State Agency and Global Health Governance: The Foreign Policy and Global Health Initiative

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Global health governance has been a budding academic field for the last decade and can benefit from utilizing political science perspectives in building a body of knowledge through empirical research. This approach has been applied in this study of the Global Health Initiative, also known as the Oslo Ministerial Group, a club of seven countries who in 2006 decided to jointly advance the issue of health as foreign policy. Our data suggests that it has proven to be a resilient group. The data brought forth three factors that seem to have worked as enablers in strengthening its role and impact, namely by bridging global arenas, supporting negotiation processes and influencing national policy arenas. Our findings suggest that the Initiative scores are somewhat higher on the first two factors than the third.

INTRODUCTION

A renewed focus on health and foreign policy emerged in the mid-2000s, at a time when global health initiatives were burgeoning and public-private partnerships became more the norm than the exception. The expansion of activities and resources at the global level now involves a variety of actors, "spanning the state and non-state, public and private, health and non-health sectors, and local to global levels of governance."[1] [2] [3] The emergence of global health governance and its increasing complexity of actors reflected a more general phenomenon, coined by Ruggie as a new global public domain—"an increasingly institutionalized transnational arena of discourse, contestation and action concerning the production of global public goods (…)"[4] Given the proliferation of institutional innovations at the global level, what more could a new form of foreign policy activism bring to the table?

For policy practitioners representing states, the expanded global health architecture brought the need for more sophisticated yet flexible skills in navigating opportunities for influence and impact in global health, also known as the practice of global health diplomacy.[5] [6] [7] The focus on health as foreign policy was also an impetus to expand countries' global health agendas beyond the traditional concept of health aid, with increasing attempts to consider health through the lens of more multi-sector driven interfaces, such as the intersection of health and governance areas like trade and security. The impact of overlapping, conflicting, and nested sets of rules creates challenges for states,[8] which the Lancet Commission on Global Governance for Health identified as an "inadequate policy space for health."[9] The policy space refers to the state's ability as a central actor to ensure that health is taken adequately into account. Indeed, states have proven able to mould and sometimes even enlarge this space. This could be observed in the cases of South Africa and Brazil, both of whom stepped up and shaped new global norms on access to antiretrovirals (ARVs).[10] [11] These and other examples of how countries handle the health/foreign policy nexus suggest that the power that belies countries as United Nations (UN) member states is different from what global organizations can do autonomously.[12] [13]

This paper examines the case of the Global Health and Foreign Policy Initiative (hereafter, the Initiative), also known as the Oslo Ministerial Group, a club of seven countries who in 2006 decided to jointly advance the issue of health as foreign policy. The seven countries, Brazil, Senegal, Thailand, South Africa, Indonesia, France, and Norway had seemingly little in common. Although it shares traits with what is known as clubs in international politics, the Initiative still evades conventional international relations-derived explanations for a like-minded alliance. Coming from a political science tradition, clubs are defined as any grouping with more than two actors, less than universal participation, and not formalized as an international organization.[14] Furthermore, the Initiative has no secretariat or website, and thus remains an enigmatic feature of an otherwise amply documented policy field. The substance presented in this paper is intended to go beyond the official declarations and shed light on the particular nature and dynamics of this seemingly unusual collective. Although alternative cases of renewed or unprecedented activism by states in global health governance could be discussed, the case of the Initiative merits attention because it has proven resilient and visibly purports the state as a crucial actor in global governance for health.

The paper builds on empirical research and observations extending over three years, from 2009 to 2011, starting with an interview study among Norwegian policy practitioners in 2009 for a conference paper,[15] and proceeding with a broader interview study in 2011 with health attachés and ambassadors of six of the seven countries who were based in their respective UN missions in Geneva at the time. The interviews were semi-structured, and lasted thirty minutes on average, covering issues such as the interaction between the national and global strategies of the Initiative's member states, institutional arrangements, and the Initiative's long-term effects on global health processes. The additional interviews from 2011 added multiple perspectives on the Initiative, as well as an opportunity to follow its activities over time. The six interviews from 2011 are referenced as numbers 1–6 and cited as (number [month-year]). Further document analysis has provided an update of the Initiative's main activities through 2014.

