McMaster University

McMaster HEALTH FORUM

STUDENT VOICES 6

Political Analyses of Five Global Health Decisions

Student Voices 6: Political Analyses of Five Global Health Decisions

June 2013

ISBN 978-1-927565-06-3 (print)
ISBN 978-1-927565-07-0 (online)
ISSN 1925-7716 (print)
ISSN 1925-7724 (online)

Suggested citation for the report

Hoffman SJ, Ali M, editors. Student Voices 6: Political Analyses of Five Global Health Decisions. Hamilton, Canada: McMaster Health Forum; 2013. Available at www.mcmasterhealthforum.org.

Suggested citation for a chapter

Boese K, Dogra N, Hosseinpour S, Kobylianskii A, Vakeesan V. Chapter 1 – Analyzing the Inclusion of MDG 5, Improving Maternal Health, among the UN's Millennium Development Goals. In: Hoffman SJ, Ali M, editors. Student Voices 6: Political Analyses of Five Global Health Decisions. Hamilton, Canada: McMaster Health Forum; 2013. Available at www.mcmasterhealthforum.org.

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Funding for this publication was provided by McMaster University's Bachelor of Health Sciences (Honours) Program. The views expressed here do not necessarily represent the views of McMaster University or the McMaster Health Forum.

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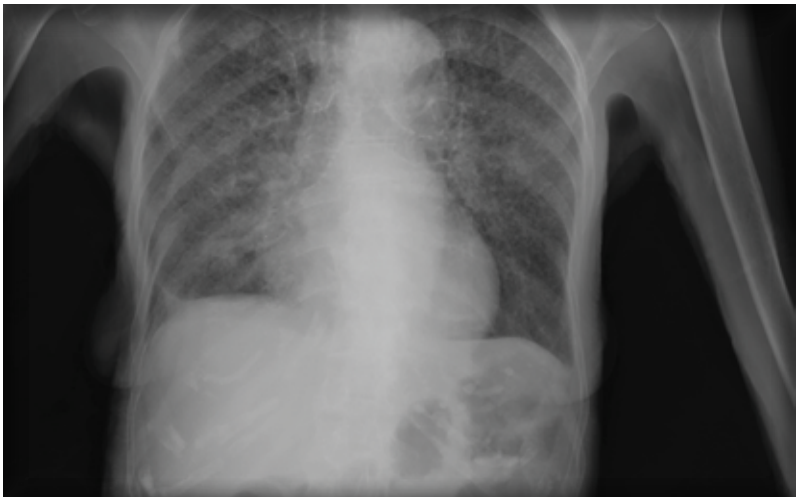
Cover photo courtesy of Michael Baxter, 2011. Macro-level malaria policies must be complemented by grassroots education programs, shown here at Oyiengo Primary School (Kanyawegi, Kenya).

About the McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.


African Vaccination Week
MAY 23-29, 2011

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Introduction

The global health system is a complex regime involving an ever-expanding cast of players, divergent interests, conflicting values, and evolving research evidence, among other factors. New ideas are floated every day to improve global health. Some ideas will receive priority, developing into full-fledged international initiatives and policies, whereas others will bear minimal consideration. Understanding the factors that contribute to this difference is relevant to researchers, policymakers and advocates alike. To this end, examining past global health decisions is insightful.

This edited volume offers political analyses of five major global health decisions: inclusion of maternal health among the Millennium Development Goals; creation of the Global Alliance for Vaccines & Immunisation (GAVI); striving for coordination in global tuberculosis control via the Stop TB Partnership and the Global Plan to Stop TB; inclusion of malaria as a focus for the Global Fund; and adoption of the WHO Framework Convention on Tobacco Control.

Each chapter relies on an extensive review of available research evidence and key informant interviews to examine the factors that influenced the agenda-setting, political prioritization, and decision-making processes of each decision. The roles of and strategies employed by advocates are also discussed. Key messages for policymakers and advocates are highlighted at the end of each chapter.

A new meta-framework was developed and utilized to structure each political analysis and chapter. Specifically, the meta-framework is a combination of Kingdon's multiple streams agenda-setting framework, Shiffman and Smith's framework on determinants of political priority for global initiatives, and the 3-I multi-causal policy choice framework. Utilizing a common analytical framework conferred the added benefit of comparability across the political analyses (see summary table on pages 8–9).

The authors of this report are all students at McMaster University who prepared these essays for a fourth-year undergraduate course on Global Health Advocacy (HTH SCI 4ZZ3), offered from September to December 2012 by the Bachelor of Health Sciences (Honours) Program, in collaboration with the McMaster Health Forum. It is our belief that today's students have an important role to play in global health decision-making for both their innovative ideas and future leadership in the global health community. Each chapter, then, also features students' reflections, inspired by their own experiences and scholarship. Through this publication, it is hoped that these students will help shape some of today's leading debates in global health as they prepare themselves to confront tomorrow's greatest challenges.

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June 2013

Summary Table	Maternal Health (MDG 5)	Childhood Vaccination (GAVI)
Components of **Agenda-setting**		
Problems	• Inadequate attention to the maternal component in maternal and child healthld health	• Focusing event: smallpox eradication • Donor fatigue • Immunization rates decline
Policies	• Development of Safe Motherhood Initiative • Half global maternal mortality by 2000	• Summits urge action, and encourage public–private collaboration
Politics	• Creating policy windows through conferences • Establishing global mood of solidarity for women	• Global goals to reduce childhood mortality • Polio eradication promoted sense of urgency
Components of **Political Prioritization**		
Actor power	• Inter-Agency Group for Safe Motherhood (IAG) forms • Support from FIGO and White Ribbon Alliance	• Coordinated global effort involving industry • Convening power of Wolfensohn and Gates
Ideas	• Key players agree on a common internal frame • Maternal health portrayed as a human right	• Shift in focus from developing new vaccines to delivery
Political contexts	• IAG creates favourable environment for maternal health, mainly through conferences	• Drafting MDGs favours childhood immunization • WHO and UN as a platform for collective action
Issue characteristics	• Country-specific indicators highlight discrepancies • Evidence-based solutions emerge	• Millions of children without immunization • Cost-effective and beneficial interventions
Components of **Decision-making**		
Institutions	• UN, IMF, World Bank, OECD release *A Better World for All (ABWA)*, goals of which encompassed by UN's *Millennium Declaration*	• Networks of international agencies • Forum for discussion • Existing administrative capacities of WHO and UN
Interests	• Clair Short and the Utstein Group propel IDGs, including improving maternal health, into greater prominence	• Shift in focus from Financial support • Commitment of industry to provide low-cost vaccines • Intellectual leadership and national support
Ideas	• Compilation of targets – International Development Goals (IDGs) – by Groupe de Réflexion	• Technological boom • Belief in vaccines to improve child health • Global partnership models encourage commitment
External factors	• Inauguration of new millennium raises key issues • UN's Millennium Assembly allows for final drafting of MDGs	• Increased availability of and need to distribute new vaccines • Global economic growth

Summary Table (continued)	Tuberculosis (Stop TB Partnership; Global Plan to Stop TB)	Funding for Malaria (The Global Fund)	Tobacco Control (FCTC)
Components of **Agenda-setting**			
Problems	• MDR-TB and HIV/AIDS are urgent threats • Slow progress towards WHA targets	• Decline in funding for malaria research & control • Concomitant surge of resistant strains	• Globalization of tobacco consumption • Ineffective national tobacco control legislation
Policies	• A new plan – combining horizontal and vertical programs – is needed	• *1992 Global Malaria Control Strategy* criticized, leading to creation of Roll Back Malaria	• Lack of civil society involvement in past policies • Persuasion and networking of Ruth Roemer
Politics	• Combination of Dr. Brundtland's election, and shift in global mood creates policy window	• Awareness and support for issue apparent in international conferences and major newspapers	• WHO convening power and resources • Past resolutions calling for a global strategy
Components of **Political Prioritization**			
Actor power	• Dr. Brundtland plays leadership role in uniting powerful stakeholders to combat TB	• Election of Dr. Gro Brundtland • *Massive Efforts Advocacy Forum* facilitated a united stance on malaria	• Support and prioritization by Dr. Brundtland • Agreement and alliances among various sectors
Ideas	• The urgency of TB framed as economic issue to encourage commitment of political leaders	• Shift in internal and external frames from a public health issue to an economic issue	• Largely framed as a health issue • Tobacco portrayed as a killer • Focus on health consequences
Political contexts	• Stop TB initiative garners global attention on economic devastation caused by TB	• Roll Back Malaria provides an existing structure to facilitate consensus within policy community	• Election of Dr. Brundtland, shifting WHO's initiatives and priorities
Issue characteristics	• TB is eighth-most cause of death, and has cost-effective cure, through effective DOTS strategy	• Insufficient funding towards Roll Back Malaria • Promising source of funding from private sector	• Size and severity of tobacco epidemic was clear • Feasible and cost-effective solution
Components of **Decision-making**			
Institutions	• A coordinated action plan called for by all TB control bodies • Administrative capacity exists within Stop TB Initiative	• G8 consensus at Okinawa Summit in 2000 • Administrative capacity of Roll Back Malaria	• Formation of policy networks between WHO member state directing decision making process
Interests	• TB-endemic countries benefit from pooled resources, new research • Donors protected from spread of TB	• Incentivizing donors through accountability and fund transparency • Increased economic growth in malaria-free countries	• FCA facing benefits from the FCTC • Powerful tobacco industry positively acknowledging the FCTC
Ideas	• New programs like Global Drug Facility struggle to reach goals • Stakeholders call for international collaboration	• Research evidence linking malaria to economic development • Public support for neglected diseases	• Research evidence of cost-effectiveness and feasibility • Public values tobacco control as a global priority
External factors	• *26th G8 Summit* calls for a global plan to tackle diseases such as TB	• Establishment of Millennium Development Goals • Elections of Kofi Annan and George W. Bush	• Release of World Bank report *Curbing the Epidemic*

Staying safe. Becky, 2008.

Chapter 1

Analyzing the Inclusion of MDG 5, Improving Maternal Health, among the UN's Millennium Development Goals

Kaitlyn Boese, Nupur Dogra, Shahob Hosseinpour, Anna Kobylianskii and Vashini Vakeesan

Abstract

Background

Maternal health has garnered significant global attention since its adoption as a Millennium Development Goal (MDG). This political analysis employs three frameworks to analyze the development of maternal health as a MDG.

Methods

Ad hoc searches were conducted using Google Scholar, PubMed and Ovid. Scholarly articles and grey literature were analyzed using the Kingdon, Shiffman, and 3-I policy frameworks. Key informant interviews supplemented research findings.

Findings

Among many events, Dr. Allan Rosenfield and Deborah Maine's Lancet article on maternal health coupled with the United Nations (UN) Decade for Women created a policy window for the launch of the Safe Motherhood Initiative in 1987, placing maternal health on the global agenda. Subsequent formation of the Safe Motherhood Inter-Agency Group (IAG) led to a common internal frame among key players. IAG identified effective indicators and solutions, and portrayed maternal health as a human right, – creating a favourable political environment to prioritize maternal health on the global agenda. Following prioritization, the Organisation for Economic Co-operation and Development included the goal of reducing maternal mortality among the International Development Goals (IDGs) as a means for global poverty reduction. Clare Short, then–U.K. secretary of state for international development, endorsed the IDGs, which were internationally reinforced through the report A Better World for All (ABWA). At the 2000 Millennium Assembly, the UN affirmed the *Millennium Declaration*, which incorporated the goals of ABWA and inspired the MDGs. Key players and organizations facilitated the policy development process through a variety of advocacy strategies, leading to the adoption of improving maternal health as a MDG.

Conclusion

The attention given to maternal health on a global scale and its subsequent inclusion in the MDGs was a complex and multifaceted process. As the 2015 deadline for the MDGs approaches, a thorough understanding of the policy development is essential for future advocacy efforts.

Keywords

MDG 5, maternal health, maternal mortality, policy frameworks, advocacy, global health

Introduction

As 2015 draws near, the world anticipates the expiry of the Millennium Development Goals (MDG). Considered to be the "world's biggest promise", the eight MDGs are a momentous global consensus to reduce poverty.[1] The fifth MDG, improving maternal health, aims to reduce maternal mortality by 75% by 2015.[1] This goal has shaped global maternal health policies, attesting to the power of united decisions. This political analysis will use policy frameworks to elucidate the factors that led to the adoption of MDG 5, outlining the evolution of its placement on the global agenda, its subsequent prioritization and, finally, its implementation.[2–4]

Maternal Health's Inclusion on the Global Agenda

Realizing the problems associated with maternal health

The 1975 International Women's Year (IWY) and the 1976–1985 UN Decade for Women addressed the ongoing infringements of women's rights. The Decade highlighted women's issues of equality, peace and development, globally empowering women's groups.[5] Nevertheless, in 1985 public health researchers Dr. Allan Rosenfield and Deborah Maine published a paper in The Lancet entitled, Maternal mortality—a neglected tragedy: Where is the M in MCH? This paper served as a global focusing event for maternal mortality.[5] By providing new statistical indicators, the paper emphasized that despite substantial global attention regarding maternal and child health (MCH), the maternal component was inadequately addressed, thus placing the issue on the global agenda.[6] In 1977, literature showed that only five of the 52 countries in Africa had given any indication of their maternal mortality ratio (MMR), the number of deaths per 100,000 live births.[7] However, in 1985 a better understanding of the developing world's MMR allowed Rosenfield and

Giving choice to women helps parents plan the size of their families (Bhubaneswar, India). Pippa Ranger/UK Department for International Development, 2011.

Maine to substantiate their paper. They stated that more than 500,000 mothers were dying annually in the developing world, with some developing countries indicating an MMR of 100–300, while others indicated an MMR of 7–13.[6] The paper also provided feedback on current programs by criticizing the public health practices that were based on "whatever is good for the child, is good for the mother"; Rosenfield and Main argued that maternal mortality required significantly different approaches than child mortality due to differences in etiology.[5] Their article reignited global discussions regarding the shortfalls of maternal health efforts.

The past, present and future of maternal health policies

Rosenfield and Maine's Lancet article stressed the need for policy changes to traditional approaches of addressing maternal mortality; thus, they criticized existing maternal-health policies and programs. For instance, since 1952 the World Health Organization's (WHO) Comité d'Experts de la Maternité promoted antenatal care as the primary strategy to address maternal mortality, despite indications from 1932 that antenatal care was insufficient.[7] In 1987, the World Bank, WHO and UN Population Fund (UNPF) responded to Rosenfield and Maine's plea by jointly sponsoring the Safe Motherhood Conference (SMC) in Nairobi, Kenya.[8] At the SMC, Dr. Halfdan Mahler, then–director-general of WHO, addressed the nations with "A Call to Action" to place maternal health on the global agenda in an effort to communicate and persuade other nations. He emphasized the need for a holistic approach that provided women with adequate primary healthcare, greater prenatal care, assistance of trained personnel during delivery, and access to emergency obstetric care.[8] Finally, Mahler reiterated Rosenfield and Maine's claims of urgency for maternal health by launching the Safe Motherhood Initiative (SMI), a global agreement to halve maternal mortality rates by 2000.[8] Through this announcement, Mahler provided the global community with a policy proposal in order to capitalize on the developing policy window.

Creating a policy window through political decisions

The launch of the 1975 IWY in Mexico City grew into a decade for women with two subsequent conferences in Copenhagen and Nairobi, increasing political attention for women's issues.[5] These events established a global mood of solidarity for women by creating an opportunity for international discussion regarding women-specific issues and rights.[5] Additionally, within the global arena, the 1978 Alma Ata Declaration's "Health for All," for which Mahler was a strong proponent, further motivated his significant leadership role at the SMC.[9] Finally, the collective support of the UN, WHO, and the World Bank provided the credibility that Rosenfield and Maine's Lancet article alone could not muster. Hence, the cascade of events leading to the SMI created a favourable global climate towards maternal health, securing the issue on the global agenda.

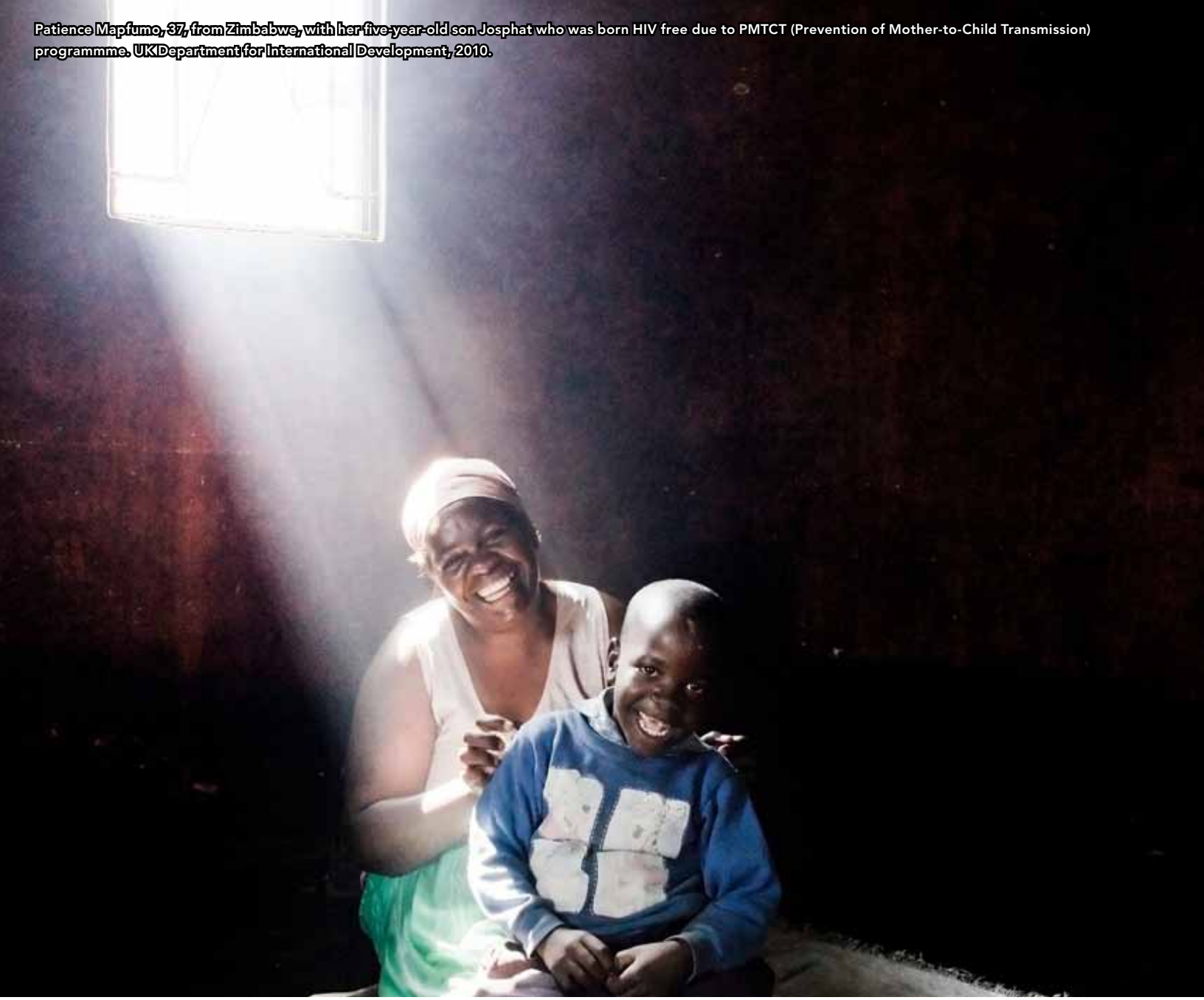
How was Maternal Health Prioritized on the Global Agenda?

