**Global Health Governance at a Crossroads**

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*This review takes stock of the global health governance (GHG) literature. We address the transition from international health governance (IHG) to global health governance, identify major actors, and explain some challenges and successes in GHG. We analyze the framing of health as national security, human security, human rights, and global public good, and the implications of these various frames. We also establish and examine from the literature GHG’s major themes and issues, which include: 1) persistent GHG problems; 2) different approaches to tackling health challenges (vertical, horizontal, and diagonal); 3) health’s multisectoral connections; 4) neoliberalism and the global economy; 5) the framing of health (e.g. as a security issue, as a foreign policy issue, as a human rights issue, and as a global public good); 6) global health inequalities; 7) local and country ownership and capacity; 8) international law in GHG; and 9) research gaps in GHG. We find that decades-old challenges in GHG persist and GHG needs a new way forward. A framework called shared health governance offers promise.*

**Introduction**

To discern new directions for global health governance (GHG), it helps to know where GHG has been. This article thus provides a much-needed review of the GHG literature. In the first section we address the transition from international health governance to global health governance, analyze the role of major players — nation-states, United Nations (UN) agencies, multilateral organizations such as the World Bank (WB) and the World Trade Organization (WTO), the G8, non-governmental and civil society organizations (NGOs and CSOs), and public-private partnerships (PPPs) — and explain some accomplishments and challenges under GHG. We then analyze the various ways health has been framed in the global health literature: as national security, human security, human rights, and global public good, as well as the implications of these frames. The third section employs the literature to identify major issues in global health governance and reveals that, despite three decades of serious commitment and earnest effort, GHG remains confounded by the same problems that Charles Pannenborg listed in his 1979 work, *A New International Health Order*. Effective global health governance demands alternative solutions.

**Search Strategy**

We searched multiple databases including, but not restricted to, PubMed, Web of Science, Medline, Scopus, Academic Search Premiere, EconLit, Public Affairs Information Service (PAIS), International Bibliography of the Social Sciences (IBSS), Social Science Full Text, General Science Full Text, Humanities Full Text, ProQuest, Westlaw, and Lexis-Nexus Academic. Search terms included “global health governance,” “health governance,” “global health,” and “governance.” References cited in relevant books and articles identified further publications. We reviewed only materials published in English. Searches had no date restrictions.

**Global Health Governance Systems and Actors**

*Transition from International to Global Health Governance*

Until the 1990s, nation-states and multilateral organizations with state members governed international health. Health funding was mainly bilateral, flowing between donor and recipient governments. National ministries shouldered responsibility for health services delivery. The World Health Organization (WHO) coordinated worldwide efforts such as smallpox eradication with a limited set of partners; it also provided for international reporting and handling of disease outbreaks through the International Health Regulations (IHR). International health governance — also referred to as “the multilateral health regime”[[1]](#endnote-1) and “horizontal germ governance”[[2]](#endnote-2) — was relatively simple, with a small cast of actors and clearer lines of responsibility. Critics have charged that IHG served the interests of powerful Western states or “Great Powers.”[[3]](#endnote-3) Moreover, the need for coordination was lower. Rapid, globalized spread of emerging and re-emerging infectious diseases was not as salient a concern as it is now. Developed states with advanced medical and administrative capacities felt competent to control outbreaks and defend borders from diseases on their own, and did not rely on the IHR to handle outbreaks.[[4]](#endnote-4)

Acceleration of globalization, increasing economic interdependence, and vast international movements of people and products ushered in the GHG era. Recognizing that infectious diseases emerging or re-emerging somewhere can have repercussions everywhere gave new urgency to addressing health on a global scale.GHG is dramatically more complex than IHG, with a plethora of new actors and the accompanying deluge of uncoordinated activities, and only recently has a definition of “global health” been attempted.[[5]](#endnote-5) Characterizations like “post-Westphalian,”[[6]](#endnote-6) “nodal,”[[7]](#endnote-7) “open-source anarchy,”[[8]](#endnote-8) and the application of complexity frameworks to globalization and global health[[9]](#endnote-9) point to the involvement of non-state actors and the non-hierarchical nature of GHG activities and influence.New actors bring new resources and ideas, but new actors and new forms of organization — e.g., networks and partnerships — also “blur[ ] lines of responsibility.”[[10]](#endnote-10)

A lack of clear structure is a conspicuous feature of GHG. The roles played by nation-states, UN organizations, international organizations, NGOs, CSOs, and PPPs are not neatly delineated. Each serves multiple functions: as sources of funding, as originators of initiatives, and as implementers, monitors, and evaluators (Figure 1). The US President’s Emergency Plan for AIDS Relief (PEPFAR), for example, is initiated and funded by the United States, with resources channeled to NGOs that propose and implement programs abroad. Another example is the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund or GFATM), which is funded by national governments, philanthropic foundations, NGOs, and corporate initiatives. Global Fund resources are disbursed to national governments, which design national plans with the input of donors and CSOs, and which may implement those plans with their assistance. Observers assert that there is “no architecture of global health,”[[11]](#endnote-11) though some characterize GHG as three concentric circles of actors: WB and WHO at the center; countries, the International Monetary Fund (IMF) and other UN organizations (UNOs) in the next ring; and NGOs, multi-national corporations (MNCs), epistemic communities, and individuals in the outermost ring.[[12]](#endnote-12) Scholars may disagree on the structural description, but the operational chaos is indisputable. Competition among actors and priorities runs rampant, funding and initiatives often bypass governments**,** which complicates national planning**,** and donor requirements (e.g., for accountability) often lead to duplication and waste. Looking at its separate actors in turn might provide a clearer view of GHG (Table 1). Though non-state actors sometimes seem to be GHG’s defining feature, traditional IHG actors prove difficult to displace and remain dominant in health governance.NGOs and PPPs earn praise for their flexibility, innovation, cost-effectiveness, and greater democratic accountability, yet experience demonstrates that these actors have problems of their own and may add new complications even as they solve others.

*Nation-States*

The bulk of GHG literature affirms the continuing primacy and ultimate responsibility of nation-states in health governance, national and global.[[13]](#endnote-13) Bilateral funding still constitutes the greatest single source of global health assistance,[[14]](#endnote-14) and national resources (public and private), even in low- and middle-income countries, still fund most national health spending.[[15]](#endnote-15) Disease surveillance and control, despite their global implications, depend on the capacity and decisions of national governments (e.g., the attempted suppression of news of the Severe Acute Respiratory Syndrome (SARS) outbreak by China in 2003 and of the plague outbreak by India in 1994; the handling of H1N1 by China and Mexico in 2005). States continue to be vital because they decide what is negotiated internationally and implemented domestically,[[16]](#endnote-16) and because member states fund and support organizations like WHO. Rich and powerful states can further affect health by using measures like bilateral trade agreements to strengthen intellectual property rights and limit drug access through measures like TRIPS (trade-related aspects of intellectual property rights) -Plus and their defense of pharmaceutical, tobacco, and food industry interests. Powerful Western states also set priorities in WHO and define the upper limits of acceptable action; WHO’s surveillance authority, for example, has been characterized as a function of what Western states allow.[[17]](#endnote-17) The globalization of public health supposedly erodes state boundaries’ significance and the nation-state’s importance (though the Westphalian model is still relevant).[[18]](#endnote-18) Episodes like SARS and H1N1, however, show that an “elusive global system” does not simply replace the international system, as public officials who face disease outbreaks revert to quarantine and other sequestration measures.[[19]](#endnote-19) Some observers suggest that GHG actually promotes “re-territorialization.”[[20]](#endnote-20)

States are relevant in other ways. Domestically, public sector or mixed public-private health systems tend to outperform strictly private sector ones in achieving equity,[[21]](#endnote-21) supporting a major role for the nation-state. States have also shown themselves able to lead successful public health efforts, such as the trachoma control campaign in Morocco, folic acid fortification of flour for neural tube defect prevention in Chile, and the HIV/AIDS programs in Brazil and Thailand.[[22]](#endnote-22)

Powerful states are important because global policies in any domain will not advance significantly without these industrialized states’ strong backing. Some scholars believe that the U.S. and the G8 countries have tremendous, even hegemonic clout.[[23]](#endnote-23) Does U.S. hegemony drive the risk factors behind infectious disease threats? Is it thus obligated to address those risks?[[24]](#endnote-24) Should the U.S. use its global influence to establish a global health agreement?[[25]](#endnote-25) Is the G8 the logical emerging global health governor?[[26]](#endnote-26) Rich and powerful states like the U.S. and those of the European Union (E.U.) can affect health by using measures like bilateral trade agreements to strengthen IP rights and limit drug access. Their defense of other industry interests — especially those of the tobacco industry — also undermines global efforts to improve health. Emerging countries, most prominently Brazil, Russia, India, and China (BRICs), are playing a larger role in GHG, as sources of financial and technical assistance, positive and negative examples of health system development, and medical services and supplies, including generic drugs. These countries are also taking a lead in challenging trade and intellectual property rules that hinder access to drugs, and are more generally giving greater voice to the concerns of the developing world in the global arena.[[27]](#endnote-27)

*World Health Organization (WHO) and Other United Nations (UN) Organizations*

The rise of non-state actors and major global health initiatives driven by public-private partnerships, foundations, G8, and other non-UN/WHO entities has diminished the importance of WHO and health-related UN organizations in GHG.[[28]](#endnote-28) Disillusionment with WHO inefficiency and ineffectiveness has arguably spurred engagement of non-state actors.[[29]](#endnote-29) Initiatives such as the Global Fund and the Joint United Nations Programme on HIV/AIDS (UNAIDS), which took away purview over major diseases, appear to challenge WHO.[[30]](#endnote-30) The UN and WHO are beset with criticisms. The UN lacks a “master plan” for health, leading to competition and duplication among UN agencies.[[31]](#endnote-31) WHO is vulnerable to bilateral influence and political pressure, hindering its role as “global health conscience.”[[32]](#endnote-32) It has no enforcement powers. Critics charge that it is too focused on technical matters and vertical programs, too bureaucratic, and insufficiently engaged with civil society.[[33]](#endnote-33) Its conflicting roles as advocate, advisor, and evaluator further limit its effectiveness.[[34]](#endnote-34) Its partnership with the private sector might undermine its ability to set norms and standards.[[35]](#endnote-35) In the past, it had been unable — and it continues to be reluctant — to use the power of international law.[[36]](#endnote-36)

For all of WHO’s flaws, the global health community continues to look to it as the leading global health governor, in the absence of a real alternative. Scholars deem WHO “unique” in its position to coordinate disease surveillance,[[37]](#endnote-37) and identify it as the “only” authority that combines the necessary “institutional mandate, legal authority, and public health expertise.”[[38]](#endnote-38) And while WHO’s budgetary weaknesses and dependence on powerful member states are clear,[[39]](#endnote-39) the prevalent proposal is to strengthen it financially and politically, by giving WHO enforcement powers and a stronger mandate, for example, rather than urging alternative institutions.[[40]](#endnote-40) Globalization for some points to a greater role for multilateral UN organizations and specifically the WHO, as they are more neutral forums than bilateral arrangements.[[41]](#endnote-41)

*World Trade Organization, World Bank, G8, G20*

Other multilateral organizations, not traditionally health-related, have gained importance in GHG. The WTO’s role has expanded as its trade regime raises issues for access to drugs and health services and for non-communicable diseases (through, for example, major risk factors such as tobacco, food safety, and unhealthy diets). By one account, it is “becoming the single most important international institution in the architecture of global health governance,”[[42]](#endnote-42) with the power to enforce compliance with WTO rules and to limit sovereign choice in public health policies even absent the authority and capacity to establish food standards and arbitrate technical regulations.

The World Bank has come to recognize the role of health in development, and is emphasizing health system strengthening and financing, technical and policy advising.[[43]](#endnote-43) Its superior resources have allowed it to displace the WHO as the main multilateral agenda-setter in health since the 1990s, especially in poor countries.[[44]](#endnote-44) Yet the displacement is incomplete: the World Bank has been called upon to support WHO functions,[[45]](#endnote-45) offer effective leadership,[[46]](#endnote-46) and to collaborate with WHO in mitigating freer trade’s negative health effects.[[47]](#endnote-47) Critics charge it with undemocratic and pro-privatization policies,[[48]](#endnote-48) closed and inefficient management,[[49]](#endnote-49) and focus on performance rather than outcome evaluation (with recent emphasis on impact evaluation).[[50]](#endnote-50)

The G8 has been discussed as a potential global health governor,[[51]](#endnote-51) or one “of last resort,”[[52]](#endnote-52) and the emerging center of GHG.[[53]](#endnote-53) Its small membership, public-private collaborations,[[54]](#endnote-54) task-orientation, common values, and a degree of intra-group accountability arguably make the G8 more effective than other global institutions.[[55]](#endnote-55) Essentially an informal network, the G8 may lack the capacity to be a “global health apex institution,” but the flexibility of its structure can be an asset.[[56]](#endnote-56) Free from the regulations constraining WHO’s interactions with NGOs and the private sector, the G8 is more flexible in its actions and can choose to sidestep extant global health bureaucracies. Its visibility and access to national financial and human resources also render it effective in highlighting global problems and raising money for specific activities.[[57]](#endnote-57) The Global Fund, for example, was formed under G8 auspices. Such a select group of nation-states, however, may prioritize their own interests over those of global health, as shown by G8’s inaction regarding tobacco[[58]](#endnote-58) and its less-than-stellar efforts toward redistribution.[[59]](#endnote-59)

Some argue that the G20, an expanded version of the G8, has more advantages: the G20 is an inter-government group based on national governments with authority and accountability to their populations; the group accounts for more than 60 percent of the world’s population; it consists primarily of finance ministers with more direct authority over funding, and is a “broadly representative leaders-level grouping.”[[60]](#endnote-60) However, the G20 made little if any mention of the poverty and suffering resulting from the world financial meltdown in their 2009 summit, and some see the G20 as unlikely to deliver “fundamental” reforms.[[61]](#endnote-61)

*Non-Governmental Organizations (NGOs) and Civil Society Organizations (CSOs)*

NGOs potentially outperform governments as service providers due to their organizational flexibility, cost-effectiveness, and access to communities, especially in remote and difficult areas.[[62]](#endnote-62) Many “proven successes in global health,”[[63]](#endnote-63) for example, stem from work of and with NGOs (e.g. Task Force for Child Survival; Bangladesh Rural Advancement Committee; Carter Center; Clark, Gates and Hassan II Foundations; Helen Keller International; International Trachoma Initiative (ITI); etc.) and most PEPFAR funding, for example, is channeled to NGOs instead of governments. Participation by NGOs and CSOs can also enhance democracy, giving voice to and empowering aid recipients,[[64]](#endnote-64) particularly those with few resources, by helping them understand issues and define positions in negotiations. NGOs get credit for making drug access a high profile issue during the WTO Doha Round[[65]](#endnote-65) and for influencing the Framework Convention on Tobacco Control (FCTC) negotiations.[[66]](#endnote-66) Calls for broader inclusion of NGOs and civil society are routine. But time and experience have shown that NGOs have their own pathologies. The survival imperative drives NGOs to compete amongst themselves for donor funding, turf, and attention, with adverse effects on program design, implementation, and inter-organization coordination.[[67]](#endnote-67) Ideology can undercut NGO effectiveness, as when religious beliefs obstruct condom use and promotion,[[68]](#endnote-68) though real needs “on the ground” can often overcome ideology in the provision of necessary interventions.[[69]](#endnote-69) A more nuanced view of NGOs evolved with the recognition that they are funded not just by “civil society,” but also by states and businesses and are therefore not divorced from those interests.[[70]](#endnote-70) Perceptions of NGO and CSO legitimacy became more critical as observers realized that, though they often purport to represent the public interest, these entities are not elected and it is unclear whom they represent or to whom they are accountable. Moreover, reliance on NGO/CSO service delivery bypasses and potentially undermines elected governments and could damage public sector organizations as higher NGO salaries cause health-worker brain drain.[[71]](#endnote-71)  Some question altogether the broader notion of a “global civil society.”[[72]](#endnote-72)