Our intent to follow the Initiative over time stems from an interest in bringing political science analysis to bear on the agency of states in the global health field and their interaction with global institutions. States' relations towards the global health policy domain resemble challenges in other issue areas, such as trade and the environment. Therefore, there is a potential to link up with related research agendas and theoretical debates in the scholarly fields of political science and international relations. Classical theoretical international relations concepts closely linked to global health and foreign policy have been discussed in the literature, such as the notion of power.[16] Notwithstanding this panoply of exploratory or discursive approaches to the topic, we argue that the different academic disciplines that have predominantly engaged in the discourse on global health and foreign policy, like international law, public health, or other social sciences, have not yet made any joint attempts in "drawing from a shared theory on what the main components of a research agenda (…) should be".[17] This paper sets out to advance this necessary debate. The importance of state agency in relation to international structures is a defining feature of the entire field of international relations. Still, the interface of domestic politics and global governance remains a frontier for exploration and further knowledge-building, while the empirical reality has shifted towards a broadening of states' foreign policy agendas to shape and implement a growing, and often overlapping, number of international regimes. In this way, research on health as foreign policy can both draw on a larger body of research practice in other relevant

issue areas, while also contributing to empirical and conceptual insights into a shared pool of knowledge.

The objective of this paper is to examine through a political science lens what an untraditional club like the Initiative can achieve, and intends to feed into a broader discussion on the agency of states in global health governance. The paper is organized in four parts. First, we discuss clubs in international relations. Next we describe the Initiative's background and formation. The third and main part presents key features and examples of the ways in which the Initiative works. The fourth and final part summarizes the Initiative's contributions Initiative and discusses the achievements in light of existing knowledge on clubs from other policy domains.

CLUBS IN INTERNATIONAL RELATIONS

In international politics more generally, clubs—also known as minilateral approaches—are a phenomenon that have long been subject to theoretical debate and research efforts. By briefly highlighting key issues in this debate, we aim for a better understanding of the contributions, potential, and limitations of the Initiative. Building on earlier theoretical work from the 1960s,[18] scholars have observed how smaller groups of countries reach agreements more quickly, and explored questions such as: under what conditions do clubs emerge and grow; what characterizes actors who play roles as initiators and political entrepreneurs; and what types of functions do clubs provide.[19] One of the most prominent premises for club emergence is the inherent shortcomings of multilateral processes, particularly the barrier inherent in consensus rule, where the least ambitious can block progress. Clubs thus provide an opportunity to begin cooperation within a small group where agreements can be reached more easily and ambition levels can sometimes be raised. The appeal of clubs is that they can offer specific incentives, or contingent offers, to participants, the benefits of which can be expected to spread as the club extends its reach by allowing new members to join.[20]

Scholars have suggested three distinct rationales or approaches for considering the difference clubs make in international relations. First, clubs can contribute to informal dialogue outside official arenas, thereby contributing to reducing the severity of interest asymmetries. Second, clubs can create member-specific incentives, thereby altering the interests of key countries who are willing or accepted to join. Thirdly, clubs can legitimate great power cooperation within the context of existing multilateral regimes, and serve as stepping stone towards more comprehensive multilateral agreements, i.e. a coalition of the willing.[21] An assessment of minilateral approaches must take into account which of the above paths the club attempts to follow.[22]

To our knowledge, the first time a club approach or a 'mini-regime' was suggested was within the United Nations Conference on the Law of the Sea in the 1970s, but the idea never materialized.[23] Since then, global environmental governance studies have been the most advanced in looking at the phenomenon of clubs through a political science lens, particularly within the global climate change negotiations having been conducted for almost twenty-five years within the United Nations framework. The most important reasons for the emergence of a number of clubs at various governance levels here are the salience of the issue, the painstakingly slow progress in the negotiations process, and the fact that some 80 percent of greenhouse gas emissions are emitted by the G20 countries. That is, in principle, this problem can be solved by a fairly small number of actors. Researchers have mapped seventeen clubs with different forms of participation by both state and

non-state actors.[24] Some researchers have claimed that the aspiration of clubs should be to instigate transformative change and increase ambition levels.[25] [26] Studies, however, have tempered such optimism, finding that although clubs make contributions to UN-led approaches and may under certain conditions speed up the process, there has yet to be a club that has instigated transformative change. [27] [28] [29]

