

Rituals of global health: Negotiating the World Health Assembly

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ABSTRACT

The World Health Assembly is the WHO's supreme decision-making body and consists of representatives from the 194 WHO Member States who take formal decisions on the WHO's policies, workplan and budget. The event is also attended by representatives of non-governmental organisations, the private sector, the press and even members of the public. Based on participant observation at six World Health Assemblies, in-depth interviews with 53 delegates to the WHA, and an analysis of WHA Official Records, this article examines the ritualistic aspects of WHA negotiations. We argue that analysing the WHA as a ritual provides an insight into power and legitimacy within global health. Not only are certain understandings of health issues and courses of actions decided by the Assembly, but also the very boundaries of global health community are set. The rules of the ritual place limits on different categories of actors, while both formal and informal rules of behaviour further serve to include or exclude actors from the rituals. Success in negotiation is measured by through the inclusion of certain ideas, norms and values in the wording of resolutions and is achieved through the repetition of language in speeches and by adhering to the rules of behaviour.

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The World Health Assembly is the WHO's supreme decision-making body and consists of representatives from the 194 WHO Member States who take formal decisions on the WHO's policies, workplan and budget. The event is also attended by representatives of non-governmental organisations (NGOs), the private sector, the press and members of the public. As the WHO's 'parliament', the WHA features as a significant body and event within research on the WHO (cf. Chorev, 2012; Lee, 2009; Siddiqi, 1995); yet, there is very little literature that describes the event (cf. Eckl, 2017) or analyses its meaning within and for the global health community.

The World Health Assembly is characteristic of secular ritual (cf. Moore & Myerhoff, 1977). The proceedings are opened with a great deal of ceremony and within the negotiations themselves, a great deal of attention is paid to rules of procedure and the structure of speeches, as if delegates are following a global health liturgy. In this article, we explore the World Health Assembly as diplomatic ritual performed in order to address conflicts in global health. While ostensibly these are disagreements over the best course of action in addressing global health challenges, they often are underpinned by political and ideological divisions. These conflicts are temporarily resolved through ritualised consensus-building, resulting in official WHO policy; this comes in the form of

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resolutions which, in turn, endorse or adopt strategies, recommendations and other types of policy documents.

A focus on the WHA provides a powerful lens through which to observe power and legitimacy within global health. First, through the process of building consensus, certain framings of health issues and courses of actions are decided upon by the Assembly, while others are ignored or rejected. Second, the very boundaries of global health community are set at the WHA. The rules of the ritual place limits on different categories of actors, while both formal and informal rules of behaviour further serve to include or exclude actors from the rituals. Success in negotiation is about gaining access to the rituals and about getting certain ideas, norms and values included in the wording of final documents. This is achieved through lobbying, the repetition of language in speeches and by adhering to the written and unwritten rules of behaviour.

Methods

This article is based on participant observation carried out by the first author at the 63rd, 64th, 65th, and 69th World Health Assemblies, in 2010, 2011, 2012 and 2016, respectively. In 2010 and 2011 the first author attended the WHA as a delegate of the Global Health Council, at the time an NGO in official relations with the WHO. In 2012 and 2016, the first author attended as a member of the public.

This engagement with the WHA is further grounded in an ethnographic study of two WHO policy documents: International Code of Marketing of Breastmilk Substitutes (1981) and the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children (2010). The Code was developed in the 1970s and early 1980s in response to the unethical marketing of infant formula and other breastmilk substitutes, particularly in low-income settings. The Set of Recommendations was developed in the late 2000s as a response to rising rates of childhood obesity and offers policy guidance to limit the impact of marketing on children. Both documents were drafted through several years of negotiation and consultations, and formally became WHO policy through their endorsement at the World Health Assembly. As part of this study the first author carried out 44 formal interviews with individuals involved in both case studies, including representatives of the WHO, Member States, non-governmental organisations and the private sector.¹ We also draw upon the WHA Official Records, which include both verbatim and summary records from the proceedings and interviews with nine individuals who have served on Swedish delegations to the World Health Assembly.

Theoretically, we use scholarship on political rituals and performance as a starting point (cf. Abélès, 2006; Abélès, 2006; Crewe & Müller, 2006; Goffman, 1956; Moore & Myerhoff, 1977; Turner, 1969). Ritual is a structured and stylised performance outside of daily life which serves to change or transform social norms; the structure and form is repetitive. It is 'action wrapped in a web of symbolism' (Kertzer, 1988:9). That is, discussing global health within the context of the WHA is meaningful in a way that discussing global health in a non-ritualized setting is not. Here the psychological and emotional aspect of rituals cannot be ignored (Kertzer, 1988). The ceremony creates a social mood which elevates normal conversation into moral decision-making. Other researchers have noted rituals in international meetings, viewing them as performative rituals that serve to affirm global norms and contribute to the construction of a global reality (cf. Lechner & Boli, 2005; Little, 1995). Although traditionally ritual is about social cohesion, ritual can also serve to highlight divisions and hierarchies (Lukes, 2004) and to legitimise norms and individuals (cf. Abélès, 1988).

