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ASIAN CONTRIBUTIONS TO THREE INSTRUMENTS OF GLOBAL HEALTH GOVERNANCE

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Abstract

It is widely recognised that the adverse impacts that transnational forces are having on health determinants and outcomes require more effective collective action. The Asian region has been among the most acutely affected by the health impacts of globalisation, while many health issues in the region have potentially far reaching consequences. The rapidly rising economic status of many Asian countries, coupled with their vulnerability to global health, points to the need to better understand their contributions to GHG. This article analyses Asian contributions to three key instruments underpinning GHG – the International Health Regulations (IHR), Pandemic Influenza Preparedness Framework (PIPF), and Framework Convention on Tobacco Control (FCTC). It finds that, if Asian countries are to move, from rule-takers to rule-makers, there is a need to address weak capacity in the region, to go beyond traditional notions of sovereignty, and to build trust and policy processes across the region.

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ASIAN CONTRIBUTIONS TO THREE INSTRUMENTS OF GLOBAL HEALTH GOVERNANCE

INTRODUCTION

It is widely recognised that the impacts that transnational forces have on health determinants and outcomes, defined here as global health, , require more effective collective action. National health systems acting in isolation and focused on domestic concerns are seen as inadequate. This has given rise to the creation of new institutional arrangements characterised by a multiplication of state and non-state actors, and innovative institutional arrangements for bringing them together (such as public-private partnerships and new financing schemes). Global health governance (GHG), in this context, is understood as the set of principles, norms, rules and institutional mechanisms that enables collective action on health issues of global concern (Lee, 2003).

To date, efforts to strengthen GHG have been largely understood as led by the high-income countries of Europe and North America, with limited analysis of other regions. This neglect includes most Asian countries which, although acutely affected by the health impacts of globalisation, have been given little attention in terms of their engagement with GHG. In recent years, the 2003 outbreak of severe acute respiratory syndrome (SARS), the continuing threat from H5N1 avian influenza, and the alarming rise in non-communicable diseases have contributed to a growing regional awareness of the global challenges to human health among Asian countries. National government responses so far have included the establishment of new centres for disease control, new investments in public health infrastructure, and the creation of schools of public health. However, how Asian countries are contributing to GHG, and the implications for future development of collective action on global health issues, remains poorly understood.This article analyses the contributions of selected Asian countries to the negotiation of three instruments underpinning GHG – the International Health Regulations (IHR), Pandemic Influenza Preparedness Framework (PIPF), and Framework Convention on Tobacco Control (FCTC). Despite increased policy attention to global health issues, and a tripling of official development assistance for health since the 1990s (Chan, 2011), there remains relatively few formal agreements governing collective action on global health. These instruments le are especially relevant to the health challenges facing Asian countries. After

describing the role Asian state and non-state actors have played in the negotiation of these instruments, the article draws conclusions regarding potential regional trends in engaging with GHG. It is concluded that, if Asian countries are to move, from rule-takers to rule-makers, weak capacity, an adherence to traditional notions of sovereignty, and a building of trust and policy processes across the region must be addressed.

METHODS

Over sixty semi-structured interviews were conducted in South Korea, Japan, Indonesia, China (including Taiwan), Vietnam, Singapore, Malaysia and Thailand to understand how Asian countries contributed to the negotiation of the three GHG instruments. Key informants comprised officials of governments (notably ministries of health and bilateral aid agencies) and intergovernmental organisations (including WHO), representatives of nongovernmental organisations (including charitable foundations), public health experts and scholars. Interviewees were initially identified via open-source material from World Health Organization (WHO) records, with further names generated through a snowballing technique. All interviews were conducted using a guide organised by key topic for discussion and corresponding open-ended questions. Interviews were conducted in English or through a locally engaged translator. Where permission was granted, interviews were digitally recorded and then professionally transcribed. For the remaining interviews, detailed notes were recorded.

In addition to interview data, primary and secondary document sources on the participation of Asian countries in GHG negotiations were reviewed to provide background context as well as detailed understanding of the negotiation positions of individual state and non-state actors. For the FCTC, this included on-line keyword searches (by country) of official records available from the WHO Tobacco Free Initiative. To understand the tobacco industry's position on the FCTC negotiations in relation to Asia, a search of internal tobacco industry documents available on-line from the Legacy Tobacco Documents Library was also conducted, using keywords "FCTC" combined with Asian country name using Boolean search terms.

NEGOTIATING GLOBAL HEALTH GOVERNANCE

The International Health Regulations: *The challenge of meaningful participation*

The International Sanitary Regulations (ISR) was first adopted by the World Health Assembly (WHA) in 1951, based on measures adopted by International Sanitary Conferences dating from the nineteenth century. Initially applying to six diseases, the renamed International Health Regulations were reduced in scope in 1969 to four diseases – smallpox, cholera, plague and yellow fever. The confirmed eradication of smallpox in 1981 further reduced the diseases subject to the IHR to three. By the mid 1990s, this narrow scope was seen as increasingly problematic in light of several emerging and re-emerging diseases such as HIV/AIDS, West Nile virus and multi-drug resistant tuberculosis (WHO, 1997: 15-16). Added to this, governments had become increasingly reluctant to report naturally occurring disease events in the wake of several incidents where declaring an outbreak had resulted in adverse economic impacts (e.g. Latin American cholera outbreak in 1991, Indian plague outbreak in 1994), while revelations about the Iraq and former Soviet Union's biological and chemical weapons programs added further concern that the IHR, and indeed WHO's entire governance framework for disease outbreaks, needed reform (Minze et al., 1998: 73).

The decision to revise the IHR was taken in 1995 but, due to various technical and political delays, the bulk of negotiations were finalised at three meetings of the Intergovernmental Working Group on Revision of the International Health Regulations (IGWG) between November 2004 and May 2005. The proposed text from these IGWG meetings was adopted by the WHA in May 2005, which then began an 18-month grace period that concluded in July 2007 when the IHR became binding on WHO member states.