As we make the case for the Global Health and Foreign Policy Initiative amidst a number of related cases grouped under the phenomenon of clubs, our starting point is a recognition that there is a wide variety in scope among clubs—set according to what issues or processes the group aims to influence. If a key driver of a club is to add value to a multilateral governance arena, we must also ask what transformative change entails, whether it be to reach a successful outcome of a process, or change the process and approach altogether.

THE ORIGIN OF THE GLOBAL HEALTH AND FOREIGN POLICY INITIATIVE

In 2006, seven ministers of foreign affairs created the Initiative with the explicit intention of strengthening the strategic focus on health as a foreign policy issue. In order to announce the newly constituted group and their mission, the ministers published in 2007 what is known as the Oslo Ministerial Declaration in *The Lancet*.[30] Together, the seven countries assert that, in view of today's globalisation dynamics where foreign policy is subjected to new complex and interdependent challenges, "impact on health" should be a "point of departure and defining lens (…) to examine key elements of foreign policy and development strategies".[31] "Impact on health" refers to the connection to other policy areas such as environment, trade, national security, and human rights. The intention is that decisions in these areas should be guided by a focus on health consequences. In addition to these ambitions for intersectoral collaboration, the declaration also sets out to explore how foreign policy can "add value" to ongoing international processes on health issues.[32]

The Oslo Ministerial Declaration is considered a starting point for the group's work and formulates a broad agenda for action that can accommodate almost any global health issue. The agenda elaborates on three main themes: (1) 'Capacity for global health security;' (2) 'Facing threats to global health security;' and (3) 'Making globalization work for all.'[33] These themes lead into ten areas of action, which the seven signatory countries pledged to pursue in their respective regional settings and in relevant international bodies.[34] The Oslo Ministerial Declaration received considerable attention and was widely cited in the following years by the global health academic and policy community.[35]

When considering the selection of countries and the fact that the Initiative was formed by ministers of foreign affairs (and not by ministers of health), it is clear that individual professional background, experiences, networks, and leadership played a decisive role. According to then Norwegian Minister of Foreign Affairs, Jonas Gahr Støre, the formation was initiated by himself and his French colleague, Philippe Douste Blazy. Having worked earlier as chief of staff under then World Health Organization (WHO) Director-General Gro Harlem Brundtland, Støre had already been exposed to newly emerging dynamics at the interface of health and foreign policy. Since Gahr Støre's departure from Geneva, the international community had experienced SARS, negotiated its first global health convention on tobacco control, and was facing the threat of bird flu as a potential new influenza pandemic.[36] Douste Blazy is a medical doctor by training and had previously been the French minister of health. In this way, both ministers drew upon their established networks when inviting five additional countries for exclusive

membership. From the Norwegian perspective, the selection was based on both strategic and geographical concerns. The members represent key states in four different regions of the world, including two emerging economies (Brazil and South Africa). Some were also countries with whom Norway had cooperated on international issues or with whom it had a vested interest in strengthening its diplomatic bonds.[37] [38] Besides these decisive factors, another significant impetus of the other five countries to join can be traced back to the personal academic backgrounds and professional experiences of all the ministers of foreign affairs, as with Gahr Støre and Douste Blazy—some were trained medical doctors, others had worked on health issues in their earlier diplomatic careers. Indeed, their common experiences enabled the seven ministers to bond in such a way that this 'personal touch' of the Initiative seems to have diffused to the countries' additional diplomatic levels.

