State Power in Global Health Policymaking:
Case-studies of Japanese and Indonesian Engagement in the Development of the Sustainable Development Goal for Health (SDG3)

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'I (Robert Marten), confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis'.
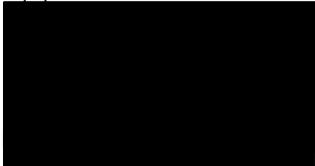
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Abstract

Although the study of 'the state' as a policy actor has diminished in the shift from international to global health, states remain critical to the creation and implementation of policies to improve health. However, assessments and understanding of why states engage (their motives), how states engage (their approaches), and where states engage (which fora and policy processes) remain limited. This study analyses the role of the state, with case studies of Japan and Indonesia, in terms of why, how and where they engage in global health, focusing on the process to conceptualize the post-2015 Sustainable Development Goal for health (SDG3). Constructivism provides the conceptual foundation to understand why states engaged, and Barnett and Duvall's power framework is applied to understand how and where states engaged. The thesis demonstrates that states construct their engagement in global health as part of their foreign policy efforts; both case studies highlight how critical the construction of a narrative, and the process to do so, is to motivate and shape state engagement. This has implications for how and where states engage. Both Japan and Indonesia state actors engaged in the post-2015 process exerting institutional, productive and structural power to advance domestic political interests. Most notably, Japan's government exerted institutional power leveraging its relationships within both the World Bank and the World Health Organisation; Indonesia's government exerted structural power with its President co-chairing the UN Secretary-General's High-Level Panel. While power frameworks do not explain all global health policymaking outcomes, they do help illuminate how and where actors engage and exert power in policymaking processes. Indeed, applying analytical frameworks focused on power in global health helps deepen understanding and insight into how and where different state (and non-state actors) coordinate, collaborate and contest policy priorities.

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Chapter One

Introduction and Background: Applying International Relations Theory and Power Analysis to Understand Why, How and Where States Engage in (and Ultimately Shape) Global Health[1]

Key Points:
- Globalisation continues to transform international relations, global governance and global health. Globalisation is causing state actors to adapt why, how and where they engage each other as well as interact with other actors in global health. State actors' engagement exerts power and contributes to the conceptualisation of global health. This chapter provides an introduction and overview of these key concepts.
- State actors play and continue to play a critical role in conceptualizing global health and determining policies and priorities. Yet research explicitly analysing state actors' roles in the era of globalisation is limited. State actors deserve further study to understand why they engage (meaning motives and objectives), how they engage (meaning their approaches and tools) and where they engage (which fora and policy processes).
- This thesis applies international relations theory, and specifically an analysis of power, to better understand state motivations and how states engage within global health. The aim is to contribute to new interpretations and understandings of global health in the current era of globalisation and suggest areas for improved engagement by states in global governance and, ultimately, the achievement of global health goals.

Conceptual Introduction and Background

The rise of new actors, mechanisms and processes is changing how state actors interact, and how state actors engage explicitly and implicitly in global health. This matters for why, how and where state actors engage in and exert power in global health. State actors play and continue to play a critical role in conceptualizing global health and determining policies and priorities. For example, states played a decisive role in determining and conceptualizing the post-2015, Sustainable Development Goals (SDGs). For global health to mature as a field, there needs to be greater attention to the importance of state actors and their roles within the field.[1] Without explicitly recognizing the critical role of states, future understandings of global health will remain limited. States' roles, both explicit and implicit, deserve additional

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research to understand why they engage (meaning motives and objectives), how they engage (meaning their approaches and tools), and where they engage (which fora and policy processes). To better and more deeply understand global health, there is a need to stop overlooking the role of states, and better appreciate states as actors.

For example, Japan is hosting the 2019 G20 Summit and will seek to position global health prominently on the agenda. Japan will likely deploy non-material resources using this G20 platform in an effort to shape and influence the global health agenda advancing its own global health interests. But how exactly will Japan seek to set the agenda, and which tools will it use? Moreover, why is Japan seeking to leverage the G20 agenda, a forum which is relatively new for global governance and until now has not had much focus on global health? Could the G20 play a similar role for the SDGs as the G7 did in advancing the Millennium Development Goal (MDG) framework? Or will other fora influence or shape the adoption or non-adoption of the SDGs? And what implications will this have for other states, and the future of global health?

To understand and appreciate why state actors engage in global health, it is useful to contextualize the state, globalisation and global governance and consider international relations theories, particularly constructivism. Building on this understanding of why state actors engage in global health, power is a useful framework for understanding how states engage. Applying power could help illuminate how and why different actors engage. It could also identify previously unrecognised efforts or strategies that different actors use to shape and set priorities within global health policymaking. Reconsidering why and how state actors engage using a combination of constructivism and power analysis could provide fresh insights into global health and contribute to deeper, more nuanced understandings of global health politics, policy and practice.

This thesis does this. It tests a framework which uses constructivism to understand why state actors engage and applies power analysis to understand how and where states engage in the negotiation of global health policies. More specifically, it focuses on two states, Japan and Indonesia, and a specific process, the conceptualisation and negotiation of the post-2015, SDG for health (SDG3). This introductory chapter reviews global health, international relations and governance and power analysis and presents an overview of this thesis.

Global Health

Conceptualized in the late 1990s and early 2000s, the field of "global health" itself is relatively new, and remains heavily contested.[2,3] There is no agreement on what is meant by "global health", or about how progress should be measured.[4] This definition matters because how global health is understood shapes the quantity, allocation and distribution of resources, influences how different actors interact with each other as well as determines the creation of new (or reform of existing) policy initiatives.[5]

For example, conceptualized during the same period as the field of "global health", the Millennium Development Goals (MDGs) became the dominant paradigm for global development. Health was a major part of the MDGs. Three out of the eight MDGs related directly to health (Goal 4: reduce child mortality; Goal 5: improve maternal health; and Goal 6: combat HIV/AIDS, malaria and other diseases) and the other five MDGs focused on critical determinants of health. Agreed upon by all countries at the United Nations in September 2015, the Sustainable Development Goals (SDGs) reflected a significant enlargement for the development agenda, especially for health, and presented an opportunity to expand the ambition of existing GHG. The SDG for health (SDG3) incorporates and builds upon the MDGs. SDG3 also includes addressing non-communicable diseases (Target 3.4) along with drugs and alcohol (3.5), halving the number of deaths and injuries from road traffic injuries (3.6), ensuring access to sexual and reproductive health care services (3.7), achieving universal health coverage (3.8) and reducing the number of deaths and illness from pollution (3.9). SDG3 also includes four "means of implementation" on the Framework Convention on Tobacco Control (3.A), support for research and development for neglected diseases (3.B), improvements in the financing and recruitment of human resources for health (3.C) and strengthening the implementation of the International Health Regulations (3.D). In addition to SDG3, there are additional indicators related to health throughout the other sixteen SDGs. The Agenda 2030 positions health as a broad development issue being both a means and an end to many of the SDGs.

Fukuda-Parr and Hulme argue that the MDGs represented a new 'super norm' dominating the global development agenda.[6] This also had implications for the emergent field of global health. The MDGs' influence in development meant that the MDGs contributed towards a 'normative global health agenda'. These new norms for the emergent field of global

health in the early 2000s continue to shape the field of global health today. The MDGs reflected an emerging definition of global health and contributed to advancing this conceptualisation of global health. This MDG-inspired understanding of global health exerts power in shaping the global health agenda and influencing global health institutions' mandates. How, or if, the SDGs, conceptualised and negotiated between 2012-2015, will continue this role of influencing policies and priorities within global health has yet to be seen, and is currently being contested.

Like global governance (described below), global health initially focused on moving beyond the state and did not focus on the role of states. Most analysis around the creation of the MDGs also downplays the role of state actors.[7] One commonly referred to definition of global health from Koplan and colleagues explains global health as "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration."[8] In practice, however, this definition is aspirational. As one commentator stated, global health is "more a bunch of problems than a discipline."[9] Critics argue that global health is "a foreign policy instrument of hyper-rich nations [...and/or...] a vehicle for already strong universities to burnish their brand, reputation, and revenues still further."[10]

Despite the fact that a consensus global health definition remains disputed between practitioners and policymakers as well as public health and social science academics, certain themes dominate.[11] Building on globalisation[12] and global governance[13], global health scholars broadly overlook the role of the state and emphasize the decline of sovereignty, borders and state power. They identify a landscape with an explosion of new actors so fragmented that state actors appear to no longer control policymaking.[14] Scholars appear to focus on two broad competing and contrasting definitional approaches to global health.

One early approach inspired by the HIV/AIDS emergency experience[15] sees global health, as defined by Brown, Cueto and Fee, defined as the "consideration of the health needs of the people of the whole planet above the concern of particular nations."[16] In practice, this form of "global health" often appears to be an extension of foreign aid and focuses on new actors, like global health partnerships or new foundations, providing assistance on certain

health issues to specific populations in developing countries. In the same way that global governance builds on international relations, this approach to global health builds on the field of international health.[17]

A second or later approach to global health is Koplan and colleagues' earlier definition, which is a more academic, interdisciplinary and aspirational approach to global health considering transnational issues and how they affect population health. This approach focuses on challenges transcending national focus; this includes topics like cross-border issues (eg outbreaks), issues of the commons (eg antimicrobial resistance), shared problems (eg obesity) and broader planetary health issues (eg climate change). Some scholars have subsequently argued global health still needs to incorporate the implications of globalisation and be further "globalised" meaning global health "should not be viewed as foreign health, but rather as the health of the global population" and that global health "should be understood as the product of health interdependence, a process that has arisen in parallel with economic and geopolitical interdependence."[18]

The practice and study of global health continues to evolve. As Horton argues, global health is "biomedicine, epidemiology, demography, public health, anthropology, economics, political science, law, engineering, geography, informatics, even philosophy" and "at present, the gestation of Global Health involves the chaotic tumbling, rumbling and knocking together of ideas and aspirations."[19] Global health is also at different times both descriptive and prescriptive.[20] These approaches are sometimes conflated leading to confusion as well as conceptual and normative clashes. As Ooms argues, "[w]hile public health (at the national level) is based on a widely accepted normative starting point – namely, that it is the responsibility of the state to improve people's health – there is no widely accepted normative starting point for international health or global health."[21] This, as Ooms argues elsewhere, has the potential to "stymie debate on the role of the powerhouses of global health, their normative premises, and the rights and wrongs of these premises."[22]

Global health literature, regarding how actors (both new and established) are adapting and engaging in the era of globalisation and global governance, is still emergent. When global health considers states, it tends to focus on how global governance and globalisation affects state efforts to improve health.[23] For example, a 2014 Lancet-University of Oslo Commission brought greater attention to how some global governance mechanisms

shape national health policies.[24] Despite a deepening understanding for and continued focus on how global policy processes affect states' abilities to deliver and ensure health, this is only half of what might be considered a "global health policy loop". The other half of the loop is how state actors can affect and shape global health, including both global health governance and global governance for health and the contours and shape of the broader field of global health. This other half of the loop is often overlooked. Understanding how states exert power as well as affect and shape global health is largely underappreciated. International relations (IR) scholars study the effects of globalisation on why, how and where states engage, exert power and pursue their interests.

International Relations and Governance

A central focus in IR is thus the role of the state. With the publication of a 1992 book, Governance without Government[25], along with the creation of a new academic journal, *Global Governance*, and a prominent Global Commission both in 1995, the emergent concept of "global governance" dominated much of the international relations discourse at the end of the Twentieth Century, and by 2005, Barnett and Duvall wrote that "the idea of global governance […] attained near-celebrity status. In little more than a decade the concept has gone from the ranks of the unknown to [be…] the central orienting theme."[26] Weiss defined "global governance" as "collective efforts to identify, understand, or address worldwide problems that go beyond the capacities of individual states to solve; it reflects the capacity […] to provide government-like services in the absence of world government."[27] Critically, global governance focuses on moving "beyond the state."

While Zuern argued that global governance is "amorphous"[28], academic literature emphases new actors and mechanisms, how they shift and shape "global governance" and how this affects states. For example, Krahmann highlights how analysis on political authority shifted away from the state and moved towards more local bodies, international organisations as well as private and voluntary actors.[29] In contrast, there has been comparatively less focus on states and their continuing abilities to exert power and influence globalisation and global governance and how this in turn affects domestic policies.[30] This is particularly true in the field of global health. There are studies examining how global health

affects states, but analysis explicitly examining why and how state actors engage, affect global health and exert power are limited.

Power Analysis

Power profoundly shapes how we conceptualize global health with implications for policy and practice. As scholars have acknowledged, power is deeply embedded in the field of international relations.[31]Power analysis is potentially critical as an approach because it could help create a deeper and more robust understanding of how actors create, manage and exploit disparities to serve their interests in global policymaking processes. Power analysis brings a more nuanced and structured framework to analyse how actors build alliances and influence others seeking to advance their interests and achieve their goals ultimately affecting and shaping global health policies. Power analysis also helps identify previously unrecognized ways in which actors engage. Illuminating these efforts and showing how different actors shape policymaking has the potential to accelerate efforts to assess different strategies, and ultimately improve how actors engage. Studying power should also contribute towards increasing and improving actor effectiveness. This will also expand emergent literature on how ideational and normative exertions of power shape policies. Applying power could also add to understanding how the designs of certain processes determine some policies with implications for implementation. A better understanding of and application of power analysis enables contributions to the design of processes and policies to redress disparities creating more legitimate and fair policy processes with greater engagement and ultimately improved or better outcomes.

Thesis and Research Questions

The negotiation of the post-2015, Sustainable Development Goals agenda was arguably one of the most inclusive and participatory global policy processes in history, and states played a critical and decisive role. Engaging for various reasons including the previous importance of the MDGs in shaping the global development agenda, states exerted institutional, structural and productive power throughout this process. As states determined the process (including ensuring that they would have the final word), the conceptualisation and negotiation of the post-2015 SDG agenda for health showcases the often-underappreciated

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role of states in shaping global health. State engagement in this process also illuminates how power analysis could help showcase how actors engage in global health. This research helps identify insights into ideational factors or non-material efforts which are useful for achieving results in global health.

This research focuses on understanding why and how the health SDG was developed, and examines how states, particularly Japan and Indonesia, developed their national positions and exerted power in the process to conceptualize the SDG for health. From the early 2000s, the government of Japan increasingly engaged on the issue of health within the field of global health as part of its Overseas Development Assistance (ODA). Japan, as an OECD or "developed" country, was also involved in the creation and conceptualisation of the MDGs. Leveraging its role within the G7 and its relationships with both the World Bank and the World Health Organization, Japan's government sought to play a similar role in the creation of the SDGs. It engaged heavily in the contestation of the SDG for health focusing on universal health coverage (UHC) as part of the Japanese Government's 2013 Global Health Diplomacy Strategy, which was part of Prime Minister's "Abenomics" economy policy and revitalized global diplomatic engagement.[32] Examining the case of Japan showcases how a comparatively experienced state engages in global health diplomacy and seeks to advance its positions and exert power.

In contrast, Indonesia demonstrates an emergent state increasingly engaging in global health policymaking. In the early 2000s, Indonesia was largely a recipient of the MDGs' influence; however, by July 2012, recognizing Indonesia's rising global influence and status as an emerging economy, the United Nations' Secretary-General asked Indonesia's President Susilo Bambang Yudhoyono (SBY) to co-chair, along with Ellen Johnson Sirleaf (President of Liberia) and David Cameron (Prime Minister of the United Kingdom), the Secretary-General's High-Level Panel (HLP) of eminent persons on the Post-2015 Development Agenda. SBY established a high-level national committee to advise him in this role. This committee, and the HLP's report following its final meeting in Bali, largely shaped Indonesia's engagement in the post-2015, SDG process as a response to Indonesia's experience with the MDGs and as part of the President's broader efforts to reposition Indonesia as both a regional and global "middle" power leader.

This could contribute to understanding how process can determine outcomes and how outcomes impact future global health processes. This empirical research could contribute to new interpretations and understandings of global health as a case study of state engagement in global health in the current era of globalisation. This might also contribute to improving state engagement in global governance as well as the achievement of global health goals.

This research is structured around three research questions (RQs), namely understanding why and how states engage in global health (diplomacy) (RQ1 and RQ2), and then where states engage in global health, specifically focused on the creation of the SDG for health (RQ3). To answer these questions, this researcher reviewed published literature, unpublished policy documents and conducted interviewers with policymakers (described in more detail in chapter 3). Specifically, the first research question (RQ1) is: *Why do states engage in global health, and particularly why did states engage in the conceptualisation and negotiation of the post-2015, SDG agenda?* This includes additional sub-questions. What are the factors for assessing the determinants of why a state engages in a given global health policy process? Do states seek to influence global health agenda setting for altruistic reasons, or to advance their own interests? In other words, what are states "really" pursuing? Is global health a tool to advance other interests? What do states seek to achieve and what constitutes success?

The second research question (RQ2) is: *How did states engage, ie: exert power, in global health, and particularly in shaping the SDGs?* This includes the following sub-questions. How do states construct national global health (diplomacy) efforts or more broadly a global health policy or strategy, ie: who are the relevant actors within governments (ministries, agencies and parastatals) and beyond states (NGOs, international institutions, other governments) and how do they engage in the process? What is the relationship between these actors, ie: what drives them to engage, and what are their relevant capacities and limitations? Which of these actors are considered most powerful, and according to which measures of power? What are the lessons for others seeking to influence and exert power in global health, and what does this mean for the future of global health? What are the implications of the SDGs, in terms of who drives agendas and how, for global health governance?

The third and final research question is: *Where do states engage in global health, specifically where, how and why did states engage in the process to create SDG 3 for health?* This includes the following sub-questions. How does the process and the conceptualisation of (global) health within the SDGs compare to the MDGs? What was the context and process for the creation of the SDGs? Why and how did states engage? Did the design of the process shape (benefit or limit) how and why certain states or actors engaged? To answer these questions and build on this conceptual introduction, this next section presents a chapter by chapter introduction to this thesis.

Chapter Overview

Chapter Two examines the existing global health literature to understand why and how state actors engage in global health. This chapter begins with a review of the state, globalisation and global governance in relation to the field of global health. It also provides an introduction to the concept of power and reviews the literature on how power has been conceptualized and applied within the existing global health literature.

Building on Chapter Two's literature review, *Chapter Three* analyses the conceptualisation and negotiation of the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs). It explores and examines why state actors engaged in these processes and how they exerted power to shape both the process and the eventual MDG framework. *Chapter Four* highlights the need for additional empirical research on state engagement in global health. It presents the study framework using constructivism from international relations to understand why states engage and applies power analysis to understand how states engage in global health policymaking. It also shares the methodology for this research, the collection of data and analysis.

Chapter Five applies this framework for a case study on Japan, and *Chapter Six* applies this framework for a case study on Indonesia. *Chapter Seven* compares these two case studies, and *Chapter Eight* concludes this study.

Chapter Two

Understated but still Powerful: Reviewing State Engagement and Power in the Global Health Literature

Key Points:
- While the terminology remains contested and profoundly political, globalisation continues to transform the fields of international relations, global governance and global health.
- The role of state actors in global health is understated and often overlooked. Compared to their importance and influence, there are comparably few studies reviewing state engagement in global health. State actors' roles, both explicit and implicit, deserve greater attention and analysis; however, assessments and understanding of why states engage (meaning their motives and objectives), how states engage (meaning their approaches and tools), and where states engage (which fora and policy processes) are still limited. There are now some initial frameworks for understanding why state actors engage in global health; however, these only loosely apply international relations theory, which is underused as an approach in the field of global health.
- The role of power in determining global health policy remains underappreciated, seldom studied and little understood in global health. This is especially significant as many of the global level policy processes have increasingly recognized implications for national health systems. Power is rarely explicitly used as a framework for analysis at the global level in health policy processes.

Introduction

Building on the discussion of global health in the previous chapter, there is sometimes an unspoken sense that "global health" is dominated by powerful states[33], current global health scholarship underestimates state actors' roles in determining what constitutes global health and underrates the power of state actors in conceptualizing and contesting global health.[34] For example, when Japanese government policymakers promote "universal health coverage" as Japan's top priority in global health in a special Lancet Series on Japan, they promote and advance a particular approach to conceptualizing global health, which exerts power within the field.[35] While appreciating the growing importance of new (non-state) actors and their engagement in global health, it is critical to recognize that global health policy processes remain largely supported, enabled and ultimately sanctioned by state actors. As the bodies

which continue to negotiate and sign international agreements, and are responsible for financing, implementing and prioritizing most global health initiatives, states remain the preeminent actors within global health. Global health is largely implemented by states and is state sanctioned. To understand global health, it is thus necessary to describe and analyse the ways in which states are adapting, exerting different forms of power, and working with partners. Section One will discuss more about the definition of states, but this work will use the term "state" interchangeably with government and consider the "unified set of actors" described below acting in global health to represent states despite recognising that state actors within one government are not always aligned or unified.

In the new era of globalisation and global governance, state actors have changed and are continuing to redefine how they engage, how they interact with new and established actors as well as how they exert power. Similarly, in the transition from international to global health, states' roles, particularly vis-à-vis other actors, evolved. The role of actors from civil society and the private sector increased, and the number of public-private partnerships in global health also increased as neoliberal ideologies and perceived financial necessities influenced donors to look beyond the state for new partnerships to implement projects.[36] This transition has implications for why, how and where state actors engage in global health. Yet the analysis on the role of states, and how their role has evolved is understated and underdeveloped. As Ricci wrote in 2009, "[e]ven as state sovereignty may be diminished in this globalised era, [...the state] still remains the main actor with its absolute and relative power to dictate global health policy far from confined."[34] States played (and continue to play) a critical role in defining and shaping global health. For example, a 2015 study found that, emerging economies are "utilizing the World Health Assembly to set the global health agenda."[37] Where states are engaging also matters; in this case, for example, why are emerging economies engaging in the World Health Assembly, instead of other fora? State actors' roles, both explicit and implicit, deserve greater attention and analysis; however, assessments and understanding of why they engage (meaning their motives and objectives), how they engage (meaning their approaches and tools), and where they engage (which fora and policy processes) remain limited and underappreciated.

For example, commentators in 2013 heralded Indonesia's arrival on the "global health diplomacy stage."[38] Why is Indonesia increasing its engagement in global health? How does it engage, and how should these efforts be assessed, or compared to other states? Is this consistent with Indonesia's engagement on other issues, or is there something which distinguishes Indonesia's engagement in health? In summary, what does Indonesia's engagement as a state actor mean and what are the implications for global health as well as health in Indonesia? In the same way that globalisation, global governance and global health affect Indonesia, Indonesia can (and does) affect global health, global governance and globalisation. While recognizing that every state could affect global health policies, not every state always does, or is able to shape global health with the same results. States have varying levels of power within global health.

To better understand the existing literature and how future research might contribute and help answer these questions, this chapter first reviews the existing literature on states in global health and second reviews the literature on power in global health. The first section presents a conceptual review of states in the era of globalisation in the fields of international relations and global governance, and then considers the implications for the field of global health. It then reviews the existing global health literature which considers states in global health. The second section does the same for power: it starts with a conceptual review of power, and then reviews how power has been applied within the field of global health. This chapter then concludes by summarizing the identified gaps within the literature.

Section One: The State in the era of Globalisation and what that means for Global Health

The role of the state remains central to international relations. As Stirk argues, "few concepts in international relations are as controversial and enduring – yet as neglected and under-theorized – as the concept of the state."[39] As Dryzek and Dunleavey argue, "the idea of 'the state' rests on the notion that there should be a single, unified source of political authority for a territory, drawing upon the undivided loyalties of its population, operating in a well-

organized and permanent way, and directed towards the interests of the whole of society."[40] Berki argued that "everybody agrees that the modern state is a rather baffling phenomenon."[41] Nevertheless, there is now "substantial agreement among different analysts" on seven defining characteristics of the state, namely that "the state is 1) a unified set of institutions; 2) controlling a given territory and distinct society; 3) making and enforcing collectively binding decisions; 4) monopolizing the legitimate use of force; 5) seeking sovereignty; 6) operating in a distinct public realm; and 7) deciding citizenship and controlling entry."[42] While a certain level of abstraction maybe required to see, for example, a "unified set of institutions" across government agencies, as state actors and non-state actors might contest or seek to influence state authority in some of the area, states, and no other actors, possess all seven of these characteristics.

Traditionally the study of international relations is the study of how states interact with each other to protect their interests. Yet in the 1990s, many scholars were quick to proclaim the decline or even the end of the state. Ohmae argued in 1995, "nation states have already lost their role as meaningful units of participation in the global economy of today's borderless world. The nation state is increasingly a nostalgic fiction."[43] In 1996, Strange proclaimed "heads of governments may be the last to recognize that they and their ministers have lost the authority over national societies and economies that they used to have."[44] In 1997, Reinicke argued states no longer had an effective monopoly of legitimate power over their territory.[45] In the same year, Mathews found that "nation-states may simply no longer be the natural problem-solving unit."[46] Stephen Walt concluded in 1998 that "the view that states are of decreasing relevance is surprisingly common among academics, journalists, and policy wonks."[47]

While these perspectives were common in the 1990s, they remain contested today. Indeed, current and ongoing political events deeply challenge these views and foretell a resurgent state re-asserting sovereignty. But these commentators were responding to transformational shifts in the 1990s, particularly the Cold War's end as well as a period of growing globalisation. Steger defines globalisation as "a multidimensional set of social processes that create, multiply, stretch, and intensify worldwide social interdependencies and exchanges [across economic, political, cultural, and ecological dimensions] while at the

same time fostering in people a growing awareness of deepening connections between the local and the distant."[48] Globalisation had occurred previously, particularly in the 1910s and the 1970s, but as Held argued the "sheer magnitude, complexity and speed distinguish[ed] contemporary globalisation from earlier periods".[49] The below reviews and summarizes how the predominant international relations theories – realism, liberal institutionalism and constructivism (each heavily contested and with multiple sub-theories) – interpret globalisation and consider its effect on states.[50] (This is important background as these theories shape and informed some of the early global health literature.) This next section also considers the particular relevance of constructivism for why, how and where states engage in global health policymaking.

International Relations Theories and States

The dominant theories in international relations are *realism, liberal institutionalism* and *constructivism*. Founded on the thinking of Carr, Morgenthau, Waltz and Mearsheimer, *realism* sees states competing for power and security in a world of anarchy, behaving similarly irrespective of their government type. For realists, geopolitics are critical to understand state interaction. Realists observes states using military and diplomatic force to achieve their interests; international institutions are tools to be used as convenient. The balance of power is an important realist construct, and according to realists, the most powerful states dominate international policymaking. Realists believe that the present world order is primarily a product of US global hegemony as US structural power is reflected in the conceptualization of global institutions.

Liberal institutionalism, grounded in the thinking of former US President Wilson and promoted notably by Keohane and Ikenberry, focuses on the spread of democracy and interdependent economic relations. Liberal institutionalism sees the proliferation of democratic states and economic interdependence strengthened and amplified through international institutions, like the WHO, which act to modify and mitigate state behaviour. While states remain the dominant actors (though their type or form of government matters), international organizations are increasingly active in an international system governed by

international law. Both realism and liberal institutionalism consider the state as a unitary actor; however, this conceptualization of the state is challenged by scholars highlighting how different government ministries or political parties can compete and contest state interests.

Constructivism, developed by Wendt and Ruggie amongst others, and explored most notably by Sikkink, Barnett and Finnemore, focuses on the creation of ideas, values and social identities. For constructivists, policy entrepreneurs and networks, including civil society organisations, are the primary actors promoting ideas and values through social interactions and institutions. Constructivists recognize states, but do not necessarily see them as dominant or unitary actors. Instead, they see state interests as "constructed". Constructivism is a particularly promising approach for a global health audience. The next section reviews some of the central issues in constructivism and explores how these might be applied to understanding why, how and where states engage in global health.

Constructivism

Constructivism is the newest of the three international relations theories mentioned earlier. It emerged in the 1990s challenging both realism and liberal institutionalism. Constructivism considers the meanings of ideas, institutions and objects and how these meanings are created, change and evolve, and the implications of this on state interests and behaviour. In other words, constructivism is the study of how social construction shapes state behaviour as well as the construction of state interests. As Martha Finnemore argued, "states are embedded in dense networks of transnational and international social relations that shape their perceptions of the world and their role in that world. States are socialized to want certain things by the international society in which they and the people in them live."[51] The same could be said for how state actors understand the field of global health. Divergent identities, norms and framings shape how states understand their interests, engage in global health policymaking and subsequently exert power within the field of global health.

As Jepperson, Wendt and Katzenstein argue, "cultural environments affect not only the incentives for different kinds of state behaviour but also the basic character of states."[52] This is what they refer to as "identity". National identities are contested; yet these identities can also change and evolve. For example, in the cases of Japan and Germany, both states, in

the wake of World War II profoundly shifted their understandings of their national military forces with implications for how these states viewed and pursued national security interests. As Berger highlights, this shift confounds both neorealism and neoliberalism which would have predicted a larger military role for both states given changes "in their security environments and steady growth in their relative power."[53] However, this did not happen in either case. As Berger contends, "Germany and Japan, as a result of their historical experiences and the way in which those experiences were interpreted by domestic political actors, have developed beliefs and values that make them peculiarly reluctant to resort to the use of military force."[53] The role of state identity also affects global health policymaking. For example, the Chinese state was reluctant to acknowledge SARS as it feared how this might change others' understandings of the government's ability to govern.[54] This ability to shift national identities in relation to global health policymaking has profound implications for where and how states engage; this is why understanding national identity is contested.

International norms also affect where and how states engage in global health policymaking. As Florini argued, international norms are standards of behaviour that are considered or seen to be legitimate in the global policy space.[55] Finnemore and Sikkink argued that there is a norm life cycle (norm emergence, norm cascade and internalisation).[56] This starts with norm emergence; norm entrepreneurs attempt to persuade a critical mass of states to become norm leaders and embrace new norms. If a tipping point happens and enough states embrace the new norm, a second stage of norm cascading occurs. If the cascade goes far enough, the process concludes with norm internalisation. Once norms are internalised, they become taken for granted and are no longer a matter of debate. For global health, Fukuda-Parr and Hulme[6] argue that the MDGs represented a new 'super norm' dominating the global development agenda with effects on state behaviour, and implications for how states engaged in the process to create the MDG's successor, the SDGs. (This is also considered in Chapter Three). Of course, international norms can be shifted and created depending on how they are framed and perceived.

Klotz and Lynch explain, "as analysts trying to understand why people do what they do, and whether they succeed in what they hope to achieve, constructivists explore the use of discourses and the diverse effects of actions."[57] To do this, constructivists study and

analyse "the production of discourse through content analysis of specific frames. Then they evaluate the impacts of these frames on actions."[57] There are numerous examples of how framing can shift actions in public health. For example, reframing discussions on tobacco control to consider the effects of second-hand smoke (away from a focus on smokers' rights to smoke) or reframing the need for and use of seatbelts on children's safety (away from a discussion of industry regulation) have led to progress in improving public health. The next section builds on this section to highlight why constructivism is most useful for understanding why states engage in global health policymaking.

Constructivist Theory to Understand Why States Engage in Global Health Policymaking

Given that global health diplomacy strategies are still an emergent practice (as discussed more below), policymakers are still working on developing these justifications for why, how and where their governments should engage more in these efforts. Constructivist analysis offers critical insight to better understand and analyse how this is happening. Identities, norms and framings influence how states develop and create their policies and their strategies to exert power within the field of global health.

For example, in terms of identity, since the end of World War II, Japan's foreign policy has remained largely pacifist and the concept of human security developed in the 1990s reflects this shift away from a focus on the military. Accordingly, any potential global health policy which Japan would advance would thus need to be aligned with and build upon human security. For norms, the global policy norm of the Millennium Development Goals (MDGs) means different things to different states. For example, states like Japan or Indonesia perceive and understand the MDGs (or the SDGs) differently to each other, and accordingly react and behave in different ways in response to these global norms. In another example, the way UNICEF or the World Health Organisation is appreciated or regarded differs between Tokyo and Jakarta given these states' political histories and unique relationships with these institutions. These two UN agencies mean different things in different states, and are thus perceived and received in different ways in different states. (This will be explained in more details in Chapters Five and Six.) The way that issues are framed or understood can also affect how and where states engage in global health policymaking. Indeed, Shiffmann

argued that attention to global health issues is largely a result of how policymakers frame the challenge and is not connected to evidence on mortality or morbidity or cost.[58]

These three theories (constructivism, liberal institutionalism and realism) from international relations also influenced some early frameworks for analysing and understanding how global health scholars consider why and how state actors engaged in global health. While each of these theories have slightly different interpretations of states, none of these international relations theories provides a coherent narrative for globalisation. To help understand why, how and where states are engaging in global health, it is critical to reflect upon how international relations theories see states evolving in response to globalisation. The next section shares one important framework for how scholars view globalisation affecting states.

States and Globalisation

The implications of globalisation remain contested within academic literature; as recent US and UK elections indicate, the effects of globalisation are also broadly contested within national electorates and specifically within the field of global health. In 1999, Held and colleagues devised a framework to distinguish between three different approaches scholars have taken to analysing globalisation, namely: 1) hyperglobalism; 2) scepticism; and 3) transformationalism.[49] These perspectives do not align with the three IR theories outlined above; however, each approach contains strands of the different IR theories. The below summarizes these three contrasting approaches, their interpretations of globalisation and implications for states.

Hyperglobalists, like Ohmae and Guehenno, argue globalisation is accelerating the arrival of a new epoch in human history. Hyperglobalists believe economic globalisation is transforming and denationalizing economies creating transnational networks of production, trade and finance. According to hyperglobalists, global governance institutions erode states' abilities to determine policy and accelerate state decline. Hyperglobalists argue, according to Held, "economic globalisation is constructing new forms of social organization that are

supplanting, or that will eventually supplant, traditional nation-states as the primary economic and political units of world society."[49]

Sceptics, by contrast, contest the hyperglobalist perspective and globalisation thesis. Scholars like Hirst, Krasner and Thompson invoke historical data on economic integration to argue globalisation is not unprecedented. They argue most interactions are between national economies and highlight regional blocs. Sceptics argue hyperglobalists vastly underestimate state power to regulate international economic activity. Sceptics dispute the idea that governments are the primary architects of internationalisation. Instead, sceptics generally consider the conceptualization and construction of both "globalisation" and "global governance" as primarily Western projects to sustain the West's primacy.

Transformationalists, like Giddens or Ruggie, believe globalisation is driving a rapid reshaping of the world order. While the ultimate outcome of globalisation remains unclear, economic, military, technological, ecological, cultural and political changes are profound and unprecedented. Transformationalists believe globalisation is "re-engineering the power, functions and authority of national governments."[49] Given this new reality, transformationalists identify states adapting and evolving to engage new globalized realities. They recognize a more activist state. In Rosenau's words, a state whose power and function are *"reconstituted and restructured in response"* to protect the state's interests from globalisation.[59]

As Keohane and Nye write, "what is striking about the last half of the twentieth century is the relative effectiveness of efforts by states to respond to globalisation."[60] In the end, state functions might simply be adapting instead of weakening, thus reinforcing the transformationalist thesis.[61] Keohane and Nye continue "governance will remain centred in the nation state. State power will remain crucially important, as will the distribution of power among states. [...] However, the image of the "state" may become increasingly misleading as [...] states are linked in networks to private and third sector actors." In other words, states remain dominant actors, but are now working with other actors in innovative ways to exert their power and adapt to globalisation. For example, Keck and Sikkink identified transnational advocacy networks (TANs) playing an increased role in

international politics to leverage national governments through the so-called boomerang effect; at the time in 1998, Keck and Sikkink imagined TANs leveraging states.[62] One could now imagine a scenario where states leverage civil society or TANs to achieve their interests vis-à-vis another state, or a scenario in which the two have shared goals and cooperate to achieve their objectives.

Since the 1990s and early 2000s, scholars continue to grapple with the new realities of globalisation and global governance and what it means for states. Hyperglobalists see globalisation as the end of the state, sceptics see globalisation as dependent on state support and transformationalists see globalisation transforming state power. While globalisation is a powerful force, the state appears to be a resilient actor. In 2019, this thesis and analysis believes that the transformationalist hypothesis seems to be the most accurate interpretation of the current situation. Yet, as described below, this transformationalist viewpoint is not often the starting point for most global health literature. The global health literature largely starts from a hyperglobalist perspective. But before getting to this, it is also important to review the interface between globalisation, international relations theory and global health.

Globalisation, IR Theory and Global Health

Similar to the field of global governance, globalisation's impact within global health is contested. It was the subject of bitter debate in the early 2000s, and the discussion remains unresolved. Critics argued globalisation was essentially neo-colonialism exploiting Africans.[63] They argued globalisation was economic neoliberalism with serious negative effects for health.[64] Feachem countered, "[t]he risks and adverse consequences of globalisation must be confronted, but they must not be allowed to obscure its overall positive impact on health and development."[65] Dollar added that while globalisation could have adverse effects, smart policies could mitigate any potential negative implications.[66] Others noted that the health implications were different across countries with select countries like China, Costa Rica, Vietnam and East Asian "tiger economies" doing well and benefitting from globalisation while for the majority of countries in Africa, Latin America and Eastern

Europe globalisation has not (yet) led to improved health.[67] As Lee and colleagues summarized in 2002, "[c]onclusions range from globalisation being essentially positive for health, albeit with a need to smooth out some rough edges, to one of utter condemnation, with adverse effects on the majority of the world's population."[68] By 2008, there was a growing sense based on experience that economic growth accelerated by globalisation could benefit poor populations, but this required strong and smart policymaking to ensure that these benefits were well distributed.[69]

Thinking about the impact of globalisation on health in some ways reflects the maturation of the field of global health originating as an extension of international health and evolving into a much more nuanced analysis of the interdependent nature of global health.[69] In the early days of discussions on globalisation and health, much of the focus was on specific diseases and the dangers of disease outbreaks, like SARS.[70] This grew out of an initial overlap between global health and IR which focused on state security.[71] IR theory was applied to understand health challenges, such as HIV[72] from a security perspective, rather than a focus on the state.[73] For example, Fidler argues like a hyperglobalist that the SARS challenge ushered in a post-Westphalian era which moved beyond state sovereignty. This debate shifted in the mid to late 2000s when scholars began to consider more complex considerations of globalisation and its effects on health, for example, how globalisation was affecting trade and health.[74,75]

While this discussion continues to evolve, it remains clear globalisation is leading to spatial, temporal and cognitive changes with specific implications for health which continue to be explored.[76] This is also increasingly linked to climate change[77] and an emerging focus on planetary health.[78] To understand the health impacts of globalisation, global health scholars developed multiple frameworks.[79,80] Building on international relations theory and global governance discussions in the era of globalisation, global health scholars also developed and contested new conceptual terms to describe and analyse emerging policy processes like global health governance (GHG) and global health diplomacy (GHD).

Global Health Governance (GHG) and Global Health Diplomacy (GHD)

Similar to global health, GHG as a subtheme is still evolving. The concept remains contested and is simultaneously shaped by both academics and policymakers. Dodgson and colleagues defined GHG as the rules by which collective action is taken to achieve agreed goals that protect and promote health within a global context.[81] In 2011, Ng and Ruger reviewed GHG literature and found "major themes and issues" included: "1) persistent GHG problems; 2) different approaches to tackling health challenges (vertical, horizontal, and diagonal); 3) health's multi-sectoral connections; 4) neoliberalism and the global economy; 5) the framing of health (e.g. as a security issue, as a foreign policy issue, as a human rights issue, and as a global public good); 6) global health inequalities; 7) local and country ownership and capacity; 8) international law in GHG; and 9) research gaps in GHG."[82] In other words, GHG considers a wide range of issues. Later in 2014, Lee and Kamradt-Scott reviewed over 1,000 works published on GHG, and found, "there is considerable variation in how the term is defined and applied, generating confusion as to the boundaries of the subject, the perceived problems in practice, and the goals to be achieved through institutional reform."[83] Conceptual clarity is still emerging; however, Frenk and Moon helpfully distinguish GHG (global entities and processes focused on specific health issues) from wider "global governance for health" concerned with policy processes outside the health sector with health implications.[84]

Like global governance and global health, the term global health diplomacy (GHD) came into usage in the early 2000s. Health professionals, academics and policymakers all refer to GHD. Again, conceptual clarity is elusive. No dominant, consistent or widely-used definition of GHD exists. Definitional questions and knowledge gaps inhibit research. Lee and Smith suggest "policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilize health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve other political, economic or social objectives."[85] Assuming a state border is crossed, this definition captures the relationship between global health and foreign policy; but the breadth of actors included and objectives considered causes the definition to encompass most activities in (global) health.

For example, what about the efforts of a small American NGO to combat HIV/AIDS in Zambia? While this NGO might be coordinating its efforts with other international NGOs, and/or the Zambian government (or not), it seems this might be beyond the focus of this definition. Non-state actors are important and critical to understanding how policy is constructed in global health, but compared to other actors, states are the actors with the greatest authority, legitimacy and power. It could be that this NGO was largely funded by the US government which took an explicit policy decision to fund health service provision through NGOs instead of via a national government.

Another example isthe Bill and Melinda Gates Foundation. The Gates Foundation has been called an "8,000 pound gorilla" and is considered to be "perhaps the most influential player in global health."[86] A review of its grant making programme for global health in 2009 categorized it as a "a major contributor to global health" and noted that "its influence on international health policy and the design of global health programmes and initiatives is profound."[87] Yet a recent study by Mahajan on the Gates Foundation's work in India found that, while it "initially circumvented the government, […the foundation] then moved on to a discourse of partnership and acknowledgment of the centrality of the nation-state in delivering public health services."[88] The point here being that what Mahajan called the "marginalization of the government vis-à-vis global philanthropic actors", which is often taken as a given within global health literature, is overstated.

In the new era of global governance, scholars are right to identify the growing importance of new actors including the private sector or nongovernmental organizations (NGOs); however, as Slaughter argues, "a gain in power by non-state actors does not necessarily translate into a loss of power for the state. On the contrary, many of these [NGOs] network with their foreign counterparts to apply additional pressure on traditional levers of domestic politics."[89] NGOs, international institutions clearly play an important and sometimes crucial role in global health; however, state actors are and remain decisive. While states are influenced and their positions are shaped by a multitude of internal and external interests and actors, state actors are often the final arbiters in global health. State actors participate in UN agencies like the World Health Organization and international institutions like the World Bank. For example, in her study on how WHO responded to member state

ideological pressures in the 1970s and 1980s, Chorev found that member states set the limits within which policy options and choices could be considered.[90] States, obviously with varying levels of success, ability and resources, can also regulate and review any non-state actors, including the private sector or NGOs, and authorize or limit their activities.

Ruckert and colleagues recently reviewed the GHD literature. They found a lack of conceptual clarity within the field, and that, "there is little academic work that has comprehensively examined and synthesized the theorization of global health diplomacy, nor looked at why specific health concerns enter into foreign policy discussion and agendas."[91] Their review also finds GHD broadly equates states and NGOs in their efforts to coordinate and improve global health. They reviewed forty-nine articles and when they looked at how each article conceptualized the "driving force of global health diplomacy" only five articles argued states alone were the driving force. States were mentioned in combination with other actors, eg international organizations, civil society organizations, social movements and/or philanthropic foundations, in another twenty-five cases. This means that states were mentioned as the sole driver or in combination with others in thirty out of forty-nine articles. States' roles within global health are not sufficiently recognized within the academic literature. This is also the case within the policy literature. While some countries are now developing global health strategies, there is little consensus on why this is happening, or what motivates states to engage.

For all of these terms – global health, global health governance and global health diplomacy – the absence of clear conceptual definitions and frameworks continues to limit research, which inhibits understanding and the ability to assess and improve the policy. Part of the reason for this abstraction is that the field lacks empirical analyses or case studies which apply or test these models against real experiences. Expanding and deepening the empirical basis is critical to the understanding of why and how states engage in global health. Ng and Ruger's global health governance literature review recognizes the "ultimate responsibility of nation-states in health governance, national and global"; however, states' continued dominance and evolving role have not been fully acknowledged or adequately analysed. Instead, states are often simply equated (and implicitly downplayed) with other emerging actors[92], or are no longer viewed as the primary actor. For example, Dodgson and

Lee argued like IR hyperglobalists in 2002 that it is necessary to "de-territorialize health ... by going beyond the primary focus on the state."[93] Others argue like hyperglobalists that the state is relinquishing its role as the dominant actor within global health.[94]

There is little global health analysis which starts from the transformationalist perspective. One anomaly from this disinterest in the role of the state is Reich's 2002 article, *Reshaping the state from above, from within, from below: implications for public health.*[95] As the title suggests, Reich argues like an IR transformationalist that the state "is being reshaped by multiple forces acting simultaneously" at the various levels by international agencies and multinational corporations, by political ideology and corruption as well as by "the expansion of decentralization and by the rising influence of nongovernmental organizations." Without explicitly acknowledging globalisation, Reich recognizes that different actors and networks of actors are acting across these three dimensions to influence state behaviour. However, since the publication of this piece, there has not been a re-examination of the role of the state within global health at a conceptual level (aside from a few specific case studies reviewed in the next section). One exception to this is Ricci's 2009 article, *Global Health Governance and the State: Premature Claims of a Post-International Framework,* in the journal *Global Health Governance*.[34] Like an globalisation skeptic, Ricci argues that the global health literature has "overemphasized globalisation and its ability to wrest health authority away from the state and diffuse it to a range of competing and interacting actors." One more most recent contribution to the literature is a chapter in the 2018 Oxford Handbook of Global Health Politics which confirms that the state has been neglected in the existing global health literature arguing that, "[a]lthough global health researchers and practitioners routinely interact with state agencies, the research literature contains little theorizing or critical reflection on the role of the state."[96]

Literature Review on States in Global Health

For the purpose of this chapter and to provide background and context on how the state is understood within global health, a literature review was conducted using the terms "global health" and "state" in the PubMed database. This returned 4,076 results in August 2017. After

reviewing these results for relevance and sorting out irrelevant articles (removing articles concerning the "state of" or references to sub-national states in federal countries like India or Nigeria), 103 articles remained. Another search included the terms "global health" and "country" returned 3,953 results. After reviewing these articles for relevance, 161 articles remained. Searches for "global health diplomacy" (76 results with 71 articles selected) as well as "global health" and "influence" (which returned 2386 with 46 results) were also conducted. After combining these selections and removing duplicates as well as excluding articles not relevant, not in English and articles before 2000, 158 articles remained. These searches were repeated for the period between August 2017 and January 2019 with additional articles being added to the discussion below.

These 158 articles were reviewed more closely and sorted into two categories: 1) articles which consider how global health affects states and 2) articles which consider how states affect global health. The vast majority of these articles (112 out of 158) are in the first category considering how global health affects states, while less than a third of the articles (46 out of 158) consider how states affect global health. This chapter focuses on the second category, ie how states affect global health. These articles are classified into three different themes: 1) articles synthesizing lessons learned from national experiences for global health (6 articles); 2) studies considering how states' global health policy was integrated into or aligned with its national foreign policy (11 articles); and 3) analyses of individual or groups of states' roles within global health (29 articles).

One of the ways in which states can affect global health is by showcasing an experience. For example, papers summarize lessons for developing responsive and resilient health systems in Fukushima, Japan[97], or implications from Nigeria's experience controlling an outbreak of Ebola.[98] These articles are usually more about a discrete national experience rather than about how states can influence global health. More recently, there have been some early studies considering why, how and where states engage in global health. First, there is literature within the nascent field of global health diplomacy examining the relationship between a state's global health policy and its foreign policy and why states engage. Second, there are now a few articles considering specific states or a group of states within global health and how and where they engage.

This overlap between global health and foreign policy was highlighted by the Foreign Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand who declared in the Oslo Ministerial Declaration, "[w]e believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make impact on health a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies."[99] Around the same time as this declaration, more states and their foreign ministries, inspired by the Declaration, began to consider global health; however, as discussed above, states' understandings of what is or how they define "global health" matter as this shapes and determines why, how and where states engage. For example, as one comparison of Norway and Switzerland's global health policies concluded, "designs contribute to constructing the global health governance system by identifying it as a policy target."[100]

As states began to develop these policies, academics began to document and assess these efforts. One study examined the barriers to integrating health into Canada's foreign policy. It found a lack of knowledge and expertise from both health experts and diplomats; it also highlighted "the limited ways in which health has become framed as a foreign policy issue" as well as a "lack of cross-sectoral policy coordination and coherence."[101] This situation is replicated in other countries, like Malaysia,[102] where Ministries of Foreign Affairs have not yet established a health division and are instead working through ad hoc coordination with the Ministry of Health. In countries with limited resources, these capabilities are also constrained, except in some states like Thailand, which is committed to achieve greater GHD coherence, particularly on trade.[103] A recent article from Indonesia[104] noted the importance and need for capacity building in global health diplomacy in low- and middle-income countries, and another article reported on WHO's efforts in Pakistan to develop global health diplomacy capacity.[105]

One study documented how external developments like the Oslo Declaration and the post-2015 development agenda debate, plus domestic research and advocates, created a German global health policy process.[106] Shortly thereafter academics analysed Germany's policy and called for the government to develop a more comprehensive strategy.[107] A similar study sought to understand how and why health was integrated into the UK's foreign policy,

and found that the UK, following a realist interpretation, decided to "focus more on global health […] to protect national and international security and economic interests."[108] Another considered how domestic health policy, building on domestic and global civil society commitments, was integrated into South Africa's foreign policy.[109] The German and South African case studies adapt and combine the Walt and Gilson policy analysis framework (context, process and actors) with the Kingdon model which is the same approach Gagnon and Labonte used for the UK case study. While scholars are continuing to build on this work with new case studies and even early frameworks to understand how states develop national global health policies[110], the question of why states engage remains.

Why States Engage in Global Health

Some of the early frameworks for why states engage broadly mirror those of the IR theories realism, liberal institutionalism and constructivism. In the realist tradition, Feldbaum and Michaud argue simply that, "[f]oreign policy priorities often determine political priority and funding for global health issues."[111] In a more liberal institutionalist tradition, Kickbusch argues that "health is on the radar of foreign policy because it is integral to three global agendas" namely: 1) security, encompassing fear of pandemics or biosecurity concerns as well as health risks in the wake of humanitarian or natural disasters; 2) economic, encompassing the economic implications of health risks to the global market as well as the growing economic opportunities related to health; and 3) social justice, meaning supporting the recognition of health as a human right and social value reinforced through both the MDGs (and now SDGs) as well as calling for wealthier states to invest in global health initiatives.[112] Alternatively, Labonte argues that six different policy frames help motivate decisions on how to integrate health into states' foreign policy: 1) security; 2) development; 3) global public goods; 4) trade; 5) human rights; and 6) ethical/moral reasoning.[113]

Watt and colleagues tested Kickbusch's framework (focused on security, economic and social justice) to explore the tension between health and foreign policy interests and analyse what motivated (and explained the differential levels of engagement of) the BRICS to engage on access to medicines questions within global health.[114] She and colleagues found

that "none of the three dimensions […] used are enough in their own right to explain all of a country's behaviour." Watt and colleagues also argued that there are "soft power" concerns (soft power as a concept is discussed in Section Two below), which need to be considered in terms of aligning or reconciling states' interests with how states want to be perceived and viewed. To advance the field and better understand why states engage, more specific empirical case studies are needed to understand state engagement. The next section starts with realism, liberal institutionalism and constructivism to begin to try to understand why states engage.

How and Where States Engage in Global Health

Beyond the question of why states engage, there is also some emergent literature on how and where individual states or states in concert engage in global health; however, this is much more limited and is often more prescriptive than analytical. These studies sometimes reflect IR theory. For example, a 1997 US National Academies Institute of Medicine report in the realist tradition argues, "America has a vital and direct stake in the health of people around the globe."[115] As US government institutions, universities, think tanks, NGOs and foundations played a decisive role in setting the boundaries of early discussions on global health, US engagement and policymaking in global health was comparatively more developed than other states and at times hegemonic.[116] This understanding might also serve a more constructivist interpretation of US engagement in global health. Alongside the United States, there have been a few other studies of Organization of Economic Cooperation and Development (OECD) states and their role or potential role in global health.

For example, a 2011 Lancet study on Japan found that its "engagement with global health has not been outstanding relative to its substantial potential, in part because of government fragmentation, a weak civil society, and lack of transparency and assessment", but argued and advocated that "Japan is [nevertheless] potentially in a position to become a leading advocate for and supporter of global health."[117] A 2014 paper reviewed and assessed Italian Development Assistance for health between 2001 and 2012, and called for "conceptual revision and deep institutional and managerial reforms" to create a paradigm shift for global health in Italy.[118] A 2016 Lancet paper reviewed France's past engagement in

global health and argued that "understanding and acknowledging France's history could help strengthen advocacy in favour of universal health coverage and contribute to advancing global equity."[119] A 2017 Lancet paper reviewed Germany's role in global health and found the country, "well equipped to become a leader in global health, yet the country needs to accept additional financial responsibility for global health, expand its domestic global health competencies, reduce fragmentation of global health policy making, and solve major incoherencies in its policies both nationally and internationally."[120] A 2018 Lancet article reviewed Canada's engagement in global health, and argued that, "Canada has often aspired to be a socially progressive force abroad, using alliance building and collective action to exert influence beyond that expected from a country with moderate financial and military resources."[121] These Japanese, Italian, French, German and Canadian studies loosely adhere to the liberal tradition; however, largely these studies do not build upon IR theory. In fact, they largely do not use any sort of standard methodological approach to assess how and where states engage.

Textbox: The Lancet's Coverage of States in Global Health

It is worth noting that of the 153 Lancet Series (in January 2019) listed on the journal's website, there have been thirteen broad country series[122], namely Brazil (2011), Bangladesh (2013), Canada (2018), China (2008), France (2016), Germany (2017), Israel (2017), India (2011), Japan (2011), Mexico (2006), Pakistan (2013), South Africa (2009), and USA (2014). Two Series (Brazil[123] and China[124]) included comments on these countries' roles within global health; however, only four (Canada, France, Germany and Japan) Series have included papers on these countries' roles within global health. These four papers all take different approaches to analysing national engagement in global health, and do not apply any consistent analytical methodology.

Alongside these OECD countries, there has also been interest in emerging economies, particularly the BRICS states, both as individual states and collectively. One realist review of the BRICS' influence found, "little evidence to support the assertion that the BRICS are influencing global health"; however, it also found that "[a]lthough influence was predominantly framed by BRICS countries' material capability, there were examples of institutional and ideational influence."[125] In terms of individual states, China has garnered the most attention with a review of its health assistance to Africa[126], its engagement in global

health diplomacy[127] and global health governance.[128] With a more constructivist lens, others have examined Brazil's engagement as soft power in the creation of the Framework Convention on Tobacco Control[129], and advocated the potential pathways for South Africa to engage more in global health diplomacy based on its history and HIV/AIDS legacy.[130] The papers reviewing emerging economies also do not use any sort of consistent methodological approach to understand how and where states engage.

This literature begins to explain why and where states engage, but to gain a deeper understanding of how states engage in global health, it is necessary to review the literature on power in global health.

Section Two: Power as a Concept and how has it been applied within Global Health?

As Shiffman recently wrote, "power is exercised everywhere in global health although its presence may be more apparent in some instances than others."[131] What is power in global health, and how is it exerted? Is exerting power a nation-state hosting an international forum to determine global priorities, an international NGO delivering services in a foreign state, an influential journal editor writing a commentary or a university producing an assessment of burden of diseases? How do states or global health policies like the MDGs or SDGs exert power? How can we distinguish between actors and assess their material and non-material resources to influence, coerce and/or persuade others in global health? Finally, why do actors exercise power and where do they exert power in global health? There is a growing recognition of the relevance of these questions for the future of global health. Despite an increasing understanding of the relevance of these concerns, analysis and empirical investigations of power in global health are nascent, and still evolving.

But why and how does power matter for the field of global health? What makes power analysis helpful, and how can we distinguish which power analysis could contribute from existing analysis and existing literature? Development assistance for health (DAH) in 2016 exceeded $37 billion.[132] These investments also influence how low- and middle-income countries (LMICs) invest their domestic resources, which dwarves DAH and is hundreds of billions of dollars in additional resources in LMICS, estimated to be at least $840 billion in public investments in 2014.[133] In spite of these DAH investments, there is a growing sense

that "global health" is not working. There is a notion that global health could be improved and practiced with better policies, outcomes and impact. The 2014-2015 Ebola crisis exemplifies this sense of failure and the need for improvement.

Despite decades of investment across Liberia, Guinea and Sierra Leone, with Liberia, specifically receiving the most per-capita US donor assistance of any country in the world, Ebola overwhelmed health systems and governments in all three countries in 2014 and 2015. The World Health Organization declared a Public Health Emergency of International Concern (PHEIC) in August 2014, but the region was not declared Ebola free until 2016. Ebola killed more than 10,000 across Liberia, Guinea and Sierra Leone and cost billions. Multiple reports criticised WHO and the global health community for numerous failures.[134] More specifically, Ebola exposed the failures of the existing International Health Regulations (IHR). Agreed to by 196 states, these regulations aimed to facilitate cooperation amongst states to contain outbreaks and avoid unnecessary interference with international traffic and trade. All three states failed to contain the initially small outbreaks; however, these three states were not alone in their inability to respond. According to a report on IHR capacities for WHO in 2013, 43 out of 46 African states had completed core IHR capacity assessments, but none of them successfully implemented the necessary capacities to contain outbreaks.[135] Moreover, in the wake of unfounded fears about the spread of Ebola, 58 states abrogated their IHR obligations and imposed travel restrictions.[136]

This sense of 'failure' in the case of Ebola and more broadly within global health stems from multiple myths and misperceptions. There is a myth that health is largely a technical issue which requires inputs to achieve outputs. There is misperception that global health is a field in which evidence determines the best policies. There is a misunderstanding that health is apolitical. Most fail to appreciate the profound political tensions within global health.[137] These myths fuel unrealistic expectations and cause confusion. Power analysis could be a compelling framework to begin to dispel some of these myths. It could bring increased clarity and improve assessments of why and how different actors engage; power analysis could also help assess and explain the outcomes of various actors' engagements in global health. To understand global health, it is critical to understand how power is used and abused. Power analysis could contribute to a reinterpretation and new understandings

within global health. The fields of international relations, political economy[138], sociology[139,140] and philosophy[141,142] apply power as a conceptual lens for understanding how actors behave and why they engage. Examining power in global health could build on this and contribute to developing greater analytical capabilities for the field.