In our analysis, the health issues negotiated at the WHO are not only about microbes or disease but are also about the social, ideological and political conflicts. At the heart of both the Code and the Set of Recommendations are concerns over the legitimacy of non-state actors (the private sector and civil society) in the global health community vis-à-vis the WHO. In these cases, transnational breastfeeding advocacy groups and consumer protection organisations have questioned the

appropriateness of the private sector to participate in policy-making processes at the WHO. That is, if unhealthy food is causing obesity or if infant formula manufacturers are aggressively marketing formula to mothers, many civil society groups (and Member States) do not think that these industries should be taken seriously as global health actors.

Power is the ability to influence the policy process at the WHO through access, decisions, framing and influence. This means the ability to influence the agenda (and to ignore or keep issues ‘off the table’) and to influence the very wording of WHO documents through the strategic use of the rules of procedure (cf. Heywood, 1994; Lukes, 2004). Within a ritual itself, individuals are assigned roles whilst others may be excluded from it completely. With regard to non-state actors, member states and other delegates, legitimacy means a right to be part of the negotiations; it implies that other actors have consented or allowed this definition of the role. Through framing diplomatic acts as rituals, one can better understand the relationships and power amongst the actors: ritual serves to legitimise actors and their roles within the global health hierarchy and to endorse specific attitudes, beliefs and values by their inclusion in policies. At the same time, these processes of creating and imposing consensus in the form of policy documents can smooth over or even hide relations of patronage and power, creating a depoliticising effect (cf. Rajak, 2016). Ritual brings order to the messiness of global consensus-building, but the results of rituals – policy documents and resolutions – often downplay or ignore the contentious contexts in which the process has taken place.

Findings

I have only been there once. And it was a quite a circus. I was shocked. I’ve been to many “circuses” but this was different. There was a complexity that spans over so much. (Member state delegate to the WHA)

One informant described negotiations at the WHA as ‘playing roles in a school play. Stagecraft for statecraft.’ Others used words and phrases like ‘formal’ and ‘arcane and overwrought with procedure.’ For some the event is an anachronism, ‘pointless’ and ‘a waste of money.’ To others it is a ‘circus’ or even a ‘Game of Thrones with smartphones for swords and no murders in the great hall’ (Abbasi, 2014, p.4265). What is undisputable is that it is a central point within the WHO calendar. A former senior staff member at the WHO described it as ‘taking the temperature’ of the global health community. He saw it as a place for countries to share where they were at in progressing toward their health goals and for the global health community to agree on which issues they felt were global priorities. In this sense, it promotes cohesion with the community by the agreement of norms – framing the scope of and action on health issues – in the form of consensually agreed upon resolutions.

Who attends the WHA?

The member state delegations to the WHA include individuals from countries’ ministries of health and other government departments directly responsible for health (i.e. food and pharmaceutical regulators) and from the countries’ permanent missions to the UN in Geneva, which is typically part of the foreign ministry. In addition to the Member States, the Rules of Procedure of the World Health Assembly govern the ‘participation of representative of associate members and of intergovernmental and non-governmental organisations and of observers of non-member states and territories.’ Such observers include the Order of Malta, Chinese Taipei and the International Committee of the Red Cross, although controversially, Chinese Taipei was not granted observer status in 2017 (Kao, 2017). In an historical parallel, the Federal Republic of Germany sought to prevent the membership of the German Democratic Republic in the 1970s (DDR, 1974). Palestine attends as an observer as well, under the conditions of Resolution WHA27.37, passed in 1974. Representatives of the United Nations and other UN specialised agencies such as the International Labour Organisation, or the World Bank also attend.

The final category of observers at the WHA are representatives of ‘non-state actors in official relations with WHO.’ This is one of the more contentious categories of observers, mainly because historically it has included both public and business non-governmental organisations so that organisations such as Consumers International and Oxfam sit alongside the International Pharmaceutical Federation, which represents the interests of the pharmaceutical industry (Allain, 2005). In another example, the International Special Dietary Foods Industries (ISDI) typically has representative from companies which make infant formula.

Many of the NGOs involved in both the Code and Set of Recommendations processes have been in favour of excluding the private sector entirely from the WHA. As part of a reform process launched in 2009, WHO examined its relationship with non-state actors, culminating in the WHO Framework of Engagement with Non-State Actors (FENSA), adopted by the 69th WHA in 2016. FENSA sets out eight key principles with the aim of ‘[strengthening] WHO engagement with non-State actors (NGOs, private sector entities, philanthropic foundations, and academic institutions) while protecting its work from potential risks such as conflict of interest, reputational risks, and undue influence’ (WHO, 2016).