THE FUNCTIONING OF THE INITIATIVE

When addressing the way the Initiative works, rather than a chronological account, we seek to highlight three features that stand out from the interview material: the relation of the Initiative to the UN General Assembly and the World Health Assembly; its interaction and interface with WHO processes; and lastly, the ways through which the Initiative influences policy processes in its member states. First, however, the Initiative's structure as a network among state representatives and diplomats at three levels merits attention. The most frequent level is the interaction among health attachés of the countries' UN missions in Geneva. The second level is among high level civil servants in the ministries of foreign affairs. The third network level is among the ministers of foreign affairs or health. On a rotating basis, the countries have taken on the roles of presidency and secretariat. In this way, the Initiative is not an organization like the Global Fund to fight HIV/AIDS, Tuberculosis, and Malaria or the GAVI Alliance. As one respondent noted, "(s)uch comparisons would misinterpret the institutional character of the Initiative, (which) is a network to strengthen the global health agenda" (4[Sep-2011]).

Bridging UN Arenas

The primary venues for the Initiative to set a global agenda for the foreign policy dimensions of health is where states meet, the annual World Health Assembly in Geneva and the UN General Assembly in New York.

At each World Health Assembly since the Initiative's inception, the ministers of health meet on the side lines, resulting in a ministerial communiqué issued by the member state holding the presidency of the Initiative at the time. The communiqués relate to the agenda of the WHO, awarding support to ongoing processes or issues for which there is consensus within the Initiative. A recent example is the communiqué from 2014, which includes a broad scope of issues, including universal health coverage; the relationship of health to core values of the post-2015 agenda; the link between climate and health; antimicrobial resistance; as well as violence against health workers.[39]

The Initiative's persistent interface with the UN General Assembly (UNGA) is more unique, as global health issues are traditionally kept to the Geneva venues, while the New York setting represents the broader scope of UN concerns. A core link between the Initiative and the UNGA is the Annual Report on Global Health and Foreign Policy from the WHO Director-General to the UNGA. The report addresses

select thematic areas each year, reflected in their titles (e.g. Health, Environment and Natural Disasters in 2011; Universal Health Coverage in 2012; and the Protection of Health Workers from Violence in 2014). The reports culminate in General Assembly resolutions. Regular ministers of health meetings occur annually at the United Nations General Assembly (UNGA) in New York, at times also among the ministers of foreign affairs. To highlight the unique nature of their meetings, one interviewee rhetorically asked: "Is there any other health ministers' meeting at the margins of the UNGA? We (the OMG) meet" (1[Aug-2011]). Although these dynamics are perceived as successes by the interviewees, these closed meetings are not widely publicized and thus have so far eluded academic scrutiny. Nonetheless, there has been wide recognition that global health and foreign policy is an important topic that needs to be regularly discussed and advanced at the UNGA level.[40]

Supporting WHO Processes

Another important inter-state venue is the gathering of the WHO to convene negotiation processes aiming at international agreements among member states. One such process so far in the lifetime of the Initiative is the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits (the PIP Framework). This agreement is consistently highlighted in our data as an area of influence by the Initiative. The PIP Framework, which was approved by the WHA in May 2011, is considered "…a landmark in global governance for health, representing the first international agreement on influenza virus and benefit sharing" (p. 200).[41] This outcome had been preceded by four-year long cumbersome and tense negotiations due to complex policy issues and WHO member countries with highly diverging interests, especially with regards to intellectual property rights. [42]

The heterogeneous collective of countries and regions within the Initiative involved several important circumstances that helped them both comprehend and influence the complexity of the PIP negotiations in its microcosmic form at group level. The initial rationale to eventually launch WHO-based negotiations on influenza virus and benefits sharing dated back to the avian influenza A (H5N1) outbreaks in late 2006. The Initiative's member state Indonesia "refused to share virus specimens with WHO, claiming it was unfair to give pharmaceutical companies access," as the Southeast Asian country feared that "industry would use (such) viruses to patent vaccines and antiviral medications that Indonesia could not afford."[43] Although this concern initially represented a particular negotiation stance of Indonesia, the situation reflected a fairly typical fault line between the rich northern countries protecting their interests at the expense of developing countries' needs, and an increasingly perceptible number of developing countries made use of sophisticated diplomatic ways to safeguard their interests. Besides Indonesia, Norway also played a considerable role as part of the negotiations' chairmanship, and according to interviewees, had obtained this position also as a result of preceding internal discussions among the Initiative's member states.

