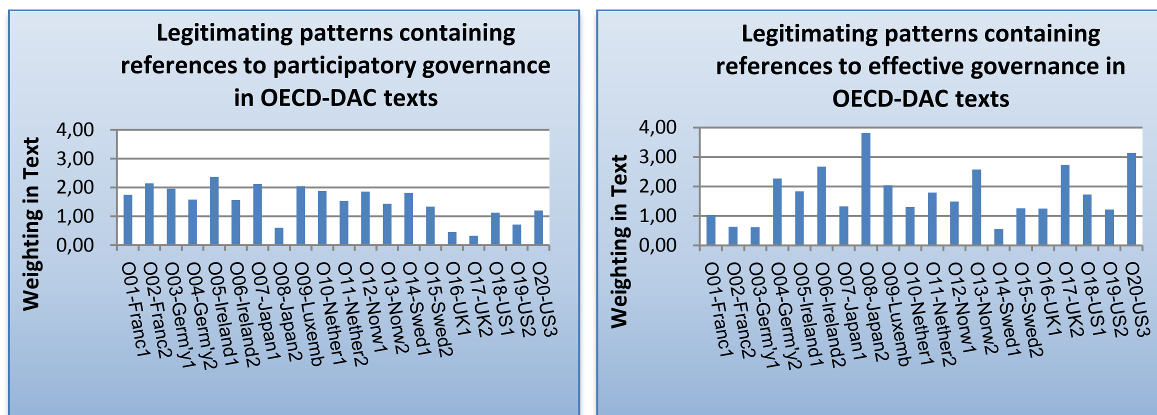

Diagram 4.5: Comparison of emphasis placed on participatory and effective governance in texts from OECD-DAC member states[62]

The use of legitimation statements containing reference to effectiveness amongst OECD-DAC states generally referred to it as the ultimate goal of governance activities, for which other elements might need to be adopted, such as participatory structures or consulting with experts. Frequent mention was also made to the Paris Declaration on aid effectiveness.

> ...Japan's assistance policy will be reconciled in order to maximize the effect of Japan's aid within those developing countries' development strategies (Japan Ministry of Foreign Affairs, 2003, p. 6).

> It not only brings hope through the commitment of extraordinary resources, but, as important, the opportunity to find new and more effective ways to fight the HIV/AIDS pandemic (United States Global AIDS Coordinator, 2004, p. 8).

> Through linking support to different partners and using different modalities Irish Aid will seek to create synergies and maximise effectiveness of its aid for health (Irish Aid, 2007b, p. 23).

> Global initiatives and funds need to increase the effectiveness of their aid (United Kingdom DFID, 2007, p. 4).

Several epidemic and at-risk states also put a particularly high emphasis on effectiveness in their texts. For example, Governments from Cambodia, Afghanistan, Botswana, Namibia, Papua New Guinea and Belize contained far more references to effective governance than participatory governance. Other states were the opposite, for example, texts from Lesotho, Mozambique, Pakistan, Guyana, Swaziland and Sudan put a higher emphasis on participation

[62] Weighting in text calculated as the proportion of text occupied to the specific reference to the legitimating pattern in the text, multiplied by 1000. For more comparisons and the explanation of the abbreviated references to texts, see Appendix II.

over effectiveness. Effectiveness however, was mentioned often in all of the texts from this stakeholder group, in the usual case when referring to own governance programmes, and occasionally in reference to expectations on international agencies. Effectiveness, cost-effectiveness and efficiency were often mentioned in close proximity in texts from this stakeholder group and increasing effectiveness was mentioned in the texts as the ultimate aim of various governance measures, to such an extent that the terms 'effective' or 'ineffective' were used as terms to judge a project, programme or institution either positively or negatively respectively.

> As an institution, the ministry not only needs more effective and efficient management but also, on the technical side, to give much greater attention to chronic diseases and health lifestyles (Cambodia Ministry of Health, 2002, p. 29).

Several texts from within the stakeholder group of civil society actors stood out as putting a particularly strong focus on effectiveness in their texts including the International Community of Women Living with HIV/AIDS, International Council of Nurses, the International HIV/AIDS Alliance, the International Union for Health Promotion and Education and the International Women's Health Coalition. Each of these texts also had a high emphasis on participation in their texts. Qualitatively, references to effectiveness in these texts presented this sub-component as an important goal for themselves, as well as a key part of their strategies. As with the texts from OECD-DAC member states and epidemic and at-risk states, effectiveness was also frequently mentioned in the texts as the ultimate reason for pursuing other sub-components of legitimacy, such as participation or expertise.

> The challenges of the epidemic are enormous, and we urgently need to increase the scale of initiatives that are proving effective (IHAA, 2004, p. 14).

> Understanding the impact of HIV/AIDS is an essential step toward formulating effective policy responses (Rockefeller Foundation, 2007, p. 9).

Amongst other texts from this stakeholder group, the level of focus on effectiveness was still generally higher than for most other sub-components of legitimacy.

Texts from business sectors actors contained the least references to effectiveness when viewed as a group. Texts amongst this group referred to effectiveness, mainly in terms of their own organisations, to approximately the same level as they referred to other components such as experts and expertise, and transparency. Texts from this stakeholder group, did however

use the term 'impact' frequently in their texts, although mainly when describing the effects of their working activities.

> We cannot solve every problem. Instead, we must focus our attention on areas where we can make the most significant positive impact (Heineken NV, 2007, p. 1).

> While these countries continue to face grave social, economic and environmental challenges, we believe that market based growth within effective regulatory frameworks can make a significant impact on poverty reduction (Unilever, 2007, p. 24).

4.5.2.5 Organisational efficiency

Texts from stakeholders made mentions of efficiency and cost-effectiveness when prioritising the organisational efficiency sub-component of legitimate governance 'for' the people. On the whole, this aspect was mentioned far less than other aspects such as expertise and effectiveness. Only amongst texts from the stakeholder group of business sector actors was it particularly evident that efficiency was given particularly high priority. Amongst this stakeholder group, several texts, including those from Eni, GlaxoSmithKline, Sumitomo Chemicals and Total made particularly strong and frequent mentions of efficiency. Assessed qualitatively, legitimating patterns found in texts from business sector actors had a high emphasis on organisational efficiency, referring to the desirability of cutting costs and using as few material resources as possible.

> In each case, the knowledge management system consists of operating procedures and organizational and technological solutions that allow Eni to: acquire, confirm, strengthen, use and spread knowledge in order to improve the efficiency and quality of operational and decision-making processes (Eni, 2007, p. 32)

> An efficient, fully operational, worldwide system for pharmacovigilance is maintained within our company (GlaxoSmithKline, 2006, p. 32).

Amongst texts from stakeholders in other groups, efficiency was generally not mentioned as frequently as effectiveness, although on several occasions the two were mentioned in conjunction. Amongst CSOs, efficiency was only mentioned at all in ten of the twenty analysed texts. Qualitatively, these mentions were generally references to the desire for increased efficiency amongst own activities and in the use of funds from the international community.

> ... in some country programmes reserves at the end of 2004 had accumulated to a level that gave us concern that we were not using supporters' donations as efficiently as we could (ActionAid International, 2006, p. 53).

> The overall health infrastructure in Uganda is not operating at full efficiency (The AIDS Support Organisation, 2002, p. 9).

> The IUHPE's HP-Source.net is a voluntary, international collaboration of researchers, practitioners and policy makers, having the common goal to maximise the efficiency and effectiveness of health promotion policy, infrastructures and practices (International Union for Health Promotion and Education, 2007, p. 7).

With the exception of texts from Japan, Luxembourg, Namibia and Botswana, texts from OECD-DAC member states and epidemic and at-risk states included relatively few mentions of efficiency overall. Qualitatively however, these texts contained stronger statements over the desirability of efficiency in health policy.

> Multilateral cooperation creates synergies through the pooling of financial resources and joint development of strategies, thus contributing to a more efficient and effective HIV/AIDS response (German Federal Ministry for Economic Cooperation and Development, 2007, p. 31).

> We will use public resources efficiently and effectively, providing value for money for the Irish taxpayer (Irish Aid, 2007a, p. 18).

> Within this Key Result Area, the Ministry of Health aims at enhancing organisational efficiency and effectiveness (Botswana Ministry of Health, 2005, p. 20).

4.5.3 Stakeholders' and other patterns of legitimation

Overall, the text analysis showed that all stakeholders used each of the nine sub-components to some degree in legitimation statements in their published texts. The sub-components of participatory governance and effective governance, often specifically as impact, were referred to the most. Problem-solving capacity and the utilisation of expertise, as well as transparency and processes of discussion and deliberation were considered important amongst some stakeholders, while almost ignored by others.

While most legitimation statements made in the analysed texts did not refer to GHG organisations as the objects of evaluation the text analysis provides an indicator of the types of values that are important for stakeholders in promoting and judging their own work and the way they perceive other actors in their environment. Stakeholders within the group of epidemic and at-risk states put a high emphasis on approach in their texts, including the

positive evaluation of Primary Health Care. Business sector actors had an additional emphasis on efficiency in their texts, although qualitatively, business sector actors were least likely to comment on their political environment in their texts, concentrating instead on technologies and their own business practices. OECD-DAC member states put a particularly high emphasis on efficiency, but at the same time also most strongly advocated participatory democracy as well as public governance. Texts from the OECD-DAC stakeholder group also put a particularly high emphasis on governance 'for' the people by means of utilising experts and expertise. Overall these stakeholders were more likely to specifically list principles or criteria of good governance that they require from global institutions or cooperation partners.

> Criteria for Irish Aid support to UN agencies: 1. Poverty reduction focus 2. Relevance to MDGs 3. Management strength 4. Commitment to reform 5. Commitment to coordinate with other multilateral and bilateral agencies especially as part of pooled funding arrangements in partner countries and in support of country coordination under UNAIDS 6. Transparency of reporting arrangements (Irish Aid, 2007b, p. 24).

Within this group some states stood out has having particular priorities, for example texts from the United States focus particularly strongly on external participation via accountability while the Republic of Ireland had the strongest focus on transparency. The stakeholder group of civil society organisations showed the least consistent results as a group. While four out of the five stakeholders that put the highest priority on participatory governance were found within this group, there were also quite a few texts from within this group that made little mention of any of the nine sub-components.

The qualitative review of the analysed texts also found that other aspects may also be used in statements legitimating governance structures and in statements promoting particular strategies. In particular, the concept of leadership was used to a high extent in texts from CSOs and epidemic and at-risk states, as well as in texts from the USA, and some business actors. Other OECD-DAC member states however, rarely spoke of leadership. CSOs made references to leadership by; 1) describing their own leadership in the field of health; 2) promoting the need to strengthen leadership within CSOs; and 3) promoting leadership in communities to increase health issue awareness. Epidemic and at-risk states often stated that good leadership was necessary to promote compliance with strategies and rules.

> The effective implementation of the NSP [National Strategic Plan] and the attainment of its goals depends on government leadership in resource allocation, policy development, and effective co-ordination of all programmes and interventions (South African National AIDS Council, 2007, p. 59).

> Strong leadership at all levels of society is essential for an effective response to the epidemic (The AIDS Support Organisation, 2002, p. 15).

Thus it appears that in addition to the nine sub-components of legitimacy as laid out in Chapter Three, good leadership might also be a criterion on which some stakeholders might judge a particular governing organisation to be worthy of support.

Several scholars in the past have made reference to the potential of individual personalities to inspire the kind of reaction from audiences that could set up a leader as the basis for the legitimacy of that leaders of an organisation, likened to the charismatic authority described by Weber (Weber, 1968). The text analysis shows that almost all stakeholders, with the exception of OECD-DAC member states in the European region and Japan, consider leadership to be an important factor when appraising an organisation.

> Leadership is an essential enabler for HIV/AIDS efforts, spurring action and magnifying its effects. Heads of state wield enormous power, authority, and legitimacy (United States Global AIDS Coordinator, 2004, p. 19).

> Trusted community leaders have reach, authority, and legitimacy to carry forward vital messages about HIV/AIDS and combat stigma, denial, and negative cultural practice (United States Global AIDS Coordinator, 2004, p. 20).

How the stakeholder preferences drawn out by the text analysis play out in the relationships that these stakeholders have with particular GHG organisations will be the topic of the following three chapters. Before proceeding however, this chapter will now be concluded by adopting the third approach to empirical research into legitimacy, namely survey research, which directly seeks out opinions of stakeholders by means of direct questioning.

4.6 Stakeholder opinions: survey research

One approach to the empirical measurement of legitimacy is survey research, in which the level of political support for a governing organisation is assessed by directly asking its relevant stakeholders: first, the level of confidence they have in the organisation and second whether this confidence (or lack thereof) is "...grounded in the kinds of normative evaluations

that distinguish legitimacy from other kinds of support" (Hurrelmann, Schneider, & Steffek, 2007, p. 7). This kind of research has a long history in the context of assessing support for governments of states, especially in pluralist democracies; as yet there have been few attempts to transfer this type of research to the global level.

Organisations that partake in global health governance have a unique, yet large and varied number of stakeholders, and are, as a rule, 'conglomerate actors' or 'conglomerate organisations', because they take the form of formal organisations that present themselves outwardly as a unit, despite being made up of many individual parts. Within conglomerate organisations a combination of processes and substantial factors determine which opinions, values and preferences will be portrayed externally and acted upon. Institutionalised rules as well as the opinions and experiences of involved individuals, or tertiary stakeholders, contribute to developing collective external positions and determining future courses of action. While published texts present the official positions of 'conglomerate actors' and therefore lend themselves to discourse analysis, often they do not offer a full understanding of underlying values, principles and norms that guide actual preferences. This is partly because formal published texts are designed to portray clear and concise conclusions and are not intended to reflect internal debate and discussion.

In order to gain a greater understanding of the underlying values, principles and norms that guide the collective positions of conglomerate actors when evaluating the legitimacy of GHG organisations, it is useful to undertake research on the level of tertiary stakeholders, in particular those that play the role of experts – i.e. members (whether paid staff or otherwise) who are active and influential within the conglomerate organisations that have been identified as primary stakeholders. Conducting empirical research in this way differs from general public opinion research in one critical aspect. It does not seek to gauge the average, or representative opinions of a general public. Rather it gathers insights from key individuals on the norms, values and principles that shape and influence the (communicative) action of conglomerate actors. In all, 185 experts working in the field and affiliated with a variety of primary stakeholders of GHG organisations responded to a survey containing questions on various sub-components of legitimate global health governance, as well as general questions on global health and questions on how they rated specific GHG organisations. For the purpose of analysing the results, respondents were divided into groups according to the stakeholders they were affiliated with, and thus influence and are influenced by. Respondents included

experts from business sector actors, from government departments in OECD-DAC member states as well as epidemic and at-risk states and civil society organisations. Experts from civil society organisations were considered separately, according to whether they were affiliated with organisations representing people living with diseases, or general social/health interest CSOs, referred to as public interest CSOs.[63]

A key advantage of the survey research method over observation and discourse analysis is the ability to directly gather opinions on the topic of research and gain insights into attitudes. The previous section concluded that stakeholders put a high priority on participatory governance and effectiveness when assessing their own work and the work of other actors in their political environment, and that certain stakeholders also prioritise some other components of legitimate governance 'by' and 'for' the people. To supplement the results found by examining stakeholder texts on general and health topics, it is important to ask experts affiliated with key primary stakeholders their opinions on how they view the importance of these components specifically when it comes to global health and GHG organisations.

4.6.1 Expressed opinions

The case study chapters (Chapters Five, Six and Seven) will cover more detailed expressed opinions from stakeholders on individual GHG organisations. This section will concentrate on three key aspects; first, opinions of experts on the general desirability of public governance and the acceptability of including non-state actors in global health governance – a key distinguishing feature of GHG organisations; second the extent to which several specific organisations are held in high regard by the surveyed experts; and third the level of importance that the survey respondents gave to the nine sub-components of legitimacy, when asked to consider them in light of GHG organisations.

4.6.1.1 Stakeholder views on public and private actors global health

In the stakeholder survey questionnaire, respondents from all stakeholder groups generally agreed that combating infectious diseases is largely a matter of setting health as a political priority and that diseases such as malaria, tuberculosis and HIV/AIDS can only be overcome by addressing issues of good governance, poverty and development. With regards to the biggest changes respondents felt needed to be made to address the issue of global health, they

[63] For a complete description of the methodology used, see Appendix III.

referred to several issues including the need for more funding and stronger political will. For example, two respondents affiliated with a government department in a OECD-DAC member state wrote that:

> *I consider lack of funding as a major constraint for tackling infectious diseases however given the dysfunctional health systems in many countries just more money won't solve it (Comment from a senior member of staff at an OECD-DAC state development agency).[64]

> *There is no one solution for tackling communicable diseases around the world. Sustained political attention and long term commitments of funds is needed for poorer countries to build up a health system that can tackle these diseases (Comment from a senior member of staff at an OECD-DAC state development agency).

Another respondent from the same group wrote that:

> *Malaria, TB and HIV can certainly be combated by addressing poverty and development, but this is not the only solution, funding is needed, political leadership is needed, mass-scale stigma reduction is needed and targeted healthcare interventions are needed. (Comment from a senior member of staff at an OECD-DAC state development agency).

It was generally agreed amongst all surveyed stakeholders that issues of governance were important. Overall only around 16% of the respondents stated that they rarely think about the governance structures of global health organisations. The vast majority do regularly occupy themselves with issues such as who is involved in decision-making and what decision-making modes exist.

The results of the text analysis presented above indicated that participatory governance is given a higher priority than democratic or representative governance on levels above, or below, that of the state, e.g. in global discussions or in local communities. In the survey, several questions posed to the experts directly addressed the issue of preferred governance forms on the global level, for example, bilateralism, multilateralism, or inclusive institutions such as GHG organisations.

When asked directly about whether bilateral programmes for health were preferable over multilateral programmes, respondents were split in their opinions. The majority of respondents associated with OECD-DAC member states and business sector actors were of

[64]Direct quotes from interview partners or from questionnaire respondents are henceforth marked with an asterisk (*) at the beginning of the quote. As respondents were asked to feel free not to be concerned with spelling or grammar, correction to the quotes may have been made by the author.

the opinion that multilateralism was better, while respondents from epidemic and at-risk states stated that bilateral programmes were more effective. When asked whether matters of global public health should preferably be handled within the World Health Organisation, there was much stronger agreement, with the vast majority of respondents from OECD-DAC member states and epidemic and at-risk states agreeing with this view. The opinions of experts affiliated with non-state actors tended to be split on the issue.

However, when asked whether important global public health projects should be conducted *wholly* within the UN system, most respondents disagreed. It was also notable that experts affiliated with business sector actors and OECD-DAC member states tended to disagree quite strongly. This indicates a willingness to include private actors in global public health projects or even to execute public health projects through private organisations.

Several respondents also commented on this issue with some voicing scepticism over how intergovernmental multi-lateral programs are currently run, for example by stating that:

> *True Global Orgs, which there is only talk of, with the proper funding would be more effective but I have witnessed the larger orgs wasting a lot of money by not hiring proper staff, having little to no accountability and no belief in empowering those being affected by the diseases (Comment from an office holding member of an Association of PLWHA).

> *The WHO should be addressing issues of global public health concern, and they should do it in a more aggressive, and intensive way but they are not the only players, they can't be expected to do it on their own. They could be more vocal, I'm sure 99% of the world's population has no idea what the WHO is up to (Comment from a senior member of staff at an OECD-DAC state development agency).

One respondent from the stakeholder group of business sector actors said that they would agree that the WHO should handle public health matters...

> *if only the organisation (would) work properly (Comment from a senior member of staff at a health product/service based company).

Other respondents were adamant the WHO should remain the central global body for public health.

> *Matters of global public health concern should be left to WHO only, all the Governments should support the idea. Currently HIV/AIDS interventions are donor driven things, with a lot of

> out of pockets allowances for staff, and patients are dying (Comment from an office holding member of an Association of PLWHA).

Another respondent from the same stakeholder group voiced scepticism over whether global level decision-making or coordination can work at all.

> *Public health issues vary globally because of socio-economic and cultural difference. The bottom line is that the grassroots person is best to determine what can or cannot work (Comment from an office holding member of an Association of PLWHA).

Several respondents pointed out that global organisations outside of the UN system are effective, but may have drawbacks due to their vertical approaches. For example one respondent from within the group of OECD-states wrote that:

> *The question - bilateral vs. global organisations does not differentiate sufficiently between different global organisations. There are the International Financial Institutions, UN-Organisations and Global Funds. In general IFIs and UN-Organisations, try more work with government structures where as Global Funds try to gain quick wins in using parallel structures. Their structures might be more efficient in the short run, but neglecting sustainability might prove to be a major draw back in the longer run (Comment from a senior member of staff at an OECD-DAC state development agency).

The surveyed experts were also asked their opinions on the inclusion of non-state actors in global-level decision-making. The vast majority were of the opinion that non-state actors, such as CSOs and business sector actors do not suffer from a lack of accountability and were willing to accept non-state actors in more than just advisory roles. When directly asked whether the inclusion of CSOs is desirable in global health decision-making respondents overwhelmingly replied in the affirmative. Only stakeholders affiliated with epidemic and at-risk states showed some level of disagreement, although, even amongst surveyed experts in this stakeholder group, 50% agreed that CSOs do help to represent the voices of people who are not helped by their governments.

When it comes to the acceptability of non-state actors in governance roles, several key issues concerning business sector actors and CSOs were commented on. One of the most debated issues was who should carry the cost of essential medicines. A large number of the surveyed experts commented on this issue including several affiliated with business sector actors.

> *... as long as pharmaceutical companies are private, how can they provide free medication? Unless governments subsidise it. If the latter happens it also means more taxation on individuals.

> No single organisation can handle global health (Comment from a senior member of staff at a health product/service based company).

Another respondent in the same stakeholder group wrote that:

> *The cost of medicines should not be born by the end-user, but not by pharma-industry either. Governments should become responsible, this would encourage them to invest more in prevention programmes (Comment from a senior member of staff at a non health product/service related company).

> *Essential medicines can only be supplied with sustainability if they are available at least at production cost and preferably with a profit margin to repay the manufacturer for the various risks involved (e.g. forecasting problems) (Comment from a senior member of staff at a health product/service based company).

Several respondents suggested alternatives, such as government subsidies for medicines. For example one respondent from an Association of PLWHA wrote that:

> *In the case of essential drugs, I believe that it is our governments who are the ones most responsible for getting medicines to people at no or at low cost. There are mechanisms that are not being implemented due to poor practices, corruption, investment in other "priority" areas - such as defence and armament- and so on. Once again, even though I believe Big Pharma can make a much stronger contribution, the ones most responsible for access (to medicines) are our own governments (Comment from an office holding member of an Association of PLWHA).

Other respondents provided detailed comments relating to the nature of medicines as goods. For example one respondent from the stakeholder group of OECD-DAC member states explained that the price of any drug or vaccine made available for use in the developing world should be linked to the true cost of goods and offered the suggestion that where a market exists for the supplier in the upper middle income or developed world, research and development costs should be recuperated from wealthier markets.

Overall the survey response showed a slight preference amongst some experts to retain public governance, but the inclusion of non-state actors on the whole was accepted.

4.6.1.2 Stakeholder views on GHG organisations

The results of the survey showed that, even amongst experts active in the field of global health, considerable differences exist in the extent to which certain global health organisations are known and the extent to which they are considered worthy of support. This was especially the case for public-private organisations or purely private organisations. For example, while

many respondents had heard of the Global Business Coalition on AIDS, Tuberculosis and Malaria many did not feel they could judge the organisation. Of six organisations specifically addressed in the survey,[65] UNAIDS was the most well known organisation. A very high percentage of respondents had also had some form of contact with UNAIDS and stated that they held the organisation in high or very high regard.[66] The GAVI Alliance was also rated highly, however a considerable percentage of respondents had not even heard of the GAVI Alliance or felt they did not know it well enough to rate it. GFATM was the next most well known organisation after UNAIDS. Overall, GFATM was held in high regard amongst the respondents. Just over 60 % of respondents had heard of Roll Back Malaria. This organisation received the lowest ratings of all the organisations addressed and several respondents justified the view they held the Roll Back Malaria in low regard by citing deficits relating to four sub-components of legitimate governance - effectiveness, purpose, problem-solving capacity and participatory governance.

> *RBM is in a state of reinventing itself (and the) jury remains out on its future effectiveness (Comment from a senior member of staff at an OECD-DAC state development agency).

> *The governance and objectives of Roll Back Malaria are all over the place. Therefore the low rating (Comment from a senior member of staff at an OECD-DAC state development agency).

Several other sub-components of legitimate governance were also mentioned by stakeholders when making legitimating statements about the organisations mentioned in the survey. In comments on why GFATM deserved a high rating one survey respondent affiliated with a stakeholder in the group of OECD-DAC member states referred to its approach as a negative aspect, but its transparency and the avenues for external participation as a positive aspect.

> *GFATM cannot get full marks - it is inherently vertical by design. That is necessary but makes it an open target for criticism. However there is frankness and they have changed their own goalposts considerably in light of this criticism (Comment from a senior member of staff at an OECD-DAC state development agency).

Other statements, for example the following response from an expert affiliated with an organisation representing PLWHA focused on participatory governance:

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[65] The organisations addressed specifically in the survey were UNAIDS, Roll Back Malaria, GFATM, GAVI Alliance, the Global Business Coalition for AIDS, Tuberculosis and Malaria, and the Global Alliance for Tuberculosis Drug Development.

[66] Complete results on file with author.

> *As stated in the previous answers these organizations need to be staffed by people living with these diseases. Also education and services delivered by people dealing with these diseases would help and cut costs. (Comment from an office holding member of an Association of PLWHA).

Also concentrating on participatory governance, a respondent from the OECD-DAC states stakeholder group wrote that:

> *The key interventions should be focussed on the highest risk population. Effective interventions should be supported by strong leadership, coordination and collaboration with all stakeholders, including NGOs, PLWHA (people living with HIV-AIDS), civil society and other key group (Comment from a senior member of staff at an OECD-DAC state development agency).

Several survey respondents also initiated further discussion on other organisations they considered to be particularly important for global health, including GHG organisations such as the Medicines for Malaria Venture (MMV) and the Malaria Vaccines Initiative (MVI). One respondent from the stakeholder group of OECD-DAC states took the opportunity to praise intergovernmental organisations.

> *We are also working with the Pan-American Health Organisation and UNICEF who have given funds to several projects in Africa. High regard in both (Comment from a senior member of staff at an OECD-DAC state development agency).

Other comments from respondents directly pointed out the diversity and importance of all the organisations as a combined global system. One respondent from the business sector actors expressed a positive view of global health governance organisations in general:

> *All of these organizations have an important role to play in improving global health -- and each reflects, in its own way, the significance of public/private partnership as a new way of working in this arena. By bringing relevant expertise and resources together... (Comment from a senior member of staff at a health product/service based company).

The survey showed that it is not a matter of course that GHG organisations will be held in high regard amongst stakeholders, and that deficits can indeed result in expressions of disapproval, based on perceived deficiencies in ability to provide good governance 'by' or 'for' the people. This will be examined further in relation to UNAIDS, GFATM and the GAVI Alliance in the case study chapters.

4.6.1.3 Stakeholder views on legitimate governance 'by' and 'for' the people

Only after being asked to rate and comment generally on specific organisations were respondents to the survey directly asked of their opinions on aspects of governance 'by' and 'for' the people. In the survey, stakeholder groups varied in the extent to which experts within any one group tended to agree or disagree on the importance of various sub-components of legitimacy. Respondents affiliated with Associations of PLWHA for example, often agreed or disagreed with statements presented in the survey in relatively equal degrees. In contrast, respondents affiliated with government departments in OECD-DAC states tended to give similar answers, suggesting that within that stakeholder group there are relatively uniform views of what makes up legitimate governance. This result corresponds with the results of the text analysis, which showed that, when referring to aspects of legitimate governance 'by' and 'for' the people, texts from OECD-DAC member states contained, on average, more mentions than texts from stakeholders in other groups and were more consistent within the group.

Consistently two aspects were given the highest ranking by respondents in all stakeholder groups, right approach (an aspects of governance 'for' the people) and external participation, enabled through transparency (an aspect of legitimate governance 'by' the people). Decreases in mortality and infection rates (effectiveness, specifically impact) were also considered very important aspects.

For example a majority of respondents affiliated with business sector actors, organisations representing PLWHA and epidemic and at-risk states agreed with the statement that it doesn't matter who is involved in decision-making in a global health project, as long as in the end it has an impact on infection rates and mortality. Respondents affiliated with government departments in OECD-DAC member states and CSOs on the other hand tended to oppose this view. This question had a very high response rate and very few respondents took a neutral position, indicating that respondents felt that this issue was important.

In terms of participatory governance, the inclusion of business sector actors in decision-making was not considered a high priority for most respondents. Respondents from public interest CSOs and Association of PLWHA gave the inclusion of CSOs in decision-making a high priority, respondents from other stakeholder groups gave this aspect a medium level of importance. Leadership was ranked as an important aspect by experts affiliated with CSOs.

This corresponds with the high level of attention given to leadership in texts from CSOs that were included in the text analysis (see section 4.5.3).

Some respondents chose to comment on other aspects that they considered to be particularly important when judging global health governance organisations, but were not explicitly covered in the survey. For example one respondent from the stakeholder group of business sector actors wrote that the organisations should:

> *be “non-bureaucratic” and listen to and cooperate with national governments, NGO's and other organisations active in their field (Comment from a senior member of staff at a health product/service based company).

Another respondent from the same group focussed on organisational efficiency.

> *…it is important that the organisations are not excessively bureaucratic (Comment from a senior member of staff at a health product/service based company).

Another respondent from the same stakeholder group emphasised governance ‘by’ the people by stating that it is of utmost importance that GHG organisations are:

> *hosted/chaired/driven by an international (state-based) organisation (WHO,WB,UNICEF) (Comment from a senior member of staff at a non health product/service related company).

Respondents from the stakeholder group of Associations of PLWHA made unprompted mention of several other aspects including: 1) “the involvement of competent people” (relating to expertise and problem-solving capacity); 2) “the willingness to involve people living with ATM” (relating to participatory governance); 3)”the adaptation of best practices” and the “willingness to speak up on controversial issues” (relating to right approach and expertise respectively); 4) “accountability to recipients” (a mode which allows indirect participation through checks and balances; and 5) “the willingness to include beneficiaries in the decision-making process” (mentioned several times).

Respondents from the stakeholder group of epidemic and at-risk states emphasised aspects that were all part of right approach such as “…having policies that focus on very poor people” and “…having policies that prevent corrupt government from attaining funds and power”. In contrast, respondents affiliated with government departments in OECD-DAC states emphasised a balance of both governance ‘by’ and ‘for’ the people. Aspects such as

"including all stakeholders, starting from the design up to evaluation phases", "maintaining communication, coordination and collaboration", and "transparency and willingness to accept critics" were mentioned alongside "sound financial management", "culturally sensitive policies" and "following the Paris principles for AID effectiveness".

In general, experts tended to emphasise aspects of good governance 'for' the people, such as effectiveness and right approach, somewhat more than aspects of participation and access – good governance 'by' the people. This corresponds with the results of the text analysis examining how aspects of legitimacy were addressed in the public discourse.

A key difference that was found to the text analysis concerned which aspects of good governance 'by' the people is of key importance. The survey found that stakeholders that can be classified as state actors still prefer intergovernmental organisations to function as the main actor in global governance, but that all stakeholders are open to civil society actors becoming more involved in decision-making. While only a few of the texts put a focus on indirect participation through accountability and transparency, almost all respondents gave this aspect a high priority when asked directly.

Importantly, while almost all stakeholders consistently agree on the importance of effectiveness, respondents to the survey were divided on who should participate in policy-making processes and whether having a high impact is so important that it overshadows issues of participation. CSO and business sector participation was welcomed at GFATM for example, but the inclusion of both of these types of actors on Boards was not given a high level of importance overall.

Experts affiliated with government departments in OECD-DAC member states and public interest CSOs put a higher emphasis on participation and access in their responses than did experts from within the other stakeholder groups. Once again this corresponds with the results of the text analysis, which indicated that a greater number of texts from within this stakeholder group listed aspects of what was considered "good governance". Experts affiliated with special interest groups – Associations of PLWHA – also put a high emphasis on representation and participation, especially with respect to GFATM and UNAIDS.

Finally, the results of the survey clearly indicated that experts affiliated with each stakeholder group put a high level of importance on the participation of actors out of their respective group. i.e. CSOs considered CSO participation in GHG organisations to be very important, and overwhelmingly experts affiliated with business sector actors considered business actor participation in GHG organisations to be important. Even respondents affiliated with epidemic and at-risk states were more likely to state that global public health projects should take place within state-controlled bodies such as the United Nations. The exception to this trend appeared to be respondents from within the stakeholder group of OECD-DAC states. These experts indicated a willingness to involve non-state as well as state actors in global health policy-making processes.

With respect to the three case study organisations, the survey found that for GFATM, and even more so, UNAIDS, aspects of governance 'by' the people were addressed frequently in comments and given a high importance in ranking questions. This seems to be somewhat less the case with respect to the GAVI Alliance. Thus it appears that the more narrow or technical the mandate of a global health organisation, the more likely it is that its relevant audience of stakeholders will emphasise its ability to provide good governance 'for' the people when assessing the legitimacy of the organisation. However, there remains a significant group of experts, found for example amongst government departments of OECD-DAC states that prioritise avenues of participation – an aspect of governance 'by' the people – in all global health governance organisations. This will be addressed further in the case study chapters.

4.7 Discussion

This chapter has presented the results of a stakeholder analysis and a three-method study into stakeholders and their relationships with GHG organisations. While this chapter did not concentrate on any one specific GHG organisation, it described the various types of actors that are stakeholders in the global health policy field and analysed the claims that GHG organisations make upon them and stakeholders' reactions. It also shed light on which sub-components of legitimate governance 'by' and 'for' the people various stakeholders in the global health policy field prioritise in their own work, and when interacting with other actors in the same field. It has been found that stakeholders do indeed give priority to various aspects of governance such as participatory governance, problem-solving capacity, efficacy and right approach, giving strength to the proposition that legitimacy can exist on the global level,

based on both governance 'by' and 'for' the people, as summarised in Table 3.3 in the previous chapter.

It is possible to distinguish between stakeholders along the lines of the types of relationships they have with GHG organisations and the roles they play in the global health policy field. For example it is possible to group stakeholders along the lines of state and non-state actors. State actors can be distinguished further according to whether they have the potential to contribute resources to global efforts or whether they have epidemics or are at risk of developing epidemics. The claims that GHG organisations make upon each type of stakeholder varies accordingly. Intergovernmental organisations are important stakeholders of GHG organisations. It is also possible to distinguish between different types of non-state actors, although categorisation is more difficult than in the case of state actors. Business sector actors vary according to the extent that they influence, or are influenced by, global health policy. Civil society actors are the most diverse group of all, and vary in their relationships to GHG organisations, according to their potential contribution to global health policy-making. In all, GHG organisations have received positive reactions to the claims they have made regarding expected behaviour on the part of their stakeholders, however, some stakeholders do not appear to offer full support for GHG organisations in all instances.