*Public-Private Partnerships*

Many have commended the emergence of PPPs as a means to bring together civil society, and the public and private sectors to correct market failures. PPPs promise private sector managerial skills, expansive financial and in-kind resources, innovation, and efficiency.[[73]](#endnote-73) They may also be inescapable in some contexts: in drug research and development, for example, the private sector “own[s] the ball.”[[74]](#endnote-74) The prominently successful PPPs, such as Merck’s ivermectin donation and Pfizer’s trachoma programs, are pharmaceutical in nature. Studies have found that most such public health partnerships do speed disease reduction at a lower cost,[[75]](#endnote-75) and target the most burdensome diseases and the most needy countries relatively well.[[76]](#endnote-76)

But reservations abound. Some argue that in PPPs the public sector carries the risks while the private sector reaps the benefits, and that PPPs are basically public relations and market expansion gambits for the private sector.[[77]](#endnote-77) Because specific companies and industries participate in PPPs, these partnerships tend to favor technical approaches and vertical programs with their attendant problems(see below).[[78]](#endnote-78) Nor are they particularly pro-poor, as impoverished countries with big populations, or countries with “unpopular” governments or bad infrastructure may tend to be excluded.[[79]](#endnote-79) PPPs are often opaque and evade accountability due to a lack of procedures to hold them responsible.[[80]](#endnote-80) Northern participants tend to dominate PPPs, with under-representation from the South,[[81]](#endnote-81) though that situation has begun to improve.[[82]](#endnote-82) PPPs may also have worrisome effects on governments and multilateral organizations, by undermining the public sector’s normative focus and compromising the values of international organizations and thus their moral authority to set norms and standards.[[83]](#endnote-83)

*Global Health Successes*

One of the most salient global health successes was the global eradication of smallpox in the 1970s, under IHG. Coordinated by WHO, member states implemented eradication programs with the help of WHO and donor governments such as the U.S., the U.S.S.R., and Sweden, as well as the invention of the bifurcated needle by Wyeth Laboratories. Smallpox was declared eradicated in 1980, 13 years after the commencement of the program in 1967.[[84]](#endnote-84) Despite the profusion of new actors and the absence of clear governance architecture under GHG, prominent examples of global health successes show that these operational difficulties can be overcome. National governments, international organizations, NGOs, the private sector, and individuals have managed fruitful collaborations (Table 2). We will mention just a few here. One well-known example is the African Programme for Onchocerciasis (APOC), started in 1995 following the success of the West African Onchocerciasis Control Program (OCP) to eliminate onchocerciasis in central, southern, and eastern Africa. It continues the collaboration between WHO, UNDP, FAO, World Bank, and Merck’s Mectizan Donation Program under OCP, and further includes the governments of 19 African countries, 27 donor governments, over 30 NGOs, and more than 80,000 rural African communities that locally distribute the medication. Polio and guinea worm eradication and lymphatic filariasis elimination campaigns are additional instances of successful global health efforts that involve large numbers of national, international, non-profit and corporate actors, including the WHO, PAHO, UNICEF, U.S. Centers for Disease Control and Prevention (CDC), the Gates Foundation, the Carter Center, Merck, and DuPont.[[85]](#endnote-85) Through regional measles elimination campaigns undertaken by national governments and entities such as WHO, UNICEF, U.S. CDC, and the International Federation of Red Cross and Red Crescent Societies, dramatic global declines in measles mortality have also been achieved since the year 2000.[[86]](#endnote-86)

Another example is the PARTNERS project on multi-drug resistant tuberculosis, a collaboration among Partners in Health, Socios en Salud, U.S. CDC, WHO, the Task Force for Child Survival and Development, and national governments. PARTNERS demonstrated the feasibility of scaling up MDR-TB treatment in resource-poor settings, and resulted in the integration of MDR-TB treatment into WHO TB policy.[[87]](#endnote-87)

Different types of actors can offer different elements necessary for good global health performance, such as adequate and sustained funding, political leadership and commitment, technical consensus and innovation, and managerial and logistical expertise.[[88]](#endnote-88) The obstacles of competing agendas, conflicting requirements, and turf disputes can be surmounted if partners with aligned interests and complementary skills can develop mutual trust, agree on goals, measurements, and strategies, and operate within an appropriate collaborative structure.[[89]](#endnote-89) International cooperation may also be facilitated by third parties, such as the Carter Center partnership with the Dominican Republic and Haiti to eliminate malaria and lymphatic filariasis, part of the greater efforts of the Carter Center’s International Task Force for Diseases Eradication.[[90]](#endnote-90)

Widely-acknowledged global health successes are notable partly because they are still relatively few in number. Meeting the challenges of cooperation under GHG remains arduous in practice. Though the Millennium Development Goals (MDGs) offer a basis for cooperation,[[91]](#endnote-91) there is no universally agreed-upon coordinating body or unified vision for global health.[[92]](#endnote-92)

**Framing of Health**

That there is no consensus vision for global health is reflected in the different frames applied to health in the GHG literature. Health policy will differ depending on whether health is framed as a matter of security and foreign policy, human rights, or a global public good.[[93]](#endnote-93) These frames are not mutually exclusive, but do have distinct implications.

*Health as Security and Foreign Policy*

Health framed as a traditional security issue emphasizes the defense of borders against infectious diseases and bioweapons with little consideration for non-communicable diseases and social determinants of health.[[94]](#endnote-94) The policy focus is on disease surveillance and outbreak control, though HIV’s demographic impact in high prevalence countries is also beginning to raise concerns about regional and economic stability.[[95]](#endnote-95) The desire of developed (mostly Western) states to protect their trading interests and their borders from contamination drives action.[[96]](#endnote-96) Given this motivation, even some infectious diseases receive little attention because they are geographically concentrated away from developed countries, and are not perceived as important threats.[[97]](#endnote-97) Some describe WHO’s IHR and Global Outbreak Alert and Response Network (GOARN) as biased toward the protection of Western states[[98]](#endnote-98) — the revised IHR’s definition of public health emergencies of international concern, for example, focuses on bioterror agents as defined by the U.S. CDC rather than diseases causing the most fatalities in the past decade.[[99]](#endnote-99) This bias could undermine WHO’s moral authority to elicit cooperation from developing states, a problematic development because the effectiveness of surveillance and response depends largely on poorer states’ ability to detect and verify outbreaks.[[100]](#endnote-100) Such perceived bias reduces poorer states’ willingness to cooperate and all states’ motivation to develop standardized procedures to address infectious agents at their origin.[[101]](#endnote-101) The incentives are few as is — nation-states fear the loss of prestige in revealing disease outbreaks associated with underdevelopment, as well as diminished trade and tourism.[[102]](#endnote-102) Reporting outbreaks could also spur the stockpiling of drugs by wealthy nations, potentially at the expense of access for poorer countries.[[103]](#endnote-103)

Treating health as a security or foreign policy issue further strengthens the state’s role in international health[[104]](#endnote-104) and the element of state sovereignty, possibly influencing the manner and extent to which states are engaged in global health. A popular example of this interplay is China. China sees health as part of foreign policy, and is thus more actively engaged in international health. But a realist agenda drives this engagement, which both guides and hinders China’s role.[[105]](#endnote-105) Some assert that neorealist and neoliberal foreign policy approaches make health matter only as a security or foreign policy issue, because they do not share the humanitarian concerns of public health.[[106]](#endnote-106) A security approach may also have the effect of shifting global health response from civil society toward intelligence and military entities with less concern for civil liberties and democratic participation. On the other hand, framing health as a security issue does have the advantage of increasing attention and resources on both domestic and international levels.[[107]](#endnote-107) The relative emphasis between health and foreign policy may also be adjusted. For example, seven countries declared their intention to view foreign policy through “a health lens,” to judge policies at least partly by their health implications; the focus remains on infectious diseases, but this alters the traditional practice of judging health policy by its foreign policy implications.[[108]](#endnote-108)

*Health as Human Security*

In contrast to traditional security, advocates have proposed treating health as a matter of “human security.”[[109]](#endnote-109) Human security aims to protect individuals’ freedom from fear and freedom from want, and to ensure physical and economic security. It is a “people-centered” — as opposed to state-centered — concept that encompasses economic, food, health, environmental, personal, community (cultural), and political security.[[110]](#endnote-110) Health is considered by some as being at the center of human security because it is universally valued and connects the other components.[[111]](#endnote-111) This viewpoint essentially shifts focus to issues neglected under the traditional security framing, such as the social and economic determinants of health and non-communicable diseases. Some advocate “human security” as a way to understand changes that are generating novel or escalated threats, and to analyze “what security is provided and for whom.”[[112]](#endnote-112) GHG should address “the structural causes of human fear and want as fundamental sources of insecurity.”[[113]](#endnote-113) Others espousing this view observe that HIV is a high human security priority.[[114]](#endnote-114) The concept of human security has been defined and operationalized in various ways,[[115]](#endnote-115) but the lack of clear agreement on what it entails draws charges of vagueness and excessive expansiveness.[[116]](#endnote-116) There is also the notion of “health security,” but its definition is also inconsistent across users and agencies, hampering its usefulness as a basis of cooperation.[[117]](#endnote-117)

*Health as a Human Right*

Health as a human right moves health provision from a discretionary charitable activity to a human entitlement or global citizenship right, adding moral force to actions and appeals to help the poor.[[118]](#endnote-118)Advancing health as a human right is consistent with advancing other human rights, such as civil and political rights imbued in democracy (believed to have positive influence on health), as well as social and economic rights.[[119]](#endnote-119) Although the impact of human rights on health awaits empirical evaluation, the effect is expected to be beneficial.[[120]](#endnote-120) International human rights law has developed to promote the pursuit of global health.[[121]](#endnote-121) There is much discussion about the swings between the traditional security/foreign policy approach and the human rights perspective in global health.[[122]](#endnote-122) Some international health policies, the IHR for instance, adopt principles from both frameworks,[[123]](#endnote-123) and in some countries, India for example, the expanding language of rights is creating popular demand for services and holding the state to account.[[124]](#endnote-124)

*Health as a Global Public Good*

The framing of health as “commons” or as a “global public good” conceives of health as something beyond the jurisdiction of any one country and of interest to two or more countries or their populations.[[125]](#endnote-125) Public goods are non-excludable and non-rival—people cannot be excluded from consuming such goods, nor does one person’s consumption of such goods preclude consumption by another. Examples of global public goods for health include communicable disease control, disease eradication, disease surveillance, the dissemination of research and best practices, and health-related rules and standards.[[126]](#endnote-126) Because the consumption of public goods is non-excludable, there is little commercial incentive for their production. Though national governments may take steps to provide public goods nationally, there is no global government to provide or pay for global public goods.[[127]](#endnote-127) A focus of the global public good perspective, then, is how to ensure collective action for health at the international level.[[128]](#endnote-128) The emphasis of this approach is that of mutual benefit among countries rich and poor, rather than that of aid from the rich to the poor.[[129]](#endnote-129) This potentially raises social justice and equity concerns, since the health interests of the rich and poor are often different, and the rich are more able to act on their own interests.[[130]](#endnote-130) The concept of global public goods itself provides no guidance as to how priority should be assigned to global health issues,[[131]](#endnote-131) nor does it set forth how provision is to be implemented.[[132]](#endnote-132) There is, however, “strong agreement” that provision of global public goods must start at the national level.[[133]](#endnote-133)

Depending on how health is framed, the major issues in GHG identified from the literature may be more or less relevant. For example, inequity in health may be more important in a human rights frame than in a national security/foreign policy frame, whereas the connection between trade and health may take on greater significance in the foreign policy frame.

**Major Issues and Challenges in Global Health Governance**

*Persistence of Global Health Governance’s Key Problems*

The most striking theme in the GHG literature is the persistence of GHG’s key problems. With the exception of more recent work on proven successes in global health, which pertain primarily to disease-specific programs, the global concerns in health governance Pannenborg listed in 1979 still persist today.[[134]](#endnote-134) In 1979, international and global health governance vexations included:

* Lack of coordination between donor governments and NGOs, and recipient countries;
* Confusion of norms and activities due to different ideas regarding health rights and obligations;
* Lack of coordination between WHO, WB, other UNOs and multilateral organizations;
* Lack of national health plans in recipient countries, or plans that do not provide for donor coordination;
* Donor neglect of recurrent expenditures;
* Donors’ short-term orientation and lack of middle- and long-term commitments;
* Health aid tied to foreign policies of donor or recipient, or to purchases of supplies from donor countries; and
* Criteria of “self-reliance” and past performance, channeling aid away from the most needy countries.

Today one, of the most salient issues remains the lack of coordination among donors and between donors and recipient governments; GHG’s proliferation of actors and initiatives has exacerbated this problem.[[135]](#endnote-135) Many donors retain their short-term orientation,[[136]](#endnote-136) and the criteria of “sustainability” and accountability as well as performance-based evaluation persist in distorting program design, implementation, and choice of funding recipients.[[137]](#endnote-137) Economic and strategic interests of donors continue to determine bilateral health aid.[[138]](#endnote-138) Enumerations of these problems are routine, but GHG solutions remain elusive after 30 years.

*Approaches to Tackling Health Challenges*

Main approaches to health challenges are vertical and horizontal, trending into calls for a diagonal third way. Vertical programs or selective primary health care are disease-specific, while horizontal programs or comprehensive primary health care entail broad-based development and strengthening of health systems without particular specification of health priorities. WHO’s Health for All initiative announced in Alma Ata in 1978 is an example of the horizontal approach, while current global health initiatives tend to be vertical.

Disease-specific programs show results; their performance and outcomes are more easily measured and assessed. The wider systemic scope of horizontal strategies, on the other hand, means that results take longer to manifest, are harder to measure, and efforts are more likely to become unmanageable.[[139]](#endnote-139) Donors therefore tend to gravitate toward vertical programs. Vertical programs have produced many of the “proven successes in global health” (e.g., smallpox eradication; onchocerciasis, trachoma, TB, measles, and Chagas disease control; polio eradication; guinea worm reduction; etc.) through international collaboration (e.g., among UNICEF, U.S. CDC, Carter Center, and WHO on guinea worm and among numerous partners through the Onchocerciasis Control Program (OCP)) and demonstrate “what works” in global health programming.[[140]](#endnote-140) But problems with the vertical approach are well recognized. Vertical programs that do not fall within the proven successes category, for example, have been criticized for exhibiting and exacerbating many of the enduring health governance challenges mentioned earlier, such as poor coordination, duplication and waste, short-term funding, unsustainability, and inadequate performance assessment,calling into question the accuracy of results reporting. Vertical programs may also distort national health priorities, and intense focus on particular diseases creates a hierarchy of diseases, in which certain ailments — like HIV/AIDS — receive extraordinary attention while other conditions are ignored (Table 3).[[141]](#endnote-141) Health staff and resources are diverted from normal functions. Nor does the vertical approach address the broader socio-economic determinants of health or social equity. Some criticize vertical programs for being technocratic, exhibiting urban bias and targeting particular populations over others,[[142]](#endnote-142) and overlooking investments in the broader health system that are prerequisites for vertical strategies’ success[[143]](#endnote-143); some argue they reduce states’ policy autonomy.[[144]](#endnote-144) Still, some believe that in countries with weak health systems, a logical first step is to direct funding toward disease-specific programs, which can foster health infrastructure as a second stage;[[145]](#endnote-145) successful programs also offer important examples and lessons for international collaboration in global health.