In understanding how the Initiative influenced the negotiations process towards the PIP agreement, a recurring issue that was mentioned in several interviews was the Initiative's capacity to serve as a trust-, confidence-, and consensus-builder among the seven member countries, where they seemed to become more sensitive to each other's political positions. The group perceives its exclusive forum as a means to discuss and understand diplomatic fault lines within the Initiative before actually being confronted with similar conflictual positions of

other countries and groups at the UN level (2[Aug-2011]; 4[Sep-2011]; 6[Dec-2011]). In this way, Initiative member states learn about the sources consensual and especially conflictual positions, which they experience as making the diplomatic day-to-day work easier, often even triggering spill-over effects from specific global health topics into other policy areas. In fact, many conflicts internally battled inside the Initiative represent a microcosm of what are often conflictual lines among northern and southern countries, as can be observed with regards to the highly controversial issues of counterfeit medicines or intellectual property rights.

Due to the group's cross-regional and distinct cross-cultural character of middle- and regional powers, member countries have the capacity to actually convince their respective regions. An interviewee described this reconciling potential of the Initiative members as follows: "(T)he cross-regional nature of the group means that we are able to breach the differences among different political groupings in the UN system" (3[Aug-2011]). Regularly, the Initiative member states decide among themselves on global health and foreign policy issues that need to be brought down to the level of regional groupings, and then take them back with new input to the Initiative. This multi-level process, which also has the potential to eventually pivot between the regional levels and the Initiative, helps to build consensus and organize negotiation positions, thereby taking the ultimate respective policy issue forward within the UN system. In reflecting on these diplomatic processes, several interviewees asserted that this way of conducting diplomacy may become even more important in the future, as today's UN negotiations are characterized by transnational power shifts where traditional powers have less influence over outcomes.

The 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, the First Global Ministerial Conference on Healthy Lifestyles and Non-Communicable Diseases in Moscow in April 2011, the UN High-Level Meeting on HIV/AIDS in New York in June 2011, ongoing WHO reform discussions, and the 2011 WHO Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products. At the 2011 UN General Assembly High- Level Meeting on HIV/AIDS in New York, the Initiative issued a joint declaration that highlighted its common understanding and position and also called for worldwide access to affordable medicines. According to one interviewee, OMG's position also resonated with many groupings, including the emergence of collaborating negotiation partners that typically would have opposed each other (3[Aug-2011]).

The relation between global level and member states home ministries

The influence of countries on global inter-state arenas is ultimately not only the result of diplomatic craftsmanship, but also grounded in national policies. Even though the most active network of the Initiative is among health attachés of member states' permanent representations in Geneva (the world's global health capital), the Initiative's ambition is to also influence the way that member states address global health issues at home, though to varying extents.[44] The variation reflects a mix of different administrational arrangements in the seven countries. Some interviewees conceded that parts of their national bureaucracies responded to the emergence of the Initiative by concerting global health and foreign policy responsibilities within their ministries of foreign affairs in conjunction with the ministry of health (2[Aug-2011]); 4[Sep-2011]; 6[Dec-2011]). Others asserted that their national

administrations have set up Initiative focal points or made use of existing relevant inter-ministerial commissions, all of which seem to have improved cross-ministerial work relationships (1[Aug-2011]; 3[Aug-2011]).

The variety of different administrative adjustments within the seven states is probably also a result of the countries' different financial, organizational, and human resources. Despite these structural differences, the members share the opinion that the Initiative has so far served as an opportunity for their ministries of foreign affairs to learn how they can take on new coordinating and expertise roles vis-à-vis different national ministries, some of which are becoming increasingly international, thereby challenging the traditional significance of the ministry of foreign affairs. At the same time, however, our data suggests that structural limitations at the national level frequently have the potential to strain the Initiative's momentum. Moreover, since the majority of the Initiative's work occurs among diplomats and primarily in Geneva or New York, its functionality is regularly stressed whenever diplomats, but also ministers at home, rotate and are replaced by new people. While this continues to be a delicate challenge, the OMG has so far proven to withstand changes that have occurred in personnel both in Geneva and the capitals.