GHG organisations and OECD-DAC member states appear to have strong relationships, and on the whole stakeholders in this group have responded positively to 'claims' from GHG organisation that they are appropriate and worthy of funding. Some countries are now giving more funds to GFATM than through bilateral health programmes. However, stakeholders within this group do have strong opinions on what they consider to be legitimate governance and often directly express views about what makes up good governance (including on the global level) in published texts. GHG organisations are thus subject to considerable critique from stakeholders in this group. Participatory governance and effectiveness were prioritised in published texts and when responding to direct questioning. Some states within the group, such as Ireland, the United States and the United Kingdom had a particularly high focus on transparency and accountability. Stakeholders within this group also put a priority on the utilisation of experts and expertise to increase problem-solving capacity.

The strongest expression of opinion in favour of participatory governance came from certain CSOs, including those that represent people living with targeted diseases. This was apparent

in analysed texts and in the results of surveys. Results of the text analysis as well as the survey questionnaire also found that most CSOs also put a high priority on leadership as an important aspect of governance. Within this group, stakeholders varied greatly in terms of the sub-components that they prioritised when making legitimation statements or recommendations for organisational improvement, some emphasised the utilisation of experts and expertise, while others emphasised the concept of external scrutiny and accountability.

Stakeholders classified as belonging to the group of epidemic and at-risk states also put a high priority on effectiveness and participatory governance as the most important of the nine-sub-components. However, it was noticeable in both published texts and responses to direct questioning from this group that participatory governance is not given quite as high a priority, as it was within other stakeholder groups. Also, important for a large number of stakeholders within this group was the sub-component of good governance 'for' the people, right approach. In particular, Primary Health Care, representing horizontal approaches to global health was considered important. Leadership was also considered an important aspect. When questioned directly, stakeholders in this group appear to rate GHG organisations highly, political behaviours have also changed considerably to move into line with the claims that GHG organisations make.

Finally, the relationship between GHG organisations and business sector actors appears to be the least concrete. Often it is not clear what expectations are placed on business actors and so is also difficult to assess whether their behaviours indicate a positive or negative response to the claims that GHG organisations make. Business sector actors tended to put the highest focus on impact when expressing values and opinions about their own work and the purpose of others in their environment. They also put a much higher focus on efficiency and transparency than stakeholders in other groups.

The empirical analysis of stakeholder behaviours, public communication and opinions found that states that have the potential to contribute resources, for example member states of the OECD-DAC, have strong and relatively consistent opinions regarding which values, principles and beliefs underlie good global health governance. Stakeholders in other groups tend to be more divided, although clear preferences are discernable for some stakeholder groups with regards to some of the specific nine sub-components of legitimacy.

It has been found that amongst all stakeholders, regardless of the their type, aspects of both governance 'by' and 'for' the people indeed provide the basis on which stakeholders make value judgements, and by no means is public governance the only acceptable basis for the legitimacy of global health organisations. Most of all, effectiveness stands out as an aspect that almost all stakeholders prioritised, both in public communication and when questioned directly, stakeholders also tended to give specific priority to impact, and to the achievement of actual solutions to pressing problems.

Table 4.7: Sub-components of legitimate governance prioritised by stakeholders

Priorities / Stakeholder Group	Governance 'by' the people	Governance 'for' the people	Comments
Epidemic and at-risk states	High priority given to participatory governance and public (UN) governance	Very high priority given to effectiveness. High priority given to right approach	All sub-components given priority by at least some stakeholders in this group; In response to direct questioning, public governance given a higher priority; Leadership is also given a high priority
States with the potential to contribute resources	High priority given to participatory governance; Some states put a high focus on transparency and external participation; Mention of all sub-components in public communication	Very high priority given to effectiveness and efficacy; high priority given to problem-solving capacity	All sub-components given at least some priority; Priorities amongst stakeholders in this group relatively consistent and expressed strongly
Civil Society Organisations	Very high priority given to participatory governance amongst certain CSOs. High priority put on external participation and accountability.	Very high priority given to problem-solving capacity and utilisation of expertise amongst certain CSOs. High priority given to effectiveness	Priorities within this group vary considerably; preferences amongst Associations of PLWHA often weak; All sub-components given some priority; Leadership Is also given a high priority
Business Sector Actors	High priority placed on and transparency and problem-solving capacity	Very high priority put on effectiveness, specifically impact; and efficiency	All sub-components given some priority; Focus on sub-components of governance 'for' the people

Participatory governance is also an aspect that was given a high priority amongst almost all stakeholders. Stakeholders appear to be open to the participation of civil society organisations in particular, when it comes to global health governance and health governance on other levels, such as local levels. There is however somewhat more scepticism amongst

stakeholders as to the appropriateness of business sector actors' involvement in global health governance.

4.8 Introducing case studies

Global health governance represents a policy field unique set of policy issues and a unique group of actors that interact and take on specific roles. In this chapter, evidence has been found to strengthen the first proposition put forward in Chapter Three, namely that legitimacy can exist on a global level, although it differs from legitimacy on the state level in that it can be based on both elements related to governance 'by' the people and governance 'for' the people. However, no two GHG organisations are exactly alike, neither in terms of their primary stakeholders, nor in terms of the types of claims they make regarding desired behaviour on behalf of those stakeholders. What specific kinds of claims do GHG organisations make and how do their stakeholders react to them? Do stakeholder reactions indicate that GHG organisations are accepted as legitimate? Is there congruence between the values, principles and norms that underpin the work of GHG organisations and the priorities of their stakeholders? Importantly, are there differences between GHG organisations in terms of what their legitimacy in based on? In the following three chapters these questions will be addressed with regard to three specific GHG organisations, UNAIDS, GFATM and the GAVI Alliance.

Each chapter begins with an outline of the aims, scope and historical development of the respective organisation. Then, in each of the case studies, the nine sub-components of legitimate global governance as outlined in the Chapter Three are systematically discussed with reference to the respective GHG organisation. Being sought are the types of judgements stakeholders might make about the organisation, if they were to prioritise that particular sub-component. The chapter then goes on to address the stakeholders that are of particular importance to each organisation and analyses their relationships with the GHG organisation in relation to how they view the organisation in terms of each of the sub-components of legitimate governance. The result is an assessment of whether the GHG organisation enjoys being perceived as legitimate amongst its stakeholders, whether this occurs as part of a congruence of priorities and organisational characteristics between stakeholders and the organisation, and whether this legitimacy is based on aspects of governance 'by' or 'for' the people, or both.

Chapter Five

Case Study - UNAIDS

Public governance with a focus on problem-solving capacity

The Joint United Nations Programme on HIV/AIDS, best known as UNAIDS, has been described as an example of an institution established within the United Nations system that serves as a 'pilot' organisation for the future of multilateral cooperation between various types of actors at the UN level (Martens, 2007, p. 29). Although it is located within the United Nations system and is accordingly primarily a state-based organisation, key features of UNAIDS also show that it can be described as part of the shift away from intergovernmentalism towards cosmopolitan (participatory) democracy. Furthermore, due to the organisation's focus on addressing a specific global challenge, it can also be described as an organisation that has adopted a managerial approach to global health governance. The key characteristics of UNAIDS, that make it an interesting case study for examining the consequences of the move away from intergovernmentalism towards cosmopolitan democracy and managerialism, were introduced briefly in Chapter Two of this dissertation. In this chapter, UNAIDS will be further examined as a case study, by means of analysing the organisation in terms of its stakeholder relationships and its legitimacy. Considering that UNAIDS is an organisation that has moved away from the purely intergovernmental model of

international politics, it raises the question of what are the grounds on which its legitimacy could be based? Who are the main stakeholders of UNAIDS and who must perceive it as legitimate? What are the priorities of these stakeholders, when it comes to deciding whether UNAIDS is legitimate and worthy of support?

The chapter begins with an introduction to the political environment in which UNAIDS was formed and continues to act within, outlining the specific features of the HIV/AIDS issue-area from a political science point of view as well as the origins and aims of UNAIDS as an organisation. The chapter then proceeds to analyse UNAIDS in terms of the nine-sub-components of legitimacy as described in Chapter Three, thereby addressing the question: On what grounds might UNAIDS be considered to be a legitimate organisation? Finally, the chapter proceeds to examine UNAIDS' relationships with its various stakeholders, asking who its primary stakeholders are, how these stakeholders respond to UNAIDS in terms of political behaviours, and how they rate the legitimacy of UNAIDS, both in communicative acts and in response to direct questioning.

Although UNAIDS has been operating for over a decade, and despite the fact that UNAIDS represents a milestone in global governance due to its unique inclusion of civil society in formal decision-making roles, surprisingly little has been written about the organisation from a political science perspective thus far. Therefore, this chapter draws mainly on primary resources, such as the first independent evaluation of UNAIDS (Independent Evaluation Team, 2002)[67], as well as the results of primary research, such as interviews conducted with staff at UNAIDS and the research project outlined in Appendices II and III.

5.1 UNAIDS and its political environment

The existence and early spread of HIV and AIDS first became evident in the early 1980s. Initially it was considered a disease of the rich world, due to the first diagnoses and evidence of spread being amongst communities of homosexual men in the USA. Later, however, it was discovered that AIDS was far more prevalent amongst populations in the world's poorest countries, especially in Sub-Saharan Africa. Three unique aspects of the HIV/AIDS epidemic have created a special political environment, made up of a unique set of stakeholders with specific priorities, in which the organisation acts.

[67] The second independent evaluation of UNAIDS is due for completion in September 2009.

First, the global HIV/AIDS pandemic is unique due to its social, political and cultural causes and consequences. As a disease that is primarily sexually transmitted and also transmitted via the sharing of needles amongst drug users, interventions require the recognition and open discussion of practices that are taboo in many societies. Furthermore, many of the causes of the spread of HIV/AIDS, as well as the barriers to prevention and treatment, are inherently social. Addressing HIV/AIDS must therefore involve the consideration of issues such as gender inequality, informal economies (such as drugs and prostitution) and human rights. The topic of HIV/AIDS, therefore, is much more difficult to address purely from a bio-medical perspective than most other diseases. The fight against HIV infection:

> ... requires the mobilisation of considerable resources and direct interventions in areas of personal behaviour which often infringe upon taboos and involve stigmatised groups. This immediately sets AIDS aside from most other diseases, where the necessary precautions may be difficult and expensive (e.g. the elimination of mosquitoes or the provision of sanitation) but they are not emotionally charged the way that is true for providing adolescents with condoms or drug-users with clean needles (Altman, 1999, p. 21).

Second, the HIV/AIDS pandemic has been described as a long-wave event, because its effects compound over generations, slowly undermining social structures and economies (Barnett, 2004, p. 931). Due to a 'pathological harmony' between the HIV/AIDS virus and human life cycles (a human immune system fights back against the virus over a mean period of about eight years with the result that actual illness may not become evident until after children are born) HIV has become a particularly devastating disease. In some countries, HIV epidemics are having such a strong effect on economic development and security, that the disease has become an issue that breaches not only borders – meaning that no state has the capacity to address the problem alone – but also the lines between policy issue-areas. HIV/AIDS has made the linkages between health, development and security much more visible than any global pandemic in the past. HIV/AIDS weakens economic growth and governance capacity. The quality and availability of human capital decreases, as does productivity. Thus HIV/AIDS is detrimental for investment and undermines the bases for development and poverty reduction (Kohlmorgen, 2004, p. 146). A short description of the impact of the disease in Sub-Saharan communities demonstrates this point.

In communities where HIV/AIDS is spread mainly through heterosexual contact, young people are likely to become infected directly preceding or during child-bearing years. Thus, each succeeding generation is '…likely to be born into an environment where HIV is more

prevalent than in that of its parents' (Barnett, 2007, p. 32). The negative cyclical effects of this phenomenon mean that school enrolments among orphans or children fall because they have to care for family members that begin to have symptoms as children reach school age. High mortality rates among school teachers, administrative staff and trainers also lead to the cancellation of classes or even school closures. Consequently, general levels of education decline. Morbidity leads to a reduction in the number of physically able workers, in turn leading to a retreat back to subsistence production. Similarly, due to high mortality rates in the working population, there is a reduction in economic activity in all sectors and especially in management. These declines, in turn, reduce levels of tax revenue, which lowers the capacity of the public sector to undertake its functions in providing health, education and training (Barnett, 2007, p. 39; Huckel Schneider, 2008, p. 101). Thus, HIV/AIDS proves to be a health issue that has inherently political, economical and social consequences.

Third, the HIV/AIDS pandemic has played a key role in spurring on developments that can be described as part of the globalisation of the health policy field, including the organisation of global civil society, calls for greater responsibility on behalf of business sector actors, and a considerable increase of financial resources flowing from development agencies into health projects. The dramatic difference in the way HIV/AIDS epidemics were controlled in developed compared with developing countries visibly highlighted the gap between wealthy and poor. Vocal advocacy groups demanded action from states and for-profit actors alike to address a massive long-term threat and pushed for innovative solutions to achieve results. With increasing public awareness, "…between 1997 and 2000, a worldwide activist movement slowly developed to address this problem by putting pressure on drug companies to lower their prices or allow the generic manufacture of the new medicines" (Garrett, 2007, p. 17). HIV/AIDS not only emphasised the gap between the wealthy and the poor, spurring on the development of a global civil society network, it also highlighted the consequences of a lack of political will to take action, and the need to address health from a public policy and politics perspective, rather than a purely bio-medical one.

Each of the three aspects named above has led to the emergence of a unique political environment in which UNAIDS now acts. The inherently social nature of the disease, the ways in which it spreads as a sexually transmitted disease making it a taboo topic, its political and economical consequences, and the global 'solidarity' community that has formed means

that UNAIDS has a unique set of key stakeholders, and makes claims on them that are inherently political. These will be described in more detail below, following a brief introduction to the organisation itself.

5.2 Aims, scope and historical developments.

A global coordinated response to the HIV/AIDS epidemic first got under way with the creation of the World Health Organisation's Expanded Programme on AIDS in 1986, which later became the Global Programme on AIDS (GPA) (Altman, 1999, p. 20). It had three main objectives: first to enhance international discourses on HIV/AIDS, focusing on aspects of empowerment and emancipation; second, to provide technical assistance for developing countries in policy development and programming and third, to mobilise donor countries to provide resources for a multilateral response to the epidemic. The GPA is widely recognised as having made progress on achieving these aims (Altman, 2001, p. 71). The organisation is said to have experienced two distinct phases marked by two directors; Jonathan Mann between the years 1986 and 1990, and then by Mike Merson until 1996. During the period when Jonathan Mann was director, the programme had an emphasis on human rights approaches and progress was made on bringing together social, cultural, and political aspects into the overall approach for addressing the challenge of HIV/AIDS. This was a significant shift away from the more technical focus that had encompassed the main work of WHO since it's inception. After the resignation of Mann, (partly related to disagreements between him and the then Director-General of WHO, Nakajama) the WHO programme withdrew partly from the strong political claims it was making on stakeholders, and the programme took on a somewhat more bio-medical approach (Oestreich, 2007, p. 127). Nevertheless, by the early 1990s progress had been made towards the establishment of an international discourse around HIV/AIDS which emphasised the language of empowerment and participation, and the establishment of networks that organised greater voice for people living with HIV/AIDS (Poku, 2004, p. 97).

> Under the GPA's aegis, networks developed such as the Global Network of People Living with AIDS (GNP Plus), the International Council of AIDS Service Organisations (ICASO) and the International Community of Women Living with HIV/AIDS (ICW) (Altman, 1999, p. 20).

Also, steps were made on the development of a comprehensive surveillance system for the global tracking of the disease. By the early 1990s, increasingly, partnering with the non-

governmental sector became a crucial part of operations and the mobilisation for donor countries to support a multilateral response to the epidemic became a focus. At the same time, efforts were made to link HIV/AIDS and development "which was significant in the decision of the Economic and Social Council of the United Nations to establish UNAIDS as a 'joint and co-sponsored program' of a number of key United Nations agencies" (Altman, HIV and Security, 2003, p. 420).

> From 1986, WHO took the lead on HIV control activities through its Global Programme on AIDS, funded largely by voluntary contributions from donors. But in the mid-1990s donors cut their funding and used it to form UNAIDS. This was partly as a protest against the leadership of the former director-general, Hiroshi Nakajama. Donors also hoped that UNAIDS would take a more multisectoral approach than WHO (Yamey, 2002, p. 1236).

Also, a number of failings concerning GPA's handling of the epidemic were also becoming clear. Existing knowledge about the underlying societal factors contributing to the epidemic was limited and there was a growing dissatisfaction among donor governments with the work of the GPA, which was seen as unable to work effectively with other UN agencies. The GPA came to suffer from a lack of support from states and other UN agencies alike, a reaction which can be interpreted as a crisis in legitimacy of the programme in the eyes of its most vital stakeholders. The programme formally ceased operation on the 31st December 1995 (World Health Organisation, 1995).

In January 1996 UNAIDS was launched in Geneva with a very different structure, - and possible legitimacy base – to that of the GPA. It was launched as a co-sponsored programme bringing together the WHO with United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organisation (UNESCO) and the World Bank. It was formally established by an ECOSOC resolution in 1994. The World Health Organisation, as one of the founding co-sponsoring organisations came to concentrate on the more technical aspects of addressing HIV/AIDS, and UNAIDS became the central coordinating agency, and organisation for public policy promotion (Oestreich, 2007, p. 128). Accordingly, the claims it makes on its stakeholders concern not only advice on technical standards, but policy promotion on several aspects including: blood safety, protection and care of children, condom promotion, counselling and testing, girls' education, HIV/AIDS financing, empowerment of people living with HIV/AIDS, HIV prevention, and social and behavioural change. Currently a further four United Nations organisations are also co-

sponsors including the World Food Programme (WFP), the United Nations Office on Drugs and Crime (UNOCD), the International Labour Organization (ILO) and the Office of the United Nations High Commissioner for Refugees (UNHCR). The core budget of UNAIDS was $US 320.5 million for the years 2006-2007. This compares with the World Health Organisation Budget of just over $US 500 million in the same biennium.

UNAIDS took on, as its main aim, the role of coordinating the many initiatives within the UN system aimed at combating the spread of AIDS and to act as the 'main advocate for global action on the epidemic' (UNAIDS 2004). Its greater aims however, correspond to those of its predecessor the GPA, with a focus on public policy. Therefore, policy formulation and breaking down stigmas can be seen as the organisations most important types of claims.

As addressed in Chapter Two, UNAIDS has many features that allow it to be labelled a GHG organisation, including inclusive decision-making structures, active-managerial follow up, a narrow one-disease focus, a high level of organisational sophistication, and some investment in legitimation strategies. Below, these and other aspects of UNAIDS will be examined in terms of the nine sub-components of legitimacy that were laid out in Chapter Three. The focus will be on UNAIDS governance and activities on the global level. Of course, UNAIDS is also very active within epidemic and at-risk states and arguably their most important work takes place on national and local levels. However, for the purpose of analysing the basis of the legitimacy of UNAIDS, high-level structures reflect the core principles that the organisation as a whole is based on. If stakeholders were to appraise UNAIDS on the basis of the questions laid out in Chapter Three, how might they view UNAIDS in terms of its legitimacy?

5.3 Basis for the legitimacy of UNAIDS

5.3.1 Governance 'by' the people

UNAIDS is an example of an organisation that retains a high level of state involvement in its governance structure, despite the inclusion of civil society actors in formal decision-making roles. The composition, role and decision-making procedures of the central decision-making body of UNAIDS – the Programme Coordinating Board (PCB) – demonstrate the extent to which UNAIDS remains essentially a public-based organisation. Stakeholders that scrutinise UNAIDS in terms of the extent to which its governance is based on principles of

representation of, and respect for, sovereign states will find that UNAIDS – and specifically its PCB – rates highly in terms of this sub-component of legitimacy in three ways.

First, the PCB – which is responsible for policy and budgetary matters within UNAIDS – is mainly composed of member states of the co-sponsoring organisations, and only states have voting rights when it comes to final decision-making at PCB meetings.[68] The PCB is composed of 37 members, and includes representatives from 22 states, five CSO delegates, as well as the 10 co-sponsoring UN organisations listed above. Second, the co-sponsoring organisations that are the second most numerous type of actor on the PCB are also all public-sector actors, themselves steered by member-states and structured as intergovernmental agencies. Formally, they represent the interests of their member-states within UNAIDS. The 10 co-sponsoring UN organisations all have continuous seats, while individual states and CSO representatives rotate every two years and are elected through regulated processes of nomination, review and voting. Third, the 22 member states that are the members in the PCB come from different geographical regions, with the intention of balancing representation of different groups of citizens, as the AIDS epidemic takes on different specific characteristics in different parts of the world. Seven representatives come from the 'Western Europe and Others' group, five representatives come from states in Asia and the Pacific, and five from Africa. Three representatives come from states in Latin America and two from states in Eastern Europe or the former Russian Federation (UNAIDS, 1999b). In 2007 and 2008 states with particularly high rates of HIV prevalence that held seats on the PCB were Zambia, Swaziland, India, Thailand and Burma (Myanmar). States on the Board that contribute large sums of financial resources to fighting HIV/AIDS worldwide included Ireland, Norway, Japan, Germany, Italy, France, Canada, the United Kingdom, Sweden, Spain and the USA. It is notable, however, that many of the countries with the highest HIV/AIDS prevalence rates have not held seats on the PCB Board at all, or haven't been present for several years.

Stakeholders that prioritise public governance will find that the governing structure of UNAIDS is largely public based. UNAIDS is an organisation based more on public than participatory governance.

When UNAIDS was established in 1996, its inclusion of CSOs in central decision-making roles made it a unique organisation in international politics. Five CSOs, – specifically

[68] In practice however, this right is rarely utilised, as decisions are generally made by consensus.

organisations representing communities of people living with HIV/AIDS – have seats on the PCB, and five alternative delegates are also active in a supportive capacity to the main CSO members. CSO members might be nationally, regionally or locally active, or may be networks of People Living with HIV (PLHIV Networks), AIDS service organisations (ASOs), community-based organisations (CBOs), faith-based organisations (FBOs), and networks or coalitions of AIDS organisations (UNAIDS, 2007c, p. 2). Three of the five main CSO delegates are from developing countries, known as the 'NGO Africa', the 'NGO Asia/Pacific' and the 'NGO Latin American/Caribbean' delegates, and two are from developed countries, known as the 'NGO Europe' and the 'NGO North America' delegates. Seats are held by the member organisation, not the individual from that organisation and the role of the CSO delegate is '…foremost representing the NGO perspective' (UNAIDS, 1999a, p. 30) but also to alert the PCB to changes they observe in the epidemic. Thus their inclusion can be seen in part as designed to increase participation and voice, but also as a source of expertise for the purpose of building problem-solving capacity.

The extent to which the CSO delegates on the Board of UNAIDS are truly representative of the wider CSO community has been debated amongst CSOs and commentators on UNAIDS alike. Some highly visible CSOs have complained that UNAIDS have ignored the voices of People Living with HIV/AIDS despite the presence of the CSO delegates on the PCB (Altman, 1999, p. 22). Furthermore, some smaller AIDS organisations have stated that predominantly those organisations that associate with the larger CSO networks such as GNP+ have greater access to UNAIDS. UNAIDS does have several other avenues for CSO participation on the global level outside of participation as a delegate on the PCB. Many more CSOs are present as observers at PCB meetings than there are actual delegates, and recently business sector actors have also been present, such as representatives from the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria and Pfizer Inc. Engagement with business sector actors is mainly conducted through project partnerships such as workplace programmes, advocacy programmes or in-kind contributions.

For stakeholders scrutinising UNAIDS in terms of the extent to which it embodies principles of participatory governance, the historical step of including CSOs as full members will help UNAIDS to be seen as a ground-breaker in global health. In fact, UNAIDS itself states on its website that the inclusion of CSOs in its governing structures served as a model for newer GHG organisations such as GFATM.

> UNAIDS was the first United Nations programme to have formal civil society representation on its governing body. The UNAIDS model helped inform the governing structures of the Global Fund to fight AIDS, TB and Malaria (UNAIDS, 2007c).

However, the restricted role of CSOs, especially in their limited rights in the final decision-making process of the PCB of UNAIDS limits the extent to which participatory governance is fulfilled within the organisation. Despite a recommendation in the first independent evaluation of UNAIDS in 2002 recommending changing the status of CSO delegates on the PCB to full voting members, as yet there is no process underway to formally make this change.

> At the time that UNAIDS was created the membership of NGOs on a UN governing body was a radical step. Events have moved on and now their non-voting status appears anachronistic in the context of the governance arrangements for the GFATM (Independent Evaluation Team, 2002, p. 50).

Nevertheless, from its inception, UNAIDS has worked closely with community-based organisations and UNAIDS has revised its strategy several times in an attempt to increase participatory avenues for CSOs at the global level (Altman, HIV and Security, 2003, p. 426). CSOs are therefore able to influence outcomes in high level decision-making.

> *They talk, help draft, have direct input and they debate. If there was a direct biomedical solution to this problem, then we probably would not be needing this dialogue as much, but we need to have the dialogue to understand the complexity of these issues.[69]

Like all GHG organisations, UNAIDS has gone, and continues to go, through regular reviews and reforms to improve its internal processes, and as a result has become increasingly sophisticated as an organisation. Several measures have been taken to reduce 'posturing' in PCB meetings, including the clause in the modus operandi that "…(t)he PCB shall endeavour to adopt its decisions and recommendations by consensus" (UNAIDS, 1999b, p. 4)

In terms of the balancing out of power differentials between represented groups, the specific requirement that CSOs, as well as state members, must come from different regions is possibly the most important characteristic of the PCB rules of procedure in this regard. Each state has one vote in an attempt to prevent the dominance of any one group, however, the fact that 7 members from the 'Europe and Others' group have seats and the 'Africa' group only 5

[69] Source: Interview with a senior member of staff at UNAIDS.

seats can be seen as somewhat unbalanced. Also, the fact that amongst developing states, frequently the same states appear as members of the PCB might be indicative of barriers to some potential contributors to meet the requirements of becoming a member of the PCB. CSOs are also reported to have had difficulty in finding the time and financial resources to fulfil their tasks as PCB members, although they are granted travelling and living expenses that are directly incurred through meeting participation (Middleton-Lee, 2007).

The process of nomination of CSO delegates has undergone the most scrutiny and number of reviews of all processes within the organisation. Although originally quite vague, there are now specified rules for the selection of CSO delegates to the PCB. These include nomination, interview and selection procedures which are laid out in a terms of reference document (UNAIDS, 2007c) as well as the requirement that the PCB formally approves all CSO delegates. Still, an internal review on CSO participation published in 2007 found that even as late as 2006 there was "…a need to strengthen and institutionalise participation" (UNAIDS, 2007b, p. 3).

The process of application for the new director of UNAIDS, to take over at the end of Dr. Peter Piot's term at the end of 2008, is indicative of UNAIDS current strong focus on having formalised processes to ensure fairness within the organisation. The process of selecting the director is laid out in a Rules of Procedure for the Search Committee for the UNAIDS Executive Director, a Terms of Reference for the Search Committee, and the Code of Conduct for the Search Committee.

UNAIDS, as with most GHG organisations, has publicly promoted the transparency of its organisation, its decision-making procedures and its operations.

> UNAIDS implements best practice policies within its own organization. This includes policies which make for transparency, accountability and openness for participation (UNAIDS, 1999a, p. 11)

Indeed, UNAIDS is an accessible organisation in terms of stakeholder ability to obtain information about the organisation, its policies and the individuals and groups involved in decision-making. This is the case even for persons that do not have direct involvement with UNAIDS. Documents prepared for PCB members in the lead up to meetings are available online, along with the names and contact details of all PCB members. As of 2006, progress

reports based on the new Monitoring and Evaluation Framework are available online – although the reports thus far have mainly focused on achievements and little on problems or room for improvement. The current application process for the new director is also being conducted in a highly transparent way, with all meetings of the Search Committee documented and made publicly available and all stages and details of Search Committee members have been made public (UNAIDS, 2008b). However, historical documents, and information on some procedures, for example, the election of state members to the PCB are difficult to come by.

Donor states and CSOs are particularly demanding of information from UNAIDS.[70] Some criticism has been voiced over a lack of transparency of some of UNAIDS' operations, notably, negotiations on the price of ARV medications between UNAIDS, state governments and pharmaceutical companies (Health GAP Coalition, 2000). Furthermore, although civil society and business partnerships are encouraged, it is difficult to see how individuals that are not affiliated with organised networks are able to discuss UNAIDS, its policies and its structure in a formal way. As yet, there is no organised and open stakeholder forum, nor has there been a widespread evaluation of stakeholder satisfaction with the work of UNAIDS. Stakeholders appraising UNAIDS in terms of the opportunities it provides for indirect participation might therefore see UNAIDS somewhat less open than, for example, GFATM.

Stakeholders appraising the institutional design of UNAIDS will find that it is an organisation still very much based on intergovernmentalism. The balancing out of power differentials is, for example, achieved by ensuring wide geographical representation, rather than ensuring a balance between 'donors' and recipients, as in the case within other GHG organisations such as GFATM. Furthermore, CSOs are not granted voting rights which might impair UNAIDS' standing in the eyes of some stakeholders that prioritise participatory approaches (Independent Evaluation Team, 2002).

5.3.2 Governance 'for' the people

UNAIDS was formed for a quite specific purpose, to overcome coordination problems between different UN Agencies that address the HIV/AIDS epidemic and formulate and

[70] Source: Interview with a senior member of staff at UNAIDS.

coordinate a unified approach – especially with respect to breaking down political and social barriers to the treatment and prevention of HIV/AIDS. Stakeholders appraising UNAIDS with respect to whether it is right to have a specific organisation to serve this purpose will find that UNAIDS is now the central global body for HIV/AIDS policy. Stakeholders may consider that it is necessary to have a specific organisation for HIV/AIDS policy on the global level for at least two reasons, first, as described above, HIV/AIDS is a global challenge that transcends policy areas. At the point of its establishment in 1996, several UN organisations, not least the WHO had programmes for addressing HIV/AIDS that permeated areas such as economic development, women and children's rights and education. Second, HIV/AIDS is a challenge that transcends national and regional borders.

While for some it will be considered unnecessary to have a separate organisation from that of the WHO's AIDS department, UNAIDS has come to serve a purpose that justifies its existence separate from the WHO. UNAIDS has the independence to fulfil the tasks of bringing together various strategies to address HIV/AIDS.

In terms of problem-solving capacity as a key component of governance 'for' the people stakeholders will consider the extent of UNAIDS' expert base. One of the most cited and well known activities of UNAIDS is its annual publication of the AIDS Epidemic Update, as well as its series of best practice publications. Key stakeholders expect that the information contained in these publications is accurate and obtained and analysed through rigorous methods. On the whole, it is recognised that UNAIDS employs or partners with experts practicing the most advanced epidemiological and evidence-based methods. UNAIDS itself also refers to the qualifications of the individuals involved in producing their data and developing their policies frequently.

> The meeting brought together more than 30 technical experts and country epidemiologists from around the world to review the current processes and methodologies used by UNAIDS and WHO to produce HIV estimates at the country, regional and global level (UNAIDS, 2007e).

> Over the last eight years, estimates of HIV prevalence, incidence and mortality have been produced in close collaboration with countries, using methods developed by a reference group of internationally renowned scientists (UNAIDS, 2007e).

> UNAIDS policy guidance articulates the broad principles and standards that should inform national (state and local) policies. It is informed by evidence and best practice gathered from multiple sources and is developed through a systematic process in consultation with relevant

constituency groups (external and internal to UNAIDS and including technical and other groups) (UNAIDS, 2008c).

In late 2007, considerable changes were made to methods used in surveillance research and thus estimates of AIDS prevalence worldwide were reported as considerably lower than in previous years (UNAIDS, 2007e). This was followed by voiced dissatisfaction with the competencies of UNAIDS on behalf of some stakeholders. UNAIDS also provides large amounts of data and results of research to the public in its online Knowledge Centre and provides software to states to assist in their monitoring of epidemics. In the field, UNAIDS has also become well known as a partner of states applying for funding from GFATM which further increases their standing as an organisation with expertise, skills and information resources at its disposal. Overall, UNAIDS can be described as an organisation with a very high standing in terms of problem-solving capacity.

As described in Chapter Three, stakeholders in the global health policy field have long differed in opinion as to the best approach to take when approaching global health challenges. Comprehensive and Selective Primary Health Care are two different approaches which are often juxtaposed. The approach taken by UNAIDS moves away from this debate somewhat, and puts a great focus on prevention as a priority, and not just diagnosis and treatment. A senior staff member at UNAIDS mentioned that the Primary Health Care model is adopted by UNAIDS in part, but even PHC is essentially bio-medical approach, and therefore more relevant to debates over how to best achieve the aims of the WHO.

*Primary Health Care is a way to deal with AIDS post-infection, but we are trying to prevent.[71]

UNAIDS' approach is represented by the way it takes HIV/AIDS as a broad social and political issue. The main approach it takes is to promote the recognition of the realities of the epidemic and to encourage states to take action. UNAIDS calls primarily on states to take responsibility for health care systems and the establishment of 'Three Ones,' referring to one national AIDS action framework, one national AIDS co-ordinating authority and one agreed country-level monitoring and evaluation system (UNAIDS, 2004). As one of the main hindrances of the fight against HIV/AIDS has been lack of coordination and overlapping mandates, stakeholders, especially in epidemic and at-risk states that spend considerable

[71] Source: Interview with a senior member of staff at UNAIDS.

resources reporting to multiple donors will consider this to be an important aspect of right approach.

One drawback of UNAIDS' approach can be seen to be its narrow focus on just one disease. Criticism has been voiced that currently, too much funding has been going to HIV/AIDS to the detriment of other diseases (Garrett, 2007).