Asian countries, as WHO member states, were invited to contribute to the IHR revision process via regional consultations and through direct participation in the IGWG. To facilitate their engagement, the draft IHR text was circulated for comment prior to the regional consultation. However, according to WHO only two Asian countries (South Korea and Japan) suggested amendments. Further, at the meeting it also became clear that some delegations lacked technical understanding of the proposals:

> *We didn't have regional meetings in the lead-up to or during the IHR negotiations other than the formal meeting arranged by the WHO Western Pacific Regional Office in*

> *Manila. Even at that regional consultation in April 2004 it was clear that many countries didn't exactly know what the IHR meant and they hadn't caught the full implications of what the negotiations were about* (Interview, 23 February 2010).

One potential explanation for this may have been that, for many of the countries – notably China (including Taiwan), Japan, South Korea, and Thailand – the negotiation teams were only formed shortly before the regional consultation and were often not closely briefed by their governments:

> *We were given a very, very broad mandate from the government when we entered the negotiations, so we had a large amount of flexibility. The only guidance or direction we were given was that our first priority was the health of our nation's population, second was the health of the region, and third, the rest of the world. That was the extent of the mandate we were given* (Interview, 23 February 2010).

Further, the composition of the teams, which usually comprised three to five persons, varied in level of expertise and experience in public health, international law, and/or foreign affairs. As one interviewee recalled,

> *Our negotiation team comprised the Director of the Infectious Disease Control Division, some of his colleagues, and me. Unfortunately the expert on international law could not attend the meeting…throughout the negotiations there were so many legal issues that came up, and it was very difficult for us to understand the differences at times between distinctions such as 'should' and 'shall'. We were conscious that other teams had their international lawyers with them, so we went to speak to representatives from the United States and other countries to get their help* (Interview, 25 February 2010).

Another factor affecting the capacity of teams to participate meaningfully in both the regional consultations and the IGWG meetings was language. As one respondent noted,

> *The negotiations were often conducted in English, with interpretation only offered in the five official languages of the United Nations. I am from a country though that does not speak any of the official languages and, even though I had worked in the international division for a number of years, even my grasp of the English language was not sufficient. I still have a barrier to negotiating complex matters and yet my linguistic abilities are still some of the best in our Ministry* (Interview, 26 February 2010).

As a consequence, at least one delegation felt disengaged from the negotiations:

> *We didn't feel the need to get heavily involved in some parts of the negotiations because it was clear that they were between the United States and some European countries on one side, and Iran and some other countries on the other. So we just watched what was going on and kept out of the way* (Interview, 23 February 2010).

Delegation size varied across Asian countries and over time, affecting the ability to cover concurrent sessions, "corridor negotiations" and other processes (Table 1). For example, the Chinese delegation increased from 12 to 17 as negotiations progressed, larger even than the traditionally well-resourced US delegation. In contrast, Indonesia, Japan, Singapore and Thailand sent smaller delegations over time; Laos, the Maldives, Sri Lanka and Vietnam sent representatives intermittently; and Timor-Leste and Nepal did not send any delegates.

[INSERT TABLE 1 HERE]

***Pandemic Influenza Preparedness Framework: A focus on building regional capacity* and a global framework**

The institutional framework for global influenza governance was born alongside the creation of the World Health Organisation (WHO) in 1946. Recalling the 1918 pandemic, which killed over 40 million people worldwide, the goal was threefold: (a) to plan for future influenza pandemics; (b) to develop control methods to limit the impact of a pandemic; and (c) to limit the economic consequences of influenza. In 1947 the World Influenza Centre (WIC) was created in London to collect and distribute information, conduct and coordinate laboratory work, and train laboratory technicians. The Global Influenza Surveillance Network (GISN), which underpins the entire system, was then established in 1952. The network operates via WHO Collaborating Centres (CCs), which receive influenza virus samples from National Influenza Centres (NICs), and undertake analysis to identify virus strains circulating at a given time. This data is passed to pharmaceutical companies to develop seasonal or pandemic influenza vaccines accordingly. In 1952, an Expert Committee on Influenza was formed to provide technical advice and general oversight (Payne, 1953: 763). Today, augmenting GISN's work is the internet-based FluNet, linking NICs and WHO CCs in a virtual network, to ensure rapid global exchange of surveillance data (WHO, 2009a).

While the SARS outbreak is credited with motivating Asian-based disease surveillance initiatives (Kamradt-Scott, 2009), the re-emergence of the H5N1 influenza virus in 2003 put the region at the forefront of global efforts to strengthen influenza preparedness. The region is a likely source of new pandemics (the 1957-58 and 1968 pandemics began in Asia), given the endemicity of the virus, and close co-habitation of human and animal populations. Since its establishment in 1967, ASEAN has periodically hosted high-level meetings on disease control between health ministers. In the wake of the SARS outbreak, these meetings have become more frequent, with ministers meeting formally on a bi-annual basis (and then as required) to discuss health security-related issues. Several declarations and statements of cooperation have been produced on cooperation on avian influenza prevention and preparedness, health emergencies, and regional production of vaccines and antiviral medications (ASEAN, 2010). In late 2003, the Asia-Pacific Economic Cooperation (APEC) forum established a Health Task Force (HTF), which met initially on an ad hoc basis to discuss 'health-related threats to economies' trade and security' (APEC, 2008). Recognising the ongoing importance of cooperation on disease pandemics, the HTF became the APEC Health Working Group in 2007 and has participated regularly in the organisation's official meetings. The Group's annual programme of work explicitly identified enhancing avian and human pandemic influenza preparedness and response capacity as one of its new priority areas (APEC, 2009).