CONCLUDING DISCUSSION

In traditional foreign policy analysis, scholars often maintain their focus on a country's foreign policy objectives, its roles in international negotiations, and alliances formed in order to leverage power to achieve stated objectives. In emerging research of global health governance, the analytical focus leans towards the global institutional architecture. While obviously important for understanding international politics, both approaches are insufficient to fully grasp the intersection of foreign policy and global health.

Our data on the Global Health and Foreign Policy Initiative suggests that it has proven to be a resilient group and not just a passing fashion—that the approach called for in the Oslo Ministerial Declaration requires deeper changes in states' foreign policymaking. The data brought forth three factors that seem to have worked as enablers in strengthening the role and impact of the Initiative and its member states, namely by bridging global arenas, supporting negotiation processes, and influencing national policy arenas. These factors, may allude to forms and functions of a state's capacity to maintain its presence and influence within the multi-actor landscape in global health governance.[45] Furthermore, our findings suggest that the Initiative scores somewhat higher on the first two factors than the third. Thus, arguments that the Oslo Ministerial Declaration "was a catalyst for raising the health-foreign policy relationship within the UN"[46] are probably right, although what constitutes *better* outcomes of processes or *heightened* awareness among policymakers at large remains more elusive. Probing such issues on a deeper level would require case studies of specific policy processes.

The Initiative reflects the new trend whereby diplomacy has steadily turned into complex relationship management, much of which is based on networks and other forms of nodal relations, such as clubs, alliances, or coalitions, none of which exercise diplomacy exclusively, but coexist and interact with each other as issues, strategies, and venues have become increasingly connected.[47] [48] Still, the Initiative is quite different from most of the clubs that have emerged in the context of global climate change in that it has a very broad scope and intends to remain small with a limited number of participating countries. Other countries have expressed interest in joining the group, but this has been declined. In this sense, the Initiative runs

counter to recommendations by scholars, suggesting that membership scope should be expanded over time. A weakness of many of the 'climate clubs' is that they have often failed to attract members from the global south, which is considered essential to deal effectively with the issue because of their large share of greenhouse gas emissions. In this regard, the Initiative deserves a high score considering that the majority of members are from the south and global health issues do not necessarily depend on such basic power resources for their solutions.

A key practical and analytical question the assessment of Initiative's contributions, and what measurement tools to apply when judging success or failure. Should one take its goals at face value, or interpret its ambitions as a new framing of the global health agenda? From a problem-solving perspective—in terms of improving global health on the ground—the Initiative cannot claim to be a success. According to our observations, it has responded to opportunities to engage within the global health domain, more than pushing the frontiers of cross-sectoral approaches. Still, our data suggests that it contributed positively to reduce the traditional north-south conflicts on important issues, and has been a champion for a broader framing of the global health agenda.

The Oslo Ministerial Declaration does indeed aim at transformative change, and as such, might have set unrealistic expectations among observers. However, it is simply unrealistic for this to be brought about by an informal club of small and medium sized states. That being said, it represents an innovative way to revitalize the role and function of states in global health governance. A challenge in the field of public health is the strong link between global health initiatives and aid financing, dividing the international community into donors, recipients, and a large group of middle-income countries. What the Initiative showcases is the emerging imperative to transcend such categorizations and view all countries instead as both makers and takers of global policies, where managing this interface to improve population health is indeed a practice of foreign policy.

No attempt has, to our knowledge, been made to identify best practices for countries actively seeking to apply a health lens to other foreign policy issues or sectors of global governance. Observers have criticized the Initiative for failing to show examples in this domain.[49] By turning the challenge over to the research community on global health governance, we propose to build upon research in global environmental governance and systematically compare the global health experience with practices in other areas of global policy coordination. From a body of cases with similar conceptual foundations, much can be learned about club strategies in relation to multilateral processes and other forms of intellectual and instrumental leadership exerted by both state representatives and epistemic communities. When considering how minilateral approaches can be made to work in a fragmented global governance system, one also needs to consider how club benefits affect sectoral or issue-specific interests at the domestic level.