During the FENSA process, concerns were raised that many industry bodies come under the umbrella of civil society as delegates of business-interest NGOs. This includes some infant formula manufacturers that violate the International Code of Marketing of Breastmilk Substitutes. (IBFAN, 2013). For example, in 2011 the WHO proposed a ‘World Health Forum’ in which Member States, civil society, private sector and other international organisations would meet, under the auspices of WHO, and have a role in ‘identifying, from the different perspectives of its participants, future priorities in global health’ (WHO, 2011). One response to this from the International Baby Food Action Network (IBFAN) was that the proposed World Health Forum: would:

[undermine] the principles of democratic governance, and the independence and effectiveness of WHO ...
[and would] institutionalize conflicts of interest as the norm within WHO by extending the role of policy and decision shaping to for-profit actors that have an interest in the outcome. (IBFAN, 2011)

In addition to concerns over conflicts of interest, there was also concern over what informants referred to as the ‘co-opting’ or ‘muddling’ of civil society. By this, they meant that private sector actors were engaging in the policy process as if they were civil society.

In addition to the official categories of observers, the WHO also hosts distinguished guests who may address the plenary sessions of the Assembly. These are often heads of state, but can also be representatives from non-state donors, such as the Bill and Melinda Gates Foundation (BMGF). The BMGF has regularly given about US\$ 2.3 billion to the WHO annually since 1998 (WHO, 2018). As a result of this financial investment, Mr Gates was invited to speak at the 63rd WHA in 2011. This platform reinforced his legitimacy as a global health actor; it also allowed him to express his views of the burden of disease and appropriate prioritisation. Here he discussed infectious disease, vaccines and child mortality but did not mention noncommunicable disease (NCDs). In an address to the European Parliament the month before he had asserted that NCDs are an issue for older people and stated that ‘people should want to live to get a noncommunicable disease (C-SPAN, 2011). While the BMGF has since begun to look at NCDs, even today they donate over 4 times as much on infectious disease than on NCDs to the WHO.

After these events, some informants from the WHO and all informants from NGOs used various phrasings of ‘they should be lucky to have an NCD’ sarcastically. There were also some mocking references to the ‘vaccines are great speech.’ Overall, there was consensus amongst NGO informants that Gates was taking funding and focus away from NCDs.

Attendance at the WHA provides the appearance of being part of the global health community and provides legitimacy to certain categories. Because some civil society groups question the legitimacy of the private sector (and certain donors) in the policy process, they question their participation in these rituals. As this inclusion/exclusion remains open to debate and discussion, the meeting also remains as a site for re-ordering and re-negotiating the boundaries of the global health

community vis-à-vis the WHO. Specifically, the role of non-state actors, particularly the private sector, has been in a constant state of transition since the time of the Code. Moreover, as we describe in the following sections, the staging of WHA places physical limits on where different actors can go in formal and informal spaces.

Formal stages/formal performances

The World Health Assembly is opened at in the Assembly Hall of the Palais des Nations. The separate Committees then meet in the New Palais, adjacent to the Serpentine Lounge. Delegates in Committee A handle health and technical matters and Delegates in Committee B handle the management of the WHO, such as budgets and staff pensions. This distinction is slightly blurred: usually there is more on the agenda than Committee A can handle and at the opening of the Committee A, some health items are moved to Committee B, usually the least politically contentious health issues. This is strategically important. One can miss something if it is unexpectedly moved to Committee B. As a generalisation, wealthier countries with larger capacity in their civil service are able to send larger delegations. Having a larger delegation also means that a country has the ability to cover all of the agenda items and, in turn, to insert or prevent the insertion of last-minute word changes.

The first author primarily observed proceedings in Committee A. On the main floor Member States are arranged behind tables in concentric circles and sit in alphabetical order by the French spelling of the country's name. This is to give the impression that no one country is favoured and that there are no hierarchies amongst Member States. The lack of hierarchy is set out in the rule of procedure: each country gets one vote regardless of size or funding.

The NGOs sit in a raised platform area in the back of the room, to the left side, along with members of the press. This area is cordoned off with a rope, but this space between the NGOs and Member States is easily permeable. There is a water fountain just inside the Member State space and NGO delegates may cross that space to get water. They may also come onto the floor, in the back, to give an intervention. In the back of the room, near the water fountain, is also a seating chart and a table where supporting documents are made readily available. However, typically NGOs are not allowed to get documents there and must walk to the documentation centre in the Old Palais. For this reason, NGOs can miss part of the negotiations if they must take time to pick up the documents. Individuals with day tickets sit in the public gallery upstairs. These so-called 'Members of the public,' including some from NGOs not in formal relations with the WHO and from private sector entities that are not part of a trade association NGO, sit in a gallery with glass windows above the floor and are completely separated from the proceedings in the Committees.