Power is a central concept in international relations (IR), but its meaning and application have been, and remain contested. Scholars disagree about sources of power, the role of power and how actors exert power. Indeed, one IR scholar describes the concept of power as one of the "most troublesome in the field" and argues that "the number and variety of definitions should be an embarrassment to political scientists."[143,144] As another scholar argues, the "meaning we choose [for power] determines which relations we consider relevant and where we locate political spaces."[145] In other words, how we conceptualize and define power itself exerts power and determines how we measure and assess power.

In the past, scholars saw power defined by state resources like armies or navies and populations or territories; in other words, state power was defined by military force. As the critical actors, states were the focus of most analysis. Realist thinkers like Morgenthau and Waltz saw states competing for power in a world of anarchy. Power was often considered the domain of realism, and as other theories tried to distance and differentiate themselves from realism, they often avoided and sometimes neglected discussions of power; however, the literature on power evolved beyond a reductionist realist approach.[146] Theories began to consider 'relational power'. In other words, how actors, primarily but not limited to states, individually or in groups, related to each other, affected or influenced others' behaviour.

Liberal institutionalist thinkers Keohane and Nye illustrated how international regimes, including rules and norms, could create complex 'interdependence', changing how states interacted with each other and how institutions might be able to limit state power.[147] Similar to later literature on globalisation, Keohane and Nye describe how both international monetary policy and the governance of oceans evolved from bilateral or limited multilateral interstate discussions to more complex processes with interests being pursued by multiple state actors representing one state as well as non-governmental actors engaging within new

international organizations' governance platforms. This theory profiles the new mechanisms and concerns states need to consider when exerting power in pursuit of their interests.

Constructivist theorist Wendt argued that power "cannot be a uniquely realist claim" and called for an understanding of "power constituted primarily by ideas and cultural context".[148] Constructivists tend to focus on norm development, identity, and ideas. For example, Indonesia and Japan might both have developed a vaccine for a health problem, but the meaning that the development of the vaccine and the vaccine itself represent likely differs in these states. The possession or absence of this resource also affects how both of these states would interact and engage with other actors and states.

These IR theories were largely developed by American political scientists during the Cold War. At the end of the Cold War, IR theory evolved away from addressing a bipolar world to grappling with a uni- or multipolar world, and other theorists beyond the US also became engaged. With increasing recognition and focus on globalisation in the 1990s, theorists began to focus on global governance.[149] Realist, liberal institutionalist and constructivist thinking on power even within this new paradigm of global governance is still progressing. For example, in 2014 Naim argued power was disbursing and decaying in The End of Power.[150] There have also been emerging arguments for considerations of "New Power"[151] and, or "Sharp Power."[152] This still evolving discussion on power constrains scholars' abilities to analyse and assess how power is exerted and assessed.

These debates continue, and different approaches in terms of how to exert, frame, measure or understand power remain. As Lukes argues, "amongst those who have reflected on the matter, there is no agreement about how to define it, how to conceive it, how to study it, […] or how to measure it."[153] While there are few conceptual agreements about power, there is more consensus on the importance of understanding power and the lack of knowledge on how power functions.[154] Indeed, power continues to be at the heart of many debates within social sciences, and is increasingly viewed as relevant within the field of global health.

This section considers the concept of power by first reviewing popular and widely understood frameworks for hard, soft and smart power. Second, it considers Lukes' "faces of

power" framework. This understanding of power broadly overlaps with the most prominent IR theories, and evolved piecemeal but broadly in alignment with these theories. Third, it considers Barnett and Duvall's framework which was developed more recently as a broader and arguably more coherent approach.. These three different frameworks, approaches and discussions are the most often used IR approaches to understand power and are helpful when considering and analysing power; however, it is important to remember understandings of and exercises of power continue to evolve.

Hard, soft and smart power

Whereas Dahl's famous formulation of hard power is the ability of A to force B to do something it would not otherwise do (usually deploying military or economic resources), Nye's conceptualization of soft power attracts or co-opts actors and persuades actors without the use of coercive force. Soft power 'rests on the ability to shape others' preferences.[155] Soft power is, in Nye's words, "not merely the same as influence. After all, influence can also rest on the hard power of threats or payments. And soft power is more than just persuasion or the ability to move people by argument, though that is an important part of it".**Error! Bookmark not defined.** Nye contrasts soft power as "attraction" as opposed to "coercion" or "inducements" and argues that a state's soft power relies on "its culture (in places where it is attractive to others), its political values (when it lives up to them at home and abroad), and its foreign policies (when they are seen as legitimate and having moral authority)." In global health, Brazil's influential role in advancing its political values on the negotiation of the Framework Convention on Tobacco Control is often cited as an example of soft power.[156]

More recently, American foreign affairs specialists have argued that to best advance interests, actors should seek to combine both hard and soft power to create 'smart power'.[157,158] Nossel argues that states could harness smart power through "alliances, international institutions, careful diplomacy, and the power of ideals."**Error! Bookmark not defined.** Nye argues states can "complement […] military and economic might with greater investments in […]soft power."**Error! Bookmark not defined.** In a special Center for Strategic and International Studies (CSIS) Commission on Smart Power which Nye co-chaired, he and his

fellow Commissioners argue that smart power should be considered as "an approach that underscores the necessity of a strong military, but also invests heavily in alliances, partnerships, and institutions of all levels to expand [...] influence and establish legitimacy of [...] action."[159] For example, one might consider American efforts on HIV/AIDS like the President's Emergency Program for AIDS Relief (PEPFAR) advancing American interests in strategic states backed up with financial resources as an example of smart power. Another example might be the US military's intervention in Afghanistan or Iraq followed by investments in infrastructure.

In contrast to other frameworks, hard, soft and smart power present a different, more popular and easily understood framework for considering power. These types of power are often referred to in popular culture and media commentary pieces. While smart and soft power could include some covert exertions of power, this (hard, soft and smart) framework is primarily concerned with overt forms of power. Broadly speaking, state engagement in global health is sometimes seen or considered as part of a soft power approach. For example, the United Kingdom's All-Party Parliamentary Group (APPG) on Global Health presented evidence in September 2013 to the UK Parliament on how the state could advance its interests using global health as soft power.[160]

Lukes' Three Faces of Power

In 1957, Dahl first published *The Concept of Power* which famously argued that power is defined "in terms of a relation between people" and when A "can get B to do something B would not otherwise do."[161] This is one of the most well-known conceptualizations of power, and is considered the first face of power, ie the ability of one actor to force another actor to do something they initially did not want to do. This face of power is usually associated with realist theory and is often equated with military power. The first face of power is considered zero-sum with power being exerted "over" another instead of "having power to". This form of power focuses largely on resources also prompts considerations of other potential resources beyond military, like financial resources. It also raises the question about how resources (and which resources) can be translated into outcomes or effects. For this face of

power, one might consider an actor like the World Bank using the threat of withholding loans to coerce a country into pursuing specific health reforms.

The second face of power is considered agenda-setting; this also sometimes known as "non-decision making" as actors can exclude some issues from even being considered. As Bachrach and Baratz argue, powerful actors can control an agenda limiting or controlling which issues are or are not on the agenda by determining who sits at the table.[162] This is the ability of actors "to create or reinforce barriers to the public airing of policy conflicts." Actors are managing, perhaps even manipulating, processes, institutional set-ups or so-called international regimes to their own favour and limiting the decision space for choices. A critical question here is the tension between actors, primarily states, and these international regimes. How much are states able to control and manage these regimes, and or how much independence do these international regimes exert on their own? An ongoing example could be how an influential actor like the Bill and Melinda Gates Foundation uses public relations and communications firms (this practice is not limited to the Gates Foundation within global health as NGOs and others also do this) to help shape and influence media (including social media) campaigns to determine which issues are considered and which issues are not considered in public debate and discourse; this contributes to the prioritization of policy issues and the eventual deployment of resources.

The third face of power is the ability to control an actor's thoughts or shape their preferences. Lukes argues, "'the most effective and insidious use of power is to prevent such conflict from arising in the first place."[163] For example, one actor might be able to influence another actor's initial interests without the other actor even realizing this thus anticipating and avoiding any potential conflicts before they even arise. In global health, this could be done by controlling how issues are conceptualized or considered. For example, the Global Burden of Disease analysis is an effective way of producing a tool for conceptualizing health challenges which shapes, and in some cases might control, how policymakers prioritize their efforts, develop policy and invest in relevant interventions.

These three faces of power could be summarized as overt, covert or latent forms of power. While the link between these faces of power and theory is not perfect, some scholars

also associate the first face of power with realism, the second face with liberalism or institutionalism and the third face with constructivism.[164] Of course there are some overlaps between and across these faces, but these different approaches evolved broadly at the same time as international relations theories evolved and are generally aligned. The next framework builds on Lukes' but advances the analysis by expanding the framework.

Barnett and Duvall's framework

Global governance scholars Barnett and Duvall present a slightly different framework for understanding power, which is helpful for understanding how states negotiate policy processes.[165] They define power "as the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate."[166] Their framework presents a coherent and integrated approach arguably helping scholars move beyond the idea that multiple concepts are competing, and instead see connections and intersections across approaches. They also contend that their framework "does not map precisely onto different theories of international relations" and thus, "help[s] scholars move away from perpetual rivalry in disciplinary "ism" wars and toward dialogue across theoretical perspectives."[165] This approach helps identify and codify different ways in which different actors engage and exert power, illustrating possible exertions of power that are overlooked by other frameworks.

The Barnett and Duvall framework differentiates between specific and diffuse relations as well as direct and indirect forms of power (included in the table below)— namely, compulsory (direct power, such as use of military or legislative force), institutional (indirect power, such as how international institutions are designed to favour one actor over another), structural (the overall constitution or framework of actor and their roles) or productive (control over the possession and distribution of resources) power.

Table 1: Barnett and Duvall's 2x2 framework for understanding power[165]

		Relational specificity is	
		Direct	*Diffuse*
Power works through	Interactions of specific actors	Compulsory	Institutional
	Social relations of constitution	Structural	Productive

For global health, one could think of a donor agency using the possibility of funding in a poor state with limited resources to exert compulsory power; for example, one could think about a wealthy state like the US or the UK using the possibility of donor support to encourage a low-income state to consider privatizing parts of its health system. For institutional power, one could consider a well-positioned state leveraging a multilateral agency to exert institutional power; for example, one could think about a country like Japan using an institution like the World Bank or the World Health Organisation to advance its interests. For structural power, one could imagine a prestigious university, NGO or private-sector actor positioning its staff as experts to exert structural power by virtue of their position; for example, in the wake of the Ebola crisis in West Africa, a number of civil society organisations and management consultancies seconded and embedded staff within governments in Liberia, Sierra Leone and Guinea to provide technical guidance and support. Finally, for productive power, one could imagine a UN agency or a private-sector actor advancing and promoting a particular agenda or approach to addressing health challenges as an exertion of productive power; for example, researchers at the University of Washington in the US work on the global burden of disease (GBD), and this approach to analysing health exerts power by shaping understanding and contributing to prioritization of health challenges.

A key insight by Barnett and Duvall is that they understand power as a relationship. Barnett and Duvall's framework provides a broad taxonomy for analysing power This framework provides a coherent way of thinking about the different ways in which actors,

particularly state actors, could exert power, and how these different exertions might interact negating or amplifying efforts. One could think about compulsory power as material power, and structural, institutional and productive power as various forms of non-material power. Differentiating between these different forms of power, as explained above, enables closer analysis and illustrates ways in which actors engage and exert their interests. It also presents opportunities for comparing and contrasting how different actors use competing forms of power in diverse settings and contexts.

Yet one limitation of Barnett and Duvall's framework is that it does not address relative power, ie how one form of power compares to another or how one exertion of power compares to another exertion of power. While the framework can help identify different exertions of power, it is not easily able to distinguish between different instances of exerting power. Moreover, the framework is not able to assess or judge persuasion, ie how persuasive one argument might be in comparison with another.

Power within Global Health Literature

There is an increasing recognition of, and attention given to, the concept of power in global health, but discussions remain embryonic. As Erasmus and Gilson argued in 2008 "power, a concept at the heart of the health policy process, is surprisingly rarely explicitly considered in the health policy [...] literature."[167] Since they wrote this, the field has slowly evolved. Similar to how power evolved in IR theory, power in international and then global health was initially primarily associated with states and material resources like financing or medical equipment or drugs. When power was considered, in the past it was taken for granted that wealthy states like the United States or the United Kingdom simply dominated the policy agenda using their monetary resources. Indeed, as one recent study concluded, "money is [...] a very important source of power" in global health.[168] In other words, the prevailing understanding of power in global health is that rich states exert power through their material resources.

Inspired by some liberal and especially constructivist thinking; however, this understanding is being challenged and is evolving within the field of global health. Following discussions of globalisation and global governance, some scholars argue that the state is becoming "hollowed out" by globalisation[169], that a proliferation of new global health actors are fragmenting the global health governance landscape to an extent that states no longer held power over policymaking.[170] Accompanying this is an increasing recognition of and understanding of epistemic communities in global health, ie how ideas, approaches expertise and networks serve as potential sources of power shaping the allocation of resources and shifting policy within global health. Scholars now argue that "[g]lobal health policy-making is an arena of contested interests, power and ideas, shaped by the interaction of coalitions."[171]

For example, Harmer showcased how "discourse justified, legitimised, communicated and coordinated ideas about the practice of global health partnerships."[172] McDougall examined how maternal and child health gained attention and resources in the MDG-era recognizing the role of networks and concluding that "how ideas are constructed, portrayed and positioned by actors within given contexts" plays a critical role."[173] Shearer and others looked at institutions, interests, ideas and networks on health policy changes in Burkina Faso.[174] In another example, Storeng and Mishra sought "to discern the genealogy of the idea of health systems within international health, and help explain the changing and varied meanings of the term within public health policy, research and practice, across a wide variety of geographical settings, cutting across global and local levels."[175] More recently, showcasing how global health networks could affect and shape policy, scholars collected case-studies examining and comparing health issues in pairs, namely tobacco use and alcohol harm, maternal and neonatal mortality, early childhood development and surgically-treatable conditions as well as tuberculosis and pneumonia.[176] This literature has contributed to a growing awareness of the politicization of evidence in policymaking[177], an understanding of how underlying power imbalances influence the prioritization of health issues, and a deeper recognition of which solutions are adopted or ignored.

While appreciating both new actors, as well as the growing importance of epistemic communities in global health, is important, analysis predicting the decline of states within

global governance may be over-stated.[34] States' roles, resources and abilities are evolving, but states appear to remain dominant and decisive actors in global health. State power to shape policy and determine priorities with global health remains unparalleled. Obviously, the magnitude of these changes varies by state, but these changes are not necessarily tied to growth or shifts in material resources. What is changing, however, is how states use and deploy non-material resources to shape the agenda and exert their power. In other words, states are "transforming" in response to globalisation. States can (and increasingly do) recognize how epistemic communities exert power, and states can seek to leverage these communities to serve and advance their interests. State actors can sponsor these communities providing financial resources or access to policymakers where epistemic communities can then exert influence. For example, both the Australian and Canadian governments support tobacco control researchers by providing research financing which is aligned with their national efforts to advance tobacco control. Scholars have also recognized how an emerging economy like Thailand plays an outsized role in global health[178], particularly at the intersection of emerging issues like trade and health.[179] More recently, scholars note how China appears to be increasing its engagement in global health using it as a tool to achieve its foreign policy goals,[180] or wonder how the US election of President Trump will change American global health policy and how other states will change their policies in response.[181]

Scholars have also considered emerging economies, like the BRICS, and sought to understand how they exert their influence. In this case, scholars suggest that "[a]lthough influence was predominantly framed by states' material capability, there were [also] examples of institutional and ideational influence.[182] In the same way scholars' understandings of power evolved from a focus on material to non-material resources, states' understanding and its abilities to exert power and influence are evolving from using material resources to more sophisticated approaches using non-material resources as they increase their experience within global health.

Literature Review on Power in Global Health

For the purpose of this chapter, the author conducted a literature review using the search terms "Global Health" and "Power" in Pubmed. This search returned 1,016 results in June 2017. After adding a filter to limit the search results to references since 2000, 962 references remained. After reviewing these results for relevance (removing the majority of references referring to statistical "power" or other non-relevant article like those concerned with "power plants"), roughly 100 articles remained. This search was repeated for the period between June 2017 and January 2019 with additional articles being added to the discussion below.

Within these remaining articles, first, many are recent commentaries or comments exploring power and the field of global health in response to Shiffman's seminal article, *Knowledge, moral claims and the exercise of power in global health*.[123] Second, there are some global and national policy articles which explicitly use or consider power as a framework for analysis; however, these studies are limited in number and are not consistent in their approaches or methodologies. The remaining articles are commentaries or editorials referring to power broadly. This search did not include journals which are not indexed, for example *Global Health Governance* or the *Journal of Health Diplomacy* (instead, these journals archives were reviewed separately).

In 2014, drawing on Dahl, Barnett and Duvall, and Bourdieu, Shiffman illustrated the importance of power for global health using three potential case studies (the role of the *Lancet*, the role of the Institute of Health Metrics (IHME) and the negotiation of the post-2015 development agenda). Shiffman argued in favour of more exploration and deeper analysis on how epistemic and normative as well as productive and structural forms of power shape global health. This article spurred a flurry of responses and further comments, particularly in the *International Journal of Health Policy and Management* (IJHPM).

Hanefeld and Walt recommended applying Bourdieu's theory of different capitals (namely, cultural capital, economic capital, social capital and symbolic capital) to better understand sources of power in global health.[183] Engebretsen and Heggen responded noting the productive power of language and concepts that shape discourse, including global health.[184] Bump highlighted a legitimacy deficit in existing global health institutions.[185] Rushton called for "social scientists interested in the global politics of health to be reflexive

about our own exercise of structural and productive power and the fact that researching global health politics is itself a political undertaking."[186] Benatar called for a whole "new framing perspective for global health that could reshape our thinking and actions."[187] Horton summarized stating, "power matters in global health."[188] He continued, "[h]ow certain issues in global health get attention, and which issues are prioritised and deprioritised (and why); how decisions are made, according to what criteria, and by whom; how actions are implemented and accounted for, and by which institutions; and how those invested with the power to make decisions are selected and rewarded should all be a much greater subject of scrutiny."

Shiffman's commentary and the ensuing discussions generated attention and new interest in power within global health. For example, Ooms highlighted how considering norms, politics and power in global health are based on shared normative premises, which the field of global health lacks given the diversity of academic backgrounds involved.[189] More recently Sheikh and others argued that "[g]lobal [h]ealth practices must actively span and disrupt boundaries of geography, geopolitics and constituency, some of which are rooted in imbalances of power and resources."[190] This growing interest in power was also reflected during the 2016 Health Systems Research Symposium in Vancouver, Canada, where power served as a conference subtheme, "engaging power and politics in promoting health and public value."[191]

This recent attention to power also builds on a handful of past articles which used power as a framework for analysis at the global level. For example, Lee used soft power to analyse Brazil's influential role in the negotiation of the Framework Convention on Tobacco Control.[192] Kevany argued that global health is itself potentially a reflection of a smart power approach.[193] Smith examined the implications of the increasing power of economic organizations for global health governance.[194] Buse and Harmer applied Lukes' three faces of power to examine the politics of public-private partnerships.[195] In 2014, Buse and Hawkes briefly invoked Lukes' three faces of power to consider the negotiation of the post-2015 development goals.[196] More recently (and after the completion of this literature review), Lima and Galea applied Lukes' to analyse corporate influence on health at the macrosocial level.[197] These few studies generally reflect upon or refer to power in global health using one

of the various theories mentioned above and are innovative in that they draw upon the concept of power; however, they do not justify their choice of a specific framework. Beyond a few applications of Lukes, they also generally do not use the same frameworks. They neither compare or differentiate between frameworks nor discuss any potential limitations of a given framework. They also do not include any empirical studies.

Alongside these few global level studies, there is a small but increasing number of studies using power explicitly as a framework to analyse national health policy processes. Dalglish and colleagues consider political authority, financial resources and technical expertise to examine how power dynamics affected child mortality policy in Niger.[198] Dalglish and colleagues also analyse medical power in two case studies in Niger and India.[199] Koduah and colleagues apply Mintzberg's five general sources of power (control of a resource, a technical skill, or a body of knowledge; authority by virtue of one's legal and structural position; and access to those who can rely on the other four sources of power) to examine how and why Ghana's maternal health policies evolved between 2002 and 2012.[200] Mwisongo and colleagues use Arts and Tatenhove's conceptual framework on power (relational, dispositional and structural) to analyse how power featured in some African countries during health policy dialogues.[201] Lehmann and Gilson apply VeneKlasen and Miller's framework (power over, power with, power to and power within) to analyse how actors exerted power in a South African community health program.[202] Fischer and Strandberg-Larsen examine power as influence using Kingdon's stream theory to investigate how donors and government actors engaged on health policy in Tanzania.[203] Barasa and colleagues combine Lang's actor interface analysis model with VeneKlasen and Miller to analyse power and actor relations on priority setting and resource allocations in hospitals in Kenya.[204] Gilson reviewed and synthesized a number of articles looking at the role of frontline health workers in exerting discretionary power in implementing health policies.[205]

Taken together these studies begin to illustrate how actors can exert power to advance their interests in national health policymaking. These different studies generally adopted and applied one power framework or extrapolated on an existing framework. Aside from one of the studies (Mwisongo), all of the studies focused on one country and did not compare across countries. Other than the two papers which drew upon the VeneKlasen and

Miller framework (Lehmann and Gilson as well as Barasa and colleagues), each of the papers applied a different framework and broadly did not rely on common literature for understanding or contextualizing their power methodology. In other words, there was no common framework for studying power at the national level as each study drew upon different fields of academic literature. After the completion of this literature review and building on an interactive consultation during the Vancouver Health Systems Research Symposium, Sriram and colleagues published, "*10 best resources on power in health policy and systems in low- and middle-income countries.*"[206] While this study is largely focused on power in health systems, it also confirms that the majority of literature on power is focused on the national level, with a growing discussion on conceptual issues, but limited research on power at the global level.

Conclusion: How might international relations and power analysis contribute to understanding Global Health?

While there are some early attempts to better understand and assess why states engage in global health, knowledge and understanding of how and where states engage remains limited and is still emerging. For why states engage, the 2006 Oslo Declaration provided catalytic encouragement and detailed why states should engage more in the nascent field of global health diplomacy. These state actors, along with global health academics and advocates, encouraged other states to engage more. Simultaneously, scholars began to delineate the various reasons and motivations to both encourage, justify and explain subsequent state actions.

While there is limited application of international relations theories, there are now some initial suggested frameworks for assessing why states might engage. Nevertheless, these studies and understandings of why states engage will need to be applied on a case-by-case basis depending on the country considered. To understand why state actors are engaging in global health policymaking, constructivism is an essential international relations theory. Constructivist theory focuses on issues like identity, norms and framing and these approaches can help illuminate why and how state actors engage in global health policymaking.

In terms of where states engage, the studies reviewed above describe OECD states participating actively in the G7 and G20 processes, through the Bretton Woods institutions and UN system as well as through their own bilateral mechanisms and relationships. The BRICS and other emerging countries have their own BRICS Summits, but generally tend to engage more through UN institutions, particularly through the World Health Organisation's World Health Assembly. BRICS and other emerging economies also engage through other institutions or fora like the WTO which are generally less used by OECD countries to engage in global health policymaking. They also engage within their own sub-regions.

For considering how states engage, however, the few studies of both OECD and emerging states' engagement in global health, remain early assessments. These studies rarely draw on IR theory or power frameworks, but sometimes implicitly align with IR theories.[2] They do not use established power methodologies or frameworks to assess how states engage in global health, and thus it is difficult to compare the studies and/or compare how states engage. These early studies provide situational and contextual backgrounds of how global health fits within states' foreign policy traditions, but they are broadly more descriptive and prescriptive than analytical. At times, some even appear to be designed more as advocacy pieces (instead of analysis) and appear to be seeking to nudge state actors to improve the implementation of their global health policies or strategies. For understanding how state engage, power analysis, specifically applying Barnett and Duvall's framework, could be helpful.

For the nascent literature applying power in global health, the overall number of studies using power explicitly is limited. There are more analyses examining power within national health policy processes than at the global level policy level. Nevertheless, the combined low number of case studies limits the ability to compare and contrast different methodologies for applying power for analysis. At the global level, the emerging discussion

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[2] It should be noted, however, that there have been discussions within global health which use or apply IR theory; however, this is applied more broadly on the field, or particularly to health security issues, and less specifically to understand state engagement. For example, McInnes and Lee apply a constructivist approach to understand how global health has been socially created, shaped in theory and practice by particular interests and normative frameworks by examining the interactions of foreign policy and health diplomacy, health and the global political economy, global health governance and global health security. McInnes, Colin, and Kelley Lee. *Global Health and International Relations.* 1 edition. Cambridge, UK; Malden, MA: Polity, 2012. In another example, Rushton and Williams argue that "global health policy" is grounded in the "deep core" of neoliberalism. Rushton, Simon, and Owain David Williams. "Frames, Paradigms and Power: Global Health Policy-Making under Neoliberalism." *Global Society* 26, no. 2 (April 1, 2012): 147–67. https://doi.org/10.1080/13600826.2012.656266.

of power is building on previous work analysing agenda setting, largely building on Kingdon's model. For example, Shiffman examines why and how a number of issues within global health gained priority and attention within global health.[207,208,209] There is also an increasing recognition of the importance of framing within health policy, which could be helpful.[210,211]

Despite an emergent interest and some studies of power on national health policymaking building on foundational work by Walt[212], the role of power in determining global health policy remains underappreciated, seldom studied and little understood. This is especially significant as many of the global level policy processes have increasingly recognized implications for national health systems.[213] Moreover, many often consider health policy processes as shaped and determined by evidence-based approaches instead of a recognizing health as a profoundly political space in which priorities and policies are contested and ideas, networks, expertise and information are deployed to advance competing approaches. As Topp recently wrote, "[w]e must […] be conscious of the power of discourse to influence the way we articulate and act our priorities."[214] While some health scholars have explored how power is expressed and exercised, or have touched upon power in examining agenda-setting, power is rarely explicitly used as a framework for analysis at the global level in health policy processes.

One important exception to this shortage of studies of power at the global level is a 2012 book, *Global Tobacco Control: Power, Policy, Governance and Transfer*, analysing global tobacco control policies. Cairney, Studlar and Mamudu apply Lukes' second face of power to showcase how the tobacco industry kept tobacco control off the agenda and ensured "non-decision making", ie that there was little discussion about tobacco control at the global and national level.[215] Applying a power framework to understand how the private sector engages in health appears like an obvious policy area in which power analysis could help illuminate how actors shape policy. Despite not using power as a framework explicitly, other studies have showcased how various industries have exerted tremendous ideational and productive power restraining public health actions.[216,217,218] More recently, evidence surfaced about how Coca Cola[219], the alcohol industry[220] and other interest groups like those supporting sugar[221] have shaped research and media in an effort to influence public discourse.

In some ways, it is easy to see some of these negative influences and exertions of power within global health; however, Lee challenges the global health community and asks how, "might [we] go further and ask how structural or productive power might be harnessed to serve, rather than obfuscate, global health efforts?"[222] To do this, it seems it would be important to have a deeper and broader understanding of how actors engage and exert power. More specifically, Shiffman calls for scholars to "examine how [power] works in practice, with a view to specifying more clearly what constitutes its legitimate use, how to ensure those who wield it are held accountable, and how best to leverage it to achieve common aims surrounding equity and improved population health."[223] This then raises the question: how could power be used for future global health analysis? The next chapter will apply power analysis to review how state actors exerted power and engaged in the process to create the Millennium Development Goals.

Chapter Three

How States Exerted Power to Create the Millennium Development Goals and How this Shaped the Global Health Agenda: Lessons for the Sustainable Development Goals and the Future of Global Health[3]

Key Points:

- From 2000, the eight Millennium Development Goals (MDGs) provided the framework for global development efforts transforming the field now known as global health. The MDGs both reflected and contributed to shaping a normative global health agenda.
- In the field of global health, the role of the state is largely considered to have diminished; however, this paper reasserts states as actors in the conceptualisation and institutionalisation of the MDGs, and illustrates how states exerted power and engaged in the MDG process. States not only sanctioned the MDGs through their heads of states endorsing the Millennium Declaration, but also acted more subtly behind the scenes supporting, enabling, and/or leveraging other actors, institutions and processes to conceptualise and legitimize the MDGs.
- Appreciating the MDGs' role in the conceptualisation of global health is particularly relevant given the transition to the MDGs' successor, the Sustainable Development Goals (SDGs). The SDGs' influence, impact and importance remains to be seen; however, to understand the future of global health and how actors, particularly states, can engage to shape the field, a deeper sense of the MDGs' legacy and how actors engaged in the past is helpful.

Introduction

From 2000-2015, the eight Millennium Development Goals (MDGs) provided the framework for global development efforts. The MDGs shaped billions of dollars of investment, and impacted the lives of many. Advocates contend they invigorated institutions, stimulated research communities, inspired civil society movements and galvanized politicians and citizens.[224] Scholars argue the MDGs represented a new 'super norm' dominating the global development agenda.[225] Three out of the eight goals related directly to health and the other

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five goals focused on critical determinants of health. The MDGs' influence was pivotal to creating a normative global health agenda, which largely continues to shape the global health agenda today. Appreciating the MDGs' role and legacy in the conceptualization of global health is particularly relevant as the world transitions from the MDGs to the Sustainable Development Goals (SDGs). The SDGs' influence, impact and importance remains to be seen; however, to understand global health now and in the future and assess how actors, like states, can engage to shape the field, a deeper sense of the MDGs' origins and of how actors engaged in the past is instructive.

Defining and determining what is and what is not considered part of the global health agenda remains disputed. There is no single global health agenda.[226,227] Yet how global health is defined and understood shapes which health challenges are considered.[228,229] The definition impacts the design of how funds are raised and eventually disbursed. It influences discourse and how policymakers consider issues. It determines the education of students and future policymakers. The global health agenda can also contribute to the creation of new global health institutions like the Global Fund or GAVI, the Vaccine Alliance. In other words, the conceptualization of global health exerts power by determining the global health agenda. As recently argued, 'power is exercised everywhere in global health although its presence may be more apparent in some instances than others'.[230]

While the tremendous normative power of the MDGs is increasingly recognized, there is limited analysis considering the explicit role of state actors within the process to create the MDGs. Existing literature highlights the important role of civil society and non-governmental actors[231], "norm champions"[225] and "well-placed individuals within the UN" [232]; however, to better identify both the origins and future of global health as a field of policy action, it is necessary to reconsider how state actors engaged in this process to create the MDGs. What were state actors' roles in the policymaking process to create the MDGs? Why and how did state actors engage to shape and influence the process?

Despite broad recognition of the MDGs' and their role in development, their relationship to the rise of the field of global health is less explicitly acknowledged. Part of this could be the tension between the normative aspiration of global health to transcend

states and national borders with the reality of the MDGs and global health institutions still operating within an UN-state system. This could help explain why seminal articles assessing the transition from international to global health do not even mention the MDGs.[233] This is somewhat paradoxical given that the MDGs had a strong health focus and that the emergence of global health in the late 1990s and early 2000s broadly coincided with the United Nations' (UN) Millennium Declaration. The MDGs also built on previous advocacy efforts. For example, MDG 4 on child mortality built on the experience of the child-survival revolution in the 1990s.[234]

The MDGs also matter for global health as issues not included within the MDG agenda, like non-communicable diseases (NCDs), received reduced interest, attention and resources within the field of global health. Conversely issues included in the MDGs, like HIV/AIDS, gained disproportionate and distortionary attention possibly displacing other health spending.[235] Some experts argued that the quantification of the MDGs and their targets led to "simplification, reification and abstraction" which contributed to redefining some of the priorities.[236] By 2014, roughly $23 billion out of a total of $36 billion of Development Assistance for Health (DAH) was directed towards MDGs Four, Five, and Six whereas only $611 million was directed towards NCDs.[237] Moreover, since 1990 DAH associated with the MDGs increased more than any other areas.[238] While this was not necessarily the case for every goal and target within the MDGs, it was the case that if a health challenge was not an MDG goal or target, it was more difficult to raise support and awareness for this issue in the MDG era. For example, anticipating this situation, former UNAIDS Director Peter Piot fiercely advocated for HIV/AIDS to be included in the MDGs.[239]

At their inception, the MDGs caused rigorous debate amongst academics, civil society and policymakers around the world with one early critic calling them a "Major Distraction Gimmick" [240] forced upon developing countries by the triad of the United States, Europe and Japan.[241] Yet these early critiques were eventually forgotten or ignored considering the power of the MDGs' supporters, and as the MDGs became more entrenched as development policy. Indeed, a recent review[242] found that "only 15 percent of MDG-related publications expressed concerns with the MDGs and only one-third of these discussed intrinsic limitations. From this narrower literature, the review considers MDGs' limitations in terms

of the development process [243], structure[243], content[244] as well as implementation and enforcement.[245]

Despite these critiques, an early Millennium Project report declared, that the MDGs were "the most broadly supported, comprehensive, and specific poverty reduction targets the world has ever established."[246] A UN MDGs final report defined them as the "most successful anti-poverty movement in history."[247] The MDGs reflected a departure from the 1980s Washington consensus development to a more people-centred or human development in the 1990s expressed during a series of UN conferences on development issues.[248] As experts noted the MDGs arguably "created a new narrative of international development centred on global poverty" with the MDGs "the legitimized framework for defining what this means" and the "reference point around which international debates about development revolve."[240]

More specifically within global health, the MDGs remained contested. The MDGs represent the apex of an extremely "vertical" (focused on specific diseases, like HIV/AIDS or malaria as opposed to a horizontal approach focused on health systems) approach to health interventions. The three health-specific MDGs focused on a small number of vertical interventions to combat specific diseases and maternal and child mortality as the most effective approach to improve health. In 2008, analysts highlighted "[t]he potentially destructive polarization" between vertical and horizontal approaches.[249] The Maximizing Positive Synergies initiative (detailed in Section Two below) helped diffuse this tension leading to greater attention to health systems and a more integrated approach within health. But the MDGs remained the dominant policy doctrine. In fact, it appears the MDGs dominated the agenda so much so that they even eventually contributed towards a more horizontal approach. One analysis found that "critical factors behind the recent burst of attention [to health systems] include fears among global health actors that health systems problems threaten the achievement of the health-related MDGs."[250] (Of course, defining health systems and how to best strengthen them to help achieve the MDGs is also heavily disputed. Health systems frameworks are strongly shaped by their authors.[251]) Within global health, the MDGs shaped priorities and investments. The MDGs both reflected an emerging definition of global health, and contributed to advancing this conceptualization. They exerted power and

facilitated by the UN and civil society partners were enacted through and within nation states.

The role of power as a concept and framework for assessing how global health policy is determined is often overlooked. As Erasmus and Gilson argued, 'power, a concept at the heart of the health policy process, is surprisingly rarely explicitly considered in the health policy implementation literature.'[252] Frameworks for understanding power remain contested and empirical evidence for applying these frameworks is often lacking. Given the importance of the MDGs in shaping the global health agenda, understanding how states engaged to create the MDGs could help illustrate how actors exert power in global health and hence inform how actors both engaged in the conceptualization of the SDGs and might engage with their implementation shaping the future of global health.

Based on published literature and unpublished policy materials, this chapter focuses on reconsidering the role of state actors as critical actors in both the conceptualization and institutionalization of the MDGs. While state engagement in the recent SDG process was more visible and legible, some states, contrary to common perceptions, were also critical actors in the creation of the MDGs. State actors within global health are sometimes overshadowed by the attention given to the proliferation of new actors, like public-private partnerships, civil society organizations or philanthropies.[253] In the case of the MDGs, state actors not only sanctioned the MDGs through head of states endorsing the Millennium Declaration, but also acted more subtly behind the scenes supporting, enabling (sometimes by not blocking), and/or leveraging other actors, institutions and processes to conceptualize the MDGs.

This chapter considers why and how state actors exerted power and engaged in the MDG process, and describes the context for the case-studies on Japan and Indonesia. This chapter starts by presenting an overview of different potential frameworks for analysing the role of states in the creation of the MDGs, and selects the Barnett and Duvall framework (considering compulsory, productive, structural and institutional power) for analysis.[254] Second, this chapter applies this framework describing and analysing how states exerted power in the creation and institutionalization of the MDGs (and emergence of the SDGs) in

three distinct phases (2000-2005; 2005-2010; and 2010-2015) in relation to the emergence of the field of global health. Finally, it considers and discusses the implications of this analysis for the recent transition from the MDGs to the SDGS, and what this might mean for the implementation of the SDGs and the future of global health.

Section One: Background on power analysis for global health

Power is a central concept in social sciences, but its meaning and application is heavily contested. Scholars disagree about sources of power, the role of power and how actors exert power. Indeed, one international relations scholar describes the concept of power as one of the 'most troublesome in the field' and argues that 'the number and variety of definitions should be an embarrassment to political scientists.'[255] Traditionally scholars have seen power conceptually defined by an actor or state resources like armies or navies and populations or territories. But in the second half of the twentieth century, this approach evolved to consider 'relational power', in other words, how actors, individually or in groups, related to each other and affected or influenced others' behaviour. Beyond this, many debates and different approaches in terms of how to exert, frame, measure or understand power remain. Yet there is a consensus on the importance of understanding power and the lack of knowledge on how power functions.[256] There is a similar, but slightly less mature, state of affairs in the global health literature.

As discussed in Chapter Two, there is an increasing recognition of the concept of power in global health, but discussions are still nascent.[257] Similar to international relations, power in health remains associated with possession of or access to material resources like financing or medical equipment or drugs; however, there is an emergent recognition of ideas[258], networks[259], expertise and information[260] as potential sources of power. This is critical for global health as many consider health a policy process dictated by technical choices instead of recognizing health as a profoundly political space in which various priorities and policies are fiercely contested and ideas, networks, expertise and information are deployed to advance competing approaches.[257]

From the international relations literature, there are a few different frameworks for understanding how power is exerted, which could be considered for global health. One of the simplest and perhaps most intuitive ways to illustrate how power is exerted is to compare hard and soft forms of power. Robert Dahl's famous formulation of hard power is the ability of A to force B to do something it would not otherwise do (usually deploying military or economic resources). Joseph Nye's conceptualization of soft power attracts or co-opts actors and persuades actors without the use of coercive force. In global health, Brazil's influential role in advancing its political values on the negotiation of the Framework Convention on Tobacco Control is often cited as an example of soft power.[261] Others argued that to best advance interests, actors should seek to combine both hard and soft power to create smart power.[262] For example, one could consider American efforts on HIV/AIDS like PEPFAR advancing American interests in geopolitically strategic countries backed up with financial resources as an example of smart power.

Anotherframework from sociology is Lukes' three faces of power.[263] The first face of power is the ability of one actor to force another actor to do something they initially did not want to do, ie hard power. The second face of power is considered agenda setting and framing; powerful actors can control the agenda and determine who sits at the table and which issues are considered to be or not be on the agenda.[264] The third face of power is the ability to control an actor's thoughts. For example, one actor might be able to shape another actor's initial interests. These three faces of power could be summarized as overt, covert or latent forms of power. This three faces of power framework was briefly applied to examine the process to create the SDGs.[265] While the hard, soft, smart power framework is helpful for examining state actions at the international level, Lukes' faces of power is most helpful for assessing the negotiation of policy processes as the framework illustrates how actors can shape the agenda by putting or removing issues from consideration (the second face of power) and/or controlling the terms or framework for conceptualizing issues (the third face of power).

Building on Lukes, global governance scholars Barnett and Duvall present a broader framework for understanding power, which is insightful for understanding how states negotiate policy processes. They consider power to be about relationships, and define it 'as

the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate.'[266] They differentiate between four forms of power—compulsory power (such as use of military or economic force), institutional power (such as how international institutions are designed to favour one actor over another), structural power (the overall constitution or framework of actor and their roles) or productive power (control over the possession and distribution of resources).[254]For global health, one could think of a donor using funding to exert compulsory power; a well-positioned state leveraging a multilateral agency to exert institutional power; a prestigious university or NGO positioning its staff as experts to provide technical policy support as exerting structural power; and a UN agency or a private-sector actor advancing and promoting a particular agenda or approach to addressing health challenges as an exertion of productive power.

Given the breadth of Barnett and Duvall's framework to distinguish between different forms of power, particularly to identify and illuminate ways in which power is exerted in ways usually unseen or unrecognized, the next section below applies this framework to analyse and illustrate state engagement in the creation of the MDGs.

Section Two: State Power and the creation of the MDGs

Phase One 2000-2005: Conceptualization and Campaign

One year after the unanimous endorsement of the 2000 Millennium Declaration during the Millennium Summit with 149 heads of states and governments (the largest ever such gathering), United Nations' Secretary General Kofi Annan submitted a report to the General Assembly entitled, a *Roadmap towards the Implementation of the Millennium Declaration.*[267]This report was adopted by the General Assembly, and recommended it be considered a 'useful guide' for operationalizing the Declaration. An annex to this report included the framework for the Millennium Development Goals (MDGs): eight goals, eighteen targets and forty-eight indicators. This MDG resolution, based on the Declaration approved and endorsed by heads of states and governments, would ultimately be leveraged

by the United Kingdom and other OECD states to exert tremendous compulsory, structural, institutional and productive power.

Recognizing the role of states in shaping policy is not to dismiss the role of message and norm entrepreneurs as well as elite technocrats highlighted elsewhere.[225] Instead it is meant to reconsider these individuals' roles as enabled by states exerting structural, institutional and productive power. For example, three of the Security Council's five permanent five seats are held by OECD-member states, the United States, France and the United Kingdom. These states have veto or structural power over the appointment of the Secretary-General, and thus have influence over the Secretary-General's office; a similar situation is true for other UN agencies and other parts of UN institutions. States use this structural power to install their nationals into key positions shaping policies within these institutions and establishing critical personal connections. States also leverage institutional power through the OECD and World Bank as well as the UN.

Following the Millennium Declaration and in coordination with the World Bank and OECD, a United Nations' interagency expert group (IAEG) both reflected institutional power and exerted productive power. Co-chaired by a special adviser in the Secretary General's office (Michael Doyle) and director (Jan Vandemoortele) in the United Nations Development Programme (UNDP) and with participants from both the Bank and the OECD, this group, sanctioned by OECD states, led the process to draft what became the eight MDGs.[225] The Goals were taken almost verbatim from the Millennium Declaration, which helped to legitimize them as the Declaration had been approved by Heads of State. The eight MDGs consolidated and built upon the so-called International Development Goals (IDGs) created at the Paris-based Organization for Economic Cooperation and Development (OECD). In fact, MDGs 1 through 7 were extremely similar to the IDGs. The biggest difference between the IDGs and the MDGs was Goal 8 on partnership, which was the result of political consultation and compromise following the Millennium Declaration, most notably between the G77 Member States who believed the Goal did not go far enough and the United States which believed it went too far.[224]

The IDGs came from a working group of national Ministers of Development which met in the Development Assistance Committee (DAC) at the OECD to produce a 1996 report, *Shaping the 21st Century*. This report selectively included goals and language from UN conferences in the 1990s. These IDGs were endorsed in June 2000 by the UN, OECD, World Bank and the IMF[268], but the IDGs' productive power had little buy-in or support from developing countries. In fact, the IDGs engendered deep critique on a number of levels from developing countries and civil society. The IDGs had been promoted by the United Kingdom, which led an informal group, the so-called Utstein Group, of female Development Ministers from the Netherlands, Germany and Norway, which sought to use the IDGs as their overarching framework for development and align their aid efforts to leverage their impact.[269] This would also be an exertion of compulsory power by developed states coercing developing states to adopt policy guidance in exchange for development assistance. The strong commitment from the United Kingdom was championed by Clare Short, who had come to lead DFID as part of the 1997-elected New Labour government.[270] As part of a broader shift in development thinking and fortuitous timing with the Millennium Summit, the UK and the other states' institutional power within the World Bank and the IMF advanced the productive power of the IDGs eventually leveraging the UN to reframe and rebrand the IDGs as MDGs through negotiation with the addition of Goal 8 on partnership to overcome resistance from developing country states.

Other than the goal on global partnership, the IDGs were largely the same as the MDGs on health except one key difference. Both lists of goals contained maternal and child mortality (although they were one goal in the IDGs and two goals in the MDGs), but the IDGs included a goal on reproductive health services, whereas the MDGs had a goal on HIV/AIDS. The removal or blocking of reproductive rights as part of the MDGs was the result of the so-called 'unholy alliance' between the Vatican and Sudan, along with Libya and Iran, which then leveraged the G-77, a large and powerful bloc of countries within the UN General Assembly, and also took advantage of a then recently-elected conservative US government (the administration of President George W. Bush), which was initially disinterested in the MDGs.[271] In this case, the Vatican State exploited institutional or structural power, joining some members of the G-77, to block a potential MDG on reproductive health. This alliance

later broke down in 2005, and reproductive health was included as a target for maternal health. HIV/AIDS was included as an MDG following vigorous lobbying from HIV/AIDS activists led by UNAIDS Director Peter Piot.

UNDP, newly led by former World Bank Vice President (Mark Malloch Brown), spearheaded the development of a strategy to exert institutional power and advocate for MDG implementation. These efforts ultimately included a Millennium Project and a Millennium Campaign to raise attention, financing and support to advance progress. UNDP worked with governments to embed the MDGs within national policy processes and monitor progress. The 2002 Monterrey Finance for Development Conference focused on financing the MDGs.[225] Despite these efforts, national commitment to the MDGs at this point was limited, and in the early stages the MDGs provoked robust critiques.

Hulme[272] distinguishes between various schools of critique classifying them as "high modernists, who take [the MDGs] at face value and are optimistic that they are a blueprint for the transformation of the human condition[273]; the strategic realists, who don't believe the MDGs are a blueprint for action but believe they are essential to stretch ambitions and mobilise political commitment and public support[274]; the critics, who see them as well-intentioned but poorly thought through – distracting attention from more appropriate targets (or non-targets)[275] and more effective policies and actions[234]; through to the radical critics, who view them as a conspiracy obscuring the really important 'millennial' questions of growing global inequality, alternatives to capitalism and women's empowerment.[240][uu]

Despite these early critiques, the commitment of states and the broader UN system during this early phase was crucial for establishing the MDGs as the dominant narrative for both international development and global health. OECD states ensured this by recalibrating and aligning their financial support and leveraging their structural institutional, productive power across the UN system. For example, the US Government launched two major funding initiatives, the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI); these initiatives combined with the Global Fund and GAVI to help boost development assistance for health in 2000 from $11.6 billion to $33.1 billion in 2012.[276] The MDGs were also supported by the creation of two new public-private

partnership institutions, GAVI for immunizations and the Global Fund to Fight HIV, TB and Malaria, to accelerate progress and provide financial resources to reinforce the MDGs' productive power.[277]

Phase Two 2005-2010: Consolidation and Critique

In 2005 UN Member States met for the World Summit at the UN in New York. With strong leadership from the UN Secretariat, the United Kingdom and other developed states, the Summit outcome document approved by national leaders continually referenced the MDGs and encouraged states to 'adopt, by 2006, and implement comprehensive national development strategies to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals'.[278] In fact, states endorsed and requested the UN system to support the development of MDG-based national development strategies and Poverty Reduction Strategy Papers at the country level.[279] The UK also made the MDGs a centrepiece of their hosting the G8 Summit in Gleneagles in 2005. This deepened and expanded the productive and institutional power of the MDG agenda amplifying this power throughout the UN and international system.

Following this Summit and the G8 meetings, more UN and international institutions became involved in national reporting;the regularity of this reporting also increased. A review of twenty-two Poverty Reduction Strategy Papers—fifteen of which were prepared between 2005 and 2007 and one in 2008— highlighted that almost all expressed a commitment to the MDGs.[280] These initiatives spurred other actions. For example, Malawi in 2006 started publishing an annual MDGs report.[281.282] Commitment to the MDGs continued to grow as states like the United Kingdom, and others like Japan, continued to advance the MDG approach as a way to consolidate, align and amplify their development investments. In 2008, governments, foundations, businesses and civil society groups met at the United Nations Headquarters in New York for another high-level event. More than $16 billion was committed to accelerate progress exerting some compulsory power using the appeal of financial assistance to support states towards the MDGs.[283]

While support for the MDGs during this period expanded, critique of the MDG approach also grew. The rise of many emerging economies, particularly in the wake of the 2008 economic crisis, began to create additional space to question the MDG approach. States like Indonesia used their experiences with the MDGs to criticize and improve the process, but also to raise their own profile. Experts noted tendencies to focus on targets which were comparatively easier to implement or monitor (some have called this the tyranny of averages) which led to variable progress and had adverse implications for equity.[245] Critics called for improvements in national averages ignoring the inverse care law with implications for equity.[284] Despite raising valid concerns, critique also indirectly reinforced the existing productive power of the MDGs.

During this period, the Global Fund and other so-called global health initiatives (GHIs), like the US' PEPFAR program, provided incredible amounts of resources and prioritized attention for HIV/AIDS, an MDG. In fact, the energy, innovation and attention from HIV/AIDS has led some to even argue that HIV/AIDS invented global health.[285] Some defined global health as 'an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide.'[286] Others argued that global health was simply "a foreign policy instrument of hyper-rich nations."[287] But more realistically, global health was, as one academic argued, 'more a bunch of problems than a discipline.'[288] The problems of global health in this period were predominantly the 'vertical' MDG health issues of child and maternal mortality and HIV/AIDS, TB and Malaria.

One MDG critic argued that, "the MDG phenomenon carries the potential for distorting meaningful intellectual and research agendas, and could function as the catalyst and vehicle for a fundamental realignment of the political economy of development at the global level."[244]This was accurate for global health. Experts noted that the MDGs were distorting priorities and spending and would not be achievable without broader, more 'horizontal' investments in national health systems.[289]

To consider this, the World Health Organization, with financial support from Italy and strong engagement from many states receiving funding from GHIs, which were funding the MDGs, convened a collaborative research effort and a high-level dialogue called Maximizing

Positive Synergies in 2009. The research consortium convened identified areas for concern, and concluded more attention should be devoted to strengthening health systems which could also encourage better alignment and integration between GHIs and health systems.[290] One synthesis analysis found positive effects of the MDG approach as, "a rapid scale-up in HIV/AIDS service delivery, greater stakeholder participation, and channelling of funds to non-governmental stakeholders, mainly NGOs and faith-based bodies" and negative effects as "distortion of recipient countries' national policies, notably through distracting governments from coordinated efforts to strengthen health systems and re-verticalization of planning, management and monitoring and evaluation systems."[291]

Phase Three 2010-2015: Accelerated Implementation, the Final Push and the Emergence of the Sustainable Development Goals (SDGs)

This phase started with the 2010 MDG Review Summit. The MDGs' strong productive power was institutionalized throughout the UN and international system, and implementation efforts continued. Despite additional pledges of more than $40 billion to accelerate progress, the Summit concluded that progress in many countries was 'patchy' and 'uneven.'[292] Focus shifted thereafter to an MDG Acceleration Framework (MAF) to support lagging countries to achieve the MDGs in the remaining five years. While discussions began to consider the end of the MDGs, UN policymakers focused on accelerating progress towards implementation accompanied by additional reviews and analyses as well as a proliferation of case studies profiling national best practices and innovations.

For example, the London International Development Centre and the Lancet collaborated on an in-depth Commission reviewing progress in 2010.[281] While heralding the remarkable success of the MDGs for agenda setting, the Commission noted particular missed opportunities for synergies between efforts across education, health and gender sectors. A lack of strong ownership by national institutions created challenges. The Commission also highlighted that MDGs disregarded and fragmented health systems (Travis et al., 2004), ignored changing demographics as well as overlooked emerging health challenges such as non-communicable diseases[293], mental health or road traffic injuries.

Other analyses showed mixed evidence on how the MDGs affected national policymaking. In one survey of 118 countries, eighty-six percent reported that they acted in response to the MDGs.[294] Another review of national development plans in fifty countries showed that thirty-two countries either adapted or localized the MDGs into national planning.[295] But low and middle-income countries could simply be referencing the MDGs in their national development plans to satisfy donor or international 'norms' of MDG political correctness.[296] Indeed, one review suggested that states had two distinct motivations for engaging with the MDGs: first, to increase their global visibility and influence (this was usually more reflective of middle-income or emerging countries); and second, to receive increases in overseas development assistance (ODA).[297] In the first case, it could be that emerging economies recognized the power of the MDGs, and wanted to use this MDG platform to amplify their own power; and in the second case, this reflects some countries' need for financing and thus be able to be "coerced" by the MDGs. Yet even when countries integrated MDGs into their policy and planning processes, this did not necessarily lead to MDG issues being domestically prioritized or provided with the necessary domestic funding. Again, it could be that countries were reacting to the productive, institutional and structural power of the MDGs by integrating them into their policy processes.

While the UN system was determined to prioritize the MDGs, discussions began during this phase to consider what would come after the MDGs. Some states, like the United Kingdom, were in favour of continuing the MDGs beyond 2015. Other states like Colombia argued for the creation of new SDGs to focus more broadly on issues like the environment and be universally applicable for all countries. In fact, many states, particularly middle-income states, wanted to broaden the MDGs to be universally relevant for all countries. An editorial in the Lancet in 2012 argued that, "there will be a major strategic shift in global health, away from development and towards sustainability" and expressed some concerns about how health might fit into the future development agenda.[298]

Starting in 2012 in the wake of the Rio+20 conference on Sustainable Development, an elaborate UN-led, multi-stakeholder, multi-sectoral process began discussions around a process to create a successor framework for the post-2015 era. The ensuing policy process was arguably the most inclusive and consultative in United Nations in history. The

extraordinary engagement and commitment reflected the MDGs' tremendous power. State actors, from Sweden and the United Kingdom, as well as other actors actively championed a goal focused on healthy lives (to be able to address health determinants beyond the health sector), implicitly aiming to block efforts to position universal health coverage as the goal for SDG3. This approach was adopted in the HLP as well as in the report of the Botswana consultation, and this alternative approach (focused on having a goal of ensuring healthy lives) eventually prevailed and incorporated UHC into the SDG3 framework as one of the targets. The final Sustainable Development Goals (SDGs) framework included seventeen goals, with one focused on health. For what became the health goal, SDG Three (SDG 3), the three most important parts of the process were the Secretary-General's High-Level Panel (HLP), the thematic consultation on health in Botswana and the Open-Working Group (OWG) process.

The HLP, co-chaired by President Susilo Bambang Yudhoyono of Indonesia, President Ellen Johnson Sirleaf of Liberia, and Prime Minister David Cameron of the United Kingdom, included twenty-seven members and was announced by the Secretary-General in July 2012.[299] In its May 2013 report, the Panel proposed expanding the MDGs to twelve goals and consolidating the three MDGs for health into one SDG for health. This one health goal to "ensure healthy lives" proposed a focus on continuing the MDGs, but also including an unspecific reference to "neglected tropical diseases and priority non-communicable diseases" as well as an explicit sexual and reproductive rights target. Neither health systems nor universal health coverage (UHC) received much attention within this report; in fact, the report was characterised as "weak" by global health critics.[300] The approach of having one goal for health would eventually prevail; however, the Botswana and OWG processes significantly expanded the agenda of the health goal beyond the MDGs.

The thematic consultation on health (co-convened and managed by the Governments of Botswana and Sweden, in collaboration with WHO and UNICEF) was part of nine thematic consultations coordinated by the United Nations Development Programme (UNDP) in 2012 and 2013. The six-month consultative process for health included over 1,500 individuals

participating in twelve face-to-face consultations[4] in Africa, Asia, South America, North America, and Europe; more than 100 papers were submitted for a web-based consultation.[301] The consultation process culminated with a three-day meeting in Botswana in March 2013, and recommended "maximising healthy lives" as the goal, which would, as the Task Team for the Global Thematic Consultation on Health argue, include "acceleration of progress on the health Millennium Development Goal (MDG) agenda; reduction of the burden of non-communicable diseases (NCDs); and ensuring universal health coverage (UHC) and access."[302] This approach of including the MDGs plus NCDs and UHC ultimately prevailed over the HLP recommendations and strongly shaped the Open Working Group (OWG) negotiations.

The OWG met between March 2013 and April 2014. The OWG was originally structured to allow thirty countries from the UN's five regional groups to engage in both informal and formal negotiations on potential SDGs; however, there was such overwhelming interest and commitment to engage that some countries needed to share their seats in so-called "troikas". Thematic discussions happened over thirteen sessions, and health was discussed during the fourth session of the OWG in June 2013. This session largely defined the eventual SDG 3 for health. Building on the HLP and the Botswana consultation, states emphasised the importance of strengthening health systems and moving towards UHC, and this was incorporated into the eventual goal as an individual target.[303] The OWG's formulation was broadly adopted in the intergovernmental negotiations that followed in 2014 and 2015, and became SDG 3. The OWG formulation focused on a goal to "ensure healthy lives and promote well-being for all at all ages" with nine targets and four mechanisms for implementation. SDG 3 builds on the MDGs and includes targets on UHC, reproductive health, NCDs as well as pollution and road traffic injuries.