Assessing the effectiveness of UNAIDS in terms of its success in achieving positive responses to its public policy claims is a highly complex endeavour and one worthy of an entire programme of study in itself. As noted in Chapter Three however, for an organisation to be able to base its legitimacy on effectiveness and efficacy, it must be able to present itself as an organisation that is, or will be, effective, in the eyes of its stakeholders. This requires being able to demonstrate that it can influence others, demonstrate results and – considering focus on impact that many stakeholders had in their communicative acts – show that it has an impact on the challenge that it is designed to address.[72] One of the most difficult aspects of measuring effectiveness – and especially impact – is that of pinpointing who is responsible for change. If data shows that HIV prevalence is reducing, for example, it is virtually impossible to pinpoint whether this would be due to the work of WHO, UNAIDS, GFATM, or bilateral assistance programmes, or even civil society organisations. Stakeholders however, will still expect to see some evidence that UNAIDS is indeed an effective organisation, if they prioritise the principle that if an organisation is successful in solving the problems which it was created to tackle, then it provides good governance 'for' the people. Three key tasks of UNAIDS are particularly important for stakeholders' appraisal of UNAIDS in terms of this sub-component of legitimacy. First, the ability of UNAIDS to influence policies in those states that have, in the past, failed to openly discuss or address HIV/AIDS as a social and political issue. Second, the ability of UNAIDS to bring together a Unified Budget and Work plan of all HIV/AIDS activities amongst the co-sponsoring organisations. Third, the ability of UNAIDS to simplify country level processes to enable epidemic and at-risk states to address their AIDS epidemics, and make use of donated resources, more efficiently. If UNAIDS is to be judged by stakeholders to be providing good governance 'for' the people, stakeholders must perceive UNAIDS as the organisation that will most likely achieve effective results and

[72] See Chapter Four and Appendix II.

consider the achievements thus far to be desirable. Epidemic and at-risk states will, for example, be more likely to engage with UNAIDS, than the WHO's GPA:

> …only if it delivers on what it is supposed to, i.e. making it easier for the country (to address coordinate and address the epidemic.[73]

For stakeholders seeking to appraise UNAIDS based on its effectiveness, two studies are key sources of information for stakeholders: First, the results of the first independent review of UNAIDS, published in 2002, and second the report of the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (GTT), itself commissioned and published by UNAIDS in 2005. Also, since the 2006-2007 biennium, UNAIDS has developed a Monitoring and Evaluation Framework that assesses its work in terms of key indicators.[74] These reports found that UNAIDS has made considerable progress in relation to UNAIDS' policy aims in epidemic and at-risk states. It is definitely the case that more countries are adopting policies along UNAIDS guidelines.

> The functional area of advocacy has been a strength of the programme. In the context of the ECOSOC objectives 'to promote broad-based political and social mobilisation…; and to advocate greater political commitment at global and country level, including the mobilisation and allocation of adequate resources', the evaluation team judges progress to be mostly successful at global and partly successful at country level. (…) Evidence from the country studies shows that whilst global advocacy has had a marked positive influence on national policies, there remains a major challenge to influence multisectoral opinion leaders (Independent Evaluation Team, 2002, p. 41)

However, amongst several countries, there are still great barriers, even amongst highest level politicians and leaders, to recognising and publicly speaking about the realities of HIV/AIDS epidemics. One major setback occurred when states could not agree to make specific mention

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[73] Source: Interview with a senior member of staff at UNAIDS.

[74] The purpose of the UNAIDS Monitoring and Evaluation Framework is to improve results-based management and accountability, and tracking of linkages between financial investments and programmatic results. The framework examines indicators classified as 'Key Outputs' and 'Principle Outcomes'. Key Outputs are defined as results of cumulative and collaborative efforts of several co-sponsoring organisations and the UNAIDS Secretariat. Principal Outcomes are defined as changes in the AIDS response to which UNAIDS Key Outputs contribute. In all, 55 indicators are used including 1) Number of countries that perform annual or biennial reporting on the established targets for universal access on prevention, treatment, care and support; 2) International funding for prevention, treatment and care; and social mitigation and support; 3) Number of countries that report having national AIDS strategies that are multisectoral, with clear strategic priorities with action plans that are costed and budgeted; 4) Number of countries that produce complete and up-to-date data on country HIV surveillance estimates and are reporting on selected UNGASS indicators; 5) Percentage of adults and children with advanced HIV infection receiving antiretroviral combination therapy—by region; 6) Percentage of HIV-positive pregnant women provided with any antiretroviral prophylaxis to reduce the risk of mother-to-child transmission (UNAIDS, 2007f).

of men who have sex with men and drug users as specific at-risk groups of contracting HIV in the final declaration of the United Nations AIDS Conference in 2006. States that resist recognition of these groups can be seen as 'hard cases' for UNAIDS, and as a test for the extent it is accepted as legitimate amongst key stakeholders. Furthermore, only if UNAIDS is seen as legitimate in the eyes of 'hard case' states, can it expect positive reactions from them to its claims. In turn, only when UNAIDS is seen to be able to induce positive reactions from hard case states, will it be seen as legitimate in the eyes of stakeholders that prioritise effectiveness when appraising global governance organisations.[75]

Effectiveness of the achievement of goals alone is not sufficient to demonstrate good governance 'for' the people. Efficacy is required, which means that the achievements of UNAIDS must be considered desirable.

Several commentators observing UNAIDS after the release of the first independent review have expressed doubts over the ability of UNAIDS to demonstrate progress in reaching its two basic aims. Kohlmorgen concluded that rivalries between the co-sponsoring organisations have only been overcome to a limited extent (Kohlmorgen, 2004, p. 157), and especially at the country level, overlap still exists.

> The UN system's response to AIDS at country level is, at the moment, unevenly coordinated, despite the existence of the Joint United Nations Programme on HIV/AIDS (UNAIDS). In many countries, the UN Theme Group on HIV/AIDS has not succeeded in establishing a truly joint programme that includes the AIDS activities of all UNAIDS Cosponsors (GTT, 2005, p. 14).

Dennis Altman for example has labelled the coordination of the various UN co-sponsoring organisations as a near impossible task, yet praises UNAIDS' ability to influence policy in some countries.

> Yet UNAIDS is caught in a contradiction it cannot resolve: its success depends on establishing cooperation between the U.N. agencies which are its co-sponsors, where territorial claims are often more important than policy outcomes. For UNAIDS to coordinate, say, the World Bank and UNESCO is rather akin to asking a sparrow to direct a herd of elephants. Increasingly it has come to act as a focal point for international activities, providing information and contacts, and in some countries, directly influencing policy from both donors and governments (Altman, HIV and Security, 2003, p. 426).

[75] The link between effectiveness and legitimacy can thus be seen a cyclical one.

Overall UNAIDS currently receives mixed appraisal from commentators in terms of its effectiveness. However, in terms of efficacy, stakeholders generally do consider the achievements that have been made thus far to be desirable. Stakeholders will also be awaiting the second independent evaluation of UNAIDS to be released in 2009, looking for signs of progress on goals that had only been marked by limited success at the organisation's five year mark.

Buse and Walt have stated that stakeholders consider one of the advantages of global health governance organisations housed outside of the UN bureaucracy is that they are viewed as "…a way of getting things done, and where industry is involved, getting things done efficiently…" following negative perceptions of UN effectiveness (Buse & Walt, 2000a, p. 552). Can this also be said for the case of UNAIDS, which, although unique in its structure, is still essentially a part of the United Nations? Stakeholders may judge the organisational efficiency of UNAIDS based on the expenses required to run the UNAIDS secretariat, and whether its organisational structure enables rapid responses without overlap, or gaps in programming.

The purpose of UNAIDS was to reduce inefficiency within the UN system due to overlap and confusion between various projects from different UN organisations. The development of the Unified Budget and Workplan can therefore be seen as an instrument for increasing organisational efficiency. Nevertheless, UNAIDS itself invests considerable resources in coordination work. As the Unified Budget and Workplan allocates resources according to the principle outcomes, it is difficult to decipher how much funding is required to maintain the secretariat itself, and how much flows into actual programmes within countries. However, in the 2008-2009 Unified Budget and Workplan it was estimated that of almost $US 147 million in funding for UNAIDS (not including funding for co-sponsor administered programmes), just under $US 579,000 was required for 'human resources and system.

The results of the three-method study into the stakeholders' priorities and preferences when judging global health governance organisations, as presented in Chapter Four found that several stakeholders put an emphasis on good leadership in communicative acts and in response to direct questioning. It can therefore be expected that for UNAIDS leadership is a further aspect by which stakeholders appraise whether UNAIDS' is legitimate and worthy of support. UNAIDS has had the same executive director since its inception in 1996, Dr. Peter

Piot. He has become a prominent and well known leader in the global health policy field and is widely regarded as having shown good leadership.

> Under Peter Piot, UNAIDS has been able to capture some of the moral weight which Jonathan Mann gave the Global Program on AIDS, and to win significant support from both Secretary General Annan and U.S. Secretary of State Powell (Altman, HIV and Security, 2003, p. 426).

UNAIDS has also enjoyed particular support form the former Secretary General of the United Nations Kofi Annan, who often spoke of the work of UNAIDS and made it a focal point of his two terms in office. Stakeholders that look at global leaders as the basis for their judgements about which global health governance organisations are worthy of support are likely to find UNAIDS to be supported by global leaders and have a highly praised executive director at its head.

Overall, UNAIDS has received little open criticism from stakeholders and, despite slow progress in its early years now appears to have become a well established organisation with a reputation as a worthy organisation. In the stakeholder analysis which examined stakeholder positions by analysing public communication and direct questioning, it was found that a large number of stakeholders put a high emphasis on participatory governance and effectiveness (see Chapter Four). With regards to these two aspects UNAIDS only partly meets high standards such as full inclusion of non-state actors in central decision-making structures, and showing evidence of goal achievement. Thus, it may be expected that amongst a number of the legitimacy of UNAIDS may be limited. Kohlmorgen, for example, suggests that UNAIDS cannot win a great relevance in global health governance for two reasons. First, because of the system of global capitalism, the powerful, (wealthiest states) as well as the financial institutions such as the World Bank will always play a dominant role in global politics, including health policy, and are not likely to surrender any power to another organisations such UNAIDS. Second, because non-state actors have gained in relevance and power in recent years, the fact that UNAIDS does not incorporate them as voting members in their organisation structure will lead to a loss in reputation when compared with other more inclusive institutions. (Kohlmorgen, 2004, p. 141).

However, amongst stakeholders that prioritise good leadership, right approach, problem-solving capacity via the utilisation of expertise, and public governance it could be expected that UNAIDS is appraised as an organisation worthy of support. In the following section two

methods for analysing empirical legitimacy – analysis of communicative acts and survey research – will be applied to UNAIDS as a case study, to examine which aspects stakeholders do indeed focus on when appraising UNAIDS and the extent to which it enjoys legitimacy. The analysis begins with an overview of UNAIDS main stakeholders before proceeding to analyse the results of the research.

5.4 UNAIDS and its stakeholders

The primary, secondary and tertiary stakeholders of UNAIDS can be ranked similarly to those listed as stakeholders in the global health policy field in Chapter Four and can be classified along the lines of donor states, epidemic and at-risk states, civil society organisations and business sector actors. Notably, UNAIDS relies considerably less on funding from individual donors than other GHG organisations, as states which pledge funds to GFATM for example, usually donate to UNAIDS also (although much smaller amounts). Donors are nevertheless primary stakeholders. Peer organisations and epidemic and at-risk states are also important stakeholders for UNAIDS. Without good relationships with these groups, the entire purpose of having UNAIDS would be at risk. Therefore, responses of IGOs, and epidemic and at-risk states, are instrumental for judging whether UNAIDS is perceived as legitimate or not.

The relationship between UNAIDS and other IGOs within the UN system can be seen as a positive one, despite a clear reluctance on behalf of co-sponsoring organisations (including WHO) to bring together all of the resources they dedicate to AIDS projects into the UNAIDS Unified Budget and Workplan.

> Overall, the UNAIDS Programme has had a positive influence on cosponsors' HIV/AIDS agendas. HIV/AIDS has moved up significantly in their institutional priorities. However, it has not yet become part of the cosponsors core business, to the extent that human and financial resources devoted to the issue are still very limited and programme strategic management has not been effective under the current workings of the CCO (Independent Evaluation Team, 2002, p. 38).

Interviews with senior staff at UNAIDS emphasised the importance of the sub-component 'right approach', as well as the geographical balance of the membership on the UNAIDS board, as sources of legitimacy amongst co-sponsors and epidemic and at-risk states. As mentioned above, certain epidemic and at-risk states can be said to represent 'hard cases' when it comes to having their 'claims' accepted as legitimate and receiving a positive response to them. One of the most central policy 'claims' of UNAIDS is that states and state

leaders need to recognise the realities of the AIDS pandemic including its main modes of transmission. For many years, the president of South Africa refused to speak of HIV/AIDS, and if he did, failed to speak out clearly against myths regarding how HIV was spread or could be treated (Cohen, 2004, p. 2). Still, even in this country, UNAIDS as an organisation rarely receives open criticism in public debate. Although UNAIDS has received mixed responses from epidemic and at-risk states, it has managed to build stronger relationships over time. Several other indicators also suggest that UNAIDS is widely accepted as a legitimate organisation when it comes to the design of AIDS national strategies.

> According to UNAIDS country offices, 80% of countries (68 of 85) provide for the full participation of civil society in the periodic review of national AIDS strategies (UNAIDS, 2007f, p. 8).
>
> Nearly all countries (75 of 78 reporting) have a national AIDS framework, although only about half (38 of 75) of such frameworks have been translated into a costed and budgeted operational plan and/or annual action plan (UNAIDS, 2007g, p. 9).

UNAIDS keeps a focus on states as decision-makers as the main actors that must implement the fight against the disease but non-state actors are also important stakeholders of UNAIDS. AngloGold, a mining company operative in South Africa, estimated that around 12000 of their employees were HIV positive in 2004 (Cohen, 2004, p. 2) and is indicative of many business sector actors that are willing to enter into partnerships with UNAIDS and will be able to contribute greatly to addressing HIV/AIDS. UNAIDS also enters into agreements with pharmaceutical companies for reducing prices of antiretroviral medication. Civil society organisations, are, as seen in the previous chapter, a diverse set of organisations, as are the CSOs that are key stakeholders for UNAIDS.

5.4.1 Perceptions amongst stakeholders of UNAIDS' legitimacy

In the analysis of 90 published texts from a range of stakeholders in the global health policy field, almost half of the texts made specific mention of UNAIDS. Often, the organisation was not commented on, but rather cited as an authoritative source of information. Compared with the GAVI Alliance and GFTAM, many aspects of governance 'by' the people and governance 'for' the people were not (or rarely) addressed in relation to UNAIDS – with the exception of frequent mentions of UNAIDS' technical (problem-solving) capacity, and its position as a public based UN Agency.

Texts from within the stakeholder group of epidemic states often simply referred to UNAIDS as a source of information by citing data and statistics. UNAIDS was also taken as an authority to set technical standards. For example, UNAIDS is mentioned once in a text from the Government of Sierra Leone referring to a sample checklist which served as a model for quality assessment procedures. UNAIDS and WHO estimates were reproduced in a text from South Africa and taken as consistent with locally gathered data. UNAIDS technical advisory data was taken up in the text and other UNAIDS texts were also cited several times. In texts from the Governments of Botswana, Swaziland, Zambia and Zimbabwe UNAIDS was mentioned in a positive light but without giving specific reasons. UNAIDS was simply mentioned as a valuable partner, and a source of information without further comment. In one text from Lesotho UNAIDS is mentioned once as a source of authoritative information (prevalence estimates). A text from Malawi also mentions UNAIDS in the same way, stating that:

> The HIV prevalence rate among this group was estimated by UNAIDS to be 15.96 percent (Malawi Government, 2004, p. 2).

Many texts in the stakeholder group of epidemic and at-risk states referred to UNAIDS as a valuable technical assistance partner. In one text from the Government of Afghanistan UNAIDS was mentioned as a consultative partner and was also named as an organisation that helped mobilise extra resources. UNAIDS was mentioned as a technical assistance partner in texts from Cambodia, in particular for the coordination of the national M&E system. In one of the texts from Guyana, UNAIDS is mentioned as a "traditional technical partner" and their plan was said to be consistent with the UNAIDS policies, the 'Three Ones', the 3x5 Initiative and the UNAIDS Declaration of Universal Access.

UNAIDS was mentioned several times in one of the texts from Swaziland and introduced in terms of its mandate and history. For example, in the text it was stated that:

> In 1996 the Joint United Nations Program on HIV/AIDS (UNAIDS) was established and mandated with the responsibility of coordinating the global effort (Swaziland Government, 2006, p. 14).

This and other texts made a point of specifically noting UNAIDS role as a coordinating body within the UN system. UNAIDS was also mentioned as the leading agency in the global fight against HIV/AIDS and is held in high regard as indicated by the following statement:

> Under the leadership of UNAIDS in September 2003, AIDS officials, bilateral and multilateral agencies, civil society organizations and the private sector agreed on the principle of the three ones which is applicable to all stakeholders in national level responses (Swaziland Government, 2006, p. 12).

Also in texts from epidemic and at-risk states, UNAIDS staff members were acknowledged as having assisted with the preparation of several of the analysed texts. For example, UNAIDS was mentioned as having been involved in the strategy building process outlined in the text from Papua New Guinea. The effectiveness of UNAIDS in providing support was also a frequently cited reason for positive judgements. In one of the texts from Pakistan, UNAIDS was mentioned as providing support for the development of the National HIV/AIDS Strategic Framework. In one of the texts from Nigeria, UNAIDS was also mentioned as a source of funding and assistance, and as the organisation that devised the base-plan for their budget framework.

In the text from Belize UNAIDS was referred to in terms of its policies and in a positive light. For example, the text states that: "Belize has embraced this level of commitment and seeks to adopt the principles proposed and endorsed by UNAIDS titled the 'Three Ones'.

Amongst texts from the stakeholder group of OECD-DAC member states, UNAIDS statistics were often cited. On many occasions texts in this stakeholder group referred to aspects of governance 'for' the people. For example, in the texts from the Government of Germany UNAIDS and WHO were mentioned as the primary organisations that increased the number of AIDS patients receiving antiretroviral treatment. UNAIDS was labelled a 'leading agency' and its 'Three One's' policy was also mentioned in a positive light.

> The most important organisation in coordinating international efforts to stem HIV/AIDS is UNAIDS. Additional efforts to dovetail international activities took the form of the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) as a financing instrument which opens up additional options for action at international level, to complement the existing activities of bilateral and multilateral donors (German Federal Ministry for Economic Cooperation and Development, 2005, p. 44).

UNAIDS was also described in terms of elements of governance 'by' and 'for' the people in statements from the Government of the USA, referring to the organisation in terms of its UN sanctioned mandate and its right approach.

Other texts from the stakeholder group of OECD-DAC member states, addressed UNAIDS in several ways: first, as an authoritative source of statistics and epidemiological data; second, as a standard setter; and third, as having the potential to play a coordinating role. For example in the texts from the Government of France UNAIDS was mentioned in terms of its projections for funding required to fight AIDS and given authority in this regard. Increased support for UNAIDS and WHO for combating AIDS and other transmittable diseases was also advocated. In one text from the USA, the formation of donor coordinating groups for strategic information that address surveillance, monitoring and evaluation, by WHO and UNAIDS was mentioned in a positive light. The United States Government stated in one text that it will actively participate in these groups beginning with adoption of the WHO and UNAIDS guidelines on the construction of core HIV indicators.

On some occasions, texts in this stakeholder group referred to aspects of governance ‘for’ the people. In one text from Ireland, both UNAIDS and WHO were mentioned in a very different light than the GAVI Alliance and GFATM. WHO and UNAIDS were mentioned as multilateral agencies that should invest more resources for technical assistance. The role that UNAIDS played in commissioning the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors was considered vital for the coordination of global efforts. In the other text from Ireland it is stated that it is a strategic focus to:

> Engage in policy dialogue with WHO, UNFPA, UNICEF and UNAIDS through their governance structures and formal bilateral consultation (Irish Aid, 2007b, p. 25).

Furthermore, IrishAid listed one criterion in its decisions whether to fund UN Agencies as:

> …commitment to coordinate with other multilateral and bilateral agencies especially as part of pooled funding arrangements in partner countries and in support of country coordination under UNAIDS (Irish Aid, 2007b, p. 24).

This reference indicates that UNAIDS is considered to have an important and legitimate purpose. In texts from the Netherlands WHO and UNAIDS were also both noted positively in terms of their perceived effectiveness:

> Thanks to support from the WHO and UNAIDS, the number of people in developing countries with access to treatment with AIDS medication has increased to more than 2 million people in 2006 (Netherlands Ministry of Foreign Affairs, 2007).

In one text from the Government of Norway, UNAIDS was portrayed as the central multilateral partner in HIV/AIDS efforts. Most of Norway's economic support for HIV and AIDS efforts was channelled through multilateral organisations in the UN system such as UNAIDS and its co-sponsoring organisations. Strengthening UNAIDS was mentioned as a goal and the UNAIDS prevention strategy was named as a guiding policy.

One of the texts from Sweden contained a high number of positive references to UNAIDS. The text cited UNAIDS data, mentioned fruitful discussions with UNAIDS and made frequent mentions of the 'Three Ones' policy. Data also showed that a large amount of funding was dedicated to UNAIDS. UNAIDS is mentioned in an authoritative light in terms of its data and estimates in texts from the UK. However, there was criticism of UNAIDS together with other UN bodies over, duplication, overlap and competition between agencies which led to inefficiencies.

In texts from the USA, GFATM, UNAIDS, the World Bank and others were all mentioned as actors that: "…have vital contributions to make to the work of saving lives in the field" (PEPFAR, 2007, p. 9). UNAIDS was also described in terms of elements of governance 'by' and 'for' the people, with a clear focus on evidence of effectiveness in the following statement:

> This results-based structure includes 16 principal results for UNAIDS as a whole, and 49 key results for individual UNAIDS cosponsors, cooperative interagency efforts, and the Secretariat. This multi-agency, results-based, and all-voluntary budget is unique within the UN system and should result in more effective services and assistance from the UN system in support of national HIV/AIDS responses (PEPFAR, 2007, p. 195).

WHO and UNAIDS were taken as authoritative with regard to data and the approval of technologies and interventions. This is indicated by stating that:

> The Emergency Plan is also ready to adapt new prevention technologies once clinical trials are complete and guidance from a normative agency, such as the World Health Organization (WHO) or UNAIDS, is available (PEPFAR, 2007, p. 31) .

UNAIDS was also said to be:

> ...at the forefront of efforts to implement management reforms and increase accountability within the UN system (PEPFAR, 2007, p. 195).

Texts from CSOs rarely mentioned UNAIDS. In the text from the International Community of Women Living with HIV/AIDS and the IHAA, data from UNAIDS was presented and taken as an authoritative source and positive (legitimating) statements were made, without a specific reasoning attached. The text from TASO was the only one in the CSO stakeholder group that contained more extensive comments on UNAIDS. In that text UNAIDS was taken as an authoritative source of data and its estimates were cited. UNAIDS is also mentioned in terms of its efforts to reduce AIDS drugs prices, and its promotion of "…the integration of HIV/AIDS in national development issues" (The AIDS Support Organisation, 2002, p. 14). WHO and several other UN agencies were also mentioned in terms of their AIDS efforts. The text from ActionAid contained both praise and criticism of UNAIDS. UNAIDS was mentioned in the context of the web of connections between ActionAid and other organisations. The text suggests that CSOs are underrepresented in the UNAIDS Monitoring and Evaluation Group, although ActionAid did state that they are proud to be one of the few CSO representatives there.

UNAIDS was only mentioned a few times in texts from business sector actors. In the text from Anglo American, the UNAIDS web address is listed for further information, but UNAIDS itself is not mentioned in the text. UNAIDS statistics were cited in the text from Merck & Co. and mentioned, together with WHO, UNICEF, UNFPA, and the World Bank in the context of the Accelerating Access Initiative (AAI). Pfizer mentioned both WHO and UNAIDS as partners in the development of medicines for HIV/AIDS and UNAIDS statistics are also used in the text from Sanofi.

Overall, the texts demonstrate that UNAIDS is valued for its problem-solving capacity, for having the right approach and for its UN sanctioned mandate. The text analysis not only indicated which norms, values and principles stakeholders choose as yardsticks by which to judge GHG organisations, it also offered an indication of the extent to which a GHG organisation is accepted as legitimate overall.

In texts where a GHG organisation, such as UNAIDS is mentioned frequently, a high proportion of de-legitimising statements over legitimising statements can be taken as an indicator of a low level of legitimacy. If negative (de-legitimising) statements dominate, it would be possible to speak of a legitimacy crisis (Schneider, Hurrelmann 138; Reus Smit 2007). However, if positive references, or legitimating statements dominate in texts, this can

be taken as a sign of the organisation being taken as legitimate. Also, frequent mentions of an organisation in a neutral or highly technical manner can be taken as an indicator of the organisation being "taken for granted".[76] A high proportion of neutral statements can therefore also be interpreted as a sign that the organization is taken as legitimate. Table 5.1 shows the proportion of positive to negative references to UNAIDS in the examined texts.

Table 5.1: Perceptions of the legitimacy of UNAIDS in stakeholder texts

Stakeholder Group	Total references to UNAIDS in texts	Proportion of references that were neutral	Proportion of references that were positive (Legitimating Statements)	Proportion of references that were negative (De-legitimating Statements)
All Texts	251	49%	47%	4%
OECD-DAC member states	127	37%	56%	7%
Epidemic and at-risk states	90	66%	34%	-
CSOs	20	49%	46%	5%
Business Sector Actors	8	38%	62%	-

Overall, UNAIDS is portrayed overwhelmingly positive in the texts, which indicates that it is considered legitimate. A large number of references made in the texts were also neutral, especially in texts from epidemic and at-risk states, indicating that UNAIDS enjoys legitimacy to the level of 'taken for grantedness'.

The extent to which UNAIDS enjoys being taken as legitimate in the eyes of its stakeholders was also investigated by means of direct questioning. Tertiary stakeholders, each affiliated with, and thus influencing, primary stakeholders were ask how they regard UNAIDS generally. The results broadly correspond with those of the text analysis, with UNAIDS enjoying high levels of approval amongst most respondents. The results of the survey showed that UNAIDS was held in the highest regard amongst experts associated with OECD-DAC member states

[76] Suchman (1995) distinguishes between 'moral' and 'cognitive' legitimacy, the former being legitimacy resulting from judgements based on values, norms and beliefs, the latter being a state of acceptance that comes automatically.

In response to direct questioning there was broad agreement amongst the respondents on many issues regarding UNAIDS. The remainder of this section summarises the results of the expert survey administered to respondents from a range of stakeholders, in which responses were expectedly somewhat more critical than formal positions published in texts.[77]

Table 5.2: Rating of UNAIDS amongst stakeholders[78]

Stakeholder Group	Held UNAIDS in high or very high regard	Held UNAIDS in Medium Regard	Held UNAIDS in Low or Very Low Regard
All Respondents	66%	26%	8%
OECD-DAC member states	79%	16%	5%
Epidemic and at-risk states	60%	27%	13%
CSOs	58%	31%	11%
Associations of PLWHA	62%	29%	9%
Business Sector Actors	63%	33%	4%

In terms of which sub-components stakeholders prioritised when make judgements about UNAIDS, public governance, participatory governance and effectiveness were all considered very important. Regarding the crucial element of effectiveness, and specifically the impact of UNAIDS, the vast majority of respondents were of the opinion that UNAIDS needs to make and demonstrate progress in terms of changing political attitudes and policies concerning AIDS, and show decreasing infection rates and mortality, in order to prove its worth. There was also agreement that UNAIDS is already an effective organisation, and that CSOs should have a place on the UNAIDS Programme Coordinating Board.

While respondents definitely considered aspects of governance 'for' the people to be important when assessing UNAIDS, in the survey stakeholders put a higher focus on aspects of governance 'by' the people. A particularly important aspect was UNAIDS' UN sanctioned mandate and the involvement of representatives from non-state actors, specifically representatives of people living with HIV/AIDS. There was disagreement on whether

[77] For an explanation of the survey methodology, see Appendix III.

[78] Based on results from 173 responses. Complete results on file with author.

representatives from the business sector should also have a place on the UNAIDS PCB, and while there was agreement that PLWHA should have voting rights at PCB meetings, the stakeholder groups of public interest CSOs and Associations of PLWHA contained more respondents that were of this opinion. Results of the survey also showed that UNAIDS was considered to be somewhat less transparent and open to criticism than GFATM and the GAVI Alliance. Also, a few respondents were of the opinion that it would have been better to strengthen the WHO's Global Programme on AIDS rather than create UNAIDS and just over half of the respondents stated that UNAIDS had high overhead costs as a UN Agency.

Additional comments made by respondents were balanced between addressing aspects of governance 'by' and 'for' the people. Regardless of whether the stakeholder expressed criticism or praise for UNAIDS, it appears that both dimensions of legitimacy were considered relatively equally important when given the opportunity to comment specifically on how they regard UNAIDS.

In making reference to aspects of governance 'for' the people one respondent from the group of business actors was critical in stating that:

> *UNAIDS has achieved far less than it could in HIV/AIDS. Particularly compared to how fast the Global Fund moved. UNAIDS has not been able to capture the world's attention on AIDS, something they should be able to do given they are a UN agency dedicated to the disease. Their messages have been weak and have not pushed people into action (Comment from a senior member of staff at a non health product/service related company).

However, for the most part, respondents directly praised UNAIDS, for example by stating that:

> *UNAIDS was very important for the fight against AIDS and working toward reducing discrimination (translation, original comment in Spanish) (Comment from an office holding member of an Association of PLWHA).

One respondent affiliated with a government department of an OECD-DAC member state stated that:

> *UNAIDS is taking the question in the right direction by showing that the problem is a problem for the whole of society. This is good because normally one disease programs are destructive to public health (Comment from a senior member of staff at an OECD-DAC state development agency).

Comments on UNAIDS referred far more frequently to aspects of representation, participation, transparency and other aspects of good governance 'by' the people, than was the case with GFATM or the GAVI Alliance (See Chapters Six and Seven). One extensive comment (from a respondent affiliated with a government department in an OECD-DAC member state) focused on describing the extent of participation in the UNAIDS decision-making body.

> *UNAIDS is a small lean organisation, primarily established to coordinate the UN's response to HIV. It plays an extremely effective advocacy role and has developed policies and guidelines that have been used around the globe. At present NGOs and PLWA sit on the board (the only UN board to do this). This is currently being reviewed to make them equal participants with the member states. Private sector participation is also being reviewed, with suggested involvement of the philanthropic foundations (i.e. Gates). No voting takes place in the UNAIDS board (Comment from a senior member of staff at an OECD-DAC state development agency).

Some respondents praised the participatory make-up of the UNAIDS PCB while a small minority found UNAIDS to be closed, elitist and troubled by the dominant politics of a few states. For example one respondent wrote that:

> *UNAIDS should diversify the people they call for consultative meetings and advocacy encouraged (Comment from an office holding member of an Association of PLWHA).

In contrast, one respondent affiliated with a business sector actor wrote that:

> *UNAIDS has a major role to play because of the leadership that Peter Piot and his team have demonstrated over the years, their success is due in part because of the role they play within the UN system, but it also depends on their ability and track record of bringing other actors from civil society into the game. UNAIDS has demonstrated a bold willingness to work closely with the private sector on tackling the manifold challenges of HIV/AIDS (e.g., their leading role in establishing and maintaining the Accelerating Access Initiative), despite the opposition -- tacit or explicit -- of others in the UN family -- and to the benefit of people living with HIV/AIDS worldwide (Comment from a senior member of staff at a health product/service based company).

Others explicitly stated that the domination of one actor in terms of UNAIDS' funding has blocked the capacity for other actors to contribute to UNAIDS governance with a detrimental effect on its effectiveness.

> *UNAIDS, though formed with good intentions and having been credible, sometimes and many times (has been) toothless. This is because it heavily relies on funding from some states like the U.S. and UNAIDS has to go by what U.S. wants and on its own conviction. Hence it is ineffective. The way UNAIDS is funded needs to be reviewed. Secondly the staffing is limited more especially at country level and hence can't perform to the expectations. Thirdly UNAIDS

> many times can't challenge the member states so it leaves a lot to be desired (Comment from an office holding member of an Association of PLWHA).

Another respondent added a comment along similar lines, criticising the United Nations system more broadly (and UNAIDS as a product of it) because of the dominance of certain states in both funding and policy-making. The respondent preferred global health governance based on expertise and technical evidence.

> *What do you expect from the United Nations? Acknowledgements of the rights of women or homosexuals? The UN can only get by on compromise agreements that satisfy all the member states, that's why we need organisations like the WHO who can often be a bit more forceful, and the Global Fund who can do what is right because it is the right thing to do, unfettered by fundamentalist dogma that stands in the way of evidence based work (Comment from an office holding member of an Association of PLWHA).

Comments were also made on the importance of rules and regulations that allows for structured policy-making. For example one respondent wrote that:

> *Rules for the election of NGO reps to UNAIDS should be strict, but no stricter than the rules that apply to business reps or other members (Comment from an office holding member of a CSO based in an OECD country).

> *There are lots of reasons for NGOs to be on boards, not just because (some citizens) are not represented by their governments. Formal decision-making is important for both short and long term projects (Comment from a senior member of staff at an OECD-DAC state development agency).

Finally, one respondent rejected outright the idea that non-state actors should have a formal role in the decision-making process of an organisation that is part of the United Nations.

> *UNAIDS is a UN structure. I think it should represent its member states. It is very difficult to see how a representative selection of NGOs and PLHAs could be formally involved in its governance. But they should of course be consulted formally (Comment from a senior member of staff at an OECD-DAC state development agency).

5.5 Outlook: The future of UNAIDS

This chapter has applied methods for empirically assessing the legitimacy of global governance organisations to the case study UNAIDS. It has been found that UNAIDS enjoys a high level of acceptance amongst stakeholders in response to 'claims' in the form of

policies, and is generally held in high regard. However, the legitimacy of UNAIDS has been limited in the eyes of some stakeholders, in particular some CSOs and Associations of People Living with HIV/AIDS that prioritise participatory governance and perceive UNAIDS as an organisation that does not offer adequate access and rights to civil society actors.

Nevertheless, in most cases it has become possible for UNAIDS to demonstrate to stakeholders that it is an organisation worthy of support, because stakeholders prioritise various norms, values and principles that correspond with the work of UNAIDS.

While some stakeholders maintain that the public base of UNAIDS is both necessary and desirable, many stakeholders praise UNAIDS' approach. One important factor stands out for UNAIDS that overshadows some criticisms over its ability to provide both participatory or effective governance, is its technical and problem-solving capacity. Communicative acts and responses to direct questioning show that UNAIDS is held in very high regard as an organisation with a high level of expertise. A congruence occurs between these priorities of stakeholders and the characteristics that the organisation itself displays.

Chapter Six

Case Study - GFATM

Inclusive governance with focus on efficacy

In the year 2002 a new global health governance organisation came into existence that has become the subject of much attention in global public health and global governance disciplines alike. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was formed to collect and distribute funds for projects addressing the three named diseases in developing countries.