Spaces can be bounded and limits can be placed on who can go where. Those with power designate particular spaces for certain actions or for multiple purposes. Terms such as 'centre' or 'periphery' may indicate one's position (Massey, 1992). The organisation of space at the WHA is about showing and being clear about one's identity, status and role in diplomacy, as well as the limits of this status. These physical boundaries reinforce hierarchies and roles. These boundaries are further enforced by security guards who check badges at each point of entry into the room.

Formal performances at the WHA are used by governments to come to a consensus on how to frame the causes and solutions to a health issue; it is about constructing and teaching a specific view of reality through performance. This framing then gradually becomes legitimised and dominant through repetition: most interventions use the same general template and build upon what other governments have said.

A typical intervention at the WHA lasts for three to five minutes with the following form:

1. A statement of the problem and its effects in that specific member state or region;
2. A description of what the member state is doing to rectify the situation, including cooperation with other countries and stakeholders;

3. Support for statements and/or resolutions given by other countries;
4. Appreciation for the work carried out by the WHO;
5. A call for what the WHO should provide in terms of assistance;
6. An appeal for increased funding to the WHO and low and middle-income countries;
7. Proposed steps forward to rectify the situation;
8. Proposed amendments to any draft resolution under consideration.

The quote below on the Set of Recommendations² from the 63rd WHA is long, but is representative of this ‘general form’ of an intervention.

Mr Larsen (Norway) said that the burden of noncommunicable diseases was spread over all WHO regions and constituted a major health challenge. However, 80% of the resultant deaths would occur in low- and middle-income countries, further widening the health gaps between and within countries, and would be the main threat to health and development in the coming years. There was a need to better understand how the various risk factors influenced the disease burden and on how to deal with them, with an emphasis on developing countries. Member States needed tools, technical assistance and information ... The practice of unhealthy diet, a main risk factor for noncommunicable diseases, was acquired in childhood and worsened throughout life; it should be tackled at an early age. In most parts of the world, prevalence of childhood obesity was increasing rapidly; an estimated more than 42 million children under the age of five were overweight or obese, and nearly 35 million of them lived in developing countries. Globally, food marketing to children was extensive and widespread; mostly it promoted foods with a high content of fat, sugar or salt. As a follow-up to resolution WHA60.23 on prevention and control of noncommunicable diseases, the Secretariat had developed a set of recommendations on the marketing of foods and nonalcoholic beverages to children. The Executive Board at its 126th session in January 2010 had taken note of the recommendations. The set of recommendations was a new and powerful tool; it would guide efforts by Member States to design and strengthen policies on marketing to children. It aimed to reduce the impact of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt. In support of the recommendations, Norway had proposed the draft resolution. Following consultations with Member States, he proposed that the word “all” should be deleted from subparagraph 2(1). (WHO, 2010, p. 116)

In this, the Norwegian delegate calls attention to the problem, explains how he understands the causes, states that member states need ‘tools, technical assistance and information’ and offers a solution in the form of the Set of Recommendations that had been drafted.

The policy process and its component parts, from consultations to interventions, are about framing a health issue and a valid set of solutions, whilst discarding others. Moore frames this basic idea as ‘processes of regularization’ (Moore 1977, p. 170). Diplomatic performances represent an effort to create a ‘durable social reality’: ‘The repetitive themes in the speeches and the format are parts of an attempt to define and teach an official version of social reality while acting it out’ (Moore 1977, pp. 169–170). Literally, a consensus of Member States’ views on the agenda item is distilled into the final resolution. More broadly, because all of the interventions start to sound alike, the repetitiveness forms a reality. Riles notes this repetition, comparing the attention to pattern and language to weaving mats. She writes that in constructing international agreements we see a patterning that is ‘replicated again and again within the document, from one document to the next, and in the mechanics of the conference at which documents are negotiated’ (Riles 1998, p. 385). Furthermore, an aspect of power is highlighted: discourses and representation of health issues are enacted and created in a particular way/style. When certain representations are dominant or legitimised in documents, this creates a level of control (Fairclough 2003, p. 28). At the same time, what is excluded is just as important as what is included (cf. Crewe, 2006, p. 109; Lukes, 2004). These representations, framings and exclusions are replicated in further documents. That is, the WHA constructs health issues, through defining the causes and solutions. These framings, which both include and exclude certain ideas and values, are further perpetuated in the documents that guide the organisation. By adopting particular framings of issues, Member States are legitimising certain policy options over others. This is why many informants expressed satisfaction at getting certain language in or disappointment at their inability to get the WHA to agree to certain wording.

