International Organization and Health/Disease

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Introduction

Patterns of health and disease have been relevant to international studies for as long as human populations have migrated across large territorial spaces, and the history of international organization, to protect and promote human health, can be traced to ancient times. Major disease epidemics, notably those causing large-scale morbidity and mortality, led to the creation of formal institutional arrangements to support health cooperation. The Plague of Athens during the second year of the Peloponnesian War (430 BC), Black Death that swept through Europe in the 1340s, cholera epidemics during the Industrial Revolution, and the influenza pandemic after World War I, for example, all prompted efforts to strengthen collective action. The resultant institutional arrangements included the International Sanitary Conferences, the Office International d'Hygiène Publique, the Health Organization of the League of Nations, and various regional bodies.

After World War II, international health cooperation was identified as a key function of the United Nations (UN), leading to the establishment of the World Health Organization (WHO) as the UN specialized agency for health. Over the next several decades, other UN bodies developed substantial health-related activities, such as the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the United Nations Development Programme (UNDP). This was accompanied by a growth in funding and activities by bilateral aid agencies, along with a substantial number of nongovernmental organizations (NGOs). By the 1980s, the World Bank and regional development banks began to lend substantial sums for health development, as well as to shape international health policy. This expansion of international health cooperation reflected a broad definition of "health," and recognition of the range of factors contributing to patterns of health and disease.

Since the mid-1990s, there has been an explosion of international institutional arrangements to protect and promote health. International health organizations now embrace intergovernmental, nongovernmental and private (for profit) organizations, in many cases innovatively combined into "public–private partnerships" such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM). Correspondingly, the study of international organization and health has grown rapidly, as a subject in itself, and as a means of understanding broader themes in international relations.

The Postwar Study of International Health Cooperation

Broadly speaking, the study of international organization and health to the 1970s is surprisingly thin despite the boom in international organization scholarship as a whole during this period. The main source of detailed analyses of international health cooperation dating before 1945 is medical historians, notably the seminal *A History*

of Public Health by Rosen (1958). Despite the long history of international health cooperation, perhaps representing the earliest forms of intersocietal cooperation, postwar scholars of international organization largely neglected this subject area. In part, this may reflect the secondary attention given to health by the architects of the UN system. As disease rates soared among military and civilian populations in the immediate aftermath of conflict, and many countries faced the rebuilding of basic infrastructure, including health systems, there was clear recognition of the importance of international health cooperation. Yet the higher priority given by major powers to peace and security, and economic stability and reconstruction, led to health being omitted from the agenda of the UN Conference on International Organization of 1945. As Murphy writes, while the US "took charge of the conferences concerned with managing potential conflicts generated by the industrial system," namely the Bretton Woods institutions, countries occupied during the war "had to be content with sponsoring conferences that strengthened society" (1994:185). This gave the impression that international health cooperation was something of an afterthought, with China and Brazil initiating the International Health Conference of 1946 which led to the formal creation of WHO in 1948.

The scholarly neglect of international organization and health during this period might also be attributed to the widely held perception that the work of WHO and other health-related international organizations is highly technical (and by extension apolitical), and thus outside the boundaries of international studies. This view fit with the prevailing notion of UN specialized agencies as embodying "the functional approach [which] circumvents ideological and radical divisions, as it does territorial frontiers" (Mitrany 1975:226). Where health issues strayed into politics, this was deemed within the realm of domestic social policy ("low politics"), and thus outside the intellectual boundaries of mainstream international relations.

Early accounts of WHO were commissioned by the organization itself (WHO 1958; 1968), or written by former senior officials (Chisholm 1951), consultants (Winslow 1951; Clements 1952) or legal experts (Sharp 1947; Levy 1954; Alexandrowijz 1962). Much of this work was published within the fields of public health or law, rather than international relations, focused on the technical or procedural niceties of the organization's activities. While offering valuable insights into the internal workings of the organization, for the most part these accounts primarily serve as a description of administrative processes and major activities.

Notable exceptions to this early writing are several studies which analyze the structure, functions, financing, and membership of WHO. Written during a period of postwar optimism toward the potential for international organization to promote human welfare, combined with major strides in medical science, their focus was identifying the appropriate institutional means for achieving collective ends. The decentralized structure of WHO's six regional offices attracted particular attention as a model for building international public administration. For example, Berkov analyzes "the manner in which [WHO] is administered, to note how it executes its programs by means of regional arrangements virtually unique in the international field, and to judge – as far as may be possible – the effect [. . .] which its structure and procedures have had upon the programs which it administers" (1957:2). He concludes that, despite the greater cost and risks of organizational fragmentation, the decentralized structure of WHO has enabled the organization to adapt its program to meet the needs of member states; member states to "feel themselves less separated from the source of control, and more readily regard the WHO as an organization in which they have a direct interest," and WHO to collect necessary information from the country level for "greater ease of coordinating projects." Gutteridge (1963) saw international health organizations as a functional extension of the "creation and maintenance of a proper organization at the national and local levels in which those directly responsible for

the promotion of public health, including members of the public itself, can work effectively."

Refining the Mandate and Functions of International Health Organizations

Underlying disagreement about WHO's appropriate mandate remained the subject of extensive and ongoing scholarly debate among policy makers and scholars of the day. Advocates of social medicine, which seeks to understand and foster the social and economic conditions that lead to healthier societies, envisioned WHO addressing the broad determinants of health. Its mandate would thus go beyond the limited functions of previous international health organizations which focused on disease surveillance and reporting. Others argued for a biomedically defined mandate focused on fighting selected diseases using scientific and technical tools. During the immediate postwar period, this disagreement delayed the formal establishment of WHO (Lee 2008). Within the scholarly literature, this tension between support for six disease-focused "priority projects" and "strengthening health services" and "technical assistance" is recognized by Ascher in his analysis of "Current Problems in the World Health Organization's Program" (1952:31).

While recognizing the clash within public health between biomedicine and social medicine, the normative basis of medical knowledge and practice was not interrogated per se, during this period of scholarship, but instead assumed to be value-neutral and unproblematic. This is not to say that scholars did not recognize that political power struggles took place. In WHO, for example, the tensions between headquarters and regional offices over resources, authority, and the eventual work program were acknowledged (Calderwood 1963). Moreover, the geopolitics of the broader UN system was seen as intruding on the universality of membership of WHO and, by extension, its higher order values of protecting and promoting human health (Allen 1950). For example, Ascher writes:

> So long as membership in WHO is open only to states, there will always be politics in the formulation and execution of its work-plan. That is, decisions will be influenced by forces other than the dictates of medical science. Scientists can secrete unnecessary adrenalin over this and raise their blood pressure; but the mature and worldly among them will address themselves more subtly t]o the question of how politics can be kept in its proper sphere in WHO's work. (1952:41)

Similarly, public health historian Fraser Brockington (a consultant for WHO and ambassador for the organization upon his retirement) argued in his book *World Health* (1975) that WHO was a creature of its member states, and shortfalls in its capacity to reach consensus and support clear international health goals should be laid at the feet of governments. As a largely descriptive account of WHO's creation and work, the book attributes problems in fulfilling WHO's mandate to the state of knowledge, inadequate resources, and insufficient political will. This perception of politics intruding on the essentially technical nature of WHO's work also underlies the writing of Frank Gutteridge (then chief of WHO's Legal Office) in his analysis of decision making. He writes that "compliance has been sought through persuasion [non-binding resolutions and recommendations based on scientific or technical advice of its expert committees] rather than by the introduction of any direct procedures [i.e., binding regulation]." This, he argues, is an appropriate and effective approach given that:

> The background of the general policy of the Organization has tended to result in the World Health Organization turning away from the traditional treaty-making process

towards a more direct procedure in those areas in which it is competent and where international action is necessary to lay down international standards and to co-ordinate the activities of governments. (Gutteridge 1971:284)