Nevertheless, a consensus is growing around the need for more action on health systems strengthening, which is more and more considered key to improving health. Systems failings are impeding the achievement of MDGs[[146]](#endnote-146) and vertical programobjectives. Scholars increasingly argue for strong commitment, funding, and technical support for building health infrastructure, ensuring access, and addressing inadequacies in human resources and data systems.[[147]](#endnote-147) The World Bank has directed its attention toward health system strengthening.[[148]](#endnote-148) Observers believe WHO’s horizontal policy to develop health systems driven by primary health care is essential for meeting developing country challenges.[[149]](#endnote-149) However, the potential of the horizontal approach is “largely unexploited,”[[150]](#endnote-150) though it showed good results in the 1980s in Mozambique, Cuba, and Nicaragua;[[151]](#endnote-151) strategies for building a strong health system vary and are undecided.[[152]](#endnote-152)

More recent is advocacy for a diagonal approach, also known as a “matrix approach.” It combines vertical and horizontal elements[[153]](#endnote-153) and allocates resources to strengthen health system components relevant to specific diseases burdening a given country.[[154]](#endnote-154) These approaches seek to use explicit intervention priorities (vertical) to drive health system improvement (horizontal). GAVI-HSS, a health systems strengthening initiative started by the Global Alliance for Vaccines and Immunisations in 2006, is an example of a diagonal approach. GAVI-HSS allows the health ministry of each applicant country to define health system constraints, and aims to improve immunization through strengthening health systems.[[155]](#endnote-155) A study of the first four rounds of applications supports the concept of developing an HSS approach starting with specific programs.[[156]](#endnote-156)

*Multisectoral Connections with Health*

Increasingly, scholars understand health as a multisectoral issue that does not exist in isolation, especially in a globalizing world.[[157]](#endnote-157) Greater intersectoral coordination[[158]](#endnote-158) to better integrate health into broader policymaking is essential to ensure coherent policies that protect health interests.[[159]](#endnote-159) The connection between the health and trade sectors is particularly challenging in this regard. Researchers recognize that economic globalization and trade liberalization are driving forces for a globalized health crisis, with implications for issues like non-communicable diseases and access to drugs and health services;[[160]](#endnote-160) yet globalization and trade also link to economic growth, which is necessary for health systems development and sustainability.These are widely discussed topics, especially in the WTO context.

Trade and trade rules affect drug access through incentives for research and development, pricing, and intellectual property (IP) rules. Pharmaceutical research and development (R&D) is concentrated in developed country markets and on conditions affecting developed country populations, because poor countries and populations do not have the spending power to make the immense time and investment for drug R&D worthwhile for private industry. Tropical diseases are neglected because profit-driven R&D is unlikely to recoup investments in developing country markets.[[161]](#endnote-161) The Drugs for Neglected Diseases Initiative (DNDi) (to deliver 6-8 drugs by 2014) and Orphan Drug Acts in the U.S., Japan and the E.U. attempt to address this.[[162]](#endnote-162)

Drug pricing, if too high, limits access,[[163]](#endnote-163) and IP rules play a major part in determining prices. IP protection can lead to huge price differences between countries where drugs are patented and countries where generic versions are available (Table 4).[[164]](#endnote-164) International price discrimination, however, can be positive if pricing in rich countries subsidizes lower prices in poor ones,[[165]](#endnote-165) and instruments such as parallel importing and compulsory licenses (allowing manufacturing or importing of generic versions) can mitigate patent-related access problems. But developing countries’ attempts to use these instruments often encounter opposition from pharmaceutical interests in rich countries. Some of these opposing actions fail (e.g., the 42-firm law suit against South Africa and threatened sanctions against Brazil), but others caused countries and companies to surrender efforts to make or import affordable generics.[[166]](#endnote-166) Are drug patents the real problem for access to essential medicines? Some note that most drugs considered “essential” by WHO are not under patent,[[167]](#endnote-167) that drug companies often do not apply for patents even where they could, and that in practice, patents are not a serious obstacle to access.[[168]](#endnote-168) This view maintains that fixing TRIPS would not solve the access situation in developing countries, because the fundamental problem—that individual nation-states have not established a right to essential medicines—remains. Others find this claim biased[[169]](#endnote-169) and inapplicable to HIV/AIDS drugs.[[170]](#endnote-170)

The General Agreement on Trade in Services (GATS) and its implications for developing countries’ health services and systems are another nexus where trade and health meet. GATS aims to liberalize trade in health services, encouraging privatization and market competition, with unclear ramifications for health and health care. Some charge that GATS is a means for multinational service corporations to increase their business prospects,[[171]](#endnote-171) while others worry that privatization of health services would be costly, generate inequitable two-tiered systems, widen health gaps, and obstruct universal access.[[172]](#endnote-172) Another concern is that “progressive liberalization” under GATS would only mean increasing privatization of health systems and health care provision, which could hinder development of public health services and limit future government options in health system design and reform.[[173]](#endnote-173) The brain drain problem may also worsen domestically and internationally, as workers move from public to private sectors, and from developing to developed countries.[[174]](#endnote-174)

Non-communicable diseases (NCDs) are receiving more attention now that the globalization of unhealthy diets and sedentary lifestyles is making them both more common and more deadly,[[175]](#endnote-175)a threat exacerbated by tobacco’s spread into developing markets[[176]](#endnote-176) and tobacco’s importance in numerous developing economies (e.g., China, Turkey, Zimbabwe).[[177]](#endnote-177) Observers urge action, particularly through multisectoral partnerships; both the environment and individual behaviors affect NCDs, which therefore involve too many sectors for any one agency to manage.[[178]](#endnote-178) Philanthropists such as Bill Gates and Michael Bloomberg are involved in global efforts to mitigate the effects of tobacco.[[179]](#endnote-179)

Trade impacts health profoundly, but health holds the weaker position in the health-trade nexus. Trade’s formalized governance as opposed to the “unstructured plurality” in health is one explanation for this uneven match.[[180]](#endnote-180) Countries believe that their economic well-being depends on participating in an effective international trade system, and are therefore willing to join the WTO, where membership comes with many legal, enforceable obligations. WHO, in contrast, lacks enforcement power and bases its authority mainly on technical expertise, and must contend with more diverse perspectives with minimal reciprocal obligations. WHO has limited access to WTO proceedings; business representatives outnumber health representatives on trade commissions. The deficiency in systematic monitoring and assessment of trade policy from a public health perspective and the absence of a unified GHG vision undermine and complicate health’s position vis-a-vis trade.[[181]](#endnote-181) Greater coordination between health and trade to achieve policy coherence is desired.[[182]](#endnote-182) WHO could help countries understand, negotiate and draft trade laws.[[183]](#endnote-183) It could mitigate the effects of global brands marketing, regulate tobacco, and monitor large-scale agricultural production.[[184]](#endnote-184) Some scholars propose direct transnational corporation (TNC) regulation to protect health from the abuses of international commerce.[[185]](#endnote-185)

Sectors other than trade also affect health. Health ties into development more generally, particularly extreme poverty and other development indicators.[[186]](#endnote-186) WHO has called for incorporating health into Poverty Reduction Strategy Papers (PRSPs) and sector-wide approaches,[[187]](#endnote-187) and the World Bank considers health a major component of its global economic role.[[188]](#endnote-188) Yet large-scale development projects are often planned without adequately assessing effects on health.[[189]](#endnote-189) Greater attention to the implications for human health from animal health,[[190]](#endnote-190) agriculture,[[191]](#endnote-191) and the environment[[192]](#endnote-192) is important.

*Neoliberalism*

The health-trade nexus may be a particularly prominent manifestation of a larger theme playing out in the globalization process: neoliberalism. Neoliberalism connotes global economic liberalization, privatization, market competition, and the pursuit of efficiency. Neoliberal economic globalization and the accompanying migration behavior increase risks from infectious disease outbreaks; economic growth, foreign direct investments, and urbanization significantly affect NCD mortality rates.[[193]](#endnote-193) Although trade openness has been found to be associated with economic growth and poverty reduction, it produces winners and losers. Liberalization does not necessarily support poverty-oriented health care, nor does public health necessarily improve under the devolution of health responsibilities to the individual level when health’s determinants are also national and global.[[194]](#endnote-194) Observers believe that international economic and financial organizations such as WTO, IMF, and the World Bank push a neoliberal agenda, favoring capital and overriding the will of national democratic institutions.[[195]](#endnote-195) Some argue that debt repayment schemes, structural adjustment programs (SAPs), and PRSPs have little regard for the economic and social costs of adjustment,[[196]](#endnote-196) especially to the health sector.[[197]](#endnote-197) They charge that policies to reduce government health expenditure, such as user fees and spending cuts[[198]](#endnote-198)undermine health care. Indeed, some propose exempting health spending from international financial institution (IFI)-stipulated fiscal restraints.[[199]](#endnote-199)  Neoliberal globalization, some argue, “simultaneously maximizes the need for social intervention,” and minimizes the political and strategic options available.[[200]](#endnote-200) Some further believe that the neoliberal pursuit of consumption and efficiency comes at the expense of equality.[[201]](#endnote-201) The neoliberal orientation is contrasted with a social-democratic one.[[202]](#endnote-202) On the other hand, a review of SAPs’ consequences for health found that empirical studies tend to present both positive and negative effects.[[203]](#endnote-203)

*Health Inequalities*

Health inequality is a widely-recognized problem (Fig. 2).[[204]](#endnote-204) In 2008, a WHO Commission on the Social Determinants of Health report named health equity a central goal in global health.[[205]](#endnote-205) This is not a new call, since WHO has already advocated reduction of economic and social inequalities and pushed for universal access to primary health care.[[206]](#endnote-206) Health equity is not an unquestioned priority, however.[[207]](#endnote-207) Some advocate providing some minimal level of opportunity and addressing basic survival needs of the poor, rather than pursuing equity per se.[[208]](#endnote-208)Others argue for reducing shortfall inequalities in health capabilities with efficiency.[[209]](#endnote-209) Proposals to mitigate inequities include greater resource transfer from rich and increasingly emerging countries to poor countries,[[210]](#endnote-210) more focus on equality in poverty reduction strategies,[[211]](#endnote-211) South-South collaboration,[[212]](#endnote-212) and clarifying duties and obligations in domestic and international policy and law.[[213]](#endnote-213) International commissions may be a way to move the health equity agenda forward, since they can assert the “power of ideas.”[[214]](#endnote-214) Fairer distribution of voting power and representation of poor countries in international organizations could be beneficial.[[215]](#endnote-215)

Along with inequalities in access to drug and health services noted earlier, another major health inequality is the 90/10 research gap: though the developing world suffers 90 percent of the global disease burden, only 10 percent of research expenditures target that burden. This gap resists remediation both because the private sector has little market incentive to make the investments, and because the means to conduct and access research are so lacking in poor countries.[[216]](#endnote-216) Under these conditions, technological and scientific advancements such as genomics, nanotechnology, and proteomics in developed countries are likely to widen the gap even more.[[217]](#endnote-217) Augmenting research capacity in developing countries, information sharing to improve knowledge access,[[218]](#endnote-218)and “fair global rules” to channel technology toward the health needs of the poor could help bridge this divide.[[219]](#endnote-219)

*Local/Country Ownership and Capacity*

Recipient countries and localities suffer from the short-term orientation and lack of coordination that plague global health programs, complicate national planning and strain national and local resources. Greater local ownership and participation in global health initiatives are seen as important for development and for sustainability,[[220]](#endnote-220) and are cited as contributing to recent successes in efforts against malaria, onchocerciasis, and guinea worm, for example.[[221]](#endnote-221) Local ownership better represents and addresses local needs,[[222]](#endnote-222) and greater control over community events improves community health.[[223]](#endnote-223)  The Healthy Cities initiative (started in the 1980s) can serve as an example of a strong local approach to development.[[224]](#endnote-224) Country leadership is important, as is the alignment and harmonization of global health initiatives with national plans.[[225]](#endnote-225) Examples of efforts to facilitate coordination and country ownership include PRSPs, the Paris Declaration on Aid Effectiveness, UNAIDS’ “Three Ones” initiative, GAVI-HSS, Committee C, and the International Health Partnership and related initiatives (IHP+). Theoretical advantages aside, however, the ability of countries and localities to take ownership of projects is a concern. These efforts must take human resources and financial capacities into account[[226]](#endnote-226) and include key stakeholders. Poor countries might not have the capacity to regulate activities of better-resourced actors,[[227]](#endnote-227) and many governments might lack competence and integrity,[[228]](#endnote-228) which require strengthening.That said, governments in impoverished countries have led and funded “proven successes” in global health.[[229]](#endnote-229) Country ownership may also be difficult to achieve, since donors are often reluctant to give up pet initiatives and longstanding procedures.[[230]](#endnote-230)

*The Use of International Law*

International health law increasingly links to human rights, environmental law, labor law, and trade, and international treaty law takes on growing significance as a mechanism of future international collective action.[[231]](#endnote-231) Some believe that international law can more effectively govern health. WHO is deemed to be uniquely positioned to draft international health law and codify international public health treaties, due to its legal authority, institutional mandate, and public health expertise. Yet it has not used its international law-making powers extensively.[[232]](#endnote-232) WHO embraced international law with the 2003 Framework Convention on Tobacco Control (FCTC), WHO’s first binding legal treaty.[[233]](#endnote-233) The FCTC, along with litigation and courts, are mechanisms for holding the tobacco industry liable.[[234]](#endnote-234) Yet WHO’s next effort, the non-binding and non-norm-setting Global Strategy on Diet, Physical Activity and Health (2004), seemed to retreat back to a technical and administrative support role.[[235]](#endnote-235) It placed responsibility mainly on nation-states and designated no entity for enforcement or interpretation of policies. More extensive WHO involvement in international law is suggested, for instance to lead effective health law development,[[236]](#endnote-236) to help countries draft and negotiate trade laws,[[237]](#endnote-237) and to coordinate, catalyze, and effectuate future health law codification.[[238]](#endnote-238) Reader argues for an “ex post facto liability regime” to hold countries accountable for the deliberate suppression of disease outbreak information, to improve compliance with IHR, to strengthen international health norms and to push governments to give GHG higher priority.[[239]](#endnote-239) He states that China’s behavior during the SARS outbreak amounted to an “abuse of rights” in customary international law.