The supporters of maternal health

Following the adoption of maternal health on the global agenda at the SMC in 1987, the sponsors of the SMC formed the UN Inter-Agency Group for Safe Motherhood (IAG) to foster policy community cohesion.[10] Several international non-governmental organizations (NGOs) including the Population Council, the International Planned Parenthood Foundation and Family Care International (FCI) collaborated with the IAG to promote maternal health.10,11 Medical professional associations, such as the International Federation of Gynecology and Obstetrics (FIGO), directly supported prioritization.[12] For example, in 1988 Dr. Mahmoud Fathalla, a former president of FIGO, created a video called Why did Mrs. X die? which, according to Ann Starrs, co-chair of the FCI, "painted [a] much fuller portrait of the issue of maternal mortality."[13] The mobilization of civil society also increased maternal health's political prioritization. For instance, the White Ribbon Alliance enabled civil society groups acting on a local level to play a larger role by uniting and connecting them with donor organizations.[3,14] Moreover, on World Health Day in 1998, which was devoted to promoting safe motherhood, the IAG featured speeches from decision-makers including James Wolfensohn (then–president of the World Bank) and Hillary Clinton (then–first lady of the United States) to government officials from developing countries, UN representatives and the media.[11,14,15] In terms of leaders, former President of FIGO Dr. Dorothy Shaw emphasized: "Maternal health has not had a single champion, it has several champions."[16] Overall, the commitment of institutions, the cohesion of the many actors involved, growing strength of civil society, and some political support contributed to the prioritization of maternal health.

Establishing global consensus on maternal health

Throughout the prioritization of maternal health, the IAG struggled with its internal and external framing. Disagreement existed about maternal health's definition and scope, as well as possible solutions.[3] Indeed, there was significant controversy concerning reproductive health among the IAG due to the external audience's perspectives and reactions. While women's groups advocated for reproductive health's inclusion within safe motherhood, conservative religious groups and countries protested its inclusion, for example, at the 1994 International Conference on Population Development (ICPD).11,17 Additionally, Mahler's proposed solutions from the 1987 SMC divided members of the IAG, with some doubting their cost-effectiveness.[3] The formulation of 10 key action messages, including a firm stance supporting quality reproductive health services and evidence-based solutions, provided a consistent internal



Patience Mapfumo, 37, from Zimbabwe, with her five-year-old son Josphat who was born HIV free due to PMTCT (Prevention of Mother-to-Child Transmission) programmme. UK Department for International Development, 2010.

Summary Table

Agenda-setting	Political prioritization	Decision-making
Problems • Inadequate attention to the maternal component in maternal and child health **Policies** • Development of Safe Motherhood Initiative • Half global maternal mortality by 2000 **Politics** • Creating policy windows through conferences • Establishing global mood of solidarity for women	**Actor Power** • Inter-Agency Group for Safe Motherhood (IAG) forms • Support from FIGO and White Ribbon Alliance **Ideas** • Key players agree on a common internal frame • Maternal health portrayed as a human right **Political contexts** • IAG creates favourable environment for maternal health, mainly through conferences **Issue characteristics** • Country-specific indicators highlight discrepancies • Evidence-based solutions emerge	**Institutions** • UN, IMF, World Bank, OECD release *A Better World for All (ABWA)*, goals of which encompassed by UN's *Millennium Declaration* **Interests** • Clair Short and the Utstein Group propel IDGs, including improving maternal health, into greater prominence **Ideas** • Compilation of targets – International Development Goals (IDGs) – by Groupe de Réflexion **External factors** • Inauguration of new millennium raises key issues • UN's Millennium Assembly allows for final drafting of MDGs

frame for the IAG at the 1997 SMI Technical Consultation.[14,18]

Initially, maternal health was externally framed as the key to women's and children's health. However, women's groups viewed maternal health as an important issue beyond its benefit for children, and rejected the over-generalized characterization of women in their motherhood role.[3,11,18] The discord was resolved by re-framing maternal health as a woman's human right at the ICPD and the SMI Technical Consultation,[11,18] which also obligated governments to act.[10,18] Overall, an internally resonating frame and an accepted external frame further prioritized maternal health.[18]

Governance structures and political events of maternal health

A strong global governance structure and the development of policy windows facilitated the prioritization of maternal health. The IAG established the global governance structure, providing the environment for various constituents to collectively act for maternal health.[11] Additionally, the IAG created policy windows by organizing regional and national conferences from 1987 to 1994. These conferences raised awareness of safe motherhood among policymakers, NGOs and the media, promulgating worldwide the concept of safe motherhood until it became "a very accepted and understood term."[13] SMI's 10th anniversary provided another policy window to further prioritize safe motherhood, with the 1997 Technical Consultation fostering cohesion within the policy community and increasing awareness among external groups.[18] This window furthered awareness of the issue among the public through a media campaign launched on World Health Day 1998, increasing safe motherhood's palatability.[18] Such policy windows, along with a strong global governance structure, were essential to maternal health's prioritization.

Further characterizing maternal health

Indicators and evidence-based solutions garnered more attention for maternal health. In 1996 revised estimates suggested that 585,000 maternal deaths were occurring each year, 85,000 more deaths than described by Rosenfield and Maine's 1985 paper.[19] Moreover, the first release of country-specific estimates drew attention to the discrepancy in maternal health between developed and developing countries.[20] For example, MMRs ranged from six in Canada to 1,600 in Somalia.[19] Additionally in 1991 the major causes of maternal death were identified as hemorrhage, infection, eclampsia, obstructed labour and complications of unsafe abortion, all of which have been extensively addressed in developed countries. This suggested that the severity of the problem is surmountable.[20,21] In fact: "The means of averting almost all maternal deaths have been available for 60 years."[20]

Following the SMC, new evidence substantiating the effectiveness of skilled birth attendants (SBA) and access to emergency obstetric services became available.[3] For instance, in almost all countries where skilled attendants were at more than 80% of births, the MMRs were below 200.[12] Furthermore, Sri Lanka decreased the percentage of births without an SBA from 40% to 10%, through improved ambulatory services and midwives, providing evidence that these solutions could be implemented.[22] In contrast, two solutions proposed at the launch of the SMI, antenatal screening and the training of traditional birth attendants (TBA), were contested and de-emphasized over time.[10,20]

Research on antenatal screening for high risk pregnancies demonstrated that it was ineffective in predicting and preventing obstetric complications, and TBAs alone had little benefit towards the reduction of maternal mortality.[12,21] According to Susan Watt, member of Save the Mothers, "Some of the traditional birth attendants' practices . . . were counter to the ways [of] saving women's lives."[16] This new evidence further guided the action messages

A mother plays with her young son in the Kenyan village of Mwea. Gates Foundation, 2009.

Student Reflections

Understanding the development of global maternal health policies over the last four decades provides the foundation for future progress. Now, we need to translate this knowledge into tangible benefits that re-define motherhood – for women everywhere!

—Nupur Dogra, B.H.Sc. (Class of 2013)

'I am going to the sea to fetch a new baby, but the journey is long and dangerous and I may not return.' This African folktale of an expecting woman reminds us: it is our responsibility to ensure that pregnancy is not a perilous but a joyous journey.

—Shahob Hosseinpour, B.H.Sc. (Class of 2013)

The seeds of maternal health were sown in history. We must continue to make every mother count, and reap the fruit.

—Vashini Vakeesan, B.H.Sc. (Class of 2013)

This project helped clarify how we, as global health advocates, can affect policy. The next step is to figure out how to translate this policy into action.

—Anna Kobylianskii, B.H.Sc. (Class of 2013)

Unraveling the prioritization of maternal health fosters an appreciation of the complexity of global health decision-making. The diversity of factors – including individual advocates, international bodies, statistical indicators, and socially resonating frames – illustrates this concept.

—Kaitlyn Boese, B.H.Sc., Class of 2013

of the 1997 Technical Consultation.[10] As such, the availability of evidence refined the list of proposed solutions and corroborated the prioritization of maternal health.

How was MDG 5 Included among the List of Eight MDGs?

Incorporating maternal health in the International Development Goals (IDG)

Amid the maternal health conferences of the 1980s and 1990s, multiple UN summits were held to address and prioritize a variety of other global issues. In 1995, the limited international resources for development aid prompted the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), which promotes global economic and social well-being, to form the Groupe de Réflexion (GDR).17 Motivated by their belief that economic growth is indispensable for reducing poverty, OECD tasked the GDR with compiling a list of focused targets by using declarations from past UN summits to effectively allocate funds for development aid.[23] Given their values of economic and social development, along with the evidence-based declarations from the various safe motherhood conferences, the OECD included improving maternal health within the list of focused targets. Eventually, the targets evolved into the OECD's seven inter-related International Development Goals (IDGs), specified in its 1996 report Shaping the 21st Century.[24]

Promoting the IDGs

Despite endorsement at OECD ministerial meetings and by the G7, the IDGs did not resonate in OECD member countries or in the developing world.[17] Clare Short, the U.K. secretary of state for international development, took this opportunity to champion the IDGs and ignite global interest. At the time of Short's appointment, the New Labour Party government was committed to development and global poverty. As well, the U.K.'s major NGOs, including ActionAid and Oxfam, were effective at selling these causes to the British public. This created a policy window for Short to use the IDGs to systematically reduce poverty.[17] Indeed, they provided the basis for her 1997 White Paper, Eliminating World Poverty: A Challenge for the 21st Century. She sold the IDGs to cabinet colleagues, international donors, and development agencies.[25] Furthermore, Short became a member of the Utstein Group, along with three other development ministers from Germany, the Netherlands, and Norway. They promoted the policy thrust of the IDGs as the means against world poverty, and their message carried through to the UN's planning of the Millennium Assembly.[17]

While the Utstein Group promoted the IDGs, the UN was also keen to develop a specific set of targets for the upcoming Millennium Assembly. Then–Secretary General, Kofi Annan, seized this policy window to produce a cohesive document called We the Peoples in hopes of shaping the global agenda and achieving international consensus. Annan's paper, however, had very different poverty reduction goals than those of the IDGs. Specifically, maternal health was excluded due to opposition by certain G7 members.[17]

Other big actors – namely, the World Bank, the IMF and the OECD – felt that the IDGs were advantageous to Annan's targets. To demonstrate UN coordination with other organizations, and to appease dissatisfaction from women's groups and reproductive health advocates regarding the omitted goal, Annan signed up to the DAC's IDGs.[17] Returning focus to the IDGs meant maternal health resumed its position at the forefront of the global agenda, leading to the explicit decision to include this goal in the *Millennium Declaration*.

Translating the IDGs into MDGs

In planning for the September 2000 Millennium Assembly, Annan's We the Peoples indicated the UN's vision for the event.[17] Meanwhile, the IMF, World Bank and OECD formed a strong policy network given their shared goal for poverty reduction through economic growth, and promoted the IDGs for the Millennium Assembly. In June 2000 the UN joined this policy network to demonstrate international cooperation, and the four major development multilaterals released A Better World for All (ABWA), which reiterated the DAC's IDGs.[26] Since the IDGs set precise goals and argued for monitoring, they created a policy legacy that strengthened the administrative capacity for the goals of the ABWA. Over the summer of 2000, UN civil servants incorporated the goals specified by ABWA in the drafting of the *Millennium Declaration*.[18] Most significantly, on September 8, 2000 the UN General Assembly approved the *Millennium Declaration*. Finally, Annan's 2001 report *Road Map towards the Implementation of the United Nations Millennium Declaration* outlined the MDGs from the resolutions of the *Millennium Declaration*, which included improving maternal health.[27] Ultimately, the most influential external event was the inauguration of the new millennium, which was an "unprecedented opportunity to raise ambitions and open up political space for key issues that have not made enough progress." This event propelled the UN's Millennium Assembly, which marked the culmination of the consensus reached over the previous decade, and allowed for the final drafting of the MDGs, including maternal health.

The Role of Advocacy Strategies

Throughout the political analysis of MDG 5, it is clear that advocacy, both through individuals and organizations, played a pivotal role in its adoption; the strategies they used serve as valuable guiding lessons.

Convening global conferences was one of the key advocacy strategies that drew attention, prioritized and led to the adoption of MDG 5. Prior to the 1970s, women's issues were often neglected on the world stage.[5] However, the 1975 World Health Assembly in Mexico City provided an environment to discuss the issue by requiring all countries to come together to discuss women's rights.[5] This initiated a series of subsequent conferences, such as the 1980 Second World Conference on Women in Copenhagen, and the 1987 SMC in Nairobi, which together created the policy window for maternal health's adoption on the global agenda.[28] Subsequent conferences, such as the 1994 ICPD conference in Cairo, the 1997 Technical Conference in Sri Lanka, and other regional conferences, served as benchmarks for progress and accountability.[11,28] Finally, the 2000 Millennium Assembly provided another policy window to take action and create MDG 5.[11,25,28]

Individuals also played a tremendous role in advocating for maternal health. Health professionals such as Rosenfield, Maine and Fathalla, used diverse strategies to promote maternal health.[13] Rosenfield and Maine's decision to gain the support of the UN and World Bank helped acquire greater convening power. By targeting institutions that have significant influence, Rosenfield and Maine were able to initiate a global movement that developed the IAG.[6,25] On the other hand, Fathalla advocated for maternal health through his iconic video Why did Mrs. X die? which employed media and the power of storytelling to shift the global view of maternal mortality from a strictly medical problem, to one with roots in the sociopolitical domain.[29]

By promoting maternal health as an issue relevant to the world – not just health professionals – other political figures also served as significant advocates. For instance, Clare Short was able to use her status to meet with many major donors and development agencies to validate the importance of

A mother and child in Punjab (Amritsar, India). Mike Reys, 2007.

Publication of *Lancet* article "Maternal mortality—a neglected tragedy" by Rosenfeld and Maine

1985

Safe Motherhood Initiative's *Technical Consultation* fosters cohesion through formation of 10 key, evidence-based action messages

1997

Agenda-setting

1975

International Women's Year in Mexico City, and launch of *International Decade for Women*

1987

World Bank, WHO, and UNFPA sponsor *Safe Motherhood Conference* in Nairobi and launch Safe Motherhood Initiative

Political prioritization

1987

UN Inter-Agency for Safe Motherhood (IAG) formed, and sponsors many conferences between 1987 and 1994

1998

World Health Day devoted to promoting safe motherhood

the IDGs.[25] By channelling her "energy, intellect and passion" into her campaigning, she was able to convince African and Asian heads of states to agree with her ideas, many of whom initially showed apathy toward the IDGs.[25]

At the turn of the millennium, maternal health was included within the most influential international development list owing to the abundance of advocacy efforts.

Conclusion

The process by which MDG 5 was included in the MDGs is complex and multifaceted. For that reason, the Kingdon, Shiffman, and 3-I frameworks can be used to contextualize the policy development process of MDG 5. The historical antecedents of maternal health, such as the UN Decade for Women and the SMC, propelled maternal health onto the global health agenda. Subsequently, support from key actors, framing of improved maternal health as a human right, and the proposed solutions through the SMI increased the precedence of maternal health in the global health agenda. Finally, by using the Millennium Summit in 2000 as an influential event, Kofi Annan collaborated with IMF, OECD and the World Bank to include maternal health in the formulation of the MDGs from the OECD's IDGs. Throughout the policy development process, political actors and organizations used advocacy tools to collectively support the inclusion of improving maternal health among the MDGs. As the 2015 deadline for the MDGs approaches, an understanding of the development and advocacy of maternal health among the MDGs is essential to future policymaking.

Key Messages

- Directing attention to the plight of maternal health in developing countries requires the creation and use of effective tools to monitor and estimate maternal mortality.
- To build on progress in improving maternal health, a champion with the necessary reputation and knowledge is needed to mobilize public and political support, promote coalitions and invest the time required.
- A common understanding and continued collective effort among global institutions invested in maternal health is essential to initiate and implement potential solutions.

Decision-making

1996

OECD releases report *Shaping the 21st Century* for global poverty reduction, which includes maternal health in International Development Goals (IDGs)

1997

Clare Short endorses the IDGs in her white paper, *Eliminating World Poverty: A Challenge for the 21st Century*

2000

UN, IMF, World Bank and OECD reiterate and promote IDGs in their report, *A Better World for All (ABWA)*

Outcome

2000

At Millennium Assembly, UN affirms *Millennium Declaration* (which incorporated goals of *ABWA*); it provides resolutions for formulation of MDGs, which, ultimately, includes reducing maternal mortality

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Immunization is an effective means of improving child health by protecting children against vaccine preventable diseases. Army Medicine, 2012.

Chapter 2

A Political Analysis of the Decisions that Led to the Creation of the Global Alliance for Vaccines & Immunisation (GAVI)

Adriana Di Stefano, Jennifer Pearson, Karthiha Raveenthiran, Usman Tarique and Daniel Tae Oh Yoo

Abstract

Background

Immunization is an effective means of improving child health by protecting children against vaccine-preventable diseases. The Global Alliance for Vaccines and Immunisation (GAVI) was established in 2000 to expand the use and supply of existing and new vaccines. While previous childhood immunization initiatives were cost-effective and successful during their early stages, their achievements eventually declined and no longer received international attention. Thus, a new immunization program that garnered the support of the international community was needed. This paper provides a political analysis and rationalization of events leading up to and surrounding GAVI's creation.