For example, the Set of Recommendations make explicit reference to previous resolutions, strategies and action plans. The style, diction and syntax reflect previous documents and that of Member State statements. One of the most contested aspects of the Set of Recommendations, and the process leading up to it, was the inclusion of the private sector as a stakeholder. In Resolution WHA60.23, passed in 2007, the WHO was requested to

promote responsible marketing including the development of a set of recommendations on the marketing of foods and non-alcoholic beverages to children ... , in dialogue with all relevant stakeholders, including private-sector parties, while ensuring avoidance of potential conflict of interest.

Through this resolution and its implementation, who ‘counts’ as a stakeholder was also defined. This definition was perpetuated in the actual Set of Recommendations, endorsed in 2010 and in the Implementation Guide for the Set of Recommendations, published in 2012. The inclusion of certain stakeholders suggests that their beliefs, attitudes and values may be legitimately considered during the policy process. The resolution from 2010 endorsing the Set of Recommendations calls on Member States and the WHO to:

cooperate with civil society and with public and private stakeholders in implementing the set of recommendations ... in order to reduce the impact of that marketing, while ensuring avoidance of potential conflicts of interest.

The Set of Recommendations (2010) states that:

Governments should be the key stakeholders ... In setting the national policy framework, governments may choose to allocate defined roles to other stakeholders, while protecting the public interest and avoiding conflict of interest. (WHO 2010)

In this section, it sets out that governments are to be in control of the process of addressing food marketing but that they should work with other stakeholders – a norm that was formally endorsed by the WHA. In this sense, the ritual confers the roles for each actor in addressing food marketing. We also see here the repetition of language as phrasing around ‘avoiding conflict of interest’ is found in all three quotes.

Although there was broad consensus amongst informants that the Set of Recommendations was a success, we also found there were tensions over the control and perceived control of the policy process; this was particularly true of informants from NGOs who were dissatisfied with the involvement of the private sector in this case study, and in the WHO more generally. The response by informants who worked at the WHO was that because the Secretariat was mandated to develop the Recommendations ‘in dialogue with all relevant stakeholders, including private-sector parties’ then it was their responsibility, as decided by Member States, to include the private sector in the process. That is, the mandate – conferred by the ritual of resolution passing – legitimised the role of the private sector in the process.

By endorsing this language, the WHA is formally defining the roles of different stakeholders. Language matters because it is referred to and replicated in subsequent documents. At the same time, the language leaves room for interpretation; such ambiguity is necessary to ensure that all Member States can reach agreement. This is why the Set of Recommendations makes room for the private sector but makes clear that the government in change. The language is also neutral: it presents a consensual view while hiding the antagonistic relationships among some of the stakeholders involved in the policy process surrounding the Set of Recommendations.

Informal stages/informal performances

All action at the WHA is a ‘performance’ but some performances are less scripted or formal than others. The formal setting and structure of the WHA allows for informal interaction in drafting groups, coordination meetings, side events and technical briefings. Drafting groups, outside of the Committees, are where most of the actual negotiation takes place. NGOs are typically not allowed to attend drafting groups, only WHO staff and Member States. In the ‘perfect model’ as described

by respondents, there should not be any surprises at the WHA. The point is that WHA is meant to be a 'rubber stamp exercise.' Norms should be agreed upon beforehand and then legitimized formally at the Assembly. However, this is not always the case and last-minute disagreements over wording or content can send a resolution into a drafting group. While there is an official record of proceedings in Committees A and B, drafting groups are off-the-record and delegates rely less on guarded and ambiguous language than in the Committees.

The hallways and lounge areas are also spaces for informal performances. The Serpentine Lounge in the New Palais, outside the rooms where the two Committees meet, is an expansive S-shaped space with a coffee shop. In the adjacent area, directly outside the Committee rooms, there are tables and displays that highlight specific health issues and the work of different WHO divisions. There are further displays outside the Assembly Hall and the corridor connecting the New and Old Palais is similarly adorned with banners and health-related artwork.

The Serpentine Lounge is full during the Assembly, particularly in the first few days. NGOs and Member States hand out advocacy materials or advertise the side events they are holding. Delegates walk around, telling others about their events and the coffee tables are covered with their flyers. An informant who was a breastfeeding activist in the 1970s and 1980s recalled that during the Code negotiations,

We created a draft of a model Code with the best polices. We just handed it out to delegates and talked it up and read from it and publicised it. Just walking around. You meet people, you build alliances.

One informant former WHO senior staff member and former Member State delegate referred to it as the 'grapevine in real time' as it was a good place to pick up news and global health gossip. Another joked about 'global health celebrity-spotting.' The lounge is a place and an opportunity to meet colleagues seen only once a year. Although described as a circus, one informant noted that:

... we will meet important partners for us at the WHO. So that's a unique opportunity. While it's a circus, it's an incredibly important opportunity to connect, to coordinate, to see where we are in with the issues right now.