But international law and agreements can be double-edged swords. As we have seen, existing laws and agreements — more particularly those related to WTO and trade — sometimes hinder health efforts. TRIPS-related obstacles to drug access and trade disputes over states’ power to ban harmful imports like tobacco and mutton flaps are examples of international legal barriers to public health promotion. Power and resources influence law-making, and the resulting legislation may favor wealthy businesses and countries. For example, industries and their powerful home countries are better able to shape the development of standards like the Codex Alimentarius, which regulates food trade.[[240]](#endnote-240)A still more fundamental problem, however, is the weakness of international law. In the absence of a supranational government with strong and independent enforcement powers, international law is unlikely to be consistently or effectively enforced, regardless of its substantive quality or equity. This problem is acute in the health arena, given WHO’s lack of enforcement powers. The record of member state compliance with WHO binding rules and non-binding recommendations is poor, even when member states can choose which policies to adopt.[[241]](#endnote-241)

*Global Health Governance Research Gaps*

The global health problem of the 90/10 gap aside, global health governance itself suffers from fundamental knowledge deficiencies. For the most important global health tasks — such as improving population health and strengthening health systems — the global health community may have an insufficient evidence base. Few global health interventions are evidence-based, and interventions to improve population health among the poor are often untested; what works in one place may not work elsewhere.[[242]](#endnote-242) More knowledge about interventions’ costs and cost-effectiveness is critical.[[243]](#endnote-243)What works and what doesn’t work in health policy design and implementation also require more examination.[[244]](#endnote-244) Other areas that stand to benefit from more research include the effectiveness of private sector contracting and its impact on the poor,[[245]](#endnote-245) biotechnology relevant to disease, agriculture, and the environment[[246]](#endnote-246),and GHG institutions and processes. Ways to enable treatment adherence by patients with limited literacy and numeracy are worth exploring as well,[[247]](#endnote-247) given the widespread need for relatively complex HIV/AIDS treatments in some of the world’s poorest countries. Perhaps more fundamentally, norms for allocating resources across health needs also demand development.[[248]](#endnote-248) To maximize usefulness, global health research should address priority health needs and contribute to policy formulation.[[249]](#endnote-249)

**Conclusion**

Despite select “proven successes in global health,” overall, the state of global health governance reflected by the literature points to continuing, decades-old problems of insufficient coordination, the pursuit of national and organizational self-interest, inadequate participation by the recipients and targets of aid, and sheer lack of resources. The world needs a new way forward, and shared health governance (SHG)[[250]](#endnote-250) may provide a useful conceptual and operative framework. A detailed description of SHG is beyond the scope of this paper; it is discussed elsewhere.[[251]](#endnote-251) SHG calls for melding values among different global, national, and local actors — a shared vision of health and health provision. Such a consensus aims to foster agreement on goals and strategies to promote program design, implementation, evaluation, and coordination. SHG is compatible with the different framings of health, and can potentially bring the frames together if consensus is sufficiently robust. SHG also advances health agency for all, as enabling affected but marginalized groups to participate in national and global health initiatives is critical for addressing the needs of aid recipients effectively and reining in powerful industry and national interests in global health and international law instruments. The global community should recognize health as a meaningful and operational right, the realization of which will require voluntary resource redistribution from rich to poor in order to narrow the vast, unjustifiable gaps in health and health services. Actors must internalize public moral norms for equity in health and commit to meeting the health needs of others.

Figure 1: Overlapping Roles of Global Health Actors



Note: “DAH” is development assistance for health. “BMGF” is the Bill and Melinda Gates Foundation. “GAVI” is Global Alliance for Vaccines and Immunization.

Source: Institute for Health Metrics and Evaluation (IHME), *Financing Global Health 2009*, p.15.

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| Table 1: Examples of Global Health Actors |
| Nation-states | *Top ten donors, by total amounts (2007):*a USA, UK, France, Germany, Japan, Canada, Norway, Sweden, Netherlands, Spain |
|  | *Top ten recipients (2002-2007):*b India, Ethiopia, Uganda, Nigeria, Tanzania, Indonesia, Kenya, Pakistan, Zambia, China |
| Multilateral Organizations | *United Nations Organizations*: WHO, UNICEF, UNFPA, UNDP, UNAIDS |
|  | *Others*: WTO, World Bank, regional development banks, G8/G20, European Commission, Global Fund |
| Non-Governmental Organizations | Save the Children, Catholic Relief Services, Medecins Sans Frontieres, Carter Center, Christian Health Association of Malawi, Task Force on Child Survival, Bangladesh Rural Advancement Committee, International Trachoma Initiative (ITI), International Life Science Institute (industry-supported), Doctors without Borders, Partners in Health, Rotary International, Red Cross and Red Crescent Societies, Helen Keller International |
| Private Sector | *Philanthropic foundations*: Bill and Melinda Gates Foundation, Edna McConnell Clark Foundation, The Rockefeller Foundation, Clinton Foundation, Bloomberg Initiative |
|  | *Industry:* pharmaceutical companies (e.g., Merck, Pfizer, GlaxoSmithKline, Aventi Pasteur), tobacco companies (e.g., Philip Morris, Japan Tobacco), food companies (e.g., makers of infant formula), BASF, DuPont, Exxon Mobil, Sumitomo, other health-related industries |

a: IHME, *Financing Global Health 2009*, Figure 15, p.30.

b: IHME, *Financing Global Health 2009,* Figure 32, p.50.

 

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| a: Levine et al., *Millions Saved*, http://www.cgdev.org/section/initiatives/\_active/millionssaved/studiesb: Rosenberg et al., *Real Collaboration*c: Okie, “Fighting HIV”d: World Bank, “Improving Healthcare and Quality of Life for People Living with HIV/AIDS in Brazil,” (27 September 2010), http://go.worldbank.org/DIZ29JT640 |

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| **Table 3: Financial Development Assistance for Health by Health Focus,**  **1990-2007** **2007 US$ (Millions)** |
| Year | HIV/AIDS | Malaria | TB | HealthSector Support | Other | Unallocable by Disease | Total |
| 1990 | 189 | 38 | 17 | - | 2,544 | 2,800 | 5,589 |
| 1991 | 201 | 43 | 18 | - | 2,618 | 2,595 | 5,474 |
| 1992 | 208 | 19 | 16 | - | 2,891 | 2,980 | 6,115 |
| 1993 | 218 | 18 | 34 | - | 3,433 | 2,909 | 6,612 |
| 1994 | 333 | 38 | 26 | - | 3,807 | 3,564 | 7,767 |
| 1995 | 344 | 33 | 26 | 8 | 3,854 | 3,750 | 8,015 |
| 1996 | 400 | 39 | 53 | 3 | 3,924 | 3,686 | 8,106 |
| 1997 | 437 | 37 | 35 | 12 | 4,303 | 3,596 | 8,420 |
| 1998 | 430 | 61 | 56 | 2 | 4,317 | 3,788 | 8,654 |
| 1999 | 557 | 76 | 75 | 6 | 4,947 | 4,136 | 9,797 |
| 2000 | 718 | 153 | 118 | 13 | 5,407 | 4,288 | 10,697 |
| 2001 | 924 | 148 | 153 | 14 | 5,431 | 4,237 | 10,907 |
| 2002 | 1,408 | 127 | 173 | 72 | 5,495 | 5,165 | 12,440 |
| 2003 | 1,820 | 184 | 213 | 124 | 6,383 | 4,825 | 13,548 |
| 2004 | 2,433 | 352 | 360 | 215 | 6,740 | 5,502 | 15,603 |
| 2005 | 3,086 | 720 | 390 | 424 | 7,015 | 6,272 | 17,907 |
| 2006 | 3,907 | 649 | 506 | 776 | 6,270 | 6,888 | 18,997 |
| 2007 | 4,943 | 724 | 649 | 937 | 6,570 | 7,968 | 21,791 |

Notes: Developmental Assistance for Health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table disaggregates financial DAH earmarked for HIV/AIDS, malaria and tuberculosis specific activities as well as DAH provided as sector-wide support. The Institute for Health Metrics and Evaluation was able to allocate flow from the following channels of assistance by their disease focus: bilateral development agencies, World Bank (International Development Association & International Bank for Reconstruction and Development), African Development Bank, Asian Development Bank, GFATM, GAVI, and the Bill and Melinda Gates Foundation. Contributions from remaining channels are shown as unallocable by disease.

Source: Adapted from IHME, *Financing Global Health 2009*, p.110.

 

Source: Adapted from Perez-Casas, Chirac, Berman, and Ford, “Access to Fluconazole in Less-Developed Countries”, p.2102.[[252]](#endnote-252)

Figure 2: Highest and Lowest Life Expectancies in Years (Both Sexes), 2006

Source: Data from World Health Statistics 2008, pp.36-44.[[253]](#endnote-253)