More recently, and focusing on building regional disease surveillance and response capacity, WHO, UN System Influenza Coordination (UNSIC), UN Development Programme (UNDP), Food and Agriculture Organisation (FAO), the World Organisation for Animal Health (OIE) and major donor countries (e.g. US, Australia, Japan) initiated a variety of new programmes. For example, in 2006 the Japanese Government contributed US$135 million to create a stockpile of personal protective equipment (PPE) and antiviral medications (ASEAN, 2007), for use by ASEAN countries in the event of an influenza outbreak (Japan Ministry of Foreign Affairs, 2007). ASEAN and APEC established pandemic influenza technical working groups to facilitate greater regional cooperation; and several regional surveillance networks, such as the Mekong Basin Disease Surveillance (MBDS), the Southeast Asian Influenza Research Network (SEA ICRN), and the Emerging Infectious Network (APEC EINet) were created (MBDS,

2010; Higgs, 2007; University of Washington, 2009). Importantly, however, these networks supplement the WHO's GISN which remains the primary global influenza governance mechanism.

Despite the above efforts, there has generally been dissatisfaction with regional organisations. As one government official noted, 'There is no genuine collaboration between ASEAN. It is just rhetoric. There is no sense of partnership' (Interview, 3 November 2009). Another informant agreed,

> *Yes, ASEAN is extremely weak but it is not a criticism per se. You have to remember that ASEAN was effectively established to be an anti-communism forum, but that is obviously not as big a threat as it once was. As such, there are no strong incentives for these countries to really work together anymore* (Interview, 16 November 2009).

One cited reason for the underperformance of regional bodies was a lack of trust among Asian governments. One official, for example, held the view that 'Singapore is outstandingly bad in terms of collaboration. They don't have the ASEAN perspective. It is the only rich country within ASEAN, and yet when we have an initiative that we need funded they simply say "no". They take and they never give' (Interview, 3 November 2009). Likewise, the Japanese government's donation to create the antiviral stockpile was seen as 'funded by Japan for the security of Japan' (Interview, 3 November 2009). More broadly, a lack of trust also appears to have contributed to undermining regional efforts to establish a new framework for whole-of-government pandemic preparedness. As one key informant stated,

> *A specific example I could share with you relates to the issue of multi-sectoral preparedness – a group of countries were supposed to be doing an assessment in every country which they had agreed they would and then pilot it in Indonesia. Firstly though, it took a lot of time to get buy-in on what should be the indicators and how was the assessment going to be done. Then, when they did do the pilot, momentum was lost as individual countries said, 'Well, we don't really need that team of consultants from other member states to come into our country. We can do a self-assessment'* (Interview, 6 November 2009).

In this context, the GISN system remained largely unchallenged until 2007 when Indonesia announced it would withhold virus samples in protest at inequities in accessing influenza vaccines and anti-viral drugs. It was argued that, while low- and middle-income

countries shared virus samples that supported global influenza control, the resultant medicines manufactured by private pharmaceutical companies were either too expensive or pre-purchased by high-income countries. As a result, negotiations commenced to achieve a "fair and equitable distribution of pandemic influenza vaccines at affordable prices in the event of a pandemic" (WHO, 2007b). Negotiations, however, proved prolonged, extending over four years. Unsurprisingly, Indonesia was a prominent participant throughout the negotiations, which were chaired respectively by Jane Halton of Australia and Viroj Tangcharoensathien of Thailand. In 2007, a proposal by low-income countries, led by Indonesia, unsuccessfully called for WHO to supply H5N1 virus samples to vaccine makers only with the consent of the donor country. Instead, the adopted resolution stated that during "public health emergencies of international concern," including influenza pandemics, manufacturers should have "full access" to viruses from all affected countries. Over the next four years, disagreement remained over the precise meanings of "timely sharing" of samples and “fair” distribution of vaccines and other benefits (Kamradt Scott and Lee 2011). After talks stalled again in 2010, the working group sought the input of non-state actors notably representing the interests of low- and middle-income countries (LMICs) and the pharmaceutical industry. The latter’s recognition, of the need to support countries such as China and Indonesia to build their own pandemic vaccine capacity, and to ensure tiered-pricing, paved the way for eventual agreement.

After four years of negotiations, the Pandemic Influenza Preparedness Framework (PIPF) was agreed in April 2011 (WHO, 2011). The PIPF sets out the terms, conditions and prohibitions governing the sharing of H5N1 influenza viruses, intellectual property pertaining to influenza vaccines and related technology, and the resulting benefits that arise from these activities. Under the terms of the new agreement, manufacturers are expected to make an annual monetary contribution to 50% of the GISN’s running costs, allow for at least 10% of vaccines or anti-viral drugs to be purchased by low-income countries at affordable prices, and encouraged to grant non-exclusive licenses at affordable royalties or royalty free to low-income countries for the production of vaccines and other products. Although the level of benefits remains lower than hoped for by LMICs, the Framework is seen as an important step forward in global influenza governance.

Framework Convention on Tobacco Control: Asian leaders and spoilers

With around 6 million deaths annually from tobacco use, projected to rise to 8 million by 2030 (WHO, 2011), the WHO initiated negotiation of the FCTC in 1999. Resolution WHA52.18 established two bodies to draft the convention and possible related protocols, complete negotiations and submit the final text for consideration by the WHA. A working group was established to prepare draft elements of the treaty, open to all WHO member states. The Intergovernmental Negotiating Body (INB), charged with drafting and negotiating the proposed treaty, held a total of six sessions between October 2000 and March 2003. Prior to the INB, by a public hearing was held to provide a forum for the public health community, the tobacco industry and farmers' groups to submit their case. Regional inter-sessional consultations were held between INB sessions. Non-governmental organisations (NGOs), with official relations with WHO, were invited to participate as observers.