While there were countless consultations and opportunities to provide input between 2012-14, UN Member States ensured they had the final decision in the process designing the

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[4] One of the twelve face-to-face consultations for the thematic consultation on health took place in Indonesia, namely the Beyond 2014 Global Youth Forum, co-hosted by International Conference on Population and Development (ICPD) and United Nations' Family Planning Agency (UNFPA), in December 2012. This meeting ended with a declaration focused on "staying healthy, comprehensive education, families, youth rights, and wellbeing including sexuality, the right to decent work and leadership and meaningful youth participation." While some Indonesian policymakers were aware of this consultation, it did not seem to influence their engagement in the process.

process to follow the OWG process to conclude with intergovernmental negotiations between 2014 and 2015 which would give the final approval for the post-2015 agenda. These state negotiations were profoundly political and heavily disputed. For health, however, these discussions affirmed the conceptualisation of SDG 3 as advocated in the Botswana consultation and the OWG discussions. More broadly, the intergovernmental negotiations reflected emerging economies recognition of the influence of the MDGs and the opportunity to exert their own institutional and productive power through shaping the conceptualization of the new agenda. Leveraging their respective structural and productive power within the UN system, for example, Brazil's hosting of the Rio+20 Forum in 2012, emerging economies shifted and reframed the discussion on the post-2015 agenda from MDGs to SDGs to reflect more closely their own national interests broadening the MDGs to a wider and more holistic development agenda. But what are the implications of these three phases of experience with the MDGs for the future of the SDGs, and the future of global health?

Summary

So, in the first phase, developed states held considerable strength in all forms of power. They were not only able to create and determine the agenda, but they were also able to use their financial and human resources leveraging both their position and networks as compulsory, structural and institutional power within the international system to ensure other states accepted and adopted their policy guidance. Developed states were also willing to sacrifice some of their control when working with the Bretton Woods institutions, the UN and other states as they rebranded and reframed their IDGs into MDGs to gain greater legitimacy.

In the second phase, building on early academic critiques and initial national MDG experience, emerging economies began simultaneously to question the MDG approach more forcefully, and engage with the MDGs within the UN system; they also recognized and responded to the increased focus on global health. On the one hand, this deepened and reinforced the productive power of the MDG paradigm, but on the other hand, it also showcased the rising and burgeoning structural power of emerging economies to begin to contribute to and shape the field of global health. This was part of a broader geopolitical shift

of power globally as well as within the still nascent field of global health which began to shift away from a heavily 'verticalized' approach in the early 2000s to a broader, more horizontal approach.[304]

The third phase exemplified the productive power of institutionalizing the MDGs as the dominant paradigm for global development. There was tremendous interest and engagement in what would come after the MDGs as well as how the post-2015 agenda would be determined. The focus onwhat would be part of this agenda illustrated the productive power of the MDGs. In this phase, the ability and success of developed states to ensure the continuation of the MDG paradigm within a new SDG approach reinforced the original MDG approach; however, it also signalled emerging economies' rising institutional and structural power as they were able to negotiate for a broadening of the goals to be a more universal agenda relevant for every country. The SDG agenda essentially incorporates the MDGs and expands this agenda to include new goals related to environmental sustainability, labour and governance. In other words, developed states were able to maintain their focus on MDGs and institutionalize them within the SDGs, but the emerging economies were also able to broaden the MDGs into the SDGs.

But what does this mean for the broader SDGs and the development agenda, as well as for the more specific global health agenda? What does the MDG experience mean for the future of the SDG agenda, and the future of global health?

Section Three: Implications for the SDGs and the future of global health

Given the MDG-established policy processes, the SDGs could continue to be as relevant and dominant for the international development agenda as the MDGs were. However, in the same way that not all of the MDGs received the same levels of attention and commitment (and some of the MDG goals and their indicators were contested and eventually revised in the early stages, eg as explained earlier on reproductive health), this is also likely to happen and is already happening within the SDGs. For example, the UN's July 2017 High Level Political Forum (HLPF) on SDGs focused on reviewing only some selected thematic goals (1-no

poverty; 2-zero hunger; 3-good health and well-being; 5-gender equality; 9-industry, innovation and infrastructure; 14-life below water; and 17-partnerships for the goals). At the HPLF, countries reported in voluntary national reviews (VNRs), some countries also only selectively reported on goals meaning that they "cherry-picked" which goals to report on and which to ignore in their reporting. Instead of implementing all 17 goals as intended, it is possible and likely that states will determine an informal prioritisation of the SDGs through their financial investments and policies as also happened with the MDGs.

A more pressing question, however, regards the role of the SDGs for global health: what will the SDGs mean for global health? Will the SDGs be as central and formative for the future of global health as the MDGs were? In other words, will the SDGs matter for global health as much as or more than the MDGs did, especially as low- and middle-income states engaged in the process to conceptualize them? Or will the future of global health better be debated and defined elsewhere? Given the centrality of health to the MDGs (3/8 Goals) compared to the SDGs (1/17), it seems unlikely that health will remain as central to the sustainable development agenda, and thus, unlikely that the SDGs will remain as central to the future of the global health agenda. Yet in the conceptualisation of SDG 3, global health actors engaged heavily as if the SDGs would remain central to the future of the global health agenda. The ongoing implementation and interpretation of SDG 3 for health in the future of global health continues to be contested.

In May 2017 the Director-General (DG) of the World Health Organization (WHO) was directly elected by states; the new DG is clearly in favour of a focus on the SDGs with a slight shift in the interpretation of SDG3 on health as he stated in July 2017 at the High-Level Political Forum: "I regard universal health coverage as WHO's top priority. [...] Universal health coverage is included in the Sustainable Development Agenda. Indeed, it is the centrepiece of the Sustainable Development Goal health targets".[305] However, two recently established global health initiatives, one the Coalition for Epidemic Preparedness Innovations (CEPI) started with $460 million from the governments of Germany, Japan and Norway, plus the Bill & Melinda Gates Foundation and the Wellcome Trust, and another "Resolve" focused on heart disease and stroke as well as disease outbreaks started with $225 million dollars from Bloomberg Philanthropies, the Chan Zuckerberg Initiative, and

the Bill and Melinda Gates Foundation, make little reference to the Sustainable Development Goals in their mission statements or aims. These new funding mechanisms could be rebranded or co-opted by the UN system at a later stage; however, for now, they seem to indicate a potential move away from the SDGs as the leitmotiv of global health. This being said, it has been acknowledged that the SDGs imply a dramatic paradigm shift within global health[306], and it could be that this transition is still ongoing. Apropos there are already some efforts to reconceptualize global health as planetary health more in line with sustainable development and the SDG agenda.[307] Regardless of the relationship with the SDGs, the exact future shape, direction and priorities of global health are continuing to evolve, and remain to be seen.

Conclusion

This analysis demonstrates the value of using power as a framework to understand and assess actors', particularly states, roles in global health. Better understanding how power is exerted and deployed could help improve how actors engage, and identify key determinants of comparatively more 'successful' or 'effective' efforts in global health; a deeper knowledge of what determines better policy efforts could also enhance policy processes and lead to better governance mechanisms.[308] This could transform states' abilities to negotiate global health policies ultimately improving and saving lives. It might also mean other actors increase their attempts to leverage states' influence.

This analysis and the transition from the MDGs to the SDGs also has implications for how power is exerted at the UN and shapes the development and global health agenda. Compulsory power has become less relevant over time (as development assistance is less critical), the exertion of structural and institutional power is becoming more contested (as emerging economies begin to demand some restructuring of the system) and productive power is becoming perhaps the most important and relevant form of power, especially for global health. In between 2000-2015, developed states started by dominating the policy process, but by the end, emerging economy states were able to contest developed states' previously unchecked structural and institutional power. They contested the agenda in the

negotiation of the post-2015 agenda and thus, the future exertion of productive power. But what does this mean for future policy making efforts, and what are the implications of this analysis?

First, the MDG experience showcases the potential for states to leverage structural and institutional power to exert productive power for policymaking within the UN system. Given the geopolitical changes in the last decade, this could mean negotiations where states can exert institutional and productive power will now become more contested, and potentially gridlocked resulting in broad or watered-down agreements. The contestation of the SDGs could represent this. The negotiated process lasted around three years and produced 17 goals and 169 indicators. If this is the case, it is possible that the UN's productive power could become challenged, or less important. It could be that states could position new or alternative actors to the UN, which are better aligned to their interests, to create productive power, and seek new policy fora in which they might be better positioned to exert institutional and structural power. Alternatively, it could be that this greater contestation, even with eventual compromise, could lead to more committed national buy-in and engagement for new policies and processes. The SDGs could be a litmus test for helping to understand and assess the productive power and influence of UN policymaking.

In the case of creating and institutionalizing the MDGs, states exerting institutional and structural power seemed to work best in alliances with other states as well as non-state actors. Even comparatively less structurally or institutionally powerful states belong to one grouping or another within the UN system, eg the African Union or the G-77, which offers states increased possibilities for exerting some institutional or structural power within the UN system. This empowers states to leverage these relationships and abilities to engage on and create new mechanisms which have the potential to exert productive power. The MDGs created new norms around international development and global health exerting tremendous productive power. States played a critical role in creating and shaping this productive power, and this story could offer insights to other states seeking to leverage national power to create or institutionalize new norms in global health policymaking through the United Nations. One potential lesson based on this experience could be that states do not need to make huge financial investments to exert compulsory power, but rather

need to consider how wield institutional, structural and productive power more effectively and strategically.

Second, this analysis illustrates the enduring importance and centrality of state engagement in global health policymaking. Without states, the MDGs and SDGs would not exist, or would look substantially different. While there is understandable excitement and interest in the role of new non-state actor engagement, the role of states within global health remains underappreciated[253] and overlooked.[309] Since 2000, the role of states in determining and managing health has changed and evolved. Globalization increased transnational actors' abilities to shape and challenge how states spend, raise and allocate resources for health.[310] Despite being responsible for health, states continue to see challenges to their prior monopoly over health governance and regulation.[311] The MDGs themselves reflect some of these tensions. At one level, the MDGs are a challenge to states' authority to manage and determine their own health priorities. The MDGs were largely crafted by developed states for low- and middle-income states. At another level, they reflect states' continued authority as all states endorsed the MDGs at the General Assembly and ultimately participated in rethinking and reframing the MDGs into SDGs. Some of these challenges to states are state-sponsored or state-endorsed as states defer some level of sovereignty empowering international institutions or non-state actors to challenge their sovereignty. Despite continuing changes in their roles and challenges to their authority, states remain the predominant and decisive actors in global health policymaking.

Third, the example of the MDGs also highlights the importance of legitimacy for policymaking in global health. While developed states likely could have continued with their IDGs at the turn of the century, they recognized the value of legitimacy in transitioning them through the Bretton Woods institutions and reframing them within the UN policy process in negotiation with other states, thus trading some level of control for greater legitimacy. As part of this, the United Nations, a state-based institution, is generally perceived to be the most legitimate forum for establishing and determining health policies and priorities. The question now is will this legitimacy still be valued highly enough to justify the likely increases in political contestation. In other words, will states, recognizing the potential limits to their institutional and structural power at the UN, now seek to exert productive power in other

policy fora like the G-7 or the G-20? Until now, the United Nations as a policy forum and the MDGs as a UN mechanism played an integral part in contributing to define and shape the field of global health. While it is clear that states will continue to be critical actors shaping the field of global health, the role of SDGs in defining the future of global health is, for now, unclear.

Chapter Four
Research Objective, Research Framework, Case Selection, Methodology and Ethics

Key Points:
- Showcasing how states or other actors exert power or seek to exert power does not necessarily mean that power is always dominant, decisive, or successful; however, simply illustrating how power affects or shapes processes and policies could be a useful start to a discussion on how to improve and enhance both processes and policies within global health ultimately making them both more equitable and effective.
- This interpretive policy analysis combines literature and policy document reviews with semi-structured, in-depth qualitative interviews with policymakers aims to analyse how the post-2015 development agenda for health (what eventually became Sustainable Development Goal Three, SDG3) was conceptualized, and why, how and where states engaged and exerted power in this process from 2012-2015 exploring national motivations for why states engage in global health using international relations theories, and testing a framework for power analysis to analyse how states engaged in the process to create the SDGs with case-studies on Japan and Indonesia.

Introduction

As described in the previous chapters, globalisation continues to transform international relations, global governance and global health. Global health remains a profoundly contested field. Because of the rise of new actors as well as changes in technology, mechanisms and processes, states are updating and refining how they interact, and how they engage explicitly and implicitly in global health. This matters for why, how and where states engage in global health. Without recognizing this, future understandings of global health will remain limited. State actors play and continue to play a critical role in conceptualizing global health. States' roles, both explicit and implicit, deserve further study to understand why they engage (meaning motives and objectives), how they engage (meaning their approaches and tools), and where they engage (which fora and policy processes). These are important, unresolved questions in the existing literature. A deeper appreciation for how, why, how and where state actors engage in global health could contribute to building a more robust understanding of the field of global health.

Ultimately to answer these questions and advance the field, it is important to recalibrate efforts within global health and conduct empirical research which explicitly focuses on the role of state actors and applies rigorous theoretical frameworks like those

considering international relations and those focused on power. Using Held and colleague's framework outlined in the previous chapter, instead of a sceptical or transformationalist perspective, the global health literature tends to view the role of the state within global health from a hyperglobalist perspective (meaning largely observing the decline of states) . Based on the literature review in the previous chapter, there are some possible models for understanding why states engage in global health; however, for assessing how and where they engage, the discussion is less mature. Going forward, empirical studies starting from a transformationalist perspective – recognizing how globalisation is transforming how states engage and project power – and combining this with existing international relations theories, particularly constructivism, to understand why states engage and Barnett and Duvall's approach to power analysis to understand how states engage in global health could advance the field.

Showcasing how states or other actors exert power or seek to exert power does not necessarily mean that they are always dominant, decisive, or successful. It also does not mean that these efforts necessarily need to be counterbalanced or addressed; however, simply illustrating how power affects or shapes processes and policies could be a useful start to a discussion on how to improve and enhance both processes and policies within global health ultimately making them both more equitable and effective.

Using power as a framework is a natural evolution of existing analytical tools within global health. Greater analysis of power is essential to understanding why certain 'technical' solutions in global health continue to fail and why others succeed. Gaining more knowledge on how and where actors engage (meaning which fora or policy processes), and the relationship between the two, is helpful to the study of process and policy. A rigorous analysis focused on how and where states as actors exert power in global health will contribute to deeper, more nuanced understanding of global health. This research aims to re-affirm the role of state actors in global health, and contribute to the growing literature on how actors exert power in global health policymaking. This chapter presents an overview of this study's research objectives, the research framework, case selection and justification, methodology and ethics,

Research Objectives

Building on the first three chapters, this research aims to analyse how the post-2015 development agenda for health (what eventually became Sustainable Development Goal Three, SDG3) was conceptualized, and why, how and where states engaged and exerted power in this process from 2012-2015. Chapter Three reviewed the experience of the SDGs' predecessor development framework, the Millennium Development Goals, and details their tremendous influence and power within the field of global health. Given the MDG experience, it is reasonable to consider that the SDGs might be equally important in terms of defining and influencing the current and future practice and study of global health; at least, this is part of the reason that many countries and other actors engaged so deeply in the process to conceptualize and negotiate the SDGs: policymakers believed and continue to believe that the SDGs will be at least as influential as the MDGs.

Accordingly, this empirical research explores national motivations for why, how and where states engage in global health using international relations theory, and analyses their power applying Barnett and Duvall's framework for power. This research also illuminates insights into ideational factors or non-material efforts which might be useful in achieving results in global health. This could contribute to understanding how process can determine outcomes and how outcomes impact future global health processes.

The empirical work is a comparative case-study of Japan and Indonesia. These countries were selected as most appropriate based on specific criteria. The criteria used for identifying and selecting the county case-studies was: engagement in the post-2015, SDG process; existing research and analysis on the state's engagement in global health; practical feasibility in terms of language and access. A more detailed justification for the selection of Indonesia and Japan is described below after the research framework.

This research addresses three research questions (RQs), namely understanding why and how states engage in global health (diplomacy) (RQ1 and RQ2), and then examining the process to conceptualize and create the SDGs (RQ3), with several associated sub-questions. These are outlined below.

(RQ1): *Why do states engage in global health, and particularly why did states engage in the conceptualization and negotiation of the post-2015, SDG agenda?* What are the factors for assessing the determinants of why a state engages in a given global health policy process? Do states seek to influence global health agenda setting for altruistic reasons, or to advance

their own interests? In other words, what are states "really" pursuing? Is global health a tool to advance other interests? What do states seek to achieve and what constitutes success?

(RQ2): *How did states engage, ie: exert power, in global health, and particularly in shaping the SDGs?* How do states construct national global health (diplomacy) efforts or more broadly a global health policy or strategy, ie: who are the relevant actors within governments (ministries, agencies and parastatals) and beyond states (NGOs, international institutions, other governments) and how do they engage in the process? What is the relationship between these actors, ie: what drives them to engage, and what are their relevant capacities and limitations? Which of these actors are considered most powerful, and according to which measures of power? What are the lessons for others seeking to influence and exert power in global health, and what does this mean for the future of global health? What are the implications of the SDGs, in terms of who drives agendas and how, for global health governance?

(RQ3): *What was the SDG process, and how did this shape why and how states, specifically Indonesia and Japan, engaged, and what did it matter?* How does the process and the conceptualization of (global) health within the SDGs compare to the MDGs? What was the context and process for the creation of the SDGs? Why and how did states engage? Did the design of the process shape (benefit or limit) how and why certain states or actors engaged?

Research Framework

To understand why states engage (RQ1), it is useful to start with the international theories of realism, liberalism and constructivism. These theories could be helpful for exploring why states have engaged in the past and might engage in the future. These theories might also be useful in considering how to motivate states to engage more. They might even help explain or predict future motivations. The case-studies in this research will apply constructivist theory to better understand why both Japan and Indonesia engaged in the post-2015 process for health. This approach for assessing why states engaged is compelling as state actors within both Japan and Indonesia contested and constructed their motivations. Constructivism considers how identities, norms and framings are understood and affect state interests (and state behaviour) and how these meanings are developed, change and

evolve. Identities, norms and framings influence how states develop and create their policies and their strategies to exert power within the field of global health. This approach is helpful to understand why both Japan and Indonesia engaged in the post-2015 process.

To understand how states engage in global health (RQ2), a broad framework to help capture and illuminate the breadth of approaches, strategies and/or resources which any given state might try to use could be a place to start. At this early stage, a clear consensus on frameworks is unlikely. Instead, it remains necessary to explore different approaches experimenting with and testing different frameworks for understanding power within global health. Recognizing the shortage of social scientists working in global health, empirical studies at both the global and national level to advance the field are possible and needed. This would make it possible to compare and contrast these approaches and begin to assess when and where which approaches work best for assessing various actors across policy processes. This research will apply Barnett and Duvall's framework to start examining institutional, productive and structural exertions of power to illuminate the myriad ways in which a state expresses power seeking to advance its national interests. (Given the focus on material power or compulsory power, this thesis will focus on non-material forms of power, and thus analyse institutional, productive and structural exertions of power.)

This research conducts two comparative country case-studies of Japan and Indonesia to answer why states engaged in the creation of the health SDG3 (RQ1). These case studies apply constructivism to examine why both Japan and Indonesia engaged in global health. To understand how states engaged in the creation of SDG3, Barnett and Duvall's power framework will be applied in the table below to compare efforts to exert power to influence and shape the process. Applying this framework enables a rigorous exploration and helps illuminate how these states engaged and exerted power to advance their interests throughout the process.

	How state engages using **institutional** power?	*How* state engages using **structural** power?	*How* state engages using **productive** power?
Indonesia			

Japan			

Both case studies will examine why and how each country engaged in the overall post-2015, SDG process (RQ3). This is to not only understand "what happened", but to understand why "what happened" happened, and assess "what explains what happened."[312] To examine process and power in the creation of the SDGs, the Walt and Gilson policy triangle framework model of the policymaking process[313] is applied, and is focused on the agenda-setting and policy formulation part of the policy process, and with particular attention to ideas, institutions and interests to understand the process, and examine the role state actors played throughout the process.[314]

Country Case Study Selection: Indonesia and Japan

Both Indonesia and Japan are individually compelling case-studies. The study of states as actors within global health is nascent. In a global health world largely dominated by Anglophone research institutions and publications, state actors from Japan and Indonesia have not received sufficient rigorous, analytical attention. Japan represents an established, but relatively understudied OECD state seeking to maintain and continue projecting its power. Indonesia represents an emerging, little-studied state seeking to exert greater influence and power globally. While research sometimes examines how powerful states engage (like the United States or United Kingdom), there are few studies of comparatively less powerful states' engagement. Studying these experiences presents an opportunity to showcase how states engage, which could provide insights for how state actors engage in global health and lessons for other states seeking to enhance their engagement. But examining these states together also presents an opportunity to compare and contrast experiences. Analysing why and how these two states engaged in comparison could highlight differences in motivations for engaging as well as varied approaches in attempting to shape the process and outcomes.

Both Japan and Indonesia committed to engaging in the post-2015 process, but both states also experienced elections and changes in governments within the period of the post-2015 process (for more on this, see the policy timelines for each country in Chapters Five

and Six). Comparing and contrasting these experience highlights how states adopt different approaches or engage with varying levels of resources and or interest in various fora. Both governments interpreted the evolving process differently and developed different strategies to engage. For example, Indonesia engaged early in the process by putting President Yudhoyono forward as one of the co-chairs of the UN Secretary-General's High-Level Panel in 2012. Japan, on the other hand, in 2012 and 2013 attempted to convene an unofficial "contact" group of countries and actors to informally discuss the post-2015 agenda. Do these different engagements represent strategic decisions taken in regard to the post-2015 process in these countries, or are they more broadly representative of domestic political processes?

For understanding why states engage in global health, and why states engaged in the post-2015 agenda, both Japan and Indonesia highlight interesting and contrasting perspectives as detailed and discussed in Chapter Five and Six. Various motivations play a role in explaining why each state engaged in the process. In the case of Japan, an influential parliamentarian and global health champion saw the post-2015 SDG process as an opportunity to project Japan's vision for global health focused on universal health coverage (UHC) by leveraging Japan's voice and influence through international institutions and platforms. In Indonesia, former President Yudhoyono was committed to projecting Indonesia's interests regionally and globally. For his role as the Co-Chair of the Secretary-General's High-Level Panel on Post-2015, he used both technocrats from within the existing government bureaucracy as well as more entrepreneurial and ambitious technocrats which he had newly brought into the government to showcase Indonesia's experience and amplify its influence within the UN system. In these efforts to influence and shape what became the SDGs, both states exerted productive, institutional and structural power according to Barnett and Duvall's framework.

The small table below outlines key differences and similarities between Indonesia and Japan.

	Similarities	Differences
Japan	• Committed to engaging in the post-2015 process	• An understudied OECD state

	• Experienced changes in government between 2012-2015	• Engaged through a more informal mechanism with the contact group • Engaged as provider of assistance
Indonesia	• Committed to engaging in the post-2015 process • Experienced changes in government between 2012-2015	• An emerging, little-studied state • Engaged with the President as the Co-Chair of the High-Level Panel • Engaged as transitioning recipient of assistance

Case-Study Selection: Indonesia

When the MDGs were conceived in the late 1990s, Indonesia largely received policy guidance from international institutions. Yet within fifteen years, Indonesia became a policy leader for other countries within the region and beyond. This is true across the policy spectrum, but particularly for health. In fact, *The Lancet* proclaimed 2013 "Indonesia's Year for Global Health Diplomacy."[315] In this year, the Indonesian President, Susilo Bambang Yudhoyono (SBY), was appointed, along with British Prime Minister Cameron and Liberian President Sirleaf, to co-chair the UN Secretary General's High Level Post-2015 panel; the Indonesian Health Minister Mboi also took over as chair of the Global Fund, and the country hosted two high-level health conferences.

Indonesia is notorious for refusing to share samples of the H5N1 virus with WHO during the avian flu pandemic in 2007 and 2008. While accused of threatening global health security, the country's action exposed challenging questions of access, equity and transparency.[316] This action signalled that Indonesia was not afraid to challenge existing international norms. Indonesia's actions created a crisis, and a special WHO working group facilitated the creation of a global framework for sharing influenza virus strains alongside a system for improving the flow of pandemic vaccine and medications in 2011. This is a textbook case in the intersection of global health and global governance and is widely referenced as exemplifying the new challenges of global health diplomacy. The fact that

Indonesia pushed the international community on an issue of health security reflected a confident and assertive foreign policy from an emerging economy. More recently in 2012, Indonesia issued compulsory licensing which enables the generic manufacturing of drugs still under patent for HIV/AIDS and hepatitis B. This experience was also largely determined by domestic political exigencies.

This experience informed Indonesia's engagement in the Foreign Policy and Global Health (FPGH) Initiative facilitated by WHO and launched by Ministers of Foreign Affairs from Brazil, Indonesia, France, Norway, Senegal, South Africa and Thailand in 2007.[317] This group of seven countries continues to meet annually and coordinate its efforts in both New York and Geneva. Indonesia also chaired this group in 2013. Indonesia's leadership in the virus-sharing crisis and as a founding member of the Foreign Policy and Global Health group both created interest internally and positioned the country for a more prominent role externally in global health. A foreign Ambassador in Jakarta recently stated, "Indonesia feels its time has come [and] wants to be taken seriously as international players. They are reaching out aggressively to take a bigger role."[318]

While Indonesia has engaged actively in global health, during Yudhoyono's tenure as President (2004-2014), the Government's engagement in global health appears to reflect a broader commitment to advance Indonesia's foreign policy efforts and project its leadership within the region and globally. President Jokowi's term (2014-now) has been much more domestically focused, and the state's role in global health has been less engaged.

Case-Study Selection: Japan

Japan supported the MDGs' conceptualization and formulation leading up to the Millennium Declaration in 2000 both at the OECD, the Bretton Woods institutions and within the United Nations. Japan saw the post-2015 process as an opportunity to shape the SDG framework to be aligned with efforts to demonstrate its influence, enhance its interests and foreign policy goals, export its own model or vision for health through universal health coverage as well as amplify future investments through a recently revitalized JICA.[319] Following his re-election in December 2012, as Prime Minister Abe wrote, "Japan is at a crossroads—in 2012, we were asked whether Japan was determined to continue to be a tier-one nation. Now I am ready to give a firm answer: of course we are."[320]

An article in an influential 2011 Lancet Series on Japan argues that the country has failed to meet its significant potential to influence and shape global health.[321] Japan's engagement is low, and leadership weak. The authors attribute this to a combination of limited civil society, government fragmentation and a weak commitment to monitoring and evaluation. They suggest Japan should increase its financial resources, establish a high-level global health committee, promote NGOs and develop global health leadership.

The authors particularly emphasize increasing financial resources for global health. They detail how development assistance for health (DAH) has decreased since 2000 and the Millennium Declaration; in fact, Japan is the only country in the OECD to sustain declines in DAH. To explain this, the authors point to Japan's stagnating economy. Yet this explanation seems insufficient. Despite an overall decrease in ODA, one might expect DAH within ODA to increase; however, this did not happen. Japan does not have deep experience in focusing on health as part its overseas development assistance (ODA).[322] Traditionally, Japan's ODA concentrated on large-scale infrastructure projects (which would include hospitals) and peacebuilding efforts.[323] It was only in 1998 when the Japanese Government endorsed a focus on "human security" did health and other social issues like education begin to play a much more prominent role in Japanese strategy.

This focus on social factors coincided with Japan's engagement in conceptualizing the MDGs, and a broader recognition of the health sector's contributions to development. Yet while all of the other OECD countries expanded support for health, Japan reduced its support after 2000.[321] The government faced more sustained challenges than most other OECD countries; however, it would seem unlikely that the economic crisis would be the only factor which contributed to Japan decreasing its DAH. In the early 2000s, Japan lacked both committed political leadership to health along with a devoted civil society advocates and policy experts. More broadly, a focus on the challenging economic situation seems to exaggerate the role of material, or financial resources, contribute to global health. For example, the government could also cultivate Japanese thought-leadership by promoting its own international experts. Chapter Five details how Japan's role within global health evolved and was transformed after the 2008 G8 Summit.

Most literature ignores Japan's role in conceptualizing the MDGs, and also overlooks how after 2000, the MDG's broader focus on health began to influence how Japan's ODA. For

example, reviewing Japan's annual ODA White Papers between 2002 and 2013 shows a steady increase in attention to the MDGs. The MDGs applied international pressure to Japan, and contributed to creating a constituency for global health in Japan.

For the post-2015 agenda and the Sustainable Development Goals, Japan engaged early despite some political uncertainties. The Government convened a so-called "Post-MDGs Contact Group" (CG) in December 2011, which held a series of quarterly meetings throughout 2012. The CG, convened and chaired by Japan's Ministry of Foreign Affairs included "participants from about 20 countries, as well as major international organizations, foundations, research institutions and NGOs exchange views and ideas informally, free from their official positions." While this effort did not seem to influence the Secretary-General's High-Level Panel, it did raise attention to the process within the Ministry of Foreign Affairs. These efforts would later be subsumed by Japan's global health diplomacy strategy.

Shortly after his election in December 2012, Prime Minister Abe released his government's Strategy on Global Health Diplomacy in June 2013 when the government hosted its fifth Tokyo International Conference on African Development (TICAD V). This strategy focuses primarily on universal health coverage (UHC) as a new pathway for global health, particularly for developing the SDGs, and positions Japan as both a model and a champion for progress. PM Abe accompanied this with a commentary in the Lancet in September, declaring that global health required "strong political leadership and that he would spare no efforts"; accordingly, he convened a high-level meeting in New York with all UN agency heads during the UN General Assembly to discuss.[319] Later, in December 2013 Japan hosted a high-level health forum focused with the World Bank. Japan's re-engagement in global health is part of a more broadly reinvigorated Japanese foreign policy and economic policy known as "Abenomics".

Japan uses health to achieve foreign policy goals and uses foreign policy to achieve health goals. But there has been no rigorous, empirical analysis on Japan's engagement in the SDG process. Research could begin to address this gap in knowledge and provide greater insights into Japan's motivations, actors in global health diplomacy and how a state develops and implements strategies.

Methodology

This interpretive policy analysis combines literature and policy document reviews (Chapters 2 and 3) with semi-structured, in-depth qualitative interviews with policymakers involved in the conceptualization of the SDGs (Chapters 5-7). For the case-studies on the SDG process in Indonesia and Japan (Chapters Five and Six), the research interviewed policymakers engaged in New York and Geneva as well as Tokyo and Jakarta.[5] It is also the case that some relevant diplomats or policymakers have, following the negotiation of the SDGs, changed jobs, or been transferred or relocated to other duty stations. When necessary, the researcher also interviewed these informants.

Interviewees in New York were initially selected based on the researcher's professional experience, supplemented by snowballing, ie: informants were asked for their recommendations and suggestions for others to interview, and these suggestions were triangulated with the researcher's doctoral supervisors. The researcher conducted more than half of the SDG interviews in New York before conducting interviews in Tokyo and Jakarta, which enabled the researcher to triangulate and corroborate any data in New York which surfaced during interviews in Tokyo and Jakarta.

For the Open Working Group (OWG) in 2014 during negotiations in New York, there was a Technical Support team (TST) on health, comprised of technical experts from UN agencies, which advised the OWG secretariat on the formulation of the health goal. The researcher interviewed members of this support team, members of the OWG secretariat (these include national representatives) as well as officials within UNDP, DESA and the UN Secretary-General's office and civil society activists to understand the process, and how power and influence were perceived to be exerted within this process. The researcher complemented this with interviews in Geneva with both UN technical experts and post-2015 focal points within UN health agencies.

Interviewees in Tokyo and Jakarta were selected starting with the Ministry of Foreign Affairs and Ministry of Health as these were the two national ministries most directly

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[5] The headquarters of the United Nations' Secretariat in New York was where the MDGs were conceived and conceptualized, and the SDGs were negotiated and agreed within the special Open Working Group (OWG) on SDGs in New York. The researcher started with interviews in New York. Negotiators worked in close cooperation with their capitals (Tokyo and Jakarta), which is why interviews were also conducted in these locations. Given that most health-related negotiations occur in Geneva, where the majority of global health institutions are based, many of the most knowledgeable diplomats on health issues are often stationed there. These Geneva-based diplomats usually work in close contact with their colleagues in both their capitals, and in New York for the SDG discussions. The researcher thus also interviewed some diplomats and policymakers in Geneva.

engaged in the negotiation of the post-2015, Sustainable Development Goals. Additional interviewees were a mix of policymakers within ministries of foreign affairs, health, finance, planning plus other policymakers, academics and members of civil society and/or the private sector involved in creating, or influencing the creation of, a national negotiating positions selected based on recommendations from interviewees in New York and Geneva, and identified in consultation with local institutional partners to ensure reliability, namely the University of Nagasaki and Universitas Indonesia. For both Indonesia and Japan, the researcher also interviewed country-specific political science or governance experts to gain deeper insights into each countries' socio-political history and to better understand their policy and governance processes.

The researcher conducted interviews in interviewees' offices in English. The researcher recorded the interviews digitally and transcribed them verbatim for subsequent review and analysis. In cases where the interviewees' office was not possible, a neutral, alternative space was identified. If geography was a challenge, interviews were also conducted via phone, Skype or Whatsapp. Conducting interviews in English in New York and Geneva was not problematic given that English is the effective working language for negotiations. Given that most of these interviews were with high-level policymakers in Tokyo and Jakarta, English was largely not a challenge.

The researcher conducted semi-structured interviews with the intention of reaching a "saturation" point, or a point at which no new information or themes are observed in the data. According to one study, this point is often reached at 12 interviews for a given group or topic.[324] To ensure saturation, the researcher aimed to interview at least 12 informants at the global level and for each of the case study countries. In the end, the researcher interviewed 13 high-level policymakers for the global-level post-2015, SDG process in New York (as well as London and Geneva), 31 individual policymakers from Japan and 27 individual policymakers in Indonesia for a total of 71 individuals interviewed between late 2015 and 2018. An annex includes an anonymized list of the interviews and the dates they were conducted. As described above, interviewees and informants were chosen based on their engagement and role in negotiating and developing policy for the conceptualization of the post-2015, Sustainable Development Goals. At the global level, two respondents were government, five from international institutions, five civil society, and one academic. In

Japan, of 31 respondents, 13 were from government, 2 from international institutions, 5 from civil society, 5 from the private sector and 6 academics. In Indonesia, of 27 informants, 16 respondents were government, 2 from international institutions, 5 from civil society, 2 from the private sector and 2 academics. The researcher used two different sets of interview questions based on interview guidelines, developed by the research in consultation with his doctoral supervisors and local institutional partners, approved by the LSHTM, Nagasaki and Indonesian Ministry of Research, Technology and Higher Education Institutional Review Board (as detailed below). The researcher used one interview guide for SDG policymakers, and one for both Japanese and Indonesian policymakers for the SDG process; this is included in an annex. The Japanese and Indonesia SDG policymaker interview guidelines were altered slightly to apply to their national policy context and included some questions on their countries' MDG experience.

For Indonesia, the researcher was able to make two two-week trips (October 2016 and March 2017) and two one-week trips (October-November 2017 and March 2018) to Jakarta to conduct interviews in 2016, 2017 and 2018, and collaborated with the Universitas Indonesia before, during and after the visits. For Japan, the researcher's institutional partner was facilitated through the London School's partnership with Nagasaki University. The researcher made one two-week trip to Japan in May 2016 to conduct interviews, and also spent nine months as a Hitachi/Council on Foreign Relations Fellow at the Japan Center for International Exchange (JCIE) based in Tokyo, Japan from September 2017 to June 2018.

The researcher focused on triangulation (comparing literature reviews of policy documents with data from informant interviews), respondent validation (preliminary data and analysis was shared with some of the key informants), fair dealing (a wide range of respondent perspectives are included) and particular attention is paid to reflexivity (detailed below in section on background).[325,326]The interview questionnaire was developed according to the research questions outlined above, and refined with national partners and based on the experience of the first few interviews.

For interviews in Japan and Indonesia, the researcher was particularly interested in identifying understandings of why and how state actors engaged, and the interview guide was designed accordingly to solicit this type of information. The researcher also conducted two or three interviews with some key informants to validate findings, ie the researcher

would recount his understanding of what happened based on ongoing research and ask the key informant to affirm or correct the narrative. This process enriched the findings as this enabled the researcher to clarify any potential misunderstandings as well as identify and interrogate varying accounts of what happened or why what happened between key informants. Upon completion of the interviews, the researcher reviewed the data according to the methodological framework outlined above and coded the data to identify and highlight key themes using qualitative analysis software Nvivo. For example, to identify different forms of power, the researcher coded the interview transcripts based on institutional, structural and productive power to identify examples when actors exerted these different forms of power.

Based on these case studies on Japan and Indonesia, it will be possible to derive some lessons learned; however, these lessons will not be relevant or applicable for all other countries as naturally these countries have their own specific historical and political economic legacies.

Ethics

This research proposal was submitted for ethical review and approved by the Institutional Review Board of LSHTM as well as Nagasaki University in Japan and the Ministry of Research, Technology and Higher Education in Indonesia. This research posed minimal risks to participants, and participation is voluntary. Participants were asked to sign a written consent form. The consent form was accompanied by a one-page document providing an overview of the research (included in an annex). Participants were informed that their participation was not required; they were allowed to opt-out at any point during the course of the interview. Participants were also informed that personal identifiers were removed from the audio recordings, transcripts, and any possible research outputs.

Reflections and Background of the Researcher

As Walt and others argue, "the role of the policy researcher and the importance of reflexivity and researcher positionality in the research process" is critical, but "seldom explicitly" discussed.[312] For positionality, the distinction is usually made between insiders and outsiders. In this case, the researcher was a part-time PhD student and an employee of the Rockefeller Foundation in New York (and later worked for WHO Sierra Leone), which

engaged in the SDG process, and thus, an "insider" in the ongoing SDG process. This might have afforded certain advantages in access to some policymakers and some level of understanding of the process; however, to mitigate any potential bias, the researcher downplayed his status as a Foundation employee when engaging in this research, eg when interviewing policymakers, and continually monitored and reflected upon his role in the research. While this status as an "insider" or a "funder" could have helped open some doors in New York or Geneva, it was not relevant, or at least did not feel relevant in Tokyo or Jakarta beyond the initial few interviews. In both Jakarta and Tokyo, the first few key informants helped identify other key informants, and usually introduced the researcher to others and then these introduced the researcher to others. As this happened, the researcher continually reflected on how discussions and process which happened in New York were perceived from and understood in other places like Tokyo and Jakarta, but also Geneva. Key informant interviews were a crucial mechanism for doing this, and informants helped rebalance potential biases in understanding and analysing the process. This was useful for helping understand and interrogate how the field of "global health" is understood in different ways in different locations.

This was also relevant to the researcher's own positionality. From 2010-2016, the researcher spent close to six years engaged in global health policy dialogue as a program officer at the Rockefeller Foundation. The researcher worked to support research and policy efforts to strengthen health systems and shape the global health agenda to focus on universal health coverage (UHC), as well as engaged in the post-2015 process. The researcher participated in and observed many high-level global health processes —at the World Health Assembly, the opening of the UN General Assembly and/or the World Bank Spring and Annual meetings—how various actors with seemingly similar resources, capacities or constraints had differential abilities to project power and influence policymaking agendas and priorities within global health. But these experiences, along with the researcher's own background as a white, American male in US American, Canadian, German and UK universities studying political science, history, public policy and public health also affected the researcher's world view in terms of understanding the field of global health and how power is conceptualized and created within this field. This experience and background afforded the researcher exposure and access to conversations about power and influence

within US and UK academic communities (and within slightly broader communities during events like the World Health Assembly or Health System Global Symposia); however, this might have also led to certain biases or limitations in understanding of the concept of power and influence. To overcome this, the researcher endeavoured to counterbalance this by devoting time to understanding the political economy and culture of both Japan and Indonesia and coupling this with key informant interviews as well as informal conversations and interactions with academics and policymakers in both countries to rebalance any potential imbalance or bias.

These experiences led the researcher to consider how different actors engaged in different policy processes, and how or where did different actors consider that they were exerting power or being influential? For example, why did Thailand seem to have such an important voice within the World Health Assembly? Was this simply a one-off, ie the result of a particularly charismatic or savvy national delegation or a calculated diplomatic strategy, or did Thailand's outsized voice depend on certain skills or resources, or was it the result of investing or providing financial support to WHO? How could one begin to explain and assess this? Alongside concerns of accountability, equity and legitimacy, this raised the question of how to shape and determine global health policy. How could actors best exert, leverage and ultimately develop their power? To consider these questions in a rigorous and methodological way, the researcher began this doctoral research on a part-time basis in October 2013 and focused on the role of state actors within the then-ongoing process to conceptualize and negotiate the post-2015 development agenda.

Chapter Five

Why, How and Where did Japan Engage in the Post-2015, SDG Negotiations for Health

Main Points

- Japanese policymakers sought to advance Japan's 2012 Global Health Diplomacy (GHD) Strategy through their involvement in the post-2015 Sustainable Development Goal (SDGs) for health. This engagement was constructed as a part of Prime Minister's Abe's assertive foreign policy to project Japanese influence globally after the so-called "Lost Decades" of the 1990s and 2000s. Building upon Japan's hosting of the 2008 G8 Summit and the 2011 Japan Lancet Series, Japan's GHD Strategy focused on universal health coverage (UHC). Policymakers constructed a narrative around UHC as a unique "Made-in-Japan" experience and a concrete example of human security aligned with the Abe administration's efforts to re-assert diplomatic influence to revitalize and stabilize Japan's economy. Given the importance of the MDGs for global development, Japanese policymakers saw the post-2015, SDG process as a critical opportunity to advance their focus on UHC and exert greater leadership within global health in line with the Abe administration's broader political and foreign policy goals.

- Japan's government exerted productive, institutional and structural power to advance Japan's Global Health Diplomacy Strategy's focus on UHC in the post-2015 SDG process, largely outside the formal process. Japan's government exerted structural power through the Prime Minister's efforts, leveraging development aid and allying with other countries; Japan exerted institutional and productive power through key global health institutions like the World Bank and the World Health Organization. It also deployed structural and productive power hosting several high-level events both in Tokyo and in New York as well as lower-level briefings and seminars on UHC.

- While Japan did not succeed in having UHC as the overall goal for SDG3, Japan's strategic leveraging of power, largely outside the official post-2015 process, contributed to positioning UHC as a global health priority. UHC was considered "a success" as it was firmly embedded as a target within SDG3. Moreover, most Japanese policymakers viewed Japan's engagement as a diplomatic success and a reflection of Japan's engagement and commitment to the field of global health.

- Demonstrating why, how and where Japan engaged and exerted power in the post-2015 process contributes to reshaping and building a more robust understanding of the field of global health and the role of state actors. Japan's engagement and exertion of structural, institutional and productive power has implications for the future of global health and possible lessons for other countries. Most importantly, Japan's engagement foreshadows a more contested global health policymaking process, and a likely more fragmented global health governance landscape as states create new structures or fora to maximize their ability to exert power and influence.

Introduction

Following his re-election in 2012, Prime Minister Abe wrote, "Japan is at a crossroads—in 2012, we were asked whether Japan was determined to continue to be a tier-one nation. Now I am ready to give a firm answer: of course, we are."[327] As global health journalist, Laurie Garrett, wrote in 2013, "foreign policy and health diplomacy followers had better pay attention: Japan means business."[328] This was correct both literally and figuratively. In 2017, Abe was re-elected with a supermajority. Abe's administration represents a more assertive and stable Japan focused on securing national economic interests. The Abe administration's policy agenda has been characterized by some experts as "defying defeat"[329] in contrast to John Dower's famous power-war history of Japan, Embracing Defeat.[330]

Following WWII, Japan emerged as an economic superpower, and became a close American political ally throughout the Cold War and beyond. By the 1960s, it was the world's second largest economy. Many predicted it would become the world's largest economy[331]; however, in the 1990s and 2000s, Japan's Gross Domestic Product (GDP) shrank, real wages fell and prices plateaued leading to "stagflation." The 1990s and 2000s are often considered "lost decades". Nevertheless, Japan remains an economic heavyweight. It is now the world's third-largest economy and has been called a "soft power super power."[332] Japan, unable to develop its military power through constitutional limitations, nevertheless seeks "to occupy an honoured place in international society."[333] To do this, Japan uses development aid.

Since the 1960s, development aid or overseas development assistance (ODA) has been considered by scholars as one of Japan's most "consistent and effective" foreign policy tools, serving a variety of strategic, diplomatic and economic purposes.[334] In fact, Japan's ODA is considered an especially important foreign policy instrument given Japan's lack of military power. By the 1990s, Japan was the world's largest donor and considered an "aid superpower." Traditionally focused on infrastructure and economic cooperation, in the 1990s Japan began to engage more in global debates on development policy championing the concept of "human security", which was rooted in Japan's post-war pacifism. Japan also engaged more on social issues in development like health. Japan supported the conceptualization of the Millennium Development Goals (MDGs), and the MDGs' focus on

health. Alongside assisting the MDGs' creation, Japan hosted the 2000 G8 Summit leading to the 2002 founding of the Global Fund to Fight AIDS, Tuberculosis and Malaria. This effort and political commitment to health continued when Japan hosted the 2008 G8 Summit.

Before this summit, Japanese parliamentarian Keizo Takemi convened a working group, with the blessing of then-Prime Minister Fukuda, to prepare policy recommendations on health, something Fukuda considered critical to human security.[335] What later would become known as the Takemi Working Group (TWG) transformed Japan's engagement in global health. The TWG emphasized the importance of health systems and initiated research codifying a narrative on the importance of the development of Japan's health system. It socialized an understanding of Japan's own domestic health gains as a result of its strong health system and constructed a narrative in which Japan's progress towards universal health coverage (UHC) was a unique reflection of "Japanese-ness" aligned with the government's focus on human security and desire to project and expand its influence and economic interests globally. Given Japan's world-leading life expectancy, UHC was an issue on which, as Prime Minister Abe would argue, Japan could exert "responsible and mature" global leadership.[320]

To demonstrate its ability to lead and advance UHC as a concept for global health, Japan contributed to shaping the global health agenda leveraging its resources and networks (through Japanese personnel and personal relationships) with key global health institutions like the World Bank and the World Health Organization as well as partnered with other countries like France and Thailand to further its agenda. In these efforts, Japan's government advanced its 2013 Global Health Diplomacy Strategy and its focus on UHC to promote Japanese interests by exerting productive, institutional and structural power. Japan is a compelling case-study for understanding how state actors are engaging in global health as it showcases how an OECD country, other than the US or UK, with a long history of providing developing aid is advancing its interests and exerting power in global health policymaking.

This chapter starts with an overview of Japan's engagement in the field of development assistance and assesses how Japan's interest in the nascent field of global health built on this experience, particularly the experience of engaging in the development

debates of the 1990s. This analysis then considers why Japan engaged, applying a constructivist approach analysing the social and relational meaning and construction of Japan's position in the post-2015, SDG process. The chapter then details Japan's specific involvement in the negotiation of the post-2015, SDGs and how it exerted power and where it engaged in the process. This is followed by a discussion of Japan's engagement in the post-2015 SDG process and how it exerted power in the process highlighting Japan's exertion of institutional, structural and productive power within and beyond the post-2015 process. (The box below serves as a refresher on Barnett and Duvall's framework from Chapter Two.)

Box: Barnett and Duvall's Power Framework

Barnett and Duvall's power framework distinguishes between four different types of power: 1) compulsory (direct power, such as use of military force); 2) institutional (indirect power, such as how international institutions are designed to favour one actor over another); 3) structural (the overall constitution or framework of actor and their roles); or 4) productive (control over the possession and distribution of resources) power. For global health, one could think of a donor agency using the possibility of funding in a poor state with limited resources to exert compulsory power; a well-positioned state leveraging a multilateral agency to exert institutional power; a prestigious university or NGO positioning its staff as experts to provide technical policy support and exert structural power; and a UN agency or a private-sector actor advancing and promoting a particular agenda or approach to addressing health challenges as an exertion of productive power. This analysis will review how Japan exerted institutional, structural and productive power in the post-2015 process.

Section One
Japan's Overseas Development Assistance, Engagement in Global Health and Why Japan Engaged in the post-2015 process

Japan's Engagement in Overseas Development Assistance

When Japan became the world's largest ODA donor in the late 1980s, new actors within Japan like parliamentarians, the Cabinet Office and civil society became more engaged in both managing and scrutinizing Japan's engagement in development cooperation. Following government efforts to "un-tie" aid in the 1980s, the private sector became alienated from the aid industry in the 1990s; the private sector would, as scholars have noted, "claim that the taxpayers' money should benefit taxpayers, that is, Japanese firms."[336] While the Liberal Democratic Party (LDP, and Japan's most important and largely dominant political party) and government were sympathetic to these arguments, NGOs offered a different opinion.

Civil society groups argued that Japan's ODA should be more aligned with global public goods, or a more broadly defined national interest.[339]An Organization of Economic Cooperation and Development (OECD) 1999 Peer Review Report on Japan development efforts called out the Japanese government's extensive use of loans instead of grants and the emphasis of investment in Asia.[337] Within Japan, the public and media voiced increasing domestic concerns about aid going to China[338] and concerns about corruption.[339] More broadly, in the early 1990s, these various actors highlighted the lack of a coherent policy framework or strategy across Japan's fragmented development architecture.

In response, Japan's Cabinet office issued the 1992 Development Charter. The Charter explicitly began to consider recipient countries' military expenditures and trade (including weapons of mass destruction) as well as countries' political and economic systems (including respect for basic human rights and freedoms) for prioritising aid investments. The Charter was subsequently revised in 2003 and 2015 and became increasingly open about expressing Japanese interests. For example, the 2003 Charter states that the objective of Japanese ODA is "to contribute to the peace and development of the international community, and thereby to help ensure Japan's own security and prosperity."[340] In 1993, Japan also hosted its first Tokyo International Conference on African Development (TICAD) to engage more directly in Africa (this would go on to be organized every four years with TICAD VII scheduled for 2019).

Following political instability in the 2000s, the (second) Abe administration came to power in 2012 introducing policies to stabilize the government, particularly to revitalize the economy and bolster security. In Prime Minister Abe's new National Security Strategy, development assistance was referred to as an important means to ensure security. It considered aid as an instrument to support Japanese business and advance the administration's economic policy known as "Abenomics." Accordingly, these new policies included another revision of the ODA Charter. It was renamed the "Development Cooperation Charter" in 2015 and emphasized development aid as a catalyst for the private sector. It emphasized the "national interest" and focused on showing value for the Japanese economy. After the "Lost Decades" of the 1990s and 2000s, the Abe administration was keen to highlight how its policies benefitted Japanese business interests and thus the average Japanese citizen. As part of efforts to revamp development cooperation, the Abe government

also released a new policy for global health cooperation.[341] The next section reviews Japan's engagement in the emergent field of global health.

Japan's Engagement in Global Health from 2000-2015

A 1999 DAC report assessment found that between 1996-1997 Japan invested roughly three percent of its ODA on development assistance for health (DAH), which was "mainly concentrated in tertiary and curative health, such as support for hospitals and high technology equipment, medical research institutions, high level training, and posting of Japanese advisors."[342] By 2014, Japan was still spending around three percent of its ODA on health, but a DAC report found, "Japan is increasingly exerting global development leadership and influence in selected policy areas, such as health […], where it believes it can add value" and continued, "Japan is demonstrating global leadership on universal health coverage in concert with other partners."[343] While Japan's investments in DAH as part of its ODA were staying roughly the same, the way in which Japan engaged changed dramatically. Despite a lack of conceptual clarity[6] and a continued evolution in the understanding of global health in Japan, the country has demonstrably increased its global engagement in health since 2000.

In the early 2000s, Japan's interest in health came from a growing understanding of health as critical to development (eg reports like the World Bank's 1993 World Development Report) and rising political support for health as a priority (eg events like the World Summit for Children in 1990 with more than seventy heads of state and close to ninety senior government officials). Japan's interest in global health was also influenced by the US; in July 1993, the US-Japan Common Agenda for Cooperation in Global Perspective focused on four pillars, the first of which was health and human development.[344] Informants highlighted US pressure for early Japanese interest and commitments to HIV/AIDS.[345] Following Japan's 1994, $3 billion commitment to a Global Issues Initiative on Population and AIDS[346], Japan invited African heads of state to join the 2000 G8 Summit. The Japanese government focused discussions on infectious diseases, and launched an Okinawa Infectious Disease Initiative,

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[6] As described in Chapter One on the concept of global health, key informants in Japan expressed wide variations in conceptual understandings of global health from thinking that global health meant Japanese government ministries working with WHO, to others who thought global health was a way for Japanese business to increase their profits by gaining access to new markets.

which contributed to the 2002 creation of the Global Fund to Fight AIDS, TB and Malaria.[7] Japan's engagement in the creation of the Fund has made it a focus of Japanese global health funding, and policymakers view it as an important "legacy" of Japan's 2000 G8 process. High-level support for global health continued in 2005 when Prime Minister Koizumi announced a $5-billion plan to combat infectious disease in Africa (HIV/AIDS, Malaria and Tuberculosis, Polio, Parasitic Disease and Avian Flu).[347] While Japan's efforts were in line with the growing global focus on health, they were still more reflective of an "international health" approach to health which largely focused on infectious diseases (explained in Chapter Two). In 2007, this changed.

In the lead up to the 2008 G8 Summit, although Japan's commitment to health continued, its focus shifted. In line with broader global health discussions, Japan's LDP Minister of Foreign Affairs argued that "international efforts in the health sector have largely centred on measures against infectious diseases. From now on, it is essential to promote [...] research and development and strengthening of health systems."[348] This shift towards health systems was strongly influenced by Keizo Takemi and his emergent working group. Takemi had lost his seat in the Japanese Diet in 2007, where he had served from 1995. (He would later be re-elected in December 2012). He then took what he has since called a "sabbatical" when he was invited[349] to be a fellow at the Harvard School of Public Health between 2007 and 2009. During his time at Harvard, he attended global health workshops and seminars deepening friendships and expanding his network. Takemi particularly worked closely with academics Michael Reich[349], Marc Roberts and William Hsiao, who spent their careers analysing, researching and conceptualising health systems. Given their expertise and experience, it was thus unsurprising when Takemi joined them to author an article in March 2008 arguing in favour of using Japan's hosting of the G8 Summit to "catalyse global action on health, this time with a focus on health systems."[350]

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[7] It is often said that Japan's tabling of health at the 2000 G8 was the first time the G8 Forum considered health; however, this is not accurate. Since 1996, health has been on the agenda of every G8 summit. For more on this, see Kirton JJ, Mannell J. The G8 and global health governance. Paper prepared for a conference on Global Health Governance: Past Practice: Future Innovation, sponsored by the Centre for International Governance Innovation, the Institute of Population Health, University of Ottawa, the G8 Research Group, Munk Centre for International Studies, University of Toronto, and Rotary International, Ottawa and Waterloo; Nov 10–12, 2005.

Around this same time, Takemi, with Prime Minister Fukuda's blessing, convened a working group to prepare policy recommendations on health, something Fukuda considered critical for human security, for Japan's hosting of the 2008 G8 Summit.[8] Supported by a think tank, the Japan Center for International Exchange (JCIE), Takemi (previously a central figure in supporting the Japanese government's efforts to develop and advance the concept of human security[351]) convened what would become known as the Takemi Working Group (TWG) from across government and included academic, civil society and private sector representatives as well as international organizations and academic institutions to develop policy recommendations. JCIE, where Takemi is also a Senior Fellow, served and continues to serve as the secretariat to this TWG providing institutional continuity and support.[352] This Takemi Working Group would advocate that health was a compelling way to realize the Japanese government's interest in human security and could represent a concrete focus for human security, which was sometimes critiqued for being vague or unclear. Once this argument was made, it was also necessary to develop a more specific focus for health, namely health systems.

As might be expected after Takemi's time at Harvard working with health systems experts, the Takemi Working Group report recommended Japan and G8 countries mobilize more funding for global health, commit to making their financial commitments more sustainable, improve the integration of disease-specific funding with support for health systems and apply the concept of human security to global health.[353] Following the G8, the TWG worked to translate the G8 Summit recommendations into more concrete proposals on health systems for further consideration at the Italian 2009 G8 Summit.[354] Preliminary findings were shared during a high-profile international conference in Tokyo in November 2008 with global health leaders, and the final report of these efforts was disseminated widely in advance of Italy's G8 Summit.

Unusually, between the end of 2009 and the end of 2012, Japan was governed by three different Democratic Party of Japan (DPJ) Prime Ministers. During this period, there was some policy uncertainty. For example, in September 2010, the then DPJ Foreign Minister

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[8] This request was the result of a meeting Takemi and the late JCIE President Yamamoto had initiated with the Prime Minister.

shared what was supposed to be Japan's new global health policy for 2011-2015 focused on three issues: "maternal, newborn, and child health (MNCH); major infectious diseases; and contribution to global public health emergencies."[355] This focus, however, was short-lived. Following a landslide LDP victory in December 2012, Japan's global health focus shifted back to health systems and UHC. Prime Minister Abe returned to lead Japan's government (he had briefly served as Prime Minister between 2006-2007) and the Ministry of Foreign Affairs released the government's Strategy on Global Health Diplomacy in June 2013 at TICAD V.

This strategy built on discussions in the Takemi Working Group, which had led to a 2011 Lancet Series positioning Japan as both a model and champion for progress towards UHC. This 2013 Global Health Diplomacy strategy focused primarily on UHC as a new "pathway for global health", particularly for the post-2015 development agenda. Writing in *the Lancet* in 2013, Prime Minister Abe directly referenced the TWG, and declared that global health required "strong political leadership and that he would spare no efforts."[327]

Japan and the Millennium Development Goals

Given Japan's role as an OECD Development Assistance Committee (DAC) member and the world's largest donor in the 1990s, it closely engaged[356] in the discussions leading to the creation of the MDGs. In fact, the approach of using the outcome documents of major UN conferences as a source for formulating what would eventually become the MDGs originated during a meeting held in Tokyo.[357] Japanese government officials specifically proposed the concept of quantitative targets[357] using the major UN conferences declarations from the 1990s as potential goals. This approach was adopted in the formulation of the International Development Goals (IDGs).[358] As detailed in Chapter Three, the IDGs eventually evolved through negotiations into the MDGs.