GFATM has received a high level of attention for at least three reasons: First, never before has a health organisation outside of the UN system disposed of such large amounts of financial resources. From the beginning of 2002, when the Fund began operation, to end of 2007, over $US 9500 million was contributed to GFATM, an amount greater than the combined programme budgets of the WHO during the same time period (GFATM, 2008b; World Health Organisation, 2005)[79]. Over 40 states as well as several private donors[80]

[79] By the end of Round Seven, which was completed in 2007, grants totalling just over $US 6047 million had been disbursed to projects in various countries. By the end of 2007, donors had contributed over $US 9087

contribute funds to GFATM and over 120 state-level groups – or recipients – have received funds since its inception. Second, GFATM boasts a highly inclusive decision-making structure that appears to encompass principles of cosmopolitan democracy, despite its operational focus on states. GFATM is sometimes described as a multi-lateral organisation, and sometimes as a public-private partnership. GFATM frequently mentions its inclusiveness when publicising itself as both 'unique' and 'innovative'. Third, it has been claimed that the governance and operational structure of GFATM was designed to allow for the tight control of donated funds by means of performance monitoring, even within a multilateral setting. The fund has therefore also been publicised as an organisation that takes a managerial approach to global health.

These three basic observations raise several questions for analysis, three of which will be addressed in this chapter: What are the consequences of having a global organisation that has so many resources at its disposal that is based on principles other than intergovernmentalism? How do stakeholders respond to this organisation? Do they consider it to be legitimate?

This chapter begins with a description of the unique defining elements of the political environment in which GFATM acts, including a brief overview of the various other options open to stakeholders that are seeking to address the global challenges of AIDS, tuberculosis and malaria. This is followed by a brief overview of GFATM's scope and operations. The chapter then proceeds to analyse GFATM in terms of the nine-sub-components of legitimacy as described in Chapter Three, from the point of view of stakeholders; thereby addressing the questions: What evidence is there that GFATM satisfies criteria to make it a worthy organisation in terms of legitimate governance 'by' and 'for' the people? What might stakeholders conclude about GFATM when looking at the available evidence? Finally, the chapter proceeds to examine the relationships between GFATM and its stakeholders, asking who its primary stakeholders are, and how these stakeholders respond to GFATM both in communicative acts and in response to direct questioning.

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million, some of which is yet to be disbursed. Total financing of the WHO for the biennium 2002-2003 was just over $US 2236 million, for the biennium 2004-2005, it was just over $US 2 824 million and for the biennium 2006-2007 just over $US 3 313 million, as cited in the relevant WHO Proposed Programme Budgets.

[80] Private donors include the Bill & Melinda Gates Foundation, donors to the United Nations Foundation, for-profit companies participating in the 'ProductRed' Donation scheme, Debt2Health and the Communitas Foundation.

Several primary resources are available to stakeholders seeking to assess GFATM. Currently, an independent review of GFATM's performance at its five-year mark is being performed – which addresses areas such as organisational efficiency and effectiveness, the success of the partnership system and impact (Macro International, 2007a). Results relating to GFATM's organisational efficiency are already available as are the results of an internally conducted stakeholder survey. In the next few months (second half of 2008) results of a review of GFATM's impact is due to be published. Although GFATM has often been the subject of editorials in key journals from medicine and health sciences, relatively few secondary analyses are available. Exceptions include analyses of the accountability structures within the fund (Bartsch, 2002) broad analysis of indicators of effectiveness (Brugha et al., 2004). explanations of its founding history (Edele, 2006) and comparisons of the levels of financial resources at the disposal of GFATM, PEPFAR and the World Bank's Multi-Country AIDS Program (Bernstein & Sessions, 2007). Several reviews and critiques prepared by and for stakeholders have also emerged over the past 5 years (ICASO, 2004; Oxfam, 2001; Global Fund Working Group, 2006; Copson & Salaam, 2005). In addition several independent studies commissioned by GFATM itself are publicly available, which provide valuable resources for stakeholders wanting to gather more information on GFATM. These documents as well as interviews with stakeholders of GFATM and senior staff members working at the Fund provide the source material for the sections 6.1 and 6.2 of this chapter.

6.1 Background: GFATM engaging in governance

Although GFATM is set up as a funding agency and the organisation is commonly introduced as a "financial instrument, not an implementing agency" (Poore, 2004), it can also definitely be described as an organisation that engages in global governance. The collection and distribution of funds is an inherently political activity that requires GFATM to set priorities, develop problem-solving strategies and then make certain 'claims' regarding the desirable behaviour of other actors that it wants to engage with to realise its aims. Three key types of 'claims' made by GFATM are particularly relevant for its role as a global governance organisation. First, GFATM makes claims regarding the desirable behaviour of resource rich actors. By making requests for funds and publicising which actors have the capacity to contribute the necessary resources to 'make a difference,' GFATM effectively declares their expectations on OECD-DAC member states and other potential donors.

Second, GFATM makes claims regarding desirable behaviour of actors who actively participate in the health policy field on the global level. GFATM effectively declares its expectations about how global health challenges should be addressed, by setting priorities in terms of what should be funded and how much funding should be allocated to which disease; and in relation to which treatments, and which prevention oriented activities are considered relevant.

> The Global Fund was created in a context where specific demands were made by a range of stakeholders regarding both what needed to be done to address three world pandemics and how it should be done (or perhaps not done) (Macro International, 2007a, p. 4).

Third, GFATM makes claims regarding desirable behaviour of state and local level health workers and managers. GFATM creates standards for funding distribution systems within states, requests that certain governance procedures should be in place when setting national health priorities and requires that certain standardised procedures are followed to report the results of funded programmes.

Therefore, although GFATM publicises that it is guided by technical aspects of financial management, just as the WHO publicises that it is guided by biomedical knowledge, it is clear that GFATM is indeed an organisation that engages in governance. Stakeholders must decide whether, or to what extent, they accept the claims made by GFATM, and such decisions will, at least in part, be based on their assessment of GFATM as a worthy, and legitimate, organisation. Any decision on behalf of stakeholders to engage with the GFATM is therefore inherently political, as, for most, other options for addressing AIDS, tuberculosis and malaria are available to stakeholders, just as the option exists, not to prioritise addressing these health challenges at all. OECD-DAC member states for example set priorities for foreign aid in terms of what aid funds should be spent on and how it should reach its target. States might choose to channel funding directly to programmes via bi-lateral aid, while others might prioritise funding the political and normative activities of the WHO. A brief overview of the various options discussed in the years leading up to the creation of GFATM also demonstrates that originally there were considerable differences in priorities amongst stakeholders when it came to what type of organisation, if any, should collect and distribute funds for health projects on the global level. Although GFATM can be seen as a new organisation without any predecessor, (as opposed to UNAIDS and the GAVI Alliance), several options were debated amongst donor states in the lead up to the establishment of the Fund, including a trust fund

within the World Bank. At least two major donors present at the founding of the GFATM expressed preference for maintaining a World Bank fund rather than creating a new organisation (Bezanson, 2005, p. 13).

By the late 1990s it had become clear that the global health situation was worsening for a large part of the world's population and that AIDS, tuberculosis and malaria epidemics were increasing in developing countries. This was despite the availability of new bio-medical breakthroughs that should – at least technologically – have made it possible to greatly reduce the impact of these diseases. Many considered inadequate funding the major obstacle to confronting these global health challenges. In 2001 Kofi Annan declared that funding of around $US 7000 to 10000 million per year would be required to address the worsening AIDS pandemic (Annan, 2001). It had also become clear that the AIDS pandemic had been exacerbated by frequent co-infection with tuberculosis and/or malaria. There was an increase in the number of cases of tuberculosis in the 1990s, in particular through multi-drug resistance that had evolved due to incomplete treatments. Anti-malarial drug and insecticide resistance had also been increasing for several years

In the year 2000 health targets featured prominently in the list of Millennium Development Goals set by the United Nations. This was combined with pronounced calls for more action and money from private and public sectors. Around this time, several OECD-DAC states were already working on an alternative mode for global health funding, to be located outside of the UN System.[81] In January of the year 2000, HIV/AIDS was discussed as a topic in the UN Security Council adding to the high focus placed on HIV/AIDS at around this time in global politics, a level of attention also deliberately lifted on the agenda by the then Secretary General Kofi Annan. HIV/AIDS was also an official topic of discussion at the International Labour Organization in that same year and was one of the main issues addressed at the G8 Summit in Okinawa in July 2000, with agreement amongst the participating states that concrete action needed to be taken to address the problem of resource shortages in global health. A follow up conference in Okinawa in December 2000[82] resulted in a proposal to form a new partnership for funding health with a similar structure to the then freshly formed Global Alliance for Vaccines and Immunization (see Chapter Seven). Out of this grew the 'Ottawa

[81] For example, in August 2000 a proposal was put forward to the UN Congress for the establishment of a World Bank AIDS Trust Fund (Copson & Salaam, 2005, p. 2).
[82] International Conference on Infectious Diseases, held in Okinawa in December 2000.

Initiative' – with a proposal for a multi-lateral fund to fight diseases such as HIV, tuberculosis, malaria, reproductive health, and childhood cluster diseases. At the same time a second proposal was being developed by what is known as the 'Italy Group'[83]. This group called for a health trust fund to be managed by the World Bank in close cooperation with the WHO (Poku, 2004, p. 104). A quite different idea to that of a public-private partnership along the lines of the GAVI Alliance. The 'Italy Group' proposal would maintain a very public character and be located firmly within the United Nations system, while the Ottawa Initiative had proposed a partnership in which non-state actors would act with full decision-making rights.

During a G8 health experts meeting held in March of 2001 experts from states such as Germany, USA, France and Japan initially expressed opposition to the creation of a new independent organisation, instead leaning towards a funding mechanism within the UN system. However, at the conclusion of the meeting a mode was proposed that was closer to a public-private partnership model than an intergovernmental entity.[84] This proposal then served as a basis for an agreement to establish GFATM. Within months, the proposal had been 'announced' and 'proposed' several times by various groups and leaders, including Kofi Annan at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in April 2001; George W. Bush at a White House ceremony in May 2001; UN Member states at the UN member states at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in New York in June 2001; and by G8 members at the G8 Summit in Genoa in July 2001. CSOs also expressed approval for the new fund.

> The 2001 Social Summit in Puerto Allegré called for "Global support for global action through a global fund to defeat AIDS, malaria and tuberculosis". At the same time Médecins Sans Frontières was awarded the Nobel Peace Prize and called for the creation of a new global trust fund to confront the AIDS epidemic (Bezanson, 2005, p. 7).

The precise governance and operational structure of GFATM was settled upon by the Transnational Working Group – composed of representatives of state and non-state actors. Finally, GFATM began operation in January 2002, officially as a non-for-profit foundation registered in Switzerland, with an organisational structure clearly separated from the United Nations system, albeit with close ties to several UN organisations. The formation of GFATM

[83] Italy held the presidency of the G8 during this year.

[84] The proposal stemming from this meeting was known as the 'Genoa Trust Fund for Healthcare', for a summary see Edele (2006).

was an inherently political process resulting in an inclusive organisation with a specific scope, focus and organisational structure. All of these aspects provide a basis for stakeholders to make judgements when assessing GFATM.

6.2 Aims, scope, and operations

GFATM has all of the key features that define it as a GHG organisation, including, most importantly, engaging in governance on the global level. It also has key characteristics such as a high level of organisational sophistication – setting it apart from other project-based public-private partnerships, active managerial follow-up as a means to ensure compliance and a high level of investment in legitimation strategies (See Chapter Two). Below, these and other aspects of GFATM will be examined in terms of the nine-aspects of legitimacy that were laid out in Chapter Three. The focus will be on GFATM governance and activities on the global level as global level structures reflect the core principles that the organisation as a whole is based on. However, first, the scope and operations of GFATM in terms of how it interacts with state-level structures that are established specifically to fulfil GFATM requirements are outlined. Many GFATM activities are indeed focused on establishing, strengthening and supporting health funding and implementation on state levels.

GFATM is not only unique due it its governance structure, but also, because in the past there has been no other organisation with the specific purpose of funding AIDS, tuberculosis and malaria programmes in developing states, while not assisting with the implementation of the projects that are funded.[85] GFATM operates by means of rounds of calls for proposals for funding and the granting of funds to successful applicants. Proposals for funding must be submitted by pre-organised in-country partnerships known as a Country Coordinating Mechanisms (CCMs), which ideally encompass state and non-state actors and are responsible for dividing responsibilities for implementation, administering funding (the so called Principle Recipient) and overseeing grant implementation within countries (GFATM, 2007a, p.12). The desirability of the CCM requirements have been debated within and outside of GFATM since

[85] The By-Laws of GFATM clearly state the purpose of the organisation is to: "attract, manage and disburse resources through a new public-private foundation that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals established by the United Nations" (GFATM, 2007b, p.2).

its inception (Redelet, 2004). Today, various CCM 'models' exist within the various states that have received grants.[86]

CCMs apply for funds by submitting proposals that fit GFATM guidelines as closely as possible. The GFATM Secretariat performs an initial screening of proposals which are then forwarded to a Technical Review Panel, composed of experts that act in an individual capacity (Brugha et al., 2004, p. 95). The Technical Review Panel assesses each proposal for its chance of successful performance and categorises proposals on a scale of 1 (ready and appropriate for funding) to 4 (not appropriate for funding). Only proposals categorised as 1 or 2 are put up for approval by the Board. Funding approved by the Board will be transferred from the World Bank (which acts as Trustee to GFATM) directly to the Principle Recipient.

Reviews of proposals should be based on technical quality and the design of projects should be locally based. Although there is no strict quotas on how much funding should be dedicated to which disease, grants to projects for HIV should include prevention activities, grants for malaria projects should include increasing access to insecticide treated bed-nets and TB projects should have a focus on DOTS (Direct Observed Treatment, Short Course). To ensure that funding is used as declared in proposals, audits are conducted by so called Local Funding Agents within each country. The GFATM designates who is to carry out these audits, and they are often private consultancy firms such as PricewaterhouseCoopers and Crown Agents but also sometimes UN Agencies such as the United Nations Office for Project Services (AVERT, 2007). Reports from audits as well as progress reports from CCMs are used to assess whether funds will be continued or suspended, with the decision being formally made by the GFATM Board. Several grants have been suspended during the history of GFATM, most notably grants to Uganda which were suspended after audits revealed financial irregularities, to Myanmar, which were suspended when severe mobility restrictions prevented aid workers from implementing tasks in the field and the Ukraine where corruption within the CCM was suspected.[87]

86 In guidelines for the establishment of CCMs it is stated that: "The membership of the CCM should comprise a minimum of 40 % representation of the nongovernment sectors such as NGOs/community based organizations, people living with the diseases, key affected populations, religious/faith-based organizations, private sector, academic institutions" (GFATM, 2008f, p.4).

[87] Later, funding was reinstated in the Ukraine with an NGO as a sole recipient of funds. In Uganda funding was reinstated after action was taken against those responsible for misspending funds within the Ministry of Health.

Because GFATM deliberately does not involve itself in implementation, yet sets standards in its proposals for funding, potential recipients are required to perform tasks either independently, or with the assistance from other external organisations, that GFATM 'claims', or requires, they should undertake. The WHO, UNAIDS, and several development agencies are often active within countries setting up proposals and carrying out projects with GFATM grant funds to ensure that requirements, e.g. reporting requirements are met.

GFATM is thus a GHG organisation with the capacity to set 'claims' regarding how much funding should be spent on fighting AIDS, tuberculosis and malaria, who should contribute, how states should organise the allocation of such funds, and what performance targets need to be met in order to receive more funding. All of these types of 'claims' stem from an organisation based on principles other than intergovernmentalism. On what basis might stakeholders judge GFATM to be a worthy organisation to make such claims? If stakeholders were to appraise GFATM on the basis of the questions laid out in Chapter Three, how might they view GFATM in terms of its legitimacy?

6.3 Basis for the legitimacy of GFATM

6.3.1 Governance 'by' the people

Stakeholders that prioritise public governance when judging whether a global health governance organisation is worthy of support will ask whether those involved in decision-making are representatives of sovereign states, and whether there is a fair level of representation of all citizens.

Stakeholders will find that the main (most numerous) actors involved in the central decision-making roles at GFATM are states, and, similar to UNAIDS, structures are in place to ensure that both developing as well as developed states are represented. Intergovernmental organisations are also represented in central decision-making structures although they have different roles to those of states. These three factors may indicate that GFATM does entail a high degree of public governance.

The central decision-making body of GFATM is the Foundation Board,[88] which is responsible for setting the policies and strategies of GFATM, setting operational guidelines and budgets for the Secretariat and Technical Review Panel, making funding decisions, setting criteria for and appointing Technical Review Panel members, and coordinating with external actors amongst other tasks. Formal meetings take place twice a year. Quotas for membership on the Foundation Board are laid out in the GFATM By-Laws. In all, the Foundation Board is composed of 20 rotating voting members, which includes seven representatives from developing countries, based on each of the six World Health Organisation regions and one additional representative from Africa,[89] eight representatives from donor states, and five representatives of non-state actors. In reality, states are classified along more narrowly defined constituency groups. Four non-voting members are also present, three of which are intergovernmental organisations as well as a Swiss citizen as required by law. The IGOs with non-rotating membership on the Board are the World Health Organisation, UNAIDS and the World Bank.

The structure of the GFATM Foundation Board (henceforth, the Board), has evolved over time by means of the right of membership groups to organise their own rules of procedure for electing Board members. Now, each Board member is accompanied by several other persons, which make up what is called a delegation, consisting of an Alternate, a Communications Focal Point, and up to twenty other delegates. While only the official Board member has voting rights, delegate members can, and often do participate, in Board meetings. The organisation of Board membership into delegations has also had the effect that Board membership amongst representatives of states has come to rotate within much smaller regional groupings. On the side of 'recipients' each delegation represents one the following regions: 1) Eastern Europe; 2) Eastern Mediterranean; 3) Eastern and Southern Africa; 4) Latin American and the Caribbean; 5) South East Asia; 6) West and Central Africa; and 7) Western Pacific. On the 'donor' side each delegation represents one of following static groupings of states: 1) European Commission, Belgium, Finland and Portugal; 2) France and Spain, 3) Germany, Canada and Switzerland; 4) Italy; 5) Japan; 6) Point Seven (Norway, Denmark, Ireland, Luxembourg, Netherlands, Sweden)[90]; 7) United Kingdom and Australia

[88] The Foundation Board is named as such because GFATM is officially registered as a Foundation under Swiss law.

[89] The six WHO regions are: Western Pacific, Americas, Africa, Europe, South-East Asia and the Eastern Mediterranean.

[90] Despite being called 'Point Seven' only six countries are in this grouping (GFATM, 2008g).

and 8) the United States of America. The fact that representatives from donor states outweigh representatives from recipient states is a notable fact. Furthermore, amongst states that donate funds, several states have come to have a de facto permanent place on the Foundation Board, including Italy, the USA and Japan, as their delegation does not include any other states.

Amendments to the By-Laws in 2004 created the extra, eighth, seat for 'donor' states and granted voting rights to the representative of Communities of People Living with the Diseases. This change can be seen to have further exacerbated the imbalance between donor and recipient states, which has been criticised by some stakeholders on the grounds that there are far more states that receive funds from GFATM than donate to it, and far more citizens living in states that have, or are at risk of developing HIV/AIDS, tuberculosis and malaria epidemics than there are citizens of states that donate funds to GFATM. Thus, advocates of public governance might claim that it would be more appropriate for epidemic and at-risk states to outweigh donor states on the GFATM Board, especially considering the fact that GFATM is stated to be based on a demand-driven model (GFATM, 2006a, p. 5). In all however, the level of rotation amongst representatives of states on the Board has been high, with 51 countries having held positions either as Full (voting) Members or as Alternates or as Communication Focal Point members.

GFATM is arguably the largest and most prominent global organisation that allows civil society full participation rights in its decision-making processes. The organisation itself frequently publicises this fact and has attempted to set itself apart, even from other GHG organisations, in terms of the extent to which it is based on principles of participatory governance.

> Although some organizations like the GAVI Alliance and UNAIDS through its Program Coordinating Board (PCB) already had a member representing civil society on their boards, no international funding institutions at the time had civil society playing such an integral role in governance both at the Board and at the country level. This involvement has influenced the way the international community considers democratic processes in the context of responding to the three diseases. The uniqueness of this structure should not be underestimated, as in many countries individuals are acquiring a powerful voice for the first time (GFATM, 2006b, p.19).[91]

[91] In contrast, a recent independent review of GFATM organizational effectiveness found that: "Some Board members also noted that the "uniqueness" argument has been overplayed; that the new models of development are all more like the Global Fund, which reflexively means it is less unique" (Macro International, 2007, p. 12).

Several features of GFATM indeed indicate a strong participatory governance base. First, as mentioned above, five of the 20 voting members of the Foundation Board are held by civil society representatives. These are broken down into the following constituencies: 1) a CSO from a developing country; 2) a CSO from a developed country; 3) a representative of Communities Affected by the Diseases; 4) private foundations and 5) the private sector (here referring to business sector actors). With one quarter of the voting members thus being non-state actors, the level of formal non-state participation in GFATM is higher than in any other global level health organisation. Furthermore, non-state actors have held positions as Chair and Vice-Chair of the Board, with the position of Chair currently being held by the representative from the private (business) sector and the Vice Chair from the representative of developing country CSOs.

As is the case with UNAIDS, each CSO constituency represented by a member of the Board is responsible for creating its own procedures for nomination and selection membership. For example, the Board Member that serves as the representative of Communities Affected by the Diseases, as well as the Alternate, is chosen from a pool of 20 persons that make up the delegation of communities of person's living with the diseases. This delegation is further divided into core and support delegation members who are chosen by means of an nomination process that also has geographic, gender and disease quotas (GFATM, 2006b, p. 20). The selection of the representative of business sector actors functions quite differently. The Global Business Coalition to Fight AIDS, Tuberculosis and Malaria (GBC) serves as the Communications Focal Point for the entire business sector actor delegation, providing considerable funds, management and coordination services for this member of the Board.

The extent to which the five non-state actors truly embody principles of participatory governance is debatable in terms of two factors, first, the extent to which non-state actor members can represent the interests of those not adequately represented by states and second, the extent to which the representatives on the Board act in the interests of persons most affected by the policies and activities of GFATM. There has been scepticism as to whether it is justified that the private (business) sector hold a seat on the Board, because to date, very few resources have been donated by business sector actors. Furthermore, rotation of membership amongst some delegations, most notably the private foundations has been limited, with the Bill & Melinda Gates foundation having almost always been represented on the Board. While the formal principles and structure are attune to participatory governance, in

reality the extent to which the goals of participatory governance have been fulfilled is questionable.

Stakeholders that prioritise fair process when appraising GHG organisations such as GFATM consider whether power differentials between represented groups are balanced out, whether decision-making is formalised and organised in such a way that it discourages 'posturing', and whether all formally included representatives have the resources available to fully participate in decision-making. For example, stakeholders may ask whether CSO delegations actually have enough resources to participate to the same extent as the business sector actor delegation which has the resources of the GCB behind it.

Stakeholders will find that decision-making procedures of the Foundation Board are laid out in the Board Operating Procedures which were last amended in 2007. It contains several measures to ensure that all Board Members have the opportunity to fully participate in decision-making. One of three in-person meetings per year takes place in a developing country, on a rotating basis. Meetings should not go over two days and meetings may take place in the form of teleconferences or email conferences. Although meetings are conducted in English, if requested, simultaneous interpretation into any UN language will be made available for delegates. Costs for attending meetings are reimbursed for Board members from CSO delegations and developing country representatives (up to three persons per meeting) (GFATM, 2007c, p.11).

The formal documents laying out the Board operating procedures state that all decisions should be reached by consensus if possible, however, any voting member may call for a vote. Voting protocol divides the members into two groups, the first consisting of donor states as well as the representatives of private foundations and business sector actors. The second group consists of the developing states as well as the CSO delegations. A two thirds majority from both groups is required for a successful passing of a motion.

Overall the level of cooperation, attendance and openness in discussion has been rated highly by independent assessments of GFATM. Nevertheless, since changes to the by-laws in 2006 the Board that added the requirement that the Board should meet 'as often an necessary', the resources required to fully participate in GFATM decision-making has markedly increased,

with one independent assessment stating that the information processing capacity of the Board had 'reached saturation' (Macro International, 2007a, p. 20).

> This is particularly the case for non-English speaking members and for some constituencies without ready access to reliable (and high speed) internet services. In addition, the recipient delegations are particularly frustrated that they cannot formulate appropriately detailed positions (Macro International, 2007a, p. 22).

In terms of indirect participation, GFATM has a policy of transparency in its governance and operations, and indeed the organisation provides access to a very large amount of information about the everyday operation of the organisation as well as formal decision-making procedures. It is also an organisation that has been very responsive to criticism. Stakeholders that prioritise this aspect will tend to ask: How can stakeholders express disapproval of decisions of GFATM? What documents from the organisation are available? Do stakeholders have access to comprehensive information?

GFATM demonstrates a remarkably high level of access to the organisation via indirect participation and open debate about shortcomings of the organisation. Three key factors demonstrate this: First, the high level of access to documentation via its website; second, participation opportunities to all interested citizens in public forums; and third, frequent independent assessments and response to critique. Despite some criticism that the process for the appointment of the second Executive Director of GFATM (which ran through 2007) was not transparent, a stakeholder survey, conducted by GFATM in 2005 to 'prioritize issues for the five-year evaluation' asked stakeholders to rate various attributes of the fund, with 'Transparent sharing of Information' being rated the highest.[92] This view was also reflected in the results of the expert survey, to be discussed in section 6.4.1.

[92] In an online survey conducted by GFATM in 2006 respondents were asked to rate GFATM in terms of performance aspects of the organisation. Although stakeholders were not directly asked to rate the governance structures of the fund, several key aspects relating to legitimate governance –'by' and 'for' the people were included. The topics to be rated were: Focus on funding for proven and effective interventions against HIV/AIDS, TB and malaria; Funding is based on achievement of measurable results; Finding a balanced approach to prevention, treatment and care/support; Supporting programs that reflect country ownership; Transparent sharing of information; People affected by the three diseases are reached by programs receiving Global Fund support; Complementarity of Global Fund grants with national programs; Improved efficiency in program implementation through performance-based funding; Independence of technical review process for proposals; Inclusion and participation of communities and people living with/affected by the three diseases in CCMs; Strengthening of the partnerships between government and civil society; Alignment of Global Fund grants with national health systems; Efficiency in disbursing funds; Mobilizing of new financial resources; Effective strengthening of health systems capacity through grants for the three diseases; Effectiveness of technical support through partners for proposal preparation; Flexibility in use of funds to support programs;

Creating a thorough overview of all the documentation from GFATM would be a large (and highly worthwhile) project. What sets GFATM apart from other organisations on the global level (state, intergovernmental, and private), is the type of information that is available to the public on its website. In a recent study by Bernstein and Session on the amounts of funds provided to AIDS projects and how these funds are spent, GFATM was the only organisation that provided detailed expenditure data.

> Data availability varies by funder. PEPFAR does not provide disbursements data disaggregated by country. The World Bank and PEPFAR do not publicly release expenditure data for their recipients. The Global Fund does provide such expenditure data… (Bernstein & Sessions, 2007, p. 1).

In fact, anyone with internet access can follow the progress and detailed spending activities of in-country projects that use GFATM funds. Furthermore, not only are recipients required to operate transparently, but detailed information is available on spending for the Secretariat and other GFATM internal bodies as well.

Governance procedures at GFATM are also highly transparent, contact information of all members of the Board and Communication Focal Points are available online, as well as all preparation material for upcoming Board meetings.

In 2004 the Partnership Forum (PF) was introduced into GFATM's governance structure as an avenue for allowing further participation for those without access to Board delegations. Thus far, PFs have taken place in 2004 and 2006 and currently a third is underway. The objectives of the PF are said to be to review and provide feedback on the progress of the GFATM; to develop recommendations on GFATM strategy, policy and practice; and mobilise and sustain political commitment (GFATM, 2008c). The primary mode for external participation that is made possible via the PF is the Online Forum which is open to all interested persons for several months – provided they have internet access. Anyone can post contributions on broadly set topics for publication on the forum website during this time. The PF then culminates with consultations on set themes at various meetings during the PF year and a

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Quality of the technical review process for proposals; Alignment of Global Fund monitoring requirements with national monitoring and evaluation systems; Effectiveness of technical support through partners for; grant implementation; Effectiveness of the Local Fund Agent (LFA) model for financial oversight; Priority given to most-affected and at-risk countries/communities; Mobilization of private sector resources (Technical Evaluation Reference Group, 2006).

stakeholder meeting for invited participants, held in developing countries. It represents a very broad mode of participation.

A final indicator that GFATM is transparent and open to criticism is the extent to which it has commissioned and published the results of independent reviews on almost all aspects of the operations and governance of the organisation. Stakeholders have access to information on a variety of topics including summary and analysis of the various statistics and results of meetings in the Board Meetings and Committees. For example, stakeholders can easily find information such as feedback from civil society representatives on the Board regarding Board operations and procedures (ICRW, 2004), critiques on gaps in performance reporting (GAO, 2005; GAO, 2007) and indeed even the opinions of other stakeholders on various performance indicators (Technical Evaluation Reference Group, 2006). GFATM itself publishes performance updates on a monthly basis. In addition, several organisations and networks have been established with the purpose of monitoring the GFATM and providing more detailed information about how GFATM works and what its effects are. The CSO Aidspan was created with the mission to serve as a watchdog of GFATM and releases regular newsletters containing information about GFATM as well as publicising issues that arise during regular interviews with secretariat staff, members of the Board and stakeholders on state and global levels (Rivers, 2008). Another is the 'The System-Wide Effects of the Fund (SWEF) Research Network', which has published several studies on the extent to which GFATM and its funded projects effect health systems within states (Bennett & Fairbank, 2003; Stillman & Bennett, 2005). Importantly, GFATM provides free access to staff and information for such watchdog groups.

In addition to all of these various modes of external participation and access to information, probably the most significant feature of GFATM is the willingness of staff and Board members to speak openly and frequently with stakeholders and external groups that seek to evaluate the organisation, about virtually any aspect of the Fund and its operations, and its preparedness to frequently review and adjust governance processes.

Overall, stakeholders that prioritise external participation via transparency and access to information will find GFATM performs well in terms of legitimate governance 'by' the people. However, despite its highly sophisticated decision-making processes and participation of a wide range of stakeholders, in terms of public governance via representation of states

some stakeholders may be concerned about the imbalance of representation of donor states compared to epidemic and at-risk states.

6.3.2 Governance 'for' the people

Stakeholders that seek to appraise GFATM in terms of the extent to which it fulfils a legitimate purpose will pose the questions: What does the organisation aim to do 'for' the people? Is it necessary, and desirable for a specifically formed global organisation to take on this task?

GFATM was formed with the specific purpose to increase the number of resources available for in-country projects to address HIV/AIDS, Tuberculosis and Malaria. As global pandemics have causes and effects that reach across state borders, globally organised efforts are clearly required to meet this challenge. However, some stakeholders may still doubt the need to have an organisation independent of existing structures to fulfil this aim. For such stakeholders, the ability of GFATM to demonstrate that it rates highly in terms of other aspects of good governance 'for' the people, such as problem-solving capacity, approach, effectiveness, efficacy and organisational efficiency will be important to demonstrate that the creation of GFATM as a new entity is still worthy of support, despite the fact that it is still possible to have developed programmes within the WHO, or provide funding via a special programme at the World Bank (See Chapter Three).

The extent to which GHG organisations demonstrate a high level of problem-solving capacity as a sub-component of governance 'for' the people, can generally be judged by asking whether the organisation can be seen to make use of experts and expertise in policy-making processes and provide evidence that they are likely to be successful in achieving their aims. Stakeholders may ask whether decision-making is based on scientific evidence, whether the organisation employs – or otherwise engages with – competent staff and/or consultants and whether it partners with other actors with relevant technical expertise. Three aspects of GFATM demonstrate a high problem-solving capacity albeit with some problems in everyday operations. First, the role of the Technical Review Panel, second, the role and competencies of staff at the Secretariat, specifically the Fund Portfolio Mangers and third, the level of partnering with other organisations that provide technical assistance to fund recipients.

As a GHG organisation that primarily manages funds for health projects, expertise in the field of financial management and public health policy are to be considered essential for problem-solving capacity. Within GFATM the Technical Review Panel (TRP) is responsible for reviewing grants and proposals and categorising them according to 'technical merit'. GFATM's TRP consists of 35 members selected for their expertise in the field, including a balance of experts in fields of HIV/AIDS, tuberculosis and malaria. Of the TRP members that were responsible for reviewing Round 8 proposals around half are trained medical doctors, with others having high levels of training and experience in health and social sciences. This can be considered a positive base for a high level or organisational expertise. The Foundation Board makes decisions on whether to approve grants based primarily on the recommendations of the TRP. Central GFATM decision-making structures can therefore be categorised as being firmly based on expertise. Once grants have been approved it is the role of staff at the Secretariat, in particular the Fund Portfolio Managers, to coordinate assessments of fund recipients, and provide support for monitoring and evaluation reporting requirements. Each fund recipient is allocated one specific Fund Portfolio Manger, and the competence and level of expertise of these staff members can be considered an essential indicator of GFATM's problem-solving capacity. There has been some criticism of the performance of Fund Portfolio Managers in recent assessments of the Fund, including a lack of clarity in what role they actually play, inexperience and a high turnover (Macro International, 2007a, p. xxiii; Rivers, 2008, p. 15). Finally, the problem-solving capacity of GFATM can also be judged on the extent to which it has been able to engage with and encourage other organisations to assist with the implementation of projects and the development of funding proposals. As GFATM provides funds on an application only basis – meaning that they do not directly approach potential recipients – a considerable amount of preparation work needs to be undertaken by applicants. Several UN Agencies, including UNICEF, WHO and the UNDP have agreed to work with developing states as they prepare their grant applications (Heijn & Heijn, 2008).

This approach of being only a funding agency and not participating in any level of implementation of technical assistance is one of the major discussion points when it comes to the extent to which GFATM is accepted amongst stakeholders on a global level. Stakeholders that put a focus on right approach will ask: How does GFATM go about achieving its aims? Does the approach embody principles that promise achieving desired effects?

Alongside the usual debates over whether programmes designed to address one or a few diseases (vertical programmes) are desirable, the approach of GFATM, limiting its role to that of a funding agency only, is also debated amongst stakeholders. While it does set requirements for successful grants, GFATM deliberately steers clear of providing any assistance in implementing its funded programmes, or designing health projects. This means that there are no GFATM staff members present in recipient countries, and GFATM staff are expected to abide by the principle that GFATM is a financing instrument only – and thus refrain from providing technical assistance (GFATM, 2002, p. 1). This lies in stark contrast to other health assistance programmes that operate either bi-laterally – such as PEPFAR – or multi-laterally, such as health projects run by UNICEF or WHO. Some stakeholders have called for changes to this system, citing it as the greatest weakness of GFATM (Heijn & Heijn, 2008; McCarthy, 2007; Global Fund Working Group, 2006, p. 12; Hruska, 2004).

However, GFATM has made progress in regard to other aspects that can also be considered part of taking right approach, in particular encouraging national ownership, finding balance between funding for prevention and treatment programmes as well as contributing to a strengthening of health systems via funding for AIDS, tuberculosis and malaria projects (McCarthy, 2007, p. 307).