Heralded as a major achievement within the public health community, the FCTC was signed in May 2003, and came into force on 27 February 2005. The treaty's objective, "to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke" (WHO 2003), was to be achieved through wide-ranging commitments by States Parties. As of January 2012, there are 174 parties to the FCTC.

The Asian region had much to gain from stronger tobacco control. Of the world's 1.3 billion smokers, 700 million live in Asia (Brandon, 2010). The region contains three of the five largest tobacco-using countries (i.e. China, India and Indonesia) in the world, and was expected to suffer the vast majority of projected tobacco-related deaths by 2030 (Mathers and Loncar, 2006). Of the 5.5 million people who die from smoking-related illnesses each year, half are in Asia. China and Indonesia alone account for 1.7 million smoking deaths (Brandon, 2010). Moreover, such issues as cigarette smuggling, the impact on tobacco consumption of trade agreements, and crossborder marketing and advertising required effective collective action across countries. At the same time, however, tobacco control was a low priority in most Asian countries which had large and thriving tobacco industries, both domestically owned (such as

Japan Tobacco International, Korean Tobacco and Gingseng and the China National Tobacco Corporation), and increasing penetration by transnational tobacco companies (TTCs).

This conflict between public health and economic interests defined the contributions of specific Asian state and non-state actors to the negotiation of the FCTC. While the FCTC process increased overall support for tobacco control in the region, and gave rise to an active regional policy network of public health advocates, some governments such as China and Japan acted as "spoilers" by seeking to weaken the measures eventually adopted. Japan's participation was led by the Ministry of Finance given its responsibility over the government's controlling interest in JTI, can be understood in this context. Japanese opposition to the FCTC was expressed early during WHO public hearings where JTI representative Axel Gietz claimed advertising bans and tax increases did not work, called instead for "sensible and meaningful tobacco control regulations" (Price 2000). This often used term by TTCs meant non-binding recommendations and guidelines that member states would be invited to voluntarily comply with as circumstances permitted. Assunta and Chapman (2006) describe how the Japanese government was a negative influence by pressing for optional and qualifying language:

> *With regard to Article 13 on regulating cross-border advertising, Japan doubted the need for a protocol. Elaboration of guidelines should take precedence....He favoured guidelines in the form of non-binding recommendations containing examples of worldwide best practices on specific measures*.

For example, Japan's position during negotiations on the adoption of such measures as "light" and "mild" labeling, health warnings; and bans on vending machines remained influenced, according to reports, by a "fear that implementing such policies in the country where 340 billion cigarettes were sold last year would be devastating to tax revenues and tobacco farmers" (Asahi News Service, 1999). This was also evident in the delegations opposition at the First Conference of the Parties (COP1) meeting in 2006 to a request by developing countries for increased resources to support the implementation of the FCTC. While being one of the world's largest donors of health development aid (see aid paper in this special section), Japan argued that "contributions should be entirely voluntary":

> *Dr KASHIWAGI (Japan) stated that the review had shown that there were already sufficient resources in donor countries to assist developing countries in tobacco control activities: the task was to raise awareness so that those resources could be effectively tapped*. (WHO, 2006)

Given the desire by WHO to enable as many countries as possible to accede to the treaty, negotiators sought to agree "the lowest acceptable common denominator in clause development" (Assunta and Chapman, 2006).

Similarly, China is the largest producer and consumer of tobacco in the world. Tobacco production is controlled by a state monopoly, the China National Tobacco Corporation (CNTC), and regulated by the State Tobacco Monopoly Administration (STMA). The industry supplies 9-11% of government revenues through taxation and has thus been nurtured as a valued economic sector. In this context, China's participation in the FCTC negotiations was strongly influenced by industry interests. Perceiving the treaty as a threat, the STMA formed a working group consisting of its research arm, as well as the Yunnan Tobacco Science Research Institute and Ministry of Foreign Affairs. As well as advising on text negotiations, members of the STMA working group also served on the Chinese FCTC delegation. Indeed, unlike most delegations which were led by senior public health officials, the Chinese delegation was led by the Commission of National Development and Reform (CNDR) under which the STMA is located. The presence of industry representation on the Chinese delegation, and incorporation of industry-led "countermeasures" in its negotiating position, shaped the country's contribution to the FCTC process (Zhou and Cheng, 2006).

Despite strong industry-driven opposition to the FCTC, the negotiations were also characterised by the emergence of a broadly-based tobacco control movement in the region with leadership demonstrated, in particular, by India, Thailand and Singapore. Despite being the second largest producer of tobacco in the world after China, India was a strong supporter of the FCTC process (Samet and Wipfli 2009). The country chaired four regional consultations during the inter-session periods between the 2nd and 6th rounds of the INB, and "catalysed consensus development and consolidated strong and unified regional positions on the draft text of the FCTC" (Reddy and Gupta 2004). This role carried over into the INB where India was unanimously elected as the coordinator of WHO South-East Asia Regional Office (SEARO)

member states, and "principal negotiator, on their behalf, on the advertising issue", as well as the Group of 77 and China to serve on the principal negotiating team on issues related to financial resources. According to Monika Arora, Director of HRIDAY, an Indian voluntary organization working in the field of health promotion, efforts were exerted simultaneously at the domestic and global policy levels, leading to a "parallel culmination of the FCTC and Indian Tobacco Control Act" in 2003. Arora described India's success as mutually reinforcing: "The strong provisions of the tobacco control bills approved by the Indian cabinet for introduction in Parliament enabled India's strong advocacy for a strong FCTC" (WHO India 2003). Correspondingly, Parliament was in favour of strong domestic legislation due to India's "lead role in the FCTC negotiations".