Observing that "the trouble with so many books on international health is that they have never been written," Goodman (1971:394) set out to provide the most complete account of international organization and health available to that date. In *International Health Organizations and Their Work*, he provides a history of international health cooperation defined as "any or all of those activities for the prevention, diagnosis or treatment of disease which require the combined consideration and action of more than one country" (1971:3). Unlike previous works, his book considers "other influences" on international health work, namely economic, social, political, and ideological factors. While he gives a fuller account of the subject, Goodman maintains a view of WHO as an essentially technical agency faced with political interference in its basic functions: "doctors are doing their job successfully but the politicians, economists and sociologists are not" (1971:230). Thus, as in Gutteridge (1971), shortfalls in the fulfillment of WHO's mandate are attributed to technical (i.e., lack of knowledge) and nontechnical (i.e., conflict, lack of political will) factors. He concludes: "The World Health Organization can hardly be blamed if others fail" (Goodman 1971:315). Notably, Goodman extends his attention to other intergovernmental agencies concerned with health (i.e., International Labour Organization (ILO), Food and Agriculture Organization, UNICEF, United Nations Educational, Scientific and Cultural Organization (UNESCO), UN Refugee Agency), and voluntary agencies (e.g., Rockefeller Foundation) in his book. In noting the growth in NGOs maintaining official relations with WHO between 1949 and 1971, from 13 to over 70, he identifies what would become a defining trend towards a highly crowded institutional environment.

Challenging Orthodoxy in International Organization and Health

The analysis of international organization and health as essentially concerned with technical, scientific, and administrative functions, in the fulfillment of agreed health goals, began to be challenged in the mid-1970s. This is most evident in studies seeking to more fully understand the internal workings of international health organizations as sites of political processes in themselves. Hoole's *Politics and Budgeting in the World Health Organization* applies quantitative methods in the study of international organization "for the first time" to "determine the manner in which inputs affect actions and to evaluate the relative importance of various types of inputs" (1976:21). In his detailed analysis of WHO's budget between 1949 and 1969, for example, Hoole observes that the Executive Board "rarely recommended a change in the Director-General's budget proposal" and that no significant cuts in the budget had been recommended since 1958.

It would be the increased assertiveness of the developing world in the UN, largely expressed through the Non-Aligned Movement (NAM), that began to challenge how international health organizations were studied. For instance, the questioning of development models advocating large-scale investment in infrastructure was expressed within the health field through the primary health care movement and the adoption of the Declaration of Alma Ata at the International Conference on Primary Health Care (1978). The declaration challenged Western-defined models of high-technology, urban and hospital based health development in favour of bottom–up, community based solutions using appropriate, low-cost technologies. The overarching Health for All movement was not only a technical strategy, but a political ideology akin to calls for a New International Economic Order. Within WHO, this new paradigm took hold

at the highest levels, led by Director-General Halfdan Mahler (1976), who stated at the World Health Assembly of 1976, "Many social evolutions and revolutions have taken place because the social structures were crumbling. There are signs that the scientific and technical structures of public health are also crumbling." Practitioners began to call for fundamental reform of health systems, with their embedded structural inequalities, in such books as *Health and the Developing World* (Bryant 1969), *Health by the People* (Newell 1975) and *Where There Is No Doctor* (Werner 1983).

The study of international organization and health during this period reflected this paradigmatic shift, with the normative basis of international health organizations receiving concerted attention for the first time. In their classic volume *The Anatomy of Influence: Decision Making in International Organization*, Cox and Jacobson seek "to understand the sources of influence and the ways influence is exercised by analyzing how decisions have been made" (1974:vii) in a number of UN organizations, including WHO. Following a familiar description of the agency's functions, structure, and evolution, Jacobson raises questions about patterns of decision making, actors and their sources of influence (including the Director-General, staff and representatives of other international organizations), and environmental impacts on WHO activities. Of particular note is how the organizational ideology of WHO has led to certain activities, such as campaigns against specific diseases, and the neglect of others, such as the organization of health care services. While dated in substantive content, Jacobson's application of international organization theory to WHO remains the most wide-ranging to date.

In a similar challenge to the "infallibility of the traditional medical ethic," C.E. Taylor analyzes "the new style of international health work" which requires practitioners "to reassess our underlying values" (1975:489). While debate about the appropriate mandate for WHO continued, questions increasingly focused on critiquing the biomedical approach to such issue areas as family planning (eventually shifting the emphasis from population control to reproductive health). Issues of whether WHO should be involved in the "health aspects of the population problem," according to Partan, "sharply divided the membership and were abandoned in the face of objections that activities in the population field lay outside the proper scope of WHO action under its Constitution" (1973:111). Finkle and Crane (1976) attribute WHO's "position toward population and family planning and its role in international population assistance" to "the organizational and professional values in the WHO Secretariat." They argue that the emphasis on the technical nature of decisions and functions should be recognized, in themselves, as sources of "discretionary power from the political interference of member governments and to legitimize the central role [of technical expertise] in the WHO policy process."

Beyond individual international health organizations, scholars began to locate patterns of health and disease within the broader international political economy. In her classic text *The Political Economy of Health* (1979), Lesley Doyal applies Marxist analysis to argue that the social construction of health extended to the international level, with historical links to imperialism, the rise of capitalism, and neocolonialism. While Doyal did not apply her ideas to the analysis of international organization, other writers began to explore this avenue. Elling (1981) begins by challenging the notion that disease, disability, and death in the developing world are, as regarded by Western public health practitioners, problems in "tropical medicine" attributable to geography or climate. He describes this perspective as "a very convenient medical/public health ideology for the established capitalist political-economic order," and a distraction from the poverty resulting from colonial expropriation. Applying Wallerstein's concepts of periphery and semiperipheral nations in a capitalist world order, and Gramsci's concept of "cultural hegemony," he directly challenges prevailing explanations of health inequalities and the policy solutions put forth by a dominant medical discourse.

Using wide-ranging examples, including the marketing of breast-milk substitutes, population control, dumping of hazardous waste, and drug policy, Elling offers an initial "analysis of a number of health problems [which] highlights the capitalist world-system as the fundamental agent in the generation of these problems." The core questions driving his analysis is "What are the mechanisms and ways by which this world-system functions to further establish itself and thereby so deleteriously affect human health and national health systems" and "how do the active agents of world capitalism function to create health problems?" (1981:44–5).

The writing of Vicente Navarro also makes a notable contribution to Marxist based approaches to international organization and health. His analyses of the health systems of Sweden, the US, the UK, and the Soviet Union led him to study health inequalities in terms of the structural features of the capitalist world order (Navarro 1980; 1986). In his critique of the Brandt Report of 1980, to review international development issues, and the Declaration of Alma Ata, he argues that they are located within "the socio-economic and political context that determined them." Like Elling, he identifies an "apolitical and technological-administrative discourse" which upholds the "hegemonic development establishments of the Western world." He also questions its "understanding of the causes of underdevelopment and its major health and disease problems" (Navarro 1984:467).

Both Elling and Navarro opened up the study of international health, including the role of international health organizations, to more critical approaches. While their work was characterized by economic determinism, others pursued what might be described as early constructivist approaches to international health. A structural/functional approach is taken by Forbes, who examines "the political economy of transnational health organizations, thus illustrating how existing economic analysis of international collective action can be adapted and utilized to examine an important, albeit neglected, form of international cooperation" (1980:115–16). His analysis focuses on WHO's role in the "production of health," drawing on the economic concepts of "pure and impure international public inputs" as a theoretical foundation for discussing the "institutional design and structure of WHO and transnational health organizations in general" (1980:121). This approach would gain wider attention from the late 1990s with the application of the global public goods concept to health policy (see below). Forbes concluded that "the array of private, impurely public, and purely public inputs, resulting from WHO required the application of the joint product, as opposed to pure public good, paradigm of international collective action." He proposed this as a "useful framework for subsequent research regarding international collaboration in public health" (1980:129). Foster (1987b) takes a different approach, assessing the nature of behavioral research supported by WHO, attributing its poor quality to the physician-dominated review committees that assume "quantitative hypothesis-testing investigation is the only acceptable research model." This, he argues, leads to a narrow understanding of behavioral research as limited to information on how to change individual and community behavior to conform to the needs of health care delivery programmes. He concludes that "research on organization policies and programs is viewed as irrelevant and perhaps even threatening" (1987b:709).