Another informant discussed how the space of the Serpentine Lounge facilitates informal contact amongst delegates:

having proximity in the lounge allows for fracture lines to surface and to be bridged ... it also allows one to cut across barriers. You can cut through and ask someone something without a third party present. This is especially true in situations where other types of interactions might be overheard.

He went on to explain that it is much easier to make a seemingly casual comment to someone in a queue for coffee in the Serpentine Lounge than it may be to use the telephone, particularly if the call is being recorded or monitored. Much of diplomacy is also about coalition building. If a country wants to pass a resolution, it must make sure to get other countries on its side. However, in order to get 'votes' this country might have to promise to support other countries' resolutions. One informant described this whole process as 'horse-trading in the lounge.' Similarly, one of the benefits of the Assembly is that it allows ministries to meet, often about topics completely unrelated to the agenda. This formal structure of the event facilitates cohesion and networking because it creates the space for the informal side of global health diplomacy.

Beyond the focal points of the Palais, the global health community seemingly takes over all of Geneva for the week and a half proceedings. In the course of our research, the first author attended side events at the Restaurant Vieux-Bois, Les Armures restaurant, and the Geneva Press Club, among others. Many of the side events advertised in the Serpentine Lounge take place in the InterContinental Hotel, which is just under a kilometre from the Palais. On the bridge at the end of Lake Geneva, the WHO's flag adorns the flagpoles. Informal meetings and dinners take place and civil servants and observers also use the opportunity to meet with other agencies in Geneva.

These informal settings allow excluded actors to take part in the WHA. For example, at the 34th WHA in 1981, which adopted the International Code of Marketing of Breastmilk Substitutes, the

International Council of Infant Food Industries (ICIFI) hosted an information centre at the Inter-Continental Hotel. The ICIFI was not on the official list of WHA delegates, but they were able to use this informal space to convey their position on the Code (Shubber, 2011 p. 40). Excluded actors may also use bilateral meetings with individual member states to advocate their views, or to even prevent delegates from attending meetings. For example, it has been reported that in the 1980s and even into the 2000s, a Swiss infant formula manufacturer would arrange trips to for Member State delegates to visit its headquarters on the day that a resolution on infant feeding would be discussed (Allain, 2005)

Many side meetings are also at the WHO headquarters, which is located about a kilometre up the hill from the Palais. An informant who had been a high-level WHO staff member described the importance of ‘visibility;’ that is, ‘it looks good to have an appointment’ at the WHO, especially for the private sector. He went on to discuss how simply showing up at the WHO demonstrates that one’s group is ‘part of the narrative’ and ‘part of the community.’ This reflects the point about how participating in the meetings provides legitimacy to actors.

Although it could be argued that informal corridor conversations are the ‘real’ spaces of diplomacy, it is only through the construction of the formal space that the informal can occur (cf. Schwartzman, 1987, p. 280). We also see how physical or geometric space can reflect and construct social and political relations (cf. Massey, 1992). The spaces – from the Serpentine Lounge to the No.8 bus – allow for both spontaneous and planned diplomatic encounters. These informal spaces may also provide an opportunity for excluded actors to meet and interact with WHA delegates.

Navigating the rituals

Performances are also dictated by the ritual structure itself. There is a shared cultural script which reflects a lack of control on the part of participants; they cannot substantially deviate from it within the ritual setting. We observed a form of global health liturgy: this is about following norms of behaviour and using the correct style in interventions and speeches. Learning these unwritten rules of behaviour and conforming to the process in order to participate influences decision-making and participation (Crewe, 2006, pp. 86-90). Normative behaviour becomes a form of exclusion and inclusion (cf. Brosius & Campbell, 2010).

This includes the informal behaviours, for example learning how to read the Journal or knowing that in Geneva it is appropriate to greet people with three kisses. It is about using genteel language – what McDonald (2010) refers to as ‘disciplined docility.’ It extends to countries, such as Thailand, that literally use the WHA as a way to train diplomats. In fact, simply understanding the spaces is a learned behaviour as one informant noted:

The papers are in one place and no one tells you where the papers are. You don’t know. You know everyone runs around and does things and has different agenda points and lists and so on. And you can not explain how it works. It takes a couple of days - I felt it took a few days before and as I understood, and then I found the room and I could at least get information.