Thailand has been another leading light in tobacco control since the late 1980s. It has been one of the few developing countries with national institutions specifically responsible for tobacco control led by the National Committee for the Control of Tobacco Use established in 1989 to conduct governmental tobacco control activities. From the earliest stages of the FCTC process, therefore, Thailand has been an active supporter of a strong treaty. Thailand (like India) saw the treaty as essential for achieving domestic policy goals (Interview with Hatai Chitanondh, Bangkok, 20 January 2010). As Bung-on Ritthiphakdee (as quoted on Hongthong, 2000) of ASH Thailand stated,

> the FCTC is needed since tobacco is a global problem…. It's impossible for any single country to cope with the tobacco problem because it is a transnational problem. Thailand would welcome protocols on the effective eradication of tobacco smuggling, a global ban on tobacco advertising and sponsorship, the elimination of duty-free sales of tobacco products, the harmonization of taxes on tobacco products at international level, the exemption of tobacco products from reduced taxation under regional free-trade agreements, the mandatory testing and reporting of toxic constituents, and the establishment of a mechanism for information-sharing.

To support the FCTC process, Thailand (in partnership with WHO) hosted several major meetings to facilitate negotiations. For example, the 2nd Intersessional Meeting for Member States in ASEAN was held in Bangkok in 2002 chaired by Thailand (WHO 2002b). Between INBs, Thailand also played a lead role in several working groups including the Working Group on

Health and Education Issues (after the first INB) (Smith, 2000). To support implementation of the FCTC, Thailand hosted the 2nd COP in 2007, conscious of the significance of having developing countries play this role:

> Because Thailand is the host country of this session of the Conference of the Parties, Thailand supports South Africa as the future host country because South Africa is a developing country just like Thailand, and because Thailand has proved that a developing country can host a big conference like this one. (WHO, 2007)

At this meeting, Chitanondh was elected COP President in recognition of his leadership role throughout the FCTC process:

While the region was far from uniform in its contributions to the FCTC, what is notable is the shift over time during the negotiations towards regional positions based on WHO regional structures, with Thailand and India nominated respectively to speak on behalf of these groupings. The strengthening of a regional presence at the FCTC negotiations was the result of efforts, spanning pre-negotiations to ongoing protocol negotiations, to develop and support regional governance. This began with the Tobacco Free Initiative (TFI) holding regional consultations in 1999-2000 leading up to the opening of formal negotiations, regional working groups between INBs, and the subsequent creation of regional coordinators for implementing the treaty. In some cases, regional positions arose from these meetings. For example, the Jakarta Declaration on the FCTC was adopted by eight SEARO countries in 2001. ASEAN also became a regional mechanism "to debate matters regarding the framework convention such as tobacco-related problems common to the members of ASEAN and possible solutions.' (WHO, 2002a). Similarly, the 2nd Intersessional Meeting held in Bangkok in 2002, attended by 10 ASEAN countries and 7 NGOs, reviewed the Chair's proposed text and endorsed the Bangkok Declaration on Tobacco Control as a tool for briefing their respective governments. It was also agreed that, for those items on which consensus was reached, interventions at INB-5 would be presented as ASEAN positions (WHO, 2002b).

The clear shift in the global burden of tobacco-related disease and death to the developing world, and Asia in particular, is now fully underway. Prior to the FCTC process, few Asian countries had adopted effective tobacco control policies to mitigate this looming public

health crisis. This follows considerable diversity in the contributions of Asian countries to the negotiation and implementation of the FCTC, closely aligned with the political economy of the tobacco industry. The subsequent growth of the tobacco control movement in Asia, led by state and non-state actors, suggest much potential for the FCTC as a GHG instrument. The effectiveness of the FCTC ultimately depends on how it catalyses actions at the national and regional levels which overcome its flexibilities and qualifying language. In this respect, much work remains to be done. Better data on tobacco production and consumption worldwide, weak capacity to adopt and enforce stronger regulation, and limited resources remain major challenges. Most importantly, it must be recognised that the FCTC, as a GHG instrument, supports rather than undermines Asian countries in a global political economy.

CONCEPTIONS OF GLOBAL HEALTH GOVERNANCE IN ASIA: BALANCING SOVEREIGNTY AND COLLECTIVE ACTION

The three case studies suggest a tension between traditional notions of state sovereignty across Asian countries, and the need for collective action to address global health issues. This was evident in both the IHR and virus sharing negotiations, which were framed in the language of "global health security" (WHO, 2008b). In the context of the IHR, many Asian governments generally saw the agreement as a technical framework for addressing disease outbreaks. Thus, even though several high-income countries had expressed concerns over the potential for terrorist-instigated public health events, many Asian delegations expressed their objections towards the inclusion of terrorism and/or terrorist-related activities within the scope of the IHR:

> *One of the main issues for us throughout the formal negotiations was the definition of 'disease' in the IHR. North America and Europe really wanted to include terrorism and terrorist events but our government objected to this notion. There was no need to include this (*Interview, 25 February 2010).

Significantly, Asian countries were not alone in their objections and, with the support from two regional blocs of Eastern Mediterranean and African states, a compromise was struck on a

definition of "disease" that avoided explicit mention of terrorist-related activities (Kamradt-Scott, in press).

The degree to which a revised IHR would be permitted to override state sovereignty became central as talks progressed. A core goal for revising the IHR was fuller and more rapid notification of outbreaks, particularly in situations where governments may seek to avoid reporting outbreaks for fear of adverse economic impacts. Many argued that this required greater openness and transparency in disease surveillance and reporting, through mandatory reporting by governments, increased authority for WHO to send investigative teams into countries, and the use of state and non-state information sources (WHO, 2000). Even in regional consultation meetings, however, some governments had argued for the sovereign right to exceed measures permitted under the IHR (the minimum necessary without impinging on international trade) in order to protect themselves from outbreaks originating from abroad. As the WHO Secretariat recorded:

> *International law, by its very nature, impinges on country sovereignty. Some participants consider the proposed IHR needs to be modified to shift the balance more towards the rights of Member States. As well as the question of team deployment, some participants wish to retain the right to impose measures in excess of those recommended by WHO, where there is an appropriate rationale* (WHO, 2004a: ii).