Global health governance has been a budding academic field for the last decade and can benefit from utilizing political science perspectives in building a body of knowledge through empirical research. This will involve building a stronger case for the politics of global health as a distinct area of research grounded in political science and international relations and in doing so, to study phenomena at the global level rooted in the practice and interaction of states as the fundamental set of actors in international relations. The past decade's focus on *global* health governance casts a veil over what always was, and continues to be, the efforts among states to create, restrict, enable, and effectuate efforts that aim for improved health conditions. A

political science focus can help lift the gaze from the global architecture and not lose track of the states' agency in increasingly overlapping levels of governance.

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[1] Kelley Lee and Richard Smith "What is 'Global Health Diplomacy'? A conceptual review," *Global Health Governance* 5 (2011):18

[2] David P. Fidler,"Navigating the global health terrain: Mapping global health diplomacy," *Asian Journal of WTO & International Health Law and Policy* 6 (2010): 1-43

[3] Kelley Lee and Eduardo J Gómez,"Brazil's Ascendance: The soft power role of global health diplomacy," *European Business Review* (2011): accessed April 5, 2012, http://www.europeanbusinessreview.com/?p=3400.

[4] John Girard Ruggie, "Reconstituting the global public domain – Issues, actors and practices," *European Journal of International Relations* 10 (2004): 499-531.

[5] Ilona Kickbusch Gaudenz Silberschmidt, and Paulo Buss, P. "Global health diplomacy: The need for new perspectives, strategic approaches and skills in global health," *Bulletin of the World Health Organization* 85 (2007):230-232.

[6] Ilona Kickbusch, "Global health diplomacy: how foreign policy can influence health." *British Medical Journal* 342 (2011): 1-4.

[7] Ronald Labonté and Michelle L. Gagnon, "Framing health and foreign policy: lessons for global health diplomacy." *Globalization and Health* 6(2010).

[8] Karen J. Alter and SophieMeunier, (2009) "The Politics of International Regime Complexity." *Perspectives on Politics* 7 (2009): 13-24.

[9] Ole Petter Ottersen, *et. al*, "Global governance gaps propagate health inequities: political determinants of health. The Lancet-University of Oslo Commission on Global Governance for Health," *The Lancet* 383 (2014): 630-67.

[10] Nicola F. Watt, , Eduardo Gomez,, and Martin McKee, "Global health in foreign policy and foreign policy in health? Evidence from the BRICS," *Health Policy and Planning*, 29 (2014):763-773.

[11] Wolfgang Hein and Suerie Moon, *Informal norms in global governance: Human Rights, Intellectual Property and Access to Medicines*. (Aldershot, UK: Ashgate, 2013).

[12] Michelle L. Gagnon and RonaldLabonté, «Understanding how and why health is integrated into foreign policy: A case study of *Health is Global, a UK government strategy 2008-2013*,» *Globalization & Health* 9 (2013): 9-24

[13] Kristin Ingstad Sandberg and Steinar Andresen, "From development aid to foreign policy: global immunization efforts as turning point for Norwegian engagement in global health." *Forum for Development Studies* 37 (2010): 301-325.

[14] Steinar Andresen, "International climate negotiations: Top-down, bottom-up or a combination of both?" *The International Spectator*. In press.

[15] Omitted for anonymity.

[16] Robert Marten, Johanna Hanefeld,, Richard Smith, "Power: The nexus of global health diplomacy?" *Journal of Health Diplomacy 1 (*2014), accessed February 1, 2014,, available at http://www.ghd-net.org/sites/default/files/marten_smith_hanefeld.pdf

[17] Chantal Blouin, et al., *Annotated literature review: Conceptual frameworks and strategies for research on global health diplomacy.* (Ottawa, Centre for Trade Policy and Law, Carleton University/University of Ottawa: 2012), EQUINET Discussion Paper 92.

[18] Mancur Olson, Jr., *The logic of collective action*. (New York: Schocken, 1969).

[19] Jon Hovi, Detlef F. Sprinz,, Hakon Sælen,, and Arild Underdal, "The club approach: A gateway to effective climate cooperation?" *International Organization* (manuscript in review).