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1. Mark Zacher, “The Transformation in Global Health Collaboration Since the 1990s,” in *Governing Global Health: Challenge, Response, Innovation,* eds. Andrew Cooper, John Kirton, and Ted Shrecker (Aldershot, UK: Ashgate Publishing, 2007), 15-27. [↑](#endnote-ref-1)
2. David Fidler, “Germs, Governance, and Global Public Health in the Wake of SARS,” *Journal of Clinical Investigation* 113, no.6 (2004): 799-804. [↑](#endnote-ref-2)
3. Obijiofor Aginam, “Between Isolationism and Mutual Vulnerability: A South-North Perspective on Global Governance of Epidemics in an Age of Globalization,” *Temple Law Rev*iew 77, Summer Symposium (2004): 297; David Fidler, “The Globalization of Public Health: The First 100 Years of International Health Diplomacy,” *Bulletin of the World Health Organization* 79, no.9 (2001): 842-49; Norman Howard-Jones, “Origins of International Health Work,” *British Medical Journal* 1, no.4661 (1950): 1032-37. [↑](#endnote-ref-3)
4. Zacher, “Transformation in Global Health Collaboration,” 16. [↑](#endnote-ref-4)
5. Jeffrey Koplan, T. Christopher Bond, Michael Merson, et al., “Towards a Common Definition of Global Health,” *Lancet* 373, no.9679 (2009): 1993-95. [↑](#endnote-ref-5)
6. Obijiofor Aginam, “Globalization of Infectious Diseases, International Law and the World Health Organization: Opportunities for Synergy in Global Governance of Epidemics,” *New England Journal of International and Comparative Law* 11, (2004): 59. [↑](#endnote-ref-6)
7. Scott Burris, Peter Drahos, and Clifford Shearing, “Nodal Governance,” *Australian Journal of Legal Philosophy* 30, (2005): 30-58. [↑](#endnote-ref-7)
8. David Fidler, “Architecture amidst Anarchy: Global Health’s Quest for Governance,” *Global Health Governance* 1, no.1 (2007): 1-17. [↑](#endnote-ref-8)
9. John Urry, *Global Complexity* (Cambridge, UK: Polity Press, 2003); James N. Rosenau, *Distant Proximities: Dynamics Beyond Globalization*, (Princeton, NJ: Princeton University Press, 2003); Anthony C. Gatrell, “ Complexity Theory and Geographies of Health: A Critical Assessment,” *Social Science& Medicine,* (January 2005): 2661-2671; Peter Hill, “Understanding Global Health Governance as a Complex Adaptive System,” *Global Public Health,* (April 2010): 1-13. [↑](#endnote-ref-9)
10. Ilona Kickbusch, “The Development of International Health Policies: Accountability Intact?” *Social Science and Medicine* 51, no.6 (2000): 979-89. [↑](#endnote-ref-10)
11. Jon Cohen, “The New World of Global Health,” *Science* 311, (January 13, 2006): 162-67. [↑](#endnote-ref-11)
12. Nick Drager and Laura Sunderland, “Public Health in a Globalising World: The Perspective from the World Health Organization,” in *Governing Global Health: Challenge, Response, Innovation,* eds. Andrew Cooper, John Kirton and Ted Schrecker (Aldershot, UK: Ashgate Publishing, 2007) 67-78. [↑](#endnote-ref-12)
13. World Health Organization, *The World Health Report 2000, Health Systems: Improving Performance,* Geneva: WHO, 2000; Ilona Kickbusch and Ken Buse, “Global Influences and Global Responses: International Health at the Turn of the 21st Century,” in *International Public Health*, eds. Michael Merson, Robert Black and Anne Mills (Gaithersberg, MD: Aspen Press, 2000); Kelley Lee and Richard Dodgson, “Globalization and Cholera: Implications for Global Governance,” *Global Governance* 6, (2000): 213-36; Allyn Taylor, “Governing the Globalization of Public Health,” *Journal of Law, Medicine and Ethics* 32, (2004): 500-8; Gill Walt, “Globalisation of International Health,” *Lancet* 351, (1998): 434-37; Laurence Helfer, “Politics, Power, and Public Health: A Comment on Public Health’s ‘New World Order’,” *Temple Law Review* 77, Summer Symposium (2004): 291-95; Jennifer Prah Ruger, “Ethics and Governance of Global Health Inequalities,” *Journal of Epidemiology and Community Health* 60, no.11 (2006): 998-1003; Allen Buchanan and Matthew Decamp, “Responsibility for Global Health,” *Theoretical Medicine and Bioethics* 27, no.1 (2006): 95-114; Sofia Gruskin, “Is There a Government in the Cockpit: A Passenger’s Perspective or Global Public Health: The Role of Human Rights,” *Temple Law Review* 77, Summer Symposium (2004): 313-33. [↑](#endnote-ref-13)
14. Lancet, “Who Runs Global Health?” *Lancet* 373, no.9681 (2009): 2083; Institute for Health Metrics and Evaluation, *Financing Global Health 2009: Tracking Development Assistance for Health,* Seattle: University of Washington, 2009. [↑](#endnote-ref-14)
15. See Table 7, “Health Expenditures.” World Health Organization, *World Health Statistics 2009*, Geneva: WHO, 2009, 107-17. Available at: http://www.who.int/whosis/whostat/2009/en/index.html. [↑](#endnote-ref-15)
16. Taylor, “Governing Globalization of Public Health.” [↑](#endnote-ref-16)
17. Sara Davies, “Securitizing Infectious Disease,” *International Affairs* 84, no.2 (2008): 295-313. [↑](#endnote-ref-17)
18. Obijiofor Aginam, “From Westphalianism to Global Governance: The G8, International Law, and Global Health Governance through Public-Private Partnerships,” Paper presented at the annual convention of the International Studies Association, Chicago, Illinois, February 28-March 2, 2007. [↑](#endnote-ref-18)
19. Roger Keil and Harris Ali, “Governing the Sick City: Urban Governance in the Age of Emerging Infectious Disease,” *Antipode* 39, no.5 (2007): 846-73. [↑](#endnote-ref-19)
20. Keil and Ali, “Governing the Sick City,” 866. [↑](#endnote-ref-20)
21. WHO, *World Health Report 2000;* Milton Roemer and Ruth Roemer, “Global Health, National Development, and the Role of Government,” *American Journal of Public Health* 80, no.10 (1990): 1188-92. [↑](#endnote-ref-21)
22. Ruth Levine and the What Works Working Group with Molly Kinder, *Millions Saved: Proven Successes in Global Health* (Washington, DC: Center for Global Development, 2004 and 2007); Susan Okie, "Fighting HIV: Lessons from Brazil," *New England Journal of Medicine* 354 no. 19 (2006): 1977-81. [↑](#endnote-ref-22)
23. Ilona Kickbusch, “Influence and Opportunity: Reflections on the U.S. Role in Global Public Health,” *Health Affairs* 21, no.6 (2002): 131-41; Obijiofor Aginam, “Salvaging Our Global Neighbourhood: Critical Reflections on the G8 Summit and Global Health Governance in an Interdependent World,” *Law, Social Justice and Global Development Journal,* (2004): 1. Available at: http://www2.warwick.ac.uk/fac/soc/law/elj/lgd/2004\_1/aginam [↑](#endnote-ref-23)
24. David Fidler, “Fighting the Axis of Illness: HIV/AIDS, Human Rights, and U.S. Foreign Policy,” *Harvard Human Rights Journal* 17, (2004): 99-136. [↑](#endnote-ref-24)
25. Ilona Kickbusch, “SARS: Wake-Up Call for a Strong Global Health Policy,” *YaleGlobal*, (April 25, 2003). Available at: http://yaleglobal.yale.edu/content/sars-wake-call-strong-global-health-policy [↑](#endnote-ref-25)
26. John Kirton, Nikolai Roudev, and Laura Sunderland, “Making G8 Leaders Deliver: An Analysis of Compliance and Health Commitments, 1996-2006,” *Bulletin of the World Health Organization* 85, (2007): 192-99. [↑](#endnote-ref-26)
27. Jennifer Prah Ruger and Nora Y. Ng, “Emerging and Transitioning Countries’ Role in Global Health,” *Saint Louis University Journal of Health Law and Policy* 3, (2010): 253-89. [↑](#endnote-ref-27)
28. Lance, “Who Runs Global Health?”; Fiona Godlee, “WHO in Retreat: Is it Losing its Influence?” *British Medical Journal* 309, no.6967 (1994): 1491-95; Kelley Lee, “The Pit and the Pendulum: Can Globalization Take Health Governance Forward?” *Development* 47, no.2 (2004): 11-7; Alison Whyte, David McCoy, and Mike Rowson (eds.), *Global Health Action: Global Health Watch Campaign Agenda,* (Russell Press, 2005-2006); Nicole Szlezak, Barry Bloom, Dean Jamison, et al., "The Global Health System: Actors, Norms, and Expectations in Transition,” *PLoS Medicine* 7, no.1(2010). [↑](#endnote-ref-28)
29. Ken Buse and Gill Walt, “Global Public-Private Partnerships: Part I: A New Development in Health?” *Bulletin of the World Health Organization* 78 no.4 (2000): 549-61; Ken Buse and Gill Walt, “Globalization and Multilateral Public-Private Health Partnerships: Issues for Health Policy,” in *Health Policy in a Globalising World*, eds., Kelley Lee, Ken Buse and Suzanne Fustukian (Cambridge, UK: Cambridge University Press, 2002): 41-62; Ken Buse and Gill Walt, “The World Health Organization and Global Public-Private Health Partnerships: In Search of ‘Good’ Global Health Governance,” in *Public-Private Partnerships for Public Health*, ed., Michael Reich (Cambridge, MA: Harvard University Press, 2002): 170-95. [↑](#endnote-ref-29)
30. Godlee, “WHO in Retreat”; Wolfgang Hein and Lars Kohlmorgen, “Global Health Governance: Conflicts on Global Social Rights,” *Global Social Policy* 8, no.1 (2008): 80-108. [↑](#endnote-ref-30)
31. Kelley Lee, Sue Collinson, Gill Walt, and Lucy Gilson, “Who Should be Doing What in International Health: A Confusion of Mandates in the United Nations?” *British Medical Journal* 312, (1996): 302-7. [↑](#endnote-ref-31)
32. Whyte et al., *Global Health Action*. [↑](#endnote-ref-32)
33. Godlee, “WHO in Retreat”; Whyte et al., *Global Health Action;* Global Health Watch, *Global Health Watch 2005-6: An Alternative World Health Report* (London: Zed Books Ltd, 2005); Gill Walt, “WHO Under Stress: Implications for Health Policy,” *Health Policy* 24, (1993): 125-44; Yagob Al-Mazrou, Seth Berkley, Barry Bloom, et al., “A Vital Opportunity for Global Health: Supporting the World Health Organization at a Critical Juncture,” *Lancet* 350, no.9080 (1997): 750-51. [↑](#endnote-ref-33)
34. Christopher J.L. Murray, Alan Lopez, and Suwit Wibulpolprasert, “Monitoring Global Health: Time for New Solutions,” *British Medical Journal* 329, (2004): 1096-100. [↑](#endnote-ref-34)
35. Whyte et al., *Global Health Action*; Ken Buse and Amalia Waxman, “Public-Private Health Partnerships: A Strategy for WHO,” *Bulletin of the World Health Organization* 79, no.8 (2001): 748-54. [↑](#endnote-ref-35)
36. Lawrence Gostin, “Meeting the Survival Needs of the World’s Least Healthy People: A Proposed Model for Global Health Governance,” *Journal of the American Medical Association* 298, no.2 (2007): 225-28; Lawrence Gostin, “A Proposal for a Framework Convention on Global Health,” *Journal of International Economic Law* 10, no.4 (2007): 989-1008. [↑](#endnote-ref-36)
37. Thomas W. Grein, Kande-Bure O. Kamara, Guenael Rodier, et al.,“Rumors of Disease in the Global Village: Outbreak Verification,” *Emerging Infectious Diseases* 6, no.2 (2000): 97-102. [↑](#endnote-ref-37)
38. Taylor, “Governing Globalization of Public Health”; Lancet, “Who Runs Global Health?”; Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, “Oslo Ministerial Declaration – Global Health: A Pressing Foreign Policy Issue of Our Time,” *Lancet* 369, (2007): 1373-78; Allyn Taylor, “Global Governance, International Health Law and WHO: Looking Towards the Future,” *Bulletin of the World Health Organization* 80, no.12 (2002): 975-80; Nicoletta Dentico and Nathan Ford, “The Courage to Change the Rules: A Proposal for an Essential Health R&D Treaty,” *PLoS Medicine* 2, no.2 (2005), doi=10.1371/journal.pmed.0020014; Jennifer Prah Ruger and Derek Yach, “The Global Role of the World Health Organization,” *Global Health Governance* 2, no.2 (2008); Lawrence Gostin and Emily Mok, “Grand Challenges in Global Health Governance,” *British Medical Bulletin* 90, no.1 (2009): 7-18; Andy Guise, David Woodward, Patrick T. Lee, et al., “Engaging the Health Community in Global Economic Reform,” *Lancet* 373, no.9668 (2009): 987-89; Shawn H.E. Harmon, “International Public Health Law: Not So Much WHO as Why, and Not Enough WHO and Why Not?”, *Medicine, Health Care and Philosophy* 12, no.3 (2009): 245-55; Suerie Moon, Nicole Szlezak, Catherine Michaud, et al., “The Global Health System: Lessons for a Stronger Institutional Framework,” *PLoS Medicine* 7, no.1 (2010). [↑](#endnote-ref-38)
39. Howard Waitzkin, “Report of the WHO Commission on Macroeconomics and Health: A Summary and Critique – Author’s Reply,” *Lancet* 361, (2003): 1477-78; Devi Sridhar, “Post-Accra: Is There Space for Country Ownership in Global Health?” *Third World Quarterly* 30, no.7 (2009): 1363-77. [↑](#endnote-ref-39)
40. Taylor, “Governing Globalization of Public Health”; Ilona Kickbusch, “From Charity to Rights: Proposal for Five Action Areas of Global Health,” *Journal of Epidemiology and Community Health* 58, no.8 (2004): 630-31; Anthony Zwi and Derek Yach, “International Health in the 21st Century: Trends and Challenges,” *Social Science and Medicine* 54, (2002): 1615-20; Kelley Lee, Devi Sridhar, and Mayur Patel, “Trade and Health 2: Bridging the Divide: Global Governance of Trade and Health,” *Lancet* 373, (2009): 416-22; Ilona Kickbusch and Lea Payne, “Constructing Global Public Health in the 21st Century,” Paper presented at the Meeting on Global Health Governance and Accountability, Harvard University, Cambridge, Massachusetts, June 2-3, 2004. [↑](#endnote-ref-40)
41. Walt, “Globalisation of International Health.” [↑](#endnote-ref-41)
42. Owain Williams, “The WTO, Trade Rules and Global Health Security,” in *Health, Foreign Policy and Security: Towards a Conceptual Framework for Research and Policy,* ed., Alan Ingram (London: Nuffield Trust, 2004), 73-87. [↑](#endnote-ref-42)
43. Jennifer Prah Ruger, “The Changing Role of the World Bank in Global Health,” *American Journal of Public Health* 95, no.1 (2005): 60-70; Jennifer Prah Ruger, “Global Health Governance and the World Bank,” *Lancet* 370, no.9597 (2007): 1471-74. [↑](#endnote-ref-43)
44. Kamran Abbasi, “The World Bank and World Health: Changing Sides,” *British Medical Journal* 318, (1999): 865-69; Caroline Thomas and Martin Weber, “The Politics of Global Health Governance: Whatever Happened to ‘Health for All by the Year 2000’?”, *Global Governance* 10, no.2 (2004): 187-205; Nana Poku and Alan Whiteside, “Global Health and the Politics of Governance: An Introduction,” *Third World Quarterly* 23, no.2 (2002): 191-95. [↑](#endnote-ref-44)
45. Dean Jamison, Julio Frenk, and Felicia Knaul, “International Collective Action in Health: Objectives, Functions, and Rationale,” *Lancet* 351, no.9101 (1998): 514-17. [↑](#endnote-ref-45)
46. Jennifer Prah Ruger, “What Will the New World Bank Head Do for Global Health?” *Lancet* 365, (2005): 1837-40. [↑](#endnote-ref-46)
47. Walt, “Globalisation of International Health”; Enis Baris and Kari McLeod, “Globalization and International Trade in the Twenty-First Century: Opportunities for and Threats to the Health Sector in the South,” *International Journal of Health Services* 30, no.1 (2000): 187-210. [↑](#endnote-ref-47)
48. Anne-Emanuelle Birn and Klaudia Dmitrienko, “The World Bank: Global Health or Global Harm?” *American Journal of Public Health* 95, no.7 (2005): 1091-92. [↑](#endnote-ref-48)
49. Daniel Tarullo, Prepared statement for the Hearing on Reforming Key International Financial Institutions for the 21st Century, Senate Subcommittee on Security and International Trade and Finance, Committee on Banking, Housing, and Urban Affairs, Washington, D.C., August 2, 2007. [↑](#endnote-ref-49)
50. John Baird, Steven Ma, and Jennifer Prah Ruger, “Effects of the World Bank’s Maternal and Child Health Intervention on Indonesia’s Poor: Evaluating the Safe Motherhood Project,” *Social Science and Medicine*, (ePub ahead of print 2010), DOI 10.1016/j.socscimed.2010.04.038; Adam Wagstaff and Shengchao Yu, “Do Health Sector Reforms Have Their Intended Impacts? The World Bank’s Health VIII Project in Gansu Province, China,” *Journal of Health Economics* 26, (2007): 505-35; Levine et al. *Millions Saved.* [↑](#endnote-ref-50)