During the IGWG negotiations some Asian countries, notably China, opposed the suggestion that investigative teams should be able to enter a country uninvited, equating this to an infringement of sovereignty. Some Asian delegations attributed this to the SARS experience:

> *SARS had been a big embarrassment for the Chinese Government. They basically had been caught out trying to engage in a cover-up over the number of cases they had. The WHO Director-General, Dr Brundtland, then publicly criticized the Chinese authorities. That had never been done before by a Director-General. I am still not entirely sure why they objected so strongly to having SARS included in the list of reportable diseases. They gave a list of reasons in the negotiations such as that it would be a further burden on developing countries and so on, but I personally suspect that they saw it as a matter of national pride. They did not want to end up in a situation where they would be again embarrassed by SARS* (Interview, 2 March 2010).

Importantly, not all Asian governments supported the view that sovereignty should trump collective interests. As one Asian government representative noted,

> *During our discussions, we did raise the issue of on-the-spot investigations and supported the idea that the WHO should be able to make them mandatory. This obviously went against the notion of national sovereignty, but we felt that sovereignty should give way in this instance to what are in the better interests of human beings* (Interview, 2 March 2010).

Overcoming restrictions based on perceived national interests, to enable WHO to investigate suspected outbreaks of collective global interest, lay at the heart of an effective global disease control system. Ultimately, the former view prevailed and, under Article 10 of the revised IHR, WHO is required to obtain the consent of governments before sending investigative teams.

The issue of state sovereignty also played an important role when the status of Taiwan was raised. In 2003 the Taiwanese government was unable to obtain technical assistance from the WHO to control the SARS outbreak because of its non-recognition in the UN. This arguably hampered efforts to control the disease both within Taiwan and globally, and became headline news around the world. Despite being formally excluded from negotiations, Taiwan remained keen to integrate itself with regional and global disease control systems, and formed a "special task force" to review the draft IHR. A special representative was also sent to Geneva to attend the IGWG meetings, but was physically prevented from entering the building (Interview, 1 March 2010). China continued to maintain that any move to recognize Taiwan as independent from China would equate to an infringement of its sovereignty. Aware of these broader political sensitivities, the Taiwanese government 'didn't solicit support from Asian countries,' but did indicate its compliance with the IHR despite not being recognized as a WHO member state (Interview, 2 March 2010). The tension between state sovereignty and the need for effective collective action on this issue has remained largely unresolved.

Asian governments approached the IHR negotiations in an individualistic and state-centric manner, declining to form regional alliances. While the Andean Pact (Peru, Bolivia, Venezuela, Colombia, Chile and Ecuador) and the Mercosur Group (Chile, Brazil, Argentina, Uruguay and Paraguay), for example, met to develop coordinated positions on the draft text, no equivalent meetings were held among Asian countries (WHO, 2010). Asian governments

also declined to raise the IHR negotiations in other state-based regional forums such as ASEAN and APEC, approaching the negotiations instead individually. As one official noted,

> *There were the regional consultations ahead of the intergovernmental working group but I don't recall that we really discussed things with other countries. We attended the meetings, and we listened to what others countries raised and we raised a couple of things ourselves, but we didn't form any partnerships or make any deals* (Interview, 22 February 2010).

It was evident that some delegates believed this approach lessened their collective impact, as one delegate observed:

> *Usually in negotiations countries don't fight alone. Usually a country will seek out other friendly countries to work together with. Africa, for example, now tends to unite as one. The European Union usually unites as one. Even the Commonwealth countries headed by the UK usually have informal meetings during these important negotiations. But here in the East Asian region we have difficulties with this. That actually lessens the Asian voice* (Interview, 26 February 2010).

To restrict the input of non-state actors, the majority of Asian governments also voted to exclude all organizations in official relations with the WHO at the commencement of IGWG meetings in November 2004 on the basis that they were "intergovernmental" meetings. Once the revised IHR was adopted, some Asian countries appeared more willing to explore alternative, innovative arrangements for implementing the IHR. As one WHO official noted, for instance,

> *[Y]ou have to make sure the government sector has the foundation to control things. Once that is achieved then you can start including other partners. We are exploring some possibilities of engaging the services of the Red Cross in countries like Laos and Vietnam, and we are also encouraging various NGOs like CARE to come in and do part of the surveillance work. But at the moment these organizations can only really be involved in data collection activities. They can't evaluate the data, nor is it their responsibility* (Interview, 20 November 2009).

There is thus little evidence that the IHR involved a diversity of institutions, or coalition building, within and across Asian countries.

This tension between state sovereignty and collective action also influenced Asian contributions to global influenza governance, notably in relation to Indonesia's withholding of virus samples. Despite having impacts beyond Indonesia, there was reluctance to address the issue in APEC and ASEAN:

> *The case of Indonesia's refusal to share viruses was not raised in ASEAN nor is it likely to be raised. The only issues that are raised are those that they are likely to get consensus on. Indonesia's refusal to share virus samples is widely perceived to be a 'national' issue even though it is recognized to have obvious transborder and regional implications* (Interview, 3 November 2009).

Another interviewee noted, in relation to APEC: 'Those sorts of issues won't go anywhere in that sort of forum as no-one wants to be seen to be interfering in the domestic affairs of another member country just in case another issue comes up that might involve their country being criticised' (Interview, 22 November 2009). Consequently, even though both APEC and ASEAN had launched various regional cooperation initiatives to enhance regional pandemic influenza preparedness, Asian governments avoided addressing the issue of virus sharing publicly (or even adopting a regional position), principally as it was deemed too controversial and could be seen as either criticising a neighbour, or infringing on Indonesia's sovereign rights. While "quiet diplomacy" occurred to some extent behind-the-scenes to develop the PIPF framework, Asian governments deferred to the WHO-initiated intergovernmental open-ended working group of pandemic influenza virus sharing to resolve the issue.