Methods

The inclusion and prioritization of childhood immunization on the global agenda and the decision to establish GAVI was analyzed using Kingdon's multiple streams agenda-setting framework, Shiffman's political prioritization framework, and the 3-I multi-causal framework. Information was gathered from various academic databases and through interviews with experts who were instrumental in GAVI's creation.

Findings

The inclusion of childhood immunization on the global agenda resulted from the failures of previous programs and declining immunization rates during the mid- to late-1990s. The issue was prioritized as a result of convening key players and the cost-effective nature of vaccines. GAVI's creation was primarily a response to a $750-million USD grant put forth by the Bill and Melinda Gates Foundation to fulfil the right of every child to be protected against vaccine-preventable diseases. Advocacy efforts on behalf of key organizations helped fuel the idea of a new public–private partnership focusing on vaccine supply and delivery.

Conclusion

A set of complex factors led to the inclusion and prioritization of childhood immunization on the global agenda, ultimately resulting in the formation of a public–private partnership: GAVI. Advocacy efforts that contributed to GAVI's development included convening key players, lobbying and acquiring financial support.

Keywords

GAVI, vaccines, immunization, policy frameworks, advocacy, global health

Introduction

Throughout the 1990s, a global movement for improving child health contributed to the inclusion of childhood immunization on the global agenda. Between March 1998 and July 1999, this issue was quickly prioritized, followed by actions to develop a new global immunization initiative. In January 2000, the Global Alliance for Vaccines and Immunisation (GAVI) was launched to save children's lives by increasing immunization coverage through expanding the use of underutilized and new vaccines.1 With the support of major global health players, GAVI catalyzed a revolution in childhood immunization. Using Kingdon's,[2] Shiffman's,[3] and 3-I frameworks,[4] this paper presents a political analysis of the inclusion of childhood immunization on the global agenda, its prioritization, and the decision to create GAVI.

Inclusion of Childhood Immunization on the Global Agenda

History of immunization

The issue of childhood immunization was highlighted through focusing events, changes in indicators, and feedback from existing programs between 1974 and 1998. In 1974, the World Health Organization (WHO) established the Expanded Programme on Immunization (EPI) to build on ongoing achievements of the Smallpox Eradication Programme, which eradicated smallpox in 1977.[5,6] This milestone served as a focusing event and brought attention to immunization campaigns, indicating "that it was possible for the public health community to reach every person in the world."[7] The United Nations Children's Fund (UNICEF) and WHO Universal Childhood Immunization campaign increased coverage with the six traditional EPI vaccines (for diphtheria, pertussis, tetanus, poliomyelitis, measles, and tuberculosis) from five to 80%, from 1974 to 1990.[8] Evidence indicated that

about five million lives were saved annually through vaccines at the time.[9] Furthermore, the Children's Vaccine Initiative (CVI) was launched in 1990 to improve the global supply of existing vaccines, and facilitate dialogue between public and private sectors to develop new vaccines.[10]

Problems associated with immunization

In the early 1990s, a lack of political commitment, donor fatigue, and other emerging priorities such as HIV/AIDS, contributed to a funding shortage for childhood immunization.[11] Throughout the 1990s, the average vaccination coverage of children under five years of age fell from 80% to 74%. Statistics showed that children in developing countries were receiving half the number of traditional vaccines and virtually no newer vaccines compared to those in developed countries.[12] Previous successes of vaccination programs were dwindling, and the global community was looking to revitalize efforts to overcome this stagnation. Aware of vaccines' potential, there was global consensus around the value that all children should have equal access to vaccines.[13]

Political influences

During the late 1990s, the global community discussed strategies to achieve goals of poverty eradication through what would become the Millennium Development Goals (MDGs).[13] In order to reduce childhood mortality and eradicate poverty, universal coverage with effective, affordable interventions was needed, highlighting the importance of vaccines. As discussed during a key informant interview with Dr. Mark Kane, "people understood that this ability to reach everybody in the world was really the key to get global immunization going. . . . And this incredible vision that we could actually immunize all the children in the world was an amazingly vivacious vision."[7] Concurrently, the WHO had set a goal to eradicate poliomyelitis by

A young girl waits with her mother for a vaccination in Haiti (Cap-Haïtien, Haiti). Alex E. Proimos, 2012.

2000. This increased public awareness and a sense of urgency surrounding the deadline, contributing to a global movement to take action.[14] The congruency of the issue with global values and mood was conducive to addressing childhood immunization effectively.

Gaining policy attention

Diffusion of ideas and communication surrounding childhood immunization contributed to this issue's inclusion on the global agenda. The 1996 State of the World's Vaccines and Immunization report warned that if urgent action was not taken to close gaps in funding, research and immunization coverage, the world would face the reintroduction of old diseases and the emergence of new infections.[15] Appropriately, the 1997 Global Supply of New Vaccines Summit promoted public–private collaboration for a sustainable supply of affordable vaccines. Consequently, James Wolfensohn, the World Bank president, convened the First World Bank Summit, Vaccine Development and Delivery: Leadership for the 21st Century, in March 1998. Attendees included high-level representatives

from international organizations, philanthropic foundations, non-governmental organization (NGOs), the pharmaceutical industry and the academic community.[16] This meeting issued the stark warning that immunization was on the decline and in need of leadership.

Prioritization of Childhood Immunization within the Global Health Agenda

Convening powerful actors

The challenge of increasing immunization coverage by introducing newer vaccines and promoting further research demanded a coordinated global effort of influential actors who helped prioritize childhood immunization within the global agenda.

Using his convening power, Wolfensohn gathered major immunization players at the First World Bank Summit to revitalize immunization efforts with a new vaccine strategy and form a working group to consult additional stakeholders.[16] Bill and Melinda Gates then hosted a dinner in September 1998 for leading scientists to discuss strategies that could overcome barriers preventing children from receiving basic vaccines.[17] They challenged their guests to come back with breakthrough solutions. At the Second World Bank Summit in March 1999, stakeholders provided answers to the Gates' challenge. The working group established at the first summit had engaged in studies and consultations addressing immunization access and funding gaps.[16] At the time, CVI was merged into WHO's immunization program, identifying the need for a new body independent of WHO's influence in order to make progress in immunization.[18] The summit concluded that CVI should be replaced by an expanded successor body that was funded and supported by major actors in immunization. However, WHO perceived this as a means to shift their ownership of immunization programs to other organizations.[19]

During a key informant interview, Michel Zaffran, WHO representative in GAVI's working group, stated that: "At [the summit], WHO was represented by a high-level person . . . with instructions from WHO, for some reason, to not let anything happen, so he did not agree to any of the proposals."[19] As a result, WHO resisted CVI's abolishment, causing frustration among summit participants.[7,19] Nevertheless, as the directing and coordinating authority for health within the United Nations (UN), WHO's regional and national presence to provide leadership and technical support was crucial to guiding global immunization efforts.[16] In May 1998, WHO's newly elected Director-General, Dr. Gro Harlem Brundtland, was determined to revitalize WHO as a moral voice and leader in improving health worldwide.[14] This revitalization was essential because, according to reports, previous mismanagement of WHO under Director-General Dr. Hiroshi Nakajima had prevented global health actors from becoming strong advocates for programs housed within WHO.[17] Additionally, prior to Brundtland's appointment,

Bill Gates administers polio drops to a child in Chad (N'Djamena, Chad). Gates Foundation, 2011.

Summary Table

Agenda-setting	Political prioritization	Decision-making
Problems • Focusing event: smallpox eradication • Donor fatigue • Immunization rates decline **Policies** • Summits urge action, and encourage public–private collaboration **Politics** • Global goals to reduce childhood mortality • Polio eradication promoted sense of urgency	**Actor Power** • Coordinated global effort involving industry • Convening power of Wolfensohn and Gates **Ideas** • Shift in focus from developing new vaccines to delivery • Moral imperative and human right **Political contexts** • Drafting MDGs favours childhood immunization • WHO and UN as a platform for collective action **Issue characteristics** • Millions of children without immunization • Cost-effective and beneficial interventions	**Institutions** • Networks of international agencies • Forum for discussion • Existing administrative capacities of WHO and UN **Interests** • Financial support • Commitment of industry to provide low-cost vaccines • Intellectual leadership and national support **Ideas** • Technological boom • Belief in vaccines to improve child health • Global partnership models encourage commitment **External factors** • Increased availability of and need to distribute new vaccines • Global economic growth

hostility existed between WHO and international pharmaceutical companies.[7,19] According to Zaffran:[19]

> [After the second summit] several heads of [the pharmaceutical] industry wrote a joint letter to Dr. Brundtland, complaining about WHO's behaviour . . . raising the expectations at a very high level that something should happen. . . . When Dr. Brundtland realized that industry was so upset at the highest level, the levels of the CEOs of the companies, she wanted to establish a new tone of relationship between the WHO and the private sector to move forward.

By urging their support for a new partnership, industry leaders successfully brought WHO on board. Brundtland also played a role in diminishing hostilities which enabled future cooperation between these influential players and encouraged momentum in leading global immunization efforts.[7,19]

Additionally, at the organizational level, cohesion among the policy community with regard to prioritizing childhood immunization was evident through the integrated efforts of leaders, institutions and decision-makers, including the World Bank and the Bill and Melinda Gates Foundation (BMGF).

The World Bank exercised its role as an influential figure in global health by convening the First World Bank Summit, addressing WHO's lagging immunization efforts and expressing interest in a new initiative to raise the momentum of new vaccine introduction.[16] In 1998, BMGF took a major step by creating the Gates' Children's Vaccine Program (CVP) with a $100 million USD grant for the delivery of new vaccines administered by the Program for Appropriate Technology in Health (PATH).[20] By the time of the First World Bank Summit, the willingness of BMGF to fund a new initiative prioritized immunization on the global agenda, and conferred BMGF's increasingly important role in immunization.[21] Consequently, strong support from these decision-makers towards improving immunization coverage prioritized the issue on the global agenda.

Framing childhood immunization

Previous successful campaigns aiming to eradicate smallpox and poliomyelitis were widely celebrated and referenced by policy leaders as evidence of the effectiveness of immunizations.[7,19] However, as indicated through an interview with Richard Mahoney, formerly of CVI, there had been a shift in focus of the global vaccine community. "Even more important than the research and development to develop new vaccines . . . was the need to address the tremendous burden of providing vaccines to developing countries."[17] Even though one of CVI's main goals was novel vaccine development, bigger problems were evident with diseases such as hepatitis B, for which newly developed vaccines were available but not used in the most needy countries.[14] The policy community, composed of both the public and private sectors, agreed on the lack of vaccine delivery as the problem, citing insufficient funding and coordination as the major causes; they therefore pushed for an initiative that provided new leadership and adequate means of financing.[17,18]

Advocates externally framed commitment for childhood immunization as a moral imperative and basic human right to the public and decision-makers. They called on the moral obligations of wealthier nations and social responsibilities of private corporations with their capacity to make significant contributions to children's health.[22,23] Efforts eventually became coordinated in a crusade to immunize and protect children's rights.[23]

Political contexts of immunization

Policy windows and a global governance structure provided a platform for effective collective action, facilitating the prioritization of childhood immunization on the global agenda. Throughout the 1990s, UN members convened at conferences intending to establish consensus on solutions

Transit polio vaccination teams working at the Patna Junction railway station, picking up their vaccine boxes, vaccines, droppers and tally sheets at the start of their shift (Bihar, India). Gates Foundation, 2010.

Student Reflections

Successfully advocating in global health requires collaborated efforts of key champions, industry leaders and international organizations – factors present in many immunization initiatives, which have highlighted the possibility of reaching every person globally through public health.

—Karthiha Raveenthiran, B.H.Sc. (Class of 2013)

A child dying from a vaccine-preventable disease is repugnant in the developed world, while it is pervasive in developing countries. We need to create a sense of global community and care for all children as they are our own.

—Usman Tarique, B.H.Sc. (Class of 2013)

It takes more than a brilliant idea to solve the world's pressing concern of disparity in immunization. But with innovative leaders at the right time, there is a great potential for the global community to move forward in its vision to reach every child.

—Daniel Tae Oh Yoo, B.H.Sc. (Class of 2014)

Vaccines are a cost-effective and highly potent form of preventative medicine that can mean the difference between life and death for a child in the developing world. No matter the technology we possess, partnerships are essential for their effective global use.

—Jennifer Pearson, B.H.Sc. (Class of 2013)

It doesn't seem so significant when you hear that 'x' amount of dollars leads to 'y' amount of vaccines being delivered to a developing country – until it's your friend who is now able to be vaccinated. My passion comes from connecting with those who are the statistic.

—Adriana Di Stefano, B.H.Sc. (Class of 2013)

for global development issues. The process of developing the MDGs, many of which aimed to address child mortality, created global conditions that aligned favourably with the issue of childhood immunization.[13] This created a window of opportunity for policymakers and advocates to generate dialogue surrounding the goal of increasing immunization coverage, thereby prioritizing the issue among various decision-makers. However, this policy window required the leadership and decision-making power of international governing bodies, including the WHO and UN, to generate policies and programs.[7] These bodies participated in global public–private partnerships, enabling political leaders, academics and investors to convene and collectively discuss and prioritize childhood immunization.[24]

The appeal of immunization

The nature of the issue of immunization and its proposed solutions contributed to its prioritization on the global agenda. Indicators reflected the severity of this issue relative to other problems. In the late 1990s, approximately 30 million children born yearly had minimal immunization access, exposing them to infectious diseases.[25] The World Bank Report World Development Report 1993: Investing in Health demonstrated that immunization progress could be quantified over time.[9] It determined that immunization scored extraordinarily well on the measure of disability-adjusted life years and, as such, called for government spending to be redirected from specialized care to cost-effective interventions like immunization. Vaccines served as a clearly explained solution to the problem, supported by scientific evidence, as they were already being used successfully in developed nations. Moreover, the benefits of vaccines included disease prevention and removal of major barriers to human development through spillover effects. By reducing illness and long-term disability, vaccines generated savings for health systems and families.[26] These characteristics successfully portrayed childhood immunization as a cost-effective, highly beneficial intervention, justifying its prioritization on the global agenda among competing interests.

Explicit Decision to Create GAVI

The birth of technological utopianism

The knowledge and values surrounding vaccines played a role in the creation of GAVI. With the technological boom of the 1990s came an unprecedented global shift in societal ideologies.[27] This technological utopianism strengthened the belief that scientific innovations would influence international development efforts by "moving towards a technology-driven basis to healthcare."[28] In the late 1990s, the belief among UNICEF and other international agencies that the health of children in developing countries could be improved by vaccines influenced the decision to create GAVI.[29] GAVI differed from previous immunization programs as it aimed to not only expand the use of existing vaccines, but to also accelerate the development and introduction of new vaccines.[12]

Partnering up

During GAVI's formation, knowledge generated from other successful international programs shaped its structure. The Roll Back Malaria coalition and PATH served as models of global partnerships, encouraging commitment and accountability among alliance partners.[16] This resulted in a focused effort to form a partnership between public and private actors with a vested interest in global immunization. Consequently, the working group established after the Second World Bank summit launched a Proto-Board meeting which contracted GAVI's objectives, including cooperation between partnering agencies.[16,30]

Alignment of interests

Those who had a vested interest in GAVI had a broad range of pre-existing capacities including financial support, academic expertise and advocacy. This ensured comprehensive support towards GAVI's development.[28] Prominent leaders such as Bill and Melinda Gates, James Wolfensohn and Dr. Tore Godal – former GAVI CEO, and current special adviser to the Norwegian prime minister about global health issues – came together as policy entrepreneurs to address the issue of childhood immunization through GAVI.

Financial support of philanthropic foundations and societal interest groups was vital in creating GAVI. BMGF was a powerful supporter of vaccine initiatives, having established CVP at PATH. BMGF's donation of $750 million USD to establish the Children's Vaccine Fund for GAVI galvanized support from other leading organizations towards GAVI's development.[17] As Richard Mahoney stated, the donation "stimulated a group of people . . . to convene a meeting, where the idea of establishing GAVI was put together."[17]

In addition to support from NGOs and multilateral organizations, GAVI received endorsement from elected national officials in Canada, the Netherlands, Norway and the U.S. These countries expressed their belief in the new initiative by pledging a proportion of their international aid towards GAVI, ranging from $5–125 million USD within the first years of GAVI's launch.11

As major suppliers and developers of vaccines, pharmaceutical companies needed to be involved to form a strong public–private coalition. In meetings leading up to GAVI's formation, pharmaceutical industry leaders articulated key ideas which would form the core of the alliance. Jean-Jacques Bertrand, CEO of Aventis-Pasteur and representative of the International Federation of Pharmaceutical Manufacturers and Associations, announced that pharmaceutical companies would commit to GAVI's efforts by developing and providing low-cost vaccines.[31] This mutually beneficial agreement ensured that the pharmaceutical industry would now have a credible and sustainable market through new vaccine sales.[7]

Intellectual leadership was another important presence at the summits leading up to GAVI's creation. Dr. Gustav Nossal, Scientific Advisory Group of Experts chair, offered his expertise in vaccines to advise WHO and influence the decision to create GAVI.[32] Godal, director of the Armauer Hansen Research Institute and leader of GAVI's working group, was instrumental in forming the final compromise between main actors.[18,19]

Structured support

As GAVI aimed to create an alliance among international agencies, it required decision-making power and networks of institutions with the ability to affect global policies. The UN provided a forum for its Member States to discuss their views on the creation of GAVI through the General Assembly, the Economic and Social Council, and other committees. Other UN affiliates like the WHO and World Bank participated in public–private partnerships at the inter-governmental level through their established networks. The World Health Assembly made decisions and determined policies of WHO, allowing them to make recommendations on policies surrounding GAVI and facilitating its launch.[33] The existing administrative capacities of these institutions minimized the need for newer roles to be established, thereby increasing the likelihood of GAVI's creation.

