



Next Steps on Civil Society and Health Policy

Comment on “Civil Society’s Evidence-Generating Role for Health Policy Decisions: A Thematic Analysis of a Healthcare Information for All (HIFA) Community Online Discussion”

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Abstract

This commentary responds to a recent discussion in the *International Journal of Health Policy and Management (IJHPM)* about civil society inputs to health policy. That exchange rightly underscored important issues regarding definitions, institutional mechanisms, complementary knowledges, and political economy dynamics. Further development of this important discussion could address six matters, respectively concerning broadening the literature coverage, widening the concept of civil society, enlarging the database, examining possible downsides of civil society input, strengthening theorization, and informing policy practice. This commentary offers suggestions on each of these six lines.

Keywords: Civil Society, Health Policy, The Local, Uncivil Society

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Civil society engagement of public policy has attracted substantial research and policy attention especially since the 1990s.¹ Lively debates have unfolded between proponents and sceptics as to whether and how civil society involvement can generate more effective, democratic, and fair governance. Feeding evidence into this discussion, empirical studies have examined civil society inputs to a wide range of global policy concerns: eg, digital technologies, disaster response, environment, finance, food, heritage, migration, peace, trade ..., and health.²

A recurrent question in these enquiries asks in what ways and to what extent civil society associations contribute distinctive perspectives to governance processes. Frequently heard claims affirm that civil society actors bring different types of evidence to policy which other sectors such as business, government, and technical experts overlook or underplay. It is moreover often said that civil society can better access and communicate “local” and “grassroots” knowledge, thereby making policy more informed, inclusive, and accountable.^{3,4}

The *International Journal of Health Policy and Management (IJHPM)* article by Gopinathan and colleagues brings to the table an important deliberation of these issues as they unfold in the 2020s in the health policy field.⁵ With thoughtful formulations, the paper advances four key propositions regarding definitions, institutional mechanisms, complementary knowledges, and political economy dynamics.

My own research on civil society and global governance has arrived at similar conclusions, so I have no issue with the paper’s principal lines of argument. Hence my response here is not so much a critique, but a reflection on matters for further research. In this respect one could look to broaden insights from the earlier *IJHPM* piece in six main ways.

First, one could broaden the literature coverage. The references in the Gopinathan et al paper date mainly from the past ten years, but a longer relevant scholarship goes back at least four decades. Moreover, whereas Gopinathan et al understandably work mainly from literature on the health sector, further relevant civil society research has addressed a full spectrum of other policy fields.^{6,7} Additional previous work on civil society and global health governance could also be consulted.⁸⁻¹⁰ A more comprehensive coverage of literature would presumably prompt Gopinathan et al to further refine their insights and temper claims to originality.

Second, a next stage of work could nurture a still broader conception of civil society. Like other thoughtful commentators before them, Gopinathan et al rightly underline that “defining civil society requires critical reflection.” In particular, it is crucial not to follow orthodox notions that limit civil society to non-governmental organizations, in the sense of formally organized, legally registered, professionally staffed service and advocacy associations. Instead, it is conceptually helpful and politically empowering to adopt a pluralistic perspective that

also encompasses community groups and social movements. Yet Gopinathan et al could cast their own net of civil society actors still wider than their 2025 article does. For example, one could also explicitly include indigenous peoples, labour unions, local markets, spiritual associations, youth groups, and informal women's networks – all of whom can have much to say on health policy. Although the text invokes vocabulary about “the grassroots” and “the local,” the civil society under discussion in the paper tends to mainly involve professional circles. The analysis addresses diversity only in terms of geographical region and professional sector, with no mention of the age, class, gender, race, and other social hierarchies that substantially influence which civil society voices get access and impact in public policy. Moreover, the concept of intersectionality can helpfully highlight ways that different hierarchies can combine to reinforce and deepen exclusions in civil society.¹¹

Third, and building on the preceding point, further development of this analysis could usefully enlarge the database. As the authors themselves acknowledge, “a key limitation” of this study is a “relatively limited number of participants,” with inputs from just 14 individuals in a single four-week period. A full-scale study of civil society and global policy would do well to consult many more (and more diverse) respondents, and over a longer period of time, as other work has shown to be possible.^{12,13}

Fourth, when expanding the data for this research, more attention could be given to the possible downsides of civil society evidence for policy-making. The current commentary notes in passing that civil society input can involve “bias or misrepresentation.” However, the unspoken predisposition of the paper seems to lean toward positive expectations regarding civil society evidence for health policy. It is important also to note potential negative scenarios. For example, some civil society quarters have spread mythologies about HIV/AIDS and COVID-19 that undercut health outcomes.¹⁴ Indeed, some civil society actors have shown themselves to be downright “uncivil” with disinformation, fraud, fundamentalism, and violence.¹⁵⁻¹⁷

Fifth, a key area for further development of this research is explanatory theory. The Gopinathan et al paper declares that “no a priori organizing theoretical framework was used to structure and interpret the data.” Yet the suggestion that governance research (or any academic scholarship for that matter) can be theory-free seems unsustainable. Surely the question is not whether one has a theoretical framework, but rather how explicitly and carefully one makes unavoidable theoretical choices? Moreover, implicit theory can encourage imprecise analysis. For instance, this paper rightly affirms that “power” operates in civil society, but the statement remains a generality until one theorizes power more specifically: what kind of power, in whose hands, exerted through what dynamics, and with what consequences? Likewise, invoking “political economy factors” does not explain much until one elaborates on the character of those factors. Needless to say, different theories of political economy (ranging across constructivism, feminism, green theory, liberalism, Marxism,

postcolonialism, realism and more) offer very different accounts of the key forces that shape civil society involvement in public policy. In addition, notions of “the local” need to be worked through theoretically, inter alia in terms of relationships of the local to the national, the regional, and the global.¹⁸ On all such points, fuller theorization is wanted in order to advance the arguments in this paper.

Sixth and finally, further research that builds on this commentary could look in more detail at implications for policy practice. Gopinathan et al in this paper convincingly underline “the importance of institutional mechanisms to support responsible evidence use,” but this exhortation remains quite general. A next stage of research can examine the substantial array of official guidelines and good practices for civil society engagement that many multilateral, multistakeholder, and national development agencies have elaborated based on their several decades of experience of civil society engagement.

In sum, Gopinathan et al have launched a valuable conversation that already offers important starting corrective insights regarding civil society evidence for health policy. Their published commentary in *IJHPM* offers provocative groundwork for more elaborate further research, including on the six lines suggested in this response.

Disclosure of artificial intelligence (AI) use

Not applicable.

Ethical issues

Not applicable.

Conflicts of interest

Author declares that he has no conflicts of interest.

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