While Japan's government was nominally committed to the MDGs, a deeper policy and institutional commitment was not immediate. Instead, in the early 2000s, Japan focused on promoting the concept of human security, which some considered a competing development paradigm to the MDGs. Civil society actors criticized the Japanese government for not including a more explicit focus on the MDGs in the revised 2003 Development Charter. In response, an official from Japan's Ministry of Foreign Affairs (MoFA) argued that

while the term MDGs did not appear in the revised Charter, this "does not lessen the importance that Japan attaches" to the MDGs; instead, he argued that given some doubts about "what the status of the MDGs will be in ten years, [...] the charter has deliberately avoided that term, while articulating major elements that encompass the MDGs."[359] Despite being closely involved in conceptualizing the MDGs, the Ministry of Foreign Affairs was not yet convinced the MDGs would become the dominant development framework. As detailed in Chapter Three, Japan was not alone in this regard, and in the early 2000s, national commitment to the MDGs was uneven across and within countries.

By 2005, however, Japan's commitment was more explicit. The Ministry of Foreign Affair's 2005 Medium-Term Policy on ODA stated unequivocally that "the MDGs are goals that the international community should work in concert to achieve in order to build a better world. Japan will contribute actively to achieving the MDGs, including through the effective use of ODA."[360] In 2005, in cooperation with the Asian Development Bank, the World Bank and the World Health Organization, Japan's government hosted a High-Level Forum on the Health MDGs in Asia and the Pacific. The meeting affirmed Japan's commitment and focus on the MDGs.

By 2010 a government review of ODA led to a deepening commitment to the MDGs, which was enshrined in Japan's 2010 ODA White Paper.[361] At the 2010 UN Summit on the MDGs, Prime Minister Kan announced the "Kan Commitment" for $8.5 billion of assistance over five years for the health and education MDGs. After 2010, both the Ministry of Foreign Affairs as well as JICA (Japan International Cooperation Agency) and other actors continually declared Japan's support for the MDGs. Yet despite the rhetoric of commitment, one study of Japan's ODA in 2012 found that, in fact, "Japan's foreign aid commitment to achieving the MDGs has been partial at best, simultaneously beset by continual budget contraction and competing development paradigms and political priorities."[362] Other studies showed more broadly that despite rhetorical commitments to the MDGs, donor countries' ODA allocations were not always aligned with the MDGs.[363,364] While studies have argued that the MDGs "may have played a role in increasing aid", the overall impact and influence of the MDGs was and remains contested.[365]

Yet by 2012 the MDGs' dominance in terms of steering the international development agenda was clear (as discussed in Chapter Three). Scholars proclaimed that the MDGs represented a new 'super norm' dominating the global development agenda.[366] This was also understood in Tokyo. In the wake of the 2010 MDG Summit, policymakers and analysts began to consider what would come after 2015, or post-2015. Given how influential the MDGs were, global policymakers and development advocates, including in Japan, were committed to ensuring that their perspective and respective issues were embedded within whatever framework followed the MDGs to ensure that they could prioritise their issues and advance their interests. For Japanese development policymakers, the post-2015 agenda was about the opportunity to amplify their past, existing and future development investments as well as influence and shape other donors' approaches to more closely resemble their own.

Considering Japan's role in the creation of the MDGs and its role as one of the world's largest development donors, the post-2015 development agenda discussions represented a strategic opportunity to assert Japanese leadership and promote Japan's influence and interests, which included the goal of advancing the concept of human security for Japan's Ministry of Foreign Affairs. While the initial process to define what was then referred to as the post-MDG agenda was unclear, policymakers knew Japan's Ministry of Foreign Affairs would engage early to shape the agenda, and constructed a narrative accordingly to ensure that health would be part of these efforts. But before describing and assessing how Japan's government engaged and exerted power, it is necessary to gain a deeper understanding of why Japan engaged in the negotiation and conceptualization of the post-2015, SDG process.

Why Japan Engaged in the Conceptualization and Negotiation of the Post-2015, SDGs

To understand why (and later how and where) Japan engaged in the conceptualization and negotiation of the post-2015 process for health, it is important to understand the motivations of Japan's diplomatic engagements and its ODA policies in the late 1990s and early 2000s. From the early 1950s, the Japanese government provided funding to Japanese companies to deliver goods and services to countries as reparations for WWII and to promote what it referred to as "economic cooperation." These initial efforts focused on advancing Japan's economic revitalization and restoring Japan's image post-WWII; the

Japanese government institutionalised an approach to development cooperation which one scholar summarized as focused on "the growth of industrial production and trade in a state-driven process."[367]

Japan quickly became one of the major international donors. In 1961, it was a founding member of the Development Assistance Committee (DAC). By 1975, the Japanese government was a founding member of the G6 Summit for the world's largest economies. By 1989, Japan was the world's largest provider of aid, and considered a "development aid superpower." Despite this growing international clout, during the First Gulf War in Iraq, Japan's government faced a diplomatic crisis of confidence. Given constitutional limitations, Japan was unable to commit troops; it instead offered $13 billion in financing. Japan's most important internationally ally, the United States, was displeased; US Secretary of State Baker dismissed this offer as "cheque book diplomacy." This was considered a serious setback in Tokyo. As one Japanese scholar observed, this experience is "remembered in Japan with bitter national consciousness" as "Japan's defeat in 1991".[368] This rebuke caused deep anxiety in the Japanese government. To respond, the government redoubled diplomatic efforts and enhanced global engagement.

This meant moving beyond just providing development aid to instead engaging in broader development debates in the 1990s and early 2000s. For example, Japan's Ministry of Finance funded a 1993 World Bank report, *The East Asian Miracle*, to explore the importance of state capacity in the successes of East and Southeast Asian countries' development. Japan's government intended this report to challenge the so-called "Washington Consensus" approach to international development, and highlight an alternative approach more aligned with Japan's experience and development cooperation policies. This was an early example of the Japanese government's new willingness to contest the then-dominant approach to international development and project an alternative "Made-in-Japan" approach; this was an example of Japan trying to exert institutional power leveraging its relationship to the World Bank and productive power through this report. One scholar notably characterized this as an intellectual confrontation between the "King Kong of 1818 H Street versus the Godzilla of Ginza" in which the World Bank ultimately ignored and overcame the pressure from Japan's Ministry of Finance and instead found "in the East

Asian experience a confirmation of its 'market-friendly' approach to policy."[369] This experience with the World Bank would later influence and shape Japanese policymakers' strategy with the World Bank in advancing Japan's focus on UHC as another way to leverage institutional and productive power.

Japan also exerted structural power to advance its global policies. The government supported a UN Commission on Human Security in 2003. As one scholar argued, "[a]lthough the origin of the human security idea and the security thinking it represents does not originate in Japan, Japanese officials liked to depict it as 'Made in Japan.'"[370] Despite significant support from Japanese Prime Ministers and senior politicians coupled with financial support, human security as an approach and concept did not resonate with the development community or global policymakers. It was criticized as conceptually unclear[371] and characterized as being vague "hot air."[372] In spite of this critique, Japan remains committed to using human security as a concept to guide its ODA, and multiple informants referenced the importance of the human security approach as critical to Japan's foreign policy and critical for justifying the Japanese government's focus on health. While health was clearly a tool of foreign policy in Japan, policymakers also recognised that this would be the best way to advance and expand Japan's global health engagement.

While Japan's government increasingly engaged to demonstrate it could offer more than just a "cheque book", there was a sense in the 1990s and early 2000s that Japan, especially compared to other countries, was not successful at advancing its ideas. As one scholar argued, Japan "was not able to come up with the compelling new ideas or to mobilize other donors to follow policies initiated by Japan."[356] One Japanese scholar complained, "[t]he global debate on development assistance is largely determined by others [...] Japan's role is no more than that of a timid co-pilot."[373] This is also aligned with a perception of Japanese policy being risk averse and reluctant to exert global leadership. This can be partly explained by struggles with English, the global lingua franca for diplomacy. But this does not entirely explain Japan's diplomatic limitations.

One scholar characterised Japanese foreign policy as being similar to a good defensive driver navigating an automobile, continuously seeking to minimize risk while exploiting

every opportunity to move forward.[374] Another scholar famously called Japan a "reactive state" meaning a state unable which, "fails to undertake major independent foreign-policy initiatives although it has the power and national incentives to do so [and] responds to outside pressure for change, albeit erratically, unsystematically, and often incompletely."[375] This "reactivism" was attributed to Japan's bureaucratic fragmentation, political factionalism and the lack of a strong central executive—all things which Prime Minister's Abe's administration would seek to change.[9]

Despite broader engagement in the 1990s, by the early 2000s, Japan's prolonged recession and large levels of public debt led to shrinking ODA levels as another reflection of the "Lost Decades". Accompanying these economic woes, the 2000s were also a decade of political instability; this was particularly the case between 2006 and 2012, which saw roughly a different Prime Minister annually as well as a rare period of Democratic Party of Japan (DPJ) government between 2009 and 2012. This changed in 2012 when new elections brought a strong LDP majority and returned Prime Minister Abe to lead the government.

While Japanese foreign policy has been traditionally viewed as passive[376], reactive[375]or in the words of one Japanese academic, "risk-avoiding and ineffective"[377], Prime Minister Abe's administration is trying to reverse this. Abe was determined to reign in Japan's traditionally powerful bureaucracy in the Ministries. Building on efforts started during Prime Minister Koizumi's administration from 2001-2006 and Abe's immediate predecessor during his first term as Prime Minister 2006-2007 (from which he resigned for both political reasons and personal health reasons, which made him more sympathetic to understand the importance of health according to one informant[378]), he accelerated consolidated efforts to centralize power in his Cabinet office at the start of his second term in 2012.

Abe's administration is trying to build a more strategic approach for global engagement. He aimed to re-assert Japanese leadership globally declaring "Japan is back" by

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[9] Of course, this point is highly contested within the literature on Japanese policymaking, others have argued that Japan is simply sensitive to the US government and that this is a deliberate political choice instead of an inability to do otherwise. For more, see: Miyashita, Akitoshi. "Gaiatsu and Japan's Foreign Aid: Rethinking the Reactive-Proactive Debate." *International Studies Quarterly* 43, no. 4 (December 1, 1999): 695–731. https://doi.org/10.1111/0020-8833.00142.

1) revitalizing Japan's global economic position through trade; 2) re-appraising Japan's relations with its Asian neighbours, especially China and South Korea; and 3) reinvigorating the Ministry of Foreign Affairs (MoFA) to engage far more significantly in multilateral diplomacy at the UN and with foreign assistance in Asia and Africa.[328]As global health journalist Laurie Garrett wrote after a meeting with Japan's Foreign Minister in 2013, "the crucial element of that third foreign policy pillar is the promotion of UHC, and diplomacy aimed at making UHC the target for the SDGs." [328]

This framing and narrative of UHC being a key contribution to Japan's foreign policy was constructed and codified in the 2011 Lancet Series on Japan. Bureaucrats in the Ministry of Foreign Affairs adapted this understanding of Japan's role in global health and aligned it with the new Abe administration's more assertive and robust foreign policy to improve Japanese security and create new economic opportunities for Japanese business. With Japan's world-leading life expectancy, focusing on global health could help export Japanese approaches and expertise to health within the region and globally. Given the large size of the still-largely domestic focused Japanese health industry, Japanese global health engagement could also help create or open new markets for Japanese health industries. For example, in 2013 Japan initiated a strategy within the Prime Minister's office to bolster its pharmaceutical export growth.[379] As one senior former Ministry of Health official stated, "by engaging more in global health, we could create opportunities for Japanese companies."[380]

According to one senior leader at JICA, who is also advising the Cabinet Office, there was also a sense of a geostrategic opening motivating Japan's engagement in global health; there was a perception that the United Kingdom, traditionally considered by Japan as a global health power, was becoming less engaged in health. As the informant argued, global health could be used as a "weapon or tool of Japanese diplomatic efforts."[381] This informant mentioned how the Abe administration could use global health to "soften" Japan's image. The thinking was that some of Abe's diplomatic efforts were viewed as too militant or aggressive and that global health could help reshape, reframe and soften views of Japan, similar to how US President used large American investments in the President's Emergency Program for AIDS Relief (PEPFAR) to showcase his "compassionate conservatism" in the wake of the Iraq War. In other words, Japan could improve its own security by focusing on and using global

health. In this sense, global health was seen and understood as a manifestation or realization of the human security concept, and as a tool to advance Japan's foreign policy interests.

Constructivists argue that understanding how non-material resources and structures shape actors' identities is important because identities inform interests and, in turn, actions. In this case, the Abe administration initiated a policy and vision to re-assert Japanese diplomatic efforts and exert leadership as a way to support Japan's foreign policy goals to stimulate the economy and improve Japanese security. Japanese politicians, academics and bureaucrats constructed a narrative building upon Japan's world-leading life expectancy and efforts to reach UHC as a policy issue which could be aligned with this vision and leveraged to exert Japanese leadership in global health. Parliamentarian Keizo Takemi and leading academics like Kenji Shibuya along with bureaucrats in the MoFA collaborated to package their existing interest in global health and strategically construct a narrative of how global health and a focus on UHC (which was "Made in Japan") was aligned with the Abe administration's foreign policy interests. They adapted this narrative with global health as a manifestation of the human security concept to align with Abe's priorities, and fed it into the political process. Abe and other senior members of his administration were interested in topics where they could exert and project Japanese influence globally to revitalize the Japanese economy, and thus were open to the idea of using global health policymaking.

The argument and language for why Japan should engage in global health was strategically constructed to appeal to the Abe administration building on Japan's domestic experience emphasizing points like "world-leading" and "global leadership". Japan's superlative life expectancy was a manifestation of these efforts and again highlighted Japan's leadership. As one key informant, someone from a Japanese NGO, stated, "we can sell this [UHC] idea as a Japan experience."[382] As multiple informants highlighted demonstrating the successful construction of this narrative, UHC was something uniquely Japanese and reflected "Japanese-ness", which Japan could export and profile on the global stage. Exporting this Japanese "UHC" was also aligned with Abe's policy of revitalizing and stimulating the Japanese economy; Japan's focus on UHC both nationally and globally would help Japan's economy. This narrative also deliberately drew upon Japan's political history.

For example, during a high-level UHC Summit hosted by the Japanese government and the World Bank in Tokyo in December 2013, Deputy Prime Minister (and former Prime Minister) Taro Aso stated, that Japan, "has an obligation to promote global health cooperation on health," because of its own UHC history.[328] After World War II, with its economy and most major cities in shambles, the government made an investment to accelerate its post-war recovery. To ensure economic vitality, Japan needed a healthy, productive labour force. Aso told the gathering that it was thus a matter of self-interest, even the survival of the nation, to pass Japan's 1958 Universal Insurance Act which put Japan on the path towards achieving UHC.

To buttress the Abe administration's political case for investing in Japan's global health efforts, it was also necessary to demonstrate domestic Japanese public support. As explained above, in the 1990s and 2000s, public support for Japanese ODA plummeted given domestic concerns about the economy. Therefore, any potential Japanese government administration was sensitive to the optics around new ODA initiatives and how they might be perceived or received by the Japanese public. Bureaucrats in the Prime Minister's Cabinet Office accordingly conducted a public survey in 2010, which found that more than 70 percent of the Japanese public rated health as the most important priority for the government to invest in of all the potential priorities for which development assistance could be provided; moreover, 58 percent of Japanese citizens thought that the government should increase its health ODA despite economic setbacks, whereas only 28 percent thought that it should be reduced.[383] Leveraging these results, an article included in the Series on Japan argued, "clearly there is a wide gap between what Japan is currently contributing to global health and what the Japanese public thinks Japan is capable of contributing. Such overwhelming public support represents a viable window of opportunity to enact reform at a time when the world so urgently needs greater global health engagement."[384] Japanese policymakers used this data to construct a new narrative about why Japan should engage more in global health, which was then consolidated in Japan's June 2013 Global Health Diplomacy Strategy.

The focus on UHC was also part of a broader shift, for example, the 2008-2009 WHO effort on Maximizing Positive Synergies project, toward a focus on health systems strengthening and a more "horizontal" approach, particularly following what many

considered the excess verticalization of the MDG approach, within the field of global health policy and part of continued contestation as described in Chapter One for priorities within global health.[385,386] Japan's engagement and leadership both contributed to and inspired this global movement for UHC.

To summarise, why did Japan engage in the post-2015, SDGs process for health? An existing group of Japanese politicians, academics and bureaucrats interested in global health worked together through an informal working group to construct a narrative about why Japan should engage in global health diplomacy and aligned this narrative to contribute to the Abe administration's foreign policy interests, which were focused on security and economic interests. This narrative also complemented a domestic and international political window of opportunity. Abe's new government began at the end of 2012, roughly the same time as the process to create the post-2015 development agenda began. This window of opportunity created the possibility for this narrative constructed about Japan's experience with UHC and its role in global health to be aligned with the Abe Administration's policy of creating new economic opportunities and preserving Japanese security.

Section Two:
Analysing How and Where Japan Engaged in the Post-2015, SDG Process

To understand how and where Japan's government engaged in the conceptualization of the post-2015, SDG process for health, this section reviews policymaking in Japan with a focus on development assistance and global health. It contextualizes the various actors in the policy process and analyses how and where the different actors engaged and exerted power in the negotiation and conceptualization of the post-2015, SDG process for health with an emphasis on the Ministry of Foreign Affair's 2013 Global Health Diplomacy Strategy. In cooperation with other Japanese government actors, Japan's Ministry of Foreign Affairs exerted institutional, productive and structural power to advance its focus on UHC. As one key informant argued, "the government is still by far the strongest [institutional actor on global health within Japan]."[387]

Political scientists consider Japan's policymaking processes to be extremely opaque and complex.[356]Broadly speaking, Japanese policymaking is dominated by three elite groups,

which have been called the "Iron Triangle"[388]: the Liberal Democratic Party (the LDP is the political party governing Japan almost exclusively since WWII), the bureaucracy (individuals working in government ministries and institutions), and the business elite (which financially support Japan's LDP and other political parties). Policymaking for Japanese ODA is different. Until the late 1980s, Japan's bureaucracy managed and contested ODA with what has been characterised as "intense bargaining"[389] between three ministries, the Ministry of Foreign Affairs (MoFA), the Ministry of International Trade and Industry (MITI, or METI since 2001) and the Ministry of Finance (MoF). This changed in the 1990s and 2000s as private businesses, politicians, civil society and the media all became more explicitly engaged in scrutinizing development aid and using it to advance their own interests.

For global health policymaking in Japan, the Ministry of Foreign Affairs (MoFA), the Ministry of Health, Labour and Welfare (MoHLW) and the Ministry of Finance (MoF) are the most relevant actors. Following the 2008 G8 Summit and the working relationships built through the Takemi Working Group, these three ministries starting meeting informally on their own to coordinate global health efforts; however, between 2013 and 2015 coordination meetings became institutionalized. One Ministry of Foreign Affairs official nevertheless characterised these internal government coordination efforts as the "most difficult of all."[390]

While health was a policy priority for Japan in the post-2015, SDG process, key informants shared a sense that this was a responsibility for the Japanese Ministry of Foreign Affairs. Since the 2000 G8, the Ministry of Foreign Affairs has been the most important actor for managing the Japanese Government's engagement in global health. Key informants expressed a great deal of respect and admiration for the Japanese Ministry of Foreign Affairs' ability to practice diplomacy and advance Japan's Global Health Diplomacy strategy. At times, the respect for Japanese bureaucracy expressed by informants and particularly the Ministry of Foreign Affairs seemed like a blind sense of faith in Japanese diplomats' effectiveness.

In 2012, the Ministry created a Global Health Policy Division in the Global Affairs Policy Directorate. MoFA manages Japan's engagement, contributions and personnel with UNICEF and UNFPA; in fact, MoFA manages Japan's relations with all of the UN agencies except the WHO and UNAIDS. MoFA also represents Japan in the Global Fund, GAVI and the

Coalition for Epidemic Preparedness Innovations (CEPI) partnerships, manages Japan's engagement in the G7/G8 and G20 policy processes as well as organizes the TICAD meetings and engages in UN processes like the negotiation of the post-2015 SDGs. Several divisions across the Ministry of Foreign Affairs share these responsibilities.

The Ministry of Health, Labour and Welfare (MoHLW) oversees Japan's relationship with the World Health Organization (although some of Japan's voluntary special contributions come from MoFA budgets) and UNAIDS. The MoFA traditionally dominated Japan's global health policymaking; however, the most recent Minister of Health, Yasuhisa Shiozaki[391] (who served from 2014 to 2017) began to shift this balance and assert the Ministry's leadership. Multiple key informants echoed what one informant stated, "Shiozaki was a very strong person."[392] Minister Shiozaki was a strong Minister for multiple reasons. He had a solid position within the LDP party, and had previously served as Vice Minister of Foreign Affairs in Koizumi's Cabinet. This experience in engaging in diplomacy, coupled with his time studying at Harvard University and as a US exchange student in high school, made Shiozaki more inclined to engage globally; moreover, his command of the English language and interpersonal skills made him a natural diplomat. To improve coordination with the Ministry of Foreign Affairs, Shiozaki instituted an exchange of personnel between MoHLW and MoFA, which meant that the Director of MoFA's Global Health Policy Division is now someone from the MoHLW, and the Director of the Ministry of Health's International Cooperation Department is from the MoFA. Shiozaki also convened an advisory group, Japan Health Care 2035[393], led by the academic and former senior WHO official Kenji Shibuya[394]. The study concluded with three recommendations one of which focused on being "a leader in global health." Shiozaki would later argue that, "through active engagement […] and leadership of global policy making […], Japan can improve upon its own health care system while also contributing to economic growth domestically and globally."[395]

Alongside the Ministry of Foreign Affairs and the Ministry of Health, Japan's Ministry of Finance manages the relationship with the World Bank, and the regional (Asian and African) development banks. Beyond these three ministries, there is JICA, which implements technical cooperation projects on health in Asia and Africa and was in the past under the jurisdiction of the MoFA; JICA is now officially independent, but maintains strong links with

the MoFA. Under the MoHLW, there is the Bureau of International Health Cooperation, National Center for Global Health and Medicine (NCGM). Prime Minister Abe has strengthened and empowered the Cabinet Office to coordinate between Ministries; in 2015 in the wake of Ebola, the Cabinet Office became much more active on health. As part of Abe's efforts to bolster Japan's private sector, the government created the Global Health Innovative Technology (GHIT) Fund in 2013 to leverage domestic research and development (R&D) capabilities.

Japan's government is the overwhelmingly dominant force in Japanese global health policymaking; however, there are also academic and research institutions as well as civil society and private sector actors engaged in global health. There are a handful of schools of public health, and a few global health policy think tanks in Tokyo: the previously-mentioned Japan Center for International Exchange (JCIE), the Health and Global Policy Institute (HGPI) and the Institute for Global Health Policy (iGHP) associated with the NCGM. For civil society organisations, there is the Africa Japan Forum and Results Japan, both of which focus largely on HIV/AIDS and TB, and have semi-regular exchanges with the Ministry of Foreign Affairs since the early 1990s. There is an independent Japanese Organization for International Cooperation in Family Planning (JOICFP). Save the Children also has a small team in Japan; however, civil society groups working on global health are relatively limited. CSOs generally follow the government's leadership.

As one civil society member stated in response to a question about the government's decision to focus on UHC, "No, there was no debate at all. Our position is we support the Japanese government's efforts to promote UHC, so that was Japanese NGOs' position, and first priority." This statement resonates with the academic literature on Japanese policymaking, which considers Japan's bureaucracy as functioning like a "powerful and respected think tank."[396] Japan's private sector working on health is largely domestically focused, and did not engage in discussions related to the post-2015 process. As one key informant stated, "the private sector did not have any interest in the discussion" on post-2015.[397] While this continues to evolve, the role of both civil society and the private sector in Japan's global health policymaking process remains weak and limited.[384]

In June 2013 the Ministry's Global Health Policy Division released "Japan's Strategy on Global Health Diplomacy."[398] This strategy reaffirmed Japan's commitment to a focus on global health in its foreign policy and declared its commitment to promote universal health coverage (UHC) as the overarching health goal. The strategy grounded Japan's interest in UHC based on its own experience (reflecting what informants considered the need for Japan's international efforts to have some level of "Japanese-ness") and world-leading life expectancy arguing that health "is indispensable to achieve human security." Japan's GHD Strategy contended that UHC could be an "effective post-2015 development agenda" providing an overarching way to achieve the remaining MDG health goals as well as advance efforts to strengthen health systems and address NCDs and aging challenges. But it is worth considering how or why Japan's 2013 GHD Strategy focused on UHC.

The focus of Japan's Global Health Diplomacy Strategy on UHC originated in the Takemi Working Group's 2011 Lancet Series on Japan. While the Takemi Working Group (TWG) described in the previous section started as an ad hoc group in 2007 in preparation for the 2008 G8, this group would go on to become an institutionalized, standing committee for global health in Japan. The working group included representatives from across the government as well as civil society, academia and the private sector meeting quarterly or bi-monthly as necessary. It continues to exist and is considered Japan's dominant informal process for global health policymaking (and as such was mentioned by almost every single informant interviewed). As one key informant stated, "without Professor Keizo Takemi and without the 'Takemi machineries' Japan probably could not be a global health champion."[392]

Takemi's role is critical. His father, Taro Takemi, was a prominent and well-known Japanese physician who served as the President of the Japan Medical Association for twenty-five years (1957-1982) and as the President of the World Medical Association between 1975-1976. This family connection gives the younger Takemi greater credibility within the health community. As an LDP politician, Takemi served as Vice-Minister of Health (in Prime Minister Abe's first cabinet in 2006-2007) as well as State Secretary for Foreign Affairs in 1998, where he was an early supporter of the Human Security approach; he thus has links

across ministry bureaucracies within the government. Takemi now serves as the Chair of the Special Committee on Global Health Strategy within the Policy Research Council of the LDP allowing him to influence the LDP position on global health, and thus the government's policy on global health. He thus has structural power, but he also has institutional power as well as productive power within Japan. He is a Senior Fellow at the Japan Center for International Exchange (JCIE), providing him with additional technical and institutional support on global health issues. Finally, he remains the chairperson for the TWG, which is now officially known as the Executive Committee on Global Health and Human Security.[399]

The TWG functioned and continues to function as a forum for information sharing as well as a platform to help facilitate coordination and address challenges across and between ministries and other actors. It also helped generate and consolidate support for additional engagement in global health. The TWG's initial efforts for the G8 Summit demonstrated what Harvard School of Public Health Professor Michael Reich (a close friend and collaborator of Takemi's) and Takemi argued was a "concerted effort by Japan and its partners to enhance its substantive contributions to global health policy making, rather than just providing financial donations."[354]This was a clear effort to move beyond "cheque book diplomacy."

Following the G8 Summit, the working group continued to meet and collaborate documenting research and analysis in a Special Lancet Series on Japan. Led by Kenji Shibuya, Naoki Ikegami and Keizo Takemi, this 2011 Series, "Japan: Universal Health Care at 50 Years", was the first time, the journal focused on a high-income country. The Series solidified existing links between the TWG and the Lancet providing a platform to continue highlighting and promoting Japan's engagement after the Series. (For example, Prime Minister Abe published a short piece when he launched Japan's Global Health Diplomacy Strategy in 2013.) The Series also codified a deeper focus on health systems, which was increasingly conflated with universal health care or coverage (UHC). (While the terms "care" and "coverage" are sometimes used interchangeably, they should not be as they imply rather different approaches.) The Series characterized Japan's efforts towards UHC as a concrete example of human security. One of the Series' commentaries argued that Japan's commitment to UHC is "indicative of the priority that Japan accords to human security."[400]

This Series represents an incredible example of productive power both within and beyond Japan. Within Japan, many key informants mentioned the Series and the impact it had in terms of transforming the discussion around global health as well as contributing to constructing a narrative about Japan's future engagement. Several informants mentioned how important the Lancet was and highlighted that even Prime Minister Abe knew about the Series (according to multiple informants, it is proudly displayed in the PM's office) and that it had shaped and influenced his thinking in terms of Japan's role in the world. Beyond Japan, this Series signalled Japan's focus on UHC to the global health community and implied that Japan would both invest its financial resources in helping countries advance towards UHC as well as exert non-material resources and diplomatic efforts into advancing UHC as a priority for the global health agenda and the process to define the post-2015 development agenda.

The Global Health Diplomacy Strategy launched in June 2013 highlighted four actions that Japan would take to advance its efforts on UHC. First, the strategy aimed to mainstream UHC and "lead the efforts to include the concept of UHC in the post-2015 development agenda" meaning positioning UHC as an "exemplary effort to realize human security", collaborating with international organizations and other partners and using high-level events like TICAD V. Second, the strategy would steer Japanese ODA and "technologies of Japan" towards UHC. Third, Japan would leverage strategic, global partners like WHO, the World Bank, the Global Fund and other partners as well as promote public-private partnerships along the lines of the 2013 establishment of the GHIT Fund. Fourth, the strategy would strengthen human resources for health, meaning advancing and promoting Japanese personnel in global health. Japan's MoFA sought to follow up on these activities within the ongoing process to define the post-2015 development agenda between 2013 and 2015.

As many informants noted, what complicated the implementation of Japan's GHD strategy was that policymakers had an unclear and limited understanding of the post-2015 process. As many informants noted, the process was messy, unclear and rapidly evolving. Moreover, the Strategy's authors were distant from the continually changing post-2015 political process in New York. This challenge was not unique to Japan; this was also the case for other countries and even troubled UN policymakers within the UN Secretary-General's office and UN agencies. As multiple key informants confirmed, the post-2015 policy process

was also seen as a technical discussion, and aside from MoFA and JICA, informants in Tokyo had a limited understanding of the technical discussions for the eventual SDG3. While it was not entirely clear at the time, as described in Chapter Three, looking at the final formulation of the SDGs, the most influential parts of the process were: 1) the Secretary-General's High-Level Panel which delivered its report in May 2013; 2) the thematic consultation on health hosted by UNICEF and WHO along with Sweden and Botswana in March 2013; and 3) the Open Working Group (OWG) between March 2013 and July 2014. To advance the 2013 Global Health Diplomacy Strategy's focus on UHC, Japan exerted three forms of power in Barnett and Duvall's framework, namely productive, institutional and structural power, both within the post-2015 process and beyond the process.

Barnett and Duvall argue that studying "global governance without power looks very different from global governance with power. With only slight exaggeration, much of the scholarship on global governance proceeds as if power either does not exist or is of minor importance."[401] The same can be said for global health: much of the scholarship on global health proceeds as if power either does not exist or is of minor importance. Instead, the role of power and how different actors exert power within the field of global health is critical for reinterpreting and gaining a deeper understanding of the field. This analysis aims to illuminate how considering power can contribute to reshaping understandings of global health policymaking process. The below examines and analyses how and where Japan's government engaged the post-2015 process and how Japan's government exerted power in these different processes. The box below provides a high-level overview of the timeline for how and where Japan engaged.

Japan's Engagement in the Post-2015 Process			
2011/2012: Japan's Ministry of Foreign Affairs sets up	**2013**:	**2014**: September 2014 Japanese Prime Minister holds high-level event at	**2015**: December Japan hosts second

"Post-MDG Contact Group" December 2012 Prime Minister Abe re-elected with strong majority	June Japan Launches Global Health Diplomacy Strategy Launches September 2013 Japanese Prime Minister holds high-level event at the opening of the UN General Assembly December Japan Convenes High-Level UHC Forum in Tokyo	the opening of the UN General Assembly	High-Level UHC Forum
The Post 2015 Process			
2013: March Botswana Thematic Consultation for Health Meeting May UN High-Level Panel Report Released June Open Working Group Meeting for Health (Sessions last between March 2013 and April 2014)	**2014**: June (2013) Open Working Group Meeting for Health (Sessions last between March 2013 and April 2014)		**2015**: From January to July Inter-Governmental Negotiations September SDGs Adopted

The Secretary-General's High-Level Panel

When Japan launched its GHD Strategy in June 2013, both the UN High Level Panel (HLP) and the thematic consultation on health in Botswana were already finished. Japan's former Prime Minister Naoto Kan had joined the HLP as one of the HLP's twenty-seven members, and his engagement was supported by the MoFA. Japan's selection and engagement in this panel was a representation of Japan's structural power in global affairs given that most countries were not represented in the panel. Yet the Japanese government was not able to make a persuasive case within the Panel in terms of promoting human security or in terms of UHC. The HLP included one mention of human security; for health, the report mentioned UHC, but proposed a goal to "Ensure Healthy Lives" with five targets, which were a modest expansion of the MDGs but did include sexual and reproductive rights and NCDs.[402] While Japan had an opportunity to exert power within the HLP, most informants felt that the Panel was unsuccessful for Japan as neither human security nor UHC were not strongly reflected in the Panel's final report released in June 2013.

The Botswana thematic consultation on health

The thematic consultation on health (co-convened by the Governments of Botswana and Sweden, WHO and UNICEF) was part of nine thematic consultations organized by the United Nations Development Programme (UNDP) starting in 2012. The six-month health consultation concluded in a three-day meeting in Botswana in March 2013. This process thus also ended before the launch of Japan's Global Health Diplomacy Strategy. The process included over 1,500 individuals participating in thirteen face-to-face consultations in Africa, Asia, South America, North America, and Europe; more than 100 papers were submitted for a web-based consultation which drew in 150,000 visitors.[403] None of the in-person consultations took place in Japan, and there was only one submission, out of the more than 100 papers submitted, from Japan (Japanese academics at the University of Tokyo), which argued against the "off-track" designation in the MDG framework.[506]While US and German Ministries submitted papers for consideration, it seems worth noting that no Japanese actor submitted to this process. One representative of the Japanese government participated in the final meeting in Botswana, but did not have a speaking role in the meeting agenda. With

only one representative attending, Japan did not have a strong representation in this meeting and thus did not have much opportunity to exert power. Broadly speaking, the Japanese government did not actively engage in this Botswana thematic consultation.

The Open Working Group (OWG)

Aside from the High-Level Panel and the Botswana thematic health consultation, there was also the Open Working Group (OWG). Originally structured to allow thirty countries from the UN's five regional groups to engage in the both informal and formal negotiations on potential SDGs, there was so much interest and commitment to engage from countries that some countries needed to share their seats in so-called "troikas". As one of the unique countries able to participate in this ad hoc mechanism, Japan was able to exert structural power. Japan was grouped together with Iran and Nepal. Between March 2013 and April 2014, the OWG had thirteen official sessions, which included week-long informal consultations and formal negotiations on the different themes. The topic of health was considered during the Fourth OWG meeting in June 2013. While for example, Botswana and Sweden (along with UNICEF and WHO) hosted a side-event to profile the thematic consultation work from the Botswana meeting, Japan did not host any official relevant side events on health during this consultation.[10] During the session, Japan emphasized the importance of realizing UHC and, as reported in a summary of the session, "promoting universal access to sexual and reproductive health and rights, including family planning and sex education; and ageing."[404] Japan coordinated its statement with other countries and tried to rally support within the OWG for UHC; however, Japan did not heavily invest in this process as it believed, like many other developed states did as described in Chapter Three, that the OWG negotiations would ultimately not be decisive. In some ways, Japanese diplomats, as well as many other policymakers engaged in the process, perceived the OWG as a practice round before what they thought would be the decisive intergovernmental negotiations later in 2014 and in 2015. As described in Chapter Three, ultimately the OWG would become the definitive process for articulating the SDG agenda.

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[10] It did, however, co-host a side event with the Government of Australia on "Sustainable Development Goals as a Driver for Trans-disciplinary Research and Education" according to the official programme of OWG side events, June 17-19, 2013.

How and Where did Japan engaged beyond the HLP, Botswana and the OWG

The Japanese government did not robustly engage in the High-Level Panel process, the Botswana thematic consultation, or the Open Working Group as outlined above. Where else then, and how, did Japan engage in the post-2015 process? How and where did it exert and express power?

Following the launch of its June 2013 Global Health Diplomacy Strategy, Japan's government exerted institutional, productive and structural power in a number of ways. The Ministry of Foreign Affairs sought to exert structural power leveraging by continuing to invest between two and four percent of its ODA on DAH. Japan's GHD Strategy sought both to re-purpose and re-brand this ODA for DAH as support for UHC and highlight this to signal Japan's backing for UHC in the post-2015 process through JICA and other partners. As part of Prime Minister Abe's renewed diplomatic efforts to revitalize Japan's trade and economic relationships in the region and beyond, he vowed to raise the topic of UHC in every official foreign visit and bilateral discussions for the duration of his time as Prime Minister.[319] Given the size of Japan's economy (the world's third largest), this sort of high-level attention should be considered an exertion of structural power as it would be difficult for many actors or institutions to ignore or resist a direct appeal from Japan's Prime Minister. This direct exertion of power also led to indirect forms of power, ie productive and institutional power.

For example, Prime Minister Abe leveraged structural power convening a high-level meeting in New York with all UN agency heads during the opening of the UN General Assembly in September 2013, 2014 and 2015 to highlight and profile some Japan-sponsored UHC outputs (the results of Japan's productive power detailed below) developed by the World Bank and the WHO. This also could be considered institutional power given Japan's role within these institutions. These exertions of power reverberating within global health policymaking as actors could, depending on their audience, point to either the Prime Minister's commitment or the WHO or Bank's products, to shape and influence policymaking.

To amplify these efforts, Japan's Ministry of Foreign Affairs sought to exert structural power and build diplomatic alliances with other states engaged in the post-2015 process. For example, in both Geneva and New York, Japan collaborated with other "like-minded"

countries, like France and Thailand, which were committed to promoting UHC as the health SDG, to augment their own efforts to advance UHC. Japan allied with these states as they were not only supporters of UHC, but they were also members of the Foreign Policy and Global Health Group (the so-called Oslo Group including Indonesia, France, South Africa, Norway, Senegal, Thailand and Brazil), which Japan sought to leverage thus exerting structural power given its broad representation and influence throughout what was perceived to be a still-evolving multilateral process.

Even before the GHD Strategy, and early in the post-2015 discussions over the course of 2011 and 2012, the Ministry convened an informal "Post-MDGs Contact Group" (CG) as "a forum for informal policy dialogue on the development agenda beyond 2015."[405] This was a clear effort from the Ministry of Foreign Affairs to exert both structural and productive power. The CG included "participants from about 20 countries, as well as major international organizations, foundations, research institutions and NGOs to exchange views and ideas informally, free from their official positions." By convening and chairing the group, Japan was demonstrating its ability to exert structural power. This group held a series of quarterly meetings in New York (December 2011), Mexico City (February 2012), Tokyo (May 2012) and New York (September 2012). Demonstrating the intention to exert productive power, the summary note concluded that for the post-2015 process "four concepts are important: human security (i.e. a people-centred approach), equity, sustainable development, and resilience."[405] Some participants saw this as an early, but ultimately unsuccessful, attempt by Japan to use both structural and productive power to advance the "human security" approach. Foreshadowing the government's eventual focus on UHC as an umbrella goal for health, the summary note for health found specifically, "that if we compile the health-related goals into one goal, those items which will have a comprehensive impact on the progress of many health-related issues should be selected as the targets, rather than setting the targets according to individual diseases or problems."

Informants also shared the belief that this CG was intended to influence the Secretary-General's High-Level Panel (HLP) on the post-2015 Development Agenda, which had been announced in July 2012.[406] While Japan's CG effort did not seem to influence the Secretary-General's HLP, it did raise attention to the strategic importance of the process within the

government and signal to both the UN Secretariat and other countries that Japan was committed to engaging in the conversation about the post-2015 development agenda.

To complement this structural power, Japan also drew upon institutional and productive power. For example, Japan's cooperation with Thailand had started even earlier. Japanese policymakers and academics previously collaborated with their Thai counterparts and participated in the annual Prince Mahidol Award Conference (PMAC) in Bangkok for several years. The January 2012 conference focused on UHC, and Japanese policymakers and academics leveraged the conference to exert institutional and productive power using the conference as an institutional forum to launch the Lancet Series on Japan. This Series served as an example of productive power at the conference and beyond. Japanese policymakers also convened a series of meetings cultivating an informal network of actors during the conference to coordinate and strategize with other like-minded states, institutions, civil society organisations and individuals about how to advance Japan's efforts on UHC within the field of global health, including within the post-2015 process and beyond.

Japan's government also exerted structural, institutional and productive power through its role and position within global health institutions like the World Bank and the World Health Organization. The Japanese government exerted institutional and productive power through their relationships and financial (plus personnel seconded to) support to the World Health Organization and the World Bank. The Ministry of Foreign Affairs and Ministry of Finance sought to leverage both institutions' abilities to produce knowledge and provide normative guidance to countries on health issues. Combining financial support with hands-on engagement from Japanese policymakers and academics, Japan was able to strongly influence the agendas of both of these institutions exerting institutional power to shape research products from both institutions, which would ultimately exert productive power. (This also represented a learning from the 1993 *East Asian Miracle* report experience with the Bank. This time, Japan's government deftly ensured that Japanese academics and policymakers were deeply engaged in the process, and that the others also engaged were friendly to Japan's perspective.)

Based on these outputs, Japan, in cooperation with these institutions, organized and hosted a number of informal technical briefings, seminars and workshops on UHC on the side lines of the Open Working Group (OWG) and intergovernmental negotiations as well as during the opening of the UN General Assembly in New York in September, the World Bank Spring Meetings in April in Washington and the World Health Assembly in Geneva between 2013-2015. In all of these events, both the WHO and the World Bank disseminated research and analytical products, much of which had been supported by Japan and or sometimes supported by Japanese experts. These research outputs had the potential to exert tremendous productive power as many countries looked to both the WHO and the World Bank to guide and inform their efforts on health.

For example, Japan established a Japan-World Bank Partnership Program on UHC starting in 2012, which according to the Bank's website, "supported systematic analyses of health policies and programs in eleven countries [in Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, Vietnam], with the aim of drawing lessons from Japan and other country experiences with UHC, in order to respond to the growing demand from low- and middle-income countries for assistance in developing UHC policies and strategies."[407] This partnership led to the production of case studies and a World Bank report and a high-profile journal article[408], seminars and books, all of which were produced under the auspices of the World Bank with input from Japanese and international academics. These materials created through Japan's institutional power at the Bank were then leveraged into productive power to provide guidance and inspire policy direction for other countries.

These outputs were then launched and amplified using structural power for example during a high-level UHC Forum which the Government of Japan co-hosted with the World Bank in Tokyo in December 2013 (this meeting would re-occur in 2015 and 2017). Controlling which actors were invited, and the agenda, Japans' government ensured many partner global health institutions and multiple ministers from Asia and Africa attended this Forum. Hosting this meeting in Tokyo, Japan exerted structural, institutional and productive power ensuring that all discussions of health were viewed under the umbrella of actions or interventions accelerating countries' progress towards UHC and showcasing Japanese-supported products or outputs which highlighted these efforts.

To help advance Japan's Global Health Diplomacy strategy, the Ministry of Foreign Affairs also sought to engage and leverage structural and productive power through the limited number of Japanese civil society organizations and global health academics. For example, in late 2012 an ad hoc consortium or network of NGOs called "Beyond MDGs", including the Japan Society for International Development, the Japan Association for International Health, the National Center for Global Health and Medicine as well JICA, was created and held seminars and workshops every few months in Tokyo in 2013 and 2014. While Japanese government policymakers recognised that civil society voices were important, they did not devote much time or effort into building or developing these relationships. These civil society organisations also engaged with the government, but in the words of one key informant involved, "the government didn't really care about this."[409] Another informant stated, "we trusted the Government and agreed with their focus on UHC, so there was not much to discuss."[410] Some Japanese academics also wrote academic articles making the case for human security and UHC in the post-2015 agenda.[411] The table below showcases the different ways in which Japan exerted power.

Japanese Government's Exertion of Power to Influence the Post-2015 Process	
Structural Power	• The Prime Minister's office using bilateral relations • The Ministry of Foreign Affairs convening a SDG Contract Group in 2011-2012 as well as high-level events (eg the UHC Forum) and lower-level briefings
Institutional Power	• The Ministry of Foreign Affairs, Health and Finance leveraging the World Bank and the World Health Organisation to prioritise Japanese priorities within these institutions as well as taking advantage of the exchange of personnel within these institutions
Productive Power	• The Ministry of Foreign Affairs, Health and Finance leveraging knowledge and technical expertise from both the World Bank and the World Health Organisation to advance Japanese priorities

In summary, Japan's government exerted power largely outside the official post-2015 process for health, and sought to align the SDG3 agenda closely with its own global health agenda to amplify its efforts and help advance Japanese foreign policy, namely economic and security, interests. Japan primarily used institutional power most successfully given its

relationships with the World Bank and the World Health Organisation; however, it was not able to wield as much structural power as it might have hoped and its productive power also had limited effects in the conceptualisation of the post-2015, SDG agenda for health. The following section discusses Japan's role in the post-2015 process and reflects on the implications of Japan's engagement.

Section Four: Discussion

Ultimately Japan was not successful in positioning UHC as the overarching SDG for health as outlined in its 2013 Global Health Diplomacy Strategy. Instead, SDG3, the one health goal in the seventeen SDGs, aims to "ensure healthy lives and promote wellbeing for all at all ages." Despite this, many Japanese institutions and individual policymakers continue to conflate SDG3 with UHC. For example, 2018 JICA materials with a timeline on global health interventions refer to the past as the MDG era and classify the current era as the "Sustainable Development Goals/Universal Health Coverage" era.[412] Conflating the SDGs with UHC is not unique. As one might expect given the role of the SDGs as the MDGs' successor and the supposed normative guidelines for global development efforts, other actors within the field of global health also attempt to position their issue as central to the SDGs and specifically SDG3. Yet the conflation of UHC and the SDGs in Japan is persistent and pervasive, and is a deliberate attempt to re-interpret, reframe and "construct" an understanding and interpretation of SDG3. In fact, in many cases, Japanese informants seemed genuinely unaware or unclear about the distinction between SDG3 and UHC.

Many informants expressed genuine surprise and disbelief about why the Japanese position to advance UHC within the post-2015 process was even contested. As one informant in the Ministry of Foreign Affairs stated, "we thought we could contribute to the world by utilizing our [UHC] expertise."[413] This reflects the widespread acceptance by Japanese policymakers and bureaucrats of the narrative of UHC as "Made in Japan" and representing a unique Japanese contribution as well as a lack of appreciation of the level of contestation in global health. Demonstrating a lack of awareness of global health politics and/or an admiration for Japan's government, some key informants seemed sincerely uncomfortable

or unable to recognize why UHC might be opposed. This again highlights the enduring relevance of constructivism for interpreting and understanding global health policy.

There was also a critical misinterpretation of the post-2015 process. The view from Tokyo for health was focused on policy processes in Geneva. Yet there was a disconnect between the post-2015 discussion in Geneva, particularly in deliberations at WHO, and the discussion at the UN in New York. Japanese policymakers, somewhat understandably, appeared to think that because the World Health Assembly and WHO's senior leadership supported UHC, this would be the health priority for the post-2015 agenda. Yet as one JICA official realised, "in Geneva, UHC was one of the very strong agenda but that information was not so much connected with the outcome of New York discussions."[414] As detailed in Chapter Three, the post-2015 process for health was ultimately determined by Ministries of Foreign Affairs in New York, not Ministries of Health in Geneva building from the three processes reviewed above (the High-Level Panel, the Botswana thematic consultation and the OWG.)

Despite these limitations, most Japanese informants did not see Japan's engagement in the post-2015 process as unsuccessful. Indeed, most Japanese policymakers viewed Japan's engagement as a diplomatic success and a reflection of Japan's commitment to the field of global health. One high-ranking Japanese official at JICA offered a more nuanced view, and assessed Japan's role in the post-2015 process as mixed.[415] According to this informant, Japan had three goals in its SDG efforts: 1) simplify the SDGs; 2) advance human security; and 3) support a few specific issues like UHC (and economic growth and the environment). The informant assessed Japan as failing to simplify the SDG conceptual framework and failing to advance the conceptual rhetoric of human security; however, this informant contended that the spirit of human security as a concept was embodied in the SDGs, and that UHC was "a success" as it was firmly embedded as a target within SDG3. This analysis seems fair, and a realistic assessment of Japan's engagement.

While Japan did not succeed in having UHC as the overall goal for SDG3, Japan's strategic investments, largely outside the official post-2015 process, contributed to positioning UHC as a global health priority and anchoring it as an institutional priority at both WHO and the World Bank. Japan's investments in advancing UHC continue to shape the

global health agenda beyond the post-2015 negotiations. WHO's Director-General since 2017, Tedros Adhanom Ghebreyesus, considers UHC WHO's top priority; the World Bank's health work continues to have a strong focus on UHC. Despite not deeply engaging on health in the formal post-2015 process (the processes which ended up being the most influential in the ultimate SDG3), Japan's government still exerted considerable power throughout its post-2015, SDG engagement. After analysing why, how and where Japan engaged, three important points emerge. (These points are focused on Japan's engagement; broader implications and lessons for how state actors engage in global health policymaking are considered in Chapter Seven.)

First, applying a constructivist analysis for why Japan engaged and a power framework for how Japan engaged provides a deeper analytical understanding of Japan's motivations and role in the post-2015 process. It also highlights potential lessons to stimulate and improve other countries' future global health engagement. As previously cited, Finnemore argued that, "states are embedded in dense networks of transnational and international social relations that shape their perceptions of the world and their role in that world."[51] This was clearly the case in Japan. The Abe administration in Japan actively engaged with and responded to one understanding of Japan's government as a "reactivist state" as well as perceptions that Japan was underperforming as a soft power leader. Using global health diplomacy as one tool, the government sought to reposition itself and continue to shift its identity re-asserting and demonstrating an ability to be an international leader. As detailed above, Japanese policymakers invested time and resources from largely within Japan (but also drew upon expertise from outside the country) in developing and constructing a narrative justifying greater Japanese engagement in global health diplomacy building on Japan's human security approach. This was then aligned with, and integrated into, a strategy to pursue Japan's foreign policy, particularly security and economic interests.

Specifically detailing the benefits to Japan and broadly outlining the links between national strategic interests and global health motivated Japan's leaders in the Prime Minister's office, Parliament and across multiple ministries to prioritize national engagement in global health, as well as deepen and amplify their coordination, engagement and alignment to further their interests. With this high-level, broad support, Barnett and

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Duvall's framework demonstrates and illuminates the different ways in which national policymakers can leverage structural, institutional and productive power.

Second, by detailing and highlighting how and where Japan exerted power, it is possible to begin to analyse how Japan engaged and how it might also improve future global health efforts. In the 2011 Lancet series, one article assessed Japan's commitment to global health and argued that government fragmentation, weak civil society and a lack of monitoring and evaluation hindered Japan's engagement and rendered it "not […] outstanding relative to its substantial potential."[384]The article characterized Japan's engagement as low, and its leadership weak. The authors suggested increasing financial resources, establishing a high-level global health committee, promoting NGOs and developing global health leadership. Since 2011, the government and Japanese policymakers have worked, with varying levels of success, to improve the country's leadership and engagement, and some of this was evident in the post-2015 process. For example, during the post-2015 process, Japan's government began to improve its coordination and alignment through the Takemi Working Group and instituting a more formal exchange process between the Ministry of Foreign Affairs and Ministry of Health to improve coordination and knowledge sharing. While this sort of assessment is useful, this sort of analysis can be augmented with Barnett and Duvall's power framework.

Applying the power framework, one can classify the different ways in which Japan engaged in the post-2015 process, and also begin to identify specific areas of focus for improvement in terms of exerting power and leveraging influence. The government had a unified approach and focused on its Global Health Diplomacy Strategy to focus on UHC. The Japanese government exerted institutional, structural and productive power. To advance its Strategy, Japan's government exerted structural power through the Prime Minister's efforts, leveraging development aid and diplomatic efforts in alliance with other countries; Japan exerted institutional and productive power through key global health institutions like the World Bank and the World Health Organization. The Ministry of Foreign Affairs leveraged structural power by creating a Contact Group, and by hosting a UHC Forum in Tokyo. It also deployed structural and productive power hosting several high-level events in Tokyo, Geneva and in New York as well as UHC briefings and seminars.

For future efforts, however, the government might consider engaging or working with other UN and international institutions and agencies, for example, UNICEF or the OECD. Similar to how it facilitated coordination between its own national ministries, it could also use its institutional and structural power within these organisations to facilitate better cooperation between these different international institutions, for example, WHO and the World Bank and others. The government could also improve its efforts by increasing capacity in global health as well as continuing to refine and improve its strategic engagement building more sustainable support for global health both within and outside the government as well as beyond Japan. The government might also think about other ways to improve and amplify how it exerts productive power deepening its capacity to exert this type of power cultivating and expanding its networks and human capacities.

This analysis also highlights some limitations of this power framework. Despite highlighting why, how and where Japan's government exerted focused power to advance its strategy on UHC, the framework does not consider the soft power, ability or skills of actors to persuade. It does not allow for strategic considerations of how or when to engage in the policy process. When considering Japan's soft power in its foreign policy for global health, one must consider diplomats' English language skills, technical expertise and savvy in terms of navigating sometimes ambiguous diplomatic processes and procedures. The ability to develop and deepen these skills is often constricted by quick rotations and turnovers before staff have time to develop their expertise and or cultivate the social capital and networks between professionals working in global health. Informants in New York also alluded to a sense that Japanese diplomats often appeared reluctant to engage without first "checking with Tokyo". This sense that diplomats were controlled by their capital or unable to manage the relationship with their capital vis-à-vis other diplomats and processes appeared to sometimes limit the ability of Japanese diplomats to engage. Moreover, sometimes shortcoming in these attributes hampered Japanese diplomats' abilities to wield influence and shape policy efforts.

Third, the role of domestic politics was critical to both determining and understanding why and how Japan engaged in the process. Japanese policymakers invested resources into ensuring its engagement was strongly aligned with its foreign policy and

efforts to advance human security. This case seems to suggest that developing a strategic narrative of why a country should engage is possibly a necessary prerequisite for engagement. While Takemi and Japanese academics were keen for Japan to engage more on global health and constructed a narrative about how this engagement could align with Japanese foreign policy, it was only after Prime Minister Abe's re-election in 2012 and the LDP's return to power that this narrative could be fully aligned with the Abe administration's diplomatic efforts and then implemented. There is definitely a skill to align global health with national politics and priorities, but the timing and domestic political opportunity coupled with the post-2015 process mattered and influenced how and where Japan engaged. This political opportunity also brought additional challenges of contestation.

Prior to the appointment of former Minister of Health, Shiozaki, Takemi dominated discussions within Japan on global health; however, in some ways, Shiozaki's appointment and eventual engagement represented a challenge to Takemi's dominance of the policy space contesting the exclusive focus of Japan's efforts on UHC. While recognizing the importance of UHC, Shiozaki also emphasized the importance of global health security (as opposed to UHC), particularly as these issues framed as threats were important to Japanese citizens and voters. The Ebola and MERS outbreaks and growing attention to health emergencies, framed as part of Japan's focus on human security, enabled Shiozaki to gain high-level support for his efforts and create some political space for himself within the field of global health within Japan. Reflecting this shift in priorities, when Prime Minister Abe described his government's three global health priorities in the Lancet in 2015 (two years after writing about his government's Global Health Diplomacy Strategy) for the 2016 G7 and TICAD, he referenced Shiozaki's Japan Health Care 2035 project, and highlighted [in the following order], public health emergencies, universal health coverage and Antimicrobial Resistance.[416] This slight shift in focus within the government reflects this contestation.

In a recent article in the WHO Bulletin, a combination of Japanese academics and policymakers argued that, "the strongest drivers for Japan's prioritization of UHC appeared to be three high-level Japanese champions of global health: Prime Minister Shinzo Abe; Yasuhisa Shiozaki, a former Minister of Health, Labour and Welfare; and Professor Keizo Takemi, a member of the House of Councillors" but also cautioned that too many champions

and allies could lead to "fragmentation."[417] Alongside fragmentation, there is also risk for "crowding out"; in other words, these political champions could support and advocate so stridently for global health that they intimidate and prevent other Japanese politicians from engaging in the space, and that they dominate the dialogue in a way that alternative approaches and perspectives are not considered.

Conclusion

This analysis demonstrates the importance of considering how state actors engage in global health, and the added value of using power as a framework to help illuminate and assess actors', particularly states', roles in global health. Better understanding how power is exerted and deployed could contribute to improving how actors engage, and identifying key determinants of comparatively more 'successful' or 'effective' efforts in global health; a deeper knowledge of what determines better policy efforts could also enhance policy processes and lead to better governance mechanisms. Ultimately, this could transform states' abilities to negotiate global health policies, eventually improving and saving lives.[11]

Understanding why Japan has engaged is also instructive for anticipating how it might engage in the future. As explained in Chapter Three, the relationship between the SDGs and the global health agenda remains actively contested. Even today, Japan has been supporting the political process behind a 2019 UN High-Level Meeting on UHC and continues to conflate the SDGs with UHC. Given Japan's experience with the human security approach and in the post-2015 process, might it be reasonable to expect that it will seek to build on and replicate some of this with its continued focus on UHC. For example, this could mean that the Japanese government will pursue and possibly fund a UN Commission on UHC similar to the one it funded in the early 2000s on human security.

In conclusion, Japan's policymakers within the government saw the post-2015 process as an opportunity to demonstrate Japan's influence, enhance its economic interests and foreign policy goals by exporting its own model or vision for health through UHC. While

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[11] Of course, having a better understanding of states' power in global health might also mean other actors, like civil society or private sector actors, increase their attempts to leverage states' influence to advance their interests.

the government and policymakers identified the post-2015 process as an opportunity, they also viewed it as just one process within a broader strategy of influencing and shaping the global health agenda. Japan's growing engagement in global health represents an evolution in a still emerging field traditionally defined and dominated by US and UK engagement. Other high-income states like Germany are now increasingly engaging in global health, and German policymakers and academics have been beginning to look to and study how Japan engages in global health as an alternative to the US and the UK to inform and inspire their own involvement. One might anticipate other high-income (as well as middle-income) countries increasing their engagement and considering Japan for lessons to inform their own engagement.

The case of Japan offers insights into why and how countries might engage in global health as well as implications for the future of global health. Growing awareness of Japan's engagement, coupled with US and UK retreat, might also encourage or inspire other high-income and middle-income countries to engage more in the field of global health with their own priorities and approaches. Ultimately, this will likely mean a more contested, and possibly fragmented, global health agenda as more states engage and seek to align their engagement with their national foreign policies. One insight from this case study is that for other high-income countries to justify continued, or even expanded, investments and engagement on global health, policymakers will need to devote time and resources to developing a strategic narrative to motivate and prioritize national engagement in global health. The process for doing so matters, and itself could contribute to generating considerable commitment and alignment.