51. Paolo Savona and Chiara Oldani, “Globalisation, Growth, and Health: The Private Sector Perspective,” in *Sustaining Global Growth and Development: G7 and IMF Governance*, eds., Michele Fratianni, Paolo Savona, and John Kirton (Aldershot, UK: Ashgate, 2003); Nicholas Bayne, “Managing Globalization and the New Economy: The Contribution of the G8 Summit,” in *New Directions in Global Economic Governance: Managing Globalization in the Twenty-First Century*, eds., John Kirton, George von Furstenberg (Aldershot, UK: Ashgate, 2001). [↑](#endnote-ref-51)
52. Andrew Price-Smith, *Plague and Politics: Infectious Disease and International Policy* (New York: Palgrave, 2001).  [↑](#endnote-ref-52)
53. Kirton et al, “Making G8 Leaders Deliver”; Aginam, “Salvaging Our Global Neighbourhood.” [↑](#endnote-ref-53)
54. James Orbinski, “AIDS, Médecins Sans Frontiéres, and Access to Essential Medicines,” in *Civil Society in the Information Age*, ed., Peter Hajnal(Aldershot, UK: Ashgate, 2002), 127-137. [↑](#endnote-ref-54)
55. Kirton et al, “Making G8 Leaders Deliver”; Orbinski, “Access to Essential Medicines.” [↑](#endnote-ref-55)
56. Michael Reich and Keizo Takemi, “G8 and Strengthening of Health Systems: Follow-up to the Toyako summit,” *Lancet* 373, no.9662 (2009): 508-15. [↑](#endnote-ref-56)
57. Reich and Takemi, “G8 and Strengthening of Health Systems.” [↑](#endnote-ref-57)
58. Ronald Labonte, Ted Schrecker, David Sanders, and Wilma Meeus, *Fatal Indifference: the G8, Africa and Global Health* (South Africa: University of Cape Town Press & Canada: International Development Research Centre, 2004). [↑](#endnote-ref-58)
59. Ronald Labonte and Ted Schrecker, “Committed to Health For All? How the G7/G8 Rate,” *Social Science and Medicine* 59, no.8 (2004): 1661-76. [↑](#endnote-ref-59)
60. Colin Bradford, “Reaching the Millennium Development Goals,” in *Governing Global Health: Challenge, Response, Innovation,* eds., Andrew Cooper, John Kirton, and Ted Schrecker (Aldershot, UK: Ashgate, 2007), 79-86. [↑](#endnote-ref-60)
61. Guise et al., “Engaging the Health Community.” [↑](#endnote-ref-61)
62. Cathal Doyle and Preeti Patel, “Civil Society Organisations and Global Health Initiatives: Problems of Legitimacy,” *Social Science and Medicine* 66, no.9 (2008): 1928-38. [↑](#endnote-ref-62)
63. Levin et al. *Millions Saved.* [↑](#endnote-ref-63)
64. Levin et al. *Millions Saved*; Doyle and Patel, “Civil Society Organisations.” [↑](#endnote-ref-64)
65. Ellen ‘t Hoen, “TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha,” *Chicago Journal of International Law* 3, no.1 (2002): 27-46. [↑](#endnote-ref-65)
66. Raphael Lencucha, Ronald Labonté and Michael Rouse, “Beyond Idealism and Realism: Canadian NGO/Government Relations during the Negotiation of the FCTC,” *Journal of Public Health Policy* 31, no.1 (2010): 74-87; Gregory Jacob, “Without Reservation,” *Chicago Journal of International Law* 5, (2004): 287-302. [↑](#endnote-ref-66)
67. Alexander Cooley and James Ron, “The NGO Scramble: Organizational Insecurity and the Political Economy of Transnational Action,” *International Security* 27, no.1 (2002): 5-39; M. Shamsul Haque, “Governance Based on Partnership with NGOs: Implications for Development and Empowerment in Rural Bangladesh,” *International Review of Administrative Sciences* 70, no.2 (2004): 271-90; Anthony Bebbington, “Donor-NGO Relations and Representations of Livelihood in Nongovernmental Aid Chains,” *World Development* 33, no.6 (2005): 937-50. [↑](#endnote-ref-67)
68. Sara Woldehanna, Karin Ringheim, Colleen Murphy, et al., *Faith in Action: Examining the Role of Faith-Based Organizations in Addressing HIV/AIDS* (Washington, DC: Global Health Council, 2005). [↑](#endnote-ref-68)
69. Oliver Bakewell, Hannah Warren, with Anna Winterbottom, *Sharing Faith with Donors: Does it Make a Difference?* International NGO Training and Research Centre (INTRAC). 2005. Available from http://www.intrac.org/data/files/resources/147/Sharing-faith-with-donors.pdf; Kathryn Joyce, *Seeing is Believing: Questions about Faith-Based Organizations that are Involved in HIV/AIDS Prevention and Treatment,* Washington DC: Catholics for Choice, 2010. Available from http://www.catholicsforchoice.org/documents/SeeingisBelieving--WebVersion.pdf [↑](#endnote-ref-69)
70. Lencucha et al, “Beyond Idealism and Realism.” [↑](#endnote-ref-70)
71. Doyle and Patel, “Civil Society Organisations.” [↑](#endnote-ref-71)
72. Doyle and Patel, “Civil Society Organisations.” [↑](#endnote-ref-72)
73. Ken Buse and Gill Walt, “Global Public-Private Partnerships: Part II: What are the Health Issues for Global Governance?” *Bulletin of the World Health Organization* 78, no.5 (2000): 699-709; Karen Caines, Ken Buse, Cindy Carlson, et al., *Assessing the Impact of Global Health Partnerships,* London: DFID Health Resource Centre, 2004. [↑](#endnote-ref-73)
74. Buse and Walt, “Global Public-Private Partnerships: Part I.” [↑](#endnote-ref-74)
75. Bill and Melinda Gates Foundation, *Developing Successful Global Health Alliances*, Seattle: Gates Foundation, 2002. [↑](#endnote-ref-75)
76. Caines et al., *Assessing the Impact*. [↑](#endnote-ref-76)
77. Eeva Ollila, “Global Health Priorities – Priorities of the Wealthy?” *Global Health* 1, (2005): 6; John Lister, “Can Global Health be Good Business?”, *Tropical Medicine and International Health* 11, no.3 (2006): 255-57. [↑](#endnote-ref-77)
78. Ollila, “Global Health Priorities.” [↑](#endnote-ref-78)
79. Buse and Walt, “Global Public-Private Partnerships: Part II.” [↑](#endnote-ref-79)
80. Zwi and Yach, “International Health in the 21st Century”; Jeffrey A. Alexander, Maureen E. Comfort, and Bryan J. Weiner, “Governance in Public-Private Community Health Partnerships: A Survey of the Community Care Network Demonstration Sites,” *Nonprofit Management and Leadership* 8, no.4 (1998): 311-32; Daniel Tarantola, “Global Health and National Governance,” *American Journal of Public Health* 95, no.1 (2005): 8. [↑](#endnote-ref-80)
81. Ken Buse and Andrew Harmer, “Power to the Partners? The Politics of Public-Private Health Partnerships,” *Development* 47, no.2 (2004): 49-56. [↑](#endnote-ref-81)
82. Sonja Bartsch, “The South in Global Health Governance: Perspectives on Global Public-Private Partnerships,” Paper presented at the annual meeting of the International Studies Association, San Diego, California, March 21-25, 2006. [↑](#endnote-ref-82)
83. Buse and Walt, “Global Public-Private Partnerships: Part I”; Buse and Waxman, “Public-Private Health Partnerships;” Ollila, “Global Health Priorities.” [↑](#endnote-ref-83)
84. Donald R. Hopkins, *The Greatest Killer: Smallpox in History* (Chicago: University of Chicago Press, 2002); D.A. Henderson, “Principles and Lessons from the Smallpox Eradication Programme,” *Bulletin of the World Health Organization* 65 no.4 (1987): 535-46. [↑](#endnote-ref-84)
85. Levine et al. *Millions Saved;* Rebecca Voelker, “Global Partners Take Two Steps Closer to Eradication of Guinea Worm Disease,” *Journal of the American Medical Association* 305 no.16 (2011): 1642; David Molyneux, “Lymphatic Filariasis (Elephantiasis) Elimination: A Public Health Success and Development Opportunity.” *Filaria Journal* 2:13 (2006),Available at: http://www.filariajournal.com/content/2/1/13. [↑](#endnote-ref-85)
86. William J. Moss and Diane E. Griffin, “Global Measles Elimination,” *Nature Review Microbiology* 4 (2006): 900-8; World Health Organization, *Global Elimination of Measles: Report by the Secretariat*, Executive Board 125th Session, provisional agenda item 5.1, EB 125/4, April 16, 2009, Available at: http://apps.who.int/gb/ebwha/pdf\_files/EB125/B125\_4-en.pdf. [↑](#endnote-ref-86)
87. Mark L. Rosenberg, Elisabeth S. Hayes, Margaret H. McIntyre, Nancy Neill, *Real Collaboration* (Berkeley: University of California Press, 2010). [↑](#endnote-ref-87)
88. Levine et al. *Millions Saved.* [↑](#endnote-ref-88)
89. Rosenberg et al. *Real Collaboration*; see also McKinsey & Company for The Bill and Melinda Gates Foundation, “Developing Successful Global health Alliances,” (April 2002), Available at: http://www.gavialliance.org/resources/7\_Developing\_sucessful\_global.pdf; Catherine Wachira and Jennifer Prah Ruger. “National Poverty Reduction Strategies and HIV/AIDS Governance in Malawi: A Preliminary Study of Shared Health Governance,” *Social Science and Medicine,* (ePub ahead of print 2010). DOI 10.1016/j.socscimed.2010.05.032. [↑](#endnote-ref-89)
90. The Carter Center, “Catalyzing the Elimination of Malaria and Lymphatic Filariasis from the Caribbean,” Available at: http://www.cartercenter.org/health/hispaniola-initiative/index.html. [↑](#endnote-ref-90)
91. Drager and Sunderland, “Public Health in a Globalising World.” [↑](#endnote-ref-91)
92. Jennifer Prah Ruger, “Global Health Justice,” *Public Health Ethics* 2, no.3 (2009): 261-75. [↑](#endnote-ref-92)
93. Ronald Labonté, “Global Health in Public Policy: Finding the Right Frame?” *Critical Public Health* 18, no.4 (2008): 467-82. [↑](#endnote-ref-93)
94. Colin McInnes and Kelley Lee, “Health, Security and Foreign Policy,” *Review of International Studies* 32, (2006): 5-23; Sandra J. Maclean, “Microbes, Mad Cows and Militaries: Exploring the Links between Health and Security,” *Security Dialogue* 39, no.5 (2008): 475-94. [↑](#endnote-ref-94)
95. McInnes and Lee, “Health, Security, and Foreign Policy”; Maclean, “Microbes, Mad Cows and Militaries”; Laurie Garrett, *HIV and National Security: Where are the Links?* New York: Council on Foreign Relations, 2005. Available at: http://www.cfr.org/content/publications/attachments/HIV\_National\_Security.pdf. [↑](#endnote-ref-95)
96. Howard-Jones, “Origins of International Health Work”; McInnes and Lee, “Health, Security, and Foreign Policy”; David Fidler, “Caught between Paradise and Power: Public Health, Pathogenic Threats, and the Axis of Illness,” *McGeorge Law Review* 35, (2004): 45-104. [↑](#endnote-ref-96)
97. Bernard Liese, Mark Rosenberg, and Alexander Schratz, “Neglected Tropical Diseases 1: Programmes, Partnerships, and Governance for Elimination and Control of Neglected Tropical Diseases,” *Lancet* 375, no.9708 (2010): 67-76. [↑](#endnote-ref-97)
98. Davies, “Securitizing Infectious Disease.” [↑](#endnote-ref-98)
99. Alexander Kelle, “Securitization of International Public Health: Implications for Global Health Governance and the Biological Weapons Prohibition Regime,” *Global Governance* 13, no.2 (2007): 217-35. [↑](#endnote-ref-99)
100. Davies, “Securitizing Infectious Disease.” [↑](#endnote-ref-100)
101. Jennifer Prah Ruger. “Control of Extensively Drug-Resistant Tuberculosis: A Root Cause Analysis,” *Global Health Governance* 3, no.2 (2010). [↑](#endnote-ref-101)
102. Allyn Taylor, “Controlling the Global Spread of Infectious Diseases: Toward a Reinforced Role for the International Health Regulations,” *Houston Law Review* 33, (1997): 1327-62. [↑](#endnote-ref-102)
103. PLoS Medicine Editors, “How is WHO Responding to Global Public Health Threats?” *PLoS Medicine* 4, no.5 (2007): e197. [↑](#endnote-ref-103)
104. Kelle, “Securitization of International Public Health.” [↑](#endnote-ref-104)
105. Yanzhong Huang, “Pursuing Health as Foreign Policy: The Case of China,” *Indiana Journal of Global Legal Studies* 17, no.1 (2010): 105-46; Joshua Reader, “The Case against China: Establishing International Liability for China’s Response to the 2002-2003 SARS Epidemic,” *Columbia Journal of Asian Law* 19, no.2 (2006): 519-71; Jennifer Prah Ruger, “Democracy and Health,” *Quarterly Journal of Medicine* 98, (2005): 299-304. [↑](#endnote-ref-105)
106. Colin McInnes, “Health and Security Studies,” in *Health, Foreign Policy and Security: Towards a Conceptual Framework for Research and Policy*, ed., Alan Ingram (London: Nuffield Trust, 2004): 43-58. [↑](#endnote-ref-106)
107. Stefan Elbe, “Should HIV/AIDS be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security,” *International Studies Quarterly* 50, (2006): 119-44. [↑](#endnote-ref-107)
108. Ministers of Foreign Affairs, “Oslo Ministerial Declaration.” [↑](#endnote-ref-108)
109. Maclean, “Microbes, Mad Cows and Militaries”; Lincoln Chen and Vasant Narasimhan, “Human Security and Global Health,” *Journal of Human Development* 4, no.2 (2003): 181-90. [↑](#endnote-ref-109)
110. United Nations Development Programme, *Human Development Report 1994,* New York: Oxford University Press, 1994. [↑](#endnote-ref-110)
111. Paula Gutlove, “Cairo Consultation on Health and Human Security,” Report on the consultation, Cairo, Egypt, April 15-17, 2002. Available at: http://www.irss-usa.org/pages/documents/CairoReport02.pdf. [↑](#endnote-ref-111)
112. Maclean, “Microbes, Mad Cows and Militaries.” [↑](#endnote-ref-112)
113. Maclean, “Microbes, Mad Cows and Militaries.” [↑](#endnote-ref-113)
114. Chen and Narasimhan, “Human Security and Global Health.” [↑](#endnote-ref-114)
115. UNDP, *Human Development Report 1994;* Gary King and Christopher J.L. Murray, “Rethinking Human Security,” *Political Science Quarterly* 116, no.4 (2001): 585-610; Carolyn Thomas, “Global Governance, Development and Human Security: Exploring the Links,” *Third World Quarterly* 22, no.2 (2001): 159-75; Fen Osler Hampson with Jean Daudelin, John Hay, Todd Martin, and Holly Reid, *Madness in the Multitude: Human Security and World Disorder* (Ottawa: Oxford University Press, 2002). [↑](#endnote-ref-115)
116. Roland Paris, “Human Security: Paradigm Shift or Hot Air?” *International Security* 26, no.2 (2001): 87-102. [↑](#endnote-ref-116)
117. William Aldis, “Health Security as a Public Health Concept: A Critical Analysis,” *Health Policy and Planning* 23, no.6 (2008): 369-75. [↑](#endnote-ref-117)
118. World Health Organization, *25 Questions & Answers on Health & Human Rights*, Geneva: WHO, 2002; Ilona Kickbusch. “Tackling the Political Determinants of Global Health,” *British Medical Journal* 331, no. 7511 (2005): 246-47; Jennifer Prah Ruger, “Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements,” *Yale Journal of Law and the Humanities* 18, no.2 (2006): 273-326. [↑](#endnote-ref-118)
119. Sophia Gruskin, Jonathan Mann, George J. Annas, Michael A. Grodin, Brian Rawson, Tilman Ruff, Victor W. Sidel, Barbara Ayotte, Vincent Iacopino, Len Rubenstein, and Susannah Sirkin. “Health and Human Rights,” *Journal of the American Medical Association* 280, no.5 (1998): 462-4; Ruger, “Democracy and Health;” Joanne Csete, “Missed Opportunities: Human Rights and the Politics of HIV/AIDS,” *Development* 47, no.2 (2004): 83-90; Stephen Marks, “Health, Development, and Human Rights,” in *Health and Development: Toward a Matrix Approach*, eds., Anna Gatti and Andrea Boggio (London: Palgrave Macmillan, 2009), 124-139; Paul Farmer, *Pathologies of Power* (Berkeley, CA: University of California Press, 2003). [↑](#endnote-ref-119)
120. Lance Gable, “The Proliferation of Human Rights in Global Health Governance,” *Journal of Law, Medicine and Ethics* 35, no.4 (2007): 534-44. [↑](#endnote-ref-120)
121. Patricia Kuszler, “Global Health and the Human Rights Imperative,” *Asian Journal of WTO and International Health Law and Policy* 2, no.1 (2007): 99-123. [↑](#endnote-ref-121)
122. Fidler, “Caught Between Paradise and Power.” [↑](#endnote-ref-122)
123. Michael Baker and David Fidler, “Global Public Health Surveillance under New International Health Regulations,” *Emerging Infectious Diseases* 12, no.7 (2006): 1058-65. [↑](#endnote-ref-123)
124. Kavita Misra, “Politico-Moral Transactions in Indian AIDS Service: Confidentiality, Rights and New Modalities of Governance,” *Anthropology Quarterly* 79, no.1 (2006): 33-74. [↑](#endnote-ref-124)