Despite effectiveness and efficacy being notoriously difficult to measure precisely, they are nevertheless two key aspects of governance 'for' the people that stakeholders give high priority to. This was shown in the results of the empirical analysis into the legitimacy of GHG organisations as presented in Chapter Four, and was also a result of GFATM's own stakeholder survey, conducted in mid 2005.[93] Data relating to GFATM's effectiveness is available in the form of numerous statistics relating to performance goals that are regularly published by GFATM, especially in the lead up to so called 'replenishment meetings' where potential donors meet to discuss the funding requirements of GFATM. If differentiating between outputs, outcomes and impacts when assessing GFATM effectiveness then stakeholders will ask: What effect did the organisation have on the actions of other actors in the policy field? What procedural indicators of success are there? Has there been an effect on infection and treatment rates?

[93] In the GFATM 360° Stakeholder Survey, 86% of respondents rated the attribute 'People affected by the three diseases are reached by programs receiving Global Fund support' as very or extremely important, making it the attribute considered most important of all amongst stakeholders (Technical Evaluation Reference Group, 2006, p. 9).

As GFATM submits grants on a performance basis, many statistics are available on defined key indicators such as amounts of funds disbursed, distribution of grants to recipients and the rated performance of grants. An important statistic in terms GFATM's success is the number of epidemic and at-risk states that are applying – and successfully applying – for grants, as well as the number of states that donate to the fund. By the end of its first year of operations, GFATM had approved 56 proposals for funding, this increased rapidly to 224 proposals one year later. The number of approved grants has increased more slowly since then, but the number of states that work to comply with GFATM guidelines is certainly very high (Bezanson, 2005, p. 11). In terms of changes in behaviour on the side of donors, overall health focused aid spending has increased significantly over the past few years (Garrett, 2007). In 2005 an independent assessment of GFATM found that:

> According to the best available calculations … the Global Fund accounted in 2004 for roughly 20% of the global expenditure on HIV/AIDS and for 50% and 45% for tuberculosis and malaria, respectively. Even allowing for a considerable margin of error, these percentages make clear the fact that the Global Fund has become a principal force in the fight against HIV/AIDS and the leading force against malaria and tuberculosis (Bezanson, 2005).

Important outcome indicators for the fund include the number of people that have received antiretroviral treatment since the Fund's inception, how many are receiving counselling and testing services, how many tuberculosis patients are receiving the DOTS treatment, how many malaria patients are receiving artemisinin-based combination drug treatments and finally how many insecticide treated bed nets have been distributed. GFATM uses three of these indicators: DOTS treatments, bed-net distribution and ARV access in frequent performance updates and highlights them on their website.

> 770,000 people have received antiretroviral (ARV) treatment for HIV. Two million people have been treated with effective tuberculosis medication. 18 million insecticide-treated bed nets (ITNs) have been distributed to protect families from malaria (GFATM, 2008d).

Statistics provided by the fund and cited in independent assessments do show considerable progress and effectiveness on behalf of GFATM. Some statistics however will be doubted or at least scrutinised more closely by stakeholders that strongly prioritise this aspect. Impact indicators are especially difficult to interpret. As of June 2008 GFATM boasts on its website that: "More than 1.8 million people are alive today thanks to efforts in 136 countries supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria" (GFATM, 2008d). However, information about methods used for calculating such statistics is more difficult to

come by. An independent assessment from the year 2005 summarised the methods used by GFATM in reaching such totals. In summary, statistics were calculated by taking the numbers of known patients receiving treatments under programmes funded by GFATM and applying them in mathematical models that calculate survival rates based on medical knowledge about chances of survival or prolonged life by means of those treatments. Impact statistics are particularly problematic because impacts on the three diseases varies significantly from country to country which is strong evidence that GFATM alone has little impact without complementary state-level policies and implementation. More detailed and comprehensive analysis of the real impact of GFATM is scheduled to be released late in 2008 as part of the 5-Year Evaluation. However, even this research is limited in its capacity.

> This approach recognizes that, in many countries, the Fund is not the single major international investor. As a financial instrument, any discernable impact that would be produced will only be accomplished through partnerships with multiple actors, including the country itself. Therefore, the impact evaluation sets out to assess overall impact on the three diseases and the contribution of the Global Fund without direct attribution (Macro International, 2007b, p. A2)

One aspect of GFATM's governance 'for' the people which has been highly publicised is its lean organisational structure. In terms of organisational efficiency GFATM can boast very low overhead costs. This has had two effects. First, GFATM can be seen as an organisation that is highly efficient in terms of funds disbursed. A comparison with other global health financing institutions showed that GFATM required considerably less staff members than other organisations to channel the same amount of funds. Overall, GFATM requires less than 3 percent of annual commitments for central administration and management of GFATM each year (GFATM, 2008e).

> Bilateral institutions like USAID and DfID reportedly disbursed respectively 1.3 and 1.5 million (US$) per staff; The World Bank, 2 million US$ per staff. Citigroup—a private banking institution—disbursed 1.8 million US$ per staff. And the two highest comparables were private foundations (Bill and Melinda Gates; and the Turner Foundation) with disbursements at respectively 4.3 and 4.4 million US$ per staff. With 1.3 billion US$ disbursed in 2006 and a staff size of 257 at the end of December 2006, the Global Fund continues to disburse a very favorable 5.1 million US$ per staff employed. (Macro International, 2007a, p. 48).

Second, GFATM works with so few resources that on some occasions staff shortages occur and available staff are unable to be flexible in taking on extra tasks that can contribute to improved performance. This has meant that some recipients of funds hire extra staff of their own, or consultants to ensure the success of grants. The number of tasks that GFATM takes

on is limited, not only by its principle of remaining a financing, and not implementing agency, but also by self imposed resource constraints.

> The GF is far and away the most complicated funder that I have ever dealt with (even more so than the EU). It is so complex that it has spawned an industry of expensive consultants with far too much power over the recipient organizations, even though their role is merely to manage the Fund's highly specific technical details (Quote from a letter from a CCM member in southern Africa as quoted in Rivers (2008, p. 17)).

In summary, GFATM has been able to provide large amounts of information to stakeholders to demonstrate that it is; firstly, a necessary organisation; secondly, has a high problem-solving capacity; and third, is able to provide evidence of effectiveness. Stakeholders that scrutinise GFATM in terms of its ability to provide good governance ‘for’ the people based on available data will find plentiful evidence of this, however, stakeholders that place a high value on certain sub-components such as effectiveness and efficiency might express some doubt over the accuracy of data.

6.4 GFATM and its stakeholders

Like all GHG organisations, GFATM acts in a political environment in which it builds relationships with primary, secondary and tertiary stakeholders. Primary stakeholders of GFATM – those directly addressed by GFATM policies and those that will directly affect GFATM if they withdraw support – can be distinguished along three lines, first, actors with the potential to contribute resources to the fund, primarily in the form of donated funds, including OECD-DAC member states as well as private donors; second, actors that receive funds from GFATM, primarily epidemic and at-risk states, but also other actors, such as civil society organisations that work in endemic regions; and third, actors that provide technical assistance to other stakeholders to ensure the successful performance of fund grants. Intergovernmental organisations are particularly important as a third type of actor.[94]

GFATM itself has made attempts to gather and analyse its reputation amongst stakeholders in a survey that it conducted in 2005. They distinguished between seven categories of stakeholder which were: recipient governments, civil society organisations, academic institutions, the private (business sector), donor governments and foundations, multilateral organisations, and bilaterally run health projects. The results of this survey found that some

[94] Intergovernmental organisations are not included in the empirical analysis summarised here.

stakeholders consistently give lower ratings for the overall effectiveness of the GFATM's partnership system: namely those working with IGOs or donor governments. Overall however, the results of the internally administered survey were that the vast majority of stakeholders rated the overall reputation of GFATM highly (Technical Evaluation Reference Group, 2006, p. 16).

6.4.1 Perceptions amongst stakeholders of GFATM's legitimacy

In the analysis of 90 texts from a range of stakeholders, it was notable that a large number of texts from the stakeholder group of epidemic and at-risk states made mention of GFATM. In many cases, mentions found in texts from epidemic and at-risk states portrayed GFATM in a generally positive light, mentioning the organisation as a provider or partner, but without including any specific reasoning about why GFATM should be held in high regard. Several texts did however contain legitimating statements suggesting that effectiveness played a role in viewing GFATM positively, as in one of the texts from Swaziland, in which it was stated that "…many developing countries are benefiting…" from GFATM (Swaziland Government, 2006, p. 11). Mention was also made of GFATM's ability to mobilise funds (Belize National AIDS Commission, 2006, p. 48). Although legitimating statements in texts from this group contained very few negative evaluations of GFATM, several issues of difficulty were mentioned including doubts over the reliability of getting approval for funding, and difficulties in satisfying set criteria (Malawi Government, 2002, p. 42; Zambia National HIV/AIDS Council, 2006, p. 54).

Legitimating statements found in texts from OECD-DAC member states positively evaluated GFATM in an overwhelming majority of cases. Several of the texts contained specific sections or 'text boxes' dedicated specifically to GFATM. Patterns of legitimation contained references to both aspects of governance 'by' the people and 'for' the people; most frequently the inclusiveness of GFATM, as well as its potential effectiveness, but also CSO participation, and state representation. The speed of GFATM in granting funds as well as its success was also noted (French Ministry of Foreign and European Affairs, 2006, p. 26). A typical example can be found in one text from Germany, in which GFATM was described in detail by focusing on aspects of participatory governance in praising the organisation.

> The strength of this new funding instrument compared with other bi- and multilateral organisations is that all relevant actors (donor and recipient countries, representatives of affected persons, non-governmental organisations from North and South, private foundations and the

> private sector) determine, in a joint process, strategies to provide support for countries requiring assistance in combating HIV/AIDS, tuberculosis and malaria (German Federal Ministry for Economic Cooperation and Development, 2007, p. 23).

Another typical example was a text from MINBUZA (the Dutch aid agency) which was said that they support partnerships for the reason that they are effective.

> With help of the Dutch contribution to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFTAM), the Fund was able to spread 18 million bed nets for malaria prevention. This will lead to about 370,000 cases of under-five mortality being prevented over the next 3 years (Netherlands Ministry of Foreign Affairs, 2007).

Several other texts in this group also made mention of both GFATM and the GAVI Alliance in terms of the amount of resources they have raised. GFATM was mentioned often in texts from the USA and was said to represent a unique model. It's inclusiveness was emphasised by stating that GFATM:

> …encourages and relies upon partnerships among governments, civil society (including community- and faith-based organizations), international organizations, bilateral and multilateral contributors, the private sector, and affected communities (PEPFAR, 2007, p. 190)

One of the texts from the United States included a one-page 'special focus' on GFATM. The Fund was said to have a "unique potential" to be an effective actor and its potential to "revolutionize" the provision of assistance (United States Global AIDS Coordinator, 2004, p. 57). Several characteristics of GFATM were portrayed as important including: Board activities, Secretariat responsibility, result orientation, accountability and coordination with other actors. GFATM was introduces as:

> …a new way of doing business, bringing together diverse partners, including the public and private sectors, donors and recipients, and CSOs and affected communities, to quickly and effectively mobilize resources for combating HIV/AIDS and the other two diseases (United States Global AIDS Coordinator, 2004, p. 50).

GFATM was also mentioned in terms of its potential outputs, by stating that:

> The Fund is a promising global force in the fight against AIDS and offers important opportunities to address needs complementary to other elements of this strategy (United States Global AIDS Coordinator, 2004, p. 57).

The texts from the Government of Ireland were among the few that contained both praise and criticism of GFATM. A focus was on aspects of governance 'for' the people, with one text stating that thanks to GFATM… "(t)housands more people have received antiretroviral treatment for HIV/AIDS" (Irish Aid, 2007a, p. 2).

Also, in another text from the Irish Aid agency, both the GAVI Alliance and GFATM were praised for their effectiveness:

> (T)hey are playing a significant role both in expanding access to existing interventions and services and in supporting research and development of new drugs and vaccines (Irish Aid, 2007b, p. 26).

However, country-level processes set up to comply with GFATM requirements, and the way that GFATM interacts with them were criticised, along with problems of overlap and vertical approach. This was one of few texts to specifically contain negative statements about GFATM. GFATM and the GAVI Alliance are said to:

> …have yet to become well coordinated at international level and being mainly single-focus initiatives do not foster an integrated approach to addressing the MDGs. Furthermore their top-down, vertical approach imposes high transaction costs and makes it difficult to harmonise global initiatives with country led programmes (Irish Aid, 2007b, p. 26).

Few CSOs mentioned GFATM specifically in legitimation statements. Unlike in the case of UNAIDS, mentions of leadership were also not found – an aspect given priority by several CSOs in legitimating statements evaluating other governing organisations. In the legitimation statements that were made, often a pattern of legitimation (or reason for judgement) was missing. Instead, the texts just included general positive statements suggesting that that GFATM was a worthy organisation. In several instances GFATM was simply mentioned as a worthy partner, but not commented on further. In texts from CSOs that did evaluate GFATM somewhat further, legitimating patterns generally made reference to effects. For example, in the text from TASO it was stated that:

> The fund seeks to mobilize and disburse additional resources to combat the above-mentioned diseases and seeks to scale up proven and effective interventions through working with public institutions, private and nongovernmental organisations (The AIDS Support Organisation, 2002, p. 14).

In texts from business sector actors, GFATM was only mentioned infrequently. When it was, it was generally evaluated positively, and with reference to its effectiveness. For example GFATM was introduced in a positive light as a funding mechanism in the text from GlaxoSmithKline

> Welcome new funding is coming through from the Global Fund to Fight AIDS, TB and Malaria, the Gates Foundation, PEPFAR (The US President's Emergency Plan for Aids Relief) and others – but funds are still inadequate (GlaxoSmithKline, 2006, p. 19) .

Table 6.1 below, demonstrates that overall, GFATM enjoyed a high proportion of positive (legitimating) statements, over negative statements. Compared with UNAIDS however, there seems to be less neutral statements. Stakeholders tend to justify their judgements more frequently.

Table 6.1: Perceptions of the legitimacy of GFATM in stakeholder texts

Stakeholder Group	Total references to GFATM in texts	Proportion of references that were neutral	Proportion of references that were positive (Legitimating Statements)	Proportion of references that were negative (De-legitimating Statements)
All Texts	337	39%	55%	6%
OECD-DAC member states	227	34%	59%	7%
Epidemic and at-risk states	86	54%	42%	4%
CSOs	26	38%	54%	8%
Business Sector Actors	7	43%	57%	-

The results of the survey administered to experts affiliated with various stakeholders of GHG organisations showed broad agreement amongst the respondents on several aspects of GFATM, including that GFATM is an appropriate organisation and a better alternative than a normal World Bank trust fund. When asked how they regard GFATM generally, results were also overwhelmingly positive (see Table 6.2).

Table 6.2: Rating of GFATM amongst stakeholders

Stakeholder Group	Held GFATM in high or very high regard	Held GFATM in Medium Regard	Held GFATM in Low or Very Low Regard
All Respondents	64%	30%	6%
OECD-DAC member states	61%	34%	5%
Epidemic and at-risk states	79%	14%	7%
CSOs	59%	29%	12%
Associations of PLWHA	63%	28%	9%
Business Sector Actors	60%	37%	3%

There is also wide belief that the Fund will be effective in the future and that its successes to date makes the GFATM worthy of support; indicating a strong leaning amongst the experts towards making elements of good governance 'for' the people a basis for their confidence in GFATM. Respondents also considered it very important that GFATM bring about decreases in mortality (has an impact) in the near future and keep its policy focus on state capacity. In all, aspects of governance 'for' the people were given greater attention and importance than aspects of governance 'by' the people. However, responses to a specific question on the GFATM Board indicated that, when asked directly, most respondents still considered the composition of the GFATM Board to be an important aspect.

Indicative of the high emphasise put on governance 'for' the people, especially problem-solving capacity, several respondents commented on the inclusion of non-state actors in terms of their potential to contribute expertise.

> *The Global Fund, while still a work in progress, is already making an important impact in the fight against the three diseases. One of the strongest factors in its success to date has been the intimate involvement of NGOs, the private sector and the public sector in all aspects of its operation. To the extent that it continues to draw on the complementary expertise of all actors in implementation of its programs, the Global Fund will see even greater success in the future (Comment from a senior member of staff at an OECD-DAC state development agency).

> *Business sector involvement must be to advise, using expertise available in international business, but not to manipulate for individual company gain or to pressurise political change in

countries to allow greater business access (Comment from a senior member of staff at a non-health product/service based company).

Governance 'for' the people was also the focus of a large number of respondents commenting on right approach. However, in terms of this aspect, GFATM received quite some criticism. GFATM's ability to demonstrate that it is a transparent organisation, open to external participation, was then the reason why respondents stated that it was still worthy of positive evaluation anyway.

*While we don't fully agree with the disease project approach we appreciate the flexibility and the transparency of the GFATM. We would most appreciate the possibility of GFATM to provide support to the strengthening of the health care services! (Comment from a senior member of staff at an OECD-DAC state development agency).

In terms of governance 'by' the people, respondents generally considered GFATM to be transparent and gave a high priority to this aspect when they evaluated GFATM, with the exception of some respondents from the stakeholder group of Association of PLWHA, most of whom held neutral position with regards to this aspect. Quite a high number of respondents from the stakeholder group of Associations of PLWHA commented on a lack of participatory avenues for stakeholders to become involved in the GFATM. There were also divergent views amongst the respondents in regards to whether aspects of governance 'for' the people, specifically an inclusive Board, was more or less important than effectiveness. Overall, both were rated as important when considered separately. Stakeholder groups also tended to disagree somewhat on the appropriateness of business sector and NGO participation in decision-making on GFATM Board, despite a clear majority in all groups welcoming their participation. In relation to this aspect, one respondent from the stakeholder group of business actors stated that:

*Important to remember that private sector representation on boards can cover both suppliers of products to be used in the fight against the disease and also employers of people affected by the disease (Comment from a senior member of staff at a health product/service based company).

Overall however, respondents expressed opinions that indicated that GFATM is received as a organisation that embodies principles, norms and values associated with almost all of the sub-components of legitimacy laid out in Table 3.3. Only with regards to right approach, have a notable number of stakeholder expressed negative opinions.

6.5 Outlook: The future of GFATM

The Global Fund to Fights AIDS, Tuberculosis and Malaria is arguably the best known and most discussed of all GHG organisations, and it is therefore the subject of much scrutiny in the public discourse. This has meant that although GFATM enjoys a high level of acceptance amongst stakeholders, positive responses to its 'claims' and is generally held in high regard, criticism is often voiced over several of its operational and organisational aspects.

An assessment of the characteristics of GFATM show that while it has maintained a public-governance base, the organisation has also incorporated a elements of participatory governance into its governance structure to a high degree. It is also an organisation that has displayed effectiveness, efficacy, transparency and problem-solving capacity. The application of empirical research methods to infer stakeholder's priorities when it comes to assessing GFATM has shown that despite a considerable amount of very specific criticism, stakeholders tend to prioritise these aspects when evaluating GFATM and this has made it possible for GFATM to be perceived as a legitimate organisation. There is a perceived congruence between the priorities of GFATM's stakeholders and its organisations characteristics. It has been found that of all the organisations examined as case studies in this dissertation, GFATM has the broadest base on which its legitimacy may be built in the eyes of its primary stakeholders and GFATM's legitimacy is based on several of the sub-components of the two dimensions of legitimacy governance 'by' and governance 'for' the people.

GFATM's primary stakeholders especially prioritise participatory governance as a sub-component of governance 'by' the people and effectiveness – specifically impact – as a sub-component of governance 'for' the people when assessing whether GFATM is legitimate and worthy of support. In particular stakeholders with the potential to donate funds evaluate GFATM in terms of both of these dimensions of legitimacy. GFATM has shown that it delivers on its goal to collect and distribute funds, and therefore display a high level of efficacy, despite some operational problems. Importantly, a wide range of political communities are involved in GFATM's governance with full decision-making rights. In addition, possibility of external participation, via transparency, open forums and a willingness to discuss and make reforms has allowed GFATM to build relationships with its stakeholders based on recognition of its legitimacy.

Chapter Seven

Case Study – The GAVI Alliance

Expertise and Effectiveness

The GAVI Alliance, formerly known as the Global Alliance for Vaccines and Immunisation was formed in the year 1999, (formally launched in the year 2000) with the aim of improving vaccine access for children in developing countries, specifically countries with a GDP per capita of less than US$ 1000. It has become well known as one of the first large scale GHG organisations which also served as a base-model for other global organisations for health, including GFATM (Jacobs, 2001; Brugha, Starling, & Walt, 2002). Key features of the GAVI Alliance include: its central decision-making body, with seats allocated to various types of (state and non-state) actors; its focus on achieving narrowly defined outcomes in a specific health issue-area; and managerial follow-up in the form of working closely with epidemic and at-risk countries to ensure compliance, all of which make it a typical – even model – GHG organisation. However, of all the three case studies examined in this dissertation, since its inception the GAVI Alliance has evolved to become the organisation that has shifted furthest away from intergovernmentalism towards basing its work on principles of managerialism. As the organisational structure of the GAVI Alliance

has become increasingly complex, experts working in an individual capacity have come to play a much larger role in the GAVI Alliance's governance processes than in the other GHG organisations examined in Chapters Five and Six. Furthermore, private sector actors, specifically foundations and for-profit actors from the vaccine manufacturing industry, have a greater influence on formal decision-making in GAVI than in the other GHG organisations. At the same time, GAVI has arguably become the most important and influential organisation for immunisation policy on the global level. Since its inception, over $US 3700 million have been pledged to the GAVI Alliance from various state and private donors, including the Bill & Melinda Gates Foundation, which alone has pledged to contribute over $US 1000 million. In addition, several states have invested much greater sums (US$ millions of millions) in immunisation financing investment bonds issued by one of the GAVI Alliance sub-organisations, the International Finance Facility for Immunisation (IFFIm), as well as in the GAVI Alliance organised Advanced Market Commitments (AMCs), which pre-purchase vaccines that are still being developed. All but one of the countries with a per capita GDP of $US 1000 or less now fund their immunisation programmes at least partly through GAVI Alliance assistance.[95] In 2007 when the GAVI Alliance announced a new immunisation strategy to focus on diseases such as rabies, cervical cancer, cholera and typhoid – a shift away from the initial focus which was purely on childhood cluster diseases – several developing countries immediately followed suit, adopting strategies to address these diseases in national immunisation programmes.

Considering that the GAVI Alliance is a highly influential GHG organisation that has moved a considerable distance away from intergovernmentalism, the question arises as to what might be the grounds on which its legitimacy is based? Who are the main stakeholders of the GAVI Alliance and what are the priorities of these stakeholders when it comes to deciding whether the GAVI Alliance is legitimate and worthy of support?

This chapter begins with a description of the complexities of immunisation as a political issue and the political environment in which the GAVI Alliance acts, including the demise of its predecessor the Children's Vaccine Initiative (CVI). This is followed by a brief overview of the GAVI Alliance's scope and operations. The chapter then proceeds with an analysis of the legitimacy of the GAVI Alliance, by examining, from the point of view of stakeholders, how the GAVI Alliance would rate in terms of the nine sub-components of legitimacy as described

[95] The exception being Timor Leste.

in Chapter Three. The question to be addressed is: What might stakeholders conclude about the extent to which the GAVI Alliance provides good governance 'by' and 'for' the people when looking at the available evidence? Finally, the chapter proceeds to examine the relationships between the GAVI Alliance and its stakeholders, asking who its primary stakeholders are, and how these stakeholders respond to the GAVI Alliance both in communicative acts and in response to direct questioning.

Although the GAVI Alliance is well known in the field of immunisation and amongst other global health experts, it has received less attention – and less criticism – than GFATM and UNAIDS. This is partly due to the fact that immunisation is a far less controversial issue than, for example, HIV/AIDS prevention and treatment. Also, very little has been written about the GAVI Alliance from a political science point of view, with the exception of some analyses of the Alliance's effectiveness (Ulbert, 2008; Schäfferhoff, 2008); the history of the period when the CVI ceased to operate and the GAVI Alliance was founded (Muraskin, The Last Years of the CVI and the Birth of GAVI, 2002) and several editorials which have appeared in medical science journals. Stakeholders seeking information on the GAVI Alliance, its governance structures, its policies and its effects are to a large extent reliant on information stemming from the GAVI Alliance itself. This chapter therefore mainly draws on primary resources, such as internal and external assessments and critiques of GAVI conducted by stakeholders (Hardon, 2001; Save the Children, 2002) as well as primary research, such as interviews conducted with staff at the GAVI Alliance Secretariat and the results of the research project outlined in Appendices II and III.

7.1 Background

In the 1960s vaccination programmes were rarely included in the activities of national health services. Particularly in developing countries, there was little systematic vaccination coverage and many years lapsed between the development of new vaccines with the potential of relatively cheap widespread coverage and the actual widespread use of these in immunisation programmes. By the mid 1970s vaccines were available for childhood cluster diseases such as diphtheria, tetanus, whooping cough, polio, measles and tuberculosis, yet less than 5% of the world's children had been immunised (Hardon, 2001, p. 2). In response, the World Health Organisation, together with UNICEF launched the Expanded Programme on Immunisation in 1974 which achieved 80% coverage by 1990, as declared at the 1990 World Summit for

Children. Achieving this scale up of coverage was considered one of the great successes of these two UN Organisations. At the Summit the goal was set to reach 90% coverage by the year 2000.

Historically, the politics of immunisation changed in the 1990s as did immunisation trends. By 2000, global coverage for the six vaccines mentioned above had decreased to 75%. And coverage for Diphtheria, Tetanus and Whooping Cough (DTP3) had dropped below 50% in some African countries (Hardon, 2001, p. 3). Reasons for this decrease in coverage have been debated, with some citing a change of priorities within the WHO towards narrow programmes (in particular the emphasis on polio eradication). Indeed, by 2000 both the WHO and UNICEF had considerably reduced the resources being put into immunisation programmes and donor-states had come to rely on bi-lateral programmes for immunisation, if the issue was given priority at all. Others cite cuts in state funding and the decision by several vaccine manufacturers to halt the production of DTP3 vaccines due to lack of profitability (Baleta, 2002; Kapp, 2002). The consequence was that diseases previously thought to have been brought under control, or virtually eliminated, re-emerged with new pandemics (Martin & Marshall, 2003).

It was during this period that the first public-private partnership for vaccines and immunisation – the Children's Vaccine Initiative (CVI) – was in operation. The CVI was founded by four UN Agencies, (WHO, UNICEF, UNDP and the World Bank, together with the Rockefeller Foundation) in the form of a consortium, similar to that of UNAIDS, but without formalised rules for representation and decision-making. Each of the organisations held supreme decision-making authority on the CVI's Standing Committee, and other actors – including vaccine industry representatives – were invited to contribute to policy-making by means of a consultative group. All in all, the CVI can be seen as an early form of a GHG organisation, albeit without the one key characteristic of existing as an independent organisation. The fact that the CVI was physically and legally housed within WHO has been cited as one reason for its lack of success and ultimate demise. It meant that it was blocked from formally integrating for-profit private sector entities.[96] The WHO's own internal vaccine programme the Global Programme on Vaccines ran parallel to the CVI, with various

[96] In his final editorial of the regular CVI publication 'CVI Forum' Roy Widdus, CVI Coordinator states that: "Industry unfortunately, never achieved the formal, legal status of a full partner, but not for lack of CVI Secretariat efforts and industry inclination" (Widdus, 1999, p. 3)

interested parties (states and industry representatives) often having to observe meetings of both groups several times each year to coordinate their vaccine activities (Children's Vaccine Initiative, 1996). Discussions to merge the two programmes ran for almost the entire decade that the CVI was in operation and the CVI was often questioned on its exact identity and role. The total CVI Budget was planned to total US$ 50 million for the years 1991-1996, however in reality it received little more than US$ 20 million from its sponsors between 1991 and 1999 (Robbins & Freeman, 1991, p. 1007). During the final years of the programme, several UN Agencies as well as other actors were already developing proposals for its successor which was to exist as an independent organisation.

7.2 Operations and historical developments

The eight year history of GAVI is marked by two major historical developments, first, the expansion of GAVI into the GAVI Alliance composed of five separate organisational entities; and second, significant changes in policy focus away from a few selected vaccines towards broader health systems strengthening. These aspects will be dealt with in depth in the analysis below, first however, in this section a brief history of these two aspects in the context of the GAVI Alliance and its operations will be laid out.

GAVI was established in 1999 with the aims of increasing DTP3, Hepatitis B and Haemophilus influenzae type b (Hib) vaccination coverage in the world's poorest countries. Based in Geneva with its Secretariat housed within the UNICEF offices, GAVI, which changed its name to GAVI Alliance in 2006, was established with a highly inclusive central decision-making body incorporating states, UN Agencies, and non-state actors (for-profit and non-for-profit). The GAVI Alliance Board is responsible for developing long-term immunisation strategies and thereby engages in governance on the highest level. It makes 'claims' regarding what is desirable behaviour for a range of stakeholders, including for-profit actors when negotiating pricing and supply of vaccines; resource rich (state and non-state) actors, when publicising who is obliged to make donations to help immunise the world's poorest children; and developing states when guiding which vaccines are to be classified as under-used and what kinds of structures should be in place to ensure effective immunisation coverage.

The GAVI Alliance operates by means of a system of funding application and approval, similar to that of GFATM. States that apply for GAVI Alliance funding must first fulfil three basic criteria, which effectively encompass the 'claims' that the GAVI Alliance makes on one of its key stakeholders – states with low rates of immunisation, specifically those with a per capita GDP of under US $1000. States should form, or have a so called inter-agency coordinating committee (ICC) or national health sector coordinating body for the strengthening of health systems, comparable to the CCMs that are to be established to receive funding from GFATM. The GAVI Alliance stipulates that ICCs should involve both state and non-state actors in decision-making. States should also provide evidence that the use of GAVI provided funds will be synchronised with national planning and budgets, and provide reports on progress and funds utilisation along the lines of GAVI Alliance stipulated guidelines. States should also develop comprehensive multi-year immunisation plans. States then apply for funding for one or more of the following types of programmes: immunisation services support (ISS), injection safety support, new and underused vaccines support, health systems strengthening support, and civil society organisation support. The scope of activities that can be funded by GAVI has expanded during its history, with the most recent – specific support for civil society organisations – currently in its pilot stage, being trialled in 10 states (Grange, 2006).

Less than one year after GAVI was officially founded, the Global Fund for Children's Vaccines (Vaccine Fund), was also launched, effectively as the financial arm of the GAVI Alliance, but formally an independent entity, incorporated in the United States where major donors are able to make tax-deductible donations (WHO, 2008). The Vaccine Fund, which later changed its name to the GAVI Fund, was officially launched at the World Economic Forum in Davos in January 2000. Six states (Denmark, the Netherlands, Norway, Sweden, the United States and the United Kingdom) and the Bill & Melinda Gates foundation made large pledges in the lead up to the creation of the Fund. The two organisations combined are known as the greater GAVI Alliance.

To add to the increasingly confusing structure of the GAVI Alliance, several other formally independent entities have been added over the past 3 years, including the aforementioned IFFIm, registered as a charity in the United Kingdom and formed in response to criticism and problems faced by GAVI to achieve long term financial security, the GAVI Foundation, registered under Swiss Law in 2006, "…to provide certain contracting and administrative

services to the GAVI Secretariat in Geneva" (GAVI Alliance, 2008b) and the GAVI Fund Affiliate, created to manage pledges to the IFFIm.

In all, the GAVI Alliance has evolved into an increasingly complex conglomerate of organisations, each with different roles, legal status and governance structures, which has made it difficult for stakeholders to get a grasp on what the GAVI Alliance is, how it functions, how it can be accessed and who is in control of decision-making. A merger of the various greater GAVI Alliance bodies was discussed as early as 2003 and has been developed in various governance committees. As of 2009 the GAVI Fund, Alliance and Foundation will merge into a single entity registered as a Foundation with International Organisation status in Switzerland.[97] The analysis presented below will primarily refer to current GAVI Alliance arrangements but also take account of the future structure of GAVI Alliance.

7.3 Basis for the legitimacy of the GAVI Alliance

7.3.1 Governance 'by' the people

Stakeholders appraising the extent to which the GAVI Alliance entails legitimate governance 'by' the people will look primarily at governance structures of the GAVI Alliance based in Geneva. In judging the extent to which the GAVI Alliance Board embodies principles of public governance, it is the level of representation of states and intergovernmental organisations which will be examined closely. Are those involved in decision-making representatives of citizens and/or sovereign states? Which states are represented?

At first glance the GAVI Alliance appears to have a firm public governance base, comparable to that of GFATM. The Board, which has the role of making overall strategic policy decisions for the greater GAVI Alliance and approving support for country immunisation programmes, consists of 14 rotating and four non-rotating members (in the year 2008). Of the rotating members, five represent developing country governments and five represent industrialised country governments. The remaining four rotating seats are occupied by representatives of non-state actors including research and technical health institutes, the vaccine industry in industrialised countries, the vaccine industry in developing countries, and civil society

[97] The Swiss Host State Act, enacted in 2007, allows non-for profit foundations that meet certain criteria to receive both Swiss Government legal status as well as privileges and immunities corresponding to those of an IO (WHO, 2008).

organisations. The balance of this composition is not laid out in any by-laws or any legal agreement, as the GAVI Board is not a formal legal entity. The precise composition of the Board has changed several times.

The Guiding Principles of the GAVI Alliance represents the baseline document of the GAVI Alliance operational rules. In it, it is stated that the Board was to contain "…two representatives of the group of the developing countries" and "…three representatives of OECD countries". Non-state actors were to hold six seats, (one representative each from each of the following groups 1) foundations; 2) industry from developing countries; 3) industry from the OECD countries; 4) research institutions; 5) technical health institutions; 6) non-governmental organisations (GAVI Alliance, 2000).

Over time, the balance between public actors and private actors amongst renewable members has therefore changed from 5 public and 6 private actors, to 10 public and four private actors. In addition, three of the four renewable member seats are allocated to intergovernmental organisations, the WHO, UNICEF and the World Bank.