More explicitly, the Rules of Procedure control the proceedings, dictating who can speak when and under what circumstances. The Rules of Procedure can also be used to tactical advantage, as is further demonstrated from the WHA proceedings in 1981 when the draft Code was discussed and voted upon. The Chair had closed the debate early, which later had to be re-opened and re-voted upon because of contention over rules of procedure. Specifically, in the 14th meeting of Committee A, the Belgian delegate called for a vote and the Chairman asked the Secretary to read out Rule 63 of the Rules of Procedure which pertains to voting (WHO 1982a, p. 7). Then, the delegate of Bangladesh said:

That he had at the previous meeting of the Committee requested limitation of the time allowed to speakers on the present item, but he had been informed that no provision existed for any such limitation of time. In that connexion he drew attention to Rule 57 of the Rules of Procedure, which stated clearly that the Health Assembly

might limit the time allowed to each speaker, and also to Rule 27, relating to the duties of the President. (WHO 1982a, p. 8)

The Chair ignored this protest from the Bangladesh delegate and then called a vote to end the debate, which passed 59 votes to 14, with 21 abstentions. The Congolese delegate then called for a roll-call vote as per Rule 74 of the Rules of Procedure (WHO 1982a, p. 8). The delegate of Bangladesh again protested, saying:

At the morning's meeting, he had realized that when 50 delegates had put their names on the list of speakers there would not be time for all to say all they wished and he had inquired if a time limit could be imposed. The Chairman had said that that would not be possible. At the time, he was aware of the Rule, but could not recall the number, 57. By allowing the closure of the debate, the Chairman had deprived him of the "right to speak" which was accorded under Rule 27, which he read out. Moreover, he drew attention of the Secretariat to a contradiction between Rule 27, which accorded that right, and Rule 55, which stated: 'No delegate may address the Health Assembly without having previously obtained the permission of the President'. (WHO 1982a, p. 10)

The WHO legal counsel then responded that:

As the motion to close the debate had been approved according to Rule 63, the Committee should proceed immediately to vote on the proposal before it. The request for a role-call vote was in accordance with Rule 74 which gave an automatic right to have such a vote upon request. (WHO 1982a, p. 10)

The delegate of Peru supported Bangladesh:

Speaking on a point of order, [he] said that while conceding that any delegate had a right to propose closure of the debate, he considered it undemocratic to do so when only seven or eight delegates had spoken on the item, out of 50 on the list of speakers. He wished to protest in the name of his delegation at the undignified way in which the closure had been handled. (WHO 1982a, p. 10)

The chair ignored this and called for a vote. The Resolution endorsing the Code passed by 93 votes to 3, with abstentions. Bangladesh voted against the Code, after which 'he reiterated his contention that the debate had been limited unfairly.' At this point the Chairman had ruled Bangladesh out of order over its concern that not all countries would be allowed to speak as per Rule 77 (WHO 1982a, pp. 10-12).

The following day, when the Committee was asked to adopt its 2nd draft report, Yugoslavia and Romania expressed concern they had accidentally abstained due to misunderstandings of the rule of procedure; the item was re-opened in plenary the next day (1982b, p. 8). After all of this, the delegate from Bangladesh stated:

Thank you, Madam President, I appreciate your democratic role, which I was deprived of yesterday. There were 51 speakers listed to speak on this subject. In spite of my point of order, it was disregarded. In spite of my saying that there are provisions for limitation of time, the Chairman was informed that there is no such rule. I quoted the Rule, that is, Rule 57, under which the Assembly may limit the time ... Anyway, because of so much procedural difficulty, instead of saying "Yes," I said "No." I repeat now that I am in favour of the Code, so my vote will be in favour of adopting this resolution. I would also like to say that, instead of recommendations, my country would like to see it in the form of regulations. (1982c, p. 5)

This episode further reiterates the ritualistic character of WHO negotiations, specifically how the Rules of Procedure guide the work of delegates. It also demonstrates that if the delegate of Bangladesh not understood how to negotiate the rituals, it would not have mattered that he was included in it at all. Performing global health rituals is not only about admission to the WHA, but about how to play the game. In this particular case, the Code passed in both instances. However, theoretically, the Assembly could have failed to pass the Code for a reason that had nothing to do with health and everything to do with ritual.

An effective performance is not only about what is said and how; it also has to do with doing this within the confines of the ritual structure. Part of what makes for successful global health diplomacy is knowing how to use the Rules of Procedure – the document guiding ritual action – to one's

advantage or to others' disadvantage. It is also about being socialised into the rituals through learning the unwritten rules. By acting appropriately, one appears to be an insider, and a legitimate part of the global health community.

Discussion

International meetings, such as the WHA, are settings for countries to discuss common health concerns and threats, and to take stock of progress (Foster, 1987). As rituals they also serve to validate and legitimize institutions, individuals, values and ideas (cf. Fortes, 1962; Justice, 1987; Moore & Myerhoff, 1977; Turner, 1974). The WHA is a site where a durable social reality is created and woven into resolutions and policies which are made 'official' through their adoption by the WHA. These documents frame the causes of and solutions to global health challenges, while leaving others out; these documents also replicate themselves in that the wording in a resolution will be used and referred to in subsequent resolutions. Being a part of this process is important to influencing the direction of global health policy. Much of this is about getting certain language into policy documents, through lobbying, coalition building or direct intervention. This important role of the WHA is why some actors attempt to limit others from participating.

