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The transnational governance of global health: Norwegian and Swiss cases of national policies on global health

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Résumé

Cette thèse de doctorat a pour but de mieux comprendre les rapports entre une politique nationale sur la santé mondiale et la gouvernance mondiale de la santé (*global health governance* - GHG). À cette fin la thèse examine un objet émergent, la politique nationale sur la santé mondiale (*national policy on global health* – NPGH) dans une perspective de science politique de la santé, un champ de recherche interdisciplinaire. Elle s'appuie sur des théories et des concepts de l'étude de politiques publiques pour explorer les processus, les règles et les relations de pouvoir qui caractérisent les arènes de politiques nationales dans lesquelles plusieurs secteurs interagissent pour coordonner la stratégie de santé mondiale d'un pays. Ainsi conceptualisée en termes de politique publique, la NPGH est une arène d'action multisectorielle dans laquelle les acteurs des secteurs de la santé, du développement, et des affaires étrangères interagissent pour prendre des décisions sur la façon de gérer le travail d'un gouvernement national concernant la santé mondiale. Étudier la NPGH permet d'éclairer trois grands enjeux de la recherche et de la pratique en santé publique et en promotion de la santé, tels que l'intersectorialité, la gouvernance et le rôle des sciences sociales. Cette thèse compte dix chapitres, dont quatre articles (deux publiés et deux à soumettre) et deux monographies de cas.

L'article 1 présente le cadre théorique qui oriente tant les questions de recherche que l'approche déductive utilisée pour générer et analyser le matériel empirique. Pour conceptualiser les processus de NPGH dans les termes de l'étude des politiques publiques, nous avons adapté le cadre théorique synthétique de Real-Dato. Ce cadre établit les catégories analytiques qui permettent de conceptualiser les arènes d'action de NPGH, de replacer ces arènes dans un ensemble de contextes multidimensionnels, et de poser leurs limites internes (nationales) et externes (globales) pour explorer les mécanismes de changement de politique entre les paliers national (NPGH) et global (GHG).

Nous avons développé un devis d'études de cas multiples, qualitatif et rétrospectif, incluant deux études de cas approfondies de NPGH en Norvège et en Suisse, pour répondre à trois questions de recherche :

1) Quels sont les éléments du *policy design* dans les documents de NPGH qui ont été formellement adoptés ?
2) Qu'est-ce qui caractérise les arènes d'action qui développent des documents de NPGH ? et
3) Comment fonctionnent les mécanismes de changement entre le système global de GHG et les arènes nationales de NPGH ?

Nous avons procédé à une collecte de données documentaires et à des entrevues pour générer les données. En 2014 et 2015, trente-trois entrevues individuelles semi-dirigées ont été réalisées avec des informateurs clés de Suisse (n = 14) et de Norvège (n = 19), en utilisant des techniques visuelles (article 2). Les informateurs clés comprenaient des acteurs politiques importants et des experts des secteurs de la santé, du développement et des affaires étrangères, ainsi que des acteurs de la société civile et des chercheurs. Pour chaque étude de cas, un « groupe consultatif contextuel » a été mis en place. Ces groupes constituent une partie intégrante du devis de recherche de la thèse : ils ont été conçus et opérationnalisés comme des dispositifs méthodologiques visant à soutenir et valider la construction des cas.

L'article 3 présente les résultats de la première étude comparative, celle des deux documents de NPGH officiellement adoptés, la *Politique extérieure suisse en matière de santé* et le *White Paper on Global health in foreign and development policy* de la Norvège. Nous avons utilisé le cadre conceptuel du *policy design* de Schneider et Ingram pour mener une analyse de contenu qualitative dirigée de ces documents, afin de comprendre les buts de ces politiques et les façons dont elles envisageaient de les atteindre. Cette étude a révélé que ces NPGH visent à opérer un changement sur le plan international et prévoient le recours à des instruments de coopération et de diplomatie en santé pour apporter des modifications dans le système de gouvernance mondiale de la santé.

En reconstituant de façon rétrospective les arènes d'action qui ont produit ces deux documents (entre 2005-2013), nous avons constaté que, dans les deux cas, les acteurs gouvernementaux de la santé et des affaires étrangères (entre autres) ont innové, usant de stratégie et d'opportunisme pour créer des arènes de collaboration leur permettant d'agir dans et sur le système de gouvernance mondiale de la santé. Pour contextualiser et construire les deux cas approfondis des arènes d'action de NPGH en Norvège et en Suisse, les analyses ont été réalisées en trois étapes :

- étape 1 : cartographier des situations d'action dans les deux arènes d'action nationales ;
- étape 2 : comprendre les processus au sein de chaque situation d'action ;
- étape 3 : produire un rapport sur chaque situation d'action axée sur les règles et le pouvoir.