Technological and economic influences

Two major external factors that contributed to the decision to create GAVI were technological and economic changes. Throughout the 1990s, despite the availability of newly developed vaccines, a lack of funds hindered their introduction into health

systems. Funding allotted for vaccines by UNICEF was depleted in the manufacturing of the six EPI vaccines for low-income countries.[14] The need to distribute vaccines served as a motivation to form a global alliance that could achieve this goal. Economic growth also played a major role in GAVI's creation. Various countries embraced capitalism and a new generation of leaders prioritized rebuilding their economies on the basis of capitalist principles, markets and privatized firms. Consequently, increases in productivity and innovations caused economic growth, which in turn affected pharmaceutical companies.[34] With further reason to take part in a public–private partnership, pharmaceutical companies played a significant role in GAVI's creation and were prepared to make vaccines available to developing countries at a low cost.[7]

Advocating for Immunization

Advocacy leaders, organizations and strategies played a key role throughout the process of including and prioritizing childhood immunization on the global agenda, and in the decision to create GAVI. In order to bring attention to the problems surrounding immunization, James Wolfensohn used his convening power to coordinate the First World Bank Summit, fostering policy community cohesion.[16] Framing childhood immunization as a moral imperative and basic human right helped garner attention and support of powerful institutions and leaders.[22,23] Bill and Melinda Gates advocated for this issue by hosting a dinner for vaccine experts and challenging them to develop a solution to declining global vaccination rates, if adequate funding was provided. By posing it as a challenge, they fuelled academics' passion for innovation. Additionally, their financial commitment to the cause drew substantial attention from influential agencies and governing bodies concerned with the issue of immunization.[17] Another strategy used to engage prominent organizations and leaders involved lobbying. As Dr. Mark Kane recalled, "AIDS, malaria and TB, the big three . . . dominated the discussion. . . . And so we had to do a lot of lobbying in politics to try to get increased funding through development agencies . . . and we were pretty successful."[7] Pharmaceutical companies and academics including Godal urged the commitment of leading institutions to address the issue of childhood immunization through GAVI by engaging them in persuasive dialogue.[18,19] Furthermore, GAVI's structure strategically ensured that the autonomy and interests of existing key players, particularly the WHO and UNICEF,

World Bank report *Investing in Health* highlights cost-effectiveness of vaccines

1993

Bill and Melinda Gates host a dinner for leading scientists to discuss strategies to overcome childhood immunization barriers

1998

Agenda-setting

1990

Children's Vaccine Initiative launched to improve global supply of existing vaccines and facilitate dialogue to spur new vaccine development

1997

Global Supply of New Vaccines Summit promotes public–private collaboration for sustainable supply of vaccines

Political prioritization

1998

James Wolfensohn, president of World Bank, convenes key global players in vaccine community at *Vaccine Development and Delivery* summit, where a working group is established

1998

Children's Vaccine Program established with $100 million USD grant from the Bill and Melinda Gates Foundation (BMGF) for the delivery of new vaccines

remained intact. It was proposed that these organizations would have a seat on the GAVI board and would appoint the first director.[19] Collectively, these strategies allowed key players to advocate to include and prioritize immunization on the agenda, and eventually to make the decision to create GAVI.

Conclusion

GAVI is a global initiative that continued the efforts of previous immunization campaigns. Such an initiative would not have been possible without support from key players and organizations, as well as the global political environment in which it was born. Decreasing immunization rates through the 1990s garnered the attention of organizational leadership through various summits, prompting revitalization of immunization efforts. Within the favourable political environment of devising the MDGs, various actors saw moral reasons and evidence of vaccines' effectiveness to prioritize childhood immunization on the agenda. Eventually, consensus regarding the effectiveness of technology and global partnerships, in addition to the continued support of interest groups, influenced GAVI's creation. This was further motivated by economic growth and the urgent need to distribute newer vaccines. GAVI's formation was facilitated by active advocacy efforts that brought these key players together, and allowed for better coordination of global immunization efforts in the new millennium. This was necessary for an issue that is an important determinant of child health unconstrained by traditional national borders.

Key Messages

✏ The commitment and cohesion of all major players by means of a partnership is highly beneficial to the development and scope of an initiative.

✏ Having a committed source of financial endorsement acts as a catalyst for further support, thereby increasing the likelihood of successful new initiatives.

✏ Program proposals are strengthened by highlighting previous successes, cost-effective approaches, and evidence-based solutions.

Decision-making

1999

Meeting of the GAVI Proto-Board held to contract its objectives, including co-operation between partnering agencies

1999

Second World Bank Summit held after working group engaged in research studies and consultations to lay foundations for a new coalition

1999

BMGF pledges to donate $750 million USD over five years for the creation of the Global Fund for Children's Vaccines

Outcome

2000

The Global Alliance for Vaccines and Immunisation (GAVI) is established

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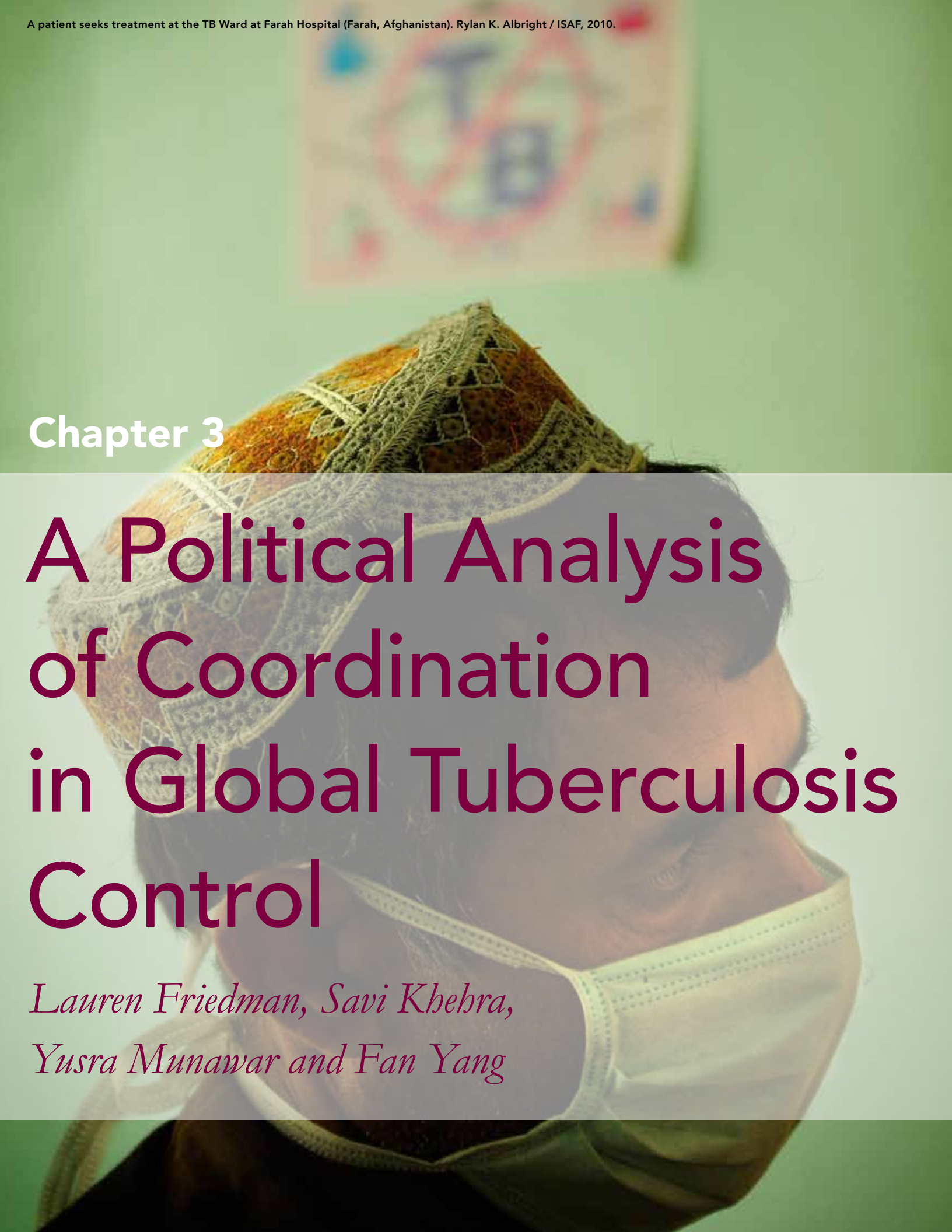
A child receives an oral vaccine (Legazpi City, Philippines). Kenneth Pornillos, 2011.



A patient seeks treatment at the TB Ward at Farah Hospital (Farah, Afghanistan). Rylan K. Albright / ISAF, 2010.

Chapter 3

A Political Analysis of Coordination in Global Tuberculosis Control

Lauren Friedman, Savi Khehra, Yusra Munawar and Fan Yang

Abstract

Background

Throughout the 1990s, tuberculosis (TB) garnered international attention as a major public health issue. TB rates worsened as the HIV pandemic created greater TB susceptibility, and the emergence of multidrug-resistant TB (MDR-TB) posed a treatment problem. The WHO's 1998 London meeting on the TB epidemic proposed increased collaboration in TB control. The Stop TB Partnership and the Global Plan to Stop TB were established in 2001 to facilitate international coordination.

Methods

Research was conducted using LexisNexis, Google Scholar and major organization websites. Kingdon's multiple streams framework, Shiffman's political prioritization framework, and the 3-I multi-causal policy choice framework were used to analyze the decision-making process.

Findings

The idea of a coordinated plan for TB control was placed on the global agenda in 1998, when increasing rates of TB infection and problems with the DOTS treatment strategy were identified. Prioritization from 1998 to 2000 occurred as a result of strong cohesion within the TB policy community, and the framing of TB as an urgent, economic issue. The Stop TB Partnership and Global Plan were chosen as the official strategies in 2001, partially as a result of benefits for vested stakeholders. Key advocacy strategies, which capitalized on the political atmosphere and problems in past policies, were crucial in the decision-making process.

Conclusion

The policy frameworks were effective tools for identifying key factors – including the global urgency created by the TB epidemic, availability of an effective cure, and involvement of key advocates – that influenced the implementation of coordination in TB control.

Keywords

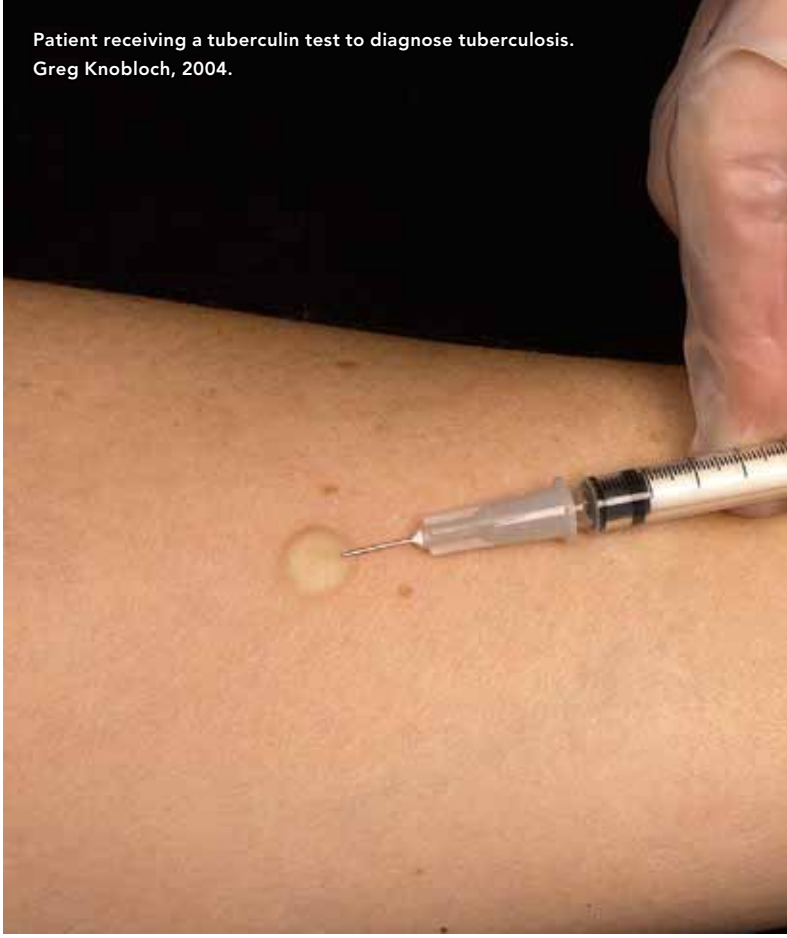
tuberculosis, Stop TB Partnership, Global Plan to Stop TB, policy frameworks, advocacy, global health

Introduction

Tuberculosis (TB) was a neglected disease in the latter half of the 20th century.[1] However, a rise in global TB incidence prompted the World Health Assembly (WHA) to set specific TB control targets in 1991. Over time, it became evident that a majority of high-burden countries, comprising 80% of the global TB burden, would not meet these targets by the 2000 deadline.[2] In response, the World Health Organization (WHO) convened in 1998, in London, a meeting of the First ad hoc Committee on the TB Epidemic, where the idea for coordination in TB control was proposed. After the London meeting, key events garnered increased support for the coordinated plan. For example, the Amsterdam Ministerial Conference on TB and Sustainable Development in 2000 convened countries with a high TB burden and called for accelerated action in TB control. This increased attention led to the First Global Stop TB Partners' Forum in 2001, where the Stop TB Partnership was established.[3,4]

The Stop TB Partnership embodied the vision for global coordination as its members included disease-burdened and donor countries, researchers and international non-governmental organization (NGOs). The Partnership facilitated discussions on how to develop a strategic plan to tackle TB, and the first Global Plan to Stop TB (2001–2005) was launched as a result. The Global Plan realized the vision for a coordinated plan to address the prevalent challenges faced by TB control.[4]

The events leading up to these decisions will be used to analyze how the idea of coordination in TB control was placed on the global agenda, prioritized, and then chosen as the most effective solution. In order to accomplish this, the events will be analyzed according to Kingdon's multiple streams framework, Shiffman's political prioritization framework, and the 3-I multi-causal framework, respectively.[5–7]



Patient receiving a tuberculin test to diagnose tuberculosis.
Greg Knobloch, 2004.

Placing TB Control on the Global Health Agenda

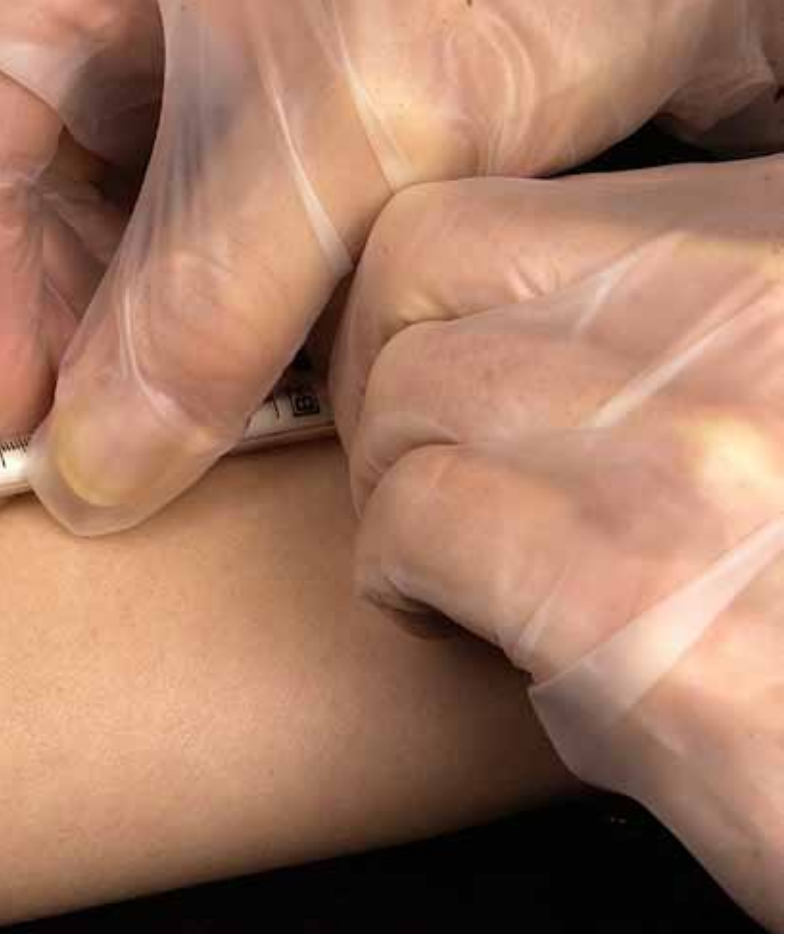
In 1998, the London meeting was held to discuss improvements in TB control amid rising TB rates, failing treatment programs, and a new political environment.[4] An in-depth analysis of events during this time, using Kingdon's framework, highlights how the issue of TB, coupled with the idea for a coordinated plan, got on the global agenda.[5]

Problems

In 1990, there were eight million new TB cases, and three million TB-related deaths.[8] The WHO responded in 1995 by endorsing the DOTS treatment strategy, a program consisting of a six-month drug regimen taken under direct observation to ensure proper administration.[3,9] However, progress in 1998 was minimal in at least 16 of the 22 identified high-burden countries.[10] Donor countries were also concerned, as the spread of TB across borders was causing national security and economic issues.[11] Dr. Lee Reichman, former member of the Stop TB Advocacy Advisory Committee, explained the sentiments surrounding TB in 1998: "TB was, in fact, an economic development and tourism problem rather than just a health problem."[12] In 1997, the Global Monitoring Report was released to assess progress towards the WHA goals, set out in 1991, of achieving a 70% detection rate for TB, and an 85% cure rate in positive patients. The Report recognized that these targets would not be met by the 2000 deadline.[13] Additionally, the 1997 Global Project on Anti-TB Drug Resistance Surveillance found significant global levels of multidrug-resistant tuberculosis (MDR-TB).[14] Resistant strains increased treatment costs by a hundredfold.14 Moreover, the growing HIV/AIDS pandemic was increasing the susceptibility of contracting TB, thereby causing a surge in TB incidence rates.[3] As Reichman explained, "AIDS facilitates TB and TB facilitates AIDS."[12] These findings set an urgent tone in the TB policy community, which consisted of a group of stakeholders with strong interests in TB control.[8] Consequently, comparing the state of the issue with goals set by the WHA allowed decision-makers to frame TB control as a global issue requiring urgent action.