As discussed below, the critical study of international organization and health remained limited. In part, this was due to the technocratic focus of mainstream public health research which eschewed political theory as peripheral to the needs of applied research. The surprising neglect of international organization and health by international studies also persisted. A notable exception is analyses of the alleged "politicization" of UN specialized agencies, including WHO. As a reaction to the Declaration of Alma Ata, along with WHO's adoption of the List of Essential Drugs and International Code of Marketing of Breast-Milk Substitutes, the organization was accused by the US government of exceeding its technical and scientific mandate.

Scholars, in turn, reflected on this debate in terms of functional theory and liberal internationalism. In his analysis of the "Problems of the United Nations Specialised Agencies at the Quarter Century," for example, Harrod describes WHO as a "hybrid" between an organization supplying technical services, and a forum "to discuss matters not essentially transnational" (1974:189–90). He discusses the attacks on functionalism from realist theory and the rise of nonstate actors, along with emerging approaches to development, including Third World nationalism, ecological approaches, and technical assistance. Finally, Harrod draws attention to the bureaucratic environment of the UN, building on the work of Etzioni (1964) to understand "how authority is maintained within the organisation" (Harrod 1974:198). He concludes that the "liberal-internationalist view is being replaced by the real-politik view in which the worth of the organisations is assessed exclusively in terms of immediate national interest" (1974:203). The perception of WHO, and international health cooperation as a whole, as ostensibly technical and even somehow morally above politics thus persisted.

Riggs (1980) interrogates functional theory in his survey of attitudes toward the World Bank, International Monetary Fund, and WHO. The core assumption in functionalist thinking, that "good behavior can be learned – that people who become personally involved in the work of international agencies will develop attitudes more favorable to international cooperation" is tested through mailed questionnaires and interviews with individuals who have worked with the organizations. Riggs found that "attitudes seem contingent upon the rewardingness of the experience," in turn affected by personal values, domestic organizational milieu, nature of the international organization, and specifics of the respondent's experience. Attitudes toward WHO were relatively positive, attributed to the perception that "Health Functions are simply less controversial" (Riggs 1980:349). He concluded that his findings were "not totally at odds with functionalist theorizing, but suggest additional variables that functionalism should take into account" (1980:329).

Foster (1987a) raises similar questions in his Weberian analysis of the activities of international health organizations as "a function of their structural and dynamic characteristics, and of the professional assumptions held by administrators, planners and technical specialists." He characterizes international health organizations as operating within the "donor-recipient model" of postwar development assistance. Foster undertakes perhaps one of the first comparative assessments of multilateral, bilateral, and what he distinguishes between private-secular (e.g. Rockefeller Foundation) and private-religious (e.g. medical missions) organizations. Among the questions he raises are: what are the strengths and weaknesses of international health organizations; does, and if so to what extent, the early enunciation of policy doctrines reduce the flexibility of international health organizations; and to what extent do professional-personality factors impinge on planning processes (Foster 1987a:1047–8)?

Acknowledging the world of international organizations as "vast and important," Groom describes UN specialized agencies as "predominantly forum or service organisations." The former serves "as a meeting place for a discussion of principles but not to negotiate the detailed design and undertake the execution of programmes" which constitutes the latter. He writes that:

> The balance is important for it is likely to have consequences on the budget, size and style of the secretariat and the characteristics of the decision-making process. Service organisations tend to have larger budgets and secretariats than forum organisations and their decision making processes are more likely to emphasise problem-solving by experts than bargaining by diplomats. (1988:7–8)

While Groom does not specifically analyze WHO in these terms, this tension between the forum and service functions succinctly characterizes the tensions that have defined

WHO from its creation. The pressure to act as a service organization, largely by developing countries, was increasingly unmatched by the resources and authority given to it by industrialized countries. This appears supported by Archer, who questions whether "existing functional organizations such as UNESCO, WHO and ILO have been riddled with ideological and racial (or at least North–South) divisions which have reflected political arguments outside the organizations, but have nevertheless adversely affected their basic work" (1992:94).

Throughout the 1980s, certain select staff of international health organizations continued to publish descriptive work of specific programs and policies (Rosenfield et al. 1981; Fluss and Gutteridge 1990; 1993). This literature takes stock of challenges faced by WHO in different regions and on specific issues. The wide-ranging menu of problems identified included the structure of the bureaucracy, budget and financing, weak capacity within developing countries, and changing epidemiological patterns of health and disease. A notable exception in this literature is a major tome on the Smallpox Eradication Programme (Fenner et al. 1988). Nestled within chapters on the clinical features of smallpox, and developments in vaccination and disease control strategies, is a detailed account of the establishment and conduct of perhaps the most notable success story in international cooperation. While atheoretical in its description of policy making within WHO, it serves as a rare example of a detailed discussion of how international health cooperation was conducted amid diverse and competing interests.

Interest in the politics of international health grew rapidly during the 1980s, with high profile initiatives on baby milk and essential drugs, with much of this work produced by social scientists working within the public health field. For example, the work of Reich applies basic political concepts, such as power and influence, to map specific international health policies. In his paper on the politics and economics of essential drugs, he notes:

> A new pattern has emerged for setting the agenda of international health issues, with open participation in international organizations by industry associations and by consumer groups. This pattern is still evolving, but it represents a significant change and poses a complex challenge to the leadership of international agencies. The more open participation also raises questions about whose interests are being represented and whose interests should be represented at agencies such as the WHO. (1987:55)

One of the few analyses from within international studies of international organization and heath during this period is a study by Mingst (1990:228n), who notes that previous research on WHO is surprisingly limited, especially in view of the alleged success of the organization, as well as the recent appearance of several controversial issues on its agenda. In her study of relations between WHO and the US government, she focuses on the former's information gathering role. She argues that the US government has pursued a "strategy of adaptation":

> This approach is designed to enable the United States to maintain a lower profile, thereby stifling charges of US manipulation of the organization and fortifying WHO's own legitimacy. American officials have worked more behind the scenes to convince countries to support specific measures, building coalitions rather than using threats or financial leverage. (Mingst 1990:219)

She argues that this has been possible because of "the organizational characteristics of WHO, including the technical orientation of the secretariat, transgovernmental networks, and the political savvy of its directors-general and other members" (1990:224). Similarly, Sikkink (1986) analyzes the politics concerning the adoption of the International Code of Marketing of Breast-Milk Substitutes, and observes that "[t]he

perception of WHO as a technical and professional organization with low politiciza-
tion increased the impact of consensual scientific knowledge."

Reform of International Organization and Health

From the 1980s, growing competition among UN organizations for scarce resources
within the international health field resulted in the study of international organiza-
tion and health extending beyond WHO. For example, while WHO and UNICEF
cosponsored the Declaration of Alma Ata, differences in their interpretation of the
most appropriate way of achieving Health for All soon became apparent. The clear
tension between comprehensive and selective primary health care (Walsh and Warren
1979) brought to light the increasing political competition among UN organizations
for donor funding. Maggie Black's two books on UNICEF (1986; 1996) provided the
first detailed accounts of the creation of the UN fund and the development of its
activities. This was followed by Beigbeder's book (2002), whose analysis delves beyond
programs, structure, and finances to examine the challenges UNICEF faces in defining
its identity and relationships with other international organizations.