125. Jamison et al., “International Collective Action”; Ilona Kickbusch, “Global Public Health: Revisiting Health Public Policy at the Global Level,” *Health Promotion International* 4, no.4 (1999): 285-88; Inge Kaul, Pedro Conceicáo, Katell Le Goulven, and Ronald Mendoza, eds., *Providing Global Public Goods: Managing Globalization* (New York: Oxford University Press for UNDP, 2003). [↑](#endnote-ref-125)
126. Inge Kaul and Michael Faust, “Global Public Goods and Health: Taking the Agenda Forward,” *Bulletin of the World Health Organization* 79, (2001): 869-74; David Woodward, Nick Drager, Robert Beaglehole, and Debra Lipson, “Globalization, Global Public Goods, and Health,” in *Trade in Health Services: Global, Regional, and Country Perspectives,* eds., Nick Drager and Cesar Vieira (Washington, DC: PAHO, 2002); Richard Smith, David Woodward, Arnab Acharya, Robert Beaglehole, and Nick Drager, “Communicable Disease Control: A ‘Global Public Good’ Perspective,” *Health Policy and Planning* 19, no.5 (2004): 271-78. [↑](#endnote-ref-126)
127. Richard Smith, “Global Public Goods and Health,” *Bulletin of the World Health Organization* 81, no.7 (2003): 475. [↑](#endnote-ref-127)
128. Smith, “Global Public Goods and Health.” [↑](#endnote-ref-128)
129. Kaul and Faust, “Global Public Goods”; Smith et al., “Communicable Disease Control.” [↑](#endnote-ref-129)
130. Lincoln Chen, Tim Evans, and Richard Cash, “Health as a Global Public Goods,” in *Global Public Goods: International Cooperation in the 21st Century,* eds., Inge Kaul, Isabelle Grunberg, and Marc Stern (New York: Oxford University Press, 1999), 284-304. [↑](#endnote-ref-130)
131. Chen et al., “Health as Global Public Goods.” [↑](#endnote-ref-131)
132. Endnote 11, in Smith et al., “Communicable Disease Control.” [↑](#endnote-ref-132)
133. Inge Kaul, Isabelle Grunberg, and Marc Stern, “Global Public Goods: Concepts, Policies and Strategies,” in *Global Public Goods: International Cooperation in the 21st Century,* eds., Ingel Kaul, Isabelle Grunberg, and Marc Stern (New York: Oxford University Press, 1999), 465. [↑](#endnote-ref-133)
134. Charles Pannenborg, *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Care* (Alphen aan den Rijn, Netherlands: Sijthoff and Noordhoff, 1979); Gill Walt, Neil Spicer, and Ken Buse, “Mapping the Global Health Architecture,” in *Making Sense of Global Health Governance: A Policy Perspective*, eds., Ken Buse, Wolfgang Hein, and Nick Drager (Hampshire, UK: Palgrave Macmillan, 2009). [↑](#endnote-ref-134)
135. Ruger, “Global Health Governance and World Bank”; Report of the Working Group on Global Health Partnerships, “High-Level Forum on the Health MDGs: Best Practice Principles for Global Health Partnership Activities at Country Level,” Paris, November 14-15, 2005. Available at: http://www.gavialliance.org/resources/Global\_Health\_Partnerships\_Best\_Practice.pdf; Ken Buse, “Global Health Partnerships: Increasing their Impact by Improved Governance,” Global Health Partnerships Study Paper 5, London: DFID Health Resource Centre, 2004; Ken Buse and Andrew Harmer, “Seven Habits of Highly Effective Global Public-Private Health Partnerships: Practice and Potential,” *Social Science and Medicine* 64, (2007): 259-71; Ruger and Yach, “Global Role of the WHO”; Laurie Garrett and Kammerle Schneider, “Global Health: Getting it Right,” in *Health and Development: Toward a Matrix Approach,* eds., Anna Gatti, Andrea Boggio (London: Palgrave Macmillan, 2009), 3-15. [↑](#endnote-ref-135)
136. Ilona Kickbusch, “Action on Global Health: Addressing Global Health Governance Challenges,” *Public Health* 119, no.11 (2005): 969-73. [↑](#endnote-ref-136)
137. Bebbington, “Donor-NGO Relations”; Ruairi Brugha, Mary Starling, and Gill Walt, “GAVI, the First Steps: Lessons for the Global Fund,” *Lancet* 359, (2002): 435-38; Ghazala Mansuri and Vijayendra Rao, “Community-Based and -Driven Development: a Critical Review,” *World Bank Research Observer* 19, no.1 (2004): 1-39; Paul Joyce, “Governmentality and Risk: Setting Priorities in the New NHS,” *Sociology of Health and Illness* 23, no.5 (2001): 594-614; Paolo De Renzio and Simon Maxwell, *Financing the Response to HIV/AIDS: Future Options and Innovations,* London: Overseas Development Institute, 2005. [↑](#endnote-ref-137)
138. Thalif Deen, “Development: Three Decades of Missed Aid Targets,” IPS, April 18, 2005. Available from http://www.ipsnews.net/interna.asp?idnews=28348; Pekka Hirvonen, “Stingy Samaritans: Why Recent Increases in Development Aid Fail to Help the Poor,” Global Policy Forum, August 2005. Available from http://www.globalpolicy.org/component/content/article/240/45056.html; Anup Shah, “Foreign Aid for Development Assistance,” *Global Issues*, April 25, 2010. Available from http://www.globalissues.org/article/35/foreign-aid-development-assistance [↑](#endnote-ref-138)
139. Phyllida Travis, Sara Bennett, Andy Haines, et al., “Overcoming Health-Systems Constraints to Achieve the Millennium Development Goals,” *Lancet* 364, no.9437 (2004): 900-6. [↑](#endnote-ref-139)
140. Levine et al. *Millions Saved;* Rosenberg et al. *Real Collaboration;* Hopkins, *The Greatest Killer*. [↑](#endnote-ref-140)
141. Travis et al., “Overcoming Health-Systems Constraints”; Ann Swidler and Susan Watkins, “‘Teach a Man to Fish’: The Sustainability Doctrine and its Social Consequences,” *World Development* 37, no.7 (2009): 1182-96; Michael Reich, Keizo Takemi, Marc Roberts, and William Hsiao, “Global Action on Health Systems: A Proposal for the Toyako G8 Summit,” *Lancet* 371, (2008): 865-69; Gostin and Mok, “Grand Challenges;” Walt et al., “Mapping the Global Health Architecture”; Paul Farmer and Jim Y. Kim, “Surgery and Global Health: A View from beyond the OR,” *World Journal of Surgery* 32, no. 4: 533-6; Garrett and Schneider, “Getting it Right;” Swidler and Watkins, “’Teach a Man to Fish;’” William R. Easterly, *White Man’s Burden* (New York: The Penguin Press, 2006). [↑](#endnote-ref-141)
142. Lesley Magnussen, John Ehiri, and Pauline Jolly, “Comprehensive versus Selective Primary Health Care: Lessons for Global Policy,” *Health Affairs* 23, no.3 (2004): 167-76. [↑](#endnote-ref-142)
143. Robert Northrup, “Critical Elements for Improved Global Health,” *Health Affairs* 24, no.3 (2005): 879-80; Sergio Spinaci and Valerie Crowell, “Strategies for Financing Universal Access to Health Care and Prevention: Lessons Learned and Perspective for the Twenty-First Century,” in *Health and Development: Toward a Matrix Approach,* eds., Anna Gatti and Andrea Boggio (London: Palgrave Macmillan, 2009), 217-28. [↑](#endnote-ref-143)
144. Jeremy Youde, “Is Universal Access to Antiretroviral Drugs an Emerging International Norm?” *Journal of International Relations and Development* 11, no.4 (2008): 415-40. [↑](#endnote-ref-144)
145. Dongbao Yu, Yves Souteyrand, Mazuwa Banda, Joan Kaufman, and Joseph Perriëns, “Investment in HIV/AIDS Programs: Does it Help Strengthen Health Systems in Developing Countries?” *Global Health* 4, (2008): 8. [↑](#endnote-ref-145)
146. Reich et al., “Global Action on Health Systems.” [↑](#endnote-ref-146)
147. Jim Y Kim and Paul Farmer, “AIDS in 2006 – Moving toward One World, One Hope?” *New England Journal of Medicine* 355, (2006): 645-7; Garrett and Schneider, “Getting it Right”; Travis et al., “Overcoming Health-Systems Constraints”; Reich et al., “Global Action on Health Systems”; World Health Organization, *Health-for-All Policy for the Twenty-First Century*, Geneva: WHO, 1998; World Health Organization, *Health and the Millennium Development Goals*, Geneva: WHO, 2005. [↑](#endnote-ref-147)
148. Ruger, “Global Health Governance and World Bank.” [↑](#endnote-ref-148)
149. Riikka Koskenmaki, Egle Granziera, and Gian Luca Burci, “The World Health Organization and its Role in Health and Development,” in *Health and Development: Toward a Matrix Approach,* eds., Anna Gatti and Andrea Boggio (London: Palgrave Macmillan, 2009), 16-55. [↑](#endnote-ref-149)
150. Magnussen et al., “Comprehensive versus Selective Primary Health Care.” [↑](#endnote-ref-150)
151. Magnussen et al., “Comprehensive versus Selective Primary Health Care.” [↑](#endnote-ref-151)
152. Travis et al., “Overcoming Health-Systems Constraints.” [↑](#endnote-ref-152)
153. Reich et al., “Global Action on Health System”; Miriam Rabkin, Wafaa El-Sadr, and Kevin De Cock, “The Impact of HIV Scale-Up on Health Systems: A Priority Research Agenda,” *Journal of Acquired Immune Deficiency Syndromes* 52, Supple. (2009): S6-S11; Julio Frenk, “The Global Health System: Strengthening National Health Systems as the Next Step for Global Progress,” *PLoS Medicine* 7, no.1 (2010). [↑](#endnote-ref-153)
154. Anna Gatti and Andrea Boggio, eds., *Health and Development: Toward a Matrix Approach* (London: Palgrave Macmillan, 2009). [↑](#endnote-ref-154)
155. B. Galichet, L. Goeman, P. Hill, et al., “Linking Programmes and Systems: Lessons from the GAVI Health Systems Strengthening Window,” *Tropical Medicine and International Health* 15, no.2 (2010): 208-15; Joseph Naimoli, “Global Health Partnerships in Practice: Taking Stock of the GAVI Alliance’s New Investment in Health Systems Strengthening,” *International Journal of Health Planning and Management* 24, no.1 (2009): 3-25. [↑](#endnote-ref-155)
156. Galichet et al., “Linking Programmes and Systems.” [↑](#endnote-ref-156)
157. Drager and Sunderland, “Public Health in a Globalising World”; Nick Drager and Robert Beaglehole, “Globalization: Changing the Public Health Landscape,” *Bulletin of the World Health Organization* 79, no.9 (2001): 803; Bruce Plotkin and Ann Marie Kimball, “Designing an International Policy and Legal Framework for the Control of Emerging Infectious Diseases: First Steps,” *Emerging Infectious Diseases* 3, no.1 (1997): 1-9; World Health Organization, *International Trade and Health*, WHA59.26, Geneva: WHO, 2006. Available at: https://apps.who.int/gb/ebwha/pdf\_files/WHA59/A59\_R26-en.pdf; Peter Piot and Awa Marie Coll Seck, “International Response to the HIV/AIDS Epidemic: Planning for Success,” *Bulletin of the World Health Organization* 79, no.12 (2001): 1106-12; Sania Nishtar, “Politics of Health Systems: WHO’s New Frontier,” *Lancet* 370, (2007): 935-36. [↑](#endnote-ref-157)
158. Jennifer Prah Ruger, “Global Tobacco Control: An Integrated Approach to Global Health Policy,” *Development* 48, no.2 (2005): 65-9. [↑](#endnote-ref-158)
159. Jennifer Prah Ruger, “Ethics of the Social Determinants of Health,” *Lancet* 364, (2004): 1092-97. [↑](#endnote-ref-159)
160. Szlezak et al., “Global Health System.” [↑](#endnote-ref-160)
161. Liese et al., “Neglected Tropical Diseases 1”; Bernard Pécoul, Pierre Chirac, Patrice Trouiller, and Jacques Pinel, “Access to Essential Drugs in Poor Countries: A Lost Battle?” *Journal of the American Medical Association* 281, no.4 (1999): 361-67. [↑](#endnote-ref-161)
162. Joseph DiMasi, Ronald Hansen, and Henry Grabowski, “The Price of Innovation: New Estimates of Drug Development Costs,” *Journal of Health Economics* 22, (2003): 151-85; Joseph Savirimuthu, “The Corporate Pharmaceutical Model and the Legacy of Doha: Whither a Global Consensus on Public Health Governance?”, *South Asia Economic Journal* 4, (2003): 73-98. [↑](#endnote-ref-162)
163. Christopher Nidel, “Public Health, Hypocrisy, and Brown-Skinned People,” *Food and Drug Law Journal* 59, (2004): 355-81; Amitava Banerjee, Aiden Hollis, and Thomas Pogge. “The Health Impact Fund: Incentives for Improving Access to Medicines,” *Lancet* 375 (2010): 166-9. [↑](#endnote-ref-163)
164. Naomi Bass, “Implications of the TRIPS Agreement for Developing Countries: Pharmaceutical Patent Laws in Brazil and South Africa in the 21st Century,” *George Washington International Law Review* 34, no.1 (2002): 191-222; Nana Poku, “Africa’s AIDS Crisis in Context: ‘How the Poor are Dying’,” *Third World Quarterly* 22, no.2 (2001): 191-204; Caroline Thomas, “Trade Policy and the Politics of Access to Drugs,” *Third World Quarterly* 23, no.2 (2002): 251-64. [↑](#endnote-ref-164)
165. Judith Wagner and Elizabeth McCarthy, “International Differences in Drug Prices,” *Annual Review of Public Health* 25, (2004): 475-95. [↑](#endnote-ref-165)
166. Thomas, “Politics of Access to Drugs”; Fantu Cheru, “Debt, Adjustment and the Politics of Effective Response to HIV/AIDS in Africa,” *Third World Quarterly* 23, no.2 (2002): 299-312; Duncan Matthews, “WTO Decision on Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health: A Solution to the Access to Essential Medicines Problem?”, *Journal of International Economic Law* 7, no.1 (2004): 73-107. [↑](#endnote-ref-166)
167. Amir Attaran, “How do Patents and Economic Policies Affect Access to Essential Medicines in Developing Countries?”, *Health Affairs* 23, no.3 (2004): 155-66. [↑](#endnote-ref-167)
168. Amir Attaran and Lee Gillespie-White, “Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa?” *Journal of the American Medical Association* 286, no.15 (2001): 1886-92. [↑](#endnote-ref-168)
169. Susan K. Sell, “The Quest for Global Governance in Intellectual Property and Public Health: Structural, Discursive, and Institutional Dimensions,” *Temple Law Review* 77, no.2 (2004): 363-400. [↑](#endnote-ref-169)
170. Mark Heywood, “Drug Access, Patents and Global Health: ‘Chaffed and Waxed Sufficient,’” *Third World Quarterly* 23, no.2 (2002): 217-31. [↑](#endnote-ref-170)
171. Labonte et al., *Fatal Indifference*. [↑](#endnote-ref-171)
172. Chantal Blouin, Nick Drager, and Richard Smith, eds., *International Trade in Health Services and the GATS: Current Issues and Debates*, Washington, DC: World Bank, 2005; Ilona Kickbusch, “Health and Citizenship: The Characteristics of 21st Century Health,” *World Hospital and Health Services* 40, no.4 (2004): 12-4. [↑](#endnote-ref-172)
173. Labonte et al., *Fatal Indifference;* Kelley Lee and Meri Koivusalo, “Trade and Health: Is the Health Community Ready for Action?” *PLoS Medicine* 2, no.1 (2005): e8. [↑](#endnote-ref-173)
174. Labonte et al., *Fatal Indifference;* World Health Organization, *World Health Report 2006: Working Together for Health*, Geneva: World Health Organization, 2006. Available at: http://www.who.int/whr/2006/en; Eric Friedman, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa,* Boston: Physicians for Human Rights, 2004. Available at: http://physiciansforhumanrights.org/library/report-2004-july.html [↑](#endnote-ref-174)
175. Tim Brown and Morag Bell, “Imperial or Postcolonial Governance? Dissecting the Genealogy of a Global Public Health Strategy,” *Social Science and Medicine* 67, no.10 (2008): 1571-79; David Stuckler, “Population Causes and Consequences of Leading Chronic Diseases: A Comparative Analysis of Prevailing Explanation,” *Milbank Quarterly* 86, no.2 (2008): 273-326. [↑](#endnote-ref-175)
176. David Fidler, “Neither Science nor Shamans: Globalization of Markets and Health in the Developing World,” *Indiana Journal of Global Legal Studies* 7, no.1 (1999): 191-224; Robert Beaglehole and Derek Yach, “Globalisation and the Prevention and Control of Non-Communicable Disease: The Neglected Chronic Diseases of Adults,” *Lancet* 362, (2003): 903-8; Jeff Collin, Kelley Lee, and Karen Bissell, “The Framework Convention on Tobacco Control: The Politics of Global Health Governance,” *Third World Quarterly* 23, no.2 (2002): 265-82; Benjamin M. Meier and Donna Shelley, “The Fourth Pillar of the Framework Convention on Tobacco Control: Harm Reduction and the International Human Right to Health,” *Public Health Reports* 121, no.5 (2006): 494-500. [↑](#endnote-ref-176)