Chapter Six

Why, How and Where did Indonesia Engage in the Post-2015, SDG Negotiations for Health

Main Points

- Between 2000 and 2015, Indonesia shifted from being a recipient of global guidelines to a producer of global guidelines on sustainable development. In line with President Yudhoyono's foreign policy goals to project Indonesian leadership and "internationalize" Indonesia's development experience as an emergent middle power, policymakers engaged to advance their own domestic interests and project Indonesia's global leadership aspirations in the conceptualization of the post-2015, Sustainable Development Goals (SDGs) for health. The government was late to embrace the MDGs, which were considered irrelevant, although the appointment in 2010 of a Special Envoy for the MDGs brought greater domestic policy attention.
- Leveraging President Yudhoyono's role as co-chair of the UN Secretary-General's High-Level Panel (HLP) on the post-2015 development agenda, Indonesia's government exerted structural and institutional as well as productive power within the HLP process and throughout the broader post-2015, SDG process. The Indonesian government leveraged the President's role as a Co-Chair within and beyond the HLP process. The Ministry of Health and Foreign Affairs exerted structural power within the Botswana Consultation by presenting in one of the limited sessions. The President's office along with the Ministries of Foreign Affairs, Health and Planning exerted structural and institutional power by engaging actively throughout the OWG negotiations unilaterally and with allies as well as through the institution of the G77.
- Along with a commitment to finishing the MDG agenda for health, Indonesia advocated for a focus on universal health coverage (UHC) and non-communicable diseases (NCDs) to be included in the Sustainable Development Goal for health despite tensions between different actors' interests (reflecting "different Indonesias") and the lack of a single, consistent strategy for the health goal across the various actors. When the Sustainable Development Goal for health (SDG3) incorporated the MDG agenda and, amongst other issues, a focus on UHC and NCDs, Indonesian informants considered their engagement in the post-2015 process broadly, and specifically on health, successful. Attributing SDG3, however, to the Indonesian government's efforts would be an exaggeration; instead, Indonesian policymakers' engagement at best contributed broadly to the final conceptualisation.
- This analysis of Indonesian global health diplomacy demonstrates that global health itself is not a high national priority; however, global health issues may gain policy prominence and attention when there is an overlap with religious (eg: maternal mortality) or political interests (eg: virus sample sharing) and/or there is an opportunity to project Indonesian leadership globally (eg: the Oslo Group). While President Yudhoyono had an ambitious foreign policy to expand Indonesian influence and accelerate economic development, global health was not a part of this strategy.

Indonesian state actors' engagement could presage a more contested global health policymaking process, and possibly, a more fragmented global health governance landscape as state actors create new structures or fora to maximize their ability to exert power and influence.

Introduction

In 2016, Richard Horton, the editor of the *Lancet*, argued that, "if you search for the word "India" in the title of *Lancet* publications, you will find 2098 entries. The US: 1287. China: 841. Indonesia? 33."[418] Indonesia is often overlooked in the global health literature. Since 2000, Indonesia has undergone a substantial political and economic transformation. When the Millennium Development Goals (MDGs) were conceptualized in the early 2000s, Indonesia was still largely a recipient of global policy guidelines from the United Nations (UN) and international institutions. By 2015, however, Indonesia was playing a leading role in providing global guidelines helping to create the Sustainable Development Goals (SDGs).

Following independence after World War II, Sukarno, Indonesia's first President, sought a "free and active" foreign policy. His government hosted the inaugural Non-Aligned Movement (NAM) conference in Bandung in 1955. This conference laid the groundwork for the establishment of the G-77 in 1964.[419] Sukarno's role in creating the NAM was an early attempt to engage and challenge the Cold War binary constellation of countries either in the US or the Soviet camp. He sought to position Indonesia in a neutral middle space between the US and USSR; however, in a military coup with US support, Suharto, an army general, overthrew Sukarno and led Indonesia from 1967-1998.

Under Suharto, Indonesia became an American ally and his government was considered an important bulwark against communism. Accordingly, Indonesia was a top recipient of American (and Japanese) Cold War aid. Suharto's government focused on developing Indonesia's economy, which grew rapidly. Indonesia played an important regional role, and was a founder of the Association of Southeast Asian Nations (ASEAN) in 1967. By the 1990s, Indonesia was one of the "Asian Tiger" economies. Yet after fuel price increases led to capital flight, currency collapse, and a tripling of the poverty rate[420] on top of popular unrest during the 1997 economic crisis, Indonesians experienced political turmoil. Suharto stepped down in May 1998. After three decades of Suharto's "New Order"

politics, the ensuing political transformation is often referred to as the start of *reformasi* (reformation).

Following initial political instability, Indonesia emerged as not only a regional political leader, but also as a model middle power globally. Susilo Bambang Yudhoyono (also known as "SBY"), was elected in 2004 in Indonesia's first direct Presidential election and re-elected in 2009. He represented, as one commentator argued, "a triumph of personality, image and popular choice over party machine politics."[421] After his election, Yudhoyono coordinated a large complex, multiparty coalition, the "United Indonesia Cabinet", informally known as a "Rainbow Cabinet'. Analysts argued that he had a "strong tendency for the government to engage in political compromise and prefer[ed] stability over unsettling political and economic change."[422]

Despite difficult challenges like the December 2004 Pacific Ocean earthquake and the October 2005 Bali terrorist attacks, scholars argued that Yudhoyono became "the symbol of Indonesia's leadership aspirations and role in regional and international affairs with a style that is widely recognized as gentle, open, and engaging."[423] While Yudhoyono's 2009 re-election was considered by some as a "beauty contest" resting on voters finding him "charismatic and wise"[424], others simply considered him a savvy politician. Experts considered Indonesia's approach as "low-key" noting "its refusal to speak loud and clear, and its tendency to take a balanced position."[422] Others criticized Yudhoyono for overextending efforts to showcase Indonesian leadership, going so far as to attempt to mediate the Korean peninsula conflict.[425] Yudhoyono was continually positioning Indonesia on issues like climate change within the G20 Forum, ASEAN, the United Nations (UN) and beyond.

President Yudhono's efforts did not go unnoticed. In 2012, only twelve years after the MDGs' creation, he was asked by the UN Secretary General (SG) to help develop the successor framework for the MDGs. Yudhoyono, was appointed, along with British Prime Minister Cameron and Liberian President Sirleaf, to co-chair the SG's High-Level Panel (HLP) of eminent persons on the Post-2015 Development Agenda. After his appointment, Yudhoyono commented, "Indonesia's part in this noble task is for the sake of all the peoples in the world"; his role as a co-chair exemplified how Indonesia was increasingly recognized as an important

global power.[426] As analysts argued "Indonesia's foreign policy and regional and global profile have always been based on its ability to harness the country's normative and moral authority."[427] This engagement coincided with a number of global health engagements, and contributed to expectations that Indonesia would take on a greater role in global health.

American global health analysts proclaimed 2013 "Indonesia's Year for Global Health Diplomacy."[428] Indonesia's Health Minister Nafsiah Mboi became Chair of the Board for the Global Fund to Fight AIDS, Tuberculosis and Malaria; the country also hosted two high-level health conferences: an Asia-Pacific Economic Cooperation (APEC) health financing meeting and the Fourth Islamic Conference of Health Ministers of the Organization of Islamic Conference. This built upon Indonesia's on-going experience in global health. For example, Indonesia's Ministry of Foreign Affairs chaired the Foreign Policy and Global Health (FPGH) initiative in 2013, which was founded by Ministers of Foreign Affairs from Brazil, Indonesia, France, Norway, Senegal, South Africa and Thailand in 2007.[429] This built on Indonesia's experience with the World Health Organization (WHO) during the 2007 avian flu pandemic when Indonesia's notorious actions challenged existing global health virus sharing policies.[430]

These global health engagements were part of a broader political commitment to advance foreign policy and project Indonesian leadership during Yudhoyono's administration (2004-2014). Aligned with its growing global role, these engagements positioned the country to exert its voice and occupy a more prominent position within global health. As one Ambassador in Jakarta stated, "Indonesia feels its time has come [and it] wants to be taken seriously as [an] international player. They are reaching out aggressively to take a bigger role."[426]International relations experts recognized Indonesia's exceptional rise "exercising normative power and influence."[423]Experts noted that Indonesia's foreign policy officials "are proud that many of their efforts have generated new ideas and thinking on important regional and global affairs."[427] Accordingly, policymakers, institutions and states were expecting Indonesia to exert greater leadership and engagement in global health.

This chapter starts by contextualizing Indonesia's relationship with the MDGs and engagements in the field of global health within Indonesia's broader historical political

economy and foreign policy efforts. This sets the background to apply constructivism theory to analyse why Indonesia engaged in the post-2015 process. After reviewing why Indonesia engaged in the post-2015 process using constructivist theory, this analysis will specifically examine how and where Indonesia built upon the historical legacies of its foreign policy engagement, and exerted institutional, structural and productive power in the post-2015 process according to Barnett and Duvall's power framework. (The box below serves as a refresher on Barnett and Duvall's power framework.) This chapter concludes by discussing the implications of Indonesia's engagement in the post-2015 process and what this might mean for future global health policymaking efforts.

Box 1: Barnett and Duvall's Power Framework and Indonesia

Barnett and Duvall's power framework distinguishes between four different types of power: 1) compulsory (direct power, such as use of military force); 2) institutional (indirect power, such as how international institutions are designed to favour one actor over another); 3) structural (the overall constitution or framework of actor and their roles); or 4) productive (control over the possession and distribution of resources) power. For global health, one could think of a donor agency using possible funding in a poor state with limited resources to exert compulsory power; a well-positioned state leveraging a multilateral agency to exert institutional power; a prestigious university or NGO positioning its staff as experts to provide technical policy support and exert structural power; and a UN agency or a private-sector actor advancing and promoting a particular agenda or approach to addressing health challenges as an exertion of productive power. This analysis will focus on non-material forms of power, and consider institutional, structural and productive power. For example, Indonesia's role in the Non-Aligned Movement was an early attempt to exert structural power. Founding the G-77 enabled Indonesia to exert institutional power. The SG's HLP was an opportunity for Indonesia to exert productive power by shaping the post-2015 process.

Section One:
Indonesia's MDG Experience, and Why Indonesia Engaged in the Post-2015 Process

When the MDGs began in 2001, Indonesia was still in political transition. Given the political instability, many informants considered the MDGs generally un- or under-impactful in Indonesia in the early 2000s. Although delays in MDG implementation are consistent across countries (as described in Chapter Three, MDG momentum mostly started between 2006-2010), multiple key informants advising President Yudhoyono argued that Indonesia was "late" to implement or take the MDGs seriously as a policy agenda.[431] These same informants

highlighted a lack of political leadership for championing MDG implementation, at least until the last phase of the MDGs after 2010. This was particularly important as according to one informant, "it takes about five years before the MDGs could be formalized and integrated into government policy."[432] Following political uncertainty in the years after Suharto with three Presidents in under six years (B.J. Habibie 1998-1999, Abdurrahman Wahid 1999-2001, Megawati Sukarnoputri 2001-2004), Yudhoyono was elected in 2004 in Indonesia's first direct Presidential election. He was a former Army general, and previously served in Megawati's Cabinet.

Multiple informants noted his "technocratic", almost academic approach to government. In his election campaign in 2004 and re-election in 2009, President Yudhoyono defeated Islamic parties continuing Indonesia's secular albeit conservative government. He presided over consistent economic growth providing political stability and continuity for government policy development and implementation. From the start of his presidency, Yudhoyono sought to exert regional leadership and project Indonesia as a global policy leader; this implicitly but not explicitly included global health policy issues. Informants indicated Yudhoyono was uninterested in health issues and was more interested in promoting economic growth. He was, however keen on promoting Indonesian leadership and sharing Indonesian experiences.

While President Yudhoyono did not mention the MDGs in his early policy speeches, he did call for an "immediate implementation of the Monterrey consensus," which was formulated during a landmark meeting in 2002 whereby more than 50 heads of state and the World Bank, the International Monetary Fund (IMF) and the World Trade Organisation (WTO) agreed to direct development financing towards the MDGs. He later expanded his foreign policy vision describing Indonesia's strategic outlook as exercising its "foreign policy freely in all directions, having a million friends and zero enemies."[433] In 2012, Yudhoyono noted "strong economic and democratic fundamentals" informing Indonesia's various roles as a "norm-setter, consensus-builder and advocate for the developing world".[434] Before he left office in 2014, Yudhoyono talked about his tenure as a "golden era".[435] In fact, almost every key informant in Jakarta mentioned the his deep commitment to global affairs as a mechanism to advance Indonesian interests and accelerate economic development.

This provided opportunities to project Indonesian perspectives in global health diplomacy. When asked about the MDGs, many Indonesian informants broadly equated the health MDGs with maternal mortality (even those not specifically working on maternal health issues), which was a challenging domestic issue. Indonesian maternal mortality increased during the MDGs compared to the 1990 baseline, and measurement was heavily contested.[436] While the issue gained political prominence in the 1990s, policy attention declined after Suharto left office. Health services were decentralized, which weakened the Ministry of Health's ability to address the issue.[437] As Minister of Health (2012-2014), Nafsiah Mboi argued maternal mortality was related to family planning and sexual and reproductive health rights.[438] Some analysts contextualize this as part of a wider backsliding for women's health during Yudhoyono's administration arguing that "his policies […were] shaped by religious conservatism and symbolic gestures rather than affirmative action and genuine concern for women's issues."[439] The majority of Indonesia's citizens are Muslim, and these issues are part of a debate over the role of religion. Academics studying Indonesia's abortion policies argue that these challenges are exacerbated by "a macro-political context increasingly defined by a polarized Islamic-authoritarian—Western-liberal agenda."[440] This debate is part of a broader discussion since Suharto's fall, sometimes considered an Indonesian version of "culture wars".[441]

Following the September 11th terrorist attacks in New York and the 2002 attacks in Bali, Indonesia's Ministry of Foreign Affairs aimed to rebrand the country as the home of "Moderate Islam." While Indonesia's leaders from Sukarno to Yudhoyono have been broadly secular and generally worked to limit the role of Islam in governance and foreign policy[442], there are a number of Islamic political parties contesting this approach. This tension influences Indonesia's global health policy positions (generally with Indonesia's Ministry of Health being more progressive than the conservative Ministry of Foreign Affairs); in fact, multiple informants referenced the influence of Saudi Arabia using Islam to build links with the Indonesian government, particularly the Ministry of Foreign Affairs and advance a particularly conservative interpretation of Islam for Indonesia's international affairs. This, of course, also shaped Indonesia's engagement in the post-2015 process.

Indonesia's maternal mortality situation remains contested—there are ongoing debates over progress on maternal mortality during the MDG period.[443] Yet there is a sense that because of the backsliding on maternal mortality, the country "got burned" on the MDGs and "looked bad" in the global MDG discussions sullying its image as an emerging middle power.[444] Informants broadly felt Indonesia lagged in MDG progress and that the MDGs did not work. One key informant argued that "everyone says that MDG 8 [on partnerships] did not work, but as a matter of fact, the whole MDG approach stopped working from 2008 onwards."[444]Furthermore, there was a sense the MDGs were mainly, as one informant argued, "a government-to-government kind of agenda" and "very heavily government-oriented."[445] Moreover, there was a sense the MDGs were not appropriate for Indonesia.

Indonesia faced, and continues to face, profound health system and environmental health challenges. While Indonesia's decentralization negatively affected maternal mortality progress, the economic crisis precipitating Suharto's resignation highlighted the need for health services for the country's poorest citizens and created political priority for addressing the health system.[446] It opened up space for policy experimentation and the development of multiple models to improve health coverage.[447] Following legislation passed in 1999 and 2004 and supportive court rulings, in 2014 in the midst of the post-2015, SDG process, the government launched its National Social Health Insurance Scheme (known as the Jaminan Kesehatan Nasional, or JKN) which aimed to provide UHC for all Indonesians, and create the world's largest single-payer system by 2019.[448] Despite this commitment, serious political and technical challenges remain.[449] This perception of MDG policy mismatch for Indonesia's context increased national policymakers' interest in engaging in the post-2015 processes. Moreover, Indonesian agricultural 'slash-and-burn' practices to clear land creates recurring episodes of smoke and haze, which continue to threaten health in both Indonesia and neighbouring countries.[450] For example, in 2015, fires led to an estimated 100,000 deaths from deadly pollutants and documented increases in respiratory, eye and skin ailments, including an additional 500,000 cases of acute respiratory illnesses.[451]

Indonesia's engagement in the post-2015 process was also informed by some of its previous global health experience. One of the most notable experiences in which Indonesia exerted leadership was the outspoken way in which its Minister of Health engaged and

refused to share samples of the H5N1 virus with the WHO during the avian flu pandemic between 2006 and 2008. This incident precipitated what some Western global health policymakers considered a global health crisis; ultimately, a special WHO working group facilitated the creation of a framework for sharing influenza virus strains alongside a system for improving the flow of pandemic vaccine and medications in 2011. In the process, Indonesia's Health Minister Supari (2004-2009) coined the term "viral sovereignty"; American policymakers, Richard Holbrooke and Laurie Garrett, worried that Indonesia conceptualized a "notion [which] has morphed into a global movement, fuelled by self-destructive, anti-Western sentiments."[452]

To advance its perspective in this case, Indonesia sought and received support from other countries by convening the first Non-Aligned Movement (NAM) meeting for health ministers at the World Health Assembly in 2007 and issued a "Bandung Message" with civil society groups from around fifty Asian and African countries in June 2007.[453] Building on and leveraging Indonesia's historical legacy, this action signalled the government's willingness to leverage structural (using the NAM) and institutional power (using WHO as a platform) to challenge existing international norms and contest ongoing policy and practice.

Supari wrote an article in 2008 arguing that, "[t]he avian influenza case in Indonesia has demonstrated once again the unresolved imbalance between the affluent 'high-tech' countries and poor agriculture-based countries."[454] She continued that,

> "If the world continues to operate in this way, the discrepancies will become wider and wider. The poor will become poorer and the rich become richer. It is the responsibility of all nations to change this situation. Indonesia believes that the world must work in unity against the H5N1 virus infection and other diseases, and not taking advantage of the misery of others. The work must be conducted side by side with mutual trust, transparency and equity as global citizens and professionals, taking into consideration the elements of human dignity and solidarity."

After invoking her Muslim faith and accusing WHO of colluding with "superpower nations" and "rich world pharmaceutical companies" as well as accusing a US Naval Medical Research Unit based in Indonesia of espionage, some analysts felt Supari might have "overplayed her hand."[455] The Minister's actions fuelled speculation she was showcasing her ability to defy

Western powers to bolster her own domestic political profile before the 2009 elections.[455] (After the elections, she was replaced in the Cabinet; in 2017, she was sentenced to four years in prison for accepting bribes during her tenure as Minister.[456]) This episode highlights the centrality of domestic political considerations for global health engagement.

While accused of threatening global health security, Indonesia's action exposed complicated questions of access, equity and transparency.[457] Indonesia's engagement also reflected its traditional exertion of structural and institutional power in its increasingly assertive foreign policy. This experience is often cited as a case-study exemplifying the challenge of global health security and global health diplomacy. As scholars have noted, "Indonesia's actions and the various global actors' responses have complex roots in self-interest, and domestic and international politics."[458] It also exemplifies how economic issues forced the government to act and engage in global health issues. More recently in 2012, in a further example of Indonesia's willingness to challenge global practices based on its economic interests, the country issued compulsory licensing, which enables the generic manufacturing and production of drugs still under patent, for both HIV/AIDS and hepatitis B medicines.

Beyond these experiences, the most substantial challenge to Indonesia's health system is arguably the NCD epidemic. With more than two-thirds of Indonesian men smoking, Indonesia has one of the world's highest rates of per capita tobacco consumption. The Indonesia tobacco industry also has close links to the government. Accordingly, NCDs continue to rise as a proportion of the country's health burden of disease, and efforts to limit and control tobacco have achieved limited success.[459] Despite NCDs already being the world's leading cause of death and disability at the MDG baseline in 1990[460], growing consensus on the importance of health systems and a recognition of environmental challenges at the time of the MDGs' formulation, these three issues (NCDs, health systems and the environment) were not adopted in the MDG framework. As discussed in Chapter Three, these issues became recognised limitations of the MDG framework[461]; moreover, the lack of policy space within the MDGs to consider these issues concerned Indonesian health policymakers.

Around the same time as the virus sharing episode in the Ministry of Health, Indonesia's Ministry of Foreign Affairs was a founding member of the Foreign Policy and Global Health Group. The Foreign Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand came together in 2007 writing in *The Oslo Declaration—global health: a pressing foreign policy issue of our time*, "health as a foreign policy issue needs a stronger strategic focus on the international agenda [… and we will] reinforce health as a key element in strategies for development and for fighting poverty, in order to reach the Millennium Development Goals."[429] This "Oslo Group" coordinates its global health engagement annually proposing a UN Resolution and often issuing communiques at the World Health Assembly.[462] It is an example of how Indonesia exerts structural power through a new, ad hoc grouping which aims to reshape global health diplomacy policy and practice.

Initial assessments from global health analysts reflect both scepticism and excitement about this new global health diplomacy grouping.[463,464] Indonesia's participation was largely perceived as recognition of the country's growing role within global health, and its willingness to engage in and help create possible new global policy alliances. In 2011, Fidler, however, critiqued the Oslo group suggesting that it "does not appear to be a promising venue in which to address the increasingly difficult environment health faces within foreign policy processes because of fiscal crises in many countries and geopolitical shifts in the distribution of power."[465] By 2016, however, Sandberg, Faid and Andresen argued that the Oslo Group had proved to be "resilient" and was successfully operating behind the scenes in "bridging global arenas" and "supporting negotiation processes."[466] This assessment found, "[t]he Initiative's influence also goes beyond formal negotiation processes. Further examples where Initiative members are believed to have played influential roles include the MDG Review Summit in 2010."

Alongside the virus samples and the Oslo Group, Indonesia engaged in MDG-related policy processes at the global level, particularly after 2010, as part of its efforts to project Indonesian leadership globally. The Oslo group's efforts to accelerate progress towards the MDGs aligned with one of President Yudhoyono's domestic political appointments in Jakarta. In early 2010 Yudhoyono established a Ministerial or Cabinet-level post for Nila Moeloek as

the "President's Special Envoy for the MDGs" to help coordinate between Indonesia's Ministries of Health, Finance, Education and Environment as well as represent the President in national and international-level MDG events. The Special Envoy's office, according to a press release, was intended to "form [a] small but yet effective organization filled with senior professionals and volunteers from academy, private sectors, NGO's, profession organization and donor community."[467] In other words, the Special Envoy was to coordinate cross-government MDG efforts, and demonstrate this progress to the global policy community.

Moeloek (later appointed Minister of Health in October 2014), hired as her deputy Diah Saminarsih (a civil society leader). Moeloek and Saminarsih together hired professionals from civil society, the private sector and academic institutions (primarily from outside the government). The Special Envoy's Office also attracted funding from foreign governments and philanthropic foundations.[468] The Special Envoy's office engaged communications professionals to ensure that "more people understand what MDGs is, how to promote that in a more realistic everyday life scenario, and to promote the movement at a more grass root level as to avoid unnecessary high-level politics at play."[469] To raise the profile of the MDGs, the Special Envoy's office established an MDG prize and cultivated local media. In 2010, the Indonesian government hosted a special ministerial meeting to review MDG progress in Asia and the Pacific in Jakarta in August 2010.

The appointment of the Special MDG Envoy led to greater policy attention and focus on the MDGs in Indonesia. This office of the MDG Special Envoy engaged in the initial discussions with the UN Secretariat on what would come after the MDGs and participated in one of the early global meetings on the post-2015 process, the 2012 Rio+20 meeting. The MDG Special Envoy's office was keen to engage to ensure the post-2015 agenda was relevant for Indonesia. The next section analyses why, how and where Indonesia engaged in the post-2015 process. Before that, it is important to understand some additional political context.

During the post-2015, SDG process, Indonesia experienced a political shift. President Yudhoyono was constitutionally barred from seeking a third term (having been re-elected in 2009), and in July 2014, Indonesia held a presidential election. Joko Widodo (popularly known as Jokowi), previously the mayor of Jakarta, was elected and took office in October

2014. The contrast between the two was stark: Yudhoyono was a former member of the military and highly technocratic, he was the embodiment of the Indonesian political elite. Jokowi was former furniture salesman and the first Indonesian president not to come from the military or the political elite. He was a populist. During his time as mayor, he introduced a "smart card" to enable poor Jakartans to access health services. In his campaign, Jokowi was extremely focused on domestic issues, and committed to expand his focus on health.[470]

To understand how Indonesia engaged in the post-2015 process, this historical background in political economy is crucial context. To summarize, when the MDGs launched, Indonesia's government was consumed by the post-Suharto transition. With Yudhoyono's election in 2004, the government stabilized yet still faced many challenges. Accordingly, it was late to embrace the MDGs, which were considered somewhat irrelevant in Indonesia, although the appointment in 2010 of a Special Envoy for the MDGs brought greater domestic policy attention. Global health issues largely did not gain policy prominence except when there was an overlap with religious (eg: maternal mortality) or political interests (eg: virus sample sharing) and/or there was an opportunity to project Indonesian leadership globally (eg: the Oslo Group). Building on this, the next section analyses why Indonesia engaged in the post-2015 process and how this evolved following the Presidential transition in 2014.

Why Indonesia Engaged in the Post-2015, SDG Process

To understand and illuminate why Indonesia engaged in the post-2015 process for health, it is necessary to contextualize the country's emergence as a middle power using constructivist theory. Indonesia is now the world's tenth largest economy. Building from the success of the BRICs, analysts currently recognize Indonesia amongst many of the acronyms for emerging economies, eg MINT (Mexico, Indonesia, Nigeria and Turkey)[471], CIVET (Colombia, Indonesia, Vietnam, Egypt and Turkey)[472] or MIST (Mexico, Indonesia, South Korea and Turkey).[473] Indonesia's size also contributes to Indonesia's emergence on the global stage. With close to 260 million citizens, Indonesia is the world's fourth largest population, third largest democracy and most populous Muslim country. After the 2003 Iraq War, when Western countries were looking to promote democracy, particularly in Muslim countries,

Indonesia, served as a potential model.[474] In 2011, Indonesia's President argued that "Indonesia is no longer 'a nation in waiting.' [It] is a nation whose time has come –and we are seizing the moment with determination and hard work."[423] Yudhoyono developed and pursued a pragmatic, non-aligned foreign policy, and preferred high-profile efforts to project Indonesia in the world as an emerging middle power.[475] Indonesia engaged in the post-2015 process in line with its broader foreign policy to project Indonesian interests and power.

Building on Indonesia's historical legacy of exerting structural and institutional power globally, Yudhoyono argued that he intended not "to re-write the book [for Indonesia's foreign policy], but simply to add more pages to it"; he wanted to empower Indonesia to act like a "peacemaker, confidence builder, problem solver and bridge builder [...] by projecting Indonesia's international identity" in the region and beyond.[476] President Yudhoyono recognized the UN as the "foremost multilateral forum" and called ASEAN the "mainstay" of Indonesia's regional foreign relations. He directed his government to lead the ASEAN Community towards greater integration and deeper cooperation. Yudhoyono also ensured the Indonesian government was a central actor in the G20 Forum arguing in a 2010 speech that the G20 "can help reform the world economic architecture and contribute to a strong, balanced and sustained global economic growth"; he continued that the G20 could be leveraged as a platform to ensure that "the achievements, products, culture and ideas of Indonesia [...] become part of the dynamics at a global level."[477] Yudhoyono engaged to expand opportunities to exert influence and accelerate Indonesia's economic development.

With this background in mind, it is unsurprising that President Yudhoyono would be considered as a Co-Chair for the UN High Level Panel in 2012, along with the United Kingdom's Prime Minister Cameron and Liberia's President Sirleaf. Informants cited a number of potential reasons for his engagement: his commitment to global affairs and multilateralism, his personal relationship with the Secretary-General forged through his annual attendance at the opening of the General Assembly (and other meetings) as well as his experience representing Indonesia on the global stage. Whereby the United Kingdom represented developed economies and Liberia represented low-income countries, Indonesia represented emerging economies and served to bridge the gap between low-income countries and developed economies. One key informant from the Ministry of Foreign Affairs recognized that "we are in the middle. Indonesia is in the middle, the President is in the

middle, and we understood our position."[478] More specifically, Yudhoyono saw his participation in this panel as an opportunity to improve the post-2015 agenda based on Indonesia's MDG experience.

The Indonesian government also recognized the chance to exert structural power to shape the post-2015 development agenda to be aligned with Indonesia's domestic interests. As a senior member of the Ministry of Foreign Affairs noted, "of course, the President's schedule is busy, but we knew exactly that by participating in the HLP, we could contribute not only to the world, not only to the other fellow members of developing countries, but also for us."[479] Policymakers in Jakarta appreciated the implications of the importance of the post-2015, SDG agenda.

One senior official at the Ministry of Planning (also known as Bappenas) noted that Indonesia engaged in the HLP and beyond so that the government could "align the global agenda with our national development agenda so that the development agendas that we are implementing and working on in Indonesia could be also the development agenda at the global level."[480] As detailed in Chapter Three, the MDGs' dominance in terms of steering the international development agenda was well recognized. Given the MDGs' influence, policymakers and development advocates, including in Indonesia, were committed to ensuring their perspective was embedded within the post-2015 agenda. There was a realization within the government that shaping the agenda would be useful as they would ultimately need to demonstrate progress against what would become the SDGs. An official from the Ministry of Foreign Affairs noted, "because we knew for sure that the SDGs will become the guidance of the global development, and especially for developing countries, Indonesia invested great attention into the process. It was high priority and I would say that we were very, very actively engaged in the negotiation process."[480]

The team working with the President on the HLP was particularly aware of the opportunity and saw it as a chance to "globalize" Indonesia's experience. Yudhoyono sought to "internationalize" Indonesian development experience as a model for sustainable development. As one member of the President's team explained, "I did not, nor did the team nor the President, I did not put things forward as an Indonesian agenda. This was humanity's agenda. I went around and kept on sharing snippets of our experience, and I have the luxury

wherever I am, in Australia, in Germany, in Denmark or in Norway, to talk about countries' contribution, saying, 'This is not Indonesian agenda. It's your agenda as well.'"[481]

While the President's participation in the HLP was perhaps predictable, the amount of global interest in the post-2015 process was not anticipated. Indonesian policymakers initially considered the High-Level Panel as just another of many UN high-level panels convened. As one key informant from the MDG Envoy's team noted, "I don't think anyone predicted that it would be this big. Everyone knew it would be complicated, but that it was so highly publicized or highly, what's the word beyond highly political? It was really a global movement. Almost everyone caught the SDG bug."[482] As the key informant continued, "everybody understood that there will be something after MDG but I don't think anyone predicted or said out loud that it would be so huge." The Indonesian government's engagement in the post-2015 process was consistent with Indonesia's foreign policy; however, this foreign policy did not include or articulate a clear global health strategy. Neither domestic health policy nor global health policy were government priorities.

Despite the President's engagement in the HLP, and this broad Indonesian interest in the post-2015 process, the Ministry of Health did not participate in the process advancing a consistent strategy. Some key informants noted the importance of either universal health coverage (UHC) and non-communicable diseases (NCDs) based on Indonesia's experience; others highlighted sexual and reproductive health rights. Yet Indonesia's Ministry of Health did not have a specific narrative for its engagement in the post-2015, SDG process for health; Indonesian policymakers broadly did not construct a strategy for the country's wider engagement on health and thus missed some opportunities to exert greater power throughout the post-2015 process. There are multiple reasons which could explain this.

Informants argued that neither the President's office nor the Ministry of Foreign Affairs prioritized health within the government's broader post-2015 engagement. A senior official from the Ministry of Health argued that "the President's team was primarily focused on environmental issues and others [within the Cabinet] were focused on their own sectoral concerns."[483] Others felt that given the President's reluctance to engage on health domestically, there was little appetite to engage in global health. Others implied that industry was intervening with the President to keep health off of the political agenda. (If this is true,

it would reflect a strong intervention by the corporate sector exerting structural power to shape the agenda.) As one Indonesian academic informant argued, "we always have kind of a "lipstick", meaning just talking. The government uses a lot of "lipstick" but has not followed through on health in a serious way."[484] Ultimately in the post-2015 process, Yudhoyono focused on the environment as it was understood to be an issue where Indonesia could exert global leadership. In comparison, there did not appear to be a cadre of policymakers developing a strategy to make this argument for health to the President, or Ministry of Foreign Affairs for health. Yudhoyono's lack of interest or commitment to health within the High-Level Panel (or within the broader post-2015 process) was itself an exertion or reflection of structural power to determine which issues are prioritised for policy attention.

While health was not a priority for the government, Indonesia's engagement in the HLP, and the President's personal commitment to multilateralism and international affairs, created greater awareness of the process and led to a constituency within the Indonesian government committed to engaging in the post-2015 process. As one key informant argued, "I think the key aspect in what we can learn from this is that once the President agreed, once he expresses his interest, the key is to capitalize on that interest."[485] The President convened a special advisory group to coordinate his engagement in the HLP. Following the HLP report's release in May 2013, this group and these actors were committed to leveraging the President's and Indonesia's engagement to advance their own interests in the OWG.

During and after the President's HLP engagement, different actors and institutions contested how and where Indonesia should continue to intervene in the process. They used the post-2015 process to advance their interests, and this continued through the Presidential transition from Yudhoyono to Jokowi. Following his inauguration in October 2014, President Jokowi did not actively prevent continued engagement in post-2015 process; however, he signalled he would take a different approach to foreign policy, and shift his focus to domestic issues. Early in his administration, Jokowi argued"[o]ur [foreign] policy is free and active, befriending all countries but [we will put first] those who give the most benefits to the [Indonesian] people [...] What's the point of having many friends but we only get the disadvantages? Many friends should bring many benefits."[486] As multiple informants highlighted, President Jokowi did not attend the September 2015 opening of the UN General Assembly indicating his desire to prioritize domestic issues.[487]

Despite Indonesia's domestic health challenges, given the country's increasing prominence in global affairs, policymakers anticipated that the country would engage more on health in the post-2015 process. In fact, many global health policymakers constructed a narrative in which Indonesia would engage more deeply within global health in line with its foreign policy efforts. For example, citing President Yudhoyono's role in the high-level panel, a report from a US think tank, the Center for Strategic and International Studies (CSIS), argued that, "Indonesia's role in global health has changed dramatically in recent years following a brief period of health nationalism in which it stopped sharing bird flu samples with the international community and shut down a U.S. naval research station doing research on infectious diseases. [...] Its leaders "are reaching out aggressively" to snare a bigger role in international health diplomacy."[426]

In line with these efforts, Indonesian health policymakers were engaging more in global health policy processes, particularly in 2012 and 2013, which was also the beginning the post-2015 policy process. Yet there was no overarching strategy or policy guiding their engagement. Given President Yudhoyono's role as a co-chair of the High-Level Panel, policymakers afforded Indonesia policy space to engage in the process on health and expected Indonesian health policymakers to heavily engage in the post-2015 process. These expectations were more unrealised projections than reality. Aside from a few interested individuals, there largely was not a group of Indonesian health policymakers heavily engaged in the process. There was not a group of policymakers who worked together (or with others from outside Indonesia) to construct a strategic policy narrative to convince or motivate policymakers on why or how Indonesia should engage in global health and/or for health in the post-2015 process. Some policymakers, particularly within the Ministry of Health, had a vision of expanding the MDG agenda to include both UHC and NCDs for the SDG agenda, but the post-2015 process was not a policy priority for health policymakers nor was health a priority for the President's engagement in the post-2015 process. Moreover, without an overarching or coordinated strategy for global health, Indonesia's engagement on health was largely ad hoc and reactive to these requests and opportunities. Indonesia's engagement did not reflect a broader Indonesian strategy for health in the post-2015 process.

In summary, constructivist analysis focuses on shared ideas, approaches and values and how these can influence political action. Constructivists argue that understanding how non-material resources and structures shape actors' identities is important because identities inform interests and policies, which, in turn, shape actions. In this case, President Yudhoyono's administration sought to invoke Indonesia's historical legacy and enlarge its global leadership role to improve its economy and global influence. How Indonesia engaged was also shaped by its domestic religious tensions and its economic interests. Integrating these interests, Yudhoyono constructed a narrative to build on Indonesia's historical legacies of exerting structural and institutional power expanding Indonesia's global engagement. This narrative, however, was not specifically intended for the post-2015 agenda for health. More broadly, health and global health were not an explicit part of this foreign policy narrative. Instead, Indonesia's engagement in the post-2015 process was a manifestation of this foreign policy, and health was implicitly included. The next section specifically analyses how and where Indonesia engaged in the post-2015, SDG process.

Section Two:
Analysing How and Where Indonesia Engaged in the Post-2015, SDG Process

This section starts with background on the evolution of Indonesia's policymaking process and how this eventually shaped how and where the government engaged in the post-2015 process for health. More specifically, it contextualizes the various institutions and analyses how and where the different actors engaged and exerted power in the policy process (and as detailed in Chapter Four), namely: 1) the High-Level Panel (HLP); 2) the Botswana thematic consultation on health; and 3) the Open Working Group (OWG). The box below provides a high-level overview of the timeline of the post-2015 process, and for how and where Indonesia engaged.

Indonesia' Engagement in the Post-2015 Process	
2012:	**2014**:

July UN Secretary General announces High-Level Panel of eminent persons on the Post-2015 Development Agenda with President Yudhoyono as Co-Chair	July Indonesia holds Presidential elections: Joko Widodo wins and is inaugurated in October 2014

The Post 2015 Process		
2013: March Botswana Thematic Consultation for Health Meeting May UN High-Level Panel Report Released June Open Working Group Meeting for Health (Sessions last between March 2013 and April 2014)	**2014**: June (2013) Open Working Group Meeting for Health (Sessions last between March 2013 and April 2014)	**2015**: From January to July Inter-Governmental Negotiations September SDGs Adopted

During the New Order era (1967-1998), Indonesian policymaking was determined by Suharto. As one scholar argued, Suharto's policymaking was similar to that "practised by Javanese kings, which was hierarchical and concentric, requiring unconditional respect, deference and obedience."[488] According to a former Indonesian Vice President, the country's policymaking was "undisputedly dominated" by "a solid group of mainstream economic professionals and bureaucrats, known as the 'Berkeley mafia'" as many studied together at the US University of California's Berkeley campus.[489] Traditionally the Ministry of Planning dominated policymaking along with policy monitoring and implementation; it was also largely responsible for coordinating with foreign governments and international organizations. The Ministry of Planning thus held considerable influence over other ministries; however, its influence seemed to fluctuate depending on its minister and their relationship with the president.[490] This was the also same for other ministries; their role largely depended on their Minister's relationship with President Suharto. This all changed once Suharto stepped down in 1998.

Yudhoyono sought to reform and modern Indonesia's bureaucracy. Even shortly after the time of the "reformasi", Indonesian bureaucracy was, according to analysts, considered among the lowest quality in the world.[491] Civil servant salaries were, for Indonesia, comparatively low, and thus despite a few unsuccessful efforts to reform the civil service, there was a high level of bureaucratic corruption.[490]As one analyst argued, "[d]ue to weaknesses in training, promotion and compensation, cumbersome reporting requirements, and a lack of significant bureaucratic reforms, the public service continues to be 'widely seen as corrupt, bloated, inefficient and either incapable or unwilling [to implement] policies."[492] Other experts recognised that during Yudhoyono's reign "policy making has become more transparent, more publicly accountable, but also more challenging, more noisy and more time consuming."[493] In other words, Indonesian policymaking became more contested with ministries now consulting with and considering inputs various sources, particularly civil society organisations and the private sector as well as from universities.

By the time the post-2015 process began in 2012, President Yudhoyono was well into his second term as president. Key informants emphasised that Yudhoyono sought to accelerate the modernization of Indonesia's civil service by bringing in new voices from the

private sector and civil society. One analyst argued that this was one of Yudhoyono's strengths, namely "his willingness to avoid the totalitarian 'strongman' mantle and incorporate an eclectic mix of views, for better or for worse."[494]

Yudhoyono's efforts to reform the bureaucracy was critical as key informants consistently identified government actors and institutions as the most important for the post-2015 process, namely the President's Office, the Ministry of Foreign Affairs as well as both the Ministry of Health and the Ministry of Planning. (While some informants occasionally alluded to other actors, like non-governmental organizations and UN agencies, these actors did not play a decisive role and were largely marginal to Indonesia's position on health in the post-2015 process.) These actors were deemed most important as they were central to the post-2015 negotiations, meaning these were the actors called upon to engage on behalf of Indonesia's government in the post-2015 process both by President Yudhoyono and by the UN Secretariat in New York coordinating the process. The President's office included both the Presidential Work Unit on Monitoring and Controlling Development (in Indonesian: Unit Kerja Presiden Pengawasan dan Pengendalian Pembangunan, or UKP-PPP, known as UKP4) as well as the office of the President's Special Envoy on the MDGs.

UKP4 was an influential, yet controversial unit established in President Yudhoyono's office following his re-election in 2009 and inspired by former British Prime Minister Tony Blair's "Delivery Unit" model. To lead the Unit, he appointed Kuntoro Mangkusubroto in a Cabinet-level post to review Ministers' performance. Upon joining Yudhoyono's administration, Kuntoro had a strong reputation from the private sector with little tolerance for government bureaucracy; he previously managed the government's efforts to coordinate the response to the tsunami in Aceh. Before he accepted his post, Kuntoro petitioned the President to appoint his own team and top up their salaries beyond normal civil servant wages when necessary.[495] As described in a case-study, Kuntoro said prospective candidates had to be "of high integrity" meaning "uncorrupted and have no political biases or affiliations."[495](This also worked well with Yudhoyono's own anti-corruption efforts and reputation as "Mr Clean.") Kuntoro himself explained in an interview: "I didn't want to take anyone with bureaucratic experience, because bureaucratic experience is damaging. They become so structured and start talking about 'this procedure, this law, this regulation.' I

didn't want to hear it. You have a problem, solve that problem."[496] He recruited and assembled his team with individuals from the private sector and academia. The background of individuals in this unit was in stark contrast to Indonesia's civil service.

In comparison, the Ministries of Foreign Affairs, Planning and Health were staffed with career civil servants. According to informants, the Ministry of Foreign Affairs was and continues to be viewed as one of the most conservative ministries, and the Ministry of Health, largely focused on domestic health issues, one of the most bureaucratic ministries. The differences between these various ministries and units in President Yudhoyono's administration were notable; one informant referred to them as representing "different Indonesias."[497] The ministries like foreign affairs, health or planning were civil servants, whereas the new units in the President's team were staffed from outside the civil service with exceptional contracts for atypical credentials and backgrounds (coming from academia, civil society or the private sector). These different perspectives caused tensions as these actors contested their positions and vied for the President's support. This tension exposed the vulnerability and insecurity of Indonesia's civil service during Yudhoyono's administration; it also reflected a growing appreciation of the opportunity of the post-2015 process (and global health policy) as a foreign policy space in which political capital could be gained. More immediately, however, it meant that Indonesia policymakers were not able to take advantage of this policy window of opportunity to exert greater power within the post-2015 process on health as they were consumed with contesting their own domestic political positions. These tensions hampered coordination efforts between actors, and thus limiting Indonesia's ability to engage in a consistent and coherent way in the post-2015 process for health. As described in Chapter Three, this also meant more space for other actors to engage instead of Indonesia.

Exacerbating these tensions, one of the main tasks of the Delivery Team was to review and evaluate each of the Ministers and issue public report cards on their performance; these evaluations and assessments were rumoured to affect the President's thinking when it came time for Cabinet reshuffles. Complicating their role, staff in both the Delivery Team (UKP4) and in the MDG Special Envoy's office felt that bureaucrats in the more traditional line ministries were conservative and ineffective. As Kuntoro himself acknowledged: "I don't

respect them [the Cabinet]. Because they just create a lot of problems, because they are basically bureaucratic."[498] At the same time, the Ministries did not respect or appreciate the new institutions (they considered them amateur interlopers) and the new teams within the President's office felt like the ministries were antiquated (they considered them as "old-school" conservative bureaucrats). The Ministries within the government resented Kuntoro and his UPK4 team as well as Moelek and her team in the MDG Special Envoy's office. They considered the UKP4 team to be something of unwelcome, temporary corporate consultants. The traditional ministries considered the MDG's Special Envoy office to represent and reflect civil society perspectives.

These tensions also had implications for how and where Indonesia eventually engaged in the post-2015 process. The Indonesian government did not have a consistent strategic approach or narrative for health. The competition between the different actors and institutions led to differences in policy positions between the state bureaucracy (the line ministries: foreign affairs, health and planning) and the special units within the President's office (the MDG Envoy's office and UKP4). This Indonesian institutional divide aligned with the various parts of the post-2015 process with agencies taking the lead in different processes, ie: the President's office led in the Secretary-General's HLP process; the health ministry (and the ministry of foreign affairs) engaged in the post-2015 thematic consultation on health; and the ministry of foreign affairs (and the ministries of health and planning) managed the OWG and the inter-governmental negotiations. This meant that instead of promoting and advancing a consistent, coherent approach, each of these institutions brought their own perspectives and emphasised slightly different approaches to health in each of these processes. The President's office was generally uninterested in health, but open to supporting reproductive health rights; the Ministry of Health advocated a position of building on the MDGs and including NCDs and UHC; and the Ministry of Foreign Affairs deferred to the President's office and the Ministry of Health, however, was slightly reluctant to take an outspoken position in support of reproductive health rights.

The below examines and analyses how and where Indonesia's government engaged in the three parts of the post-2015 processes (the HLP, Botswana and the OWG), and how Indonesia's government exerted power in these different processes. The Indonesian

government was not able to exert compulsory power in this process; however, in cooperation with other Indonesian government actors, Indonesia's Ministry of Foreign Affairs and Ministry of Health as well as both UKP4 and the office of the Special Envoy in the President's office exerted institutional, productive and structural power to advance their interests both within Indonesia and beyond. The analysis below applies Barnett and Duvall's power framework for analysis.

The High-Level Panel on Post-2015

Shortly after Yudhoyono was named as one of the Co-Chairs of the High-Level Panel in 2012, he created a fifteen-person national committee to coordinate across the government and advise his engagement. This committee was led by Kuntoro Mangkusubroto, who led UKP4 (the Delivery Unit) in the President's office, and his deputy Heru Prasetyo. This committee included cabinet members like the Special Envoy for MDGs, Nila Moeloek, and others like the Ministry of Foreign Affair's Director of Multilateral Affairs, Hasan Kleib, who was also the President's Special Envoy on the SDGs. The committee amongst others included a senior advisor to the Minister of Health as well as a senior official from the Planning Ministry. Having Kuntoro lead this group signalled the President's reliance on him to deliver on special projects, but it also exacerbated existing tensions between the President's office and both the Ministries of Planning and Foreign Affairs. One informant working in the HLP Secretariat argued that Indonesia appeared to have two processes for its inputs to the Panel: one political and one technical, which hampered its ability to advance a consistent and coherent position.[499] Kuntoro's UKP4 team was leading the technical inputs, and Ambassador Hasan Kleib was leading on the political inputs, but both (UKP4 and the Ministry of Foreign Affairs) were jockeying to influence their President's inputs as this same informant explained, "when the sitting President of Indonesia spoke on the Panel, it was heard."

Multiple informants mentioned that the Ministry of Health did not consistently engage within the Committee advising the President on the HLP. Informants shared that the MDG Special Envoy's office seemed more engaged on health issues within the Committee; however, these perspectives reflect the tensions between these various government agencies and ministries within the Committee. The Ministry of Health was undertaking a

major domestic reform trying to push forward its efforts towards UHC. Moreover, the more established bureaucracy, like the Ministry of Health, had a clear mandate, whereas the Special Envoy's office was a new agency and was positioning to establish its relevance. This viewpoint also reflects the fact that neither the Ministry of Health nor the Special Envoy had a consistent perspective on health in the post-2015 process. This did not mean Indonesian policymakers were disinterested in the process or in how Indonesia should engage.

Given Indonesia's experience with the MDGs, Indonesian policymakers were committed to broadening the MDGs' focus in health. Indonesian policymakers shared a wide interest in building on the MDG agenda and adding health systems, NCDs and mental health, equity, nutrition and sexual and reproductive rights to the eventual SDG for health; however, there was not an agreed upon approach or strategy to focus on a specific challenge. The approach and emphasis as one informant argued was "unfocused at best."[500] There also did not appear to be a consistent understanding of how the absence of a more coherent approach was limiting Indonesia's ability to advance its position within the process. There was also a lack of leadership to advance and position health within this process.

Nevertheless, the government exerted power throughout the HLP process. The President's attendance in the HLP meetings and direct engagement was a clear example of how Indonesia's government exerted structural power within the HLP. This structural power was built into the design and conceptualization of the HLP. As one of the three Co-Chairs, Yudhoyono and the Indonesian government had substantial structural power to influence and shape the HLP process determining which issues were included for consideration (and which issues were not considered). This also meant the possibility of applying productive power in shaping and writing the eventual HLP outcome report. While Yudhoyono exerted structural power over the process and the HLP report broadly, for example advocating for inter-sectoral cooperation and a focus on the environment, the government did not take advantage of the opportunity to exert structural or productive power for health in terms of engaging in the conceptualization (or writing) of the proposed SDG for health.

While Indonesian policymakers could have exerted considerable structural and eventual productive power for health in the HLP given Yudhoyono's role as Co-Chair and the

government's role in managing the Panel process and authoring the final report, this largely did not happen. Informants highlighted that health was not a priority issue for the government within the HLP. Some respondents cited the President's reluctance to move forward on domestic health issues as likely to contribute to a reluctance to push on health at the global level. The President and members of the Committee instead placed a greater priority for Indonesia's inputs on environmental issues and exerted structural and productive power to ensure these issues were well positioned within the HLP report. Environmental issues benefitted from strong leadership within the Indonesian government; in contrast, health did not have such leadership.

Yet the Indonesian government did exert structural power by not engaging in or prioritising health. In doing so, the Indonesian government signalled within the HLP that health was not necessarily a priority for middle-income or emerging countries, and thus ceded the issue to other members of the High-Level Panel more interested in health issues, particularly representatives from higher-income and lower-income countries. (This partly explains the eventual emphasis on continuing the health MDGs in the HLP's final report.) While some Indonesian health policymakers were interested to engage more deeply on health in the HLP, informants shared that they felt the requisite policy space for health was not present. Health was not a priority for Yudhoyono or the government's HLP engagement.

Following HLP meetings in Monrovia, London and New York, the HLP convened its fourth and final (despite a few smaller discussions afterwards) meeting in Indonesia from 25-27 March 2013. This was the result of a deliberate Indonesian strategy to host the final HLP meeting in Bali (instead of Liberia as originally planned). Informants described how they used Bali to attract the HLP Secretariat; they believed they would have greater abilities to shape the discussion and exert structural power, eventually leveraging the final report and exerting productive power within the broader post-2015 process.

Following Kuntoro and some of his team members' experiences managing the Aceh tsunami response, there was a sense that the HLP was too focused on governments' roles, and not enough on inter-sectoral collaboration. As one informant argued "international organizations like the UN are not prepared to do integrated holistic development. They are

very agency-based. Again, that is a repeat of the Aceh experience whereby 24 UN agencies tried to help with humanitarian money but did no coordinating amongst themselves."[501] Using Yudhoyono's role as a Co-Chair to exert structural power within the Panel to redress this perceived imbalance, Indonesia highlighted the importance of going beyond governments, for example, ensuring that civil society and youth groups played prominent roles in the Bali meeting and had opportunities to elevate their voice within the HLP process.

Following the final HLP meeting in Bali, Kuntoro dispatched one of his UKP4 staff to New York to serve in the small writing team for the final HLP report ensuring Indonesia's priorities were represented and thus exerting productive power within the broader post-2015 process; however, as discussed earlier, health was not an Indonesian government priority.[502] The President's national committee on the HLP formally ended when the final report was delivered in May 2013.

As detailed in Chapter Four, the HLP report included a goal of working towards efforts to "ensure healthy lives" with five targets focused on under five deaths, vaccinations, maternal mortality, sexual and reproductive rights as well as HIV, tuberculosis and malaria plus neglected tropical diseases and "priority non-communicable diseases."[503] But it did not refer to environmental health issues, and only referred to UHC in passing stating, "[b]ut in addition, we must make steady progress in ensuring Universal Health Coverage and access to quality essential health services."[503]When asked about the HLP report a senior official from the Ministry of Health said, "I was very disappointed with the report –it was an extremely political process, everyone wanted their input-- but there were many, many more meetings after that."[504] More broadly, the HLP report was contested both within the health sector and beyond, and faced challenges upon its delivery as many UN Member States felt the HLP process was not open and not transparent, which undermined the legitimacy of the report.

While the mandate for President Yudhoyono's HLP committee formally ended after the report was finalised, the President's role as a Co-Chair positioned Indonesia globally as one of the key states to influence and shape the post-2015 development agenda discussion. Within Indonesia, the process of supporting the President for the HLP built key relationships

between the Delivery Team (UKP4), the MDG Special Envoy's office and the Ministry of Planning, which would later inform the Ministry of Foreign Affair's engagement in the Open Working Group (2013-2014). This was particularly the case following a perception amongst the others that the Ministry of Foreign Affairs was not fulfilling its role and adequately representing the Government's interests in advancing the HLP report as Indonesia's primary input to the rest of the post-2015 process, especially in the early OWG sessions.

While this perspective was shared across the President's Office and the Ministry of Planning, this served these actors' interests as it predicated their deeper engagement and involvement in the process to support the Ministry of Foreign Affairs. These actors coordinated closely with the Ministry of Foreign Affairs (and also coordinated with the Ministry of Health), but there were continued tensions between actors and confusion over mandates. In the OWG and the inter-governmental negotiations, the Ministry of Health was involved, but some informants felt it was sometimes eclipsed by the MDG Special Envoy's office. This was, however, not the case for the March 2013 Botswana consultation on health.

The Thematic Consultation on Health in Botswana

Given Yudhoyono's critical role in the HLP, the organizers of the Botswana thematic consultation on health invited Indonesia's Minister of Health to have a speaking role in the in-person meeting and share her perspective. This empowered the Indonesian government to exert structural power through its engagement. As detailed in Chapter Four, the thematic consultation on health (co-convened by the Governments of Botswana and Sweden, in collaboration with WHO and UNICEF) was part of nine thematic consultations coordinated by the United Nations Development Programme (UNDP) in 2012 and 2013. The six-month consultative process for health included over 1,500 individuals participating in twelve face-to-face consultations[12] in Africa, Asia, South America, North America, and Europe; more than 100 papers were submitted for a web-based consultation.[505]

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[12] One of the twelve face-to-face consultations for the thematic consultation on health took place in Indonesia, namely the Beyond 2014 Global Youth Forum, co-hosted by International Conference on Population and Development (ICPD) and United Nations' Family Planning Agency (UNFPA), in December 2012.[12] This meeting ended with a declaration focused on "staying healthy, comprehensive education,

Out of the more than 100 papers submitted for consideration for this consultation, there were no submissions from Indonesia.[506] This process was open to any institution or actor, and some state actors, for example the German Ministry of Cooperation and Development or the US Department of State submitted papers. While the importance of this part of the process should not be overstated, no Indonesian institutions contributed. This could be because these institutions were unaware of the process, uninterested or not sufficiently capacitated to respond. For key informants, there was generally a lack of awareness about this opportunity to engage in the process.

This consultation process culminated with a three-day meeting in Botswana in March 2013; Indonesia's Minister of Health, Nafsiah Mboi, along with three advisors and the Indonesian Ambassador in South Africa attended the meeting. According to informants in attendance, the Minister focused on a vision of expanding the MDG approach to include a focus on NCDs and on UHC. But as one informant shared about the Ministry's overall engagement in the post-2015 process, "[Minister Mboi] was pretty calm [about the post-2015 process]. She didn't push anything hard."[507] Yet, others still sought the Ministry and Indonesia's collaboration. For example, Thailand, advocating for a stronger focus on UHC, actively engaged the Indonesian Ministry of Health to support a UHC goal for SDG3; Thailand felt that it might be able to leverage Indonesia's structural power as a Co-Chair of the HLP. Indonesia, however, was not seen to be driving efforts to promote such an approach in health.

Despite the opportunity to engage and offer leadership or a vision, Indonesia's Ministry of Health's engagement was not a strident exertion of structural or potentially productive power. Nevertheless, Indonesian policymakers were pleased with the process and the outcome as they felt their viewpoints were ultimately included in the outcome report. The Botswana consultation recommended maximising healthy lives as the goal, which would, as the Task Team for the Global Thematic Consultation on Health argued, include "acceleration of progress on the health Millennium Development Goal (MDG)

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families, youth rights, and wellbeing including sexuality, the right to decent work and leadership and meaningful youth participation."
While some Indonesian policymakers were aware of this consultation, it did not seem to influence their engagement in the process.

agenda; reduction of the burden of non-communicable diseases (NCDs); and ensuring universal health coverage (UHC) and access."[508] As detailed in Chapter Four, ultimately, this approach prevailed over the HLP recommendations and strongly shaped the OWG negotiations which would largely define the eventual SDG 3 for health. As an informant from the Ministry of Health argued, "there was a lot of support for our ideas."[509] This is correct, yet, few participants in the process would identify or associate this position with Indonesia. Indonesia contributed to the Botswana outcome, but as this outcome was supported by many others, it would be difficult to attribute this outcome to Indonesia's engagement.

The Open Working Group

Aside from the High-Level Panel and the Botswana thematic health consultation, there was also the Open Working Group (OWG) (between March 2013 and April 2014). In this process, Indonesia exerted both structural and institutional power. The OWG was originally structured to allow thirty countries from the UN's five regional groups to engage in both informal and formal negotiations on potential SDGs; however, there was such overwhelming interest and commitment to engage that some countries needed to share their seats in so-called "troikas" (three country groupings). Indonesia exerted structural power by being a member of the OWG.