This however, does not provide a complete picture of the extent to which the GAVI Alliance has a public governance base because other governance structures within the greater GAVI Alliance also need to be taken into account. Of particular importance when assessing the extent to which the GAVI Alliance embodies principles akin to legitimate governance 'by' the people is decision-making structures within the GAVI Fund, which presides over the financial arm of the greater Alliance and, formally, is under no obligation to follow the decisions made by the GAVI Alliance Board in Geneva regarding which applications for funding should be approved. In effect, the recommendations of the Alliance Board in Geneva are accepted by the GAVI Fund, its Board however is made up of up to thirty individuals that serve in an individual capacity and do not represent any kind of specific constituency (GAVI Alliance, 2004; WHO, 2008). Currently, fifteen individuals are listed as serving on the GAVI Fund Board, four of which are citizens of the United States, and four are citizens of developing countries. Six of these Board members make up the GAVI Fund Executive Committee which is responsible for the final approval of the allocation of Funds to successful applicants.[98]

[98] These six Executive Committee members serve as individuals and their professional and country affiliation therefore should play no role in their decision-making roles. Their affiliation and experience is however, a

As of 2009, when several organisations within the greater GAVI Alliance will be merged, the new Board will retain several seats for individuals acting in their own capacity. It has been agreed that central decision-making authority of the Board of the combined GAVI Alliance entity will be based on a 2/3 to 1/3 weighting between representative and non-representative actors. Representative members act in the interests of a particular constituency, whether it be a state, group of states, an IO, industry or CSOs. Non-representative actors will have a seat on the Board in an individual expert capacity. Overall, 13 representatives of public sector actors will have decision-making authority for the greater GAVI Alliance[99], along with five non-state actors[100] and nine unaffiliated individuals "…appointed in their personal capacity on the basis of their skills and networks" (GAVI Alliance, 2008c).

Therefore, under close inspection stakeholders might conclude that the legitimacy of the GAVI Alliance can only be based on the sub-component of public governance to a small extent. Stakeholders that prioritise governance 'by' the people might therefore look more closely at the extent to which the GAVI Alliance appears to embody other sub-components such as participatory governance, fair processes and indirect participation.

In assessing the extent to which its governance structure embodies principles of participatory governance, stakeholders will ask whose interests are represented by those involved in decision-making. Does the governance structure of the GAVI Alliance enable a broad representation of the interests of affected groups?

Four aspects are particularly noteworthy in assessing the extent to which the GAVI Alliance bases it work on participatory governance. First, membership of non-state actors on the GAVI Board, and participation in other GAVI activities, is based heavily on reciprocity and the ability to contribute specific resources, whether financial, operational, technical or networking. Therefore, although the GAVI Alliance does include roles for non-state actors in

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criterion for selection on the GAVI Fund Board and executive committee. In 2008 the Executive Committee was made up of professionals with the following roles: President of the U.S. Programme at the Bill and Melinda Gates Foundation; vice chairman of the Securities Division at Goldman, Sachs & Co; Chief Executive Officer of The GAVI Fund and Executive Secretary of the Global Alliance for Vaccines and Immunization (GAVI); Managing Partner of D.L. Bush & Associates; Partner and National Director of Not-for-Profit Services at BDO Seidman; and President of the CSO 'Realizing Rights: The Ethical Globalization Initiative' (GAVI Alliance, 2008).

[99] Comprising a representative from WHO, UNICEF, World Bank, 5 developing countries and 5 developed countries.

[100] Comprising a representative from the Bill and Melinda Gates Foundation, the vaccine industry in industrialised countries, the emerging vaccine industry, civil society and technical and health research institutes.

its decision-making structures, seats on its Board are specifically allocated to those types of actors that have the knowledge and resources to contribute to the aim of increasing immunisation levels. Concerned business sector actors from industries other than vaccine manufacturing for example are not allocated a role, but vaccine research institutes are. Also, although the CSO representative on the GAVI Alliance Board is not required to be active exclusively in the field of immunisation, thus far all CSO representatives have had a focus on immunisation. Participation in the GAVI Alliance is specifically based on reciprocal utility, rather than the need, or desire, to increase the voice of those most affected by vaccine preventable diseases.

Second, business sector actors, specifically representatives of the vaccine industry (both in industrialised and developing countries), are granted full participation rights and voting rights in the GAVI Alliance. This serves the purpose of bringing the interests of both emerging and established vaccine industries together in strategy development and has also had the effect that vaccine industry partners have been willing to enter into Advance Market Agreements with the GAVI Alliance. On the GAVI Alliance Board, established and emerging vaccine industry representatives have a platform to discuss their, inevitably sometimes conflicting priorities and strategies.[101]

Third, compared with GFATM and UNAIDS, the GAVI Alliance awards a relatively lesser role to civil society. There is no seat on the Board that is allocated to representatives of groups of people that seek immunisation, such as concerned parents in developing countries. Although civil society is present with one representative with full voting rights on the GAVI Alliance Board in Geneva, very few CSOs have come to actually hold seats. Only CSOs with considerable resource capacity will have the ability to fulfil the roles expected for the CSO representative, which includes amongst others, the expectation to: “Maintain contact with the over 150 international Private Voluntary Organisations (PVOs)/CSOs to keep them informed and engaged in CSO activities relating to immunisation and GAVI” (GAVI Alliance, 2008d). Although requests had been made for greater representation of civil society in the process of the merger of various greater GAVI Alliance boards, this suggestion was rejected.

[101] The GAVI Alliance describes the rationale for including business sector actors in GAVI decision-making structures as follows: “… the inclusive nature of the Alliance encourages vaccine manufacturers to take a positive view of developing country markets and add relevant, affordable products to their portfolios” (GAVI Alliance, 2007).

> The Committee considered the request by the civil society task team that an additional seat be allocated for civil society so that organisations from both North and South can sit at board meetings. The Committee did not feel that an additional seat for civil society would be justified, in the interest of keeping board numbers manageable, and the requirement for a 2/3 - 1/3 split between representative and unaffiliated board. A continued arrangement with a Board member and an Alternate for the civil society seat, and the possibility for nominating experts to Board Committees should provide opportunities for meaningful inclusion in decision making (GAVI Alliance Transition Committee, 2008).

Fourth, one particular private sector actor, the Bill & Melinda Gates Foundation is afforded a particularly privileged role in the GAVI Alliance governance structure. At the GAVI Alliance Board in Geneva the Bill & Melinda Gates Foundation has a renewable seat. The justification of its inclusion is based on the fact that the Foundation was a founding partner of GAVI which has contributed large sums of funding, rather than any principle that they are part of a larger political community representing the interests of those affected by the GAVI Alliance.

> The Foundation is a founding partner of the GAVI Alliance. Its initial grant helped establish GAVI and it continues to support its work. It has committed more than $1.5 billion to GAVI, of which GAVI has received US $988 million, as at December 2007 (GAVI Alliance, 2008b).

Immunisation is an issue-area that involves the work of a relatively clear set of operational actors. The governance structures of the GAVI Alliance embody principles of participatory governance by including full participation rights for non-state actors, such as business sector actors and civil society. However, the weighting given to certain actors suggests that principles of participatory governance, such as the recognition that the interests of affected individuals can be represented by various political communities, do not necessarily lie behind the decision to have both public and private actors on the GAVI Alliance Board.

As mentioned above, GAVI Alliance Board meetings are not regulated by by-laws, but the GAVI Alliance has developed rules of procedure and included specific mechanisms to balance out power differentials between represented actors. Stakeholders that prioritise fair process in their judgements of whether the GAVI Alliance is a legitimate organisation will ask questions such as: How do the persons that are meant to represent the interests of stakeholders come to have this representative role? How are power differentials between represented groups balanced out? How is decision-making formalised and organised?

The deliberate balancing of representation between developed and developing countries, both in terms of business sector actors and state representatives, can be considered of particular

importance for stakeholders that emphasise fair process, along with the rule, as stated in the GAVI Guiding Principles that: "the Board shall normally take its decision by consensus. Nevertheless should a vote be required each member will have one vote only" (GAVI Alliance, 2000). Nevertheless, the lack of a clear obligation of the Board of the GAVI Fund to follow the agreements met by the GAVI Alliance Board in Geneva might be considered a drawback.

Also of importance is the manner by which the various Board members actually come to hold such positions. Representatives of 'constituencies' i.e. the members on the Board representing industries, research institutes and civil society are all elected by a process determined by the constituencies internally, and are then approved by current Board members. As a general rule, a call for applications is distributed amongst networks and posted online on the GAVI Alliance website. Amongst some constituency groups, rules for eligibility severely limit the number of potential applicants. Most notably amongst CSOs, only a few specific organisations have even come to apply for a seat on the Board, and the seat has remained vacant for periods in the past.[102] This is despite financial assistance being offered specifically to CSO members for travel and lodging when attending meetings, a waiver of the usual US$ 300,000 expected contribution (to be made by other organisations represented on the Board) and several meetings taking place in the form of teleconferences and/or email meetings. Amongst other constituencies, most notably that of the technical and research institutes, the process appears to be far more open. The representative of this constituency group rotates every two years (rather than every three years as with most others). Following the 2009 merger of some of the various greater GAVI Alliance Boards, a 'Nomination Committee' made up of some of the GAVI Alliance Board members will be responsible for establishing criteria for, and overseeing, the selection of the unaffiliated Board members.

Considering the high level of participation of persons working in an individual capacity and the highly complex structure of the greater GAVI Alliance, transparency and access of information will be considered particularly important if the GAVI Alliance is to be seen as engaging in governance 'by' the people by means of indirect participation. Stakeholders will

[102] Since the founding of the GAVI Alliance, the CSO seat has been held by either the Children's Vaccine Program at PATH, the Sierra Leone Red Cross, the International Paediatric Association or the BRAC Health Programme, Bangladesh.

ask: Do stakeholders have access to comprehensive information? How can stakeholders express disapproval of decisions? Is the GAVI Alliance then responsive?

Access to GAVI organisation basic documents, including the reports of all Board meetings of the GAVI Alliance in Geneva are available on their website, as is background information about each of the Board members. In particular the process of arranging the merging of the GAVI Alliance in Geneva with the GAVI Fund and the GAVI Foundation has been a transparent process, with the reports of several task teams, governance studies and the summarised opinions of each delegation and/or Board member on each aspect of the governance reform made public via the website, as well as on request. This level of transparency, however, does not apply to the Boards that make up the other parts of the greater GAVI alliance. While the GAVI Fund did have a website for a few years (during the time that it was still called the Vaccine Fund) now there is no easy access to any information about the internal decision-making process or Board decisions. This also applies to the GAVI Foundation, the GAVI Fund Affiliate and the IFFIm.

Possibly the most important area for transparency in activities of the GAVI Alliance is the process of approval or rejection of funding applications and the procurement of vaccines. For each country that has received funds the full proposal including information on the exact planned use of those funds, as well as who is involved in the development of the proposal and the inter-agency coordinating committee, is available. Each country also submits annual progress reports which are available on the GAVI website.

Stakeholders assessing the GAVI Alliance by examining the extent to which its legitimacy might be based on sub-components of governance 'by' the people will find that it provides a high level of participatory governance, as well as a high degree of transparency. However, the fact that the operations of the GAVI Alliance are tied with various other organisations within the greater alliance, that are, more or less, run as private organisations might detract from the GAVI Alliance's legitimacy in terms of the extent to which it represents governance 'by' the people. The work of these sub-organisations is neither based on public governance, nor are they transparent or designed to allow for representation of affected individuals by means of indirect participation or representation via diverse political communities.

7.3.2 Governance 'for' the people

The extent to which the GAVI Alliance represents good governance 'for' the people can be appraised by examining its purpose, problem-solving capacity, approach, effectiveness and efficacy, and organisational efficiency. In terms of the first aspect, purpose, stakeholders will pose the question of whether it is necessary, and desirable for a specifically formed global organisation to take on the tasks that the GAVI Alliance aims to fulfil.

The GAVI Alliance was formed with the aim of improving immunisation coverage in the world's poorest countries. This is a global challenge requiring a global response, as the actors with the resources, technology and knowledge that can contribute to problem-solving come from different geographical regions and take on different organisational forms. Coordinating the efforts and combining the resources of these various actors makes a common global level platform necessary. Several stakeholders however, have expressed that it should, at least in principle, be possible for an organisation within the UN System, such as the WHO, to take on this task, considering that successful immunisation programmes have been conducted from within the WHO in the past (Muraskin, 2004).

The ability of the GAVI Alliance to demonstrate to stakeholders that it delivers good governance 'for' the people may therefore rest with its demonstrated higher problem-solving capacity compared with previous global immunisation programmes. Stakeholders seeking to assess GAVI problem-solving capacity will tend to ask: Is decision-making based on scientific evidence? Does the organisation employ competent staff, involve experts and follow proven management strategies?

The GAVI Alliance puts a heavy focus on its problem-solving capacity and publicises this fact in publications and on its website. Four elements are indicative of the GAVI Alliance's strong problem-solving capacity: First, within the GAVI Alliance in Geneva two bodies, the Technical Review Panel (TRP) and the GAVI Working Group are responsible for assessing country progress and reporting and overseeing the implementation of Board decisions respectively. The TRP and GAVI Working Group are comprised of experts with training and experience relevant to the type of proposal they review, such as, expertise in health with specific knowledge of vaccines and immunisation; health systems and injection safety. Most of the members of these groups are private health consultants and/or health economists. Second: as a financing instrument, GAVI consults and engages with experts in the field of

strategic finance at high levels. A large private investment bank was engaged by GAVI to develop and release the Bond Issuances of the IFFIm to create a long term secure funding source (IFFIm, 2008). The adoption of this system has made GAVI unique amongst GHG organisations. Third, the fact that the Board of the GAVI Fund, and the future merged GAVI Alliance Board, have seats specified for individuals acting in an expert capacity demonstrates that the GAVI Alliance puts a greater emphasis on the technical and scientific based aspects of immunisation policy-making. Fourth and finally, the inclusion of technical and research institutes on the board has formally given a decision-making rights role to actors who are given the specific task of contributing to evidence-based policy-making. In all, the GAVI Alliance has a particularly strong base for acceptance as a legitimate organisation worthy of support based on its problem-solving capacity via the utilisation and incorporation of expertise.

In terms of the sub-component right approach, stakeholders may be particularly critical of the GAVI Alliance, because it is an organisation that addresses one specific area of health. Stakeholders that give a high importance to the Primary Health Care approach have criticised the GAVI Alliance in the past on the grounds that it does not have a promising strategy to achieve long term increases in the health status of those living in the world's poorest countries (Save the Children, 2002). Indeed, from its inception the GAVI Alliance has faced criticism that its approach has been deficient in terms of lack of sustainability and failure to strengthen health care systems. Originally, GAVI grants were in the form of one time 5-year investments for the introduction of immunisation services. The GAVI Alliance itself stated that its approach was to offer a temporary boost to in-country services and not provide long term support.

> While the lowest income countries may require continued external support for their immunization programs, support from the Global Fund [for Children's Vaccines] cannot continue indefinitely. Global Fund [for Children's Vaccines] support has been designed to give governments of low-income countries a temporary financial boost to their immunization systems and to provide a foundation for them to expand support from other sources, especially their own government budgets (GAVI Alliance, 2001).

The GAVI Alliance reacted quickly to criticisms that its approach was too narrow and unsustainable and its current approach now consists of making longer commitments to developing countries, focusing on the five areas, immunisation services support, new and underused vaccine support (currently for DTP3, Hepatitis B, Hib, Pneumococcal, Rotavirus

and Yellow Fever), injection safety support, health systems strengthening support and civil society support.

Another key feature of the GAVI Alliance approach is its market orientation and use of the financial and banking industries. Advanced Market Commitments are used to encourage further research into new vaccines while bond issuances seek to secure long term funding by borrowing against pledge funds. For some stakeholders, these mechanisms help solve some of the problems of the GAVI Alliance's vertical approach, others have criticised that the GAVI approach is geared towards ensuring the profitability of vaccines ahead of assuring equity in access (Hardon & Blume, 2005).

> …by commercialising vaccines for poor people, the AMC approach is making the culture of the GAVI Alliance more commercially oriented than it previously was, and it is shifting the Alliance towards becoming the vehicle for making vaccines for poor individuals into the next main market for the drug industry (Light, 2007, p. 297; Hardon & Blume, 2005).

Ultimately, perceived effectiveness and efficacy is one of the main factors by which stakeholders appraise GHG organisations (see Chapter Four). The GAVI Alliance's stakeholders will first and foremost ask whether it has been successful in increasing immunisation rates in its target countries and in reversing the negative trends from the 1990s.

In terms of attracting funds, it is notable that thus far, far fewer OECD-DAC member states have contributed to the GAVI Alliance than to GFATM or to UNAIDS. The sums of funding are also considerably less. Nevertheless, the number of OECD-DAC states contributing to the GAVI Alliance has increased from six in 2000, to 14 in 2007, often after quite public and intense lobbying efforts.[103] The rate of eligible countries that have applied and successfully been granted GAVI support is near 100%. Of the 75 states with a GDP per capita of under US$ 1000, only one (Timor Leste) has not applied for funding.

The GAVI Alliance releases indicators of its effectiveness in annual reports as well as progress and achievement updates on its website. In addition, several independent reviews of the extent to which the GAVI Alliance has been able to increase immunisation rates and critiques of its performance have been published in the years 2002, 2004, 2006 and 2007 (Milsten, Cohen, & Olsen, 2007; Save the Children, 2002; Lu et al., 2006; Chee et al., 2004;

[103] Direct donations have also come from the Russian Federation and the European Commission.

Chee et al., 2007). An evaluation of the GAVI Alliance's Injection Safety Support is expected for publication in late 2008. The GAVI Alliance has also put an emphasis on performance monitoring and has established a Monitoring and Evaluation Technical Advisory Group to monitor the activities of involved partners and commission independent assessments. In its performance updates the GAVI Alliance provides statistics on the number of children that have achieved vaccinations though programmes funded by the GAVI Alliance globally, using WHO estimated coverage rates as its source. The number of additional children which are said to have been protected with the basic DTP3 vaccine is set at 25.6 million (GAVI Alliance, 2008e). Similar to GFATM, the GAVI Alliance also makes mentions of number of lives saved – or number of future deaths prevented – which it puts at 2.9 million (GAVI Alliance, 2008e).

Assessing the true effectiveness of any one organisation is complex, due to reasons already outlined in this dissertation, such as problems of allocating results to any one action, and the problem of identifying a possible counterfactual condition. Could, for example, the WHO have had just as much success as the GAVI Alliance? How is it possible to trace improvements in state level immunisation rates to a global level organisation? Stakeholders basing their judgements of whether the GAVI Alliance is worthy of support on its effectiveness will be seeking evidence of improvements in immunisation coverage by means of a before-after comparison, with baseline immunisation rates being those of the years 1999 and 2000. They will also assess the extent to which the GAVI Alliance has had an impact on reducing disease burden. As reliable data on immunisation rates have been available in most countries for the last 20 years – gathered and made available through UNICEF and WHO - it has been possible for epidemiologists to use regression modelling to assess the effectiveness of the GAVI Alliance.

With regard to the key aim of increasing coverage of DTP3 vaccines, the GAVI Alliance has been able to demonstrate a high level of effectiveness. Two separate studies have found that DTP3 coverage has increased in countries receiving GAVI support, in particular in countries that began with a very low level of coverage of under 65% (Chee et al., 2007, p. 36; Lu et al., 2006, p. 1092).

> The success of ISS (immunisation services support) funding in countries with baseline DTP3 coverage of 65% or less provides evidence that a public-private partnership can work to reverse a

> negative trend in global health and that performance-related disbursement can work in some settings (information in bracket added) (Lu et al., 2006).

Other significant improvements such as an increase in the number of regional districts with over 80% coverage, and parallel increases in measles vaccination coverage were also found in these two studies.

Finally, stakeholders may also look at organisational efficiency as a key aspect of governance 'for' the people. They may ask: Does the organisation work in a lean and efficient manner? During the early GAVI history, the organisation had a very lean structure and often publicised its low overhead costs. The Secretariat maintained only 6 staff through to the years 2003, and has been housed within UNICEF, which took on some administrative tasks such as payroll services (Martin & Marshall, 2003, p. 589). The size of the Secretariat has expanded rapidly since then, with 55 staff members by the end of 2005, 70 by the end of 2006 and 88 by the end of 2007 (GAVI Alliance Executive Committee, 2007). This may be interpreted as a sign of increasing bureaucracy by some stakeholders, although others have claimed that stakeholders, in particular donors, have unrealistic expectations on how lean a partnership such as the GAVI Alliance can actually be (GAVI Alliance, 2008f; Caines et al., 2004, p. 29). At a recent GAVI Alliance Executive Committee meeting, this expansion was justified by the CEO of the GAVI Fund and GAVI Alliance as being necessary considering the ever expanding role of the Secretariat.

> While 'lean and mean' was a principle for the early GAVI Secretariat, given the increased responsibilities and wider scope of work a more robust staffing structure is needed. Partners also need to be well supported, and this is reflected in a significant increase in partner budgets and funded posts (GAVI Alliance Executive Committee, 2007).

A second important factor of organisational efficiency for GHG organisations, especially those that fund and implement in-country programmes is aligning projects with existing structures. The GAVI Alliance can be seen to avoid parallel implementation structures by channelling funding primarily through Ministries of Health.

Overall, it is to be expected that the GAVI Alliance will rate highly amongst stakeholders that make worthyness judgements based on its ability to demonstrate good governance 'for' the people. Most importantly, it can demonstrate a high level of effectiveness and efficacy in terms of its primary aims. Also its problem-solving capacity – with its strong expertise base –

increases the ability of GAVI to project itself as an organisation engaging in governance 'for' the people.

7.4 The GAVI Alliance and its stakeholders

Each GHG organisation with a specific scope in terms of health policy will have slightly different primary stakeholders. GHG organisations will make 'claims' regarding the desirable behaviour of these stakeholders and will seek to build supportive relationships with them, in they want these claims to be accepted as legitimate. The primary stakeholders of a GHG organisation are those directly addressed by GHG organisations' policies and those that will directly affect the GHG organisations if they withdraw support (see Section 4.2.1). For the GAVI Alliance therefore, not only are the WHO, UNICEF and donor and epidemic and at-risk states main stakeholders – as can be said generally for almost all GHG organisations - but in addition, the various actors involved in developing, manufacturing and administering vaccines are also primary stakeholders. In turn these stakeholders can be classified along the lines of state actors (IGOs, donor states and their development agencies, and epidemic and at-risk states and state run research institutes) and non-state actors (for-profit vaccine developers and manufacturers, non-for-profit vaccine manufactures, civil society organisations such as those concerned with children's health and medical health professions such as nursing and private donors, such as the Bill & Melinda Gates Foundation).

7.4.1 Perceptions amongst stakeholders of The GAVI Alliance's legitimacy

In an analysis of 90 texts from a range of stakeholders, including vaccine manufacturers, CSOs concerned with children's health and OECD-DAC state development agencies, the GAVI Alliance was, by far, mentioned the least of all the case study organisations. It appears to be less well known, which can be partly explained by the fact that many of the texts addressed the issue of HIV/AIDS. However, even in many of the texts that addressed health generally, or even the issue of immunisation, the GAVI Alliance was not mentioned. Thus, it appears that the GAVI Alliance as an organisation is not subject to a high level of scrutiny in the public discourse. When the GAVI Alliance was mentioned in a text, references were overwhelmingly made to aspects of governance 'for' the people, including its effective financing management. Its decision-making structures or Board composition were discussed in only a few texts.

In one of the texts from the Government of France the GAVI Alliance was mentioned as an innovative funding system and continued financial support for the GAVI Alliance was considered to be the right strategy to combat infant and maternal mortality (French Minstry for Foreign and European Affairs, 2007). In texts from the Government of Ireland, both the GAVI Alliance and GFATM were named as 'systems-focused' partnerships, indicating that their approach was valued positively (Irish Aid, 2007a, p. 12). The impacts of the GAVI Alliance (and the GFATM) were mentioned in specific detail and in a positive light in this text. GAVI was praised in one particular passage for supposedly averting "2 million deaths of children under-five" (Irish Aid, 2007a, p. 2). The GAVI Alliance and GFATM were presented as examples of Global Health Partnerships which receive both criticism and praise.

In one text from the Netherlands, the GAVI Alliance was mentioned and presented as worthy of Netherlands development aid funding. As one of the few texts that mentioned any aspects of governance 'by' the people in relation to the GAVI Alliance, the Alliance was introduced as an organisation that brings together the strengths of various actors, including WHO and UNICEF, recipient countries, donors and industry. The organisation's positive effects were also described by stating that: the GAVI Alliance brings children and mothers into contact with health care and "…saves children's lives" (Netherlands Ministry of Foreign Affairs, 2007). Specific outcomes are mentioned several times in the text. For example:

> With support from the Netherlands GAVI was able to vaccinate 138 million children with new vaccines in 2006 (Netherlands Ministry of Foreign Affairs, 2007).

In one of the texts from the Swedish Development Agency, the GAVI Alliance was presented in a very positive light and its outcomes were listed in detail. The text also mentioned that Sweden occupies a seat on the GAVI Alliance board. The GAVI Alliance's introduction of a special programme on strengthening health systems was mentioned as particularly welcome (Swedish International Development Cooperation Agency, 2007). GFATM and the GAVI Alliance were both mentioned in texts published by the United Kingdom Development Agency DFID in terms of their ability to provide governance 'for' the people. The amount of resources that have been raised by the GAVI Alliance body and the potential of the IFFIm to raise additional funds were praised. In a second text from DFID, the GAVI Alliance was referred to in terms of its potential effects. It was stated that:

> GAVI, with long term and predictable financing provided through IFFIm, can play a key role in helping countries put in place stronger systems for vaccine delivery as part of the overall effort to improve health services (United Kingdom DFID, 2007, p. 45).

Other aspects of the GAVI Alliance that were mentioned in a positive light included: stability, predictability and long term sustainability. Funds and agencies such as GFATM and the GAVI Alliance were rated positively, however, this DFID text did include some hints of deficits in terms of performance and accountability of individual institutions and effective co-operation between agencies.

Only three CSOs made mention of the GAVI Alliance, each of which were involved in the work of the GAVI Alliance. In the text from the Bill & Melinda Gates Foundation the GAVI Alliance is mentioned quite often and was introduced by making reference to its effectiveness. It was said that: “Partnerships like the Global Alliance for Vaccines and Immunization (GAVI) are working” (Bill & Melinda Gates Foundation, 2007). Mention was also made of the GAVI Alliance’s inclusive structure by stating that:

> Through GAVI, donor governments, governments in developing countries, nongovernmental organizations, private donors, and pharmaceutical companies are all working together with a shared goal (Bill & Melinda Gates Foundation, 2007).

The effectiveness of the GAVI Alliance was demonstrated in this text by the use of statistics. The text made little reference to effectiveness of governance structures within other organisations, states or international organisations: Therefore, the GAVI Alliance seems to have been given a special place in the Bill & Melinda Gates Foundation text.

The GAVI Alliance is mentioned several times in the text from PATH, mostly by being listed as a partner in several projects. In the main body of the text the GAVI Alliance was introduced by emphasising its inclusive structure, followed by its aims.

> In November, the GAVI Alliance—a coalition that brings together global health institutions, the vaccine industry, national governments, and nongovernmental organizations committed to global access to immunization— pledged financial support to bring lifesaving rotavirus vaccines to the developing world (PATH, 2007).

Two business sector actors also mentioned the GAVI Alliance in their texts, however, this is normally within a factual statement. The organisation was not evaluated in texts from stakeholders within this group, despite several of the texts stemming from vaccine

manufacturers. Although high level staff members were willing to respond to direct questioning about the GAVI Alliance, they appear to participate little in the public discourse about the appropriateness of this organisation. The GAVI Alliance was also hardly mentioned at all in texts from epidemic and at-risk states. One country that did mention the GAVI Alliance in its texts was Guyana, albeit only briefly. Texts from Guyana listed the GAVI Alliance and UNAIDS as development partners (for immunisation and AIDS respectively). The GAVI Alliance was mentioned once in a positive light by stating that: "Guyana's immunization program benefits significantly from GAVI" (Guyana Ministry of Health, 2003).

The balance between positive and negative statements found in the texts indicate that GAVI also enjoys being seen as legitimate amongst a large percentage of stakeholders. However, compared with GFATM and UNAIDS, there were far fewer neutral mentions of the GAVI Alliance in the texts.

Table 7.1: Perceptions of the legitimacy of the GAVI Alliance in stakeholder texts

Stakeholder Group	Total references to the GAVI Alliance in texts	Proportion of references that were neutral	Proportion of references that were positive (Legitimating Statements)	Proportion of references that were negative (De-legitimating Statements)
All Texts	70	19%	74%	7%
OECD-DAC member states	50	21%	71%	8%
Epidemic and at-risk states	3	33%	67%	-
CSOs	12	8%	92%	-
Business Sector Actors	5	20%	80%	-

In a survey of global health experts affiliated with various stakeholders, including immunisation coordinators, high level staff at OECD-DAC member development agencies and vaccine manufacturers, opinions on GAVI were not as strong as opinions on the GFATM. A high number respondents felt that they could not form an opinion about GAVI, however, amongst those that did know of the GAVI Alliance, it was generally held in high to very high regard.

Respondents were divided on several issues, for example, whether the formation of the GAVI Alliance was necessary because of UNICEF and the WHO failure with their immunisation programmes. There was a reasonable level of agreement amongst the respondents that GAVI was transparent and open to criticism and that the interests or various groups are balanced by GAVI. There was also general approval of GAVI's approach. There was strong agreement amongst the respondents that public entities, such as states and UN Agencies, should make up the majority of seats on the GAVI Board. Agreement amongst the respondents was strongest with respect to the role of experts, which respondents stated should be involved in decision-making. Primarily global health experts focus on good governance 'for' the people, in terms of the ability to create good and effective policies that serve the interests of stakeholders. However, when asked directly, aspects of participation and good governance 'by' the people are also said to be important.

Table 7.2: Rating of the GAVI Alliance amongst stakeholders

Stakeholder Group	Held the GAVI Alliance in high or very high regard	Held the GAVI Alliance in Medium Regard	Held the GAVI Alliance in Low or Very Low Regard
All Respondents	72%	24%	4%
OECD-DAC member states	76 %	24 %	-
Epidemic and at-risk states	59 %	33 %	8 %
CSOs	60 %	30 %	10 %
Business Sector Actors	77 %	23 %	-

These opinions were also reflected in the comments made by respondents at the conclusion of the section of the survey that directly addressed the GAVI Alliance. Several respondents commented on the involvement of non-state actors, and in doing so focused on the ability of CSOs to contribute to more effective governance rather than their ability to increase participation or representation, for alternative political communities. For example one respondent wrote that:

> *It is important that GAVI recognizes the critical role of the private sector in its work -- not only in the discovery and development of new vaccines, but also as a key partner in designing and implementing immunization programs around the world (Comment from a senior staff member of a vaccine manufacturer).

Criticisms of the GAVI Alliance was often directed at a lack of good governance 'for' the people, for example in terms of GAVI having "become too bureaucratic" or that the "members of board lack knowledge of field realities".

> *GAVI was supposed to balance the interests of industry, states and persons in need of immunization but this has not been fully done. Whereas GAVI gave initial support for states to have access to certain vaccines, governments were supposed to take over the costs (Comment from a senior staff member of a non-health related business).

There were numerous positive comments from respondents affiliated with government departments of OECD-DAC states, most of these comments focused on aspects of governance 'for' the people. For example right approach, as in the following comment:

> *At the beginning GAVI was too narrowly focused. Indeed, even if immunization is critical, it is only one aspect of the whole package of intervention in the health sector. We appreciate most the Board's decision to provide financial support to the strengthening of health systems in developing countries most in need (Comment from a senior member of staff at an OECD-DAC state development agency).

> *GAVI has generated a lot of innovative thinking on health development, such as the performance based funding, the ISS and recently the emergence of innovative financing instruments (Comment from a senior member of staff at an OECD-DAC state development agency).

Once again some comments also indicated that the GAVI Alliance, like GFATM is seen as a good solution offering governance 'for' the people, but is only needed because of an unsatisfactory situation in the world today.

> * GAVI has picked up an issue that no-one else seems willing to tackle despite the fact that it is at the core of what all of these efforts are trying to achieve. The GFATM has moved away from special support for HSS [Health Systems Strengthening] and the WB [World Bank] has not picked it up as some had (naively?) hoped. (Comment from a senior member of staff at an OECD-DAC state development agency).

> *In general, I think the existence of the [GAVI Alliance] is a reflection of the world today. So the answer to your question about whether we need them (rather than strengthening WHO and UNICEF) is more a reflection on the rich world's attitude to the UN system at this point of time. Without them I doubt the world would have invested billions through WHO and UNICEF. Also

> the UN system does need to change, to modernize (Comment from a senior member of staff at an OECD-DAC state development agency).

7.5 Outlook: The future of GAVI

The GAVI Alliance is a GHG organisation that bases its work on public governance to a limited extent only. With its dual governance structure, consisting of one public-private and one exclusively private Board, the GAVI Alliance can be seen as an organisation that has moved considerably away from principles of intergovernmentalism. Principles of cosmopolitan democracy and to a large extent managerialism emerge as dominant working principles. Despite this, it enjoys high rates of approval amongst stakeholders.

By applying methods of empirical examination into the legitimacy of a GHG organisation to the GAVI Alliance as a case study it has been found that this is possible because stakeholders mainly base their judgements on whether the GAVI Alliance is legitimate and worthy of support on components of governance 'for' the people. Some stakeholders also prioritised participatory governance as a sub-component of governance 'by' the people.

Effectiveness – specifically- 'impact' as a sub-component of governance 'for' the people provided one of the main bases for the legitimacy of the GAVI Alliance. In particular, the relationship between GAVI and its stakeholders is marked by stakeholders prioritising the need for the GAVI Alliance to have a high problem-solving capacity and show evidence of goal achievement. Of the three GHG organisations examined in this dissertation, the GAVI Alliance has come to have sub-components of governance 'for' the people as a basis for its legitimacy to the greatest extent.

Chapter Eight

Conclusions

Today, the challenge of health inequality is being addressed by various organisations on the global level. Whereas global health policy during the post World War II era was dominated by the World Health Organisation today, several other UN Agencies, large civil society organisations, bilateral health projects and hybrid organisations that include both public and private actors working together – here labelled GHG organisations – all claim political space in the global public health landscape. GHG organisations are representative of a new trend in global governance, away from intergovernmentalism, towards global governance based on principles such as cosmopolitan governance and managerialism, and their presence raises many questions about the empirical workings of global governance. Initial observations that motivated this dissertation were that GHG organisations appear to have increased their level of acceptance amongst key stakeholders and increased their scope of influence in global health, despite breaking with the convention of intergovernmentalism. The 'claims' that they make on various other actors – regarding contributing resources, adopting policies and offering political support – are being met with positive responses. This dissertation set out to gain a better understanding of how this is possible, by analysing the interactions between GHG organisations and the various actors that make up the political

environment of the global health policy issue-area. It did so by taking legitimacy as a possible key factor for understanding the support that GHG organisations receive from their primary stakeholders.

Legitimacy as concept is experiencing increased popularity in analyses amongst constructivist scholars and has remained contested. This dissertation therefore set out with two main aims: first, to provide a basis for examinations into the legitimacy of global governance organisations via a comprehensive systematic description of what legitimacy entails and then proposing how the legitimacy of global governance organisations can be conceptualised; and second, to develop and apply methods for a qualitative analysis of legitimacy for the purpose of gaining a greater understanding of how it is possible for three GHG organisations to be accepted as legitimate amongst their primary stakeholders. Accordingly, this concluding chapter will be divided into two parts, addressing conclusions drawn with respect to each of these two aims. The first part of the chapter addresses consequences for the discipline of International Relations, and global governance studies in particular, while second part draws conclusions relevant for the global health policy field.