177. Food and Agriculture Organization (FAO), *Projections of Tobacco Production, Consumption and Trade to the Year 2010*, Rome: FAO, 2003. Available from http://www.fao.org/docrep/006/y4956e/y4956e08.htm [↑](#endnote-ref-177)
178. Buse and Harmer, “Seven Habits”; Sania Nishtar, “Time for a Global Partnership on Non-Communicable Diseases,” *Lancet* 370, (2007): 1887-88; R. S. Magnusson, “Rethinking Global Health Challenges: Towards a ‘Global Compact’ for Reducing the Burden of Chronic Disease,” *Public Health* 123, no.3 (2009): 265-74; Susan Raymond, ed., *Global Public Health Collaboration: Organizing for a Time of Renewal* (New York: New York Academy of Sciences, 1997). [↑](#endnote-ref-178)
179. Gates Foundation, “Bloomberg Commit $500 Million to Global Anti-Tobacco Campaign,” *Philanthropy News Digest*, July 24, 2008. Available from http://foundationcenter.org/pnd/news/story.jhtml?id=221900040 [↑](#endnote-ref-179)
180. David Fidler, Nick Drager, and Kelley Lee, “Managing the Pursuit of Health and Wealth: The Key Challenges,” *Lancet* 373, no.9660 (2009): 325-31. [↑](#endnote-ref-180)
181. Lee et al., “Trade and Health 2.” [↑](#endnote-ref-181)
182. Drager and Sunderland, “Public Health in a Globalising World”; Kickbusch, “Action on Global Health”; Drager and Beaglehole, “Changing the Public Health Landscape”; WHO, *International Trade and Health;* World Trade Organization/World Health Organization, *WTO Agreements and Public Health: A Joint Study by the WHO and the WTO Secretariat*, Geneva: WHO/WTO, 2002. Available at: http://www.who.int/media/homepage/en/who\_wto\_e.pdf [↑](#endnote-ref-182)
183. Thomas, “Politics of Access to Drugs.” [↑](#endnote-ref-183)
184. Kelley Lee, “Global Health Promotion: How Can We Strengthen Governance and Build Effective Strategies?” *Health Promotion International* 21, Suppl. 1 (2006): 42-50. [↑](#endnote-ref-184)
185. Julio Frenk, Jaime Sepúlveda, Octavio Gómez-Dantés, Michael McGuinness, and Felicia Knaul, “The Future of World Health: The New World Order and International Health,” *British Medical Journal* 314, (1997): 1404-7. [↑](#endnote-ref-185)
186. Jennifer Prah Ruger and Hak-Ju Kim, “Global Health Inequalities: An International Comparison,” *Journal of Epidemiology and Community Health* 60, no.11 (2006): 928-36. [↑](#endnote-ref-186)
187. WHO, “Health and the MDGs”; WHO, *World Health Report 2006.* [↑](#endnote-ref-187)
188. Ruger, “Changing Role of World Bank.” [↑](#endnote-ref-188)
189. Burton Singer and Marcia Caldas de Castro, “Bridges to Sustainable Tropical Health,” *Proceedings of the National Academy of Sciences of the United States of America* 104, no.41 (2007): 16038-43. [↑](#endnote-ref-189)
190. Singer and De Castro, “Sustainable Tropical Health;” Heike Baumüller and David Heymann, “Hooves and Humans,” *World Today* 66, no.3 (2010): 21-3. [↑](#endnote-ref-190)
191. Peter Singer and Abdullah Daar, “How Biodevelopment Can Enhance Biosecurity,” *Bulletin of the Atomic Scientists* 65, no.2 (2009): 23-30; Corinna Hawkes and Marie Ruel, “The Links between Agriculture and Health: An Intersectoral Opportunity to Improve the Health and Livelihoods of the Poor,” *Bulletin of the World Health Organization* 84, no.12 (2006): 984-90. [↑](#endnote-ref-191)
192. Yasmin Von Schirnding, William Onzivu, and Andronico Adede, “International Environmental Law and Global Public Health,” *Bulletin of the World Health Organization* 80, no.12 (2002): 970-74; Jean Lebel, *Health: An Ecosystem Approach,* Ottawa: International Development Research Centre, 2003; Carlos Corvalan, Simon Hales, and Anthony McMichael, et al., *Ecosystems and Human Well-Being: Health Synthesis*, Geneva: WHO, 2005. Available at: http://www.who.int/entity/globalchange/ecosystems/ecosys.pdf; Margot Parkes and Pierre Horwitz, “Water, Ecology and Health: Ecosystems as Settings for Promoting Health and Sustainability,” *Health Promotion International* 24, no.1 (2009): 94-102; Lauren Fry, James Mihelcic, and David Watkins, “Water and Nonwater-Related Challenges of Achieving Global Sanitation Coverage,” *Environmental Science and Technology* 42, no.12 (2008): 4298-304; M. Jay and M. Marmot, “Health and Climate Change,” *Lancet* 374, (2009): 961-62; Kristin Sandberg and Gunnar Bjune, “The Politics of Global Immunization Initiatives: Can We Learn from Research on Global Environmental Issues?” *Health Policy* 84, no.1 (2007): 89-100. [↑](#endnote-ref-192)
193. Stuckler, “Population Causes and Consequences”; Solomon Benatar, Stephen Gill, and Isabella Bakker, “Making Progress in Global Health: The Need for New Paradigms,” *International Affairs* 85, no.2 (2009): 347-71; Nana Poku, “Confronting AIDS with Debt: Africa’s Silent Crisis,” in *The Political Economy of AIDS in Africa*, eds., Nana Poku and Alan Whiteside (Burlington, VT: Ashgate, 2004); Kelley Lee, *Health Impacts of Globalization: Towards Global Governance* (London: Palgrave Macmillan, 2003); David Woodward, Nick Drager, Robert Beaglehole, and Debra Lipson, “Globalization and Health: A Framework for Analysis and Action,” *Bulletin of the World Health Organization* 79, no.9 (2001): 875-81; Ichiro Kawachi and Sarah Wamala, eds., *Globalization and Health* (Oxford: Oxford University Press, 2006). [↑](#endnote-ref-193)
194. Wolfgang Hein and Lars Kohlmorgen, eds., *Globalisation, Global Health Governance and National Health Politics in Developing Countries* (Hamburg: Deutschen Ubersee-Instituts, 2003); Robert Beaglehole and Ruth Bonita, “Reinvigorating Public Health,” *Lancet* 356, no.9232 (2000): 787-88. [↑](#endnote-ref-194)
195. Kawachi and Wamala, *Globalization and Health*; Janine Brodie, “Globalization, In/Security, and the Paradoxes of the Social,” in *Power, Production and Social Reproduction: Human In/Security in the Global Political Economy*, eds., Isabella Bakker and Stephen Gill (New York: Palgrave Macmillan, 2003). [↑](#endnote-ref-195)
196. Walter Eberlei, “Poverty Reduction Strategies between Global Governance and National Politics,” in *Globalisation, Global Health Governance and National Health Politics in Developing Countries: An Exploration into the Dynamics of Interfaces*, eds., Wolfgang Hein and Lars Kohlmorgen (Hamburg: Deutschen Ubersee-Instituts, 2003). [↑](#endnote-ref-196)
197. Global Health Watch, *Global Health Watch 2005-6;* Poku and Whiteside, “Politics of Governance;” Cheru, “Debt, Adjustment and Politics.” [↑](#endnote-ref-197)
198. Poku, “Confronting AIDS with Debt.” [↑](#endnote-ref-198)
199. WHO, *World Health Report 2006.* [↑](#endnote-ref-199)
200. Brodie, “Paradoxes of the Social.” [↑](#endnote-ref-200)
201. Jim Yong Kim, Joyce V. Millen, Alec Irwin, and John Gershman (eds), *Dying for Growth: Global Inequality and the Health of the Poor* (Monroe, ME: Common Courage Press, 2000); Zwi and Yach, “International Health in the 21st Century”; Lister, “Can Global Health be Good for Business?” [↑](#endnote-ref-201)
202. Thomas and Weber, “Politics of Global Health Governance;” Thomas, “Politics of Access to Drugs;” Benatar et al., “Making Progress in Global Health.” [↑](#endnote-ref-202)
203. Anna Breman and Carolyn Shelton, “Structural Adjustment and Health: A Literature Review of the Debate, Its Role-Players and Presented Empirical Evidence,” CMH Working Paper Series, Paper No. WG6:6., Geneva: WHO, 2001. [↑](#endnote-ref-203)
204. WHO, *World Health Statistics 2009*; Prabhat Jha, Anne Mills, Kara Hanson, et al., “Improving the Health of the Global Poor,” *Science* 295, (2002): 2036-39; Paul Farmer, *Infections and Inequalities* (Berkeley, CA: University of California Press, 1999); Kim et al., *Dying for Growth*. [↑](#endnote-ref-204)
205. Kelley Lee, “How do We Move Forward on the Social Determinants of Health: The Global Governance Challenges,” *Critical Public Health* 20, no.1 (2010): 5-14; The Economist, “The Price of Being Well,” *Economist* 388, no.8595 (2008): 59-60. [↑](#endnote-ref-205)
206. WHO, *Health for All.* [↑](#endnote-ref-206)
207. Lee, “Move Forward on Social Determinants of Health.” [↑](#endnote-ref-207)
208. Gostin, “Meeting the Survival Needs”; Gostin and Mok, “Grand Challenges”; M.A. Roberts, A.G. Breitenstein, and C.S. Roberts, “The Ethics of Public-Private Partnerships,” in *Public-Private Partnerships for Public Health*, ed., Michael Reich (Cambridge, MA: Harvard University Press, 2002). [↑](#endnote-ref-208)
209. Jennifer Prah Ruger, “Toward a Theory of a Right to Health”. [↑](#endnote-ref-209)
210. Ruger and Ng, “Emerging and Transitioning Countries’ Role.” [↑](#endnote-ref-210)
211. Labonte and Shrecker, “How the G7/G8 Rate”; Benatar et al., “Making Progress in Global Health.” [↑](#endnote-ref-211)
212. D. Maher, S. Biraro, V. Hosegood, et al., “Translating Global Health Research Aims into Action: The Example of the ALPHA Network,” *Tropical Medicine and International Health* 15, no.3 (2010): 321-28. [↑](#endnote-ref-212)
213. Jennifer Prah Ruger, “Normative Foundations of Global Health Law,” *Georgetown Law Journal* 2, (2008): 423-43. [↑](#endnote-ref-213)
214. Lee, “Move Forward on the Social Determinants of Health.” [↑](#endnote-ref-214)
215. Chris Simms, “Good Governance at the World Bank,” *Lancet* 371, (2008): 202-3. [↑](#endnote-ref-215)
216. N. Pakenham-Walsh and C. Priestley, “Towards Equity in Global Health Knowledge,” *Quarterly Journal of Medicine* 95, (2002): 469-73. [↑](#endnote-ref-216)
217. World Health Organization, *Genomics and World Health*, Geneva: WHO, 2002; V. Ozdemir, D. Husereau, S. Hyland, et al., “Personalized Medicine Beyond Genomics: New Technologies, Global Health Diplomacy and Anticipatory Governance,” *Current Pharmacogenomics and Personalized Medicine* 7, no.4 (2009): 225-30. [↑](#endnote-ref-217)
218. Pakenham-Walsh and Priestley, “Equity in Global Health Knowledge.” [↑](#endnote-ref-218)
219. WHO, *Genomics and World Health*. [↑](#endnote-ref-219)
220. De Renzio and Maxwell, *Financing the Response to HIV/AIDS*. [↑](#endnote-ref-220)
221. Gerald Keusch, Wen Kilama, Suerie Moon, Nicole Szlezák, and Catherine Michaud, “The Global Health System: Linking Knowledge with Action – Learning from Malaria,” *PLoS Medicine* 7, no.1 (2010); Levin et al. *Millions Saved.* [↑](#endnote-ref-221)
222. Louise Trubek and Maya Das, “Achieving Equality: Healthcare Governance in Transition,” *DePaul Journal of Health Care Law* 7, no.2 (2004): 245-79. [↑](#endnote-ref-222)
223. Scott Burris, “Governance, Microgovernance and Health,” *Temple Law Review* 77, Summer Symposium (2004): 335-62. [↑](#endnote-ref-223)
224. Trevor Hancock, “Healthy Cities and Communities: Past, Present, and Future,” *National Civic Review* 86, no.1 (1997): 11-21; Ilona Kickbusch, “New Players for a New Era: Responding to the Global Public Health Challenges,” *Journal of Public Health Medicine* 19, no.2 (1997): 171-78; Ilona Kickbusch, “Global + Local = Glocal Public Health,” *Journal of Epidemiology and Community Health* 53, (1999): 451-52; Roderick Lawrence and Colin Fudge, “Healthy Cities in a Global and Regional Context,” *Health Promotion International* 24, Suppl. 1 (2009): i11-i18. [↑](#endnote-ref-224)
225. Caines et al., “Assessing the Impact;” Report of the Working Group on Global Health Partnerships, “High-Level Forum on Health MDGs;” De Renzio and Maxwell, *Financing the Response to HIV/AIDS*; Galichet et al., “Linking Programmes and Systems;” Naimoli, “Global Health Partnerships in Practice;” Mark Dybul, “Lessons Learned from PEPFAR,” *Journal of Acquired Immune Deficiency Syndromes* 52, Suppl. 1 (2009): S12-S13; Wachira and Ruger, “National Poverty Reduction Strategies.” [↑](#endnote-ref-225)
226. Caines et al., “Assessing the Impact.” [↑](#endnote-ref-226)
227. Lilani Kumaranayake and Sally Lake, “Regulation in the Context of Global Health Markets,” in *Health Policy in a Globalising World,* eds., Kelley Lee, Ken Buse, and Suzanne Fustukian (Cambridge UK: Cambridge University Press, 2002), 78-96. [↑](#endnote-ref-227)
228. Gostin, “Meeting the Survival Needs”; Easterly, *White Man’s Burden.*  [↑](#endnote-ref-228)
229. Levine et al., *Millions Saved*. [↑](#endnote-ref-229)
230. Simon Maxwell, “Can the International Health Partnership Deliver a New Way of Funding Health Spending?”, Overseas Development Institute, September 7, 2007. Available from http://blogs.odi.org.uk/blogs/main/archive/2007/09/07/5364.aspx [↑](#endnote-ref-230)
231. Taylor, “Governing Globalization of Public Health.” [↑](#endnote-ref-231)
232. Gostin, “Meeting the Survival Needs”; Reader, “Case against China.” [↑](#endnote-ref-232)
233. H. Wipfli, D. Bettcher, C. Subramaniam, and A. Taylor, “Confronting the Tobacco Epidemic: Emerging Mechanisms of Global Governance,” in *International Co-operation and Health*, eds., Martin McKee, Paul Garner, and Robin Stott (Oxford: Oxford University Press, 2001). [↑](#endnote-ref-233)
234. Wipfli et al., “Confronting the Tobacco Epidemic.” [↑](#endnote-ref-234)
235. Emily Lee, “The World Health Organization’s Global Strategy on Diet, Physical Activity, and Health: Turning Strategy into Action,” *Food and Drug Law Journal* 60, (2005): 569-601. [↑](#endnote-ref-235)
236. Taylor, “Governing Globalization of Public Health.” [↑](#endnote-ref-236)
237. Thomas, “Politics of Access to Drugs.” [↑](#endnote-ref-237)
238. Taylor, “Global Governance, International Health Law.” [↑](#endnote-ref-238)
239. Reader, “Case against China.” [↑](#endnote-ref-239)
240. Lee, “WHO’s Global Strategy.” [↑](#endnote-ref-240)
241. Ruger, “Normative Foundations.” [↑](#endnote-ref-241)
242. Northrup, “Critical Elements”; Pierre Buekens, Gerald Keusch, Jose Belizan, and Zulfiqar Ahmed Bhutta, “Evidence-Based Global Health,” *Journal of the American Medical Association* 291, no.21 (2004): 2639-41; J.J. Furin, H.L. Behforouz, S.S. Shin, J.S. Mukherjee, J. Bayona, P.E. Farmer, J.Y. Kim, and S. Keshavjee, “Expanding Global HIV Treatment: Case Studies from the Field,” *Annals of the New York Academy of Sciences* 1136, (2008): 12-20. [↑](#endnote-ref-242)
243. Frenk et al., “Future of World Health.” [↑](#endnote-ref-243)
244. Szlezak et al., “Global Health System;” Ruger, “Global Health Governance and World Bank;” Travis et al., “Overcoming Health-Systems Constraints;” Reich et al., “Global Action on Health Systems;” Raymond, *Global Public Health Collaboration*. [↑](#endnote-ref-244)
245. Roger England, “Experience of Contracting with the Private Sector: A Selective Review,” London: DFID Health Systems Resource Centre, 2004. [↑](#endnote-ref-245)
246. Singer and Daar, “Biodevelopment Can Enhance Biosecurity.” [↑](#endnote-ref-246)
247. Benjamin Powers, Jane Trinh, and Hayden Bosworth, “Can This Patient Read and Understand Written Health Information?” *Journal of the American Medical Association* 304, no.1 (2010): 76-84. [↑](#endnote-ref-247)
248. Moon et al., “Lessons for a Stronger Institutional Framework.” [↑](#endnote-ref-248)
249. Maher et al., “Translating Global Health Aims into Action.” [↑](#endnote-ref-249)
250. Jennifer Prah Ruger, “Global Health Governance as Shared Health Governance,” Paper presented at the Values and Moral Experiences in Global Health Conference, Harvard University, Cambridge, Massachusetts, May 25-26, 2007; Jennifer Prah Ruger, *Global Health Justice and Governance* (Oxford, UK: Clarendon Press, in press); Wachira and Ruger, “National Poverty Reduction Strategies.” [↑](#endnote-ref-250)
251. Ruger, “Global Health Governance as Shared Health Governance.” [↑](#endnote-ref-251)
252. Carmen Perez-Casas, Pierre Chirac, Daniel Berman, and Nathan Ford, “Access to Fluconazole in Less-Developed Countries,” *Lancet* 356 (2000): 2102. [↑](#endnote-ref-252)
253. World Health Organization, *World Health Statistics 2008,* Geneva: WHO, 2008. [↑](#endnote-ref-253)