Politics

The political atmosphere in 1998 helped to launch the idea of a coordinated plan for TB control on the global agenda. Specifically, the election of Dr. Gro Harlem Brundtland as director-general of WHO presented a unique opportunity for the London meeting participants to consolidate known information and bring the idea for a coordinated plan to the new director-general.[8] Furthermore, in referencing the 1997 TB Drug Resistance report, the London meeting proceedings reflect a shift in the global mood to increased urgency. It became apparent that MDR-TB needed to be dealt with before TB treatment became too complicated and expensive.[15,16] The combination of Brundtland's election and the shift in the global mood created a policy window to elevate the idea of a coordinated plan for TB control to the global agenda.



Policies

To develop a new, successful TB control approach, past approaches needed to be analyzed. First, Dr. Carlyle Guerra de Macedo, chair of the 1998 London meeting, examined policies from the 1980s, a time when WHO embraced horizontal programs.[9] However, there were clear challenges with such programs, including minimum participation and a lack of funding.[9] Thus, WHO adopted DOTS, a vertical program, in 1995.[3] However, this approach was unsuccessful; the 1997 Global Monitoring Report indicated that only 11% of cases were treated by DOTS despite its theoretical 78% cure rate.[13] Feedback from the DOTS program showed a need for political participation and increased collaboration between sectors. Taking this into account, stakeholders at the London meeting suggested an integration of vertical programs and called for a coordinated partnership.[8,9] This new plan, a combination of horizontal and vertical approaches, was deemed technically feasible as it incorporated aspects of previous plans.[9] Specifically, it was to bring together various existing vertical efforts, including research, DOTS and drug access, under one plan.[9]

In summary, clear issues with past TB control strategies, high TB prevalence and resistance, and a new political environment facilitated the adoption of a coordinated plan to fight TB on the global agenda.

Prioritizing TB Control on the Global Health Agenda

The idea for increased coordination in TB control continued to gain traction after the 1998 London meeting until the early 2000s. At the Amsterdam Conference in 2000, stakeholders demonstrated increased political commitment to the idea of a coordinated plan.[9] Shiffman's framework is used to analyze this prioritization.

Actor power

A policy proposal must involve multiple actors with significant influence in order to be prioritized.[6] Dr. Marcos Espinal, former executive secretary of the Stop TB Partnership, explained the nature of the collaborative effort in TB control: "WHO couldn't do it alone and needed help . . . from . . . civil society, private sector, multilaterals."[17] WHO Director-General Brundtland had substantial influence in the WHO and recognized that global TB prevalence was drastically increasing due to MDR-TB and the HIV/TB co-pandemic. Her influence was demonstrated when she united powerful stakeholders at the 1998 Global Conference on Lung Health and launched the Stop TB Initiative.[4] With members such as the United States and WHO, the Initiative was influential and served as a guiding authority for the coordinated plan.[18] In addition, Brundtland emphasized the influence of civil society organizations, such as the International Union Against Tuberculosis and Lung Disease (IUATLD).[19] As a large international NGO, the IUATLD provided TB services to more than 40 countries and was a key stakeholder in global discussions surrounding the coordinated plan.[17] Apart from influential leaders, the plan also gained strength from increased decision-maker support as a result of

Tuberculosis-free health camp. Birjusis, 2006.

Summary Table

Agenda-setting	Political prioritization	Decision-making
Problems • MDR-TB and HIV/AIDS are urgent threats • Slow progress towards WHA targets **Policies** • A new plan – combining horizontal and vertical programs – is needed **Politics** • Combination of Dr. Brundtland's election, and shift in global mood creates policy window	**Actor Power** • Dr. Brundtland plays leadership role in uniting powerful stakeholders to combat TB **Ideas** • The urgency of TB framed as economic issue to encourage commitment of political leaders **Political contexts** • Stop TB initiative garners global attention on economic devastation caused by TB **Issue characteristics** • TB is eighth-most cause of death, and has cost-effective cure, through effective DOTS strategy	**Institutions** • A coordinated action plan called for by all TB control bodies • Administrative capacity exists within Stop TB Initiative **Interests** • TB-endemic countries benefit from pooled resources, new research • Donors protected from spread of TB **Ideas** • New programs like Global Drug Facility struggle to reach goals • Stakeholders call for international collaboration **External factors** • *26th G8 Summit* calls for a global plan to tackle diseases such as TB

consensus regarding the severity of the issue.[20] For example, the Amsterdam Conference produced the Declaration to Stop TB in 2000, which received unanimous support from the 20 highest burden countries, and was later endorsed by G8 countries and the WHA.[21] Overall, the strength of key actors and increased support from decision-makers ensured greater coordination in TB control was prioritized.

Issue characteristics

In 2000, TB was the eighth leading cause of death worldwide.[22] However, unlike other diseases, TB had a cost-effective cure: DOTS.[21] Nevertheless, the window of opportunity for using DOTS was closing. At the Amsterdam Conference, the second report on Anti-Tuberculosis Drug Resistance in the World provided evidence for the alarming trends of MDR-TB. Confirming the worst fears of policymakers, this report emphasized the urgency of fighting the TB epidemic to avoid the increased cost of addressing drug-resistant strains.[21] Additionally, it was found that the DOTS strategy on its own was insufficient to treat TB in areas endemic with HIV due to a lack of infrastructure, political support and funding.[23,24] The coordinated plan would be effective in addressing these challenges, as exemplified by the success of sector coordination during the 1989 MDR-TB outbreak in New York.[24,25] Furthermore, it was proposed that coordination would provide a cost-effective means of funnelling and re-allocating funds.[26] Overall, the urgent nature of TB, in conjunction with the viable, cost-effective solution, facilitated the prioritization of a coordinated plan to fight TB.

Ideas

Due to the rising TB incidence worldwide, there was consensus within the TB policy community on the urgency of the matter.[27] The urgency was fuelled by the expanding HIV/AIDS epidemic and the knowledge that travel was increasing the spread of TB.[11] The rising prevalence of MDR-TB also prompted health experts, such as Dr. Lee Reichman, to identify the encroaching possibility of a time when TB could no longer be cured.[11] In understanding the potential of a coordinated plan to effectively combat TB, academics and advocates within the policy community agreed that a rapid acceleration of efforts was needed to achieve the global TB reduction targets.[27]

Key actors, including Brundtland, externally framed TB control as an economic issue to political leaders at the Amsterdam Conference.[19] A report released by the Stop TB Initiative in 2000 revealed that 75% of TB patients were between the ages of 15 and 54, comprising a majority of the workforce. This data demonstrated that TB patients lost an average of three to four months of work, reducing annual household income by 20–30%.[27] Framing TB as a major obstacle for sustainable economic growth increased political commitment to the idea of coordination of TB efforts.

Political Context

The political environment from 1998 to 2000 facilitated the establishment of a coordinated plan for TB control.[7] First, WHO created the Stop TB Initiative at the Global Conference on Lung Health in 1998.[27] The Initiative functioned as a small precursor to the Partnership and published reports that brought global attention to the economic devastation caused by TB.[27] Additionally, it provided a forum to rally various stakeholders and to strengthen commitments to TB control. For example, the Initiative hosted the Amsterdam Conference, which produced a declaration from endemic countries agreeing to meet the WHA's TB control targets by 2005.[3] Moreover, an additional governance structure, the Interim Coordinating Board, was set up at this Conference to develop the Stop TB Partnership Framework.[3] Thus, the formation of governance structures created a policy window for the prioritization of a coordinated plan to fight TB.[6]

Overall, the collaboration among key actors, consensus within the policy community, and effective

Firland tuberculosis hospital beds (Seattle, USA). Seattle Municipal Archives, 1927.

Student Reflections

Experience reminds me that more numerous than global health issues are the barriers that impede their resolutions. However, the noble efforts of TB advocates shows that change requires persistent hard work and collaboration.

—Lauren Friedman, B.H.Sc. (Class of 2013)

In order to tackle global health challenges, we need to collaborate on a global level. As exemplified in global TB control, coordination on a macro level is critical for progress.

—Savi Khehra, B.H.Sc. (Class of 2013)

We saw how the TB policy community called for a global plan and, with strong leadership, created an international partnership and action plan. You will appreciate their dedication to the cause, willingness to collaborate, and motivation to see a plan through.

—Yusra Munawar, B.H.Sc. (Class of 2013)

When we travel to TB-endemic countries, we witness the struggles, realizing the challenges faced by humanity. However, when we step back and look at TB from a global health advocacy perspective, we leave humanity behind and all that is left is politics. Let us bring it back.

—Fan Yang, B.H.Sc. (Class of 2013)

external framing in the presence of a favourable political environment prioritized the idea of a coordinated plan to fight TB.

Enacting Policies for TB Control

The First Stop TB Partners' Forum was held in October 2001, where stakeholders endorsed the Stop TB Framework and developed the Global Plan to Stop TB.[28,29] An analysis according to the 3-I framework reveals why these decisions were chosen over alternatives.

Ideas

After the Amsterdam Conference, various efforts were initiated to curb the TB epidemic. Specifically, the Global DOTS Expansion Plan (GDEP), the Global TB Drug Facility (GDF), and the Global Alliance for TB Drug Development (GADD) were launched.[28,30] However, by 2001 it became clear that these programs were not sufficient and had obvious issues: the GDEP was facing resistance at national levels, the GDF needed additional funds, and a comprehensive plan was needed to tackle the threat posed by MDR-TB and HIV/AIDS.[28] Apart from what was known, the First Partners' Forum recognized shared values upheld by different stakeholders, such as the need for public awareness and adequate financial investment.[28] Advocates for TB worried that the opportunity for control would be jeopardized if MDR-TB spread uncontrollably.[11] Other stakeholders, including financiers, also valued the need for coordination. For instance, the philanthropist George Soros promised financial support for a coordinated plan based on a business model.[31] Dr. Marcos Espinal emphasized this value, explaining that "it was necessary to have a business plan . . . with clear goals, objectives, [a] clear mission and deliverables."[17] Consequently, knowledge of the issue, in combination with value statements about what was required, led to the implementation of the Global Plan and Stop TB Partnership.

Interests

To gather the support necessary for implementation, the coordinated plan needed to align with the interests of stakeholders.[7] It was important for key advocates, such as Brundtland, to benefit from implementation of the coordinated plan. Nevertheless, potential benefits of the plan were dispersed for Brundtland. On the one hand, Brundtland, as WHO director-general, had an interest in seeing a successful plan for TB control come to fruition. However, an effective plan would address only one of WHO's many health responsibilities.[12] Despite this, more direct benefits were identified by other interest groups at the Partners' Forum.[29] High-burden countries, such as Nigeria, would benefit because increased international support and pooled resources would enhance their national plans.[28,31] Donor countries, such as the U.S., would benefit by preventing TB, limiting its spreading across borders, as this would strengthen their national security.[11] As Reichman explained, "you can go anywhere in the world from anywhere else in the world in 24 hours. You can't keep people with TB out, and so they have to get treated all over the world."[12] Societal interest groups and researchers also discussed significant benefits, such as increased networking opportunities and the ability to share valuable, up-to-date information.[31] Additionally, researcher groups, such as the GADD, would benefit from increased investment and coordination.[31] These benefits substantiate why a coordinated plan was favoured.

Institutions

The TB policy community and governmental leaders played an integral role in developing and implementing the coordinated plan. The community consisted of many stakeholders, including funding bodies, research groups, and international organizations with strong interests in TB control.[4] While having many stakeholders could theoretically impede the decision-making process,

opinions had already been aligned due to previous events, such as the Amsterdam Conference. This facilitated the formation of the Stop TB Partnership.[4] Additionally, several programs, such as the GDF and GDEP, had already been launched prior to the establishment of the Global Plan.10 These initiatives developed the administrative capacities needed to create a more comprehensive, coordinated plan.[3,4] As substantial TB response capacity was already present from previous strategies, there was minimal hesitation towards the launch of the Stop TB Partnership and Global Plan.[7]

External Factors

Furthermore, external events provided momentum for the decision to implement a global partnership and plan. The 26th G8 Summit was held in July 2000, a few months after the idea for a coordinated plan had been prioritized at the Amsterdam Conference. At this summit, global health was introduced on the agenda for the first time, and leaders discussed the need for a "new global partnership to address the infectious diseases of poverty, including TB."[32] As a result, coordination in TB control gained further attention and strengthened commitment from key donors. Moreover, the United Nations released the *Millennium Declaration* in 2000, signed by 189 nations, confirming a commitment to eradicate extreme poverty. When stakeholders recognized the obstacle TB posed to such a commitment, political support for the TB Partnership increased further.[33,34]

Overall, a combination of prevalent knowledge and values, benefits for interest groups, existing administrative capacity, and external events allowed for the formation of the Stop TB Partnership and Global Plan.

Advocacy for a Global Partnership and Plan

In the early 1990s, there was a rise in TB levels due to inadequate TB control. Advocates and academics began constructing links between HIV prevalence and the obstacle it posed to TB eradication. Dr. Kevin de Cook, an infectious-diseases specialist, emphasized the need for a coordinated plan to fight the co-pandemic.[24,35–37] This idea was circulated by advocates in the academic community, and allowed London meeting participants to propose a solution for TB control. Championed by Dr. Guerra de Macedo, the committee outlined strategies needed to address the previous lack of political commitment. They identified four main advocacy strategies: aligning popular perceptions, building consensus on technical strategies, receiving feedback from local leaders, and using the mass media to create awareness.[8]

Following this, Dr. Gro Harlem Brundtland, as director-general of WHO, became a visible advocate for TB control and expanded the plan to a wider audience. The Stop TB Initiative was launched in 1998 to bring together groups who strongly believed in developing increased measures for TB control.[3] The Initiative aimed to coordinate advocacy efforts that would address the lack of political and financial commitment.[3] Additionally, the 2000 Amsterdam Conference was organized to strategically target high-burden countries and increase their commitment.[21] Another advocacy strategy used at this conference was humanizing the issue by sharing patients' personal experiences with TB.[21] Reichman highlighted the ability of this strategy to influence stakeholder commitment: "Most important are patients themselves who have the potential to be most powerful."[12]

As policymakers looked to implement coordination in TB control, advocacy strategies began targeting political leaders and financiers. Advocates from WHO and the World Bank used mass media to release public statements. For

A boy is given a physical exam. His community suffers from high tuberculosis rates, resulting from mining practices at a local quarry (Harayana, India). J. P. Davidson, 2009.

WHO declares TB a "global emergency"

1993

Election of WHO Director-General, Dr. Gro Harlem Brundtland

1998

Agenda-setting

1991

WHA sets resolution for TB control targets to be achieved by 2000

1995

WHO endorses DOTS as the TB treatment strategy

Political prioritization

1997

Release of the Global Project on Anti-TB Drug Resistance Surveillance

1998

Launch of the Stop TB Initiative at the *Global Conference on Lung Health*

example, a Massive Effort to Fight Diseases that Cause or Perpetuate Poverty was an advocacy forum held by WHO in 2000 to increase media attention and build support for global intervention.[3] As a result of the advocacy strategies, many countries and organizations attended the First Partners' Forum in 2001 to officially endorse the Stop TB Partnership and to launch the Global Plan to Stop TB.[30]

In analyzing the advocacy strategies, it is evident that the issue was lacking a key advocate throughout the decision-making process. However, the concerted efforts of several key advocates helped to implement the strategies surrounding coordination in TB control. In Dr. Marcos Espinal's words: "I would say [TB control] is a shared credit. It doesn't belong to one person."[17]

Key Messages

- Policy proposals must effectively address clearly stated and evidence-based issues to get on the global agenda.
- A favourable political environment, including cohesion within the policy community and support from key decision-makers, can facilitate the decision-making process.
- Advocates and advocacy tools, particularly strategic framing, can play a key role in advancing policy proposals.

Conclusion

In developing this political analysis, the three policy frameworks enabled a thorough examination of underlying factors behind the key events in the decision-making process. Overall, the potential devastation caused by TB, coupled with the availability of an effective treatment, put the idea of a coordinated plan for TB control on the global agenda in 1998. This plan was prioritized by the early 2000s, when it became clear that accelerated social and political action was necessary to alleviate the global burden of TB. The Stop TB Partnership fulfilled this need by providing a platform for international organizations, countries, donors, NGOs and researchers to join a cohesive campaign to fight TB. As the first integrated plan of action, the Global Plan to Stop TB increased the effectiveness and efficiency of TB control. Key advocates played a major role in advancements seen in the creation of the Stop TB Partnership and the Global Plan.

Decision-making

1998

Meeting of the *First ad hoc Committee on the TB Epidemic* in London, United Kingdom

2000

Formation of the Global Alliance for TB Drug Development, Global Drug Facility, and Global DOTS Expansion Plan

Amsterdam *Ministerial Conference on TB and Sustainable Development*

2000

Outcome

At *First Global Stop TB Partners' Forum*, formal endorsement of Stop TB Partnership and launch of Global Plan (2001–2005)

2001

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Scanning electron micrograph of Mycobacterium tuberculosis, bacterium which causes tuberculosis. NIAID, 2012.

The UN General Assembly Hall in the UN Headquarters (New York, USA). Basil Soufi, 2011.

Chapter 4

Money Matters for Malaria: A Political Analysis on the Inclusion of Malaria as part of the Global Fund to Fight AIDS, Tuberculosis & Malaria

Mohsin Ali, Michael Baxter, Allan Jone, Carson Lo and Jeffrey Wong

Abstract

Background

The Global Fund to Fight AIDS, Tuberculosis and Malaria was created in 2002 as the first international funding agency to use a public–private partnership to combat the most pressing infectious diseases in the world. This paper analyzes the historical antecedents leading to malaria's inclusion as one of the Global Fund's three foci.

Methods

Articles and events surrounding the issue were analyzed using Kingdon's agenda setting, Shiffman's political prioritization, and the 3-I policy choice frameworks. The information presented was gleaned from a literature review incorporating peer-reviewed articles, news stories, conference proceedings and other grey literature. Three key informants – Awash Teklehaimanot, Jeremy Shiffman and John Gallup – were interviewed.