[20] David G Victor, *Global warming gridlock: Creating more effective strategies for protecting the planet. (*Cambridge: Cambridge University Press, 2011).

[21] Robert Falkner, *A Minilateral Solution for Global Climate Change? On Bargaining Efficiency, Club Benefits and International Legitimacy*. (London: Grantham Research Institute on Climate Change and the Environment, Working Paper No. 197, 2014).

[22] *Ibid.*

[23] Richard G. Darmann, "The Law of the Sea: Rethinking U.S. Interests," *Foreign Affairs (*1978): 372-395.

[24] Lutz Weischer, Jennifer Morgan, , and Milap Patel., M. "Climate Clubs: Can Small Groups of Countries Make a Big Difference in Addressing Climate Change?" *Review of European Community & International Environmental Law* 21 (2012):177–92.

[25] *Ibid.*

[26] Frank Biermann, Phillip Pattberg, Harro van Asselt, H, Zelli, E. "The Fragmentation of Global Governance Architecture: A Framework for Analysis," *Global Environmental Politics* 2 (2009): 14–40.

[27] *Ibid.*

[28] Weischer *et al*, 2012.

[29] Steinar Andresen, "Exclusive Approaches to Climate Governance: More Effective than the UNFCCC?" in *Toward a New Climate Agreement: Conflict, Resolution and Governance*, edited by T. Cherry,J. Hovi,, and D.M. (London and New York, Routledge, 2014): 155-67.

[30] Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand, "Oslo Ministerial Declaration: Global health – a pressing foreign policy issue of our time," *The Lancet 369 (*2007): 1373-1378.

[31] *Ibid.*

[32] *Ibid.*

[33] *Ibid.*

[34] *Ibid.*

[35] Eggen Ø., Sending, O.J, «Recent contributions to research on health and foreign policy. A report of the International research initiative 'Foreign Policy as Part of Global Health Challenges'." NUPI Report. Oslo, Norwegian Institute of International Affairs 2010.

[36] Sandberg, and Andresen,, 2010.

[37] Jonas Gahr Støre, *Making a difference: Reflections from a Norwegian Minister of foreign Affairs* (translation from Norwegian) (Oslo, Cappelen Damm: 2009).

[38] Sandberg and Andresen, 2010.

[39] Permanent Mission of Norway in Geneva. "Ministerial Communique Foreign Policy and Global Health Initiative. 20 May 2014." accessedFebruary 17, 2015, available at http://www.norway-geneva.org/health/Ministerial-Communique-Foreign-Policy-and-Global-Health-Initiative/#.VQCJLEsrhg1.

[40] Sigrun Møgedal, and Benedikte Louise Alveberg, "Can Foreign Policy Make a Difference to Health?" *PLoS Medicine* 7 (2010): e1000274.

[41] David P. Fidler and Lawrence O. Gostin, "The WHO Pandemic Influenza Preparedness Framework: A Milestone in Global Governance for Health," *JAMA*. 306 (2011) :200-201. doi:10.1001/jama.2011.960.

[42] David P. Fidler, "Negotiating Equitable Access to Influenza Vaccines: Global Health Diplomacy and the Controversies Surrounding Avian Influenza H5N1 and Pandemic Influenza H1N1," *PLoS Med*icine 7(2010): 1-4.

[43] Fidler and Gostin,, 2011.

[44] Sandberg and Andresen, 2010.

[45] Miriam Faid,"Tackling Cross-Sectoral Challenges to Advance Health as Part of Foreign Policy," (Oslo: Fridtjof Nansen Institute, 2012).

[46] David Fidler, "Assessing the Foreign Policy and Global Health Initiative: The Meaning of the Oslo Process." Briefing Paper. (London: Chatham House, Centre on Global Health Security, 2011).

[47] Jorge Heine. "On the Manner of Practising the New Diplomacy," Working Paper 11, (Waterloo, Ontario, Canada: The Centre for International Governance Innovation, 2006).

[48] David Fidler,"Asia's Participation in Global Health Diplomacy and Global Health Governance.," *Asian Journal of WTO & International Health Law and Policy* 269 (2010): 269-300.

[49] Fidler, 2011.