Indonesia was able to participate in the OWG, and the Ministry of Foreign Affairs negotiated for Indonesia to be grouped with China and Kazakhstan. While there was an initial possibility of Indonesia joining a troika with other ASEAN countries, the Ministry of Foreign Affairs felt its priorities were better served grouped with China; this would also give Indonesia an opportunity to exert structural power by leveraging China's voice in the G-77 plus China Group, which would complement Indonesia's own institutional power within the G-77. Working with China was also aligned with Indonesia's broader foreign policy efforts of projecting Indonesia's leadership and role as an emergent middle power. Indonesia, China and Kazakhstan rotated their troika chairmanship and according to informants, the coordination worked relatively well. As this was a UN multilateral process, the Ministry of Foreign Affairs was the lead institution for the Indonesian government. During the OWG

negotiations, Foreign Affairs convened informal and formal consultations in Jakarta before and between sessions to coordinate and seek input; informants from the Ministry of Foreign Affairs argued that some of the other ministries, including the Ministry of Health, and agencies did not take these coordination meetings seriously, attended irregularly and/or often did not attend or provide substantial input. Officials in the Ministry of Health, on the other hand, suggested that they did not have confidence in the Ministry of Foreign Affairs and that health was not a priority for the government in the post-2015 process anyways.

After the publication of the HLP report in May 2013, the President's Committee's mandate officially ended; however, as mentioned above, the process of working together in this Committee created relationships between the Delivery Team (UKP4), the MDG Special Envoy's office and the Ministry of Planning, which arguably informed the Ministry of Foreign Affair's engagement in the OWG. Following the first sessions of the OWG in March, April and May 2013, the Delivery Team, the MDG Special Envoy's office and the Ministry of Planning became concerned the Ministry of Foreign Affairs was not sufficiently engaging, and without support, might not sufficiently leverage Indonesia's contributions to the HLP for the OWG.

Between March 2013 and April 2014, the OWG had thirteen official sessions, which included week-long informal consultations following week-long formal negotiations on the different themes. The topic of health was considered during the fourth OWG meeting in June 2013.[13] On behalf of the troika, China, according to a summary of the negotiations, argued in a statement that "priority areas for health include decreasing the spread of communicable diseases and NCDs, UHC, accessibility to medicine, and reducing maternal and child mortality."[510] Informants in the Ministry of Foreign Affairs shared their perspective that the health goal was considered relatively uncontroversial as long as it went beyond the MDGs (the so-called MDGs+ approach) and included both UHC and NCDs (which informants indicated were important for Indonesia domestically and for Indonesian health activists).[511]

In other words, because SDG3 on health seemed to be moving in the right direction from Jakarta's view, it was not an issue or area on which Indonesia's Mission in New York

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[13] During these consultations, many states and other institutions would organize side-sessions to advance or highlight certain issues or perspectives seeking to exert some eventual productive power over the process. Indicative of the lack of commitment to the issue of health, Indonesia did not host any relevant side events during this health consultation within the OWG.

and/or the Ministry of Foreign Affairs felt it needed to engage and/or expend political capital. During the OWG negotiations, there was also a sense that the post-2015 process was ongoing and continuous, and that the OWG was not necessarily the final decision on the post-2015 framework. Indonesia's negotiators agreed with the summary statement posted by the OWG Co-Chairs which included references to UHC and NCDs.[512]

The Indonesian position in the negotiations was considered, according to one informant, "quite conservative and safe."[513] Some informants felt that the Ministry of Foreign Affairs was reluctant to engage in the process or move beyond or outside the broad consensus or beyond the general approach of the High-Level Panel report endorsed by President Yudhoyono. As one informant shared "the Ministry of Foreign Affairs would usually take the safest position."[514] In the end as another informant stated, "actually, the health goal was quite easy because it didn't need a lot of complicated negotiations or lobbying to be accepted."[515] This perspective seemed to summarize the Ministry's engagement on health. As an Indonesian academic concluded, "Indonesia could do much better on health. We engage but we don't fight hard to make it happen. We participate, but we do not go all the way."[516] In the post-2015 process, it seems there was a lack of leadership and political space, given that the President was not committed to a focus on health.

One of the main concerns of the Indonesian delegation during the health negotiations was how to address sexual and reproductive rights; this was particularly complicated for Indonesia given the tension between cultural values and public health between the Ministry of Foreign Affairs and the Ministry of Health. To avoid having this issue affect the health goal (and possibly limit consensus), the MDG Special Envoy's office suggested a strategy to separate the issue from health and move discussion of sexual and reproductive rights to the gender goal (eventual SDG5 on Gender Equality). Working through the Ministry of Foreign Affairs, this approach was eventually advocated by the G-77 plus China group, and later adopted. This was another example of Indonesia leveraging structural power through its position within the OWG and President Yudhoyono's role as a Co-Chair, and institutional power through the G-77. This was a tactic the Indonesian delegation used to amplify their efforts in the OWG and later also the inter-governmental negotiations.

Some informants mentioned using "backchannels" to other governments through institutional relationships cultivated during the HLP process. A member of the UKP4 Delivery Team shared, "[o]nce you say something, and you have your flag in front of you, things are different. This is where the first- not the first time, of course, but then I realized fairly strongly how life of negotiator in that case is really, really challenging. As a negotiator, now it was so clear for me at the time to see what we would term power contestation."[517]As multiple informants shared, there was a tremendous amount of informal lobbying over meals and using WhatsApp in the OWG sessions in New York[518]; there were multiple alliances and topic groups. As one member of Indonesia's delegation said, "country groupings are still very much important at the UN. G-77 and China are one of, I would say, the primary "movers" in the UN. You get their support, everything will go smoothly. You do not get their support, then it is a big pain."[519] Working with China in the OWG troika was a key strategy for Indonesia to exert structural power in the negotiations.

From Indonesia, the OWG was largely perceived as a governmental process which would incorporate and build upon the HLP. The OWG concluded in July 2014, which was around the same time as the Indonesian Presidential elections. With Jokowi's election in July 2014, the situation began to change after Jokowi's inauguration in October 2014. While President Yudhoyono was committed to the process given his engagement in the HLP and commitment to position Indonesia in global affairs, the new Jokowi government was less ambitious and less engaged.[520] The special units in the President's office: the MDG Special Envoy's office and the Delivery Team (UKP4) units were abolished; some members of UKP4 stayed in the President's office and joined the new administration, and the MDG Special Envoy, Nina Moeloek, became Minister of Health. Many informants noticed that Jokowi had no plans to attend the opening of the United Nations' General Assembly, and or engage in multilateral affairs at the same level as President Yudhoyono. Analysts correctly predicted that as President Jokowi was primarily focused on economic interests[520] he would likely defer and delegate his foreign policy decisions to his advisers and the Ministry of Foreign Affairs.[521]

Despite this Presidential transition, Indonesia remained engaged in the process. Unencumbered by the need to coordinate with Delivery Team (UKP4) or the Special Envoy's

office, the Ministry of Foreign Affairs continued to engage in the inter-governmental negotiations and even before the SDGs were officially launched, the Foreign Minister called for greater commitments from the G-77 and China to achieving the 2030 Agenda for Sustainable Development.[522] The Ministry of Foreign Affairs remained committed to the SDG process later becoming heavily engaged in the July 2016 SDG High-Level Political Forum and proposing Indonesia to serve as one of the Volunteer National Reviews. This table below summarises how Indonesia exerted power in the process.

Indonesian Government's Exertion of Power in the Post-2015 Process	
Structural Power	• The President and his office influencing the process for the High-Level Panel as well as the Ministry of Foreign Affairs and others using the President's role as a Co-Chair to amplify its influence through the post-2015 process • The Ministry of Health and Foreign Affairs presenting during the Botswana Thematic Consultation on Health
Institutional Power	• The Ministry of Foreign Affairs working through the G77 to shape and influence the OWG discussions on health
Productive Power	• The President and his office shaping the writing of the High-Level Panel report

Beyond the HLP, Botswana and the OWG

Beyond the HLP, the Botswana thematic consultation and the OWG, there were some other processes related to the post-2015 negotiations where Indonesia and other partners engaged. Informants from UN agencies, like UNDP, UNICEF and WHO in Jakarta classified Indonesia's commitment and engagement across these various processes as high, and comparatively strong. In fact, informants in Jakarta stated that there were countless national consultations and meetings between 2012-2014 with one informant referring to a sense of "post-2015 euphoria."[523] UN agencies, like UNDP and WHO, and some international NGOs, like Save the Children, also facilitated various consultations and workshops serving as bridges between Indonesian government actors and civil society to understand and engage

in the process. Given President Yudhoyono's role as a HLP Co-Chair, Indonesia was afforded continual special status within the process, and Indonesian policymakers were often invited to participate in many of the various global post-2015 meetings and consultations.

The largest meeting within Indonesia was the UNDP-organized national consultation held in August 2013. These consultations were intended to complement the thematic consultations like the health meeting in Botswana; however, informants seemed sceptical about the relevance of the process and highlighted that they did not feel this consultation was taken seriously in New York. Instead they noted that the OWG was much more important and influential in terms of shaping the SDG agenda. Informants who had been trying to advance their own positions shared how they tried to link their process and inputs directly to Indonesia's negotiating team, specifically noting inputs shared with members of both the Special Envoy's office and the Delivery Team (UKP4) who were liaising with the Ministry of Foreign Affairs in New York. (While the Ministry of Foreign Affairs was officially leading the process, it is clear from informants that both the Special Envoy's Office and UKP4 engaged civil society and academic partners to solicit input and feedback.) Following the High-Level Panel Report, however, informants in Jakarta considered the post-2015 process as primarily one for governments centred in the OWG and intergovernmental negotiations.

Section Three: Discussion

Ultimately, Indonesia did not come to the post-2015, SDG negotiations for health with a specific strategy or approach. Instead some Indonesian policymakers, particularly in the Ministry of Health, engaged with a broad vision: they were largely committed to ensuring that the MDG agenda for health was continued and the new SDG agenda built on the MDG agenda to include both universal health coverage (UHC) and non-communicable diseases (NCDs). In this regard, Indonesia may consider itself successful: SDG3 for health incorporated the MDG agenda and includes, amongst other issues, a focus on UHC and NCDs. Attributing this, however, to the Indonesian government's efforts would seem like an exaggeration; instead, Indonesian policymakers' engagement contributed to this outcome for health, along with many other actors. The Indonesian government exerted institutional,

structural and productive power throughout its engagement in the post-2015, SDG process, but its engagement was largely focused on expressions of structural and institutional power. Indonesia's government exerted limited productive power. In analysing why, how and where Indonesia engaged, three important points emerge.

First, the role of domestic politics and timing of political processes in Indonesia were crucial for determining (and understanding) why, how and where (as well as when) the government engaged in the post-2015, SDG process. President Yudhoyono's tenure and appointment to Co-Chair the HLP was decisive for Indonesia's engagement, and was a policy window. For example, had Indonesia's Presidential elections occurred in 2012 instead of 2014, it is difficult to imagine President Jokowi being named as one of the HLP Co-Chairs. Moreover, President Jokowi also would not have had the Delivery Unit (UKP4) or the Special Envoy for the MDGs team within his office to support his engagement in any HLP process (both were established as special initiatives of President Yudhoyono). Yudhoyono was committed to both reforming and challenging Indonesia's civil service, and without his leadership, these offices would not have existed.

Indeed, these efforts were related to President Yudhoyono's efforts to shift and change Indonesia's political situation at home as well as abroad. He wanted to shift the government's identity re-engaging more robustly globally following Indonesia's transformation. As Klotz and Lynch argued, constructivist theorists consider, "the production of discourse through content analysis of specific frames. Then they evaluate the impacts of these frames on actions."[57] The President's framed Indonesia's rising status within the region and the world as an opportunity to re-exert leadership globally and regionally. The HLP was framed as a tool and mechanism to showcase Indonesia's leadership, and achieve these goals. Without Yudhoyono's leadership and his co-chairing of the HLP, Indonesia would likely have lost some of the opportunities this created beyond the HLP in Botswana and in the OWG. On the one hand, this would have meant that the Ministry of Foreign Affairs would have only had to work with the Ministry of Planning and the Ministry of Health and together these ministries might have been able to more easily align their efforts; on the other hand, this might also have meant that, without any tension or sense of competition from the President's office, the Ministries would not have engaged at the same

level or with the same rigour as they ultimately did. While it is always challenging to predict what might have happened, it seems safe to say that without the President's engagement in the HLP, the Indonesian government's engagement in the whole process would have been a lower priority and would have been less robust.

Second, applying a power framework enables a deeper analytical understanding of how states, and actors within states, engage in global health policy processes by illuminating how and where Indonesia engaged in the post-2015 process; this analysis highlights potential implications for the future of global health. Indonesia's government was able to leverage Yudhoyono's role as an HLP Co-Chair exerting structural power to gain the potential to exert institutional and productive power. With emerging economies increasingly engaging in global health and exerting structural and institutional power, global health governance, similar to global governance, could become more diffuse with states and other actors seeking, and sometimes creating, new policymaking fora, where they can more easily or ably exert power. For example, one might expect the Indonesian government to amplify its engagement in the Oslo group and/or to consider including global health as a focus in new partnerships, like the 2013-initiated "MIKTA" grouping, between Mexico, Indonesia, South Korea, Turkey and Australia.[524] Expanding to accommodate inputs from emerging economies, the global health agenda will likely shift and become broader as ultimately happened with the SDG for health. In this sense, the SDG3 might also represent the basis for a wider future global health agenda.

More broadly, this likely portends a more contested global health policy and, possibly, a more fragmented global health governance landscape, as states vary the institutions where they focus their efforts and the fora in which they engage. Barnett and Duvall's power framework helps to illuminate the different ways in which the Indonesian government engaged and contributes to classifying the various ways states (and other actors) engage in global health beyond the most obvious ways of exerting compulsory power or offering financial assistance to advance national interests. It also highlights some of the different ways in which states can move beyond material power, and exert structural, institutional or productive power. It also showcases a concrete example of how states are influencing policy

and practice within global health. Identifying these practices could inspire some reflection and consideration as states seek to improve and expand their global health engagement.

Third, by identifying how and where the Indonesian government engaged in the post-2015 process, one can begin to codify, assess and evaluate this engagement. Understanding these efforts to advance Indonesia's approach, one can also begin to consider how the Indonesian government might build and develop the capacity to improve its future strategic engagement. The analysis above highlighted some challenges for the Indonesian government when exerting both institutional and productive power. What steps might the government take to enhance its future capacity, or how might the government prepare for its next engagements in global health policy processes? For institutional power, as mentioned above, it seems reasonable to expect that the Indonesian government will continue to expand its engagement in existing global health initiatives and create new initiatives when and where possible. Indonesia's Ministry of Foreign Affairs continues to explore new ways and emerging fora in which the country can engage diplomatically; other institutions and actors beyond Indonesia will also likely look to the country to continue to expand its engagement. Accruing additional institutional (and structural) power appears a likely consequence of Indonesia's growing economic and diplomatic importance both regionally and globally. Accompanying this structural and institutional power creates additional opportunities to exert productive power. Yet when it came to realising the potential of these opportunities in the post-2015 process, the government did not always have a coherent, coordinated strategy ready to implement or a consistent narrative it could present to advance the government's approach and take advantage of these increasing opportunities to exert productive power. With growing institutional and structural power, the question of how the country will capitalize on these new opportunities emerges.

In the mid-nineteen-fifties, the American novelist Richard Wright argued that "Indonesia has taken power away from the Dutch, but she does not know how to use it."[525] Indonesia eventually used this power in the 1960s to contribute to re-shaping the international order. Building from the accrual of structural or institutional power now, particularly in the ASEAN region, it seems reasonable to expect that there could be more openings for Indonesia to exercise power in global health, and perhaps continue to reshape

it as it did in the case of the discussion on virus sample sharing. While Indonesia is already exerting structural and institutional power, it is still developing its ability to exert productive power. How Indonesia exerts this new power exactly remains to be seen.

To exercise greater productive power will require both technical expertise in health, political skills and global partnerships. It requires awareness and capacity in global health as well as a commitment to refine and improve Indonesia's strategic engagement and build more sustainable support for global health both within and outside the government. Not unrelated to these challenges is the need for much greater alignment across government ministries and agencies (as well as incorporating feedback and input from civil society, academia and the private sector) as well as coordination with global partners. As detailed above, the lack of a coherent approach in Indonesia's engagement in the post-2015 process was evident. Had the different ministries and agencies within the government invested their efforts in aligning and coordinating their efforts to come up with one strategy instead of contesting the other actors' abilities to engage, Indonesia's government might have had greater success within the process. Recognising and understanding this need is a necessary first step; however, this requires both political leadership and space to engage on health, both which were missing during Indonesia's engagement in the post-2015 process. The need to deepen coordination and alignment between the Ministry of Foreign Affairs and the Ministry of Health is also critical. Indonesia's experience also offers lessons for other countries (this will be considered in Chapter Seven).

Conclusion

This case study on Indonesia's engagement in the SDG3 negotiations has implications for assessing how power is exerted in global health policymaking. It also showcases how emerging economies and middle states might seek to shape or reshape the global health agenda in the future. In the past, global health policy analysis largely focused on material resources. Policy analysis is evolving and beginning to study how and where nonmaterial forms of power shape global health priorities. At the same time as there is a shift towards a deeper understanding of nonmaterial power, there is also an ongoing evolution in practice.

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As this case study on Indonesia shows, state actors engage across the "power spectrum" and exert different forms of power from compulsory to productive power. It appears that states start their engagement by spending resources. As they engage more, they begin to refine and develop their capabilities to influence and shape the policy space beyond crude forms of compulsory power. They begin to cultivate opportunities to exert structural and institutional forms of power. This then evolves with opportunities to exert productive power. Of course, these different forms of power are not exclusive. As Barnett and Duvall argued, they are "operating simultaneously, intersecting with and reflecting off of each other."[526]

This new way of understanding how state actors engage presents opportunities to consider how states can affect and shape priorities in global health. For emerging economies like Indonesia, compulsory power is unlikely to be a primary expression of power in global health. Indonesia is much more likely to build on its historical legacy of foreign policy engagement leveraging both structural and institutional power. Exerting structural and institutional power are increasingly possible for emerging economies and middle country powers with experiences similar to Indonesia. This could herald the beginning of expanding engagement in global health as part of emerging economies' foreign policy efforts. As emerging economies begin to demand some restructuring of the existing system and are increasingly able to contest the previously unchecked structural and institutional power of developed states, this engagement might portend a more contested global health governance landscape. This could mean future gridlock in existing global health policy fora and might spur increased global health policy fragmentation as emerging economies continue to contest and exert structural power. Given that this will likely lead to a more fragmented global health agenda, the capacity, skills and ability of different actors to exert productive and nonmaterial power are going to become even more important.

But this case study on Indonesia also highlights the limitations of state actors' abilities to engage in and exert power in global health policymaking. As detailed above, Indonesian state actors struggled domestically to align their efforts around a coherent approach. They would have had multiple opportunities to advance an approach; however, government actors were unable to agree on one strategic approach. This case study highlights the

continued dominance of state actors within domestic global health policymaking. Other than state actors in Indonesia, there were few domestic non-state actors engaged in global health.

More broadly, this analysis demonstrates the added value of using power as a framework to help illuminate and assess actors', particularly states', roles in global health. Better understanding how power is exerted and deployed could contribute to improving how actors engage, and identifying key determinants of comparatively more 'successful' or 'effective' efforts in global health; a deeper knowledge of what determines better policy efforts could also enhance policy processes and lead to better governance mechanisms.

For example, having reviewed this process, the Indonesian government might seek to reconsider and reform its engagement in global health starting by ensuring coordination between its Ministries of Foreign Affairs and Health. Indonesia could also consider reviewing other countries' engagement and strategies for global health; for example, some countries, like Japan, have developed explicit Global Health Strategies, or have appointed Ambassadors for Global Health. This might also help Indonesia overcome the lack of coordination and leadership within its government on global health issues. A more strategic reconsideration of how states engage in global health could transform states' abilities to negotiate global health policies, eventually improving and saving lives. Of course, having a better understanding of states' power in global health might also mean other actors, like civil society or private sector actors, increase their attempts to leverage states' influence to advance their interests. This is a possibility; however, as states expand their knowledge, they might also gain knowledge of how to improve their position vis-à-vis other commercial or civil society actors. For the future, it could be that state actors able to partner with (or orchestrate a combination of) both domestic and global non-state actors will be more successful. Indeed, state actors able to leverage or harness non-state actors' capabilities might be an important attribute of more 'successful' actors.

Chapter Seven

Comparing and Contrasting Japan and Indonesia's Engagement in the Post-2015, Sustainable Development Goals Process: Implications for the Future of Global Health Policymaking

Main Points:

- Global health policy engagement serves as a policy tool to advance domestic political interests. Both Japan and Indonesia engage in global health, and specifically engaged in the post-2015 process for health, as part of their broader foreign policy efforts. These efforts primarily served domestic political interests and should be understood within their respective political settings as part of national foreign policy efforts.
- Why a state actor engages in global health has implications for how and where states engage. This motivation animates a country's engagement and shapes its commitment as well as the level and distribution of resources from state actors to achieve these objectives. How a government engages in global health should be contextualised and framed within a government's broader foreign policy and diplomatic priorities.
- National narratives constructed to justify greater state engagement in global health policymaking, and the process to create these strategies, are critical. For these processes, the role of individual policymakers (meaning their leadership, their strategy and their involvement of both national and international partners) in developing these narratives have implications for the implementation of these strategies. The processes to construct these narratives shape state actors' capabilities to engage and contribute to determine how these narratives are implemented.
- How state policymakers and institutions construct global health narratives has profound implications for how and where states exert power and engage in the policy and practice of global health. For example, how different state institutions, particularly the Ministry of Foreign Affairs and the Ministry of Health, collaborate and coordinate their engagement is critical to determine states' abilities to exert power and where they engage in global health.
- While how contextualised the global health strategy is within, or aligned with, a national foreign policy and how understood and coordinated it is within and across a government is important, the way it is implemented and asserted is also crucial. It is necessary to consider strategy, or how strategic states are when they engage in global health, and exert power.
- As states deepen their engagement in global health and the field becomes more contested, states will need to think more carefully and strategically about how they engage and exert power. As states' understandings of, and experience in, engaging in global health mature, states will likely expand their ability to exert non-material forms of power. For example, state actors able to harness the knowledge and experience of non-state actors will likely able to amplify their influence.

Introduction

The case-studies on Japan (Chapter Five) and Indonesia (Chapter Six) analyse these states' engagement in the field of global health, and specifically their engagement in the conceptualisation of the post-2015 Sustainable Development Goal for health (SDG3). Highlighting how state actors exert power to influence and shape global health, they contribute to a deeper understanding of global health policymaking. These case-studies contribute to a better understanding of why, how and where states engage in global health and demonstrate the critical role of states within global health policymaking. Applying constructivism to understand why Japan and Indonesia engaged in the post-2015 process, and using Barnett and Duvall's power framework to analyse how and where states engaged, these case-studies demonstrate the resilient value of state engagement in the field of global health. A more nuanced understanding of why, how and where states engage contributes to an expanding analysis illuminating how power is exerted in global health; in turn, an explicit recognition of how power works can help improve global health policy and analysis.

There is a complex combination of strategic factors advanced by domestic and global actors both within and beyond states shaping why actors engage in global health policymaking. Analysts have used different frameworks to classify various rationales motivating state engagement. For example, Stuckler and McKee consider global health to be motivated by foreign policy, security, charity, investment and/or public health considerations.[527] Kickbusch identifies security, economic and social justice concerns to be the primary motivations linking health to foreign policy.[528] Dhillon and Karan most recently argue that actors' motivations can be grouped into three overarching rationales: "ensuring health security, promoting economic and political development, and achieving health equity as a universal human right."[529] While achieving health equity as a universal human right might motivate practitioners (and likely motivated some policymakers in both Japan and Indonesia), the other two rationales -- focused on health security as well as economic and political development -- were decisive objectives motivating both Japanese and Indonesian governments to engage in the conceptualization of the post-2015 development agenda for health as well as within the broader global health agenda.

Ministries of Foreign Affairs in Japan and Indonesia played a decisive role in determining why, how and where each state engaged in global health policymaking, as global health was understood as part of each country's foreign policy. Interests and political policy goals were dominant; global health was considered within the context of Japan and Indonesia's broader foreign policy goals. Indeed, Japanese policymakers deliberately constructed a narrative to position global health as aligned with the country's security, economic and political goals. Japanese policymakers were committed to and interested in using global health policymaking to advance Japanese foreign policy interests and serve domestic political interests. Policymakers built upon Japan's hosting of the 2008 G8 Summit and the 2011 Japan Lancet Series. Policymakers constructed a narrative to animate the country's engagement leveraging its world's highest life expectancy justifying its focus on universal health coverage (UHC) and aligning this with an emphasis on human security within the context of an assertive new government's geopolitical and economic interests.

In Indonesia, the government used and amplified the President's role as a Co-Chair within and beyond the High-Level Panel (HLP) process to advance its broader foreign policy goals of extending Indonesian influence and raising the country's profile to accelerate economic development. Yet domestic political contestation limited Indonesian state engagement in the SDG for health discussions. Nevertheless, along with a commitment to finishing the MDG agenda for health, Indonesian government policymakers focused on using the SDG3 discussions to advance domestic health priorities; this meant advocating for health systems moving towards UHC and improving efforts to address non-communicable diseases (NCDs). In both cases, why Japan and Indonesia engaged also influenced how they exerted power and where they engaged.

As argued in Chapter Two, state actors historically engaged in tropical medicine and international health activities primarily by providing financial resources. In the era of global health, financial resources are still important and their role in shaping global health discourse and the global health agenda cannot be ignored. Yet development assistance for health (DAH) at the global level is beginning to plateau (at around $36.9 billion in 2016); in the meantime, domestic spending on low- and middle-income countries (LMICs) on health is growing and dwarves DAH (estimated at $840 billion in 2014).[530] DAH is still important in

terms of driving the global health agenda and thereby shaping domestic spending; however, expanding domestic spending in LMICS as well as growing interest in some emerging economies to contest the global agenda are challenging the previous centrality of DAH for determining global health priorities.[530]Given this changing situation, there are increasing opportunities for nonmaterial resources to shape global health policy priorities, and some states are embracing the use of nonmaterial resources to influence global health policy.

These case-studies demonstrate how states are using nonmaterial resources to exert power and are likely to continue to cultivate and develop their influence, shaping global health policy and priorities. These case-studies apply Barnett and Duvall's framework for understanding power, and focus on three out of their four different types of power: 1) institutional (indirect power, such as how international institutions are designed to favour one actor over another); 2) structural (the overall constitution or framework of actor and their roles); and 3) productive (control over the possession and distribution of resources) power. For global health, one could think of a well-positioned state leveraging a multilateral agency to exert institutional power; a prestigious university or NGO positioning its staff as experts to provide technical policy support and exert structural power; and a UN agency or a private-sector actor advancing and promoting a particular agenda or approach to addressing health challenges as an exertion of productive power.

Both Japan and Indonesia exerted structural, institutional and productive power to advance their interests and further their policy goals. The growing role of nonmaterial resources will shape and influence how actors participate as well as where actors engage in global health policymaking. For future global health policy making, nonmaterial resources will likely play an important, and expanding, role.

In terms of where both Japanese and Indonesian actors engaged, the Japanese government engaged *largely beyond* the post-2015 process exerting considerable institutional, structural and productive power to influence and shape the post-2015 agenda for health. The case-study on Indonesia highlights the motivations for why the Indonesian government engaged *largely within* the post-2015 process (meaning with the High-Level Panel, the Botswana thematic consultation on health and the Open Working Group

negotiations) exerting structural, institutional and productive power. Indonesian policymakers were strongly committed to health; however, unlike their Japanese counterparts, they were unwilling, or perhaps unable, to create a narrative which captured high-level political attention and justified high-level commitment and support for global health. As shown in these two cases studies, why states engage has implications for how and where states engage; at the same time, how and where states engage also shapes the construction of national motivation narratives. These factors are complex and inter-related.

As detailed in Chapter One, globalisation continues to transform international relations, global governance and global health. Globalisation, along with shifts in geopolitics, is causing states to adapt why, how and where they engage each other as well as interact with other actors in global health. State engagement in global health exerts power shaping the conceptualisation of global health with implications for policy and practice. These case-studies contribute to building a more robust understanding of why and how state actors engage in global health. Reflecting on the international relations theory of constructivism, first, this chapter first reviews and contrasts why both Japan and Indonesia engaged. Second, reflecting on Barnett and Duvall's framework of power, this chapter explores how and where both Japan and Indonesia engaged and exerted power. Third, this chapter considers the implications of this analysis for future global health analysis and policymaking.

Section One: Why both Japan and Indonesia Engaged

Using constructivist analysis, this section reviews and assesses why both Japan and Indonesia participated in the post-2015 SDG3 process, and compares and contrasts these states' engagement. There are three points worth noting and considering for better understanding why states engage in global health policymaking.

First, in both case-studies, global health policy engagement (as part of national foreign policy efforts) served as a policy tool to advance domestic political interests. Both Japan and Indonesia engage in global health, and specifically engaged in the post-2015 process for health, as part of their broader foreign policy efforts. These efforts served domestic political interests. In both cases, engaging in global health was used as a tool to advance each state's wider foreign policy and strategic interests; these broader foreign

policy efforts are largely determined by domestic political interests. Governments used global health policy to achieve domestic aims: in the case of the post-2015 process, both Japan and Indonesia developed narratives (Japan explicitly; Indonesia implicitly) highlighting the importance and success of the MDGs and identifying the new process to create their successor framework as critical for international development and global health, and thus necessary for domestic political goals to project national interests globally. Japan focused on promoting human security, and Indonesia was interested in projecting an image of an emerging, middle economy. Since the 1990s, Japan had actively been contesting the focus of global development policies. In contrast, Indonesia had initially contested the international order in the 1960s, but then became a recipient of global development policies, including the MDGs, until the late 2000s.

Constructivist analysis focuses on how actors' identities, ideas and interests are socially constructed through interaction with other actors. Given the prohibition of a military in its post-World War II Constitution, Japan's political system is anchored in pacifism. Policymakers sought to identify other, non-military ways to express and advance Japanese interests. Japan's Overseas Development Assistance (ODA) has been one of the primary ways in which Japan engages and exerts influence. In the late 1990s and early 2000s, politicians and policymakers sought to reconceptualize Japan's ODA under the umbrella of an effort to promote the concept of "human security." Responding to critique of this concept, policymakers advanced health as a concrete way to promote human security, which became a leading principle of Japanese foreign policy. Following the 2008 G8 Summit in Toyako, Hokkaido, health became increasingly important both in its own right as a policy agenda for Japan, but also as a way to further Japan's promotion of human security.

In advance of the 2008 G8 Summit and with the support of Japan's Prime Minister at the time, Keizo Takemi, a Japanese politician and policy entrepreneur, initiated a policy process to develop policy recommendations for Japan and the (then) G8's engagement in global health. Building on inputs from global and domestic policymakers, this process focused on strengthening health systems. An informal working group evolved and developed a special Lancet Series on Japan; the process for this Series built on the focus on health systems and constructed a narrative focused on advancing the concept of universal health

coverage (UHC). This process coincided with a political window of opportunity with a new Japanese administration in 2012, which was committed to asserting Japanese leadership and advancing Japanese interests globally. Policymakers in the Ministry of Foreign Affairs then adapted this constructed narrative to animate its focus on human security and shape its 2013 Global Health Diplomacy Strategy. With cross-government support, including from the Prime Minister, this plan aligned efforts to advance UHC. Ultimately, policymakers invested resources in a process which helped construct a narrative focused on UHC shaping how and where Japan could engage in global health, including the post-2015, SDG agenda for health.

For Indonesia, a country which had been a MDG "policy recipient" in the early 2000s, the opportunity to engage in the conceptualisation and creation of the post-2015, SDG agenda, with President Yudhoyono co-chairing the HLP, built upon the country's proud legacy of bold international leadership starting from the Bandung Conference in 1955. Drawing upon multiple institutions within the Indonesian government to inform the government's engagement in the HLP, Yudhoyono highlighted his pluralistic ambitions to reform Indonesian government bureaucracy. Yudhoyono's engagement in the HLP also reflected his aspirations to project Indonesian leadership and "internationalize" Indonesia's experience affirming the country's emergence as a middle power. It was important for his government to lead, and to be seen in this position globally by a domestic audience.

Outside Indonesia, particularly in the US and the UK, there was great anticipation and expectation that Indonesia would increasingly engage on global health issues. Inside Indonesia; however, the reality was slightly different. Policymakers were more interested in advancing domestic health reforms. Once the President committed to serving as a Co-Chair for the HLP, Indonesian policymakers sought to take advantage of his role as Co-Chair to advance their interests and consolidate their domestic political positions. Policymakers assessed the President's engagement as an opportunity to solidify their institutional interests within a rapidly evolving and shifting political environment by actively contesting how and where the President and the government should engage in the process across sectors, including health.

Unlike in Japan, however, there was not an ongoing, wider policy dialogue across Indonesia's government on global health. Instead, the government's engagement in health appeared more opportunistic. This is a key point of comparison between Japan and Indonesia. Both Indonesia's Ministries of Foreign Affairs and Health had a number of prominent engagements in the global health policy space which served Indonesia's foreign policy aims; however, these were not part of a broader strategy. While there was a coherent foreign policy to project Indonesia as a regional (and global) emergent power, there was not an Indonesian global health strategy aligned with this national foreign policy. Policymakers advancing these global health engagements viewed them as an opportunity to advance their domestic positions, but these engagements were not part of an overall effort to mobilize, and then leverage, deeper Indonesian commitment to global health. Despite anticipation, or even expectations, from external observers, these engagements, like Indonesia's role in the Foreign Policy and Global Health Group, were not part of a wider, integrated strategy. The need for (and/or potential benefits from) coordinating these efforts did not seem to be necessary to key informants in Jakarta.

On the contrary, given the tension between different domestic actors' interests, Indonesian policymakers did not attempt to create an overall global health narrative. Policymakers in the Ministry of Health were fully committed to and engaged in their own domestic reform efforts, and did not necessarily see the value of global engagement for their domestic objectives. Moreover, Indonesian policymakers were sceptical that they would be able to cultivate or develop the necessary political support from the President's office for strident global health engagement. Accordingly, policymakers were unable to agree upon a consistent strategy for Indonesia's engagement on SDG3. Instead, policymakers advanced discreet issues and contributed to an emergent consensus on SDG3 (which ultimately succeeded) aiming to incorporate the MDG agenda with a focus on UHC and NCDs along with other health issues. In sum, Indonesia's engagement in the post-2015 discussions for health goal were driven by the President's foreign policy efforts. His appointment as Co-Chair of the High-Level Panel ensured that Indonesia had a prominent role throughout the process; however, he was not convinced or interested in leveraging this opportunity for health. Nevertheless, his role as a Co-Chair afforded and created opportunities for Indonesian health

policymakers to engage and advance their perspectives as part of the global discourse and contestation around the eventual SDG3 for health.

In Japan, policymakers built on the country's growing exertion of soft power, identifying a policy space, namely global health, which could help promote Japanese political interests, advance Japan's foreign policy concept of human security and further Japanese economic interests. Building on Japan's prior engagements exerting power to shape global development policies, policymakers constructed a political narrative which ensured high-level political attention and commitment to global health, including engaging in the process to conceptualize and create the post-2015 SDG3 agenda. In Indonesia, policymakers were less interested in global health, and more interested in projecting Indonesia as an emergent middle power, advancing the Indonesian experience globally as well as their individual and institutional perspectives; policymakers used the opportunity of the post-2015 SDG3 agenda to advance these interests. For Indonesia, it was important to have a seat at the table and to be seen sitting at the table. Both of these cases demonstrate how global health engagement is shaped by domestic political exigencies, and considered a foreign policy issue. This is something policymakers should keep in mind when considering how to improve their ability to engage in global health policymaking. These cases also reflect the potential value (as well as the perceived cost) of developing a global health narrative. While most countries will likely not invest the same amount of time or resources as Japan did into its process to develop a global health strategy, other countries might consider replicating this experience to be ready with a narrative and strategy as possible political opportunities might arise to advance their position.

Second, these cases highlight how narratives justifying greater state engagement in global health policymaking, and the process to create these strategies, are critical. For these processes, the role of individual policymakers and their leadership in creating these narratives also matters. In Indonesia, there was not an explicit policy process to develop a global health diplomacy strategy; there also was not an explicit process to develop a narrative or strategy to engage on health in the post-2015 SDG process; moreover, there was not an individual leader empowered or able to steward a process like this. Implicitly what happened was that the Ministry of Foreign Affairs engaged with both the Ministry of Health

and the Delivery Unit (UKP4) in the President's Office which deferred to the office of the President's Special Envoy on MDGs when questions around health surfaced in the post-2015 process. There was never a systematic effort to develop a more coordinated, comprehensive approach between and across these institutions.

In contrast, Japan had an explicit, ongoing policy dialogue on global health starting in 2007, led by Takemi, which evolved into a more robust and strategic discussion on how the country should engage globally. As personal health issues had contributed to shortening his first administration, Japan's Prime Minister was also sympathetic to health issues and quickly grasped the opportunities to expand opportunities for Japanese health and medical industries. This led to an explicit Japanese Global Health Diplomacy Strategy in 2013 which identified the post-2015 process as an important target. While an explicit strategy or narrative does not guarantee success, it undoubtedly helps align different domestic policy actors, and can attract high-level political support. In this sense, Japan was better positioned for its engagement than Indonesia. It had an explicit strategy and narrative motivating its engagement; this helped motivate and justify broader engagement across state actors. Japan also had politicians, like Takemi and Shiozaki (along with the Prime Minister), as described in Chapter Five, uniquely positioned to play this role and exert this leadership.

Third, these cases illustrate why a country engages has implications for how and where states engage. This motivation can animate a country's engagement, and shape its commitment as well as the level and distribution of resources from state actors to achieve these objectives. In Japan's case, the GHD Strategy served to align actors across the government and coordinate efforts ultimately improving how and where it engaged; in Indonesia, in contrast, the lack of a strategy or compelling narrative on why the government should engage undermined the government's ability to engage and limited how and where it engaged in the process. Appreciating states' motivations are helpful to understand why states engage in global health, but does not alone explain state engagement in global health.

More broadly, this analysis documents how constructivist analysis is essential to understand why state states engage in global health. In fact, both cases showcase how critical the construction of a narrative, and the process to do so, is to motivate and shape state

engagement in global health. While a realist perspective might justifiably highlight Indonesia's interest in projecting national interests globally, and a liberal perspective could emphasize how Japan is integrated into international institutions, neither of these perspectives would identify the nuance which explains why each state engaged (and how actors engaged within the state to make this case) as well as how and where each state engaged globally.

These two case-studies also highlight the importance and the limits of individual leadership to motivate state engagement in global health. Parliamentarian Takemi, Minister of Health Shiozaki and Prime Minister Abe all wanted Japan to engage more deeply, and ideally lead, in global health; their leadership and commitment coupled with the Japanese bureaucracy, international partnerships and technical capacity enabled Japan to exert considerable power. Whereas in Indonesia, there was strong commitment and leadership from President Yudhoyono in projecting Indonesia's global engagement; however, there was a reluctance or an absence of interest in engaging in global health. Indonesia state institutions might have had comparatively fewer international partnerships than Japan; but Indonesia's bureaucracy did have the technical capacity to engage. The difference was likely the political space and leadership. Japan's leadership was committed to engaging and leading in global health. Building on its unique history and presidential commitment to foreign policy issues, Indonesia's leadership was committed to engaging globally, but was less committed to engaging in global health. Building on this comparison of why both Japan and Indonesia engaged, this next section reviews how and where these states engaged in the process.

Section Two: How and Where both Japan and Indonesia Engaged

National motivations shaped and continue to shape Japan and Indonesia's global health engagement; more specifically, their motivation defined how and where each state engaged in the post-2015 process for SDG3, the goal for health. After reviewing how and where each exerted power according to Barnett and Duvall's framework (considering structural, institutional and productive power) in the previous chapters, three points emerge for states considering engaging in global health diplomacy and policymaking.

First, how a government engages in global health should be contextualised within a government's broader foreign policy and diplomatic priorities. This is about framing, or what McInnes et al define as how an "issue is presented in such a way as to tie it into a broader set of ideas about the world, or 'socially constructed reality', and through this gain influence and policy purchase."[531] As McInnes and colleagues argue, "actors often deliberately (and in many cases strategically) use frames as a tool of persuasion, deploying them to call attention to an issue, influence other actors' perceptions of their own interests and convince them of the legitimacy/appropriateness of the advocate's preferred policy response."[531] How national policymakers frame their government's engagement in global health is critical to a state's ability to engage and exert power. The construction of a narrative to motivate engagement was an explicit process in Japan, but happened more implicitly, if at all, in Indonesia.

In Japan, policymakers jointly developed a compelling framing for Japan to engage in global health across the government; this worked to inspire policymakers' engagement and to align different actors across the Japanese government. In Indonesia, this sort of policy dialogue did not exist. Policymakers were still contesting which institutions should be engaged and how as well as what Indonesia's contribution should be. Policymakers were not able to recognize the need to create a process to develop such a shared perspective.

Second, how different state institutions, particularly the Ministry of Foreign Affairs and the Ministry of Health, collaborate and coordinate their engagement is critical to determine states' abilities to exert power and where they engage in global health. It seems reasonable to contend that the more understood or embedded a global health strategy is across actors within a government policy process, the stronger broad engagement might be, and the more power a state might be able to exert. This also raises a broader point about power within global health. It is not finite. It is not necessarily dependent on financial resources. On the contrary, as these cases show, state actors' power to influence and shape global health can be developed through international partnerships and technical knowledge. State actors can cultivate and expand their ability to influence global health policymaking through combining their ability to exert power with strategic engagement. This naturally affects where, meaning the policy fora in which, states engage.

In Japan's case, the rationale for its engagement was understood across state institutions. Japanese policymakers interested in global health successfully constructed a compelling case framing why and how the Japanese government should engage on health. The Japanese government was interested in projecting Japanese leadership and demonstrating the global relevance of Japan's experience with UHC. To ensure coordination, the Ministry of Foreign Affairs and the Ministry of Health exchanged and rotated personnel working on global health between the two institutions to help align their policies and build trust between the two state institutions. Moreover, there were regular, formal coordination meetings between these two ministries along with the Ministry of Finance as well as informal meetings across government institutions to share updates on Japan's engagement in global health policy, and opportunities to promote UHC. As the focus on UHC was aligned with Japan's broader foreign policy, Japan's Global Health Diplomacy Strategy was not just about engaging within the post-2015 process, but this strategy motivated wider engagement beyond[14] the process.

In comparison, Indonesia's government largely engaged within the post-2015 process. It was keen to serve, and be seen serving, in a leading position (eg: President Yudhoyono's role as Co-Chair in the HLP), consistent with its interest in projecting Indonesian leadership and an image of the country as an emerging economy; however, it did not have a specific approach or focus for its efforts on health. Instead, the Indonesian government focused its efforts on other issues. Like Prime Minister Abe in Japan, President Yudhoyono was looking for issues where Indonesia could lead and have global impact as this was important for his domestic audience. Ultimately for Indonesia, however, health did not appear to be, or there was not an active effort to construct a rationale for health to be, an issue on which Indonesia could lead globally.

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[14] This happened for several reasons. First, by the time Japan's GHD Strategy was launched in June 2013, the post-2015 process was well advanced with the main inputs from the Botswana consultation (April 2013), the HLP (completed in May 2013) and the OWG (which commenced in March 2013 and had its meeting on health in June 2013) already complete. Japanese policymakers were nevertheless keen to advance and project their commitment for UHC, and so had to look elsewhere to find and create opportunities to advance their commitment to UHC. Second, while the post-2015 process was well underway, there was a sense that Japan's government could nevertheless still exert influence and power over the evolving post-2015 process in alternative ways, for example through its relationships with the World Health Organisation (WHO) and the World Bank, which were both engaged in the process. Third, Japanese policymakers, like many others, questioned where or not the official post-2015 SDG policy process would evolve along the lines originally intended, especially given the circuitous evolution of the MDGs and other global policy processes. Many policymakers considered the possibility that another side process might eventually come to derail or overshadow the process. More broadly, the relevance of the SDGs for the broader global health agenda was uncertain. As argued in Chapter Four, while the MDGs were central to the prevailing global health agenda, the importance of the SDGs for the future global health agenda was (and still remain) somewhat unclear. Like they did in the early days of the MDGs, Japanese policymakers were hedging their investments in the SDG process.

This raises questions of leadership. In Japan, the government was led by Prime Minister Abe who was determined to exert leadership globally; in Japan, there were also policymakers ready and able to make the case on how the country could and should lead on global health. In Indonesia, there was a President committed to and interested in exerting leadership globally; however, there was not a leader or group of leaders within the health sector in Indonesia able to make the case for how health might fit into this. This had implications for how each Japan and Indonesia engaged and exerted power. In Japan, the Prime Minister's leadership created political space and a window of opportunity for Japanese politicians, policymakers and academics to engage, and thereby also gain domestic political capital with the Prime Minister. Whereas in Indonesia, President Yudhoyono was committed to lead globally, but his commitment for global health engagement was less palpable. This meant policymakers had less political space and fewer incentives to engage in global health policymaking which offered little political capital, especially when there were seemingly more pressing domestic demands on policymakers' time.

Japanese policymakers leveraged the government's diplomatic influence, ultimately exerting complementary productive, institutional and structural power to advance the government's GHD Strategy's focus on UHC (as detailed in the table below). The government exerted structural power through the Prime Minister's office, using development aid and alliances taking advantage of Japan's position as the world's third largest economy in its direct, bilateral diplomatic relationships with other countries. The Ministry of Foreign Affairs exerted structural power directly leveraging Japan's diplomatic abilities and resources by convening an informal SDG-specific contact group comprised of national representatives and key policymakers in the early days of the post-2015 process to advance human security. Parliamentarians and the Ministries of Finance, Foreign Affairs and Health together coordinated their efforts to exert institutional and productive power indirectly leveraging key global health institutions like the World Bank and the World Health Organization. Exerting institutional power, Japan strategically used its relationships and small amounts of funding in both institutions to ensure and support a focus on UHC. Japan then exerted productive power through the World Bank and WHO; both the Bank and WHO convened meetings and released reports and other knowledge products focused on UHC

shaping the priorities of other countries. Japan's Ministry of Foreign Affairs also deployed structural and productive power hosting several high-level events as well as lower-level briefings and seminars on UHC again signalling the government's focus and wielding its role as a leading global economy to steer and direct other countries towards a focus on UHC. The government leveraged G7 diplomacy as well as its TICAD meetings with African states and bilaterally using its JICA development cooperation to exert additional power to advance a focus on and prioritisation of UHC within the global health agenda. Japan's exertion of power is summarised in the table below.

Japanese Government's Exertion of Power to Influence the Post-2015 Process	
Structural Power	• The Prime Minister's office using bilateral relations • The Ministry of Foreign Affairs convening a SDG Contract Group in 2011-2012 as well as high-level events (eg the UHC Forum) and lower-level briefings in Geneva and New York
Institutional Power	• The Ministry of Foreign Affairs, Health and Finance leveraging the World Bank and the World Health Organisation to prioritise Japanese priorities within these institutions as well as taking advantage of the exchange of personnel within these institutions
Productive Power	• The Ministry of Foreign Affairs, Health and Finance leveraging knowledge and technical expertise from both the World Bank and the World Health Organisation to advance Japanese priorities

Whereas Japanese policymakers identified the post-2015 process to advance their global health interests, in Indonesia's case, the situation was the opposite. The post-2015 process "identified" Indonesia. The UN secretariat chose Indonesia's experience as important and relevant for incorporation into the post-2015 process. Given Indonesia's rising global profile, the UN Secretary-General requested then Indonesian President Yudhoyono to serve as one of the three HLP Co-Chairs. In this role, Yudhoyono sought to draw upon Indonesian policymakers to reflect and embed Indonesia's national development experience into the Panel's deliberations and eventual recommendations. In turn,

Indonesian policymakers leveraged the President's role as a Co-Chair within and beyond the HLP process. Yet health was not a high priority for Yudhoyono's HLP involvement.[15]

Despite this challenge, Indonesia's government exerted structural and institutional as well as productive power in the post-2015, SDG process for health (as detailed in the table below). The President's office exerted structural power throughout the HLP process by Co-Chairing the report. The HLP was an informal group established by the UN Secretary-General's office for the post-2015 process, and for Indonesia to be one of the three leaders of this Panel and subsequent report was an opportunity to exert structural power controlling how the panel was constituted, for example, by determining to host the final consultation in Bali. This hosting of the final meeting in Bali, combined with dispatching one of the few authors for writing the final report, enabled the Indonesian government to have considerable productive power over the report's content. This was particularly influential as the HLP report was one of the first and most substantial contributions within the official post-2015 process. While the government exerted power in these instances, it did not exert this power within the HLP process on health issues; however, Indonesia's government did engage on health in both Botswana and the OWG. While its position differed from the HLP approach, the Ministry of Health and Foreign Affairs exerted structural power within the Botswana Thematic Consultation by presenting in one of the limited sessions during the two-day meeting. The President's office along with the Ministry of Foreign Affairs, Health and Planning exerted structural and institutional power by engaging actively throughout the OWG negotiations both unilaterally and multilaterally through its troika with China and Kazakhstan as well as through the institution of the G77. More broadly, the government exerted structural power via its role in the HLP throughout the wider post-2015, SDG process as many sought to engage Indonesia to leverage its role as a Co-Chair. In contrast to Japan, Indonesia's government largely engaged within the official process and did not seek to

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[15] There are several reasons for this. First and most importantly, there were simply higher priority issues for the Indonesian government, like the environment. There was a compelling narrative around why and how Indonesia should engage on the environment, and the government had already earned some profile on this issue globally; moreover, the issue of the environment had supporters with links throughout the government to champion the issue. Second, President Yudhoyono had been reluctant to move forward with domestic health reforms; in fact, the courts had ruled against him to expand domestic health reforms as detailed in Chapter Six. Third, while some Indonesian policymakers had strong ideas on certain health issues (like on sexual and reproductive rights or non-communicable diseases), Indonesian health policymakers were struggling to get high-level support for their efforts to advance domestic health reforms, and did not yet have a compelling narrative on how to link this to why and how Indonesia should engage in global health.

engage on health outside the official process. Indonesia's engagement on health was not part of a broader global health strategy. The table below summarises the Indonesian Government's exertion of power in the post-2015 process.

Indonesian Government's Exertion of Power in the Post-2015 Process	
Structural Power	• The President and his office influencing the process for the High-Level Panel as well as the Ministry of Foreign Affairs and others using the President's role as a Co-Chair to amplify its influence through the post-2015 process • The Ministry of Health and Foreign Affairs presenting during the Botswana Thematic Consultation on Health
Institutional Power	• The Ministry of Foreign Affairs working through the G77 to shape and influence the OWG discussions on health
Productive Power	• The President and his office shaping the writing of the High-Level Panel report

Reviewing how and where both the Japanese and Indonesian governments engaged and exerted power according to Barnett and Duvall's framework demonstrates the utility of identifying the different ways in which states engage in global health. This framework helps classify and contrast how states engage. This lays the groundwork for beginning to improve abilities to assess, and ultimately improve how states act and engage in global health policymaking. Comparing Indonesia and Japan, the Indonesian government exerted less power than the Japanese government did. The Indonesian government's engagement was not closely integrated into national foreign policy efforts and was not coordinated across ministries. In contrast, support across the Japanese government for the national Global Health Diplomacy Strategy enabled the government to exert comparatively considerable power. Yet the mere exertion of power, considerable or inconsiderable, does not necessarily explain success or failure in achieving global health policy objectives. While applying Barnett and Duvall's power framework illustrates the different ways how and where states engage and exert power, it alone does not explain global health policymaking outcomes.

Third, as more states begin to expand their engagement in global health and the field becomes more contested, states will need to think more carefully and strategically about how they engage and exert power. For example, a focus on one form of power will not be enough. The importance of coordination and collaboration between state actors within states as well as with non-state actors will likely become increasingly necessary, not only to exert power within global health, but also to exert power more impactfully, strategically and successfully. As these case-studies highlight, the mere exertion of power is not always sufficient. While Japanese policymakers were able to exert considerable power to advance a focus on UHC across Japanese institutions, they were not able to persuade all global health actors of this same approach. In this case, Japanese policymakers successfully exerted power domestically, but were not able to replicate this at the global level. It is likely that policymakers need to possess different resources to exert power domestically versus globally; for example, while certain national policymakers might be able to exert their dominance domestically due to their position or their domestic network, this might be more difficult at a global level. In Indonesia's case, policymakers struggled to unite around one perspective within Indonesia. In line with its focus on UHC, Japan exerted power across the spectrum; on a few different issues, Indonesia exerted structural and institutional power (with limited forms of productive power). For neither state, however, was this entirely sufficient. It is possible that to improve future global health engagement, states will need to deepen their coordination and collaboration between different government institutions as well as call upon non-state actors to exert power across the spectrum of power as global health is an increasingly prominent part of foreign policy efforts.

Analysing why, how and where Japan exerted power in the process only tells part of the story. As detailed in Chapter Five, the results of Japan's efforts were broadly successful, but there is some room for improvement, according to the government's own GHD Strategy. The GHD strategy called for Japan to lead efforts to include UHC in the post-2015 development agenda as well as to shift its bilateral assistance towards UHC, collaborate with Japan's global partners (WHO, the World Bank and Global Fund particularly) as well as strengthen human resources for global health. On the one hand, Japan's GHD Strategy was successful as the government was indeed a lead actor calling for UHC to be included in the

post-2015 agenda; the government exerted considerable power to advance UHC. The government also began to shift its bilateral aid towards UHC, collaborate with global partners and begin to improve the skills of Japanese global health specialists. On the other hand, the Japanese government hoped to position UHC as the overall goal for SDG3 and exerted power to achieve this; however, this did not happen. Instead, UHC was included as a target for SDG3 and the overall SDG3 goal focused on ensuring healthy lives. Japan did not exert its power within the post-2015 process. While Japan's strategy was launched around the same time as some of these processes, the government could have engaged more strenuously in this process. Appreciating the exercise of power does illustrate the different, sometimes less visible, ways in which actors might engage and seek to advance their interests, but to understand more fully how actors engage, one must identify the countervailing exertions of power as well as consider the context and how different narratives can be more or less persuasive in determining policymaking outcomes.

As detailed in Chapter Four, there were other states, like Sweden and the United Kingdom, as well as other actors actively championing consideration of factors beyond the health sector to have a goal focused on healthy lives, implicitly aiming to block Japan's efforts to position UHC as the goal for SDG3. This approach was adopted in the HLP as well as in the report of the Botswana consultation, and this alternative approach (focused on having a goal of ensuring healthy lives) eventually prevailed and incorporated UHC into the SDG3 framework as one of the targets. Yet, Japan's efforts were not without effect. Indeed, UHC is now often conflated with the SDGs in global health discourse and is now near the top of the global health agenda despite SDG3. Japan's government continues to prioritise UHC at the G7 and G20, supports efforts at WHO and the World Bank to help advance progress on UHC and promotes UHC as a global health priority.

Even if Indonesian policymakers had engaged in external or parallel post-2015 processes, it is not entirely clear which perspective or approach they would have advanced as there was not a consistent or coherent narrative which framed Indonesia's position on health in the post-2015 negotiations. In comparison to Japan which was firmly committed to a focus on UHC, as explained in Chapter Six, Indonesian policymakers advocated for health systems moving towards universal health coverage (UHC) and non-communicable diseases

(NCDs), along with a commitment to finishing the MDG agenda for health, to be included in the SDG agenda for health. Policymakers focused on UHC and NCDs as they were national priorities for Indonesia; however, policymakers did not develop a rationale for why these issues were important for Indonesia and other countries and how focusing on this issue could be aligned with Indonesia's broad foreign policy efforts. While Indonesian policymakers did exert some power, they did not consistently exert it to advance a coherent position or approach for health within the post-2015 agenda. In comparison to the government of Japan, Indonesia's government exerted considerably less power to advance its position on health in the post-2015 process. Policymakers focused on UHC and NCDs; efforts from Indonesian policymakers were not decisive, but broadly contributed to both issues being incorporated into the eventual goal, SDG3.

Section Three: Implications for the Future of Global Health Policymaking

To better understand global health, it is critical to appreciate actors' motivations and identify why, how and where different actors engage and exert power. Combining constructivism to explore how states create narratives justifying their engagement with a power framework to illustrate how and where state actors engage showcases how state actors define and shape policymaking. This section summarises this discussion by considering three broader implications from these case-studies on state engagement for the future of global health.

First, how state policymakers and institutions construct global health narratives has profound implications for how and where states exert power and engage in the policy and practice of global health. (It also has implications for how state actors assess the "success" of their engagements; this will be considered more in the next and final chapter.) As documented in Chapter Five, Japanese policymakers have varying levels of understanding of the field of global health. Given that a number of Japanese policymakers, largely from the Ministry of Health or Finance, served or continue to serve in senior roles working for the World Health Organisation or the World Bank, there is almost a continuous exchange of staff between the Japanese government and these institutions. This engagement, and their subsequent knowledge, personal networks and understanding of global health policy, is another way in which Japan exerts power. The government exerts structural and

institutional power using its role as a funder of these institutions to influence who these institutions hire; it then uses these individuals to exert institutional and productive power over the agenda and knowledge products of these institutions. In fact, the Ministry of Foreign Affairs cultivates these relationships and actively seeks to send more Japanese nationals to serve in these institutions as well as other UN agencies and global health partnerships. (The Ministry of Health also supports its staff to study at institutions like the Harvard School of Public Health, or the London School.) Japan is seeking to expand these efforts, and this rotation of Japanese government bureaucrats with international institutions contributes to a deepening appreciation for how and where Japanese policymakers and institutions can engage in the field of global health.