Findings

In the early- to mid-1990s, the issue of malaria funding reappeared on the global agenda with the recognition of inadequate and dwindling funds. Global leaders convened at international conferences to provide a united political stance on the issue, culminating in the creation of a global initiative known as Roll Back Malaria. This placed the issue of malaria funding on the global agenda. The establishment and shortfalls of Roll Back Malaria, in conjunction with new research evidence highlighting the economic burden of malaria, forged consensus among stakeholders to prioritize malaria funding. With strong advocates for malaria such as Dr. Gro Harlem Brundtland and Kofi Annan coinciding with the inception of the Millennium Development goals, momentum garnered G8 support for the creation of, and malaria's incorporation in, the Global Fund as an evidence-based solution.

Conclusion

Advocacy strategies involving conferences, powerful actors and established academics ultimately allowed for a decision to incorporate malaria in the Global Fund, which provided a novel funding mechanism to address the need for malaria funding.

Keywords

Global Fund, malaria funding, Roll Back Malaria, policy frameworks, advocacy, global health

About The Global Fund

The Global Fund to Fight AIDS, Tuberculosis and Malaria was established in January 2002 as an independent funding mechanism to combat the three most pressing infectious diseases.[1] It is a global public–private partnership which funds local disease control and eradication efforts, rather than an implementing agency.[1] This paper focuses on malaria, analyzing the factors leading to its inclusion in the Global Fund. We examine how the issue of developing an independent funding mechanism for malaria control programs got on the global agenda,[2] how it was subsequently prioritized,[3] and the factors thereafer that influenced the decision to include malaria when establishing the Global Fund.[4]

Placing Funding for Malaria on the Global Health Agenda

The problem of malaria funding: inadequate and declining

The issue of developing an independent funding mechanism for malaria control programs came on the global agenda due to changes in indicators and feedback from existing programs. Indicators highlighted decreased public expenditures for malaria research and control efforts. It was emphasized that malaria received considerably less funding compared to asthma and HIV/AIDS. In 1996, key indicators reported asthma and HIV/AIDS research funding at $789 and $3274 USD per fatal case, respectively, whereas malaria research was a meagre $42 USD per fatal case.[5] Malaria funding was not only scarce, but also had dwindled over time. For instance, half of funding for malaria research stemmed from the United States, whose contributions were reduced by almost half over a decade: from $60 million USD in 1985, to $35 million USD in 1994.[6] Concomitant with this drop in funding, malaria control programs

noted the surge of drug- and insecticide-resistant strains of malaria, especially chloroquine-resistant strains, in the early- to mid-1990s.[5]

A favourable political atmosphere for malaria funding

This problem garnered international attention, not only in prominent newspapers such as The New York Times,[7] but also in a series of international conferences, reflecting the global mood to address the issue. Funding was especially emphasized. The U.S. National Institutes of Health organized the International Conference on Malaria in Africa, held in Dakar, Senegal, in 1997. This conference emphasized that a sustainable initiative to combat malaria in Africa required "long-term commitment . . . from governments and external funding institutions."[8] Similar sentiments were voiced at another conference that year, which convened African heads of state and government in Harare, Zimbabwe, pledging to "allocate sufficient human, financial and material resources, and mobilize other local resources including resources from non-governmental and private and civil sectors, for the sustained prevention and control of malaria in Africa."[9] The issue of funding for malaria control programs then garnered both global awareness and support.

Policies placing malaria funding on the agenda

In the early- to mid-1990s, a lack of funding for malaria control programs was recognized among political leaders and other stakeholders as a problem requiring attention. The 1992 Ministerial Conference on Malaria in Amsterdam published the Global Malaria Control Strategy, endorsed by many malaria–affected nations, WHO, and the UN General Assembly.[10] The Strategy emphasized that fragmented past policies left malaria poorly

A young child is being diagnosed with malaria (Nairobi, Kenya). Novartis AG, 2011.

funded, and proposed other funding mechanisms. In response to pressure by health ministers at World Health Assemblies, WHO scaled up annual malaria contributions by $10 million USD in 1996.[11] Despite these efforts, the aforementioned conferences in 19978,[9] and the 1998 G8 summit in Birmingham, U.K.,[12] stated that such policies were insufficient: a larger-scale, comprehensive approach was needed. These efforts culminated in a WHO–initiated partnership for malaria control, Roll Back Malaria (RBM), launched in 1998 by then–newly elected WHO Director-General, Dr. Gro Harlem Brundtland, an ardent champion of the initiative.[11] RBM would coordinate consensus on issues relating to malaria control, but did not address the need for an independent mechanism for funding malaria control programs. Awash Teklehaimanot, who served as the second interim director of RBM and has spent more than 13 years at WHO supporting malaria–endemic countries, stated:[13]

> [RBM] was very good – in terms of putting it on the globe that malaria is a serious health problem . . . . But basically, there was no meaningful amount of money coming

> . . . to undertake malaria control programs based on the 1992 Global Malaria Control Strategy. So we have to wait until 2002 . . . until the Global Fund.

Therefore, the need to fund malaria control programs, though placed on the global health agenda in the early- to mid-1990s, was not prioritized until after the creation of RBM.

Prioritizing Malaria Funding on the Global Health Agenda

RBM – no funds, no malaria control

Due to the lack of a comprehensive funding mechanism for malaria, RBM quickly faced doubts regarding its goal to halve malaria deaths by 2010.[14] This impending failure prioritized the issue of funding malaria. The annual budget of $100 million USD proved insufficient given the initial estimate of $1.5–$2.5 billion USD to reach RBM's goals.[14]

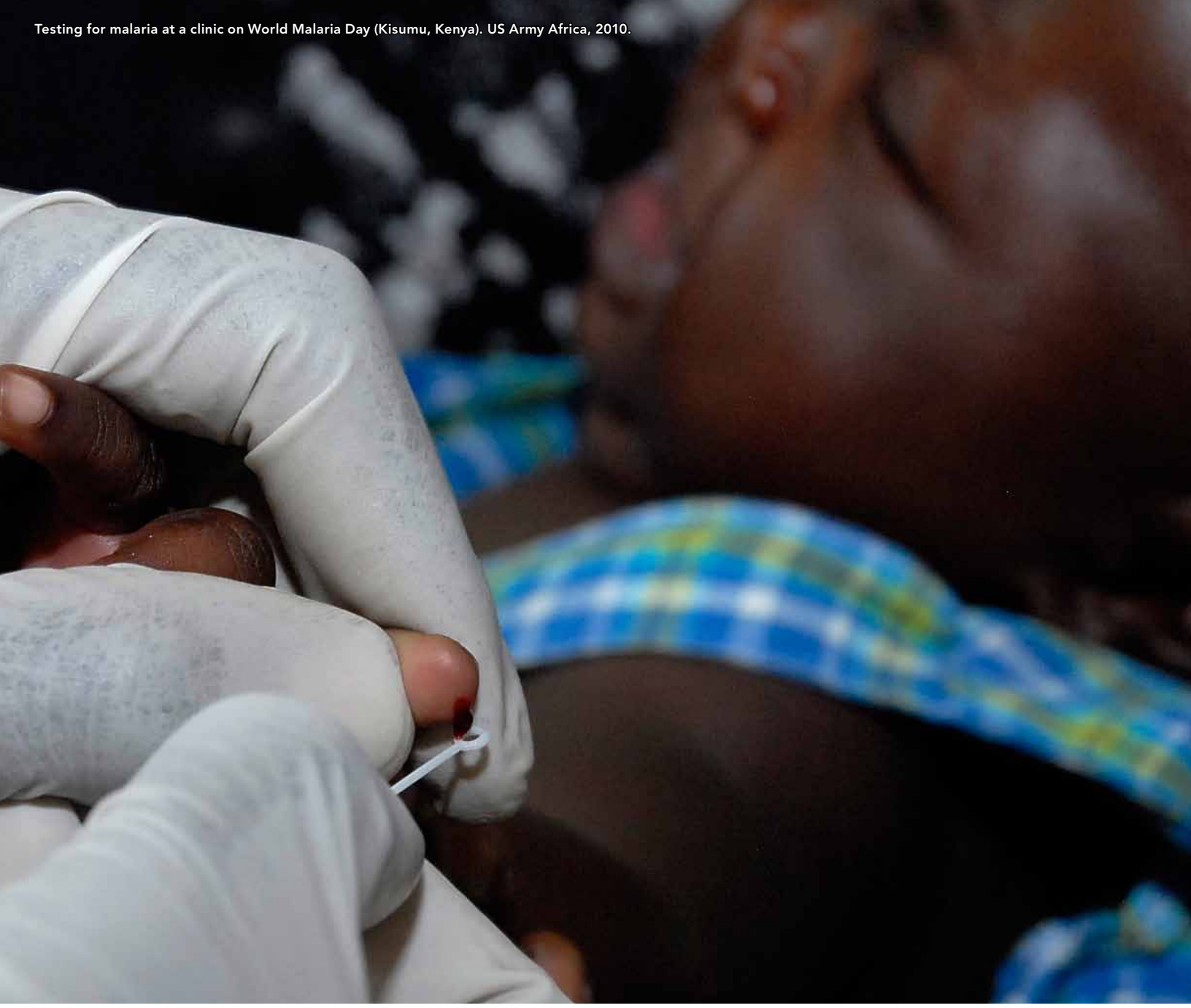
Other global initiatives at the time, such as polio eradication, solicited close to $1 billion USD from its donors within three years.[15] RBM's inability to sustain such levels of funding led to shortfalls,[14] hence, initiatives to provide a more robust and s

Powerful actors forging cohesion for malaria funding

Following the creation of RBM, the global momentum towards creating an independent funding mechanism for malaria was propelled by the favourable political atmosphere, initiated by the 1998 election of Brundtland. With the power of WHO as a guiding institution, Brundtland immediately championed malaria control, calling for attention and funding by creating a partnership between stakeholders such as UNICEF and the World Bank.[16,17] Her leadership also forged policy community cohesion and mobilized civil society groups via the Massive Effort Advocacy Forum in 2000.[18] As a discussion space organized by WHO, this forum gathered almost 200 representatives from non-governmental organizations (NGOs) and civil society groups to address methods for tackling diseases of the poor.[18] This spurred mobilization of advocacy networks to increase and improve funding mechanisms for diseases such as malaria. The support from said powerful actors provided a united stance for funding malaria and opened a policy window, providing a sense of legitimacy and urgency for the issue of malaria funding on the global agenda.

Abuja conference: A recommitment to funding malaria

The issue of malaria funding was effectively framed as an economic issue both internally within the policy community, and externally to donor organizations. Jeremy Shiffman, an academic who has written on the effort to control malaria, noted the advantage of framing issues as economic ones: it builds "a



Testing for malaria at a clinic on World Malaria Day (Kisumu, Kenya). US Army Africa, 2010.

Summary Table

Agenda-setting	Political prioritization	Decision-making
Problems • Decline in funding for malaria research & control • Concomitant surge of resistant strains **Policies** • *1992 Global Malaria Control Strategy* criticized, leading to creation of Roll Back Malaria **Politics** • Awareness and support for issue apparent in international conferences and major newspapers	**Actor Power** • Election of Dr. Gro Brundtland • *Massive Efforts Advocacy Forum* facilitated a united stance on malaria **Ideas** • Shift in internal and external frames from a public health issue to an economic issue **Political contexts** • Roll Back Malaria provides an existing structure to facilitate consensus within policy community **Issue characteristics** • Insufficient funding towards Roll Back Malaria • Promising source of funding from private sector	**Institutions** • G8 consensus at Okinawa Summit in 2000 • Administrative capacity of Roll Back Malaria **Interests** • Incentivizing donors through accountability and fund transparency • Increased economic growth in malaria free countries **Ideas** • Research evidence linking malaria to economic development • Public support for neglected diseases **External factors** • Establishment of Millennium Development Goals • Elections of Kofi Annan and George W. Bush

broader coalition that includes policy makers that control public budgets."[19] Research at the time began to recognize malaria as an economic issue contributing to underdevelopment and poverty in endemic regions.[20] Awash Teklehaimanot revealed that the issue of malaria "evolved over time from a mere humanitarian issue to an economic one."[13] This shift in framing was evident at the African Summit on Roll Back Malaria with more than 40 African governments present, where the discussion revolved around the economic burden of malaria.[21] At the summit, heads of states discussed the economic costs, estimated to reach $100 billion USD annually with families spending 25% of their annual income on prevention and treatment.[21] As a result of effective framing within the policy community, these states mobilized and recommitted to RBM by signing the Abuja Declaration, calling for at least $1 billion USD to fund RBM, and debt forgiveness to free up resources to help implement RBM.[20,21]

After this plea, donors from developmental agencies such as the Canadian International Development Agency and the Human Development division of the World Bank, also responded to the economic rationale behind funding malaria, pledging $6.5 million USD and $300–500 million USD, respectively, to malaria control.[20,22] According to Amir Attaran, a malaria advocate and associate professor at the University of Ottawa, this was "the first time in history that donors have responded explicitly to the economic cost of malaria."[20] These examples show that a global momentum was building: conferences between international stakeholders echoed the need to provide sustained and substantial funding toward malaria control programs.

The potential in public–private partnerships

Despite the issue of funding, evidence suggested that global public–private partnerships can assist in increasing the available pool of funds. In 2000, WHO acknowledged that "resources from the private sector are more than welcome; they are necessary."[23] For example, the International Trachoma Initiative highlighted the viability of public–private partnerships as a solution for funding neglected tropical diseases.[24] Established by a $3.2 million USD grant from the Clark Foundation that was matched by Pfizer, and a commitment by Pfizer to provide $60 million USD in anti-trachoma drugs, policymakers started to realize the untapped resources of the private sector.[24]

Unfortunately, RBM faced shortfalls due to its lack of a sophisticated funding mechanism involving the private sector. Despite this, it is clear that RBM provided a platform for effective collective action that drew together stakeholders interested in malaria control at national and international levels. It facilitated consensus among malaria advocates, raising the profile of malaria funding among policymakers.[25] However, while RBM's goals were ambitious, its cohesion ultimately provided a structure to convene an international funding mechanism – the Global Fund.

With the recognition by powerful stakeholders that inadequate funding toward malaria had negative consequences, it was an opportune time to put forward funding mechanisms for evaluation.

Incorporating Malaria When Establishing the Global Fund

MDGs and political support

The Millennium Development Goals (MDGs), the re-election of Kofi Annan at the UN, and the election of George W. Bush as U.S. president promoted a favourable global atmosphere for the inclusion of malaria as part of the Global Fund. The enactment of MDG 6 in September 2000 stressed the importance of combatting HIV/AIDS, malaria and other diseases.[26] Subsequently, Annan called for the adoption of a funding mechanism for these diseases with an annual budget of at least $7 billion USD.[27] Bush, Annan and Nigerian President Olusegun

Seen as the most vulnerable child in the family, an 11-year-old girl sleeps under the family's only mosquito net. Michelle Siu/World Vision, 2012.

Student Reflections

Framing is paramount. For the issue of malaria – or any global health issue – it influences from whom you garner support: an economic frame solicits support from different stakeholders than a human rights one.

—Mohsin Ali, B.H.Sc. (Class of 2012)

Immersing first-hand in global health spurs a realization: there are often barriers stemming from ethical, cultural and religious differences. Understanding these differences is empowering: only then can we explore possible solutions with the best care in mind.

—Carson Lo, B.H.Sc. (Class of 2013)

It's incredible how just a few individuals who are inspired enough by a problem can make a serious change in the world. Whether that means working on real world, grassroots issues or tackling macro-level policy matters, all it takes is one.

—Michael Baxter, B.H.Sc. (Class of 2013)

Global health problems are layered with complexities stemming from historical legacies and permutations of socioeconomic and political forces. When we effect positive change, we must incorporate these complexities – realizing that changes need not flow from the top down.

—Allan Jone, B.H.Sc. (Class of 2013)

The plethora of ways to influence global health policymaking is inspiring. Whether research or advocacy, from the grassroots to the international stage, this paper highlights how the global health community harnesses efforts from all sectors to promote solutions.

—Jeffrey Wong, B.H.Sc. (Class of 2013)

Obasanjo made the founding pledges to the Global Fund.[28] Their support brought together groups from both public and private sectors to mobilize resources for the Global Fund.[28] Overall, the MDGs and the election of key political leaders opened the window of opportunity to establish the Global Fund.[29]

Governance structures and past policies

Policymaking in the global context presents many institutional barriers due to the number of stakeholders involved, including governments, multilateral organizations, NGOs and private foundations. However, consensus on a global level is often influenced more so by powerful stakeholders.[30] Indeed, in the decision to include malaria in the Global Fund, the G8 – representing eight of the world's largest economies – advocated for a fund to combat infectious diseases at the 26th G8 Summit in Okinawa, in 2000.[31] Their support superseded the institutional barriers within government structures and policy networks, facilitating the policy's adoption.[31] Furthermore, in June 2001 the proposal for the Global Fund achieved a high degree of consensus among representatives from more than 50 countries, and stakeholders from the public and private sectors.[32] As well, the administrative capacity of RBM reduced the changes required to initiate the Global Fund, as RBM coordinated existing efforts against malaria.[33] Hence, the Global Fund was favourably received by influential

Existing knowledge and beliefs

History has proven that the battle against malaria can generate results if sufficient funds are available.[34] The Global Fund presents a solution that addresses the economic burden of malaria backed by research evidence from economists Jeffrey Sachs, John Gallup and Pia Malaney.[35,36] Their findings suggest that in regions with high malaria burden, countries suffered a 1.3% decrease in annual GDP growth.[35] As Gallup stated in an interview: "Our papers together really were the first to establish this very strong correlation between malaria and economic growth."[37] This finding corroborated the beliefs of the Organization of African Unity, which cited malaria as a leading deterrent for economic development and poverty reduction at the Harare and Abuja summits.[9,21] Moreover, a global trend of malarial drug resistance was becoming a major concern, especially in endemic regions, threatening to destroy malaria control efforts.[34] The Global Fund would facilitate immediate solutions before resistance could further develop. If neglected, the development of more costly and potent antimalarials would be needed.[38] Gallup noted that "Jeff [Sachs] . . . was pretty much the first person to say, 'Look, there's less than 100 million dollars spent on malaria research . . . . [We need] billions of dollars.'"[37] The Global Fund would provide a mechanism for soliciting this amount of funding.[39]

Aside from research evidence, global public opinion pushed developed nations to increase spending toward infectious diseases. When Kofi Annan first introduced the idea of the Global Fund, he stated: "There has been a worldwide revolt of public opinion. People no longer accept that the sick and dying, simply because they are poor, should be denied drugs which have transformed the lives of others who are better off."[40] With research evidence and public support, policymakers mobilized upon realizing the foreseeable global burden of malaria and its costs, if this issue was ignored.