Participation in global health rituals provides a measure of legitimacy for actors and for the WHO itself. The fact that actors attend WHO meetings can be interpreted to mean they are reaffirming the WHO's legitimacy as the lead organisation in global health; at the same time, the invitation to a WHO event provides legitimacy to that actor. This is why it 'looks good to have a meeting.' However, attendance can also lead to tensions when there is disagreement over participation, as has been the case with certain non-state actors or political entities.

Financing is one aspect of power. In the case of marketing food to children, Norway's position as a large donor helped it push for action. Conversely, countries that are primarily recipients of funding need to demonstrate the actions that they have taken to, for example, decrease maternal mortality or increase breastfeeding rates. Factors such as the capacity of civil service or lobbying before and during the WHA directly and indirectly impact the course of policy decisions.

However, the exercise of power within a political ritual goes beyond financing. Power is also found in what decisions can and cannot be taken; to some extent, the formal structures and spaces mediate this through dictating the form and structure of performance. The ritual framework is about creating a safe space to address conflict in global health. The rigid structure, expectations of formal behaviour and rules of procedure allow contentious global health matters to be debated in a 'civilised' manner. Global health negotiations are often over highly contested issues; by bringing negotiations into a constructed framework, the issues become controllable and manageable; however this also means actors can be prevented from expressing serious concerns (Crewe, 2006, p. 109). In the process of creating global health policy, ritual limits the boundaries of the debate. At times, in the interest of achieving consensus, the norms of behaviour prevent 'tough' questions from being asked and addressed (cf. Rajak, 2016). In these cases, agenda items may be tabled for the near or distant future.

Finally, knowing how to perform and move through this constructed framework – knowing how to navigate the circus – is a further manifestation of power. Part of this is about working around spatial and physical boundaries – for example, seating arrangements or the inclusion/exclusion from drafting groups – that can limit or increase influence. Yet, influence can be also obtained by knowing which side events to attend or by knowing who to catch in the lounge. Navigating the circus is also about knowing how to delay or expedite a decision using the Rule of Procedures or using diplomatic wordplay to strengthen or weaken a text. It can be about not taking decisions, or about deciding to table a resolution or agenda item to next year. In the case of the Code, we see how Bangladesh's knowledge of the Rules of Procedure changed the content of negotiations.

Conclusions

As a global health ritual, the World Health Assembly is a forum for adjusting and refining normative framings about the causes of health issues and appropriate ways forward. Individuals are removed from their normal life and, through rituals of global health, express a belief in the sacred cause of improving health worldwide. Delegates address the conflicts in health through building consensus; through this process they legitimise certain courses of action by formally adopting and endorsing resolutions and other WHO policies. For example, we described how the Set of Recommendations explicitly set out the causes of childhood obesity and the role of different actors in limiting the impact of marketing food to children.

To Turner, ritual is a series of ‘transformative performances revealing major classifications, categories and contradictions of cultural processes’ (cf. Turner, 1987, p. 75). While ritual actions provide cohesion within the global health community, the WHA also highlights division and hierarchies, as different groups – Member States, the private sector, civil society, and others are governed by different rules that affect their engagement.

Rituals also reflect wider conflicts and tensions in society. In some cases, this is directly related to health. For example, both the Code and the Set of Recommendations reflect wider economic and political questions around the role of governments and the private sector in regulating marketing of goods. In other cases, geopolitical grievances spill over into WHA negotiations, as in the historical case of East and West Germany. At the same time, ritual creates a safe space for two groups or countries in conflict to come together and come to a consensus on the best ways forward to solve global health issues. Consensus-building allows policies to move forward but may also mean losing strong policy language or setting aside certain policy options in favour of passing or adopting a resolution that is acceptable to 194 countries.

Finally, form is key in diplomacy (cf. Black, 2001). At the WHO this means tailoring one’s performance to fit into a global health liturgy. Actors within the process strive to obtain legitimacy for their values and ideas through their inclusion into the final documents. By framing one’s views and position in the correct manner – and by attending to normative behaviours in informal spaces, one is able to ‘perform’ diplomacy better, and thus exert more influence over the content of negotiations and the final wording of policies. Through learning these behaviours they also become socialised and accepted into the global health community vis-à-vis the WHO.

Notes

1. In keeping with ethnographic tradition we use the term ‘informant’ in the text to refer to interviewees.
2. The Set of Recommendations on the Marketing of Food and non-Alcoholic Beverages to Children was discussed under agenda item 11.9 ‘The Prevention and control of noncommunicable diseases: implementation of the global strategy.’ As such, the intervention refers both to The Global Strategy on the Prevention and Control of Noncommunicable Disease, as well as the specific Set of Recommendations.

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