This experience also influences how Japanese policymakers consider global health issues, and ultimately shapes the government's ability to exert power. For example, this close relationship to WHO most likely contributed to the Ministry of Foreign Affairs thinking that WHO's influence would be stronger within the SDG3 process, and that the government could rely on WHO to make the case for UHC. These relationships also likely influence the issues Japanese policymakers consider as "global health" issues. For example, Japanese policymakers generally consider MDG-health challenges as well as UHC, amongst others, as part of the global health agenda; however, they do not often consider issues like climate change or tobacco control as global health challenges. In other words, these relationships can sometimes distort Japanese policymakers' understandings of global health, and these relationships can sometimes serve as a crutch in place of a strategy.

As detailed in Chapter Six, Indonesian policymakers, on the other hand, have a comparatively limited exposure to, and understanding of, the field of global health policy as it is currently practiced. With a few notable exceptions, few Indonesian policymakers have served in senior roles in existing global health governance institutions. Indonesian experts and policymakers sometimes engage in health discussions within the ASEAN region; however, more global engagements are comparatively limited. Despite this, Indonesia is actively increasing its international engagement through a mix of engaging in and with existing institutions (like WHO), and sometimes creating new policy fora (like the Foreign Policy and Global Health Group). Indeed, the Indonesian government is actively trying to

create and cultivate new opportunities to engage; at the same time, these efforts sometimes appear ad hoc and uncoordinated. This raises the issue of the importance of moving beyond contestation and towards coordination between institutions. In Indonesia's case given the changes in the broader political system, ministries and government agencies appeared to be strongly contesting their institutional position during the period of the post-2015 process whereas Japan's government was moving towards a more coordinated approach aligning its efforts between the Ministries of Foreign Policy, Health and Finance.

Moreover, this engagement in global health also occurred during an evolving geopolitical shift. While key informants in Japan perceived the United States and United Kingdom to be retreating from engagement in global health policymaking; key informants in Indonesia noted the importance of both these states as key reference points for Indonesian diplomacy.[532] Traditionally, the US and UK have dominated global health policymaking; however, recent domestic political trends in both these countries has signalled the possibility of reduced engagement. This has created policy space and motivated Japanese policymakers to seek to take advantage of what they perceive as a policy window to engage and advance their interests in global health policy; Indonesian policymakers, on the other hand, see their engagement as part of Indonesia's rise in global engagement.

Second, as state understanding of, and experience in, engaging in global health mature, states actors can expand their ability to exert nonmaterial forms of power. State actors able to harness the knowledge and experience of non-state actors can augment their impact and influence in global health policymaking. This has many potential implications for how state (and non-state) actors engage and exert power within global health. There is possibly a transition or evolution in understanding of global health which coincides with the ability and skill to engage and exert more sophisticated forms of power. More specifically, state engagement could evolve as states come to better understand global health policymaking from exerting structural and institutional power to productive power.

While financial or material resources are still important and play an important role in determining global health priorities and policies, states no longer need to make multi-million-dollar investments to successfully engage. States can leverage much smaller

amounts, and amplify this with strategic engagement and coordinated exertions of power in global health. States can develop the knowledge and understanding of global health to exert more power, and thus expand their ability to influence the field and practice of global health. There is a spectrum of power with more experienced (and powerful) actors able to exert power across a spectrum, and less powerful states focusing more on one power form, or some combination of structural or institutional power. In both cases studies, state engagement in global health remains largely dominated by government institutions primarily led by the Ministry of Foreign Affairs or the Ministry of Health with relatively limited input from non-state actors, like civil society, the private sector or academia.

In Japan's case, in the beginning of its engagement in global health in the early 2000s, the government largely exerted power through providing financial support, but as its engagement deepened, its exertion of nonmaterial power evolved. Japan expanded its engagement to exert structural and institutional as well as productive power, including in the post-2015 process. In Indonesia's case, the government is still emerging on the global stage and is at a comparatively earlier point than Japan, as it is still navigating how it engages in global health. Nevertheless, the Indonesian government was able to exert high levels of structural and institutional power, but only exerted limited expressions of productive power; thus, while Indonesia was in a position to exert influence over the content of SDG3, it did not shape the goal as much as might have been expected.

The transition from structural and institutional power to productive power is also likely indicative of better coordination between the Ministry of Foreign Affairs and the Ministry of Health as well as other state actors and non-state actors. As Barnett and Duvall argued, different forms of power are not exclusive and often work together. It is possible that different forms of power are most powerful or most impactful when combined, or rather that actors have most power where they can use different forms of power together. For example, a Ministry of Foreign Affairs might be able to create opportunities to exert structural and institutional power; however, this is could be improved and substantiated with technical inputs (possible forms of productive power) from the Ministry of Health (and possibly others). Given its likely deeper knowledge of global health policy, a Ministry of Health would likely be in a better position to exert productive power; however, this would be best

leveraged with opportunities to exert structural and institutional power. In Japan's case, coordination between the Ministry of Foreign Affairs and Health notably improved around the time of the GHD Strategy; there were also mechanisms to solicit input from non-state actors like universities, think tanks and civil society. This enabled Japan to combine its structural and institutional power with productive power and exert considerable influence in the deliberations on SDG3. In Indonesia, coordination between the Ministry of Foreign Affairs, the Ministry of Health and the President's office in this same period was challenging. While the President's Office and the Ministry of Foreign Affairs were able to create opportunities for the government to exert structural and institutional power, a lack of coordination with the Ministry of Health and other actors limited the exertion of productive power, and thus Indonesia's overall exertion of power and influence in the conceptualization of SDG3.

Third, it is necessary to consider strategy, or how strategic states are when they engage in global health, and exert power. While how contextualised a global health strategy is within or aligned with a national foreign policy and how understood and coordinated it is within and across a government, the way it is implemented and asserted is also important. This is also about aligning a strategy with state capacity and resources. Aside from exerting power, the implementation of national strategies matter, particularly in relation to what Rushton and Williams referred to as ideas (ie how persuasive these are and/or how they are framed), agency (ie which actor or which state is advocating which position) and structure (ie the existing global health governance architecture).[533]

In other words, a state actor could exert tremendous amount of power and still not get exactly the outcome it desired (like Japan focused on making UHC the overarching focus of SDG3 instead of a target as it is now); another actor could exert little power and get the outcome it desired (like Indonesia expressing an interest that both UHC and NCDs be incorporated along with the MDGs into the new SDG3). Whereas some Indonesian policymakers advocated to incorporate UHC and NCDs along with the DGs into the new SDG3, this was not a concerted government effort with consistent and deliberate exertions of power to this effect; moreover, Indonesian policymakers' voices were one amongst many in the global discourse on SDG3.

In contrast, Japanese policymakers had an aligned government policy of why, how and where it would exert power to advance a focus on UHC. While Japanese policymakers were some of the most strident actors globally positioning UHC for SDG3 and engaging heavily in efforts to advance UHC in the global discourse, Japanese efforts largely overlooked the official post-2015 process. This was a strategic decision. Japanese policymakers engaged outside the official process knowing that they could and would have more control over these types of engagement, which would then be easier to showcase domestically.

It is challenging to quantify or assess how "strategic" a state is when implementing a global health diplomacy policy. Considering these broader issues of the links between power, ideas, agency and structure; however, one could start by reviewing the goals in national global health strategies or similar policy documents, and comparing these with national resources in terms of global partnerships and technical capacity.

Conclusion

Global health is an increasingly important part of national foreign policy. Globalisation is changing how states interact and engage, explicitly and implicitly, in global health. This matters for why, how and where states engage in and exert power in global health. As these case-studies on Japan and Indonesia demonstrate, states continue to play a critical role in conceptualizing and defining global health through their engagement. Power analysis helps create a better understanding of how actors create, manage and exploit disparities in power to serve their interests in global policymaking processes. A more robust understanding of how to exert power also presents states with the ability to improve how they engage in the field, and potentially bring a more balanced, equitable approach to determining global health priorities. Simultaneously, there are risks that non-state actors, including commercial and philanthropic actors, also expand their understanding of how power is exerted and thus improve their ability to shape and sometimes distort global health policy. In fact, this is already happening with commercial actors acting to exert their power, for example, with regard to efforts to regulate the determinants of non-communicable diseases.[534]

These case-studies focused on the conceptualisation and negotiation of the SDGs, the successor to the MDGs. The post-2015 process clearly highlights some of the challenges of multi-level and multi-sectoral governance for health. As the global health policy agenda expands beyond the focus of the MDGs, the position of health within the broader global sustainable development agenda will become more relevant and critical. Indeed, as the global health policy agenda increasingly considers broader issues like the commercial determinants of health and/or planetary health, policymaking will certainly become more contested. The more contested the policymaking is, the more important it is to have a deeper and clearer understanding of how actors will likely seek to exert their power. This also means that analysis could begin to anticipate and predict how or where different state, and non-state, actors might intervene or engage.

A deeper understanding of both why and how states engage and exert power brings a more nuanced and structured framework to assess how actors build alliances and influence others seeking to advance their interests and achieve their goals ultimately affecting and shaping global health policies. An analysis of power also helps identify previously unrecognized ways in which actors engage. Illuminating these efforts and showing how different actors shape policymaking could accelerate efforts to compare and assess different strategies, and ultimately improve how actors engage.

The capacity, skills and ability of different national actors to coordinate their efforts and exert power across the power spectrum is increasingly important as states seek to improve and increase the impact of their engagement. As global health policy has been traditionally dominated by technocrats coming from a biomedical tradition, these new challenges will require the consideration of new skills, including but not limited to expertise like that found in political science and/or political lobbying. This also then shapes who can participate and engage, and privileges which actors can engage how and where.

Globalisation will likely continue to transform global health. To accommodate increased inputs from both developed economies and emerging economies, the global health agenda will likely become broader and less focused to accommodate deeper and growing state engagement. This portends a more contested global health policy, and possibly, a more

fragmented global health governance and global governance for health landscape. This then also means new challenges for international institutions like the United Nations to continue to fulfil their mandate and maintain their relevance as a policy forum for states (and other actors) to set and agree upon global health priorities and policies. The next and final Chapter Eight begins to consider some of these questions.

Chapter Eight

Conclusion and Implications for Future Research

Main Points
- Given states' abilities (and limitations) to exert power and shape priorities, global health policy analysis and literature requires a much more nuanced understanding of the role of state actors. Constructivism is essential for understanding why states engage in global health. Global health policy analysis would also benefit from more research and analysis using a power framework. Applying analytical frameworks focused on power to global health helps deepen understanding and insight into how, where and when different state (and non-state actors) coordinate, collaborate and contest policy priorities.
- The increasingly global nature of health diplomacy and policymaking means that state actors will have to engage more deeply with other institutions within and beyond their borders. Building on partnerships, state actors can also cultivate relationships with national and international academic institutions as well as policy research institutes to develop their technical knowledge and professional networks. These relationships not only facilitate the sharing of expertise, but also serve to cultivate potential allies for future efforts. State actors seeking to engage more should invest in developing their own health policy leaders who have both technical expertise and abilities to operate globally.
- States actors should consider creating explicitly consultative processes to develop global health strategies aligned with existing foreign policies. A more inclusive process (both domestically and globally) can facilitate support for greater engagement across state actors from the highest levels and across bureaucracies to ensure commitment for implementation.
- There is clearly an uneven playing field across state actors, both between and within states, in how they are able to engage and advance their interests in global health. For example, whilst Prime Minister Abe was supportive of Japanese efforts to engage in global health, Indonesia's President was not interested in global health engagement. The support of a high-level leader can be transformational; if not always immediately available, it can also be strategically cultivated. The absence of this support, however, can be a significant barrier to advancing global health issues. With it, however, states can exert institutional, structural and productive forms of non-material power.
- States' abilities to orchestrate actors, including non-state actors, is critical for their ability to exert power and influence the global health agenda. Indeed, it is possible that the most successful states are those able not only to align state actors, but those also able to cultivate and harness the interests and energies of non-state actors.

Introduction

Despite a relative diminution of state actors within global health literature in recent years, this analysis supports the argument that states remain critical actors in global health. Their interactions – why and how states engage and exert power explicitly and implicitly – shape key processes in global health, including the conceptualisation and negotiation of the post-2015, Sustainable Development Goal for health (SDG3). For example, governments in Japan and Indonesia played a decisive role in determining how their states engaged in conceptualizing SDG3. However, as a sub-field of international relations, global health is comparatively new (roughly emerging in the last twenty-five years). To better and more deeply understand global health, there is a need to better appreciate state actors in global health explicitly. Continuing to overlook state actors' role could limit future global health analysis. State actors' roles, explicit and implicit, deserve greater attention to understand why they engage (meaning motives and objectives), how they engage (meaning their approaches and tools), and where they engage (which fora and policy processes).

As explored in the preceding chapters, considering why, how and where state actors engage using a combination of constructivism theory and power analysis provides fresh insights into global health and contributes to deeper, more nuanced understandings of global health politics, policy and practice. This thesis tested a framework applying constructivism to understand why states engage and applied power analysis to assess how and where states engage in the negotiation of global health policies. This research focused on examining why and how state actors engaged in the negotiation of SDG3, particularly why, how and where Japan and Indonesia developed their respective strategies, engaged in and exerted power in the process.

From the early 2000s, the government of Japan deepened its engagement in global health as part of its Overseas Development Assistance (ODA). Japan, as an OECD country, had previously been involved in the creation of the MDGs. Leveraging its position within the G7 and its relationships with both the World Bank and the World Health Organization (WHO), Japan's government sought to play a similar role in the creation of the SDGs. Japanese policymakers focused on universal health coverage (UHC) as part of the Japanese Government's 2013 Global Health Diplomacy Strategy, which was aligned with Prime Minister's "Abenomics" economy policy and revitalized global diplomatic engagement.[535]

In the early 2000s, Indonesia was largely a recipient of the MDGs' influence; however, by July 2012, recognising Indonesia's rising global influence and status as an emerging economy, the United Nations' Secretary-General asked Indonesia's President Susilo Bambang Yudhoyono to co-chair the Secretary-General's High-Level Panel (HLP) of eminent persons on the Post-2015 Development Agenda. President Yudhoyono established a high-level national committee to advise him. Building on Indonesia's MDG experience and as part of the President's broader efforts to reposition the country as both a regional and global "middle" power, the President, this committee and the HLP's report, following a final meeting in Bali, largely defined Indonesia's engagement in the post-2015, SDG process.

This final Chapter starts with this study's Research Questions, and reflects on these in Section One. This section reviews both constructivism and power analysis individually and combined as a potential framework for studying how states engage in global health. This chapter then builds on this to consider how state actors in both Japan and Indonesia engaged and achieved varying levels of success in Section Two as well as what lessons this might hold for states and other actors engaging in global health diplomacy. Finally, Section Three considers implications for future research.

Section One:

Reflecting on Research Questions and a Framework for Studying State Actors

This section starts by reviewing each of the Research Questions and the findings from this research, and considers the utility of constructivism and Barnett and Duvall's power framework for analysing how states engage in global health. This analysis was structured around three research questions (RQs).

The first research question (RQ1) is: *Why do states engage in global health, and particularly why did states engage in the conceptualisation and negotiation of the post-2015, SDG agenda?* This includes additional sub-questions. What are the factors for assessing the determinants of why a state engages in a given global health policy process? Do states seek to influence global health agenda setting for altruistic reasons, or to advance their own interests? In other words, what are states "really" pursuing? Is global health a tool to advance other interests? What do states seek to achieve and what constitutes successful actions?

States engaging in global health are driven by domestic policy objectives. In both Japan and Indonesia, policymakers engaged in global health to advance foreign policy interests as defined by domestic politics. In both states, personal leadership played a critical role, and global health engagement largely served (and was limited by) domestic political interests and constraints. States construct a narrative guiding their engagement in global health, based on their history and other political and strategic considerations – and this narrative determines where and how countries engage. At the same time, there were clear differences between these states, and how they engaged. For example, Japan's engagement was carefully constructed and largely aligned across state actors; Japanese actors proactively sought opportunities to advance their perspective. In contrast, Indonesia's government's engagement was more responsive to specific opportunities, and was not coordinated or aligned.

In Japan, parliamentarians like Keizo Takemi and Yasuhisa Shiozaki collaborated across the government through an explicit process to construct a narrative about why and how the Japanese government's global health engagement should be aligned with broader national policy goals. Japan's engagement in global health was a part of Prime Minister Abe's foreign policy efforts to revitalize and expand industry's access to international markets. Japanese policymakers constructed and advanced an understanding of UHC which would expand Japanese global diplomatic influence and create new economic opportunities for Japanese industry in line with the government's efforts to revitalize Japan's economy (popularly known as "Abenomics").

Japan's global health policy was also a concrete representation of the government's efforts to advance the concept of human security. Japan did not engage in global health and the post-2015 process (solely) to advance altruistic interests, but instead Japanese policymakers used global health as a tool to exert national interests as constructed by Japanese policymakers. As the Abe administration adopted a more assertive foreign policy, global health diplomacy served to help soften Japan's image, particularly with China and Korea. The government advanced universal health coverage (UHC), a concept constructed as "Made in Japan", at the heart of the global health agenda to ensure that UHC was the health sector goal for the post-2015 agenda.

In Indonesia, President Yudhoyono positioned his country as a global middle power and a critical international partner essential to multilateral and global diplomacy. Global health was not part of President Yudhoyono's ambitious foreign policy to project Indonesia's development experience, expand Indonesian influence and accelerate economic development. Global health did not figure as a prominent part of Yudhoyono's domestic or global agenda except when it interfaced with religious or political interests and/or there was an opportunity to project Indonesian leadership globally. In the case of the post-2015 process, Yudhoyono's role as Co-Chair of the High-Level Panel created opportunities for Indonesian actors to engage in global health policymaking. Yet these opportunities were largely unrealised as Indonesian government policymakers did not have an explicit process to develop a global health strategy. Instead, this happened implicitly, and in an uncoordinated manner with different state actors contesting how they should engage. High-level political transitions also complicated Indonesian policymaking.

Yudhoyono's successor, President Joko Widowo, took office in October 2014 and prioritised domestic policymaking over global efforts. In his Presidential campaign, he committed to a focus on domestic health reforms; however, since he came into office, his priorities shifted to national infrastructure and accelerating economic development. These priorities have not allowed much policy space for considering global health policy. Policymakers have yet to begin to construct a narrative on why and how Indonesia can improve and expand its engagement in global health. Advancing domestic efforts on health systems reform, NCD control or planetary health concerns might enable, but are not necessary for, future Indonesia policymakers to construct a compelling narrative for greater global health engagement.

As detailed in the previous chapters, applying constructivism to understand why Japan and Indonesia engaged illustrates insights into how state actors participate in global health policymaking. Both cases showcase how critical the process of (and role of policymakers in) constructing a strategy and compelling narrative is to how state actors exert power. For global health analysis, advocacy and policy, this is a crucial point and highlights the value of constructivism as a theory for understanding and advancing global health policymaking. For example, as described in Chapter Two, Four Lancet Country Series, including the Series on Japan, included articles on these states' roles in global health. While

each of these papers attempt to construct a rationale for why and how these states could expand their engagement in global health, these articles do not use a common framework for analysis to examine national motivations. These Series also have varying levels of engagement with ongoing policy processes. In the future, analysts and researchers might examine Japan's experience to understand how policymakers and academics were able to link their analysis with policy processes and embed them into national foreign policy efforts.

The second research question (RQ2) is: *How did states engage, ie: exert power, in global health, and particularly in shaping the SDGs?* This includes the following sub-questions. How do states construct national global health diplomacy efforts or more broadly a global health policy or strategy, ie: who are the relevant actors within governments (ministries, agencies and parastatals) and beyond states (NGOs, international institutions, other governments) and how do they engage? What is the relationship between these actors, ie: what drives them to engage, and what are their relevant capacities and limitations? Which of these actors are considered most powerful, and according to which measures of power? What are the lessons for others seeking to influence and exert power in global health, and what does this mean for the future of global health? What are the implications of the SDGs, in terms of who drives agendas and how, for global health governance?

State actors dominated the policy process for each country's respective national engagement in the conceptualization of SDG3. These case studies detail how Japan's and Indonesia's global health engagement was determined by actors within these states' respective governments. Driven to engage by domestic national interests, state actors construct global health strategies implicitly or explicitly, largely in line with their national foreign policies. State actors are preeminent given their position, their authority and legitimacy as well as their networks and technical expertise. (This highlights the importance of state actors, but also exposes their limitations.)

National Ministries of Foreign Affairs engage in global health diplomacy policy processes as they view health, at least in Japan's case viewed health, as a policy space where they can exert leadership and advance national foreign policy priorities. Japan's government had an *explicit* strategy to engage; Indonesia's government had an *implicit* strategy. While NGOs, international institutions and other governments might be considered or consulted on global health policy issues, the primary and decisive actors are state actors. These state

actors are not always unitary actors; indeed, they are often negotiating and contesting their relative positions amongst other state actors (the relationship between Ministries of Health and Ministries of Foreign Affairs are particularly critical), and in regard to a head of state. (The next section will consider lessons for others seeking to exert power in global health.)

As showcased throughout the post-2015, SDG process, state actors expressed and exerted differing levels of power through their various global health engagements. Illustrating how state actors exert power enables analysis to classify the different ways they engage, and facilitates greater comparison and assessment of success and failure. (The specific question of success will be considered in the next section.) The post-2015, SDG process signalled emerging economies' rising institutional and structural power as they were able to negotiate and ensure a widening of the agenda relevant for all countries. (The SDG agenda essentially incorporates the MDGs and expands it to include new goals related to environmental sustainability, labour and governance amongst others.) The compromise was that while emerging economies were able to broaden the agenda, OECD states were able to institutionalise the MDGs within the SDGs (integrating all three MDG health goals into SDG3 targets). This new SDG agenda is yet another reflection of the growing and continued contestation of international and global policies between OECD countries and emerging economies.

Emerging economies are expanding their foreign policy efforts to include global health diplomacy. Given shifts in geopolitics and the emerging economies' growing influence, it seems reasonable to expect that more states will exert power and contest global health policymaking. These states might also seek to shift policymaking venues to fora, structures and institutions more favourable to their own ability to exert power. This seems likely to fragment and widen the global health agenda. It could also create opportunities for existing institutions like the WHO to affirm its policy agenda setting role; however, it could also expose new risks as emerging economies position new fora as alternative policymaking spaces for global health and challenge existing policy processes.

The third and final research question is: *Where do states engage in global health, specifically where, how and why did states engage in the process to create SDG 3 for health?* This includes the following sub-questions. How does the process and the conceptualisation of (global) health within the SDGs compare to the MDGs? What was the context and process

for the creation of the SDGs? Why and how did states engage? Did the design of the process shape (benefit or limit) how and why certain states or actors engaged?

States engage in global health in places (when and) where they can exert power and advance their efforts to further domestic interests. Japan *proactively* engages in global health as it sees it as a policy space in which it can exert leadership, and thus advance its foreign policy; to do this, it engages in institutions, policy fora, or structures where it can maximise its power to advance these interests. Indonesia *reactively* engages in global health largely when religious or political interests intersect, or there is an opportunity to project Indonesian leadership globally. Given Yudhoyono's role as a Co-Chair of the post-2015 High-Level Panel, Indonesia's government closely engaged within the official process; in comparison, Japan engaged in the negotiation and contestation of the Sustainable Development Goal for health largely outside or beyond the official process. Whereas Japan's government focused on the health goal with an explicit global health strategy, health was not a priority for Indonesia. Indonesia had competing narratives on how it should engage; however, this was not explicitly articulated, and there was not a widely shared or endorsed understanding of how Indonesia should engage.

As detailed in Chapter Four, the shift in the process from the MDGs to conceptualise the SDGs was profound. Given the geopolitical changes in the last decade, more states can exert institutional and productive power increasingly contesting global policies, potentially leading to broader and potentially weaker agreements. State actors, like others, recognised the critical role the MDGs played in determining global development policy priorities and norms, and thus were committed to engaging in the creation of the successor framework. Indeed, these states insisted that they would have the final say over the SDG agenda.

The experience of the MDGs showcased the potential for states to leverage structural and institutional power to exert productive power for policymaking within the UN system. The process to conceptualise the MDGs was top-down and closed-door; in contrast, the process to create the SDGs was deliberately designed to be bottom up and open-door. The process facilitated and ensured state actors engaged, at least to varying degrees. Indonesia was eager to engage when it was in a leadership position as Co-Chair of the High-Level Panel, but Indonesian state actors were less able and willing to engage when this was not the case

in the SDG process. Japanese state actors, on the other hand, sought to shift the SDG policymaking venue to other spaces where it was better able to exert its own power.

The SDG process was also deliberately designed such that states (primarily Ministries of Foreign Affairs) would be responsible for finalizing, effectively determining, the agenda. While this change to the process made it appear more democratic and perhaps also more legitimate, this might also have implications for implementation. It is too early to compare and assess the SDG framework's implementation with the MDG framework's implementation; however, the SDG framework is a much broader agenda. Compared to the eight MDGs, the post-2015 process negotiated, which lasted more than three years, produced 17 goals and 169 indicators. Despite there only being one health goal in the SDGs compared to the three health goals in the MDGs, the health goal (SDG 3), represents a significant widening of the health agenda compared to the MDGs.

SDG3 incorporates and builds upon the MDGs (Targets 3.1-3.3). Additionally, SDG 3 includes addressing NCDs (Target 3.4) along with drugs and alcohol (3.5), halving the number of deaths and injuries from road traffic injuries (3.6), ensuring access to sexual and reproductive health care services (3.7) and achieving universal health coverage (3.8) as well as reducing the number of deaths and illness from pollution (3.9). SDG 3 also includes four "means of implementation" on the Framework Convention on Tobacco Control (3.A), support for research and development for neglected diseases (3.B), improvements in the financing and recruitment of human resources for health (3.C) and strengthening the implementation of the International Health Regulations (3.D).

As demonstrated in the preceding chapters, combining constructivism with Barnett and Duvall's power framework provides a possible framework for more deeply analysing and understanding why, how and where state actors engage in global health. Having applied this framework to both Japan and Indonesia, this next section will reflect upon what this analysis might mean for considering global health diplomacy "success" and more broadly what lessons this might entail for other state actors seeking to expand their engagement.

Section Two:

Success and Lessons for State Actors and Others in Global Health Diplomacy

Researchers and policymakers alike have long wondered what constitutes success in global health diplomacy.[536] In the case of both Japan and Indonesia, policymakers in both countries largely considered their engagement on health in the post-2015 agenda successful. As detailed in the previous chapters, Japan's government supported engaging at the highest levels on global health. In fact, Prime Minister Abe detailed his commitment to Japan's Global Health Diplomacy strategy in a commentary in the Lancet.[537]

The Japanese government's engagement was comparatively robust (at least compared with Indonesia) in terms of having an explicit global health diplomacy strategy, and dedicated personnel within the Japanese bureaucracy who could leverage resources across the Japanese government. For some global health advocates, this might already constitute success. While the government did not achieve all of its goals, particularly in terms of making UHC the overall goal for SDG3, the Japanese government did exert considerable power to ensure that UHC was an individual target within SDG3 and was more broadly prioritised within the global health policy agenda. It is notable that despite Japan's considerable resources and focused exertion of power, UHC was ultimately not the overall goal for SDG3 as Japan desired, but instead one of the nine SDG3 targets. This shortcoming underlines the limitations of one state's engagement in global health. Nevertheless, Japan's efforts were identified and recognised amongst key informants and policymakers engaged in the post-2015 process. Indeed, Japan's consistent efforts to engage and exert power to position and support a focus on UHC were widely respected and understood. Subsequently, the Japanese government broadly considered its engagement successful.

In contrast, Indonesia's engagement in the post-2015 process was dominated by President Yudhoyono's role as the Co-Chair of the High-Level Panel, but did not include much political support or space to engage on health issues. The Indonesian government did not advance a consistent position on health issues; as detailed in Chapter Six, Indonesian state actors, when they engaged, advanced different positions without a coherent approach coordinated amongst state actors. For Indonesia, success was being at the table, and being seen at the table; the specific position or approach was less important. Despite an opportunity to engage and offer leadership or a vision, Indonesia's government did not exert much power to shape the eventual SDG3. While Indonesia's Ministry of Health supported a focus on continuing the MDGs, controlling NCDs and emphasising strengthening health

systems towards UHC, this position was not stridently advanced and did not enjoy support across government actors. Indonesia's President and the Ministry of Foreign Affairs did not equally or strongly support this position on health. While the position was largely adopted in the eventual SDG3, few, if any, participants in the process would identify or associate this position with Indonesia's government. Indonesia contributed to this outcome, but this position was supported by many others. Indonesia's contributions on health were not widely recognised. It would be difficult to attribute this outcome to Indonesia's engagement; indeed, it is likely this outcome would have occurred without Indonesia's engagement.

Studying how both Japan and Indonesia engaged in this process makes it possible to begin to compare and contrast their engagements to reflect upon what constitutes successful engagement in global health diplomacy. Indonesia's Ministry of Health obtained its goals with little resources, but its likely contribution was minimal and is therefore not recognised as such. In contrast, Japan's government invested comparatively more resources and did not fully achieve its goals, but received considerable recognition for its efforts. These governments had different objectives for their engagement, and thus cannot be assessed in the same way; yet, both actors consider their engagements successful.

Based on both Japan and Indonesia's engagement, future successful global health diplomacy could be predicated on a mix of constructing high-level political support and a compelling narrative for engagement aligned with the state's existing foreign policy which generates support across state actors and coordination and cooperation between state actors. This might also generate a certain amount of recognition from other actors within the policy space. Of course, achieving objectives like shaping and setting the global health agenda would also seem like an obvious hallmark of success; however, this does not always appear entirely necessary for an effort to be considered successful amongst state actors.

Beyond assessing success, this analysis reinforces the enduring importance and centrality of state actors in global health policymaking. This analysis also demonstrates how beyond financial investments, state actors can exert power in global health and shape global health policies and practices for example leveraging an institution like the World Health Organisation or the World Bank. State actor engagement and power are central forces shaping global health. To expand and improve state actors' ability to exert such power, governments might consider reflecting upon how they can cultivate and improve their ability

to wield institutional, structural and productive power more effectively and strategically. Yet these case studies also highlight the limitations of state actors' engagement. They showcase how state actors also might not be able to achieve their objectives.

Since 2000, the role of states in determining and managing health has changed and evolved in response to both globalisation and geopolitical shifts. Without state actors' engagement, the MDGs and SDGs would look substantially different; in fact, these frameworks would not exist as no other actor could enact and implement them. Indeed, state actors cannot be ignored or diminished as they are critical for understanding and implementing global health policymaking. While the MDGs were critical to shaping the global health agenda, the role and influence of the SDGs is not yet known. Based on these case-studies, there are some lessons for states seeking to engage more deeply in global health diplomacy.

First, as state actors engage more deeply in global health diplomacy and policymaking, they should build partnerships and links with other institutions within and beyond their state. These links are not only a way to share experiences and expertise, but can also serve to cultivate potential partners and allies for future engagement. For example, Japan's links and collaboration with Thai partners was useful in terms of both leveraging the Prince Mahidol Award Conference as a venue to exert influence as well as using Thailand's membership in the Foreign Policy and Global Health Grouping (the "Oslo Group"). These sorts of links can also help create institutional and professional networks which can also later be helpful as state actors expand their engagement in global health policymaking.

Second, state actors seeking to engage more should seek to develop global health policy leaders, and their technical expertise and capacity. Indeed, as some Indonesian policymakers recently wrote, "growing interest in a more prominent role [in global health diplomacy], however, needs to be accompanied with the necessary capacity in health diplomacy."[538] Building on partnerships with other actors, state actors can also cultivate relationships with academic institutions as well as policy research institutes both within and beyond their countries to develop their personnel's technical knowledge. This knowledge and these relationships can also contribute towards creating a wider network of experience and expertise which can be useful when and as countries deepen their engagement.

Third, states actors should consider creating consultative processes to develop global health strategies aligned with existing foreign policies. A more inclusive process can also facilitate support for greater engagement across state actors and ensure commitment for eventual strategy implementation. While this analysis only focused on two case-studies, it would seem reasonable to extrapolate based on Japan's experience that global health strategies embedded into existing foreign policy efforts would likely have better chances of being adopted and understood across state actors. As detailed in Chapter Five, Japanese policymakers, in close consultation with domestic and international partners, constructed a narrative aligning Japan's nascent global health strategy within Japan's foreign policy efforts. Aligning how state actors should engage within national foreign policies would not only make them more legible for state actors (beyond foreign ministries), but also make them more easily understood by other global health diplomats, and thus possibly more easily advanced.

Section Three:
Implications for Future Research

Based on these considerations, this section reviews the implications of these case-studies on Japan and Indonesia for future global health research.

First, there needs to be a much more explicit acknowledgment and recognition by researchers of the role of state actors given their abilities (and limitations) to exert power and shape priorities within global health policymaking. For example, recent changes in American politics have exposed the tremendous and dramatic power US government actors have to affect and influence global health policy. The politicization of policy approaches or interventions policymakers believed were long established have been questioned and undermined; for example, American interventions in the 2018 World Health Assembly[539] or the WHO Independent NCD Commission.[540] In the current geopolitical environment, state actors are more visibly exerting their power and making unilateral policy decisions, or perhaps analysts are simply recognising this behaviour more clearly now given some of the ongoing shifts in geopolitics. Commentators have warned about the collapse of the Western order and multilateralism.[541]

While some commentators have expressed concern about US disengagement from global health policymaking, other state actors, like Japan, have been increasing and amplifying their engagement. These recent current events (and the surprised reactions to them) exemplify and showcase how the power of state actors to influence global health is often overlooked. These case-studies highlight why and how other state actors, beyond the most powerful, are actively contesting global health policymaking. To better understand these dynamics and deepen understanding of policymaking in global health, more attention needs to be given to why and how state actors are engaging. These case studies contribute to rebalancing and recognising state actors in global health policy literature.

Second, there is clearly an uneven playing field across state actors, both between and within states, in how they are able to engage and advance their interests in global health. While Prime Minister Abe was supportive of efforts to engage in global health, Indonesia's President was not interested in global health. President Yudhoyono signalled his disinterest within the Cabinet and with other policymakers, which effectively stifled any potential deeper engagement or strategy development. In contrast, Japanese policymakers had prepared for, and possibly contributed to, creating this policy window of opportunity. Indonesian policymakers made no such plans. While the diverging resources of Japan and Indonesia to contribute development assistance for health (DAH) is obvious and recognisable, the divergent abilities of these two governments to exert non-material power and influence within global health is also noteworthy. Building on this research, future research might consider continuing to compare and contrast state actors, and advance conceptual thinking about how to assess state actors' contributions, which will contribute to a more robust understanding of global health policymaking. This is not only necessary for improving these processes, ideally making them more equitable, but also ultimately could and should improve health outcomes.

Third, global health policy analysis could benefit from more research and analysis using a power framework. Applying power frameworks to global health help illustrate, and sometimes unveil, how different state and non-state actors engage to shape and shift policy priority setting. Recognising the ways in which actors exert power might also contribute to making global health analysis more rigorous and robust. Identifying these influences does not necessarily equate to curbing these exertions of power; however, illuminating them

might help begin a discussion about how to improve governance mechanisms and/or possibly enhance the legitimacy of global health policymaking. This being said, there are also limitations. Simply showcasing how actors exert power does not on its own explain decision and policymaking. This analysis applied Barnett and Duvall's framework; however as discussed in Chapter Two, there are multiple possible frameworks, and future research could consider mixing and matching different frameworks. Recognising the limitations of power frameworks, it is also necessary to consider power contestation, ie how to distinguish between varying levels of power and the resolution of power conflicts.

Conclusion

Illustrating and understanding how different actors exert power is critical for future global health policy analysis. It is also critical for designing effective strategies and ultimately improving global health policymaking. Acknowledging and appreciating financial resources will remain important for understanding global health; however, this research, contributes to a growing body of research documenting how nonmaterial factors shape the field. Yet simply highlighting these examples of power in global health policy and practice is not enough. Describing, assessing and interrogating how actors are using nonmaterial factors to contest global health priorities is necessary for a deeper and more nuanced analysis of global health, and is a starting point for enhancing future engagement and eventually improving health outcomes.

For example, the contrast between Japan and Indonesia in their ability to engage is stark. Despite having different objectives from the Indonesians, Japanese state actors and policymakers were able to leverage a legacy of experience engaging in global development discussions to advance their perspective. Building on the capacity of the Japanese bureaucracy, Japanese state actors drew upon individual and institutional networks, technical knowledge and global partnerships to help advance their efforts. In contrast, despite great interest and support for engagement in the post-2015 process, Indonesian actors were not able to wield the same depth of knowledge and relationships to engage. Beyond political support and material factors, there remains an uneven playing field

between actors engaging in global health policymaking and imbalances in how priorities are determined and established.

Moreover, both Japan and Indonesia struggled to engage with non-state actors. While the Japanese government had more domestic institutions to work with, and attempted to engage them, the Indonesian landscape was comparatively limited. In both Japan and Indonesia, the government had limited ability to engage with and develop relationships and alliances with domestic non-state actors; in both cases, this limited these states' abilities to engage and advance their efforts. Future research, perhaps building on the nascent research on global health research networks[542], might consider additional comparative work to assess state actor engagement (including framing and developing global health narratives) as well as how state actors might interact, leverage and collaborate with research networks and other non-state actors.

Annex One: Interview Guides for New York as well as Tokyo and Jakarta, Consent Form and Information Sheet

INTERVIEW GUIDE FOR NEW YORK (AND LONDON AND GENEVA) INTERVIEWS

Introduction

Hello, my name is Robert Marten. I am a part-time research degree student with the London School of Hygiene and Tropical Medicine (LSHTM). I know your time is valuable and I'm grateful you are taking the time to speak with me today.

I'm conducting a study on how countries exert power and influence in global health by examining the post-2015 development process. This research will analyze how and why states (specifically Japan or Indonesia) exerted influence in the conceptualization of the Sustainable Development Goals for health, with a specific empirical focus on power and process. My research will focus on understanding why and how the health SDGs were developed as well as states' roles in their conceptualization. Studying the process to establish the health SDGs will contribute to broader knowledge, and provide a better understanding for future global health policy efforts. This could be useful to enhance global health governance and global governance for health making prospective processes more inclusive, equitable and responsive to health needs, ultimately improving and saving lives.

I am hoping to talk with you for no more than an hour. There are no correct 'answers' – I am just seeking your views, experience and opinions. Please talk to me freely and frankly and let me know if there are any issues I bring up which you do not want to discuss. I will not be attributing your statements to you by name, but will use your official designation and type of institution (eg. Ministry of Health, Ministry of Foreign Affairs, National Health Research Institute, International Institution, Non-Governmental Organization, etc.). You can also let me know if there is another way I should cite your statements in my reports and publications.

Please let me know if you have any questions. Once I address those, we'll get started.

Participant Information Could you tell us/me about your work experience?

1. Organization_____
2. Position_____   3. Department   _____

5. No of years in current position_____   6. Date of Interview _____

BACKGROUND/WARM-UP

1.   Can you outline your understanding of the post-2015 Sustainable Development Goals and the process to create them? How does this relate to the Millennium Development Goals?

2.   What's your view on the Sustainable Development Goals? What are their major strengths and major weaknesses?

3.   How important was health? Why?

THE PROCESS and CONTEXT OF THE SDGs (plus POWER)

4.   What was the general context for the process to create and conceptualize the SDGs

5.	How was your institution involved in this process? What was your role, and engagement in the creation of the SDG process?

6.	What role did the process and experience to establish the Millennium Development Goals play in the design of the creation of the Sustainable Development Goals?

7.	What do you see as global governance related to health? Which are the key institutions and how do they relate? How do the Sustainable Development Goals fit into this global governance?

8.	How impactful do you think the SDGs will be?

9.	Which actors were important in both designing the process, and then the process itself? Why? Who was most powerful? Why and on what basis would you consider these actors as particularly powerful? What do you understand "power" to mean?

10.	How important were states in the process?

WHY DID STATES ENGAGE?
11.	What was the nature or form of national engagement in the SDG process? Why did it take that form?

12.	Did the design of the process benefit certain states or actors? Did states engage? Ie: what were states "really" pursuing?

HOW DID STATES ENGAGE?
13.	How did states engage, ie: exert power and influence, in shaping this process and these goals? For example, did states use enticements to encourage other states to support their positions? Did states use international institutions to support their interests? Did states leverage policy entrepreneurs and policy research?

14.	Who were the relevant actors aside from states? (b) Which government actors (ministries or agencies) are/were involved? (c) Which NGOs? Think tanks? Or universities? Others?

ADDITIONAL ACTORS
15.	Which other (international) institutions, actors or individuals are involved how?

16.	Is there a difference amongst actors within and beyond states?

FINALIZING THE SDGs
17.	How was the health goal formulated, and where did the health goal fit into the broader framework?

18.	Are you content with the outcome? With the process? Do you consider it successful?

19.	Do you think you would have achieved a different, or a better outcome if the process would have been different?

CONCLUSION
20.	Is there anything else you would like to add about the issues we have discussed and your role?

21.	Are there any other people either within or outside your organization with whom it would be beneficial for me to speak? Would you be willing to be contacted again if I need to clarify anything in the future?

Thank you very much for participating in this interview. It takes time to participate in these surveys and I very much appreciate your valuable time.

INTERVIEW GUIDE FOR TOKYO AND JAKARTA

Introduction

Hello, my name is Robert Marten. I am a part-time research degree student with the London School of Hygiene and Tropical Medicine (LSHTM) (and Nagasaki University /or/ the University of Indonesia). I know your time is valuable and I'm grateful you are taking the time to speak with me today.

I'm conducting a study on how countries exert power and influence in global health by examining the post-2015 development process. This research will analyze how and why states (specifically Japan or Indonesia) exerted influence in the conceptualization of the Sustainable Development Goals for health, with a specific empirical focus on power and process. My research will focus on understanding why and how the health SDGs were developed as well as states' roles in their conceptualization. Studying the process to establish the health SDGs will contribute to broader knowledge, and provide a better understanding for future global health policy efforts. This could be useful to enhance global health governance and global governance for health making prospective processes more inclusive, equitable and responsive to health needs, ultimately improving and saving lives.

I am hoping to talk with you for no more than an hour. There are no correct 'answers' – I am just seeking your views, experience and opinions. Please talk to me freely and frankly and let me know if there are any issues I bring up which you do not want to discuss. I will not be attributing your statements to you by name, but will use your official designation and type of institution (eg. Ministry of Health, Ministry of Foreign Affairs, National Health Research Institute, International Institution, Non-Governmental Organization, etc.). You can also let me know if there is another way I should cite your statements in my reports and publications.

Please let me know if you have any questions. Once I address those, we'll get started.

Participant Information Could you tell us/me about your work experience?

      1. Organization   _____
2. Position_____   3. Department   _____

4. No of years in current position_____   5. Date of Interview _____

BACKGROUND/WARM-UP

6. Can you outline your understanding of the post-2015 Sustainable Development Goals and the process to create them? How does this relate to the Millennium Development Goals?

7. What's your view on the Sustainable Development Goals? What are their major strengths and major weaknesses?

THE PROCESS and CONTEXT OF THE SDGs (plus POWER)
8. What was the general context for the process to create and conceptualize the SDGs, and how is this seen from your country?

9. How was your country, and your institution specifically, involved in this process? What was your role, and engagement in the creation of the SDG process?

10.   What role did the process and experience to establish the Millennium Development Goals play in the design of the creation of the Sustainable Development Goals?

11.   What do you see as global governance related to health? Which are the key institutions and how do they relate? How do the Sustainable Development Goals fit into this global governance?

12.   How will the SDGs impact your country? Did the design of the SDG process benefit your country? Do you think the SDGs will benefit your country moving forward? If so, how? If not, why not?

13.   Which actors were important in both designing the process, and then the process itself? Why? Who was most powerful? Why and on what basis would you consider these actors as particularly powerful? What do you understand "power" to mean?

WHY DID STATES ENGAGE?
14.   What was the nature or form of [your country's] engagement in the SDG process? Why did it take that form? Do you think there should have been another or different form of engagement?

15.   (Why) Did your state engage? Ie: what was it "really" pursuing? Was your country engaging for its own interests? Was your country engaging to support international institutions? Was your country engaging to support the idea and creation of the SDGs?

HOW DID STATES ENGAGE? And WHICH ACTORS?
16.   How did your state engage, ie: exert power and influence, in shaping this process and these goals? For example, did your state use enticements to encourage other states to support their positions? Did your state use international institutions to support their interests? Did your state leverage policy entrepreneurs and policy research?

17.   Who were the relevant actors within your state? (b) Which government actors (ministries or agencies) are involved? (c) Which NGOs? Think tanks? Or universities?

18.   Who were the relevant actors beyond or outside your state? (b) Which government actors (ministries or agencies) are involved? (c) Which NGOs? Think tanks? Or universities? Is there a difference amongst actors within and beyond states?

19.   Were there other actors you haven't mentioned which were involved? Which other (international) institutions, actors or individuals are involved how?

FINALIZING THE SDGs
20.   What was your country's position on health within the SDGs, and how does this compare to the final framework? Where does the health goal fit into the broader framework?

21.   Are you content with the outcome? With the process? Do you consider it successful? (And on what basis do you consider this "successful"? Do you think you would have achieved a different, or a better outcome if the process would have been different?

CONCLUSION

22.   Is there anything else you would like to add about the issues we have discussed?

23.   Are there any other people either within or outside your organization with whom it would be beneficial for me to speak? Would you be willing to be contacted again if I need to clarify anything in the future?

Thank you very much for participating in this interview. It takes time to participate in these surveys and I greatly appreciate your valuable time.

Information for Participants
Study Title:
The Sustainable Development Goals: Understanding why and how states exert power and influence in global health

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

1.   What is the purpose of the study?
This study is examining how countries exert power and influence in global health, and the post-2015 development process. This research will analyse how and why states, specifically Japan and Indonesia, exerted influence in the conceptualization of the health SDGs, with a specific empirical focus on power and process. This research will focus on understanding why and how the health SDGs were developed as well as states' roles in the SDGs' conceptualization. Studying the process to establish the health SDGs will contribute to broader knowledge, and provide a better understanding for engaging in future global health policy processes. This could be useful to enhance global health governance and global governance for health making prospective processes more inclusive, equitable and responsive to health needs, ultimately improving and saving lives.

2.   Why have I been chosen?
You are being invited to take part in this research project because your engagement and experience in shaping, influencing, or supporting the development of the post-2015 development agenda for health will help illuminate the process and provide valuable insights for this study.

3.   Do I have to take part?
It is up to you if you want to join the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. Your participation in this research is completely voluntary. You will make the choice about whether you will participate or not.

4.   What will happen to me if I take part?
You will be interviewed for roughly one hour. Once this study is finished, I will share draft sections of materials which include any direct quotations for your approval. I will also share my final published results. This is a qualitative research project that will use interpretive methods including analysis of documents as well as in-depth semi-structured interviews with those participating.

5.   What do I have to do?
Please talk to me freely and frankly and let me know if there are any issues I bring up which you do not want to discuss. There are no correct or incorrect answers.

6.   What are the possible disadvantages and risks of taking part?
There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics in this study. However, I do not wish for this to happen. You do not have to answer any question or take part in the survey if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

7.   What are the possible benefits of taking part?
There are no direct benefits available to you through taking part in this study, but your participation is likely to contribute to a better understanding of global health governance and global governance for health making prospective development agenda-setting processes more inclusive, equitable and responsive to health needs, ultimately improving and saving lives

8.   Will my taking part in the study be kept confidential?
Yes. All information collected about you during the course of the research will be kept strictly confidential.

9.   What will happen if I don't want to carry on with the study?
You do not have to participate in this research if you do not wish to do so. If you withdraw from the study, I will destroy all data collected from you.

10. What will happen to the results of the research study?
The knowledge collected in this study will be published.

11. Who has reviewed the study?
This study was given a favourable ethical opinion by the London School of Hygiene and Tropical Medicine's Research Ethics Committee.

12. Contact Details
If you have any questions, you can ask me now or later. If you have questions later, please feel free to contact:

Robert Marten, +1-347-439-3578 or Robert.Marten@lshtm.ac.uk
c/o the London School of Hygiene and Tropical Medicine
15-17 *Tavistock Place*, London, WC1H 9SH
United Kingdom

You will be given a copy of the information sheet and a signed consent form to keep.

Thank you for considering taking the time to read this sheet.

INFORMED CONSENT FORM

Full Title of Project:

The Sustainable Development Goals:
Understanding why and how states
exert power and influence in global
health

Name of Principal Investigator: Robert Marten

**Please
initial box**

1. I confirm that I have read and understand the participant information sheet dated .... (version ....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered fully.	
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	
3. I agree to take part in the above study.	

Name of Participant	Signature	Date
(printed)		
Principal Investigator	Signature	Date

Annex Two: Lists of Interviews in New York (and Geneva and London) as well as Tokyo and Jakarta

New York (plus London and Geneva) Interviews
12 Interviews with 13 individuals

1. Two NGO Officials (November 18, 2015)
2. NGO Official (December 3, 2015)
3. Senior Academic (December 4, 2015)
4. UNICEF Official and member of the post-2015 Task Team (December 10, 2015)
5. WHO Official and member of post-2015 Task Team (December 15, 2015)
6. Senior National Ambassador of Key Country in OWG (December 15, 2015)
7. National Counselor Officer of major country engaged in the process (May 16, 2017)
8. Senior UNDP Official (May 17, 2017)
9. Senior UNDP Official (July 20, 2017)
10. Senior UNICEF Official (July 7, 2016)
11. Senior NGO Representative (July 8, 2016)
12. Senior Official in the HLP Process (May 22, 2018)

Tokyo Interviews
29 Interviews with 32 Individuals

1. Official at Japanese Mission in UNHQ (in New York) (December 17, 2015)
2. NGO Official (May 6, 2016)
3. Senior Academic and Adviser to the Government (May 6, 2016)
4. Senior NGO Official (May 9, 2016)
5. Three Officials in the Ministry of Foreign Affairs (May 11, 2016)
6. Private Sector Representative (May 11, 2016)
7. Senior Academic and Adviser to the Government (May 12, 2016)
8. JICA Official (May 12, 2016)
9. NGO Representative (October 6, 2017)
10. JICA Official (October 6)
11. NGO Representative (October 10, 2017)
12. Academic Researcher (October 19, 2017)
13. Senior Official at JICA (October 20, 2017)
14. Private Sector individual, former Ministry of Finance (October 20, 2017)
15. Senior WHO Official (October 27, 2017)
16. Academic (November 7, 2017)
17. Private Sector Representative and former senior JICA official (November 16, 2017)
18. Senior Academic (November 17, 2017)
19. Senior Academic (November 20, 2017)
20. JICA Official (November 21, 2017)

21. Private Sector Representative and former Senior WHO Official (November 22, 2017)
22. Politician and former Ministry of Foreign Affairs (December 11, 2017 and March 15, 2018)
23. Two Officials in the Ministry of Finance (February 5, 2018)
24. Official in the Ministry of Finance (February 6, 2018)
25. Official in the MoHLW (March 1, 2018)
26. NGO Representative (March 6, 2018)
27. Senior Official in the Ministry of Foreign Affairs (May 16, 2018)
28. Politician and former MoHLW (May 17, 2018)
29. Senior Ministry of Foreign Affairs (July 18, 2018)

Jakarta Interviews
23 Interviews with 27 Individuals

Interviews Completed in October 2016
1. Senior Academic (10/3/2016)
2. Three officials from the Ministry of Health (10/4/2016)
3. Senior Official in the Ministry of Health (10/5/2016)
4. Former Staff Member in President's Special Envoy on MDGs office (10/5/2016)
5. Health Official within the Office of the Vice President (10/6/2016)
6. State Official, Formerly with the Delivery Unit (10/11/2016)
7. Two Officials from the Ministry of National Planning (BAPPENAS) (10/13/2016)
8. Civil Society Representative (10/13/2016)
9. Senior Official in the Ministry of Foreign Affairs (10/13/2016)

Interviews conducted in early March 2017
10. Former Staff Member in President's Special Envoy on MDGs office (10/5/2016)
11. United Nations Development Program Staff (3/2/2017)
12. Official in the Ministry of Foreign Affairs (3/2/2017)
13. Private Sector Representative, Former Member of the President's Delivery Unit (3/3/2017)
14. NGO Representative (3/3/2017)
15. NGO Representative (3/6/2017)

Interviews Conducted in November 2017
16. United Nations Development Program Staff (31/10/2017)
17. Private Sector Representative, Former Member of the President's Delivery Unit (31/10/2017)
18. Two Senior Members of the Ministry of Foreign Affairs (31/10/2017)
19. NGO Representative (1/11/2017)
20. Ministry of Foreign Affairs Official (2/11/2017)

Interviews Conducted in March 2018
21. Ministry of Foreign Affairs Official (March 29, 2018)
22. Former Ministry of Health Senior Official (March 31, 2018)
23. Former Senior Ministry of Health Official (July 25, 2018)

Annex Three: Published Articles, as part of, or related to this Thesis

These follow after the endnotes.

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Power: The nexus of global health diplomacy?

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Power: The nexus of global health diplomacy?

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Earlier this year the US government established a new Office of Global Health Diplomacy. Following a number of other countries, the Japanese Prime Minister recently launched his country's Global Health Diplomacy strategy. Commentaries in the Lancet, in the WHO Bulletin, and even the launch of this journal, confirm global health diplomacy as an issue of growing relevance and importance (see Jaffe, 2013; Seiff, 2013; Abe, 2013; Kickbusch & Kokeny, 2013). Yet three critical, and interlinked, research questions remain to be understood. First, what exactly is global health diplomacy, and how should it be defined? Second, how can we measure or assess global health diplomacy effectiveness? Third, what are the key determinants of 'successful' or 'effective' global health diplomacy? These questions, and the interface between them, should be the core focus of this journal. We suggest that the concept of power links all of these questions, and is critical to understanding and assessing global health diplomacy.

A definition for global health diplomacy has been much discussed and debated. Definitions range from normative, "an emerging field that addresses the dual goals of improving global health and bettering international relations" (Adams et al., 2008), or "winning hearts and minds of people in poor countries by exporting medical care, expertise and personnel to help those who need it most" (Fauci, 2007) to a more technical, "multi-level, multi-actor negotiation processes that shape and manage the global policy environment for health" (Kickbusch et al., 2008). Scholars have classified different types of global health diplomacy; one such analysis found three categories of global health diplomacy: 1) core or formal diplomacy between or amongst countries (e.g. the Framework Convention on Tobacco Control); 2) multi-stakeholder diplomacy between and amongst state, non-state and multilateral actors (e.g. the Global Fund or the GAVI Alliance); and 3) non-official interactions between state representatives (e.g. personnel from the American Center for Disease Control (CDC) health serving outside the United States) (Katz et al., 2011).

The Global Health Diplomacy Network (GHD.Net), a group of academics and practitioners, recently suggested that GHD be defined as "the policy-shaping processes through which states, intergovernmental organizations, and non-state actors negotiate responses to health challenges or utilize health concepts or mechanisms in policy-shaping and negotiation strategies to achieve other political, economic, or social objectives" (GHD.Net, 2009). Although not perfect, this definition seeks to explicitly balance the utilization of health to achieve foreign policy goals and the utilization of foreign policy to achieve health goals. Of course, what it does not do is indicate the likely imbalance in power that results in the former application being perhaps more prevalent than the latter at present. In both cases, however, global health diplomacy may be thought of as the "software" that enables the dynamic processes of negotiation to occur between various levels of actors and institutions (the "hardware" of global health diplomacy). These diplomatic policy processes are clearly

about different aspects of power like attraction, persuasion, coercion and compulsion (Smith, 2010), and about overt, covert and latent power (Lukes, 2005). Regardless of the exact definition, power is a critical underlying feature of global health diplomacy. Defining global health diplomacy, or forms of it, depends on actors' relative power, and the type of power observed or deployed.

Understanding how we can measure or assess global health diplomacy effectiveness necessarily depends on the intended goal of the efforts and type of power. Is global health diplomacy about getting A to do what B wants (by whatever means necessary) or is it about getting A to come to the realization that it wants the same as B (and change its respective values or norms)? Each approach will be based on different forms, or dimensions, of power. For example, this could be compulsory (direct power, such as use of military or legislative force), institutional (indirect power, such as how international institutions are designed to favour one actor over another), structural (the overall constitution or framework of actor and their roles- this is a form of ideological power) or productive (control over the possession and distribution of resources, or economic) power (Barnett & Duvall, 2005), or hard or soft power – there are different ways of assessing and analyzing power, and these could be adapted according to the specific context. Assessing power could be a method to measure global health diplomacy. For example, when country X proclaims a certain objective in their global health strategy, the concept of power can be used to analyze their relative ability, be it successful or not, to reach this diplomatic objective.

Assessing the relative importance of various forms of power could help identify the key determinants of 'successful' or 'effective" global health diplomacy. For example, one could argue that deploying coercive power is more tenuous and subject to change if relations evolve, whereas changing values or norms is a more long-term and sustainable approach. If country X is looking for a yes or no vote on an issue, using hard power might be more effective; however, if country X is promoting a new approach to financing health systems, a soft approach might be more impactful. Depending on the goal, for example, deploying hard or soft power could thus be a determinant or a mechanism of global health diplomacy.

To understand global health diplomacy, studying the dynamic relationships, policies and processes between actors and institutions is necessary; to understand these interactions, power is the critical unit to study to help assess and understand how countries influence global health policy. This could contribute to developing a conceptual framework to better understand why certain health diplomacy efforts succeed or fail. Designing such a framework is critical for improving global governance and global health governance. Better and deeper knowledge of what determines this effectiveness will create more inclusive and equitable governance mechanisms, which will be more responsive to health needs globally and ultimately improve and save lives.

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Commission on Global Governance for Health: what about power?

The Lancet—University of Oslo Commission on Global Governance for Health (Feb 15, p 630)[1] articulates the various global non-health sector influences on health—namely, the global political determinants of health. The recognition of these effects is not new, but articulating a compelling way to refer to them is a useful contribution and will help to shape the future research agenda. The Commission highlights the way in which some actors are able to exert disproportionate levels of influence to serve their interests. We commend the Commission for identifying these serious power disparities in global governance, and illustrating their profound implications for health. The Commission has provoked attention to these political realities and created an important discussion. Yet the Commission's recommendations, as the companion Youth Commission[2] noted, "are likely to be influenced by the same diverging interests and power asymmetries described by the Commission". We would like to propose a possible path forward.