Benefits to managing a global fund for malaria

The Global Fund would provide benefits for NGOs and governments in malaria–endemic countries, as well as investors from private organizations and developed nations. Awash Teklehaimanot explained that prior to the establishment of the Global Fund, funding mechanisms were not based on affected countries' needs and priorities.[13] The

Global Fund would address this issue by including a grassroots perspective when allocating funds to local programs.[41] As a result, local governments and organizations would be able to cater to their populations.[41] Next, the Global Fund would promote accountability through auditing, providing transparency to donors and encouraging continued support for locally contextualized programming.[41,42] The Global Fund would benefit both malaria–free and malaria–endemic countries through reduction of malaria incidence.[35,36] For example, after eradicating malaria in Greece, Portugal and Spain, tremendous economic growth was realized through increased tourism, trade and foreign investment.[36] In a globalized economy, these benefits would reciprocate to donor nations.[36] The coordinated efforts of the Global Fund culminated in significant benefits to both donors and recipients, subsequently bringing hope for malaria management and eradication.

The Role of Advocacy

The issues of malaria control and funding have been on and off the global agenda since the mid-1900s, and thus required strong advocacy strategies to reintroduce them on the agenda in the 1990s.[27] Summits and conferences were used as significant advocacy methods to place malaria back on the agenda. For example, the 1997 Assembly of Heads of State and Government of the African Union in Harare published the Harare Declaration, demonstrating to the world that a united front representing the developing world was concerned about malaria.[9] This spearheaded a year of conferences and meetings related to malaria, adopting resolutions and publicly advocating for an increased dedication to malaria control.[44] Newly elected Brundtland, who held malaria near the top of her agenda, was able to take advantage of this increased global attention.[13] This opened policy window culminated in the formation of RBM, which brought global attention to the issue, but did not address its funding need.[11]

Following the debut of RBM, failures of its funding methods were quickly brought to light through many avenues. Once again, conferences were used to elucidate key failures and to advocate for alternative proposals. One major example was the 2000 African Summit on Roll Back Malaria in Abuja.[21] At conferences and through publications, academics also played a role in evaluating RBM's failures. John Gallup acknowledged that he and other academic economists were able to critically analyze the social and economic burdens of malaria and, for the first time, portray malaria as a fundamentally economic issue.[35–37] Having academics advocate for malaria increased its legitimacy on the global stage, prompting decision-makers to address the problem. This was apparent in 2000 at the 26th G8 Summit in Okinawa, where tangible targets were created for malaria control, with the belief that increased funding was required to achieve these goals.[32]

As an independent funding mechanism for neglected diseases was being prioritized on the global agenda, several strong advocates were pushing for a decision to be made. Brundtland convened WHO's Massive Effort Advocacy Forum in October 2000 to mobilize advocacy networks for increased and improved funding mechanisms targeting diseases such as malaria.[44] In the subsequent year, Jeffrey Sachs published another paper detailing the need for a dedicated funding organization and encouraging governments to design and implement programs to address local needs.[41] Other figures in the global leadership unions such as the UN started calling for a "global trust fund" for neglected diseases, specifically HIV/AIDS, TB and malaria. Eventually, the G8 nations came to a consensus in Genoa to advocate for a global fund, and Kofi Annan officially called for the creation of the Global Fund in July 2001.[44]

A custom-made mosquito net (La Paz, Centenario, Baja California Sur, Mexico). Flickr/ Wonderlane, 2011.

Lack of funding emphasized, for instance, in *Malaria Research: An Audit of International Activity*, a report by The Wellcome Trust

1996

Economic burden of malaria discussed at conference in Abuja, Nigeria

2000

Agenda-setting

1992

Publication of *Global Malaria Control Strategy*

1997–1998

International conferences—in Dakar, Senegal; Harare, Zimbabwe; and Birmingham, UK—call for policies to address malaria control

Political prioritization

1998

Dr. Gro Brundtland elected WHO Director–General

2000

Massive Effort Advocacy Forum convened through Dr. Brundtland's leadership

Key Messages

- The use of conferences can forge cohesion among global leaders to establish and revitalize issues on the global agenda.
- Academics can not only generate evidence-based findings, but also can act as key advocates in helping define and frame the problem to appeal to the policymaking community.
- External global events can help create a window of opportunity to influence the adoption of a particular policy.
- Advocates must emphasize the benefits provided to powerful stakeholders in striving to garner consensus on a global level.

Conclusion

Historical malaria eradication campaigns, although somewhat effective in controlling the disease, have witnessed notable failures, particularly in the realm of funding. Especially when compared to other infectious diseases such as HIV/AIDS, malaria had been underfunded.[5] It was not until 1997, sometimes referred to as the year of malaria,[43] that malaria funding was included on the global agenda as an issue independent of malaria control. Through advocacy efforts from leaders of the developing world and WHO Director-General Dr. Gro Harlem Brundtland, a major milestone was reached upon the implementation of RBM in 1998.

Using RBM as a base, academics and world leaders alike identified weaknesses in current funding systems and proposed a novel global trust fund for the most pressing diseases. Actors ranging from civil society groups to leaders of the world's strongest countries united to work toward a common goal, and in 2001, at the 27th G8 Summit in Genoa, Kofi Annan officially introduced the newest global funding mechanism for infectious diseases:[45]

> At Okinawa last year, we pledged to make a quantum leap in the fight against infectious diseases and to break the vicious cycle between disease and poverty. To meet that commitment and to respond to the appeal of the UN General Assembly, we have launched . . . a new Global Fund to fight HIV/AIDS, malaria and tuberculosis.

The analysis of malaria's inclusion in the Global Fund shows a clear path of malaria funding ascending on the global agenda, its subsequent prioritization thereon, and then the selection of the Global Fund as a viable solution. This analysis, informed by three policy frameworks,[2–4] can be applied to other global health decisions. Examining agenda-setting, prioritization and decision-making can provide a holistic understanding of how certain global health issues are identified as pressing health challenges in need of international attention, planning and funding.

Creation of Millennium Development Goals (especially of relevance, MDG 6: combat HIV/AIDS, malaria and other diseases)

2000

Formal creation of the Global Fund at first Board of Directors meeting

2002

Decision-making | **Outcome**

2000

Support for an infectious-diseases fund at *26th G8 Summit* in Okinawa, Japan

2001

Kofi Annan calls for creation of a global fund at *27th G8 Summit* in Genoa, Italy

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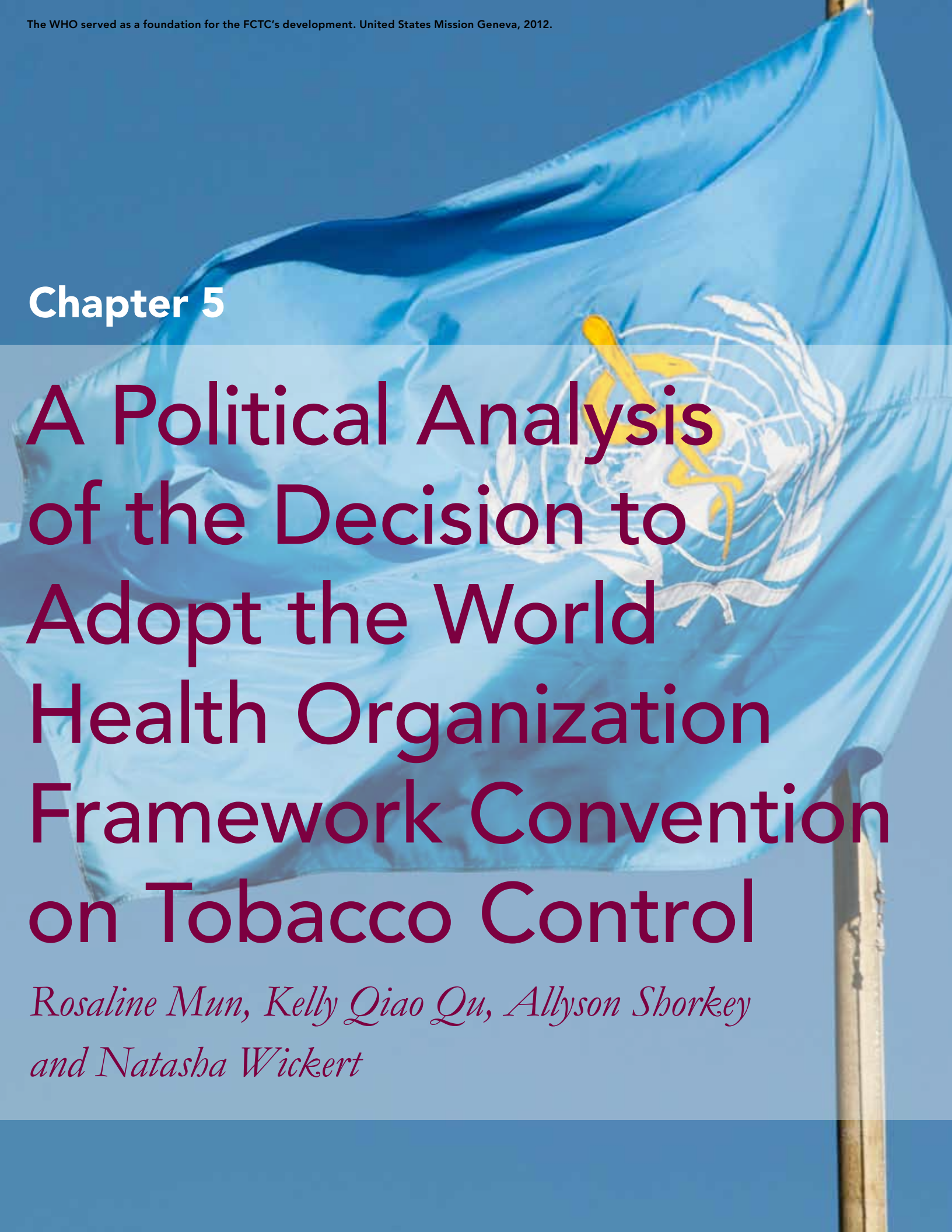


The WHO served as a foundation for the FCTC's development. United States Mission Geneva, 2012.

Chapter 5

A Political Analysis of the Decision to Adopt the World Health Organization Framework Convention on Tobacco Control

Rosaline Mun, Kelly Qiao Qu, Allyson Shorkey and Natasha Wickert

Abstract

Background

Throughout the 1990s, the increasing globalization of the tobacco epidemic was recognized as a problem that could no longer be tackled by individual countries. The World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) was adopted in 2003 to address this issue. This was the first time in history that WHO used its constitutional authority to establish an international treaty, which many have called a turning point in public health.

Methods

Relevant papers and media publications discussing the FCTC were collected from a variety of sources including PubMed, Ovid, organization web pages, and LexisNexis. These findings were analyzed using Kingdon's multiple streams framework, Shiffman's political prioritization framework, and the 3-I multi-causal policy choice framework. Key informant interviews were also conducted.

Findings

Through persistent advocacy efforts, policy entrepreneurs Ruth Roemer and Dr. Judith Mackay pushed for the placement of the FCTC on the global decision-making agenda. As the FCTC proposal reached various policy communities, cohesion developed among numerous WHO and United Nations sectors. This cohesion, combined with strong leadership by then–WHO Director-General, Dr. Gro Harlem Brundtland, accelerated the FCTC's political prioritization. The final decision to adopt the FCTC was guided by civil society, scientific evidence and lessons learned from past national tobacco control programs. Throughout the FCTC's development, the advocacy efforts of policy entrepreneurs and civil society groups fostered a mutual understanding of the urgent need for a global tobacco control strategy, creating the ideal political environment.

Conclusion

The historical development of the FCTC resulted in a comprehensive international treaty that offers promise for tobacco control in the future.

Keywords

tobacco control, framework convention, Framework Convention on Tobacco Control, policy frameworks, advocacy, global health

Introduction

In the 1990s, the number of deaths due to tobacco consumption was expected to increase threefold by 2030 if left uncontrolled.[1] This was during a time when the increasing globalization of tobacco consumption had tremendous implications on health.[2] The globalization of the tobacco epidemic meant that it could no longer be tackled by individual countries, and instead required global cooperation.[3,4] The World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) was adopted in 2003 to address this issue.[5] In essence, the FCTC is an international treaty encompassing broadly stated goals. Since the treaty's adoption in 2003, protocols have been developed by treaty members to address these goals.[6] This multilateral and dynamic strategy covers a wide array of tobacco control strategies, including measures to restrict tobacco advertising and promote public awareness.[1] The introduction of the FCTC was the first time in history that WHO used its constitutional authority for an internationally binding treaty, representing a significant milestone in global public health promotion and international cooperation.[1,2,4] This political analysis will explore how the FCTC got on the global agenda, how it was prioritized, and why the final decision to adopt the treaty was made.

How did a Global Tobacco Control Strategy reach the Global Agenda?

The introduction of the FCTC on the global agenda occurred in 1994 at the Ninth World Health Conference on Tobacco or Health, where a resolution was drafted urging the WHO to "immediately initiate action to prepare and achieve an International Convention on Tobacco Control."[1] Using Kingdon's multiple streams framework, this section will analyze how the FCTC reached the global agenda.[7]

Tobacco industry and farmers resisted the FCTC. Dan Rickershauser, 2009.

By the early 1990s, the globalization of tobacco consumption transformed the tobacco epidemic into a worldwide problem, necessitating its inclusion on the global agenda.[4] The ever-growing rise in tobacco consumption allowed for tobacco to be seen as a global epidemic.[1,8] Tobacco consumption transcended national borders, and consumption rates increased by two billion cigarettes from 1970 to 1990.[9] Worldwide data also indicated a shift in tobacco consumption to developing countries that often lacked effective tobacco control legislation.[1,10] In fact, it was predicted that approximately 70% of tobacco-related deaths would be in low-income countries.[11] Even the tobacco control legislation of developed countries could not successfully tackle the epidemic, demonstrating that a multilateral strategy was required.[4] These difficulties were often due to strong opposition from the tobacco industry, which negated many countries' national attempts at tobacco control. For example, in the 1970s, Singapore enacted a ban on all tobacco advertising. Yet despite Singapore's strict tobacco laws, tobacco companies circumvented the ban by taking advantage of the Malaysian television advertising spillover. This enabled tobacco giants, such as Philip Morris International (PMI), to transcend national borders and operate successful businesses despite unrelenting national government resistance.[12,13] These indicators and past failures clearly demonstrated that the tobacco epidemic was a global problem requiring a global strategy, such as the FCTC.[14]

Feedback from existing national tobacco control policies demonstrated the need to develop a global strategy that heavily involved civil society. For instance, feedback from existing Canadian policies demonstrated a lack of civil society mobilization. The Canadian Tobacco Manufacturers Council issued the first voluntary code to restrict tobacco advertising in 1964. They later introduced a Smoking and Health Program, with the intention of providing health information to the public. In both instances numerous recommendations were made, yet these policies lacked civil society mobilization and tangible change on the ground. It was clear that civil society involvement was essential for a successful global tobacco control strategy.[6,15]

The FCTC originated from the collaboration between numerous anti-smoking advocates. Central to this collaboration was policy entrepreneur and American lawyer Ruth Roemer. In 1993, WHO legal advisor Allyn Taylor published a paper strongly urging WHO to use its legal authority to advance global public health. Roemer subsequently chose to apply Taylor's ideas to tobacco control, which led to the initial FCTC proposal. Despite resistance from WHO, Roemer continued to meet with WHO's representatives and persuaded many influential stakeholders, including WHO consultant Dr. Judith Mackay. Roemer promoted the FCTC at various tobacco conferences, including the 1993 First All-Africa Conference on Tobacco or Health. Taylor and Mackay assisted in the initial stages of the FCTC. However, it was Roemer's persistence and networking across borders that placed her idea on the global agenda.[1]

The global mood and political environment were extremely influential in facilitating the FCTC's placement on the global agenda. Prior to the treaty's

development, the global mood positively facilitated discussion among policymakers. The link between cancer and tobacco had been well-established in 1953, and the world understood the health consequences of smoking, and the need to address worldwide tobacco consumption.[1,16] Moreover, political structures and the political mood within WHO fostered an environment conducive to collaboration at an international level. In providing the necessary convening power and resources, WHO spearheaded the FCTC's development. From the 1970s to 1990s, there were 14 World Health Assembly (WHA) resolutions that addressed almost every aspect of tobacco control. Discussions also occurred within WHO's various tobacco expert panels. These resolutions and discussions collectively called for a comprehensive tobacco control framework. However, WHO member states realized that these resolutions were not being implemented.[8,14] Neil Collishaw of Health Canada, who led WHO's tobacco control program in the 1990s, noted:[8]

> Resolutions are statements of good intentions and people don't follow them. . . So I think the members of the WHA had had enough of stuff that wasn't working. They wanted to provide something that would have more standing in both national and international law by drafting the convention.

Evidently, there was consensus among WHO's decision-makers that a stronger tobacco control strategy was needed, facilitating the rise of the FCTC on the global agenda.[8,14]

Therefore, the combination of Roemer's persistent efforts, failed national programs, and a favourable political environment were vital to the recognition of the problem, and to the subsequent placement of the FCTC on the global agenda.

How was the FCTC Prioritized?

After the FCTC was placed on the global agenda in 1994, it was prioritized until 1999 when the WHA established "an intergovernmental negotiating body to draft and negotiate a framework convention on tobacco control".[17,18] Using Shiffman's political prioritization framework, this section will examine how the FCTC gained political priority.[19]

The features of the tobacco epidemic and necessary global solution allowed the FCTC to gain political priority. The size and severity of the tobacco epidemic was a clearly defined problem that allowed the issue to be prioritized. The World Bank's influential Curbing the Epidemic report highlighted many smoking-related health indicators, including tobacco's strong link to lung cancer and its highly addictive nature.[20] Furthermore, the FCTC was prioritized as a solution due to its feasibility and cost effectiveness. Curbing the Epidemic confirmed the cost-effectiveness of the FCTC's proposed interventions by studying both price interventions such as tax raises, and non-price interventions such as advertising bans. For example, tax increases could be implemented for $5 USD for each year of healthy lives saved. This was extremely favourable compared to other health interventions, such as childhood immunizations.[20] This report also confirmed that

Man smoking a bidi (Allahabad, India). Rajesh Kumar, 2012.