8.1 Legitimacy in global governance studies

The initial question posed in this dissertation was: How can GHG organisations, that have based their work on principles of managerialism and cosmopolitanism, rather than intergovernmentalism, come to be accepted as legitimate organisations in the global health policy field? In order to answer this question, the dissertation investigated how GHG organisations are regarded by states and other actors in situations where they initiate policy and claim the right to govern. Both the characteristics of the organisations (internal structures), as well as the perceptions of the stakeholders which surround the organisation (external structures) were examined for how they determine whether the organisation is accepted as legitimate or not. The cases studied in this dissertation showed that a congruence between stakeholder's priorities regarding which values, norms and principles should underlie global health governance, and the actual characteristics of a GHG organisation, allowed legitimacy to be granted. It was also found that the priorities of stakeholders when making judgements about GHG organisations can refer to either aspects of governance 'by' or governance 'for' the people, including several sub-components of these two dimensions. Evidence drawn from statements made in stakeholder texts and a broad based questionnaire

also suggested that all three case study organisations do indeed enjoy a high degree of legitimacy. This occurred despite each of the studied organisations having different organisational characteristics and different dominant working principles.

Methods used in this dissertation can be adopted for use in future research in which it is necessary to operationalise legitimacy or when offering a normative assessment of global governance organisations.

For researchers assessing the legitimacy of a global governance organisation, it is useful to break down the various priorities of stakeholders according to the principles, values and norms to which they refer. In this dissertation, values, norms and principles were categorised as relating to either good governance 'by' the people or good governance 'for' the people. However, other factors (such as charismatic leadership) were also observed as being a possible priority of stakeholders and can therefore also serve as a basis for a global governance organisation's legitimacy. Following this clarification of the various norms, values and principles on which the legitimacy of a GHG organisation might be based, three main options are opened for researchers of global governance organisations.

First, the researcher may take a normative-prescriptive approach and assess the legitimacy of a global governance organisation by judging the extent to which the organisation in question meets criteria that represent good governance 'by' the people and 'for' the people. For example, the researcher may ask whether the organisation is receptive to external criticism in assessing whether channels of indirect participation are available, or may ask which procedural indicators of success are present in assessing its effectiveness. In doing so, the researcher may attempt to assess the organisation from a stakeholder's point of view - making presumptions about what he/she believes stakeholders prioritise - or assess the organisation as an 'objective observer', by making philosophically-based judgements about what *should* be prioritised. The researcher may also decide to select just one, or a few, of the nine sub-components of legitimacy for the purpose of a simplified operationalisation, and rank the importance of each selected component to quantify the legitimacy of each examined organisation.

Second, the researcher may analyse stakeholders' perceptions of the legitimacy of an organisation by adopting methods of a stakeholder analysis. This involves two steps. First, the

researcher identifies stakeholders, their proximity to the global governance organisation and the claims that are made by global governance organisations on these stakeholders – thereby distinguishing between stakeholder types and whether they are primary, secondary or tertiary stakeholders. Second, the researcher conducts empirical research into the behavioural dispositions, attitudes and communicative behaviour of these stakeholders. For this second step, methods of direct observation, discourse analysis and survey research can be used to assess the extent to which the global governance organisation enjoys positive responses from stakeholders, and whether the stakeholders justify these based on the view that the organisation embodies the same principles, norms and values that the stakeholders themselves rate as important. Observing behavioural dispositions allows the researcher to monitor whether an organisation is accepted or not accepted to such an extent that stakeholders accept a governing organisation's claims. By assessing the strength and frequency of legitimating statements in discourse and in response to direct questioning, the legitimacy of a governing organisation can be operationalised, either quantitatively or qualitatively, along the lines of the extent to which it has been accepted on grounds relating to aspects of governance 'by' and 'for' the people, or whether it has been rejected as illegitimate or unworthy. Here, a researcher may also choose to undertake a ranking of legitimating statements, by means of the frequency or strength of legitimating statements or acts.

Third, the researcher may combine both of these methods for the purpose of finding out not only the extent to which a GHG organisation is accepted as legitimate, but also to address the question: In reference to which principles, norms and values does congruence between the stakeholder and the organisations actually occur? This approach was taken in the three case study chapters in this dissertation. Primary stakeholders were identified, and empirical research methods were adopted to identify what kinds of principles, norms and values were prioritised by these stakeholders when making judgements about governing organisations, and in regards to GHG organisations in particular. An assessment of three GHG organisations, UNAIDS, GFATM and the GAVI Alliance was then carried out with the priorities of these stakeholders in mind. The research concluded with the finding that all three GHG organisations observed as case studies are indeed accepted amongst stakeholders as legitimate, albeit based on differing principles, norms and values.

Scholars researching global governance organisations can use the three methods for operationalisation of legitimacy in research that places legitimacy either in the place of

dependent or independent variables, addressing various questions such as: Are organisations that include public and private actors in decision-making considered to be more legitimate than intergovernmental organisations? Or will an organisation that bases its legitimacy on participatory governance be more effective than an organisation that bases its legitimacy on problem-solving capacity? To answer such questions, it is first necessary to be able to operationalise legitimacy, by means of one of the inference methods outlined above.

8.2 GHG organisations in the global health policy landscape

From the point of view of global health policy, the legitimacy of GHG organisations is an important topic of investigation because "…(a)t the broadest level, it is often argued that international orders that enjoy high levels of legitimacy – where there is broad agreement on norms governing membership, procedure, and substantive values – also enjoy high levels of stability" (Reus-Smit, 2007, p. 170). Inequality in global health and the causes and consequences of major pandemics such as tuberculosis, malaria, HIV/AIDS and childhood cluster diseases are long term challenges that require long term strategies and thus organisations that enjoy stable, predictable relationships with their primary stakeholders. This makes global public health an inherently political undertaking, and understanding how GHG organisations come to enjoy being accepted as legitimate amongst stakeholders is important for understanding the political aspects of global health. Furthermore, "Generally speaking, if an institution is legitimate, then this legitimacy should shape the character of our responses to the claims it makes…" (Buchanan & Keohane, 2006, p. 407).

GHG organisations represent a significant development on the global health landscape. They are unique in the extent to which they base their work on principles other than intergovernmentalism, which dominated global health policy during the post World War II era. Stakeholders of GHG organisations are well aware of the fact that GHG organisations represent a new phenomenon in global health and they have subsequently become the focus of close attention. The historical perspective outlined in Chapter Two of this dissertation showed that non-state actors have long played a part in global health policy. Also, at various times, major health organisations, (including the World Health Organisation) have also based their work on principles other than intergovernmentalism. GHG organisations, whose work is based on a mix of intergovernmentalism, managerialism and cosmopolitanism can therefore be seen as a product of historical evolution. Nevertheless, the current end-products of this

evolution face governance challenges that their predecessors – programmes housed within UN System organisations – did not. Like their predecessors, GHG organisations do indeed engage in governance, as they enter into relationships with relevant actors in the global health policy field by means of making certain claims, which may be accepted or rejected, depending on whether that claim is seen as just or rightful (Kelman, 2001, p. 55). Claims might come in the form of requirements, requests, rules or policies – all of which put forward the desired political behaviours they would like their stakeholders to adopt (Zelditch, 2001, p. 37). The difference for GHG organisations compared with IGOs however, is that these claims are not necessarily based on the principle of stemming from formal agreement between sovereign states.

The main question posed at the beginning of this dissertation was therefore: How do GHG organisations – having broken away from conventional models of intergovernmentalism – gain and maintain stable political support amongst the key stakeholders in global health? The short answer to this question is that it is possible for GHG organisations to come to be accepted as legitimate when stakeholders come to value sub-components of governance 'by' the people, other than public governance, and when they also value a governing organisation's ability to provide governance 'for' the people.

In this dissertation, the main research question was approached by posing the following three sub-questions: What different GHG organisations exist and what are their characteristics? *Which actors must perceive GHG organisations as legitimate, appropriate, or worthy of support? On what grounds do actors such as donors, addressees and other stakeholders accept GHG organisations as having the right to govern and to make requests to accept and follow their rules for behaviour?*

In response to the first question, it was found that several GHG organisations were formed around the turn of the 21st century with certain characteristics in common, but varying in the extent to which they to move away from intergovernmentalism. This dissertation examined three GHG organisations in depth, each of which can be seen to base its work on principles of intergovernmentalism, cosmopolitan governance and managerialism in different measure. The Joint United Nations Program on HIV/AIDS (UNAIDS) is a GHG organisation that retains a strong intergovernmental basis to its work. The composition, role and decision-making procedures of the central decision-making body of UNAIDS – with its public actors in formal

voting roles – demonstrate that it remains essentially a public-based organisation. Although it is located within the United Nations system and is accordingly primarily a state-based organisation, key features of UNAIDS show that it can be described as part of the shift away from intergovernmentalism towards cosmopolitan (participatory) democracy. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has a highly inclusive structure that specifically gives decision-making rights to both state and non-state actors. Finally, the GAVI Alliance is an organisation that has shifted furthest away from intergovernmentalism towards managerialism. Within this organisation, experts working in an individual capacity have come to play a large role, while states and actors representing non-territorial political communities also have decision-making rights on its Board.

Primary stakeholders of these three GHG organisations react to these different working principles in varying ways. When examining the legitimacy of GHG organisations, stakeholders can be distinguished along two lines: first, in terms of the closeness of their relationship with the GHG organisation – i.e. as primary, secondary or tertiary stakeholders, and second, by means of the organisation type of stakeholders, as being state or non-state-based, or being intergovernmental, for-profit or non-for-profit. Several organisations of each stakeholder type can be considered primary stakeholders of each of the three GHG organisations examined in depth as case studies in this dissertation. Of particular importance are: first, states that have the potential to contribute resources to GHG organisations, primarily those that are members of the OECD-DAC and have specific budgets for development aid; second, states that are burdened by poor health due to existing in-state epidemics or are at risk of becoming burdened by poor health; third, IGOs that are involved in shaping global health policy; fourth, business sector actors that are either directly involved in the health sector as manufacturers of medical or hygiene products or through business operations that affect or are affected by global level health policy or are involved in global health as part of CSR activities; and fifth, civil society organisations, with varying organisational structures and functions, that in some way are influenced by, or influence, global health policy.

The empirical research undertaken to extract which values, norms and principles are considered priorities by primary stakeholders of GHG organisations found that within each stakeholder group, priorities can vary between actors, and between individuals affiliated with those actors. Nevertheless, some general trends can be inferred. Member states of the OECD-DAC project hold strong and relatively consistent opinions regarding which values, principles

and beliefs underlie good global health governance when they engage in public discourse. Principles related to participatory governance, problem-solving capacity and effectiveness are considered to be important bases on which they judge a GHG organisation to be worthy of support. Stakeholders in other groups tend to be more divided. However, amongst all stakeholder groups, aspects of both governance 'by' and 'for' the people provide the bases on which stakeholders make value judgements. Despite a few exceptions, public governance - based on principles of consent between sovereign states – is not portrayed as the only acceptable basis for the legitimacy of global health organisations amongst stakeholders. A large number of stakeholders conveyed the opinion that they found it appropriate for civil society organisations in particular to participate in decision-making.

When assessed directly against criteria that indicate good governance 'by' and 'for' the people, all three of the case study GHG organisations do display some deficits. Thus, critical actors have grounds on which to base disapproval, though for each organisation expression of disapproval is aimed at different deficits. UNAIDS has been criticised for being too slow and cumbersome in its working procedures, for not being able to act independently of certain states and for a lack of diversity in terms of who sits as members on its programme coordinating board. GFATM has been criticised for its approach, including strict funding requirements and being vertical by design. The GAVI Alliance on the other hand has been criticised for allowing over-representation of business sector actors and donor interests. These perceived shortcomings may demand responsiveness to criticism in the future.

However, all three case study organisations were found to enjoy being seen as legitimate amongst a high percentage of stakeholders. In each case, stakeholders came to prioritise somewhat different norms, values and principles when judging different organisations.

Congruence was found between the GAVI Alliance and its stakeholders regarding the importance of expertise and problem-solving capacity. GFATM has become known and accepted as an organisation that is worthy due to its high level of transparency, levels of participatory access and effectiveness. The legitimacy of UNAIDS is also based on a congruence of priorities in the internal and external structures – specifically those relating to problem-solving capacity and retaining an intergovernmental base.

All three of the GHG organisations examined in this dissertation have been able to gain and maintain stable political support amongst the key stakeholders in global health by basing their work on a combination of principles of good governance ‘by’ the people and ‘for’ the people. As these principles coincide with the values of a large number of primary stakeholders – and as in each case stakeholders have a different focus depending on the working principles of the organisation – GHG organisations have come to be regarded as legitimate organisations. However, two qualifications of this conclusion are necessary. First a number of stakeholders are dissatisfied with the trend towards managerialism and governance ‘for’ the people, and prefer state controlled GHG organisations. Evidence of this came about in response to direct questioning of stakeholders, but remained hidden in public discourse. While these stakeholders are not concentrated in any one stakeholder group, their dissatisfaction could serve to undermine the legitimacy of these organisations in the future. Second, having such a broad base for legitimacy inherently leads to the challenge that GHG organisations have to meet a large number of criteria to retain a reservoir of support from a diverse number of stakeholders. While the possible bases of the legitimacy of a GHG organisation have expanded to include more than just principles associated with intergovernmentalism, today there is less of a clear consensus of what makes governance legitimate. This might have advantages and disadvantages for governance organisations and stakeholders alike.

The findings of this dissertation stand in contradiction to those arguments that state that, at the global level, only agreements between sovereign states – which infer quasi-democratic expression of consent – are accepted as legitimate. Objections to non-state actor involvement in global level governance (based on the argument that they can not be held to account by means of democratic process, and are not responsible for a recognised territory) are not so widespread as to hinder GHG organisations from finding acceptance as legitimate governing organisations amongst primary stakeholders (Conzelmann & Wolf, 2007, p. 146). This dissertation found that other principles, such as those relating to participatory governance and effective problem-solving ability, can serve as the basis of the legitimacy of global governance organisations – especially those aimed at addressing specific issues-areas as in the case of GHG organisations.

The extent to which intergovernmentalism has had to give way to alternative working principles has reached a new level within GHG organisations and GHG organisations also display a range of common features that distinguish them from IGOs. Stakeholders assessing

these organisations make decisions as to whether these developments are appropriate and whether GHG organisations are worthy of support despite this move away from intergovernmentalism. This dissertation found that it is not necessary for all nine sub-components to be completely recognised by a certain stakeholder for legitimacy to be granted nor it is necessary for a GHG organisation to have a purely intergovernmental basis for it to be accepted as worthy amongst its primary stakeholders. Legitimacy comes to exist on a global level as a specific feature of the relationships that exist between global governance organisations and stakeholders. Claims made within such relationships will be considered acceptable when there is a perceived congruence between the values, norms and principles of the stakeholders and the characteristics of the governing organisation.

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Appendix I

Summary

The face of global health is changing, not only in terms of the effects that globalisation is having on the spread of diseases around the world, but also in terms of the way public health is approached, managed and governed on local, regional and global levels. This book is concerned with health governance on the global level, where over the past fifteen years, a number of new organisations have emerged that have taken on major global public health issues, offering new policy approaches and comprising new organisational features. Three examples are the Global Fund to Fight AIDS, Tuberculosis and Malaria, (GFATM), the Global Alliance for Vaccines and Immunisation (GAVI Alliance), and Joint United National Programme on HIV/AIDS (UNAIDS), each of which are examined in depth in this book.

These organisations differ significantly from intergovernmental organisations such as the WHO and can be classified as organisations of 'global governance'. In the book they are referred to as global health governance (GHG) organisations. Two basic observations concerning these organisations provide the motivation for inquiry. First, GHG organisations

represent new governance forms with unprecedented characteristics in terms of their organisational features and their approach to achieving outcomes. The work of each of these organisations can be said to be based on principles that shift away from intergovernmentalism, towards managerialism and cosmopolitanism. Second, despite this break with the conventional model of intergovernmentalism, these organisations are increasing their operational scope in terms of determining rules for action, and gaining funding.

How do GHG Organisations – having moved away from the conventional model of global level governance of intergovernmentalism – come to be accepted a legitimate governing organisations?

Despite its increasing popularity and a number of studies which use legitimacy as an explanatory variable, it remains a contested concept lacking sound explication of what it is based on, or, importantly, who determines what is legitimate or not. Doubts are expressed as to whether legitimacy can even really exist for global level organisations because of the absence of a global *demos* that would grant legitimacy (Dahl, 1989; Dingwerth, 2007; Reus-Smit, 2007). Therefore, this book begins with two overarching aims, first to provide a basis for examinations into the legitimacy of GHG organisations via a systematic description of what legitimacy entails, the formulation of a conceptualisation of the legitimacy suitable for the global level, and the development of methods suitable for empirically examining the legitimacy of GHG organisations. Second, to apply the resulting methods in an examination of three GHG organisations in an attempt to find out whether they are considered legitimate amongst stakeholders and what the sources of their legitimacy are. Importantly, the applied research methods move beyond a normative-prescriptive approach to legitimacy, seeking to analyse stakeholders' priorities in terms of what constitutes good, appropriate and 'legitimate' governance, and how they view GHG organisations with respect to these priorities.

The main research question is approached by applying three methods of empirical analysis, first, observation of stakeholder behaviour; second, discourse analysis and third, surveying expressed opinions of stakeholders. From the resulting data, inferences are made regarding which norms, values and principles stakeholders prioritise when making judgements about global governance organisations, and how stakeholders rate the three case study GHG organisations in relation to these priorities.

It is found that while on the global level the absence of a clear demos may limit the possibility of a minority accepting the will of the majority based on collective identity, legitimacy can still exist on a global level because a range of norms, values and principles underlie the work of global governance organisations. On the global level legitimacy can be based on both aspects of governance 'by' and 'for' the people. These two dimensions of legitimacy can be broken down into nine sub-components each of which refer to specific principles, values and norms that can underpin legitimacy considerations, as summarised below.

Governance 'by' the people may entail:

Public governance: Are those involved in decision-making representatives of citizens and/or sovereign states? And do they have the role of acting in the best interests of their citizens?

Participatory governance: Are the interests of all affected parties represented in decision-making?

Fair processes: How do the persons that are meant to represent the interests of stakeholders come to have this representative role? How are power differentials between represented groups balanced out? How is decision-making formalised and organised?

Indirect participation: How can stakeholders express disapproval of decisions? Is the organisation responsive to criticism? What documents from the organisation are available? Do stakeholders have access to comprehensive information?

Governance 'for' the people may entail:

Right purpose: What does the organisation aim to do 'for' the people? Is it necessary, and desirable for a (new) global organisation to take on this task?

Problem-solving capacity: Is decision-making based on scientific evidence? Does the organisation comprise an expert base? Does the organisation employ competent staff and consult and partner with necessary experts?

Right approach: How does the organisation go about achieving its aims? Does the approach embody principles that promise achieving desired effects?

Effectiveness and Efficacy: What effect did the organisation have on the actions on other actors in the policy field? What procedural indicators of success are there? What impact has the organisation had? Are these effects desirable?

Organisational Efficiency: Does the organisation work in a lean and efficient manner? Does the organisational structure allow the organisation to produce outcomes that benefit its stakeholders?

Global governance organisations can be viewed as operating within a system of heterarchical, rather than hierarchical governance. Therefore, legitimacy, on the global level, can be understood as an "... issue that arises in an interaction or relationship between two individuals, or between one or more individuals and a group, organisation, or larger social system" (Kelman, 2001, p. 55). Organisations that engage in global governance, such as GHG organisations, therefore come to enjoy legitimacy in instances where relevant stakeholders perceive that there is a congruence between the norms, values and principles conveyed through the characteristics of the organisation and their own normative priorities, as portrayed in the following diagram.

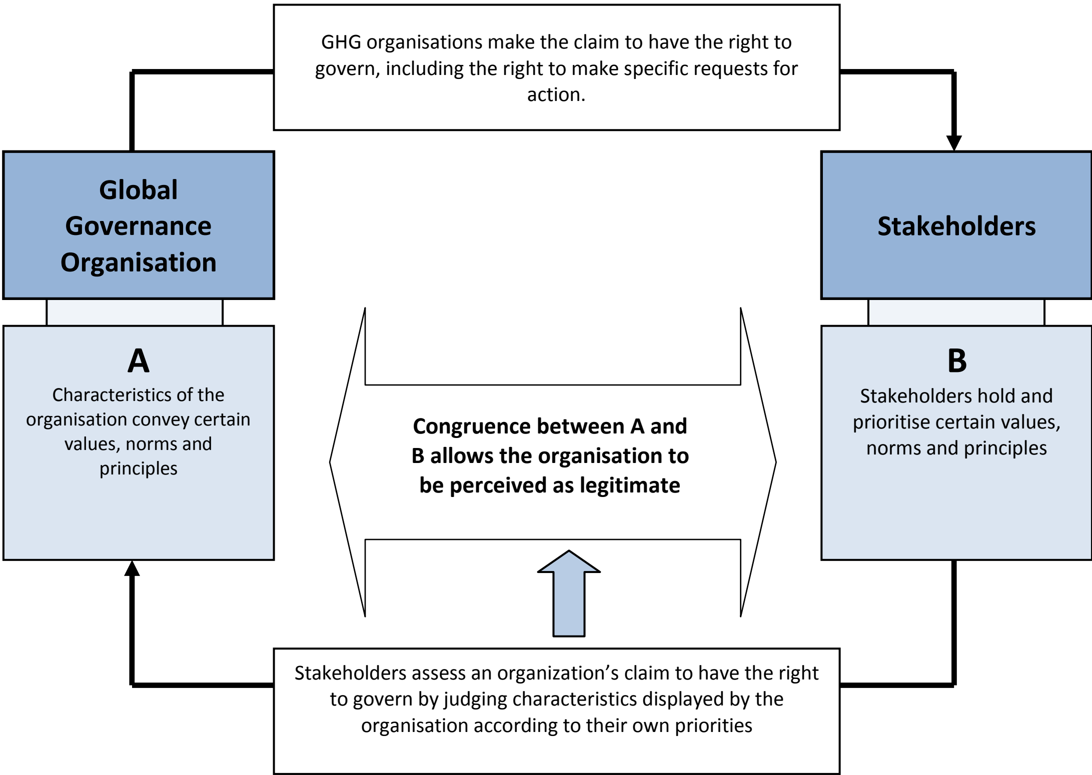

Diagram 1: Relationships between global governance organisations and stakeholders

In the cases examined in the book, it is found that stakeholders prioritise principles, values and norms relating to aspects of both governance 'by' and 'for' the people, including participatory governance, right process, problem-solving capacity and efficacy, thus allowing GHG organisations that base their work on principles associated with managerialism and cosmopolitanism, rather than intergovernmentalism to also become accepted as legitimate.

In the case of UNAIDS it was found that it has become possible for UNAIDS to demonstrate to stakeholders that it is an organisation worthy of support, because stakeholders prioritise a range of organisational characteristics which combine to make up good governance 'by' and 'for' the people. While some stakeholders maintain that the state base of UNAIDS is both necessary and desirable, many stakeholders emphasize participatory governance and praise UNAIDS approach. An assessment of the characteristics of GFATM shows that while it has maintained a public-governance base, the organisation has also incorporated elements of participatory governance into its governance structure. It is also an organisation that has displayed effectiveness, efficacy, transparency and problem-solving capacity. The application of empirical research methods to infer stakeholder's priorities when it comes to assessing GFATM has shown that despite a considerable amount of very specific criticism, stakeholders tend to prioritise these aspects when evaluating GFATM and this has made it possible for GFATM to be perceived as a legitimate organisation. Finally, in the case of the GAVI Alliance, the relationship between this organisation and its stakeholders is marked by stakeholders prioritising the need for problem-solving capacity and evidence of goal achievement. Of the three GHG organisations examined in this book, the GAVI Alliance has come to have sub-components of governance 'for' the people as a basis for its legitimacy to the greatest extent.

The extent to which intergovernmentalism has had to give way to alternative working principles has reached a new level within GHG organisations; and GHG organisations also display a range of common features that distinguish them from IGOs. Stakeholders assessing these organisations make decisions as to whether these developments are appropriate and whether GHG organisations are worthy of support despite this move away from intergovernmentalism. It has been found that it is not necessary for all nine sub-components to be completely recognised by a certain stakeholder for legitimacy to be granted, nor it is necessary for a GHG organisation to have a purely intergovernmental basis for it to be accepted as worthy amongst its primary stakeholders. Legitimacy comes to exist on a global level as a specific feature of the relationships that exist between global governance organisations and stakeholders. Claims made within such relationships will be considered acceptable when there is a perceived congruence between the values, norms and principles of the stakeholders and the characteristics of the governing organisation.

Appendix II

Text Content Analysis –

Perceptions of legitimacy in stakeholder publications

AII.1 Introduction

When it comes to establishing rules of practice for their own actions, or to aligning themselves with the rules of practice of global health governance organisations, actors in global health make their judgements (at least in part) based on what they consider to be legitimate governance – i.e. governance that they consider rightful, appropriate and worthy of support because it aligns with their own values, principles and guiding norms. Empirical social science recognises that the legitimacy of any governance organisation (or governing entity) is factually granted (or withheld) by those actors that have a vested interest. One method for extracting and assessing the position of stakeholders towards governance

organisations from this empirical science standpoint is to analyse political discourses. According to Hurrelmann, Schneider and Steffek:

> …the conceptual schemes and worldviews of political actors, and hence the benchmarks used in their legitimacy evaluations, are, to a large extent, shaped by political discourses. Thus it seems worthwhile to study the legitimacy claims advanced in public communication (Hurrelmann, Schneider, & Steffek, 2007).

The aim of the text analysis was to find out, from the point of view of various types of actors, here labelled stakeholders, how various global health governance organisations are viewed in terms of their legitimacy, and what values, principles and guiding norms are referred to in public communication as providing a basis for the legitimacy of GHG organisations.

Formal published texts represent the official positions of 'conglomerate actors' such as states, civil society organisations (CSOs), businesses, UN agencies and so on. While various individuals working in, or associated with, such conglomerate organisations might hold varying opinions, official published texts represent the formal position of the actor as a unit. States, non-governmental organisations and business sector actors alike create texts for the public to express their views, expectations and priorities. Published texts also form part of a global political discourse and are therefore a useful resource for an initial analysis aimed at answering the question: *In the opinion of stakeholders, what provides the basis for the legitimacy of global health governance organisations?*

The aim of the text analysis was to extract, from formal publications, the extent to which an actor:

1) refers to principles, values and norms that they consider provide the legitimate basis for their own work and practices;
2) refers to the principles, values and norms that might provide the basis for the legitimacy of other actors in global health;
3) shows approval or disapproval for certain other actors active in global health;
4) refer to and/or judge the global health governance organisations UNAIDS, GFATM and the GAVI Alliance.

The text analysis shows that there are considerable variations in the extent to which stakeholders refer to certain values, principles and guiding norms. While all actors referred to

elements of both governance "by" the people, and governance 'for' the people to some extent, it is possible to discern a considerable leaning towards principles relating to good governance 'for' the people in the discourse surrounding global health organisation, in particular those with a narrow, technical focus. Nevertheless, frequent mentions of the importance of "participatory approaches" indicates, that at least amongst certain stakeholders, good governance 'by' the people is considered important.

AII.2 Methods

Based on the differentiation of the various sub-components of governance 'by' and 'for' the people that provide the basis for legitimacy as documented in Chapter Three of this book; a qualitative analysis of texts was carried out to identify and evaluate contextual references made in published texts. Research sourced: 1) references to an object of legitimation (e.g. a GHG organisation, private sector actors); 2) evaluations of the object of legitimation (e.g. is good, is wrong); and 3) patterns of legitimation containing references to norms, values or any of the sub-components of legitimacy previously identified.

The analysis was carried out in two steps:

Step 1. Particular word clusters and references to key concepts' were sought in texts that indicate references to good governance 'by' and 'for' the people as well as other values and principles, such as leadership. The various word clusters are reproduced in Figure AII.1. The use, significance and meaning of these word clusters were qualitatively reviewed in a summary of the texts. Any references to the case study organisations were also sought out and analysed in terms of the way they were portrayed in the text.

Step 2. The frequencies of use of the most significant "key concepts" and "word clusters" indicating values, beliefs and principles relating to governance 'by' the people and governance 'for' the people were presented in graphs comparing individual texts, as well as stakeholder groups. Differences between texts, and stakeholder groups were compared by referring back to qualitative review undertaken in step 1.

The analysis thereby encompassed elements from descriptive, contextual and comparative analysis types (Sarantakos, 2005). The descriptive element identified and described the content of the data in relation to the key themes – bases of legitimacy. The contextual element

contributed to an understanding of the context through which certain statements and references were made. The comparative element compared texts from different stakeholders to identify differences in priorities.

AII.3 Sampling

Texts were selected from primary stakeholders of GHG organisations, i.e. those directly addressed by GHG organisations' policies and those that will directly affect the GHG organisations if they withdraw support. Sampling was based on being a primary stakeholder of the three case-study organisations: The GAVI Alliance, GFATM and UNAIDS. A total of 90 texts were selected for analysis from four stakeholder groups:

1st Stakeholder Group Governments of member states of the OECD Development Assistance Committee (OECD-DAC). This group was selected because states that participate in development assistance play a key role in providing resources for addressing global health challenges. Their views of legitimate global health governance may influence whether they provide funding to the case-study organisations, or whether their development assistance activities are aligned to complement the work of the case study organisations. 20 texts were chosen from this stakeholder group.

2nd Stakeholder Group Governments of states that have, or are at risk of developing, epidemics in HIV/AIDS or diseases preventable through immunisation. This was defined by the rates of deaths from immunisation-preventable childhood cluster diseases and rates of HIV/AIDS infection.[104] This group was selected because of their key role in providing the necessary environment to combat poor health. Their views of legitimate global health governance may influence the alignment of their activities and priorities with the work of the case-study organisations. 30 texts were chosen from this stakeholder group.

3rd Stakeholder Group Civil society organisations (non-for-profit) (CSOs) active in global health. This group was selected because there are a large number of nongovernmental organisations that work in global health, either as their main realm of activity, or as part of a wider programme of activities. Their views on legitimate global health governance may have

[104] A larger number of texts were selected from this group. The role and importance of state-governments from epidemic countries justifies this higher weighting. There are also significantly more countries with high rates of diseases than there are donor countries.

an effect whether or not they support the case study organisations or oppose them. Support for the case study organisation may include public advocacy, contributing resources (financial, knowledge etc.), or operational assistance. In contrast, opposition may involve restraint in terms of cooperation, or even calls for a completely new approach to global health governance. 20 texts were chosen from this stakeholder group.

4th Stakeholder Group Business sector actors (for-profit), involved in global health, directly or indirectly as part of their business activities. This group was selected because businesses, both as a consequence of the pursuit of their own goals, as well as through participating in corporate social responsibility (CSR) activities, effect global health outcomes. Their views on legitimate global health governance may influence their decision to adopt one policy approach over another (e.g. in terms of workplace programmes, or contributing to a health fund). 20 texts were chosen from this stakeholder group.

AII.4 Data Collection

Directly comparable texts were not available, i.e. texts with the exact same purpose, format and length. Therefore, each text was treated as a research object in its own right. However, for the purpose of the cross-analysis (step 2), texts were only selected if they met the following criteria:

1. The text was available to the public. Texts taken into the analysis were received on request or were available online.[105]
2. The text contained policies, strategies, aims or evaluations of own activities.
3. The text contained policies, strategies, aims or evaluations of health related activities.
4. The text was published between 2005 and 2007. Documents published immediately prior, but relevant for the years 2005-2007 were also included if no up-to-date alternative for the specified time frame was available.
5. The text was at least 500 words long, and of a static nature, i.e. it conveyed strategies, policies and official position of the stakeholders at the time. Research and discussion papers were not included. [106]

[105] Where no suitable publication was available, website texts were also taken.
[106] The shortest text included in the analysis was from Luxemburg which contained 490 words. This text was included as the most appropriate available from that country.

Figure AII.1: Word clusters and key concepts in stakeholder texts

Words clusters referring to governance ‘for’ the people		Words clusters referring to governance ‘by’ the people	
Word Cluster	**Evaluated by:**	**Word Cluster**	**Evaluated by:**
• Mentions in text of the use of "experts" "expertise" and "competence" • Mentions in text of "effectiveness“, “efficiency" and "efficacy" • Mentions in text of differentiation between "outputs", "outcomes" and "impact" • Mentions in text of policy preferences "Primary Health Care" and "evidence-based policy"	• **Positive labelling as:** – "important" "high priority"; – "necessary", "needed"; – to be "encouraged" "strived for"; and – to be "improved". – By emphasizing it's utilization. • **Negative labelling as:** – "unnecessary" "unimportant" – "cumbersome" – "causing problems" – "exaggerated" and – "not an adequate measure". – By only briefly or by not utilizing the term.	• Mentions in text of “democracy” and/or “representation” • Mentions in text of “participation”, “involvement” and “inclusiveness” • Mentions in text of “access”, “openness” and ‘transparency’ • Mentions in text of “responsibility” and ‘accountability’ for actions. • Mentions in text of processes of “deliberation”, “consultation”, “debating” and “discussing”.	• **Positive labelling as:** – "important" "high priority"; – "necessary", "needed"; – to be "encouraged" "strived for"; and – to be "improved". – By emphasizing it's utilization. • **Negative labelling as:** – "unnecessary" "unimportant" – "cumbersome" – "causing problems" – "exaggerated" and – "not an adequate measure". – By only briefly or by not utilizing the term.

Use of Key Concepts		Mentions of Global Health Organisations	
Concept	**Evaluated by asking:**	**Word Cluster**	**Evaluated by:**
• “leadership” • “appropriateness” • “governance” • “responsibility” • “CSOs and “civil society”	• **How was this concept used?** • **Was the concept used to lend support to governance ‘by’ and/or ‘for’ the people?** • **Was the concept used when referring to a Global Health Organisation?**	• World Health Organisation • The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) • GAVI Alliance • UNAIDS	• **Assessments of the organisation's governance ‘by’ the people:** – referring to Board composition – labelling organisation "transparent", "accountable" – referring to decision-making **processes.** • **Assessments of the organisation's governance ‘for’ the people** – using the organisation as a source of information – referring to achievements, successes and effectiveness and/or efficiency • **General positive assessments:** – "innovative", "promising" "best" • **General negative assessments:** – "unknown" "unreliable" "problem”

AII.5 Analysed texts

AII.5.1 First stakeholder group: Governments of OECD-DAC member-states

Countries that contributed over 0.5% of Gross National Income to Overseas Development Aid in 2006 were included in the sample. These countries are an asterisk (*) in the table below.. Also taken into the sample were countries that donated a total of more than 10,000US$Million in 2006. These countries are marked with a double asterisk (**) in the table below.