To tackle the global political determinants of health, there is first a need for more rigorous analysis of how national, international, and institutional actors shape and influence the global political determinants of health. The Commission refers to power, but it does not consider the need to better understand empirically how power is expressed in global health governance. The fields of international relations, sociology, and philosophy, however, do apply power as a conceptual lens for understanding how actors behave. While global health scholars led by Gill Walt[3] have explored how power is expressed and exercised, power could be particularly useful to understand the global political determinants of health.

There are a number of analytical frames to better understand or investigate power. Robert Dahl[4] proposed power as decision making (ie, A forcing B to do A's choice against B's will). Peter Bachrach and Morton Baratz[5] argued for the importance of non-decision making (A confines B's spectrum of possible choices); this has also been called the mobilisation of bias. Steven Lukes[6] considered power as thought control (ie, A makes B want A's choice). Together these three approaches to assess power, be it overt, covert, or latent, present one possible framework. Michael Barnett and Raymond Duvall[7] presented another frame based on four approaches to power—namely, compulsory, institutional, structural, and productive forms.

These frameworks, or a mix of them, could be a useful place to begin. A greater and more explicit focus on power as a tool for analysis of global political determinants of health can help to illuminate how actors create and exploit disparities to serve their interests. Crucially, a better understanding of power, which is especially important with the rise of non-health and non-state bodies' influence over the global policy environment within which health systems must navigate, will allow for the design of policies and processes to redress disparities.

We declare no competing interests.

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A platform for a Framework Convention on Global Health

The right to health provides the foundation to accelerate recent global health gains, extend them to the most excluded populations, and fortify them against threats beyond the health sector. Yet states often fail to meet their obligations. And the national focus can diminish effectiveness because solutions require global cooperation, from shared financing and capacity building to global norms and accountability.[1]

An innovative global health treaty—a Framework Convention on Global Health—could establish a right to health for the 21st century. The binding power of law would enhance the ability of civil society advocates to hold governments accountable through courts, parliaments, and the media, while creative incentives and sanctions would encourage compliance. Through international law, the Framework Convention on Global Health would ensure respect for the right to health within other legal regimes, such as trade, investment, and intellectual property—aspects of which might otherwise undermine this right.

A treaty could establish the legal framework to achieve the grand convergence in global health envisioned by the *Lancet* Commission on Investing in Health.[2] A Framework Convention on Global Health could chart the path towards true global health convergence, both among countries and within them, demanding the full gamut of actions to close domestic and international health inequalities that leave poorer and marginalised populations dying earlier than the well-off.

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Commentary

Global Health Warning: Definitions Wield Power

Comment on "Navigating Between Stealth Advocacy and Unconscious Dogmatism: The Challenge of Researching the Norms, Politics and Power of Global Health"

Robert Marten[1,2*]

Abstract
Gorik Ooms recently made a strong case for considering the centrality of normative premises to analyzing and understanding the underappreciated importance of the nexus of politics, power and process in global health. This critical commentary raises serious questions for the practice and study of global health and global health governance. First and foremost, this commentary underlines the importance of the question of what is global health, and why as well as how does this definition matter? This refocuses discussion on the importance of definitions and how they wield power. It also re-affirms the necessity of a deeper analysis and understanding of power and how it affects and shapes the practice of global health.
Keywords: Global Health, Power, Policy
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In this journal, Gorik Ooms recently made a strong case for considering the centrality of normative premises to analyzing and understanding the underappreciated importance of the nexus of politics, power and process in global health.[1] Here and elsewhere,[2] he argues that if global health scholars continue to avoid acknowledging and debating normative notions, they "not only mislead each other," but risk limiting the evolution and maturation of the field of global health. Ooms recognizes that while public health at the national level is usually predicated on the norm that it is the state's responsibility for improving health, there is no such equivalent norm for global health. This lack of a unified narrative normative framework at best limits the evolution of global health as a field and at worst endangers the coherence and maturation of the field.

Building on Ooms, there are numerous normative narratives within global health which compete to capture policy-makers' attention and resources. Consider the recent example of the Ebola outbreak in West Africa to illustrate what this means and why it matters. Some advocates within global health call and have been calling for using burden of disease analysis to be used for setting priorities, but as Grepin recently noted, "if burden of disease metrics are the only criterion that should be used to set resource allocation priorities, then, according to this logic it was perfectly acceptable that the world invested so little in epidemic preparedness, such as Ebola."[3] Given the impact of the outbreak, this now appears questionable. Other actors within global health advocate adherence to the International Health Regulations for determining which health challenges constitute priorities in terms of a Public Health Emergency of International Concern (PHEIC); however, as Yach et al recently described, "the current framing of health security focuses almost entirely on infectious diseases" and largely overlooks other threats to global health like non-communicable disease (NCD).[4] The case of HIV/AIDS also offers a few different examples with advocates arguing alternatively that HIV/AIDS was a security threat, a looming economic disaster or a challenge to human rights and law. In these examples, as Ooms warns, actors and advocates avoid stating their normative values and risk serving as "stealth advocates" overstating their case. But what does this mean, why does it matter and how does it limit the maturation of global health as a field?

Ooms' commentary raises critical questions for the practice and study of global health and global health governance. First and foremost, this underlines the centrality of the question of what is global health, and why or how does this definition matter? This refocuses discussion on the importance of definitions and how they wield power. It also re-affirms the necessity of a deeper analysis and understanding of power and how it affects and shapes the practice of global health.

What Is Global Health and Why Does It Matter?

Defining and determining what is and what is not considered global health remains contested. Global health was coined partly in response to globalization and the rise of the field of global governance, which explicitly identified the rise of other actors alongside or beyond the state. Whereas public health acknowledges the state as a dominant actor, global health recognizes the rise of other actors like international institutions, civil society and the private sector affecting health and health policies transcending states. Yet in reality, the practice of global health often focuses on health in poor countries in Africa and Asia, and still represents more of a continuation of the field of international health.[5] The field of global health rarely addresses the interconnected nature

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of truly "global" health challenges between and across continents. As Frenk et al argue, "the notion of global health fails itself to capture the essence of globalization [and there is a real] need to globalise the concept of global health." Largely influenced and shaped by the HIV/AIDS emergency,[6] the current field of global health is, as Kleinman argued, "more a bunch of problems than a discipline."[7] Lacking a clear definition limits research, which inhibits understanding as well as the possibility of improving health.

While an agreement on a single definition of global health remains contested and elusive, there is a growing consensus around the importance of why and how a definition matters.[8,9] It matters for which issues are and are not considered, which issues receive funding and accordingly which issues are studied and addressed. How global health is understood influences which health challenges are addressed, the design of how funds are raised and allocated, the public discourse and how policy-makers consider issues, the education of students as well as the creation of institutions.[10] The Millennium Development Goals (MDGs) conceived around the same time as the emergence of the term global health illustrate this.

In 2000, the United Nations (UN) agreed upon the Millennium Declaration in 2000 from which the MDGs were conceived. MDGs Four, Five, and Six (Reduce Child Mortality, Improve Maternal Health and Combat HIV/AIDS, Malaria and other diseases) determined the health challenges addressed, shaped how funds were raised and spent, enabled new policies, created public awareness and influenced the design of, amongst other institutions, the Global Fund to Fight AIDS, Tuberculosis and Malaria as well as the GAVI Alliance for Vaccines. The MDGs both shaped the conceptualization of global health, and reflect the representation of a 2001 normative global health agenda. In fact, the MDGs became the overarching framework for global development efforts and are "arguably the most politically important pact ever made for international development."[11,12] Fukuda-Parr and Hulme argue the MDGs represent a new "super-norm."[11,13] The MDGs both reflected an emerging conceptualization of global health, and contributed to advancing this conceptualization. Indeed, even in 2014, roughly $23 billion out of a total of $36 billion of Development Assistance for Health (DAH) was directed towards MDGs Four, Five, and Six whereas only $611 million was directed towards NCDs. While the spending of DAH is one way to exert influence, this conceptualization of global health in line with the MDGs, a new normative framework to end poverty, also shapes and determines which issues and challenges are considered and researched. In other words, normative views and frameworks can exert power, and as Shiffmann cogently argues, "power is exercised everywhere in global health although its presence may be more apparent in some instances than others."[14]

Understanding Power and How It Affects Global Health
The role of politics and power in determining policy are often underappreciated and underutilized. As Ooms' commentary as well as others in this journal demonstrate, there is a need for a much deeper and more nuanced understanding of power in global health. As Erasmus and Gilson argue, "power, a concept at the heart of the health policy process, is surprisingly rarely explicitly considered in the health policy

implementation literature."[15] Who has and exerts power, and how? What are the resources of power? The most obvious resource in global health are financial or material resources, but there are also other resources and ways to express power. To better understand how power is exerted, there is a need to identify and develop methodologies for assessing power in global health.

Global governance scholars Barnett and Duvall present a useful framework for understanding power, which they define "as the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate."[16] They differentiate between specific and diffuse relations as well as direct and indirect forms of power—namely, compulsory (direct power, such as use of military or legislative force), institutional (indirect power, such as how international institutions are designed to favor one actor over another), structural (the overall constitution or framework of actor and their roles) or productive (control over the possession and distribution of resources) power.[17] Beyond methodologies, there is a need for a number of case studies to illustrate how different actors – institutions, states, non-governmental organizations (NGOs), private sector organizations, and networks – use and exert power to establish authority and legitimacy in global health. One of the classic examples is the role of the tobacco industry in exerting power to manipulate global health policy, but more recently, evidence of other private sector actors, like Coca Cola, have come under greater scrutiny for their efforts to fund research and shape public discussions. But there are many other examples that are less prominent and less well-understood. For example, consider the role of various NGOs working across Africa—these often work on behalf of the foreign governments or wealthy individuals advising governments and delivering health services, or the role of states like Germany or Japan using the G7 to shape new priorities for global health spending. Alternatively, institutions like the World Bank try to shape and influence discussions around responding to the Ebola crisis and reforming global health governance. Having a more robust understanding of how power is exerted also enables a discussion to consider effectiveness. While there are some frameworks that examine agenda-setting in global health,[18] there is not yet an established methodology or framework to assess and measure effectiveness in exerting power to influence and shape global health policy.

Of course, understanding the importance of the definition of global health and how it exerts power requires some reflection on who is practicing global health and how. While some argue that "global health is usually more inclusive of social sciences than public health or international health" it will require much greater efforts to ensure that global health is truly multi-disciplinary. How might this happen? How could we accelerate the evolution and maturation of global health? This question should be at the top of the agenda in academic centers of excellence and the leading journals in global health.

Author' contribution

RM is the single author of the manuscript.

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Commentary

State Support: A Prerequisite for Global Health Network Effectiveness

Comment on "Four Challenges that Global Health Networks Face"

Robert Marten[*], Richard D. Smith

Abstract
Shiffman recently summarized lessons for network effectiveness from an impressive collection of case-studies. However, in common with most global health governance analysis in recent years, Shiffman underplays the important role of states in these global networks. As the body which decides and signs international agreements, often provides the resourcing, and is responsible for implementing initiatives all contributing to the prioritization of certain issues over others, state recognition and support is a prerequisite to enabling and determining global health networks' success. The role of states deserves greater attention, analysis and consideration. We reflect upon the underappreciated role of the state within the current discourse on global health. We present the tobacco case study to illustrate the decisive role of states in determining progress for global health networks, and highlight how states use a legitimacy loop to gain legitimacy from and provide legitimacy to global health networks. Moving forward in assessing global health networks' effectiveness, further investigating state support as a determinant of success will be critical. Understanding how global health networks and states interact and evolve to shape and support their respective interests should be a focus for future research.
Keywords: Global Health, Health Policy, Global Health Networks

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Introduction

Shiffman recently summarized lessons for network effectiveness from an impressive collection of case-studies across tobacco use and alcohol harm, maternal and neonatal mortality, early childhood development and surgically-treatable conditions as well as tuberculosis and pneumonia.[1] The networks involved in these areas, and their effectiveness, matter as they contribute to the shaping and framing of areas competing for attention and resources in global health. Recognizing that their effectiveness is determined by strategic decisions and contextual factors, including historical legacies, current political environments and specific issue characteristics, Shiffman argues persuasively how these networks are likely to achieve better results when they construct compelling framings and build broad strategic coalitions.[2] Based on this analysis, Shiffman suggests more generally that networks face four challenges in generating attention and resources: problem definition; positioning; coalition-building; and governance.

However, in common with most recent global health governance analysis, Shiffman underplays the important role of states in these global networks in his analysis. Shiffman argues, "The spread of these [global health] networks represents a transformation in the way global health is governed: from a system largely dominated by hierarchical

forms of organization—particularly nation-states and inter-state organizations—to one also characterized by horizontal networking and growing participation of non-state actors." Our commentary questions the basis of this assertion, and poses the question if, instead states' roles might simply be evolving. As the body which negotiates and signs international agreements, (often) provides the resourcing, and is responsible for implementing and prioritizing initiatives, state recognition and support is a prerequisite to enabling and determining global health networks' success. The role of states deserves greater attention, analysis and consideration, particularly when considering new or emerging actors like networks. In this response, we first contextualize the underappreciated role of the state within the current conceptualization and discourse on global health. Second, we use the tobacco case study to showcase the decisive role of states in determining progress for global health networks. Third, we highlight how states use a legitimacy loop to gain legitimacy from and provide legitimacy to global health networks.

The Underappreciated Role of States Within Global Health

Discussions of globalization and global governance continue to grapple primarily with the evolving role of non-state actors in a rapidly changing world.[3] Definitions remain contested, but global governance generally focuses on the management

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of challenges previously considered within the domain of a sovereign state, and are now considered unmanageable by single or multiple states.[4] Global governance and global health share a focus on transnational issues and a need to go beyond the state to address new challenges. Globalization, and the accompanying proliferation of new actors, changed and challenged the role of states within global health governance. During the 2002 SARS situation, for example, the World Health Organization (WHO) assumed and asserted authority over individual states, supporting the perception of major a change in what Fidler called "Westphalian public health."[5] This decline of the state and rise of an assertive WHO secretariat supported by global civil society and transnational media networks resonated with scholars seeking to understand a growing shift away from the state. Indeed, some argued that the state was becoming "hollowed out" by globalization[6] and that the global health governance landscape was so fragmented that states no longer held power over policy-making.[7] However, reports of the 'death' of states within global health governance may be 'greatly exaggerated.'[8] While recognizing the rise of new actors and partnerships, the state remains a dominant and decisive actor in global health.

For example, in the SARS case, states did not contest WHO's assumption of broader powers as SARS containment served their interests; if it had not and threatened their interests, they could have blocked or ignored WHO. For example, just a few years later in 2007, Indonesia did just this. Indonesia refused to share avian influenza samples with the global community.[9] More recently in the wake of Ebola, 58 states party to the apparently legally binding International Health Regulations (IHR) disregarded their commitments imposing travel restrictions.[10]

There is no doubt that globalization challenges states to evolve. But rather than simply decline, states continue to adapt and respond. States no longer solely reflect national preferences, but instead accommodate both national and international policy demands.[11] Recent political shifts in the United States and Europe reveal one response to the disenfranchisement felt at national levels from globalization (and the need to accommodate international policy demands) and reflect an attempt to reassert sovereign power. Different ideologies and approaches dictate various state responses to the new reality, but what is clear is that the state is aiming to retain a dominant position, even as it continues to respond to increasing influence and engagement from business, civil society and international institutions.

The Tobacco Global Health Network

Tobacco, as presented in the global health network case study, exemplifies the challenges globalization posed to states trying to protect their citizens' health.[12] The international tobacco industry capitalized on changes in technology and trade liberalization to target emerging markets and expand their business in states with less effective tobacco control.[13] States responded with the Framework Convention on Tobacco Control (FCTC).[12] The process to start the FCTC only began once state representatives attending the World Health Assembly approved the process to begin with a resolution.[14] States like Canada were strong supporters.[15] Other states such as Brazil[16] and Thailand,[17] which had made domestic

progress combatting tobacco, viewed the FCTC process as an opportunity to exert soft-power leadership and expand their influence both deepening the consolidation of their own domestic progress against tobacco, and also inspiring other states.

States not only empowered WHO to move forward to negotiate a FCTC, but states also funded and directed WHO in the 1990s to provide resources to facilitate the creation of a civil society alliance to co-ordinate non-governmental organization (NGO) participation in negotiations to ensure the FCTC agreement was approved. States used their ability to direct and fund WHO to support NGOs and research networks creating a global health network to achieve their interests in achieving a treaty. In May 2003, WHO's 192 member states approved this treaty which entered international law in February 2005. This treaty challenged and shifted state sovereignty, but these changes were state-initiated, state-sponsored, state-approved and state-ratified. Researchers, advocates and policy-makers acting within this network were crucial, but they were also supported, enabled and ultimately sanctioned by states. The FCTC should also serve as reminder of the continued primacy of the state as an actor within global health. More recently, global tobacco companies have sought to challenge states' ability to enact plain package labelling using international trade agreements; however, states have prevailed, against much of the global health communities' concern and predictions.

The Legitimacy Loop Between States and Global Health Networks

The importance of state support for global health networks is also related to legitimacy, where states and global health networks each use the other to legitimize and amplify efforts; establishing a 'legitimacy loop.' For example, during the FCTC process, states supported and sanctioned networks as they served their interests, legitimizing their efforts and advancing their positions, as NGOs could take approaches states could not. In other words, states used global health networks as a tool to shift other states' positions, and legitimize the continued dominance of the state-centric system.

More recently, the conceptualization of the post-2015 development agenda showcases this policy loop. Starting in 2011 and 2012, states determined and established a United Nations' process whereby states determined the final framework. To legitimize the effort, this process accommodated and included countless consultations with many non-state actors, but this was at the discretion of states and the shape of the consultations controlled by states. States still negotiated and determined the outcome framework. Yet during both the FCTC and post-2015 negotiations, global health networks sought to foster relationships with states to leverage states to legitimize their positions and advance their interests; this was both welcomed and facilitated by states.

Conclusion

Shiffman provides a valuable service in highlighting the importance of global health networks and how they can be improved. Adding to this foundation, it is critical to recognize the decisive role states play. Moving forward in assessing global health networks' effectiveness, identifying and further

investigating state support as a determinant of success will be critical. Some scholars have argued that global health still needs to be further "globalized."[18] Current trends, however, like the recent change to the WHO's Director-General election process giving all states an equal vote, seem to reflect the opposite: a re-assertion of state power within global health. The question, in the shifting international environment, is how will this continue to evolve? Will states continue to sanction global health networks to advance their interests and fill governance gaps? Will states continue adapting and facilitating innovation within global health capitalizing on new ways to generate ideas, pool resources and enable more shared decision-making processes?[19] Or will states seek to re-assert their role more forcefully, re-consolidating their power and reversing some changes over the last twenty years?

Of course, states are not unitary actors. State actions and decisions are heavily contested and determined by a number of other national and international non-state actors, global institutions, as well as other states. Analyzing what drives states to commit, prioritize, invest and implement agreements is the critical issue. Understanding how global health networks and states interact and evolve to shape and support their respective interests should be a focus for future research.

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Competing interests
Authors declare that they have no competing interests.

Authors' contributions
RM conceived and drafted the article. RDS provided critical input and comments.

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How states exerted power to create the Millennium Development Goals and how this shaped the global health agenda: Lessons for the sustainable development goals and the future of global health

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How states exerted power to create the Millennium Development Goals and how this shaped the global health agenda: Lessons for the sustainable development goals and the future of global health

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ABSTRACT

Since 2000, the eight Millennium Development Goals (MDGs) provided the framework for global development efforts transforming the field now known as global health. The MDGs both reflected and contributed to shaping a normative global health agenda. In the field of global health, the role of the state is largely considered to have diminished; however, this paper reasserts states as actors in the conceptualisation and institutionalisation of the MDGs, and illustrates how states exerted power and engaged in the MDG process. States not only sanctioned the MDGs through their heads of states endorsing the Millennium Declaration, but also acted more subtly behind the scenes supporting, enabling, and/or leveraging other actors, institutions and processes to conceptualise and legitimize the MDGs. Appreciating the MDGs' role in the conceptualisation of global health is particularly relevant as the world transitions to the MDGs' successor, the Sustainable Development Goals (SDGs). The SDGs' influence, impact and importance remains to be seen; however, to understand the future of global health and how actors, particularly states, can engage to shape the field, a deeper sense of the MDGs' legacy and how actors engaged in the past is helpful.

Introduction

From 2000–2015, the eight Millennium Development Goals (MDGs) provided the framework for global development efforts. The MDGs shaped billions of dollars of investment, and impacted the lives of many. Advocates contend they invigorated institutions, stimulated research communities, inspired civil society movements and galvanised politicians and citizens (McArthur, 2013). Scholars argue the MDGs represented a new 'super norm' dominating the global development agenda (Fukuda-Parr & Hulme, 2011). Three out of the eight goals related directly to health and the other five goals focused on critical determinants of health. The MDGs' influence was pivotal to creating a normative global health agenda, which largely continues to shape the global health agenda today. Appreciating the MDGs' role and legacy in the conceptualisation of global health is particularly relevant as the world transitions from the MDGs to the Sustainable Development Goals (SDGs). The SDGs' influence, impact and importance remains to be seen; however, to understand global health now and in the future and assess how actors, like states, can engage to shape the field, a deeper sense of the MDGs' origins and of how actors engaged in the past is instructive.

Defining and determining what is and what is not considered part of the global health agenda remains disputed. There is no single global health agenda (Fried et al., 2010; McInnes & Lee, 2012). Yet how global health is defined and understood shapes which health challenges are

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considered (Frenk, Gómez-Dantés, & Moon, 2014). The definition impacts the design of how funds are raised and eventually disbursed. It influences discourse and how policymakers consider issues. It determines the education of students and future policymakers. The global health agenda can also contribute to the creation of new global health institutions like the Global Fund or GAVI, the Vaccine Alliance. In other words, the conceptualisation of global health exerts power by determining the global health agenda. As recently argued, 'power is exercised everywhere in global health although its presence may be more apparent in some instances than others' (Shiffman, 2014).

While the tremendous normative power of the MDGs is increasingly recognised, there is limited analysis considering the explicit role of sovereign states as actors within the process to create the MDGs. Existing literature highlights the important role of civil society and non-governmental actors (Brinkerhoff, Smith, & Teegen, 2007), 'norm champions' (Fukuda-Parr & Hulme, 2011) and 'well-placed individuals within the UN' (Miskimmon, O'Loughlin, & Roselle, 2017); however, to better identify both the origins and future of global health as a field of policy action, it is necessary to reconsider how state actors engaged in this process to create the MDGs. What were states' roles in the policymaking process to create the MDGs? Why and how did states engage to shape and influence the process?

Despite broad recognition of the MDGs' and their role in development, their relationship to the rise of the field of global health is less explicitly acknowledged. Part of this could be the tension between the normative aspiration of global health to transcend states and national borders with the reality of the MDGs and global health institutions still operating within an UN-state system. This could help explain why seminal articles assessing the transition from international to global health do not even mention the MDGs (Brown, Cueto, & Fee, 2006). This is somewhat paradoxical given that the MDGs had a strong health focus and that the emergence of global health in the late 1990s and early 2000s broadly coincided with the United Nations' (UN) Millennium Declaration. The MDGs also built on previous advocacy efforts. For example, MDG 4 on child mortality built on the experience of the child-survival revolution in the 1990s (Díaz-Martínez & Gibbons, 2014).

The MDGs also matter for global health as issues not included within the MDG agenda, like non-communicable diseases (NCDs), received reduced interest, attention and resources within the field of global health. Conversely issues included in the MDGs, like HIV/AIDS, gained disproportionate and distortionary attention possibly displacing other health spending (Shiffman, 2008). Some experts argued that the quantification of the MDGs and their targets led to 'simplification, reification and abstraction' which contributed to redefining some of the priorities (Fukuda-Parr, Yamin, & Greenstein, 2014). By 2014, roughly $23 billion out of a total of $36 billion of Development Assistance for Health (DAH) was directed towards MDGs Four, Five, and Six whereas only $611 million was directed towards NCDs (Dieleman, Murray, & Haakenstad, 2015). Moreover, since 1990 DAH associated with the MDGs increased more than any other areas (Dieleman et al., 2016). While this was not necessarily the case for every goal and target within the MDGs, it was the case that if a health challenge was not a MDG goal or target, it was more difficult to raise support and awareness for this issue in the MDG era. Anticipating this situation, former UNAIDS Director Peter Piot fiercely advocated for HIV/AIDS to be included in the MDGs (Piot, 2013).

At their inception, the MDGs caused rigorous debate amongst academics, civil society and policymakers around the world with one early critic calling them a 'Major Distraction Gimmick' (Antrobus, 2005) being forced upon developing countries by the triad of the United States, Europe and Japan (Samin, 2006). Yet these early critiques were eventually forgotten or ignored considering the power of the MDGs' supporters, and as the MDGs became more entrenched as development policy. Indeed, a recent review (Fehling, Nelson, & Venkatapuram, 2013) found that 'only 15 percent of MDG-related publications expressed concerns with the MDGs and only one-third of these discussed intrinsic limitations.' From this more narrow literature, the review considers MDGs' limitations in terms of the development process (Samin, 2006), structure (Saith, 2006), content (Easterly, 2008) as well as implementation and enforcement (AbouZahr & Boerma, 2010).

Despite these critiques, an early Millennium Project report declared, that the MDGS were 'the most broadly supported, comprehensive, and specific poverty reduction targets the world has ever established'(UN Millennium Project, 2005). A UN MDGs final report defined them as the 'most successful anti-poverty movement in history' (United Nations, 2015). The MDGs reflected a departure from the 1980s Washington consensus development to a more people-centred or human development in the 1990s expressed during a series of UN conferences on development issues (Wilkinson & Hulme, 2012). As experts noted the MDGs arguably 'created a new narrative of international development centred on global poverty' with the MDGs 'the legitimised framework for defining what this means' and the 'reference point around which international debates about development revolve' (Wilkinson & Hulme, 2012).

More specifically within global health, the MDGs remained contested. The MDGs represent the apex of an extremely 'vertical' (focused on specific diseases, like HIV/AIDS or malaria as opposed to a horizontal approach focused on health systems) approach to health interventions. The three health-specific MDGs focused on a small number of vertical interventions to combat specific diseases and maternal and child mortality as the most effective approach to improve health. In 2008, analysts highlighted '[t]he potentially destructive polarisation' between vertical and horizontal approaches (Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008). The Maximizing Positive Synergies initiative (detailed in Section Two below) helped diffuse this tension leading to greater attention to health systems and a more integrated approach within health. But the MDGs remained the dominant policy doctrine. In fact, it appears the MDGs dominated the agenda so much so that they even eventually contributed towards a more horizontal approach. One analysis found that 'critical factors behind the recent burst of attention [to health systems] include fears among global health actors that health systems problems threaten the achievement of the health-related MDGs' (Hafner & Shiffman, 2013).[1] Within global health, the MDGs shaped priorities and investments. The MDGs both reflected an emerging definition of global health, and contributed to advancing this conceptualisation. They exerted power and facilitated by the UN and civil society partners were enacted through and within nation states.

The role of power as a concept and framework for assessing how global health policy is determined is often overlooked. As Erasmus and Gilson argued, 'power, a concept at the heart of the health policy process, is surprisingly rarely explicitly considered in the health policy implementation literature' (Erasmus & Gilson, 2008). Frameworks for understanding power remain contested and empirical evidence for applying these frameworks is often lacking. Given the importance of the MDGs in shaping the global health agenda, understanding how states engaged to create the MDGs could help illustrate how actors exert power in global health and hence inform how actors both engaged in the conceptualisation of the SDGs and might engage with their implementation shaping the future of global health.

Based on published literature and unpublished policy materials, this paper focuses on reconsidering the role of states as critical actors in both the conceptualisation and institutionalisation of the MDGs. While state engagement in the recent SDG process was more visible and legible, some states, contrary to common perceptions, were also critical actors in the creation of the MDGs. States as actors within global health are sometimes overshadowed by the attention given to the proliferation of new actors, like public-private partnerships, civil society organisations or philanthropies (Ricci, 2009). In the case of the MDGs, states not only sanctioned the MDGs through head of states endorsing the Millennium Declaration, but also acted more subtly behind the scenes supporting, enabling (sometimes by not blocking), and/or leveraging other actors, institutions and processes to conceptualise the MDGs.

This paper considers why and how states exerted power and engaged in the MDG process. This paper starts by presenting an overview of different potential frameworks for analyzing the role of states in the creation of the MDGs, and selects the Barnett and Duvall framework (considering compulsory, productive, structural and institutional power) for analysis (Barnett & Duvall, 2005a). Second, this paper applies this framework describing and analyzing how states exerted power in

the creation and institutionalisation of the MDGs in three distinct phases (2000–2005; 2005–2010; and 2010–2015) in relation to the emergence of the field of global health. Finally, it considers and discusses the implications of this analysis for the recent transition from the MDGs to the SDGS, and what this might mean for the implementation of the SDGs and the future of global health.

Section one: power as a new framework for understanding global health

Power is a central concept in social sciences, but its meaning and application is heavily contested. Scholars disagree about sources of power, the role of power and how actors exert power. Indeed, one international relations scholar describes the concept of power as one of the 'most troublesome in the field' and argues that 'the number and variety of definitions should be an embarrassment to political scientists' (Gilpin, 1975, 1983). Traditionally scholars have seen power conceptually defined by an actor or state resources like armies or navies and populations or territories. But in the second half of the twentieth century, this approach evolved to consider 'relational power', in other words, how actors, individually or in groups, related to each other and affected or influenced others' behaviour. Beyond this, many debates and different approaches in terms of how to exert, frame, measure or understand power remain. Yet there is a consensus on the importance of understanding power and the lack of knowledge on how power functions (Baldwin, 2016). There is a similar, but slightly less mature, state of affairs in the global health literature.

There is an increasing recognition of the concept of power in global health, but discussions are still nascent (Shiffman, 2014). Similar to international relations, power in health remains associated with possession of or access to material resources like financing or medical equipment or drugs; however, there is an emergent recognition of ideas (McDougall, 2016), networks (Shiffman, 2016), expertise and information (Shearer, Abelson, Kouyaté, Lavis, & Walt, 2016) as potential sources of power. This is critical for global health as many consider health a policy process dictated by technical choices instead of recognising health as a profoundly political space in which various priorities and policies are fiercely contested and ideas, networks, expertise and information are deployed to advance competing approaches (Shiffman, 2014).

From the international relations literature, there are a few different frameworks for understanding how power is exerted, which could be considered for global health. One of the simplest and perhaps most intuitive ways to illustrate how power is exerted is to compare hard and soft forms of power. Robert Dahl's famous formulation of hard power is the ability of A to force B to do something it would not otherwise do (usually deploying military or economic resources), and Joseph Nye's conceptualisation of soft power attracts or co-opts actors and persuades actors without the use of coercive force. In global health, Brazil's influential role in advancing its political values on the negotiation of the Framework Convention on Tobacco Control is often cited as an example of soft power (Lee, Chagas, & Novotny, 2010). More recently, others argued that to best advance interests, actors should seek to combine both hard and soft power to create smart power (Nossel, 2004). For example, one could consider American efforts on HIV/AIDS like PEPFAR advancing American interests in geopolitically strategic countries backed up with financial resources as an example of smart power.

A similar framework from sociology is Lukes' three faces of power (Lukes, 2004). The first face of power is the ability of one actor to force another actor to do something they initially did not want to do, ie hard power. The second face of power is considered agenda setting and framing; powerful actors can control the agenda and determine who sits at the table and which issues are considered to be or not be on the agenda (Bachrach & Baratz, 1962). The third face of power is the ability to control an actor's thoughts. For example, one actor might be able to shape another actor's initial interests. These three faces of power could be summarised as overt, covert or latent forms of power. This three faces of power framework was briefly applied recently to examine the process to create the SDGs (Buse & Hawkes, 2014). While the hard, soft, smart power framework is helpful for examining state actions at the international level, Lukes' faces of power is most helpful for assessing the negotiation of policy processes as the framework illustrates how actors can shape the agenda

by putting or removing issues from consideration (the second face of power) and/or controlling the terms or framework for conceptualising issues (the third face of power).

Building on Lukes, global governance scholars Barnett and Duvall present a broader framework for understanding power, which is insightful for understanding how states negotiate policy processes. They consider power to be about relationships, and define it 'as the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate' (Barnett & Duvall, 2005b). They differentiate between four forms of power—compulsory power (such as use of military or economic force), institutional power (such as how international institutions are designed to favour one actor over another), structural power (the overall constitution or framework of actor and their roles) or productive power (control over the possession and distribution of resources) (Barnett & Duvall, 2005a). For global health, one could think of a donor using funding to exert compulsory power; a well-positioned state leveraging a multilateral agency to exert institutional power; a prestigious university or NGO positioning its staff as experts to provide technical policy support as exerting structural power; and a UN agency or a private-sector actor advancing and promoting a particular agenda or approach to addressing health challenges as an exertion of productive power.

Given the breadth of Barnett and Duvall's framework to distinguish between different forms of power, particularly to identify and illuminate ways in which power is exerted in ways usually unseen or unrecognised, the next section below applies this framework to analyze and illustrate state engagement in the creation of the MDGs.

Section two: state power and the creation of the MDGs

Phase one 2000–2005: conceptualization and campaign

One year after the unanimous endorsement of the 2000 Millennium Declaration during the Millennium Summit with 149 heads of states and governments (the largest ever such gathering), UN Secretary General Kofi Annan submitted a report to the General Assembly entitled, a *Roadmap towards the Implementation of the Millennium Declaration* (UN Secretary-General, 2001). This report was adopted by the General Assembly, and recommended it be considered a 'useful guide' for operationalising the Declaration. An annex to this report included the framework for the Millennium Development Goals (MDGs): eight goals, eighteen targets and forty-eight indicators. This MDG resolution, based on the Declaration approved and endorsed by heads of states and governments, would ultimately be leveraged by the United Kingdom and other OECD states to exert tremendous compulsory, structural, institutional and productive power.

Recognising the role of states in shaping policy is not to dismiss the role of message and norm entrepreneurs as well as elite technocrats highlighted elsewhere (Hulme & Fukuda-Parr, 2009). Instead it is meant to reconsider these individuals' roles as enabled by states exerting structural, institutional and productive power. For example, three of the Security Council's five permanent five seats are held by OECD-member states, the United States, France and the United Kingdom. These states have veto or structural power over the appointment of the Secretary-General, and thus have influence over the Secretary-General's office; a similar situation is true for other UN agencies and other parts of UN institutions. States use this structural power to install their nationals into key positions shaping policies within these institutions and establishing critical personal connections. States also leverage institutional power through the OECD and World Bank as well as the UN.

Following the Millennium Declaration and in coordination with the World Bank and OECD, a United Nations' interagency expert group (IAEG) both reflected institutional power and exerted productive power. Co-chaired by a special adviser in the Secretary General's office (Michael Doyle) and director (Jan Vandemoortele) in the United Nations Development Programme (UNDP) and with participants from both the Bank and the OECD, this group, sanctioned by OECD states, led the process to draft what became the eight MDGs (Fukuda-Parr & Hulme, 2011). The Goals were taken

almost verbatim from the Millennium Declaration, which helped to legitimize them as the Declaration had been approved by Heads of State. The eight MDGs consolidated and built upon the so-called International Development Goals (IDGs) created at the Paris-based Organization for Economic Cooperation and Development (OECD). In fact, MDGs 1 through 7 were extremely similar to the IDGs. The biggest difference between the IDGs and the MDGs was Goal 8 on partnership, which was the result of political consultation and compromise following the Millennium Declaration, most notably between the G77 Member States who believed the Goal did not go far enough and the United States which believed it went too far (McArthur, 2014).

The IDGs came from a working group of national Ministers of Development which met in the Development Assistance Committee (DAC) at the OECD to produce a 1996 report, *Shaping the 21st Century*. This report selectively included goals and language from UN conferences in the 1990s. These IDGs were endorsed in June 2000 by the UN, OECD, World Bank and the IMF (A Better World for All, 2000), but the IDGs' productive power had little buy-in or support from developing countries. In fact, the IDGs engendered deep critique on a number of levels from developing countries and civil society. The IDGs had been promoted by the United Kingdom, which led an informal group, the so-called Utstein Group, of female Development Ministers from the Netherlands, Germany and Norway, which sought to use the IDGs as their overarching framework for development and align their aid efforts to leverage their impact (Hulme, 2009). This would also be an exertion of compulsory power by developed states coercing developing states to adopt policy guidance in exchange for development assistance. The strong commitment from the United Kingdom was championed by Clare Short, who had recently come to lead DFID as part of the 1997-elected New Labour government (Hulme, 2007). As part of a broader shift in development thinking and fortuitous timing with the Millennium Summit, the UK and the other states' institutional power within the World Bank and the IMF advanced the productive power of the IDGs eventually leveraging the UN to reframe and rebrand the IDGs as MDGs through negotiation with the addition of Goal 8 on partnership to overcome resistance from developing country states.

Other than the goal on global partnership, the IDGs were largely the same as the MDGs on health except one key difference. Both lists of goals contained maternal and child mortality (although they were one goal in the IDGs and two goals in the MDGs), but the IDGs included a goal on reproductive health services, whereas the MDGs had a goal on HIV/AIDS. The removal or blocking of reproductive rights as part of the MDGs was the result of the so-called 'unholy alliance' between the Vatican and Sudan, along with Libya and Iran, which then leveraged the G-77, a large and powerful bloc of countries within the UN General Assembly, and also took advantage of a recently-elected conservative US government (the administration of President George W. Bush), which was initially disinterested in the MDGs (Hulme, 2010). In this case, the Vatican State exploited institutional or structural power, joining some members of the G-77, to block a potential MDG on reproductive health. This alliance later broke down in 2005, and reproductive health was included as a target for maternal health. HIV/AIDS was included as a MDG following vigorous lobbying from HIV/AIDS activists led by UNAIDS Director Peter Piot.

UNDP, newly led by former World Bank Vice President (Mark Malloch Brown), spearheaded the development of a strategy to exert institutional power and advocate for MDG implementation. These efforts ultimately included a Millennium Project and a Millennium Campaign to raise attention, financing and support to advance progress. UNDP worked with governments to embed the MDGs within national policy processes and monitor progress. The 2002 Monterrey Finance for Development Conference focused on financing the MDGs (Fukuda-Parr & Hulme, 2011). Despite these efforts, national commitment to the MDGs at this point was limited, and in the early stages the MDGs provoked robust critiques.

Hulme (2009) distinguishes between various schools of critique classifying them as

> high modernists, who take [the MDGs] at face value and are optimistic that they are a blueprint for the transformation of the human condition (Sachs & McArthur, 2005); the strategic realists, who don't believe the

> MDGs are a blueprint for action but believe they are essential to stretch ambitions and mobilise political commitment and public support (Fukuda-Parr, 2008); the critics, who see them as well-intentioned but poorly thought through – distracting attention from more appropriate targets (or non-targets) and more effective policies and actions (Clemens, Kenny, & Moss, 2007; Easterly, 2006); through to the radical critics, who view them as a conspiracy obscuring the really important 'millennial' questions of growing global inequality, alternatives to capitalism and women's empowerment (Antrobus, 2003; Eyben, 2006).

Despite these early critiques, the commitment of states and the broader UN system during this early phase was crucial for establishing the MDGs as the dominant narrative for both international development and global health. OECD states ensured this by recalibrating and aligning their financial support and leveraging their structural institutional, productive power across the UN system. For example, the US Government launched two major funding initiatives, the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI); these initiatives combined with the Global Fund and GAVI to help boost development assistance for health in 2000 from $11.6 billion to $33.1 billion in 2012 (Murray, 2015). The MDGs were also supported by the creation of two new public-private partnership institutions, GAVI for immunizations and the Global Fund to Fight HIV, TB and Malaria, to accelerate progress and provide financial resources to reinforce the MDGs' productive power (Hanefeld, 2014; Storeng, 2014).

Phase two 2005–2010: consolidation and critique

In 2005 UN Member States met for the World Summit at the UN in New York. With strong leadership from the UN Secretariat, the United Kingdom and other developed states, the Summit outcome document approved by national leaders continually referenced the MDGs and encouraged states to 'adopt, by 2006, and implement comprehensive national development strategies to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals' (United Nations, 2005). In fact, states endorsed and requested the UN system to support the development of MDG-based national development strategies and Poverty Reduction Strategy Papers at the country level (Pizarro, 2013). The UK also made the MDGs a centerpiece of their hosting the G8 Summit in Gleneagles in 2005. This deepened and expanded the productive and institutional power of the MDG agenda amplifying this power within the UN and international system.

Following this Summit and the G8 meetings, more UN and international institutions became involved in national reporting and the regularity of this reporting increased. A review of twenty-two Poverty Reduction Strategy Papers—fifteen of which were prepared between 2005 and 2007 and one in 2008— highlighted that almost all of them expressed a commitment to the MDGs (Fukuda-Parr, 2010). These initiatives spurred other actions. For example, Malawi in 2006 started publishing an annual MDGs report (Waage et al., 2010).[2] Commitment to the MDGs continued to grow as states like the United Kingdom, and others like Japan, continued to advance the MDG approach as a way to consolidate, align and amplify their development investments. In 2008, governments, foundations, businesses and civil society groups met at the United Nations Headquarters in New York for another high-level event. More than $16 billion was committed to accelerate progress exerting some compulsory power using the appeal of financial assistance to support states towards the MDGs.

While support for the MDGs during this period expanded, critique of the MDG approach also grew. The rise of many emerging economies, particularly in the wake of the 2008 economic crisis, began to create additional space to question the MDG approach. States like Indonesia used their experiences with the MDGs to criticise and improve the process, but also to raise their own profile. Experts noted tendencies to focus on targets which were comparatively easier to implement or monitor (some have called this the tyranny of averages) which led to variable progress and had adverse implications for equity. Critics called for improvements in national averages ignoring the inverse care law with implications for equity (Gwatkin, 2005). Despite raising valid concerns, critique also indirectly reinforced the existing productive power of the MDGs.

During this period, the Global Fund and other so-called global health initiatives (GHIs), like the US' PEPFAR programme, provided incredible amounts of resources and prioritised attention for HIV/AIDS, a MDG. In fact, the energy, innovation and attention from HIV/AIDS has led some to even argue that HIV/AIDS invented global health (Brandt, 2013). Some defined global health as 'an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide' (Koplan et al., 2009). Others argued that global health was simply 'a foreign policy instrument of hyper-rich nations' (Horton, 2014). But more realistically, global health was, as one academic argued, 'more a bunch of problems than a discipline' (Kleinman, 2010). The problems of global health in this period were predominantly the 'vertical' MDG health issues of child and maternal mortality and HIV/AIDS, TB and Malaria.

One MDG critic argued that, 'the MDG phenomenon carries the potential for distorting meaningful intellectual and research agendas, and could function as the catalyst and vehicle for a fundamental realignment of the political economy of development at the global level' (Saith, 2006). This was accurate for global health. Experts noted that the MDGs were distorting priorities and spending and would not be achievable without broader, more 'horizontal' investments in national health systems (Travis et al., 2004).

To consider this, the World Health Organization, with financial support from Italy and strong engagement from many states receiving funding from GHIs, which were funding the MDGs, convened a collaborative research effort and a high-level dialogue called Maximizing Positive Synergies in 2009. The research consortium convened identified areas for concern, and concluded more attention should be devoted to strengthening health systems which could also encourage better alignment and integration between GHIs and health systems (World Health Organization Maximizing Positive Synergies Collaborative Group et al., 2009). One synthesis analysis found positive effects of the MDG approach as, 'a rapid scale-up in HIV/AIDS service delivery, greater stakeholder participation, and channeling of funds to non-governmental stakeholders, mainly NGOs and faith-based bodies' and negative effects as 'distortion of recipient countries' national policies, notably through distracting governments from coordinated efforts to strengthen health systems and re-verticalization of planning, management and monitoring and evaluation systems' (Biesma et al., 2009).

Phase three 2010–2015: accelerated implementation and the final push

This phase started with the 2010 MDG Review Summit. The MDGs' strong productive power was institutionalised throughout the UN and international system, and implementation efforts continued. Despite additional pledges of more than $40 billion to accelerate progress, the Summit concluded that progress in many countries was 'patchy' and 'uneven' (United Nations, 2010). Focus shifted thereafter to a MDG Acceleration Framework (MAF) to support lagging countries to achieve the MDGs in the remaining five years. While discussions began to consider the end of the MDGs, UN policymakers focused on accelerating progress towards implementation accompanied by additional reviews and analyses as well as a proliferation of case studies profiling national best practices and innovations.

For example, the London International Development Centre and the Lancet collaborated on an in-depth Commission reviewing progress in 2010 (Waage et al., 2010). While heralding the remarkable success of the MDGs for agenda setting, the Commission noted particular missed opportunities for synergies between efforts across education, health and gender sectors. A lack of strong ownership by national institutions also created challenges. The Commission also highlighted that MDGs disregarded and fragmented health systems (Travis et al., 2004), ignored changing demographics as well as overlooked emerging health challenges such as non-communicable diseases (Alleyne et al., 2013), mental health or road traffic injuries.

Other analyses showed mixed evidence on how the MDGs affected national policymaking. In one survey of 118 countries, eighty-six percent reported that they acted in response to the MDGs (United Nations Development Group, 2005). Another review of national development plans in fifty countries

showed that thirty-two countries either adapted or localised the MDGs into national planning (Seyedsayamdost, 2014). But low and middle-income countries could simply be referencing the MDGs in their national development plans to satisfy donor or international 'norms' of MDG political correctness (Fukuda-Parr, 2008). Indeed, one review suggested that states had two distinct motivations for engaging with the MDGs: first, to increase their global visibility and influence (this was usually more reflective of middle-income or emerging countries); and second, to receive increases in overseas development assistance (ODA) (Sarwar, 2015). In the first case, it could be that emerging economies recognised the power of the MDGs, and wanted to use this MDG platform to amplify their own power; and in the second case, this reflects some countries' need for financing and thus be able to be 'coerced' by the MDGs. Yet even when countries integrated MDGs into their policy and planning processes, this did not necessarily lead to MDG issues being domestically prioritised or provided with the necessary domestic funding. Again, it could be that countries were reacting to the productive, institutional and structural power of the MDGs by integrating them into their policy processes.

While the UN system was determined to prioritise the MDGs, discussions began during this phase to consider what would come after the MDGs. Some states, like the United Kingdom, were in favour of continuing the MDGs beyond 2015. Other states like Colombia argued for the creation of new SDGs which would focus more on broader issues including the environment and be universally applicable for all countries. In fact, many states, particularly middle-income states, wanted to broaden the MDGs to be universally relevant for all countries. Starting in 2012 in the wake of the Rio + 20 conference, an elaborate UN-led, multi-stakeholder, multi-sectoral process began discussions around a process to create a successor framework for the post-2015 era. The ensuing policy process was arguably the most inclusive and consultative in United Nations in history, and the extraordinary engagement and commitment reflected the MDGs' tremendous power.

While there were countless consultations and opportunities to provide input between 2012–14, UN Member States ensured they had the final decision in the process designing it to conclude with intergovernmental negotiations between 2014 and 2015 which would give the final approval for the post-2015 agenda. These state negotiations were profoundly political and heavily disputed. This reflected emerging economies recognition of the influence of the MDGs and the opportunity to exert their own institutional and productive power through shaping the conceptualisation of the new agenda. Leveraging their respective structural and productive power within the UN system, for example, Brazil's hosting of the Rio + 20 Forum in 2012, emerging economies shifted and reframed the discussion on the post-2015 agenda from MDGs to SDGs to reflect more closely their own national interests broadening the MDGs to a wider and more holistic development agenda. But what are the implications of these three phases of experience with the MDGs for the SDGs, and the future of global health?

Section three: implications for the SDGs and the future of global health

Before considering the implications, it is useful to summarise and review how states engaged and exerted power. In the first phase, developed states held considerable strength in all forms of power. They were not only able to create and determine the agenda, but they were also able to use their financial and human resources leveraging both their position and networks as compulsory, structural and institutional power within the international system to ensure other states accepted and adopted their policy guidance. Developed states were also willing to sacrifice some of their control when working with the Bretton Woods institutions, the UN and other states as they rebranded and reframed their IDGs into MDGs to gain greater legitimacy.

In the second phase, building on early academic critics and their initial experiences, emerging economies began simultaneously to question the MDG approach more forcefully, and engage with the MDGs within the UN system; they also recognised and responded to the increased focus on global health. On the one hand, this deepened and reinforced the productive power of the

MDG paradigm, but on the other hand, it also showcased the rising and burgeoning structural power of emerging economies to begin to contribute to and shape the field of global health. This was part of a broader geopolitical shift of power globally as well as within the still nascent field of global health which began to shift away from a heavily 'verticalized' approach in the early 2000s to a broader, more horizontal approach (Bärnighausen, Bloom, & Humair, 2011).

The third phase exemplified the productive power of institutionalising the MDGs as the dominant paradigm for global development. There was tremendous interest and engagement in what would come after the MDGs, how the post-2015 agenda would be determined and what would be part of it illustrated the productive power of the MDGs. In this phase, the ability and success of developed states to ensure the continuation of the MDG paradigm within the beginning of a new SDG approach reinforced the original MDG approach; however, it also signaled emerging economies' rising institutional and structural power as they were able to negotiate for a broadening of the goals to be a more universal agenda relevant for every country. The SDG agenda essentially incorporates the MDGs and expands this agenda to include new goals related to environmental sustainability, labour and governance. In other words, developed states were able to maintain their focus on MDGs and institutionalise them within the SDGs, but the emerging economies were also able to broaden the MDGs into the SDGs.

But what does this mean for the broader SDGs and the development agenda, as well as for the more specific global health agenda? What does the MDG experience mean for the future of the SDG agenda? Given the MDG-established policy processes, the SDGs could likely continue to be as relevant and dominant for the international development agenda as the MDGs were. However, in the same way that not all of the MDGs received the same levels of attention and commitment (and some of the MDG goals and their indicators were contested and eventually revised in the early stages, eg as explained earlier on reproductive health), this is also likely to happen and is already happening within the SDGs. For example, during the UN's July 2017 High Level Political Forum (HLPF) on SDGs focused on reviewing select thematic goals (1-no poverty; 2-zero hunger; 3-good health and well-being; 5-gender equality; 9-industry, innovation and infrastructure; 14-life below water; and 17-partnerships for the goals). At the HPLF, countries reported in voluntary national reviews (VNRs), some countries also only selectively reported on goals meaning that they 'cherry-picked' which goals to report on and which to ignore in their reporting. Instead of implementing them in whole as they were designed, it is possible and likely that states will determine an informal ranking of the SDGs through their financial investments and policy priorities as also happened with the MDGs.

A more pressing question, however, regards the role of the SDGs for global health: what will the SDGs mean for global health? Will the SDGs be as central and formative for the future of global health as the MDGs were? In other words, will the SDGs matter for global health as much as or more than the MDGs did, especially as low and middle-income states engaged in the process to conceptualise them? Or will the future of global health better be debated and defined elsewhere? Given the centrality of health to the MDGs (3/8 Goals) compared to the SDGs (1/17), it seems unlikely that health will remain as central to the sustainable development agenda, and thus, unlikely that the SDGs will remain as central to the future of the global health agenda. But the interpretation of Goal 3 on health for the future of global health continues to be contested.

The recently directly-elected-by-states Director-General of the World Health Organization (WHO), is clearly in favour of a focus on the SDGs with a slight shift in the interpretation of SDG 3 on health as he stated in July 2017 at the High Level Political Forum: 'I regard universal health coverage as WHO's top priority. […] Universal health coverage is included in the Sustainable Development Agenda. Indeed, it is the centrepiece of the Sustainable Development Goal health targets' (Ghebreyesus, 2017). However, two recently established global health initiatives, one the Coalition for Epidemic Preparedness Innovations (CEPI) started with $460 million from the governments of Germany, Japan and Norway, plus the Bill & Melinda Gates Foundation and the Wellcome Trust, and another 'Resolve' focused on heart disease and stroke as well as disease outbreaks started

with $225 million dollars from Bloomberg Philanthropies, the Chan Zuckerberg Initiative, and the Bill and Melinda Gates Foundation, make little reference to the Sustainable Development Goals in their mission statements or aims. These new funding mechanisms could be rebranded or co-opted by the UN system at a later stage; however, for now, they seem to indicate a potential move away from the SDGs as the leitmotiv of global health. This being said, it has been acknowledged that the SDGs imply a dramatic paradigm shift within global health (Buse & Hawkes, 2015), and it could be that this transition is still ongoing. Apropos there are already some efforts to reconceptualize global health as planetary health more in line with sustainable development and the SDG agenda (Whitmee et al., 2015). Regardless of the relationship with the SDGs, the exact future shape, direction and priorities of global health are continuing to evolve, and remain to be seen.

Conclusion

This analysis demonstrates the value of using power as a framework to understand and assess actors', particularly states, roles in global health. Better understanding how power is exerted and deployed could help improve how actors engage, and identify key determinants of comparatively more 'successful' or 'effective' efforts in global health; a deeper knowledge of what determines better policy efforts could also enhance policy processes and lead to better governance mechanisms (Marten, 2015). This could transform states' abilities to negotiate global health policies ultimately improving and saving lives. It might also mean other actors increase their attempts to leverage states' influence.

This analysis and the transition from the MDGs to the SDGs also has implications for how power is exerted at the UN and shapes the development and global health agenda. Compulsory power has become less relevant over time (as development assistance became less critical), the exertion of structural and institutional power are becoming more contested (as emerging economies begin to demand some restructuring of the system) and productive power is becoming perhaps the most important and relevant form of power, especially for global health. In between 2000–2015, developed states started by dominating the policy process, but by the end, emerging economy states were able to contest the previously unchecked structural and institutional power of developed states. They contested the agenda in the negotiation of the post-2015 agenda and thus, the future exertion of productive power. But what does this mean for future policy making efforts, and what are the implications of this analysis?

First, the experience of the MDGs showcases the potential for states to leverage structural and institutional power to exert productive power for policymaking within the UN system. Given the geopolitical changes in the last decade, this could mean negotiations where states can exert institutional and productive power will now become more contested, and potentially gridlocked resulting in broad or watered-down agreements. The contestation of the SDGs could represent this. The negotiated process lasted around three years and produced 17 goals and 169 indicators. If this is the case, it is possible that the UN's productive power could become challenged, or less important. It could be that states could position new or alternative actors to the UN, which are better aligned to their interests, to create productive power, and seek new policy fora in which they might be better positioned to exert institutional and structural power. Alternatively, it could be that this greater contestation, even with eventual compromise, could lead to more committed national buy-in and engagement for new policies and processes. The SDGs could be a litmus test for helping to understand and assess the productive power and influence of UN policymaking.

In the case of creating and institutionalising the MDGs, states exerting institutional and structural power seemed to work best in alliances with other states as well as non-state actors. Even comparatively less structurally or institutionally powerful states belong to one grouping or another within the UN system, eg the African Union or the G-77, which offers states increased possibilities for exerting some institutional or structural power within the UN system. This empowers states to leverage these relationships and abilities to engage on and create new mechanisms which have the potential to exert productive power. The MDGs created new norms around international development and global

health exerting tremendous productive power. States played a critical role in creating and shaping this productive power, and this story could offer insights to other states seeking to leverage national power to create or institutionalise new norms in global health policymaking through the United Nations. One potential lesson based on this experience could be that states do not need to make huge financial investments to exert compulsory power, but rather need to consider how wield institutional, structural and productive power more effectively and strategically.

Second, this analysis illustrates the enduring importance and centrality of state engagement in global health policymaking. Without states, the MDGs and SDGs would not exist, or would look substantially different. While there is understandable excitement and interest in the role of new non-state actor engagement, the role of states within global health remains underappreciated (Ricci, 2009) and overlooked (Marten & Smith, 2017). Since 2000, the role of states in determining and managing health has changed and evolved. Globalisation increased transnational actors' abilities to shape and challenge how states spend, raise and allocate resources for health (Smith & Hanson, 2011). Despite being responsible for health, states continue to see challenges to their prior monopoly over health governance and regulation (Walt, 1998). The MDGs themselves reflect some of these tensions. At one level, the MDGs are a challenge to states' authority to manage and determine their own health priorities. The MDGs were largely crafted by developed states for low- and middle-income states. At another level, they reflect states' continued authority as all states endorsed the MDGs at the General Assembly and ultimately participated in rethinking and reframing the MDGs into SDGs. Some of these challenges to states are state-sponsored or state-endorsed as states defer some level of sovereignty empowering international institutions or non-state actors to challenge their sovereignty. Despite continuing changes in their roles and challenges to their authority, states remain the predominant and decisive actors in global health policymaking.

Third, the example of the MDGs also highlights the importance of legitimacy for policymaking in global health. While developed states likely could have continued with their IDGs at the turn of the century, they recognised the value of legitimacy in transitioning them through the Bretton Woods institutions and reframing them within the UN policy process in negotiation with other states, thus trading some level of control for greater legitimacy. As part of this, the United Nations, a state-based institution, is generally perceived to be the most legitimate forum for establishing and determining health policies and priorities. The question now is will this legitimacy still be valued highly enough to justify the likely increases in political contestation. In other words, will states, recognising the potential limits to their institutional and structural power at the UN, now seek to exert productive power in other policy fora like the G-7 or the G-20? Until now, the United Nations as a policy forum and the MDGs as a UN mechanism played an integral part in contributing to define and shape the field of global health. While it is clear that states will continue to be critical actors shaping the field of global health, the role of SDGs in defining the future of global health is, for now, unclear.

Notes

1. Of course, defining health systems and how to best strengthen them to help achieve the MDGs is also heavily disputed. Health systems frameworks are influenced by their authors (van Olmen, Marchal, Van Damme, Kegels, & Hill, 2012) as well as new global health institutions many of which were funded and influenced by the creation of the Bill and Melinda Gates Foundation (Storeng, 2014) in the late 1990s (Birn, 2014) and their focus on vertical and technocratic approaches to health (McCoy, Kembhavi, Patel, & Luintel, 2009).
2. Eventually by 2013, the UNDP counted more than 400 national MDG reports.

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