Similarly, state sovereignty was given primacy at times during the FCTC negotiation process, notably by state and non-state actors opposed to a strong and binding treaty. For example, some member states sought the insertion of qualifying phrases such as 'in accordance with its national laws' to circumscribe FCTC commitments. China, for example, argued that 'price and tax measures were matters for national authorities' (WHO, 2006) and that 'Every Party should formulate and promulgate the relevant specific provisions concerning licensing arrangements in accordance with its national laws' (WHO, 2008a). Japan similarly argued, regarding a protocol on illicit trade, that 'since responsibilities were allocated by individual governments, the protocol should not seek to regulate the issue' (WHO, 2008a).

The alleged encroachment by the FCTC on state sovereignty was also an argument put forth by the tobacco industry. British American Tobacco (BAT) claimed that proposed measures 'risk undermining governments' self-determination' (WHO, 2001):

> *The INB is now starting substantive negotiations for the first time. These offer governments, particularly of developing nations, an important opportunity to ensure that their sovereignty is not undermined or their domestic priorities ignored. So far, many governments' health ministers and officials have only been partly involved. The FCTC process is mainly being driven by a small number of countries with a particular 'anti-tobacco' agenda, such as Canada, Australia, New Zealand, Thailand and the European Union - which appears to be attempting to act without a clear mandate from its individual member states* (WHO, 2001).

A Japan Tobacco International (JTI) representative, speaking at the pre-negotiation public hearings, similarly argued that a "one size fits all" global solution to smoking was flawed, and that "national governments were best placed to know what their country needed' (Fujii and Price, 2000). In the end, the adoption of qualifying language throughout the final text of the FCTC reflected the uneasy balance between strong measures to protect public health and vested economic interests.

Sovereignty-based arguments against the FCTC, genuine or otherwise, seem to have been countered by the degree to which non-state actors contributed to the negotiation process. With the notable exception of tobacco industry-related interests, TFI actively supported the mobilisation and participation of CSOs. This began with a grant from the UN Foundation to foster tobacco control advocacy in developing countries. Then TFI fast-tracked applications by selected NGOs for officially recognised status to enable them to attend negotiations. As a result, non-state actors played a key role at all stages of the FCTC process, going beyond the usually circumscribed engagement by NGOs with WHO (Collin et al, 2002).

In Asia, Thailand was among the strongest supporters of a Canadian proposal to allow "national NGOs `with relevant expertise'…to apply for accreditation and attend, but without the right to vote in plenary meetings and in the main committee meetings" (British American Tobacco, 2000).

> *Dr CHITANONDH (Thailand) commended the Canadian proposal but suggested refining it by explicitly excluding nongovernmental organizations that received financial or other support from tobacco companies and their acolytes, thus echoing the recommendations made by the August 2000 committee of experts on the tobacco industry's strategies designed to undermine the work of WHO….accredited nongovernmental organizations should have the right to participate in all meetings of the Negotiating Body - working groups, ad hoc bodies or any other committees - helping to craft a strong convention* (WHO, 2000b).

Canada and Thailand were subsequently appointed to co-ordinate enquiries from NGOs. Similarly, India supported regional consultations that would enable, inter alia, broad involvement by NGOs:

> *Dr PRASAD (India), speaking on behalf of the Parties to the Convention in the WHO South-East Asia Region, suggested the addition of a phrase at the end of paragraph 7(2), calling for regional consultations [to] facilitate participation by lower-income countries, nongovernmental organizations, customs and law-enforcement officials and other stakeholders* (WHO, 2006).

While nascent in many countries, NGOs from supporting countries played prominent roles in the FCTC process. Action on Smoking and Health (ASH) Foundation Thailand played a lead role in FCA briefings on such matters as graphic warnings, illicit trade and crossborder advertising (Philip Morris, 2002):

> *Thanpuying Sumalee Chartikavanij, President of Thai Women Watch, promised to disseminate and share information concerning the outcome of this conference to the regional network as well as her organization in Thailand and integrate it into the Beijing process. Ms Bung-On Ritthhipakdee, Project Director of Action on Smoking and Health, pledged to mobilize more media women, to enhance the [smoke-free] beauty contest anti-tobacco strategy and to make pharmaceutical companies more active in anti-tobacco campaigning* (WHO, 1999).

The creation of the Asia Pacific Association for the Control of Tobacco (APACT), and its mobilisation of advocacy in the region, generated substantial support for tobacco control in the region. According to Chitanondh, "the Region consists of less than a dozen countries and we are a closely-knit small family. That allows us to work successfully. Member countries of the Region will forge ahead both at the regional and global level" (Interview with Hatai Chitanondh, 20 January 2010). In this way, state-based distrust and resultant emphasis on national

sovereignty appears to have given way, during the negotiation of the FCTC, to a regional movement of state and non-state actors not found during the revision of the IHR and negotiation of the PIPF.

Overall, the case studies suggest that traditional notions of state sovereignty continue to strongly define conceptions of GHG, in relation to infectious disease outbreaks, within many Asian countries. The focus has been on minimizing perceived intrusions on national authority, and maximizing opportunities to enhance national capacities. One Chinese interviewee attributed this to cultural factors: 'Compared to Europe or North America, Asian countries have a very different culture which does not easily translate into collective action. For instance, they [Asian countries] often say to each other "that's your population, nothing to do with any other country"' (Interview, 10 December 2009). The enduring influence of the Five Principles of Peaceful Coexistence (particularly mutual respect for state sovereignty and territorial integrity), and the diversity of the region, may also explain Asian reluctance to strengthen collective action:

> *Improving technical collaboration between Asian countries is one issue. But all these countries have different cultural backgrounds, and culture influences our way of thinking in so many ways including how we respond to these sorts of challenges. It is really difficult to overcome* (Interview, 10 December 2009).