Table AII.3: OECD-DAC Member Overseas Development Aid 2006.

DAC Member Country	ODA % Gross National Income	NET ODA (US$ million)
Australia	0.30	2127.50
Austria	0.48	1512.69
Belgium	0.50	1967.66
Canada	0.30	3713.14
Denmark	0.80	2234.00
Finland	0.39	826.11
France**	0.47	10448.19
Germany**	0.36	10350.89
Greece	0.16	384.07
Ireland*	0.53	997.21
Italy	0.20	3672.16
Japan**	0.25	11607.91
Luxembourg*	0.89	291.02
Netherlands*	0.81	5451.50
New Zealand	0.27	257.28
Norway*	0.89	2946.31
Portugal	0.21	390.99
Spain	0.32	3801.25
Sweden*	1.03	3967.33
Switzerland	0.39	1647.49
United Kingdom**	0.52	12606.91
United States**	0.17	22738.75

Source: OECD Statistical Tables "Net ODA in 2006" accessed online: 20th November 2007. http://www.oecd.org/dataoecd/12/8/38346276.xls

From these countries texts were selected that represent ed policies on overseas aid and multilateral cooperation. Where possible, texts were taken which were specifically focused on health policy.

Text: DGCid (Ministry of Foreign and European Affairs-France) (2006): *French International Cooperation.*
Approx. Length (in words): 25380

Text: DGCid (Ministry of Foreign and European Affairs-France) (2007): *Sectoral Strategy Health*. (Online Text)
Approx. Length (in words): 7810

Text: BMZ (Federal Ministry for Economic Cooperation and Development-Germany) (2005): *The German Government's 12th Development Policy Report (Topics 152).*
Approx. Length (in words): 190230

Text: BMZ (Federal Ministry for Economic Cooperation and Development-Germany) (2007): *Promoting Health – Fighting HIV/AIDS (Topics 178)*
Approx. Length (in words): 19910

Text: Irish Aid (2007): *Strategy for supporting Global Health Partnerships 2006-2010*.
Approx. Length (in words): 10620

Text: Irish Aid (Department of Foreign Affairs-Ireland) (2007): *Health Policy: Improving Health to Reduce Poverty*.
Approx. Length (in words): 10960

Text: Luxembourg Ministry of Foreign Affairs (2007): *La coopération luxembourgeoise au développement: Lëtzebuerger Entwécklungszesummenaarbecht. Rapport Annuel 2006.* (English Translation Used)
Approx. Length (in words): 490

Text: MOFA (Ministry of Foreign Affairs-Economic Cooperation Bureau-Japan) (2003): *Japan's Official Development Assistance Charter.*
Approx. Length (in words): 3780

Text: Government of Japan (2005): *"Health and Development" Initiative (HDI): Japan's contribution in achieving the health related MDGs.*
Approx. Length (in words): 4950

Text: MINBUZA (Ministry of Foreign Affairs – Netherlands) (2007): *Policy Agenda 2008.*
Approx. Length (in words): 6880

Text: MINBUZA (Ministry of Foreign Affairs – Netherlands) (2007): *Dutch Aid Policy* (Online Text).
Approx. Length (in words): 3830

Text: Ministry of Foreign Affairs - Norway (2006): *Norwegian Action Plan for Environment in Development Cooperation.*
Approx. Length (in words): 5460

Text: Ministry of Foreign Affairs - Norway (2006): *Norway's HIV and AIDS Policy: Position Paper in Development Cooperation.*
Approx. Length (in words): 7060

Text: SIDA (Swedish International Development Cooperation Agency) (2007): *Progress in Health Development – Sida's Contributions in 2006.*
Approx. Length (in words): 58940

Text: SIDA (Swedish International Development Cooperation Agency) (2005): *Turning Policy into Practice: Sweden's Implementation of the Swedish HIV/AIDS Strategy.*
Approx. Length (in words): 38680

Text: DFID (Department for International Development – United Kingdom) (2006): *Eliminating World Poverty. White Paper. Making Globalisation Work for the Poor.*
Approx. Length (in words): 30380

Text: DFID (Department for International Development – United Kingdom) (2007): *Working Together for Better Health. DFID Health Strategy 2007.*
Approx. Length (in words): 18650

Text: US Department of State/USAID (2007): *Strategic Plan Fiscal Years 2007-2012. Transformational Democracy.*
Approx. Length (in words): 28220

Text: PEPFAR (U.S. President's Emergency Plan for AIDS Relief) (2007): *The Power of Partnerships. The President's Emergency Plan for AIDS Relief. Third Annual Report to Congress.*
Approx. Length (in words): 111820

Text: United States Global AIDS Coordinator (2004): *The President's Emergency Plan for AIDS Relief. U.S. Five-Year Global Health Strategy.*
Approx. Length (in words): 49420

AII.5.2 Second stakeholder group: epidemic and at-risk states

The health topics most closely related to the work of the case study organisations, UNAIDS, the GAVI Alliance and GFATM are vaccine preventable childhood diseases, and HIV/AIDS. The sampling strategy for gathering texts from this stakeholder group was therefore based on prevalence and mortality rates of these diseases. Texts were selected that were produced by the governments of countries with high rates of HIV/AIDS prevalence (Adult (15–49) rate (%) in 2005) and high death-rates from the childhood cluster diseases, pertussis, poliomyelitis, diphtheria, measles, tetanus, (age-standardised rates in 2002). To ensure geographical diversity, sampling was undertaken separately for various regions, as classified in the UN World AIDS Report 2006. Both childhood disease mortality and HIV/AIDS

infection rates were particularly high in the Sub-Saharan Africa region. Therefore, more texts were taken from governments of that region than any of the others.

Table AII.4 to Table AII.9 below list countries with the highest HIV/AIDS prevalence and highest death-rates from childhood cluster diseases in each region. Statistics on death rates from childhood cluster diseases were retrieved from the World Health Organisation Statistical Information System (WHO, 2004): HIV/AIDS prevalence rates refer to the year 2005 as published in the WHO/UNAIDS 2006 Report on the Global Aids Epidemic (UNAIDS, 2006).

Countries marked with an asterisk (*) had particularly high HIV/AIDS prevalence rates and/ or high death rates from childhood cluster diseases and were therefore taken into the sample.

Table AII.4: Age-standardised death rates of childhood cluster diseases and HIV/AIDS prevalence in Sub-Saharan Africa

Country	Age-standardised death rates from childhood cluster diseases (2002 per 100,000 population).	HIV/AIDS prevalence rates (2006)
Angola	41.5	3.7
Botswana*	0.9	24.1
Burkina Faso	24.9	2
Cameroon	25.7	5.4
Central African Republic*	68.4	10.7
Chad*	69.6	3.5
Congo	58	5.3
D.R. Congo	57	3.2
Equatorial Guinea*	61.6	3.2
Guinea*	82.5	1.5
Guinea-Bissau*	84.6	3.8
Lesotho*	38	23.2
Liberia*	70.1	n/a
Malawi*	10.2	14.1
Mozambique*	54	16.1
Namibia*	12.6	19.6
Niger*	85	1.1
Nigeria*	76.9	3.9
Sierra Leone *	77.5	1.6
Somalia*	94.9	0.9
South Africa*	7	18.8
Swaziland*	4.7	33.4
Zambia*	16.6	17
Zimbabwe*	15.3	20.1

Table AII.5: Age-standardised Death Rates of Childhood Cluster Diseases and HIV/AIDS Prevalence in Asia

Country	Age-standardised death rates from childhood cluster diseases (2002 per 100,000 population).	HIV/AIDS prevalence rates (2006)
Cambodia*	18.7	1.6
China	2	0.1
Thailand	0.7	1.4
India*	21.5	0.9
Burma (Myanmar)*	24.1	1.3
Bangladesh	18.4	< 0.1
Indonesia	15.6	0.1
Nepal	20	0.5
Pakistan*	30.8	0.1
Bhutan	29.2	< 0.1
Afghanistan*	34.3	< 0.1

Table AII.6: Death Rates of Childhood Cluster Diseases and HIV/AIDS Prevalence in Oceania

Country	Age-standardised death rates from childhood cluster diseases (2002 per 100,000 population).	HIV/AIDS prevalence rates (2006)
Papua New Guinea*	17.4	1.8

Table AII.7: Death Rates of Childhood Cluster Diseases and HIV/AIDS Prevalence in Eastern Europe and Central Asia

Country	Age-standardised death rates from childhood cluster diseases (2002 per 100,000 population).	HIV/AIDS prevalence rates (2006)
Estonia*	n/a	1.3
Ukraine*	0.1	1.4
Russian Federation	0.1	1.1
Republic of Moldova	0.1	1.1
Georgia*	0.8	0.2
Tajikistan*	0.8	0.1
Turkmenistan	0.5	< 0.1

Table AII.8: Death Rates of Childhood Cluster Diseases and HIV/AIDS Prevalence in North Africa and the Middle East

Country	Age-standardised death rates from childhood cluster diseases (2002 per 100,000 population).	HIV/AIDS prevalence rates (2006)
Sudan*	52.7	1.6
Algeria*	10.8	0.1
Morocco	5.2	0.1
Turkey	7	n/a

Table AII.9: Death Rates of Childhood Cluster Diseases and HIV/AIDS Prevalence in Latin America and the Caribbean

Country	Age-standardised death rates from childhood cluster diseases (2002 per 100,000 population).	HIV/AIDS prevalence rates (2006)
Bahamas*	n/a	3.3
Barbados	0.3	1.5
Dominican Republic	0.8	1.5
Haiti*	16.1	3.8
Jamaica	0.1	1.5
Trinidad and Tobago	0.1	2.6
Suriname	0.7	1.9
Guyana	0.3	2.4
Belize	n/a	2.5
Panama	0.1	0.9
El Salvador	0.1	0.9
Guatemala	2	0.9
Honduras	0.1	1.5
Bolivia	2.3	0.1
Nicaragua	1.7	0.2
Peru	1.4	0.5

As texts were not available from all the countries identified in the sampling strategy, in total 30 texts from the countries taken into the sample were selected for the text content analysis.

AII.5.2.1 Sub-Saharan Africa

Text: Republic of Botswana National AIDS Coordinating Agency (2003): *Botswana National HIV/AIDS Strategic Framework 2003-2009.*
Approx. Length (in words): 46700

Text: Republic of Botswana Ministry of Health (2005): *Corporate Performance Plan 2005-2009,* (Version 3).
Approx. Length (in words): 5720

Text: Lesotho Ministry of Health and Social Welfare (2005): *Lesotho Revised EPI Policy 2005*.
Approx. Length (in words): 6890

Text: Kingdom of Lesotho (2004): *Lesotho Poverty Reduction Strategy 2004/2005 – 2006/2007-*
Approx. Length (in words): 6445

Text: Government of Malawi (2000): *The National Strategic Framework for HIV/AIDS, Malawi 2000-2004*.
Approx. Length (in words): 5170

Text: Government of Malawi (2002): *The Malawi Essential Health Package.*
Approx. Length (in words): 62590

Text: Government of the Republic of Namibia Ministry of Health and Social Services (2003): *Policy on Development Cooperation.*
Approx. Length (in words): 1530

Text: Republic of South Africa - Department of Health (2007): *Strategic Plan 2007/2008 2009/2010.*
Approx. Length (in words): 10800

Text: Republic of Mozambique, Committee of Counsellors (2003): *Agenda 2025: The Nation's Vision and Strategies.*
Approx. Length (in words): 73504

Text: Sierra Leone Office of the President - National HIV/AIDS Secretariat (2006): *National HIV/AIDS Strategic Plan 2006-2010.*	
Code on Diagrams: E12-SL2	**Stakeholder Group:** Epidemic and at-risk states
Approx. Length (in words): 8210	

Text South African National AIDS Council (SANAC) (2007): *HIV & AIDS and STI National Strategic Plan 2007-2011.*
Approx. Length (in words): 25610

Text: Federal Ministry of Health – Republic of Sudan (2006): *The National Strategy for Reproductive Health 2006 - 2010.*
Approx. Length (in words): 7420

Text: Government of the Kingdom of Swaziland (2006): *The Second National Multisectoral HIV and AIDS Strategic Plan 2006-2008.*
Approx. Length (in words): 37971

Text: Swaziland Ministry of Health and Social Welfare (2007): *Swaziland National Health Policy.*
Approx. Length (in words): 7090

Text: Zambia National HIV/AIDS Council (2006): *National HIV and AIDS Strategic Framework 2006-2010.*
Approx. Length (in words): 24980

Text: Zimbabwe National AIDS Council (2006): *Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006-2010.*
Approx. Length (in words): 16060

AII.5.2.2 Asia

Text: Afghanistan (Transitional Government of) Ministry of Public Health (2003): *HIV/AIDS & STI National Strategic Plan for Afghanistan 2003-2007.*

Approx. Length (in words): 9930

Text: Ministry of Health, Kingdom of Cambodia (2002): *Health Sector Strategic Plan 2003-2007,* Volume 1.
Approx. Length (in words): 20830

Text: Cambodian National AIDS Authority (2006): *National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2006-2010.*
Approx. Length (in words): 8340

Text: Pakistan Ministry of Health (2001): *National Health Policy 2001. The Way Forward.*
Approx. Length (in words): 3450

Text: Pakistan Ministry of Health National AIDS Control Programme (2007): *The National HIV/AIDS Strategic Framework: An Overview.*
Approx. Length (in words): 17600

AII.5.2.3 Oceania

Text: Papua New Guinea National AIDS Council (2004): *Papua New Guinea National Strategic Plan on HIV/AIDS 2004-2008.*
Approx. Length (in words): 20090

AII.5.2.4 Eastern Europe and Central Asia

Text: Estonian Ministry of Social Affairs (2000): *Strategic Action Plan 2000 – 2010.*
Approx. Length (in words): 15980

AII.5.2.5 Latin America and the Caribbean

Text: Guyana Ministry of Health (2003): *National Health Plan 2003-2007.*
Approx. Length (in words): 23570

Guyana Ministry of Health (2006): *Guyana National HIV/AIDS Strategy 2007-2011*.
Approx. Length (in words): 18980

Belize National AIDS Commission (2006): *The National Strategic Plan; A Multi-Sectoral Approach to Addressing HIV & AIDS in Belize (2006-2011).*
Approx. Length (in words): 20200

AII.5.3 Third stakeholder group – Civil society organisations (non-for-profit)

CSOs with a clear focus on health were selected as part of the sampling strategy. Documents taken into the sample were published discussion, strategy, position and policy papers as well as activities reports from CSOs that are either:

1) Listed as one of the 182 non-governmental organizations in consultative status with the WHO in 2006 with particular policy relevance to communicable diseases including childhood diseases and HIV/AIDS, Tuberculosis, Malaria (See Table AII.10 below) or;
2) Prominent CSOs not listed as having consultative status with the WHO but with particular policy relevance for communicable diseases including childhood diseases and HIV/AIDS See Table AII. 11 below.
3) Charitable foundations with a focus on health.

Texts were not available from all the organisations identified in the sampling strategy. The CSOs marked with an asterisk (*) had published texts in the time-frame 2005-2007 which were available to the public and therefore taken into the sample for the text analysis.

Table AII.10: Examples of CSOs in Consultative Status with the WHO.

Name of Organisation	Main working focus
Family Health International *	Global public health
Global Forum for Health Research*	Health Research Policy
Global Health Council*	Global public health
International Council of Nurses*	Nursing policy and interests
International Council of Women	Women's rights
International Hospital Federation	Patient and hospital policy
International Network on Children's Health, Environment and Safety	Children's health and safety
International Planned Parenthood Federation (IPPF)	Reproductive health
International Society of Doctors for the Environment	Environmental protection
International Union against Sexually Transmitted Infections	Reproductive health
International Union against Tuberculosis and Lung Disease	Lung disease prevention and control
International Union for Health Promotion and Education*	Health promotion
International Women's Health Coalition*	Women's health
Medicus Mundi International	Global public health
OXFAM*	Global development
The Population Council *	Reproductive health
The Save the Children Fund*	Children's rights
World Federation of Public Health Associations*	Global public health
World Vision International*	Global development

Table AII. 11: Examples of CSOs with particular policy relevance for communicable diseases including childhood diseases.

Name of Organisation	Main working focus
ActionAid International*	Global development
Action For Global Health	Global public health
Doctor's Without Borders / Médecins Sans Frontières	Global health and emergency relief
Global Network of People living with HIV/AIDS (GNP+)	HIV/AIDS
Health Action International (HAI) *	Global public health
Health GAP	Global public health
HealthNET International	Global public health
Insitut Pasteur	Global public health and research
International Civil Society Support	HIV/AIDS
International Community of Women Living with HIV/AIDS (ICW) *	HIV/AIDS
International HIV/AIDS Alliance*	HIV/AIDS
International Pediatric Association	Children's health
PATH*	Global public health
People's Health Movement	Global public health
The AIDS Support Organisation (TASO) *	HIV/AIDS
World Care Council	HIV/AIDS, tuberculosis and malaria

Table AII.12: Charitable foundations with a focus on heath.

Name of Organisation	Main working focus
Rockefeller Foundation*	Global development
Bill & Melinda Gates Foundation*	Global development

In all the following 20 texts were taken into the sample.

Text: ActionAid International (2006): *Annual Report 2005.*
Approx. Length (in words): 31480

Text: Bill & Melinda Gates Foundation (2007): *Annual Report 2006.*
Approx. Length (in words): 12560

Text: Family Health International (2007): *Impact: A Decade of Global Leadership and Innovation. Final Report in Implementing AIDS Prevention and Care Project, 1997-2007.*
Approx. Length (in words): 20090

Text: Global Forum for Health Research (2007): *2006 Review: Innovating for Better Health.*
Approx. Length (in words): 7120

Text: Global Health Council (2006): *Annual Report 2005,* (Online Edition).
Approx. Length (in words): 3740

Text: Health Action International Africa (2006): *Annual Report 2006.*
Approx. Length (in words): 4480

Text: International Community of Women Living with HIV/AIDS (ICW) (2003): *International Strategic Plan for 2003-2007.*
Approx. Length (in words): 2420

Text: International Council of Nurses (2007): *ICN on Nursing and Development – Policy Background Paper.*
Approx. Length (in words): 5900

Text: International HIV/AIDS Alliance (2005): *Strategic Framework 2005-2007. Supporting Communities to Reduce the Spread of HIV and Meet the Challenges of AIDS.*
Approx. Length (in words): 9900

Text: International Planned Parenthood Federation (2005): *IPPF's Strategic Framework 2005-2015.*
Approx. Length (in words): 4240

Text: International Union for Health Promotion and Education (2007): *IUHPE Activity Report 2004-2007.*
Approx. Length (in words): 18750

Text: International Women's Health Coalition (2007): 2006 *Annual Report: Invest in Women, Invest in the World.*
Approx. Length (in words): 4100

Text: Oxfam International (2007): *Oxfam International Strategic Plan 2007-2012: Demanding Justice.*
Approx. Length (in words): 2640

Text: PATH (2007): *Health Within Reach: 2006 Progress Report.*
Approx. Length (in words): 9050

Text: Population Council (2007): *Annual Report 2006 Global Reach, Global Impact.*
Approx. Length (in words): 12040

Text: Rockefeller Foundation (2007): *Impact. The Rockefeller Foundation 2006 Annual Report.*
Approx. Length (in words): 8360

Text: Save the Children Fund (2007): *Annual Report 2006.*
Approx. Length (in words): 15130

Text: The AIDS Support Organisation (TASO) (2002): *Strategic Plan for the Period 2003-2007.*
Approx. Length (in words): 33400

Text: World Federation of Public Health Associations (2007): *WFPHA Report, Winter 2007.*
Approx. Length (in words): 5520

Text: World Vision International (2007): *2006 Annual Review.*
Approx. Length (in words): 5130

AII.5.2.4 Fourth stakeholder group: Business sector actors

Businesses sector actors(or for-profit actors) that were listed as members of the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) were included in the sample. As of November 2007 over 120 businesses were listed as members. Three types of business sector actors were differentiated between, according to their involvement in the health sector. First, business sector actors directly involved in the health sector as part of their business activities e.g. pharmaceutical and hygiene product manufacturing (e.g. Sanofi-Aventis, Pharmaceuticals Holding, Unilever, Bristol-Myers Squibb). The large proportion of the business sector actor texts were from these types of companies due to the relevance of their activities for health policy. Second, companies active in regions where HIV/AIDS, Tuberculosis and Malaria have direct effects on business activates, e.g. through high prevalence rates amongst staff. Third, business sector actors that have little direct involvement with health, but were involved with the GBC as part of 'Corporate Social Responsibility' or charitable activities.

Table AII.13: Examples of GBC members with their main field of business activities also concerning the health sector

Business Name	Main Area of Business Activities
Becton, Dickinson and Company	Pharmaceutical manufacturing
GlaxoSmithKline	Pharmaceutical and hygiene manufacturing
Merck & Co. Inc.	Pharmaceutical manufacturing
Novartis International AG	Pharmaceutical manufacturing
Pfizer Inc.	Pharmaceutical manufacturing
Sanofi Aventis	Pharmaceutical manufacturing
UniLever	Pharmaceutical and hygiene manufacturing
Abbott Inc.	Pharmaceutical and diagnosis tools

Table AII.14: Examples GBC members active in areas where HIV/AIDS policies play a major role

Business Name	Main Area of Business Activities
Anglo American	Extraction
Eni	Extraction
Exxon Mobil	Extraction
StatoilHydro	Extraction
Total	Extraction

Table AII.15: Examples business that engage with the GBC as part of corporate social responsibility activities

Business Name	Main Area of Business Activities
Accenture	Management Consultancy
Heineken N.V.	Drink Manufacturing
Standard Chartered	Financial Services
Sumitomo Chemical	Chemical manufacturing
Sun Life Financial	Financial Services
Tata Steel	Steel Production and Goods Manufacturing
Diageo	Drink (Spirits) Manufacturing

In total 20 publications were found and selected for the text analysis.

Text: Abbott Inc. (2007): *Generations:2006 Global Citizenship Report.*
Approx. Length (in words): 14180

Text: Accenture (2007): *Second Annual Corporate Citizenship Review – 2006*
Approx. Length (in words): 14160

Text: Anglo American (2007): *Report to Society 2006. A Climate of Change.*
Approx. Length (in words): 41840

Text: Becton, Dickinson and Company (2006): *Online Citizenship Report.*
Length (in words):213710

Text: Diageo (2007): *Corporate Citizenship Report 2007.*
Approx. Length (in words): 30390

Text: Eni (2006): *Eni Sustainability Report 2006.*
Approx. Length (in words): 50180

Text: ExxonMobil (2007): *2006 Corporate Citizenship Report.*
Approx. Length (in words): 28950

Text: GlaxoSmithKline (2006): *Corporate Responsibility Review 2006: A Human Race.*
Approx. Length (in words): 53020

Text: Heineken N.V. (2007): *Sustainability Report 2006: Focus on Impact.*
Approx. Length (in words): 17910

Text: Merck and Co. Inc. (2005): *Corporate Responsibility 2004-2005 Report: Committed to Making a Difference.*
Approx. Length (in words): 12430

Text: Novartis International AG (2007): *Corporate Citizenship Review: Creating Value Through Responsible Business.*
Approx. Length (in words): 6000

Text: Pfizer Inc. (2006): *Corporate Responsibility Report 2007: Strong Actions: Partnering for Positive Change.*
Approx. Length (in words): 42030

Text: Sanofi-aventis (2006): *Sustainable Development Report 2006.*
Approx. Length (in words): 42190

Text: Standard Chartered (2006): *Sustainability Review 2006: Leading the Way.*
Approx. Length (in words): 15290

Text: StatoilHydro (2007): *Mastering Challenges: Statoil and Sustainable Development 2006: Mastering Challenges.*
Approx. Length (in words): 31210

Text: Sumitomo Chemical (2006): *CSR Report 2006.*
Approx. Length (in words): 36230

Text: Sun Life Financial (2006): *Public Accountability Statement 2006: Delivering on the Promise.*
Approx. Length (in words): 12530

Text: Tata Steel (2006): *Corporate Sustainability Report 2005-06.*
Approx. Length (in words): 50170

Text: Total S.A. (2007): *Sharing Our Energies - 2006 Corporate Social Responsibility Report.*
Approx. Length (in words): 42350

Text: Unilever (2007): *Sustainable Development Report 2006.*
Approx. Length (in words): 23650

AII.6 Presentation of Results

Results of the text analysis are on file with the author and are available in the following format.

- First, the text is named and a qualitative assessment of the text in terms of key words, phrases and references is given. These results are presented in the boxes on the following pages. In this abridged version of the text analysis, only short summaries of the qualitative assessments are given. Relevant quotes are reproduced in the assessments as published in the original texts.
- Second phase results are presented in diagrams showing how often word clusters and keywords are used in each individual text and amongst each stakeholder group.

  Two types of diagrams are presented serving different purposes:

  1) *Diagrams that show the number of times a particular keyword, cluster or phrase is used.* The purpose of these diagrams is to provide a basis for qualitative assessments of the way that various themes are addressed. Diagrams comparing the most frequently used word clusters, such as 'effectiveness and efficiency' and 'participation, involvement, inclusion' are presented in column graphs with a y-axis ranging from 0 – 100 uses of words in the cluster in the text. Diagrams comparing other important but not as frequently used word clusters and key words such as 'legitimacy' and "leadership" were presented in column graphs with a y-axis ranging from 0-20 uses of words in the cluster in the text.
  2) *Diagrams that show the proportion of the text that was taken up with using the particular keyword, cluster or phrase.* The purpose of these diagrams is to give a first indication of how important the particular theme is in text, and to balance out distortions in the first type of diagram that occur due to the differences in lengths of the texts. Diagrams comparing the most frequently used word clusters, such as 'effectiveness and efficiency' and "participation, involvement inclusion" were presented in column graphs with a y-axis ranging from 0 – 0.0004 of the text being taken up by words in the cluster. Diagrams comparing other significantly, but not as frequently used, word clusters and key words such as 'legitimacy' and "leadership" were presented in column graphs with a y-axis ranging from 0 – 0.0001 of the text being taken up by words in the cluster.

- Third, the diagrams are interpreted and commented on while referring back to the qualitative assessment undertaken in the first phase. These results are presented as comments below the diagrams from phase two.

Appendix III

Stakeholder Survey Questionnaire – Perceptions of legitimacy amongst global health experts

AIII.1 Introduction

Analysing the legitimacy of a global governance organisation from an empirical-science perspective requires knowledge of the views and opinions of its relevant audience – or stakeholders. While a normative-prescriptive or theoretical assessment of a global governance organisation's legitimacy involves comparing particular characteristics of the respective organisation with principles of established philosophical reasoning; empirical science recognises that legitimacy is factually granted (or withheld) by those with a vested interest in the governing organisation. Thus, both the legitimacy claims of an organisation and the beliefs of stakeholders are "...worth studying as social facts" (Hurrelmann, Schneider, & Steffek, 2007, p. 6).

Opinion research represents one approach to empirical research into legitimacy. A representative audience is asked directly the extent to which they think a governing organisation (in most cases a government) is worthy of support, and whether they do so for reasons that are "...grounded in the kinds of normative evaluations that distinguish legitimacy from other kinds of support" (Hurrelmann, Schneider, & Steffek, 2007, p. 7). The stakeholder survey documented below was conducted to answer these questions in the context of global health governance.

The conducted survey differs from standard public opinion research in that its purpose is to gather insights from key individuals on the norms, values and principles that shape and influence the (communicative) action of conglomerate actors. In this sense the survey documented here is to be classified as an expert survey, rather than broad public opinion research.

AIII.2 Methods

An expert survey was undertaken to gather the opinions of senior members of staff (or senior voluntary members) of organisations that are primary stakeholders in global health governance regarding their views of the legitimacy of various global health organisations. The information conveyed by these experts provided a deeper understanding of the values, norms and principles that guide the preferences of conglomerate actors as a whole, as were found by means of the accompanying text analysis (see Appendix II). The survey specifically asked questions on the topic of the legitimacy of GHG organisations. The aim of the expert survey was to:

5) gather opinions from senior global health workers (experts) on what the legitimacy of global health governance organisations should be and are based upon;
6) gather opinions on whether the global health governance organisations UNAIDS, GFATM, the GAVI Alliance and others were held in high, medium or low regard.
7) ask, using various terms and phrases, whether these opinions were based on elements of legitimacy and good governance 'by' or 'for' the people.

The expert survey was conducted by means of a questionnaire sent to various experts sampled by occupation. Respondents were able to return the questionnaire in electronic format, or fill out the questionnaire anonymously on a website accessible via an individual identification

code. This code then served to identify the stakeholder group to which the respondent belonged. Respondents were assured of confidentiality of their responses but told that their responses would be assigned to a stakeholder group (see section on sampling below). To increase the response rate, the experts were also given the opportunity to receive the questionnaire in hardcopy via mail, or in a standard text format per email. The questionnaire was administered in English; however, some respondents gave comments in other languages which were then translated. In all 185 respondents replied to the survey, representing a response rate 20.5%. Most questionnaires were completed online (90%), other responses were sent per email. The questionnaire took place over two month period at the beginning of 2007.

The questionnaires were designed using the 'funnel format' beginning with general questions on global health first. Questions then gradually became more specific and finally concentrated on aspects of governance 'for' and 'by' the people with respect to specific case study organisations (Sarantakos, 2005, p. 241). The questionnaire included both closed format (graded response) questions and open response questions. Respondents were given the opportunity to provide general comments throughout the questionnaire. The following question types were included:

1. Knowledge and general opinion questions such as: Which of the following organisations have you heard of and how do you regard them generally?
2. Questions asking respondents to agree/disagree with statements such as: "GAVI is transparent and open to criticism"; or "I rarely think about issues of how these organisations are governed".
3. Questions asking respondents to label legitimacy aspects as important/not important such as "How important is it that the Global Fund includes a representative of the business sector in its board?"
4. Open Ended Questions such as: "If you have any comments on any of the questions or topics on this page, feel free to add them here".
5. Questions asking respondents to rank legitimacy factors in order or importance such as: "Give a score of one to ten for how important the following aspect is for you".

The questionnaire contained six sections, each of which gathered opinions on various issues. In the first section, general questions on issues in global health were posed. The second section contained questions on global health governance organisations and how they regarded them generally (level of confidence). Questions in the third, fourth and fifth sections addressed The Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and UNAIDS respectively. The sixth section contained questions on aspects of legitimacy and

asked respondents the extent to which they agreed or disagreed with certain statements. The final section asked respondents to rank aspects of legitimacy against each other.

Within each section questions were presented in random order to prevent any bias in questioning, in case the respondents became more or less critical over the course of the questionnaire.

AIII.3 Sampling

Sampling was based on respondent's appropriateness in terms of the ability to answer the questions in the survey in an expert capacity. Experts were sought from five stakeholder groups.

1st Stakeholder Group Government departments in OECD-DAC member states.
From this group senior respondents including senior advisors, policy specialists, unit heads and HIV/AIDS ambassadors. A total of 46 responses were received from 18 OECD-DAC member states as well as from the European Union.

2nd Stakeholder Group Government departments in epidemic and at-risk states. This group of states was defined by mean of elevated rates of HIV/AIDS prevalence and a high number of deaths from childhood cluster diseases. From this group senior staff members such as national immunisation programme managers, chief epidemiologists and MOH directors responded to the survey. A total of 16 responses were received from staff in 16 states in a wide range of geographical regions.

3rd Stakeholder Group Associations of people living with HIV/AIDS (PLWHA).
From this group respondents included executive directors, presidents and coordinators from organisations listed in the Directory of Associations of People Living with HIV/AIDS (2004). A total of 71 responses were received from experts affiliated with 71 different associations of which 51 were located in non-OECD countries and 20 were located in OECD countries.

4th Stakeholder Group Civil society organisations (including in some cases private foundations).
From this group senior staff such as executive directors, programme directors and senior programme officers and communications directors responded to the questionnaire. In total 20 responses were received from experts affiliated with 20 different CSOs, 15 of which were located in OECD countries and five of which were located in developing countries.

5th Stakeholder Group Business sector actors involved in the Global Business Coalition to Fight AIDS, Tuberculosis and Malaria.
From this group senior staff including presidents, vice-presidents, chief medical officers, director-generals and external affairs managers responded to the survey. In

total 32 responses were received from 29 respondents affiliated with business sector actors.

Several respondents declared that they were involved with various organisations and even worked simultaneously with organisations in different stakeholder groups.. In such cases the respondent was categorized according to their main affiliation. Response rates were highest from the stakeholder group of business sector actors (30%) and lowest from the stakeholder group of government departments in epidemic and at-risk states (10%). Responses from each category as a total of the whole are represented in diagram below.

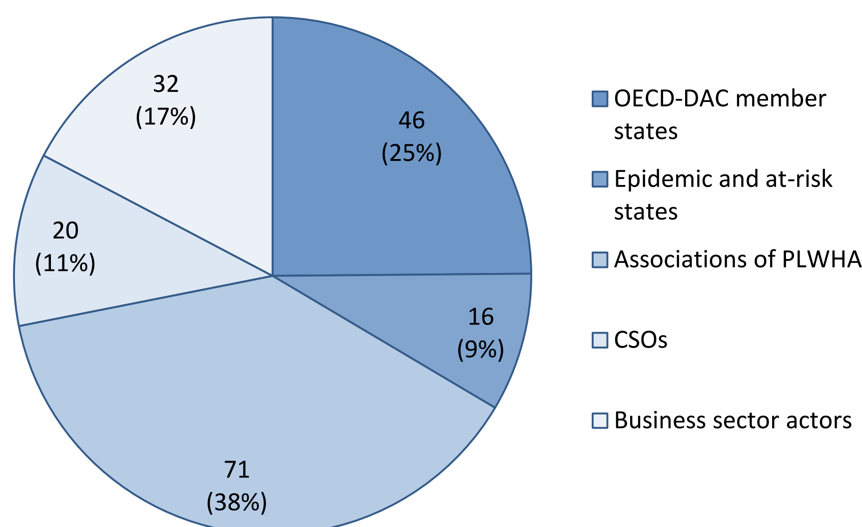

Diagram AIII.2: Responses to Stakeholder Survey Questionnaire According to Stakeholder Group Diagram shows Total number of responses followed by fraction of total responses in brackets.

Respondents were asked to answer the questions as an expert in their field, and not necessarily as representing the formal outward positioning for their associated organisation.

AIII.4 Presentation of Results

The results of the survey are on file with the author. The results from each survey question are available in bar diagram format. Responses from within each of the five stakeholder groups are tallied together in one bar. A sixth bar shows the results from all respondents grouped together. A short analysis of the results and the relevance of responses (in light of response rate and the level of agreement and disagreement amongst the respondents within and across stakeholder groups) are presented below each diagram.