A spate of assessments of international health organizations, largely from within
the public health field, were undertaken from the early 1990s. In part, this was due
to dissatisfaction among major donor countries with the performance of WHO under
Director-General Hiroshi Nakajima. Major aid donors funded several studies which
reviewed the activities, funding, and, given the growth of international health activi-
ties, division of labour among international health organizations. The Nordic UN
Project (1991), for instance, included a study of UN specialized agencies (including
WHO). It attributes contemporary problems to the shift from traditional normative
and informative roles to technical cooperation activities with developing countries.
The study focuses on the operational capabilities of WHO, in terms of the changing
nature of technical cooperation, and identifies functions the organization might best
perform (Stenson and Sterky 1994; Sterky et al. 1996). In 1991, the Danish International
Development Agency (DANIDA) commissioned its own review of 11 multilateral
agencies, including an analysis of the "Effectiveness of Multilateral Agencies at Country
Level: WHO in Kenya, Nepal, Sudan and Thailand." The study seeks to understand
the "comparative advantages" across agencies at the country level and considered, in
particular, whether WHO "managed to formulate and support a set of activities
(projects and programmes) that are relevant to the present needs of the country"
(DANIDA 1991:2). Based on field visits, discussions with agency staff, review of policy
and project documents, the study takes a program evaluation approach to assess
administrative and technical effectiveness. It recommends "a fundamental review of
the role and mode of WHO's regional offices," given a "too politicised organizational
structure," and "a strengthening of its non-medical, professional resources" in the
form of health management and capacity-building expertise. The theme of country
level presence would later be taken up by another multidonor review (Australia,
Canada, Norway, Sweden, and the UK) of WHO activities in 12 countries (Lucas
et al. 1997).

The proliferation of health-related activities by different UN organizations, as well
as bilateral aid agencies, became a particular focus of public health research during
this period. Walt (1993) published the first detailed analysis of the changing context
of international health cooperation from the 1940s, in the form of major shifts in
financing and activities, and "an increasingly political milieu." Lee et al. (1996) raise
the normative question of who should be doing what in international health, mapping
out formal and effective mandates, resources, and comparative advantages. At the
same time, donor concerns about "value for money" led to a multidonor study (UK,

Australia, and Norway) of WHO finances (Vaughan et al. 1996). Operating since 1980 under a donor-imposed policy of zero real growth (and later zero nominal growth), WHO faced increasingly severe pressure to focus its limited resources more effectively. Based on detailed review of budget and program documents, and semistructured interviews, the study confirmed the need for the organization to strengthen priority setting. Importantly, it undertook groundbreaking analysis of the shift from regular budget to extrabudgetary (voluntary) funds, with the latter giving donors a stronger (and uncoordinated) voice over agenda setting. The study highlighted for the first time the mutual responsibility of international health organizations and donor countries for the serious problem of poor coordination and overlapping mandates. Koivusalo and Ollila (1997), commissioned by the Finnish Ministry of Health, compare the organizational structures, finances, accountability, policies, and cooperative arrangements of various UN organizations concerned with health. Finally, a hard-hitting series by Fiona Godlee in the influential *British Medical Journal* levelled unprecedented criticism at WHO, pointing to problems of efficiency and effectiveness, as well as nepotism, bureaucratic waste, and weak leadership (Godlee 1994a; 1994b; 1994c; 1994d). While journalistic rather than scholarly in style, the series captured the loss of confidence in the mid-1990s in the lead role of WHO in international health cooperation, a subject that would prompt ongoing debate (Brown et al. 2006; Lee and Buse 2006).

The ascendance of the World Bank as a major institutional player in international health became the subject of growing scholarly attention from the early 1990s. The substantial financing provided by the Bank for health development prompted questions about its political influence (Buse and Gwin 1998; Abbasi 1999). The controversial impacts of structural adjustment programs and policy conditionality on health in low- and middle-income countries prompted critiques of the neoliberal ideology underpinning the Bank's policies. This signaled a revival of critical approaches to the study of international health cooperation, focusing not only on operational issues, but on the normative basis of international health policy (Sanders and Chopra 2003).

The Shift from International to Global Health

The prescient call by Thomas (1989) for concerted attention by international relations scholars to health issues began to be heeded in the mid-1990s, first, as part of the rapidly growing study of global governance, which soon acknowledged the innovative changes taking place within health. Second, the end of the Cold War shifted attention to nontraditional security issues which embraced selected health issues.

The politics of international health, in terms of state influence over policy making, remained one analytical focus. Siddiqi's *World Health and World Politics* evaluates "the influence of political and other factors on the WHO's effectiveness in its efforts to achieve universal membership, a workable decentralized structure and the eradication of malaria." Seeking to redress "the non-medical analyses of programmes and policies," he challenges the assumption by functional theory that "politics can be segregated from the technical or 'apolitical' work of an organization like the WHO," and that the failure to do so results in ineffectiveness (1995:41). Dividing politics into four realms (positive, inevitable, legitimate, and negative politics), he argues that politicization specifically concerns "negative politics," defined as that "category of politics which results in the consideration of extraneous issues such as those concerning security and power-politics within the confines of a specialized agency like the WHO" (1995:51). He concludes that politics should be seen not simply as interfering with international health cooperation, but embedded within its very nature. A similar

recognition of the importance of interstate relations is the focus of Panisset's study of the Peruvian cholera epidemic of the 1990s (2000:14). Adopting a utilitarian approach, he puts forth a model of "international health statecraft" for use by foreign and health policy makers to analyze and respond to international health issues.

A recognition of the politically "volatile atmosphere" (Siddiqi 1995:5–6) of international health cooperation is also the starting point for a growing number of studies concerned with why the health needs of certain population groups and issues receive priority while others do not (Shiffman et al. 2002). For example, Muraskin's *The Politics of International Health: The Children's Vaccine Initiative and the Struggle to Develop Vaccines for the Third World* (1998) is the first detailed account of how political rivalry among international health organizations has shaped child immunization campaigns. Shiffman (2006:419) raises similar questions comparing funding from donor organizations for dealing with 20 communicable diseases with the affected numbers of people (as calculated by the Global Burden of Disease Project). Within the context of chronic underfunding for dealing with communicable diseases in the developing world, he concludes that "many funding decisions [are] based on the disease targeted, influenced by industrialized world interests and priorities of the moment. The result will be ongoing competition among diseases for attention. This dynamic makes continued research and monitoring of funding patterns essential."

Kaddar et al. (2004:697) reach a similar conclusion in their economic analysis of the financing of the Global Alliance for Vaccines and Immunization (GAVI). The authors describe a financially sustainable approach to overcome how "funding in poor countries is often at risk and subject to the political whims of donors and national governments."

Equally, the shift in focus to nontraditional security issues in the mid-1990s allowed scholars to explore more fully the convergence between international organization and health. Graphic journalistic-style accounts of Ebola, Marburg and Lassa Fever outbreaks (Garrett 1994; Preston 1998) and revelations about the former Soviet Union's offensive biological weapons program (Alibeck and Handelman 2000) resulted in emerging infectious diseases and the threat of bioterrorism gaining new prominence (Henderson 1999; Fidler 1999). The realization that potentially any population – including that of any Western developed nation – was now at risk, combined with new conceptual frameworks based on the notion of "human security" (Chen et al. 2003), encouraged the change from "international" to "global" thinking, leading Fidler and Gostin (2008) to conclude:

> The biological weapons threat has forced states, intergovernmental organizations, and non-state actors to build more comprehensive and complex strategies to protect against the proliferation and use of biological weapons. Similarly, traditional approaches to infectious diseases proved inadequate as microbial dangers grew in scope and seriousness. These dangers prompted policy makers to engage in the securitization of public health and to embark on unprecedented efforts to remake global surveillance and intervention policies.