Summary Table

Agenda-setting	Political prioritization	Decision-making
Problems • Globalization of tobacco consumption • Ineffective national tobacco control legislation **Policies** • Lack of civil society involvement in past policies • Persuasion and networking of Ruth Roemer **Politics** • WHO convening power and resources • Past resolutions calling for a global strategy	**Actor Power** • Support and prioritization by Dr. Brundtland • Agreement and alliances among various sectors **Ideas** • Largely framed as a health issue • Tobacco portrayed as a killer • Focus on health consequences **Political contexts** • Election of Dr. Brundtland, shifting WHO's initiatives and priorities **Issue characteristics** • Size and severity of tobacco epidemic was clear • Feasible and cost-effective solution	**Institutions** • Formation of policy networks between WHO member state directing decision making process **Interests** • FCA facing benefits from the FCTC • Powerful tobacco industry positively acknowledging the FCTC **Ideas** • Research evidence of cost effectiveness and feasibility • Public values tobacco control as a global priority **External factors** • Release of World Bank report *Curbing the Epidemic*

tobacco control policies were unlikely to harm national economies, supporting the feasibility of the FCTC and reducing fears of economic harm.[21]

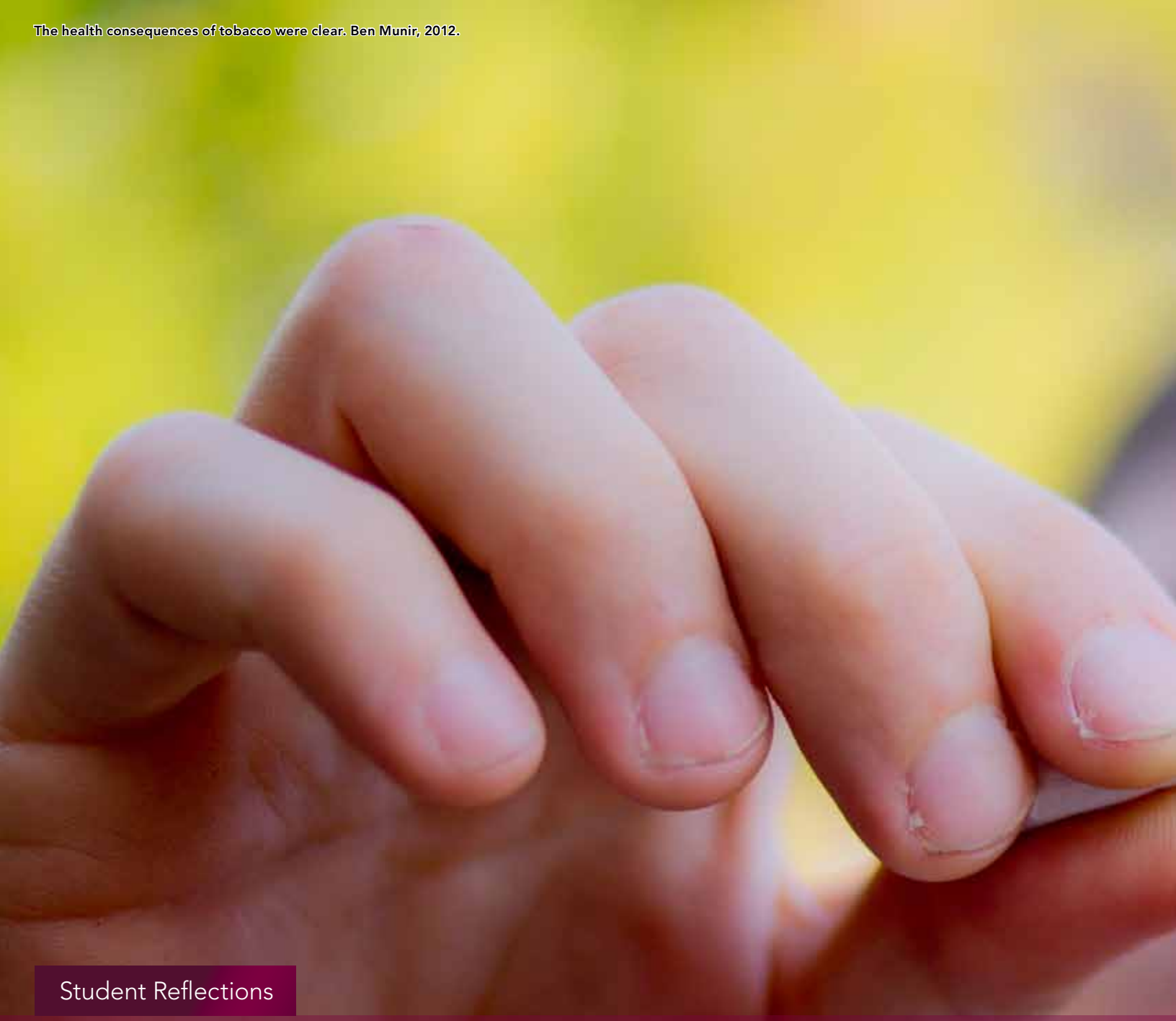
The presence of strong leaders and organizations in the decision-making process also facilitated the FCTC's prioritization. The FCTC did not gain political momentum until the 1998 election of WHO Director-General, Dr. Gro Harlem Brundtland.[1] Tobacco control was among her top priorities, and she immediately allocated resources to transition the FCTC from concept to reality.[1,22] Brundtland commissioned a report to analyze previously unreleased information outlining the tobacco industry's deceitful practices, assisting in the FCTC's prioritization. This report exposed how the industry had defrauded countries and paid off public health officials to deny that smoking was harmful.[14] Additionally, Brundtland established the Tobacco Free Initiative (TFI) to spearhead the FCTC's development. The TFI provided technical guidance and partnered with various WHO collaborating centres, non-governmental organizations (NGOs), and United Nations (UN) agencies to further develop the FCTC.[23] Brundtland's bold leadership also extended beyond WHO's borders into the UN system, leading to the establishment of the UN Ad Hoc Interagency Task Force on Tobacco Control in 1999.[1,24]

Furthermore, agreement and alliances were formed among a variety of sectors, creating a cohesive policy community committed to the FCTC's prioritization. The Food and Agriculture Organization (FAO), International Labour Organization, and the World Bank ensured that the non-health related aspects of tobacco control would be addressed in the FCTC proposal, such as crop diversification for tobacco-dependent countries.[1] The United States' Centres for Disease Control and Prevention and the Canadian Public Health Association also collaborated to track the progress of tobacco control.[1] This strong policy community cohesion was essential in ensuring that the broader determinants of health were addressed among decision-makers, allowing the FCTC to quickly gain political momentum.

The political environment in which these important actors operated was extremely conducive to the prioritization of the FCTC. The election of Brundtland as WHO director-general served as a policy window for the FCTC to gain further prioritization. Dr. Prabhat Jha, the lead author of Curbing the Epidemic, confirmed this by stating: "Much of the credit goes to Gro Brundtland when she came in and [said] yes, she was going to make that a priority."[11] This change in leadership brought forth the opportunity to shift the direction of WHO initiatives and actively prioritize tobacco control.[1]

Moreover, the global tobacco epidemic was largely framed as a health issue to both the general public and aforementioned policy communities.[25] WHO advisor Dr. Judith Mackay substantiated this health frame, noting that the health consequences of tobacco use, tobacco-related deaths, and increasing enormity of the epidemic were the focus within the policy community.[26] Led by WHO, the policy community also framed the tobacco epidemic as a health issue to the general public. They combined images of dying individuals with frightening health-related statistics, framing tobacco as a killer.[27] The David-versus-Goliath frame was also present within the policy community and general public. This frame portrayed the tobacco industry as manipulative and a clear enemy to society's well-being. Anti-smoking advocates were portrayed as unable to combat the powerful and manipulative tobacco industry. These two frames were extremely effective at convincing both the policy community and external audiences that the tobacco epidemic was a serious health issue that urgently required a global strategy.[28]

Thus, the shared understanding of the problem and solution, Brundtland's leadership and political cohesion assisted in prioritizing the FCTC on the global agenda.



The health consequences of tobacco were clear. Ben Munir, 2012.

Student Reflections

Ruth Roemer has proved to us that with perseverance, anything is possible. We can use creative approaches to generate action for the world's global health challenges and be the generation that makes an impact.

—Kelly Qiao Qu, B.H.Sc. (Class of 2013)

By exploring the history of the FCTC, I have come to truly appreciate the efforts of global health advocates. These individuals persevere, regardless of the many challenges they come across, and in the end their work impacts the lives of many.

—Rosaline Mun, B.H.Sc. (Class of 2013)

I have learned that we will all inevitably affect the global community surrounding us, but it is in our power to choose the direction of our influence. The actions of Ruth Roemer have shown us that one person can make a difference.

—Allyson Shorkey, B.H.Sc. (Class of 2013)

This process has opened my eyes to the complexities and barriers of implementing international health policy, while providing hope for future cooperation and development.

—Natasha Wickert, B.H.Sc. (Class of 2013)

Why was the FCTC Adopted?

Following the FCTC's prioritization on the global agenda, the final decision to adopt the FCTC was made at the Fifty-Sixth World Health Assembly in 2003.[1] Using the 3-I multi-causal policy choice framework, this section will analyze why this decision was made.[29]

The feasibility and potential effectiveness of the FCTC led it to be favoured over competing alternatives, such as comprehensive approaches and voluntary codes of conduct. In a feasibility study conducted by Ruth Roemer and Allyn Taylor, it was concluded that the dynamic, incremental and politically feasible nature of a framework convention was favourable when compared to more comprehensive treaty approaches. The report highlighted that these comprehensive approaches often lack political consensus. Additionally, Roemer and Taylor cited the FAO's International Code of Marketing of Breast-milk Substitutes as a failed attempt to implement a voluntary code of conduct. Many countries failed to implement this code of conduct, and manufacturing companies failed to comply. This problem, they argued, would be similarly encountered with tobacco control. Thus, it was concluded that a framework convention was the ideal solution.[6] Additionally, past policies in other sectors demonstrated the feasibility of the FCTC. Tobacco control shared the characteristic of scientific certainty that had galvanized effective international action in environmental law.[30] Most notable was the UN Framework Convention on Climate Change, which bound countries in an international treaty to reduce rising earth temperatures and climate change. The success of this international treaty highlighted the plausibility of an international treaty for tobacco control, and provided a model for the FCTC.[6,30,31,32] Furthermore, the cost-effectiveness and feasibility research evidence presented in Curbing the Epidemic that assisted in the FCTC's prioritization also assisted in its adoption. This report served as an essential external event throughout all stages of the FCTC's development.[1]

At a global level, public values indicated increased support towards anti-tobacco legislation. As the science behind tobacco consumption and control continued to substantiate the problem and provide evidence for a solution, the public began to increasingly value tobacco control policies as a global priority. For instance, in the United States the percentage of the public in favour of eliminating tobacco product advertising increased from 38% in 1992, to 46% in 2002.[33,34] This ideal combination between knowledge and values facilitated the decision to adopt the FCTC.[35]

Moreover, the benefits and costs faced by anti-smoking NGOs, the tobacco industry, and civil servants heavily affected the decision to adopt the FCTC. Anti-smoking NGOs, whose objectives aligned with the FCTC's objectives, faced concentrated benefits from its implementation. The relationship between NGOs and WHO formed late in the prioritization period, providing NGOs with credibility in the decision-making process.[1] Approximately 350 organizations from more than 100 countries partnered under the Framework Convention Alliance (FCA) to advocate for the FCTC. The FCA provided secretariat support, which encouraged increased communication and capacity-building in tobacco control, and played a significant media role.[1,3,23] For example, the FCA held capacity-building workshops to assist NGOs in advocating for the FCTC in their home countries. These workshops also enabled the FCA to leverage support in developing countries where minimal tobacco control legislation existed.[36] Under the FCA, these NGOs held tremendous power in the form of resources, influence and sheer numbers. The FCA effectively used this power to direct the decision-making process in its favour.[3] Civil servants within the health sector also benefited from the FCTC's implementation. Advertising bans removed some of the burden placed on healthcare systems from smoking-related illnesses. A United Kingdom study found that if the illicit

smoking market decreased by 50%, their National Health Service would save between £0.7 and £2.2 billion annually.[37] On the contrary, the powerful tobacco industry faced obvious costs from the FCTC. Due to these costs, tobacco companies strategically interfered with tobacco control efforts. Although PMI initially opposed the FCTC's development in 1999, they later acknowledged WHO's legitimate role in controlling the growing tobacco epidemic. Coming from a well-known tobacco executive, this statement was crucial in the adoption of the FCTC.[38]

In 2000, an interesting political development during the FCTC's negotiations was the formation of a type of policy network among WHO's member states.[1] Between formal FCTC negotiation sessions, WHO regional inter-sessional meetings were held, leading to the formation of regional voting blocs. These powerful blocs often voted on behalf of an entire continent, effectively directing the decision-making process. A particularly influential bloc throughout the negotiations was the African bloc, which was united by the belief that the tobacco industry should be held accountable for its abusive practices in many African nations.[35]

Thus, the FCTC's feasibility and cost-effectiveness, public support, concentrated benefits for powerful groups, and influential policy networks gave way to the adoption of this treaty.

Advocating for the FCTC

The advocacy roles of individuals and organizations were essential in the FCTC's placement on the global agenda, prioritization and eventual adoption. Policy entrepreneur Ruth Roemer was bold and persistent in ensuring that the public knew the truth of the "enemy" of tobacco industries.[1] Noted as the initiator of the FCTC by Dr. Judith Mackay and Neil Collishaw, Roemer's dedication was pivotal to the initial stages of development in the 1990s.[1,8,26] Roemer's desire for an international treaty connected her to Mackay in 1993, who became a "tireless tobacco-control advocate."[39] As Roemer's messenger, Mackay presented the idea to establish the FCTC to Dr. Gro Harlem Brundtland in 1998.[1,39,40] She presented increasing death data, consumption rates, and emotion-evoking images. Immediately after her successful presentation, Brundtland confirmed that tobacco control would be a WHO priority moving forward.[1,26] Overall, the combined efforts of Roemer, Mackay and Brundtland assisted in the FCTC's eventual adoption.[1]

Media campaigns contributed to the political prioritization of the FCTC by targeting the general public. WHO's Tobacco kills – Don't be Duped campaign took place in 1999 to raise awareness of the industry's deceitful practices.[41] This strategic campaign used celebrity diplomacy, the entertainment industry, industry whistleblowers, and numerous media outlets to promote the FCTC by influencing public policy and promoting the development of strict control measures.[41,42] Most notably, high-ranking tobacco executive Dr. Jeffrey Wigand partnered with the campaign to release The Insider, a film based on his personal struggle to expose the tobacco industry.[41] The film featured celebrities such as Al Pacino, and effectively framed the tobacco epidemic as an urgent issue requiring global measures.[41]

Furthermore, the FCA was one of the predominant advocacy groups for the FCTC, and specifically targeted WHO member states. During FCTC negotiations, the FCA produced the daily Alliance Bulletin publication. This publication summarized the negotiations and provided scientific evidence on important background issues being discussed during negotiations, which helped to persuade initially hesitant member states, especially the African voting bloc.[3] The Alliance Bulletin also employed a shaming technique by publishing awards in each issue. The Orchid Award was given to countries that positively contributed to the negotiation progress, whereas the Dirty Ashtray Award was awarded to the worst contributing member states, which were then criticized throughout negotiations.[3] The FCA was

Young girl smokes a cigarette (Laos). Jim Holmes, 2008.

Dr. Ruth Romer promotes the Framework Convention on Tobacco Control (FCTC) at *First All-Africa Conference on Tobacco or Health* and other conferences

1993

World Bank's influential *Curbing the Epidemic* report confirms the cost-effectiveness of the FCTC

1999

Agenda-setting

1993

Dr. Allyn Taylor publishes paper encouraging WHO to use its legal authority to advance public health

1994

Introduction of the FCTC on the global agenda at the *Ninth World Health Conference on Tobacco or Health* by Dr. Ruth Roemer

Political prioritization

1998

Dr. Gro Harlem Brundtland elected as WHO Director-General, and declares tobacco control a top priority

1999

World Health Assembly establishes an intergovernmental negotiating body to draft and negotiate a framework convention on tobacco control

also effective at framing tobacco control as a global public health issue. For instance, in 1999 the FCA unveiled the death clock. By running an ongoing tally of tobacco-related deaths, it served as a constant reminder of the severity of this issue.[3] Important FCTC advocates, such as Collishaw, agreed that NGOs were extremely influential. Collishaw noted that NGOs were "recognized as credible and responsible advisors to the member states . . . People in delegations often [did not] know what the issues [were], and they [were] happy to have somebody to help them navigate through some discussions."[8]

Therefore, the combination of the persistent efforts of individual advocates, media advocacy campaigns, and the FCA influenced the decision to implement the FCTC in 2003.

Conclusion

This political analysis examined all stages of the FCTC's development. In the early 1990s, policy entrepreneurs Ruth Roemer and Dr. Judith Mackay were very influential in the placement of tobacco control on the global agenda. Policy communities and the strong leadership of Dr. Gro Harlem Brundtland then accelerated the prioritization of tobacco control. The influential role of the FCA during negotiations, strong scientific evidence, civil society mobilization, and the failures of national tobacco programs helped to shape the adoption of the FCTC. Notably, the treaty's development would not have been possible without the efforts of leaders and determined tobacco-control advocates. Today, 172 countries have ratified the FCTC, and implementation teams have been established. As policymakers look towards the future, the FCTC proves to be a promising tool for controlling the global tobacco epidemic.

Key Messages

- The increasing globalization of health issues requires multilateral collaboration among policymakers and global governing bodies.
- Persistent and resourceful policy entrepreneurs can effectively place pressure on global decision-makers to prioritize policy proposals on the global agenda. Civil society has the ability to direct global decision-making processes, and leverage support from countries at a local level, often through advocacy efforts.
- Cohesion and collective action among global stakeholders enables policy proposals to gain political momentum globally.

First meeting of the technical working group convenes

1999

The FCTC is adopted by the World Health Assembly

2003

Decision-making | **Outcome**

1999

Framework Convention Alliance is established

2000

Blocs form during the FCTC's negotiations to direct decision-making process

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