There is some evidence from the FCTC process that non-state actors have helped some Asian countries move beyond traditional notions of sovereignty. Recognising that the globalisation of the tobacco industry can pose a threat to sovereignty, Thailand and India were leaders in the treaty's negotiation. More broadly, the FCTC process challenged territorially-defined notions of interests, highlighting how the protection and promotion of public health involves supporting and opposing interests that span national jurisdictions. GHG, in this context, challenged Asian countries to redefine the concept of sovereignty in tackling global health challenges.

CONCLUSION: TRENDS IN ASIAN ENGAGEMENT IN GHG

There is little doubt that Asian countries have a high stake in ensuring the establishment, and effective functioning, of GHG instruments to deal with shared health challenges affecting the region. However, as Gostin (2005) writes, GHG arrangements to date are a reflection of 'entrenched power structures' given 'disproportionate influence on the global health agenda' by powerful countries principally in Europe and North America. The case studies examined in this article suggest several trends concerning Asian engagement in GHG.

First, there appears to be a growing willingness by state and non-state actors in Asia to challenge existing arrangements, although to date this has been more through unilateral action rather than active engagement in negotiations to revise existing GHG arrangements.. China's failure to report the SARS outbreak in a timely manner (Ford et al., 2007), Indonesia's decision to withhold the sharing of influenza virus samples, the challenging of intellectual property rights protections by India and Thailand, alongside the limited participation by most countries in the revision of the IHR, are examples of this apparent trend.

Second, the emergence of a more assertive and proactive Asian presence or "voice" in GHG appears to be circumscribed by a limited capacity to engage meaningfully in GHG negotiations. In two of the case studies, specialist technical and legal expertise was needed to contribute to the revision of the IHR and pandemic preparednesss in relation to intellectual property rights. Sufficient language skills to negotiate on such technical matters was also variable across Asian countries.

Third, there remains enduring tensions between traditional notions of state sovereignty and recognition of the need for more effective collective action. Many Asian countries still look to their own first, even if it means incurring regional or global costs.[1] Cultural and socioeconomic diversity across Asia is an important reason for this, punctuated by a conflict-ridden and divisive regional history. Trust of neighbouring countries, in many cases, and regional organisations such as ASEAN and the ADB, remains delicate at best.

[1] One example is the Vietnamese government's national campaign to vaccinate all poultry despite warnings that the policy was not sustainable in the long-term given high costs and labour-intensiveness.[1] Ceasing the programme, after commencement, raises the risk that new, resistant strains of the H5N1 virus may emerge to threaten the region.

Yet, at the same time, the region is at the forefront of grappling with globalisation which is driving the region's rapid economic growth and development. While the economic benefits of this headlong rush to develop are palpable, so too are the profound social and environmental costs accompanying Asia's transformation. Within the field of global health, there are opportunities for population health in Asia to improve through greater economic prosperity, improved housing and food security, and better health care. There are also clear health risks from more rapid and far reaching spread of certain communicable diseases, rise in non-communicable diseases from changing lifestyles, environmental degradation, and greater social inequities. Moreover, the health impacts of Asian globalisation are not confined to the region but have the potential to affect the rest of the world.

These findings point to the need for more active engagement by Asia in GHG. The revision of the IHR showed that strengthening capacity in the region, to enable Asian countries to participate meaningfully on the technical and legal content of negotiations, and also to engage in diplomatic processes, is critical. The negotiation of the PIPF demonstrates how emerging Asian powers may increasingly chafe at rules, such as the intellectual property rights affecting access to vaccines, made by other countries. Most interestingly, perhaps, the FCTC negotiations demonstrated the unprecedented emergence of regional positions in Asia on GHG, prompted by the dual roles of both state and non-state actors. Regional mechanisms for facilitating processes allowing policy consultation, formulation, and implementation in future negotiations may enable the region to shapeprospective GHG instruments.

POLICY IMPLICATIONS

- The impacts of globalisation on health within the region, and the potential for health issues in the region to have global consequences, suggest that strengthening GHG requires increased Asian engagement commensurate with the region's growing economic strength.
- Emergent forms of GHG have been shaped to date by a small number of high-income countries. Asian state and non-state actors have been increasingly inclined to challenge existing institutional arrangements and rules.
- Without stronger technical capacity and political processes to enable meaningful participation in global health governance negotiations, Asian countries will remain rule-takers rather than rule-makers.

Table 1: Asian Country Participation in the IHR Intergovernmental Working Group Meetings by number of delegates

Country	Nov 2004	Feb 2005	May 2005
Bangladesh	3	3	5
Brunei Darussalam	4	2	4
Cambodia	1	2	2
China	12	15	17
India	3	3	3
Indonesia	9	5	6
Japan	9	7	7
Lao People's Democratic Republic	1	-	1
Malaysia	3	4	6
Maldives	-	1	1
Mongolia	1	1	2
Myanmar	1	2	5
Nepal	-	-	-
Philippines	3	3	4
Republic of Korea	5	2	4
Singapore	5	4	4
Sri Lanka	1	-	1
Thailand	3	1	2
Timor-Leste	-	-	-
Vietnam	1	-	1

Source: Compiled from World Health Organization. 2004. *List of Participants*. Document: A/IHR/IGWG/DIV/3_Rev.1; World Health Organization. 2005. *Provisional List of Participants*. Document: A/IHR/IGWG/2/DIV/3; and World Health Organization. 2005. *List of Participants*. Document: A/IHR/IGWG/2/DIV/3_Rev.2.

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