Indeed, as the political nature of international organization and health has been more fully explored by scholars (Kickbusch 2002), the role of nonstate actors is increasingly recognized. Reminiscent of Sikkink (1986), the interaction of state and nonstate actors at the 1992 International Conference on Population and Development attracted attention because of the influential role of transnational policy networks of women's health organizations (Finkle and McIntosh 1994). By the late 1990s, the significant role of nonstate actors in international health led Lee (1998) and others to apply the concept of "global governance" to the study of international organization and health. Of particular interest has been the innovative nature of institutional

arrangements that have been established, bringing together new combinations of state, private, and civil society organizations (Dodgson et al. 2002). The prominent role of civil society organizations in the negotiation of the WHO Framework Convention on Tobacco Control, for example, is analyzed by Collin et al. (2002) as an example of the shift from international to global health governance (GHG). Finally, the substantial resources of large charitable trusts such as the Bill and Melinda Gates Foundation have come under greater scrutiny in terms of their influence on decision making and authority within GHG (Moran 2008).

The popularity of global public–private health partnerships (GHPs) has received particular attention within the GHG literature. Seeking to make sense of these new institutional arrangements, Buse and Walt (2000a; 2000b) classify GHPs in terms of their functions as product based, product development based, and issues/systems based. Similarly, Nishtar (2004:5) organizes such arrangements by six purposes, and explores the complex ethical and process-related challenges created by the "transnational nature of some of these partnership arrangements." As such arrangements have rapidly grown in number, some criticize their uncritical use, ideological basis, and compromise of core public health values (Richter 2004). In recent years, attention has turned to assessing how such arrangements can best contribute to global health goals. Trow and Reich (2002) examine the organizational and ethical challenges of product based GHPs, and explore such questions as how organizations with different values, interests, and worldviews come together to resolve critical public health issues; how shared objectives and shared values are created within a partnership; and how relationships of trust are fostered and sustained in the face of the inevitable conflicts, uncertainties, and risks of partnership. The authors draw lessons from successful partnerships as well as troubled ones in order to help guide efforts to reduce global health disparities. In a similar way, Buse and Harmer assess the strengths and weaknesses of GHPs, identifying "seven habits many GHPs practice that result in suboptimal performance and negative externalities," and developing "a simple assessment mechanism [. . .] to score GHPs on a biennial basis on their performance across a range of indicators" (Buse and Harmer 2007:259, 270).

The role of relevant institutional actors formally outside of the health sector has been the subject of growing scholarship. The impact of the World Trade Organization, for example, and its trade policies such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) prompted scholars such as Bettcher et al. (2000) and Trouiller et al. (2002) to question the appropriateness and influence of market-driven forces on global public health. Reminiscent of Navarro and others, who locate international health policy within a capitalist world order, for example, Schrecker et al. (2007) argue for the promotion of health equity within global governance more broadly. The increased funding given by the Group of Eight (G8) countries, for example, has been critically reviewed by Labonte et al. (2004) and Kirton et al. (2009), who compare funding commitments with actual disbursements. The question of how global health fares within the world trading system is also addressed by Fidler et al. (2009) and Lee et al. (2009), who review the global governance of the two realms in terms of institutional mechanisms, policy making processes, and policy coherence.

As well as assessing these individual contributions to GHG, attention has been given to how this increasingly complex institutional environment contributes collectively to GHG. Such analyses go beyond issues of the efficiency and effectiveness of specific institutional arrangements, to assessing the quality of governance they represent. For example, Sidibe et al. conclude that the GFATM "must seek to foster an environment and procedures for public and mutual accountability, involving North and South, non-state and parliamentary actors" (2006:500). Similarly, as part of their assessment of "public health in the new era," Beaglehole et al. call on public health practitioners "to understand the political nature of the process of developing health policy and act

accordingly" (2004:2086). In this sense, scholars have shifted to analyzing how to raise the quality of politics rather than exclude it from an assumed apolitical issue area. Key questions concern the balance of power among institutional players, notably vis-à-vis WHO, in terms of resources, authority, and responsibility (Silberschmidt et al. 2008). To what extent does the proliferation of institutional actors in global health reflect greater democratization or elitism in GHG? Are emerging forms of GHG contributing positively or negatively to global health inequities?

While a substantial literature has emerged on the numerous and diverse institutional actors concerned with global health, a further approach has been to understand the functional needs to be achieved through collective action, amid a shift from international to global health. The prolific work of David Fidler is prominent in this respect for documenting the legal dimensions of GHG in general, and in relation to specific issue areas. He is among the earliest writers to frame emerging infectious diseases (EIDs) as a problem in international relations, and the need "to measure the impact infectious diseases have on international relations, but also to consider how the nature of the international system itself contributes to the global problem of EIDs" (Fidler 1997:810). Case studies edited by Lee (2003b) describe how globalization is impacting on health and the global governance responses needed to address them, while other contributors (Taylor 2002; Gostin 2004; Aginam 2005) expand on the role of international law in both shaping and facilitating global public health collaboration. Similarly, the concept of global public goods for health seeks to apply the basic economic concepts of public goods to identify core functions that international health cooperation should seek to provide in the face of market failure (Smith et al. 2003). More recent works have built on this early analyses (Cooper et al. 2009; Zacher and Keefe 2008). For example, Cooper et al. (2007) write:

> Recently global health issues have leapt to the forefront of the international agenda and are now an everyday concern around the world. The war for global health is clearly being lost on many fronts and the massive body count is mounting fast. Re-emerging diseases such as polio and tuberculosis, long thought to be on the verge of elimination, are now coupled with the devastation of newly emerging ones such as SARS and avian influenza. In addition, the shock of bioterrorism has given a tragic poignancy to the importance of studying the failure of the global health governance system [. . .] [T]his volume studies the global challenges and responses to these issues, as well as the roles of central institutions such as WHO, the World Trade Organization and the G8.

The starting point for such analyses is a key issue area, such as infectious disease control or access to essential medicines, and the existing institutional mechanisms for protecting and promoting human health are then assessed.

Fidler has also been prominent in the analysis of health using a security lens. While Price-Smith (2001; 2002) and others (Rodier et al. 2007) have argued that infectious diseases, in particular, constitute part of a post–Cold War and post–9/11 "new security agenda," Fidler (2003) explores the different meanings of security and the normative basis for linking the health and security policy agendas. This approach is also taken by Elbe (2006), Feldbaum et al. (2006), and others (McInnes and Lee 2005; 2006; Davies 2008; Aldis 2008) who explore the political reasons for the securitization of health issues, such as HIV/AIDS (Ostergard 2007), and the implications for ethics, policy, and practice.

Future Directions

The bulk of scholarship on international organization and health continues to be produced from outside the formal disciplinary boundaries of international relations.

This literature, primarily from the perspective of public health, is understandably concerned with improving the contemporary institutional mechanisms for addressing collective health problems. Moreover, such analyses have often been undertaken by individuals straddling additional roles as practitioners, policy makers, or advocates. While insightful of the practical challenges facing international organization and health, such works tend to be what Strong (1986) describes as "technocratic, ahistorical, apolitical and unreflexive."

The recent growth of attention to global health by international relations scholars suggest opportunities to broaden the perspectives undertaken to date. Building on the work of medical historians (Weindling 1995; Packard 1998) and legal scholars (Fidler 2001; Aginam 2005), there is need to locate the history of international health cooperation more fully within the history of international organization as a whole.

The politics of international organization and health is now well established, not simply as an external interference in the technical workings of intrinsically scientific bodies, but as embedded within their very nature. Fuller analyses of politics within the numerous and diverse institutional actors in global health – how politics is defined and measured, distributed and used – are warranted. How does politics, in turn, shape individual and collective policies and actions? How is contemporary politics shaping the emerging nature of GHG? From such analyses, the broader question of what international organization and health tells us about emerging forms of global governance can be raised. For example, what do innovations in international health co-operation tell us about the shifting boundaries between the state, market, and civil society? What is the quality of global governance as provided by these diverse institutional actors? Admittedly, while the recent shift in the literature to exploring "how" international organizations matter (Koremenos et al. 2001) and the role of delegation and agency (Hawkins et al. 2006) has prompted some preliminary, albeit competing views on the WHO's recent activities (Cortell and Peterson 2006; Kamradt-Scott, 2009), it is simply the case that more analysis, both beyond WHO and in terms of the volume of quality research, is required.

In this sense, there is broad scope for a more critical study of international organization and health. To date, such approaches have been marginalized by a strong emphasis on problem solving. The long debated problems of overlapping mandates, poor coordination, and unclear leadership remain relevant and, indeed, more so amid the proliferation of GHPs and other institutional arrangements. Critical analysis should seek to deepen understanding of this complex institutional context, not as administrative or operational challenges, but as manifestations of different discourses or worldviews shaping GHG (Lee and Zwi 1996). How do different paradigms determine what issues and interests are addressed and neglected? What is the normative nature of health knowledge? How are embedded power relations influencing thought and action on global health? In this way, critical approaches to international organization and health will reveal deeper insights into the nature of emerging global health issues and the institutional responses to them.

References

Abbasi, A. (1999) The World Bank and World Health, Changing Sides. *British Medical Journal* 318 (7187), 865–9.
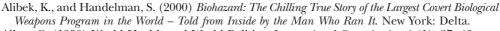
Aginam, O. (2005) *Global Health Governance: International Law and Public Health in a Divided World.* Toronto: University of Toronto Press.

Aldis, W. (2008) Health Security as a Public Health Concept: A Critical Analysis. *Health Policy and Planning* 23 (6), 369–75.

Alexandrowijz, D. (1962) The World Health Organization. In C. Alexandrowijz (ed.) *World Economic Agencies: Law and Practice.* London: Stevens.

Alibek, K., and Handelman, S. (2000) *Biohazard: The Chilling True Story of the Largest Covert Biological Weapons Program in the World – Told from Inside by the Man Who Ran It.* New York: Delta.

Allen, C. (1950) World Health and World Politics. *International Organization* 4 (1), 27–43.

Archer, D. (1992) *International Organizations*, 2nd edn. London: Routledge.

Ascher, C.S. (1952) Current Problems in the World Health Organization's Program. *International Organization* 6 (1), 27–50.

Beaglehole, R., Bonita, R., Horton, R., Adams, O., and McKee, M. (2004) Public Health in the New Era: Improving Health through Collective Action. *The Lancet* 363 (9426), 2084–6.

Beigbeder, Y. (2002) *New Challenges For UNICEF: Children, Women and Human Rights.* London: Palgrave Macmillan.

Berkov, R. (1957) *The World Health Organization: A Study in Decentralised International Administration.* Geneva: E. Droz.

Bettcher, D., Yach, D., and Guindon, G. (2000) Global Trade and Health: Key Linkages and Future Challenges. *Bulletin of the World Health Organization* 78 (4), 521–34.

Black, M. (1986) *The Children and the Nations: The Story of UNICEF.* New York: UNICEF.

Black, M. (1996) *Children First: Story of UNICEF, Past and Present.* New York: UNICEF.

Brockington, F. (1975) *World Health.* London: Churchill Livingstone.

Brown, T., Cueto, M., and Fee, E. (2006) The World Health Organization and the Transition from International to Global Public Health. *American Journal of Public Health* 96 (1), 62–72.

Bryant, J.H. (1969) *Health and the Developing World.* New York: Cornell University Press.

Buse, K. and Gwin, C. (1998) The World Bank and global cooperation in health: the case of Bangladesh. *The Lancet*, 351, 665–669.

Buse, K., and Harmer, A. (2007) Seven Habits of Highly Effective Global Public–Private Health Partnerships: Practice and Potential. *Social Science and Medicine* 64 (2), 259–71.

Buse, K., and Walt, G. (2000a) Global Public–Private Partnerships: Part I – A New Development in Health? *Bulletin of the World Health Organization* 78 (4), 549–61.

Buse, K., and Walt, G. (2000b) Global Public–Private Partnerships: Part II – What Are the Health Issues for Global Governance? *Bulletin of the World Health Organization* 78 (5), 699–708.

Calderwood, H.B. (1963) The World Health Organization and Its Regional Organizations. *Temple Law Quarterly* 37 (1), 15–27.

Chen, L., Leaning, J., and Narasimhan, V. (2003) *Global Health Challenges for Human Security.* Cambridge: Harvard University Press.

Chisholm, B. (1951) International Health: The Role of WHO, Past, Present, and Future. *American Journal of Public Health* 41, 1460–3.

Clements, F.W. (1952) The WHO in Southern Asia and the Western Pacific. *Pacific Affairs* 25 (2), 334–48.

Collin, J., Lee, K., and Bissell, K. (2002) The Framework Convention on Tobacco Control: The Politics of Global Health Governance. *Third World Quarterly* 23 (2), 265–82.

Cooper, A., Schrecker, T., and Kirton, J. (eds.) (2007) *Governing Global Health.* Aldershot: Ashgate.

Cooper, A., Schrecker, T., and Kirton, J. (eds.) (2009) *Innovations in Global Health Governance: Critical Cases.* Aldershot: Ashgate.

Cortell, A., and Peterson, S. (2006) Dutiful Agents, Rogue Actors, or Both? Staffing, Voting Rules, and Slack in the WHO and WTO. In D. Hawkins, D. Lake, D. Nielson, and M. Tierney (eds.) *Delegation and Agency in International Organizations.* Cambridge: Cambridge University Press.

Cox, R., and Jacobson, H. (1974) The World Health Organization. In R. Cox and H. Jacobson, *The Anatomy of Influence: Decision Making in International Organization.* New Haven: Yale University Press, pp. 175–215.

DANIDA (1991) *Effectiveness of Multilateral Agencies at Country Level: WHO in Kenya, Nepal, Sudan and Thailand.* Copenhagen: Danish International Development Agency (DANIDA).

Davies, S. (2008) Securitizing Infectious Disease. *International Affairs* 84 (2), 295–313.

Dodgson, R., Lee, K., and Drager, N. (2002) Global Health Governance: Practice and Prospects. In R. Wilkinson and S. Hughes (eds.) *Global Governance: Critical Perspectives.* London: Routledge, pp. 92–110.

Doyal, L. (1979) *The Political Economy of Health.* London: Pluto Press.

Elbe, S. (2006) Should HIV/AIDS Be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security. *International Studies Quarterly* 50 (1), 119–44.

Elling, R.H. (1981) The Capitalist World-System and International Health. *International Journal of Health Services* 11 (1), 21–51.
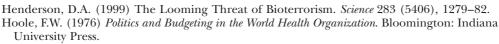
Etzioni, A. (1964) *Modern Organizations.* Englewood Cliffs: Prentice-Hall.

Feldbaum, H., Lee, K., and Patel, P. (2006) The National Security Implications of HIV/AIDS. *PLoS Medicine* 3 (6), 171–5.

Fenner, F., Henderson, D.A., Arita, I., Jezek, Z., and Ladnyi, I.D. (1988) *Smallpox and Its Eradication.* Geneva: World Health Organization.

Fidler, D. (1997) Return of the Fourth Houseman: Emerging Infectious Diseases and International Law. *Minnesota Law Review* 81 (4), 771–868.

Fidler, D. (1999) *International Law and Infectious Diseases.* Oxford: Oxford University Press.

Fidler, D. (2001) Public Health and International Law: The Impact of Infectious Diseases on the Formation of International Legal Regimes, 1800–2000. In A. Price-Smith (ed.) *Plagues and Politics: Infectious Disease and International Policy.* London: Macmillan.

Fidler, D. (2003) Public Health and National Security in the Global Age: Infectious Diseases, Bioterrorism, and Realpolitik. *George Washington International Law Review* 35, 787–856.

Fidler, D., and Gostin, L. (2008) *Biosecurity in the Global Age: Biological Weapons, Public Health and the Rule of Law.* Stanford: Stanford University Press.

Fidler, D., Drager, N., and Lee, K. (2009) The Trade and Health Imperative: Managing the Pursuit of Health and Wealth. *The Lancet* 373 (9660), 325–31.

Finkle J.L., and Crane, B.B. (1976) The World Health Organization and the Population Issue: Organizational Values in the United Nations. *Population and Development Review* 2 (3–4), 367–93.

Finkle, J.L., and McIntosh, C.A. (1994) The New Politics of Population. *Population and Development Review* 20, 3–34.

Fluss S.S., and Gutteridge, F. (1990) Some Contributions of the World Health Organization to Legislation. In T.A. Lambo and S.B. Day (eds.) *Issues in Contemporary International Health.* London: Plenum Medical, pp. 35–54.

Fluss S.S., and Gutteridge, F. (1993) *World Health Organization.* Boston: Kluwer Law and Taxation.

Forbes, J.F. (1980) International Cooperation in Public Health and the World Health Organization. Iin T. Sandler (ed.) *The Theory and Structures of International Political Economy.* Boulder: Westview, pp. 115–31.

Foster, G.M. (1987a) Bureaucratic Aspects of International Health Agencies. *Social Science and Medicine* 25 (9), 1039–48.

Foster, G.M. (1987b) World Health Organization Behavioural Science Research: Problems and Prospects. *Social Science and Medicine* 24 (9), 709–17.

Garrett, L. (1994) *The Coming Plague: Newly Emerging Diseases in a World Out of Balance.* London: Virago.

Godlee, F. (1994a) WHO at Country Level: A Little Impact, No Strategy. *British Medical Journal* 309, 1636–9.

Godlee, F. (1994b) WHO in Crisis. *British Medical Journal* 309, 1424–9.

Godlee, F. (1994c) WHO in Retreat: Is It Losing Its Influence? *British Medical Journal* 309, 1491–5.

Godlee, F. (1994d) The World Health Organization: The Regions – Too Much Power, Too Little Effect. *British Medical Journal* 309, 1566–70.

Goodman, N.M. (1971) *International Health Organizations and Their Work.* London: Churchill Livingstone.

Gostin, L. (2004) International Infectious Disease Law: Revision of the World Health Organization's International Health Regulations. *Journal of the American Medical Association* 291 (21), 2623–7.

Groom A.J.R. (1988) The Advent of International Organisation. In P. Taylor and A.J.R. Groom (eds.) *International Institutions at Work.* London: Pinter, pp. 3–20.

Gutteridge, F. (1963) The World Health Organization: Its Scope and Achievements. *Temple Law Quarterly* 37 (1), 1–14.

Gutteridge, F. (1971) Notes on Decisions of the World Health Organization. In S. Schwebel (ed.) *The Effectiveness of International Decisions.* Leyden: A.W. Sijthoff, pp. 277–84.

Harrod, J. (1974) Problems of the United Nations Specialised Agences at the Quarter Century. *Yearbook of World Affairs* 28, 187–203.

Hawkins, D., Lake, D., Nielson, D., and Tierney, M. (2006) *Delegation and Agency in International Organizations.* Cambridge: Cambridge University Press.

Henderson, D.A. (1999) The Looming Threat of Bioterrorism. *Science* 283 (5406), 1279–82.

Hoole, F.W. (1976) *Politics and Budgeting in the World Health Organization.* Bloomington: Indiana University Press.

Kaddar, M., Lydon, P., and Levine, R. (2004) Financial Challenges of Immunization: A Look at GAVI. *Bulletin of the World Health Organization* 82 (9), 697–702.

Kamradt-Scott, A. (2009) The WHO and SARS: The Challenge of Innovative Responses to Global Health Security. In A. Cooper and J. Kirton (eds.) *Innovation in Global Health Governance: Critical Cases.* Aldershot: Ashgate.

Kickbusch, I. (2002) Influence and Opportunity: Reflections on the US Role in Global Public Health. *Health Affairs* 21 (6), 131–41.

Kirton, J., Roudev, N., Sunderland, L., and Kunz, C. (2009) Explaining Compliance with G8 Health Commitments, 1996–2006. In A. Cooper and J. Kirton (eds.) *Innovation in Global Health Governance: Critical Cases.* Aldershot: Ashgate.

Koivusalo, M., and Ollila, E. (1997) *Making a Healthy World, Agencies, Actors and Policies in International Health.* London: Zed Books.

Koremenos, B., Lipson, C., and Snidal, D. (2001) The Rational Design of International Institutions. *International Organization* 55 (4), 761–99.

Labonte, R., Schrecker, T., Sanders, D., and Meeus, W. (2004) *Fatal Indifference: The G8, Africa and Global Health.* Lansdowne: University of Cape Town Press.

Lee, K. (1998) Shaping the Future of Global Health Cooperation: Where Can We Go from Here? *The Lancet,* 351 (9106), 899–902.

Lee, K. (2003a) *Globalization and Health: An introduction.* London: Palgrave Macmillan.

Lee, K. (ed.) (2003b) *Health Impacts of Globalization: Towards Global Governance.* London: Palgrave Macmillan.

Lee, K. (2008) *The World Health Organization.* London: Routledge.

Lee, K., and Buse, K. (2006) Assuming the Mantle: The Balancing Act Facing the New Director-General. *Journal of the Royal Society for Medicine* 99, 494–6.

Lee, K., and Zwi, A. (1996) A Global Political Economy Approach to AIDS: Ideology, Interests and Implications. *New Political Economy* 1 (3): 355–73.

Lee, K., Collinson, S., Walt, G., and Gilson, L. (1996) Who Should Be Doing What in International Health: A Confusion of Mandates in the United Nations? *British Medical Journal* 312, 302–7.

Lee, K., Sridhar, D., and Patel, M. (2009) Bridging the Divide: The Global Governance of Trade and Health? *The Lancet* 373 (9661), 416–22.

Levy, D. (1954) L'Organisation Mondiale de la Santé. *Revue Internationale d'Histoire Politique et Constitutionnelle* 4, 64–79.

Lucas, A., Mogedal S., Walt G., Hodne Steen, S., Kruse, S.E., Lee, K., and Hawken, L. (1997) *Cooperation for Health Development: The World Health Organisation's Support to Programmes at Country Level.* London: Governments of Australia, Canada, Italy, Norway, Sweden and UK.

Mahler, H. (1976) Social Perspectives in Health: Address in Presenting his Report for 1975 to the 29th World Health Assembly, Geneva, 4 May.

McInnes, C., and Lee, K. (2005) Health and Security. *Politik* 8 (1): 33–44.

McInnes, C., and Lee, K. (2006) Health, Foreign Policy and Security. *Review of International Studies* 32 (1), 5–23.

Mingst, K. (1990) The United States and the World Health Organization. In M.P. Karns and K. Mingst (eds.) *The United States and Multilateral Institutions.* Boston: Unwin Hyman.

Mitrany, D. (1975) *The Functional Theory of Politics.* London: Martin Robertson.

Moran, M. (2008) "The 800 pound gorilla": The Bill and Melinda Gates Foundation, the GAVI Alliance and Philanthropy in International Public Policy. Paper presented at the Annual Meeting of the International Studies Association, San Francisco.

Muraskin, W. (1998) *The Politics of International Health: The Children's Vaccine Initiative and the Struggle to Develop Vaccines for the Third World.* New York: State University of New York Press.

Murphy, C.N. (1994) *International Organization and Industrial Change: Global Governance since 1850.* Cambridge: Polity Press.

Navarro, V. (ed.) (1980) *Imperialism, Health and Medicine.* New York: Baywood.

Navarro, V. (1984) A Critique of the Ideological and Political Positions of the Willy Brandt Report and the WHO Alma Ata Declaration. *Social Science and Medicine* 18 (6), 467–74.

Navarro, V. (1986) *Crisis, Health, and Medicine: A Social Critique.* New York: Tavistock.

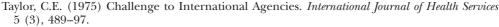Newell, K. (1975) *Health by the People.* Geneva: World Health Organization.

Nishtar, S. (2004) Public–Private "Partnerships" in Health – A Global Call to Action. *Health Research Policy and Systems* 2, 5.

Nordic UN Project (1991) *The United Nations: Issues and Options.* Stockholm: Almqvist och Wiksell.

Ostergard, R.L. (ed.) (2007) *HIV/AIDS and the Threat to National and International Security.* Basingstoke: Palgrave.

Packard, R.M. (1998) "No Other Logical Choice": Global Malaria Eradication and the Politics of International Health in the Post-war Era. *Parassitologia* 40, 217–29.

Panisset, U. (2000) *International Health Statecraft: Foreign Policy and Public Health in Peru's Cholera Epidemic.* New York: University Press of America.

Partan, D.G. (1973) World Health Organization (WHO). In *Population in the UN System: Developing the Legal Capacity and Programs of UN Agencies.* Leiden: A.W. Sijthoff.

Preston, R. (1998) *The Hot Zone: A Terrifying True Story.* New York: Anchor.

Price-Smith, A. (ed.) (2001) *Plagues and Politics: Infectious Disease and International Policy.* London: Macmillan.

Price-Smith, A.T. (2002) *The Health of Nations, Infectious Disease, Environmental Change, and Their Effects on National Security and Development.* Cambridge: MIT Press.

Reich, M.R. (1987) Essential Drugs: Economics and Politics in International Health. *Health Policy* 8, 39–57.

Richter, J. (2004) Public–Private Partnerships for Health: A Trend with No Alternatives? *Development* 47 (2), 43–8.

Riggs, R.E. (1980) The Bank, the IMF, and the WHO: More Data on Functionalist Learning. *Journal of Conflict Resolution* 24 (2), 329–57.

Rodier, G., Greenspan, A.L., Hughes, J.M., and Heymann, D.L. (2007) Global Public Health Security. *Emerging Infectious Diseases* 13 (10), 1447–52.

Rosen, G. (1958) *A History of Public Health.* Baltimore: Johns Hopkins University Press.

Rosenfield, P.L., Widstrand, C.G., and Ruderman, A.P. (1981) Social and Economic Research in the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. *Social Science and Medicine* 15 (5), 529–38.

Sanders, D., and Chopra, M. (2003) Globalization and the Challenge of Health for All: A View from Sub-Saharan Africa. In K. Lee (ed.) *Health Impacts of Globalization: Towards Global Governance.* London: Palgrave Macmillan, pp. 105–17.

Schrecker, T., Labonte, R., and Sanders, D. (2007) Breaking Faith with Africa: The G8 and Population Health after Gleneagles. In A. Cooper, J. Kirton and T. Schrecker (eds.) *Governing Global Health: Challenge, Response, Innovation.* Aldershot: Ashgate, pp. 81–205.

Sharp, W. (1947) The New World Health Organization. *American Journal of International Law* 41 (3), 509–30.

Shiffman, J. (2006) Donor Funding Priorities for Communicable Disease Control in the Developing World. *Health Policy and Planning* 21 (6), 411–20.

Shiffman, J., Beer, T., and Wu, Y. (2002) The Emergence of Global Disease Control Priorities. *Health Policy and Planning* 17 (3), 225–34.

Siddiqi, J. (1995) *World Health and World Politics: The World Health Organization and the UN System.* London: Hurst.

Sidibe, M., Ramiah, I., and Buse, K. (2006) The Global Fund at Five: What Next for Universal Access for HIV/AIDS, TB and Malaria? *Journal of the Royal Society of Medicine* 99, 497–500.

Sikkink, K. (1986) Codes of Conduct for Transnational Corporations: The Case of the WHO/UNICEF Code. *International Organization* 40, 817–40.

Silberschmidt, G., Matheson, D., and Kickbusch, I. (2008) Creating a Committee C of the World Health Assembly. *The Lancet* 371, 1483–6.

Smith, R., Beaglehole, R., Woodward, D., and Drager N. (eds.) (2003) *Global Public Goods for Health: Health Economics and Public Health Perspectives.* Oxford: Oxford University Press.

Stenson, B., and Sterky, G. (1994) What Future WHO? *Health Policy* 28: 235–56.

Sterky, G., Forss, K., and Stenson, B. (1996) *Tomorrow's Global Health Organization: Ideas and Options.* Stockholm: Ministry of Foreign Affairs.

Strong, P.M. (1986) A New-Modelled Medicine? Comments on the WHO's Regional Strategy for Europe. *Social Science and Medicine* 22 (2), 193–9.

Taylor, A. (2002) Global Governance, International Health Law and WHO: Looking Towards the Future. *Bulletin of the World Health Organization* 80 (12), 975–80.

Taylor, C.E. (1975) Challenge to International Agencies. *International Journal of Health Services* 5 (3), 489–97.

Thomas, C. (1989) On the Health of International Relations and the International Relations of Health. *Review of International Studies* 15 (3), 273–80.

Trouiller, P., Olliaro, P., Torreele, E., Orbinski, J., Laing, R., and Ford, N. (2002) Drug Development for Neglected Diseases: A Deficient Market and a Public-Health Policy Failure. *The Lancet* 359 (9324), 2188–94.

Trow, M.J., and Reich, M. (2002) *Public–Private Partnerships for Public Health.* Cambridge: Harvard University Press.

Vaughan, J.P., Mogedal, S., Kruse, S.E., Lee, K., Walt, G., and de Wilde, K. (1996) Financing the World Health Organisation: Global Importance of Extrabudgetary Funds. *Health Policy* 35: 229–45.

Walsh, J.A., and Warren, K.S. (1979) Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries. *New England Journal of Medicine* 301, 967–74.

Walt, G. (1993) WHO under Stress: Implications for Health Policy. *Health Policy* 24, 125–44.

Weindling, P. (ed.) (1995) *International Health Organisations and Movements 1918–1939.* Cambridge: Cambridge University Press.

Werner, D. (1983) *Where There Is No Doctor.* Berkeley: Hesperian Foundation.

Winslow, C. (1951) International Co-operation in the Service of Health. *Annals of the American Academy of Political and Social Sciences* 273, 192–200.

WHO (1958) *The First Ten Years of the World Health Organization, 1948–1957.* Geneva: World Health Organization.

WHO (1968) *The Second Ten Years of the World Health Organization, 1958–1967.* Geneva: World Health Organization.

Zacher, M., and Keefe, T. (2008) *The Politics of Global Health Governance: United by Contagion.* London: Palgrave Macmillan.

Online Resources

World Health Organization. At www.who.int, accessed Mar. 30, 2009. The official website of the UN specialized agency for health. Provides comprehensive technical data and information on health topics ranging from accidents to zoonosis, as well as for 192 member states and six WHO regions. Includes searchable databases on mortality and morbidity, health systems, risk factors, and chronic diseases, as well as a global health atlas. Descriptions of the governance of WHO is also provided.

Global Health Council. At www.globalhealth.org/, accessed Mar. 30, 2009. The world's largest membership alliance dedicated to saving lives by improving health throughout the world. Provides up to date news and events on global health, and topic based information on women's health, child health, HIV/AIDS, infectious diseases and emerging issues.

Global Health. At www.cabi.org/datapage.asp?iDocID=169, accessed 30 Mar. 2009. A bibliographic service derived from over 3500 journals, plus reports, books, and conferences. Contains over 1.2 million scientific records from 1973 to the present. Over 90,000 records added each year, and over 95 percent of these records include an abstract.

Globalization and Health. At www.globalizationandhealth.com/articles/browse.asp, accessed Mar. 30, 2009. An open access, peer-reviewed online journal that provides an international forum for high quality original research, knowledge sharing and debate on the topic of globalization and its effects on health, both positive and negative. The journal focuses on advancing the conceptual and theoretical tenets, empirical evidence base, and policy applications relevant to globalization and health.

International Organizations, Health and HIV/AIDS. At www.lib.berkeley.edu/doemoff/govinfo/intl/gov_intlhealth.html, accessed Mar. 30, 2009. A project of the University of California providing a guide to serve as a basic research tool for international organizations and public health, with a special emphasis on HIV/AIDS.

Acknowledgments

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