Dans les cinq situations suisses, les règles ont institutionnalisé les arrangements de partage du pouvoir et ont mis au défi les cultures sectorielles. Dans les six situations norvégiennes, elles ont renforcé l'asymétrie du pouvoir et la territorialisation sectorielle. Dans les deux cas, ce sont des secteurs différents qui sont à l'origine des NPGH : le secteur de la santé en Suisse et le secteur des affaires étrangères en Norvège.

L'article 4 présente les résultats de la deuxième étude comparative, qui visait à mieux comprendre la relation entre les processus de gouvernance de la santé mondiale aux échelles nationale et mondiale. Les données des deux cas ont été analysées pour cerner les structures relationnelles entre les processus nationaux et internationaux de gouvernance de la santé mondiale. Nous avons trouvé cinq formes d'interactions entre les arènes de NPGH et la GHG : les entités responsables de la gouvernance des organisations intergouvernementales pour la santé, la gouvernance des partenariats mondiaux de santé public-privé, les accords de coopération formels et informels, les carrefours mondiaux d'acteurs de santé, et les élites transnationales. La circulation des idées et la rétroaction entre différents processus de production des politiques publiques qui se chevauchent dans un espace transnational de gouvernance de la santé mondiale signifient qu'une arène NPGH est partiellement intégrée dans le système de GHG, de même que le système de GHG est en partie intégré dans une arène NPGH.

Dans l'ensemble, trois principaux résultats de cette thèse contribuent à mieux comprendre le NPGH en tant que processus politique à la jonction de la diplomatie de la santé et de la gouvernance mondiale de la santé : la répartition des rôles entre les secteurs varie selon les arènes multisectorielles de NPGH ; les idées politiques circulent dans les interactions entre les arènes de NPGH et la GHG ; la GHG se matérialise comme une cible systémique pour les arènes de NPGH. En tant qu'arènes de politiques transnationales, les NPGH sont des *politiques intersectorielles sans frontières :* elles ciblent et interagissent avec des acteurs et des institutions ancrés dans les arènes nationales, internationales et mondiales de gouvernance de la santé mondiale. Cette forme de gouvernance transnationale de la santé mondiale peut renforcer le statut privilégié de certains acteurs étatiques dans la GHG et créer potentiellement des conditions pour le transfert de politiques publiques par le biais de mécanismes de réseautage et d'apprentissage.

Cette thèse apporte trois contributions distinctes. Premièrement elle contribue de deux façons à la connaissance sur les politiques publiques : 1) empiriquement, elle contribue à la connaissance des processus et des façons dont le secteur de la santé s'engage avec d'autres secteurs dans la politique et la gouvernance intersectorielles, et 2) d'un point de vue méthodologique, elle contribue au développement de devis de recherche et de méthodes qualitatives pour la recherche comparative sur les politiques de santé qui prennent en compte la contextualisation de la politique. Deuxièmement, elle fait une contribution théorique à la conceptualisation de la gouvernance transnationale de la santé mondiale, dans laquelle la gouvernance de la santé mondiale est comprise comme un processus qui se construit par le bas à travers des interactions transnationales. Cette conceptualisation de la gouvernance transnationale de la santé contraste avec la conception généralement admise d'un processus qui se construit par le haut, à partir des organisations internationales. Troisièmement, par son ancrage dans un domaine de recherche interdisciplinaire de la science politique de la santé, cette thèse offre à la fois un exemple de la façon dont les théories des politiques publiques peuvent être utilisées pour comprendre les politiques intersectorielles liées à la santé et à la

gouvernance de la santé mondiale, et un exemple de la manière dont l'étude de politiques sur la santé mondiale peut être utilisée pour élaborer des théories sur les politiques publiques.

Mots-clés : politique nationale sur la santé mondiale, gouvernance mondiale de la santé, Norvège, Suisse, action intersectorielle, santé dans toutes les politiques, processus politique, gouvernance intersectorielle, gouvernance transnationale

Abstract

The objective of this thesis is to understand the relationship between national policy on global health and global health governance (GHG). To this end, the thesis examines an emergent object, national policy on global health (NPGH), from the perspective of the interdisciplinary research field of health political science. It draws on theories and concepts from policy studies to explore the processes, rules, and power relations that characterise national policy arenas in which multiple sectors interact to coordinate the global health strategy of a country's government. Conceptualised in public policy terms, NPGH is a multisectoral action arena wherein actors from health, development, and foreign affairs sectors interact to make decisions about how to manage the government's work on global health. The study of NPGH as a research object sheds light on three broad areas of concern for public health and health promotion policy-related research and practice, such as intersectorality, governance, and the role of social science. The thesis is presented in ten chapters, including four articles (two published and two to be submitted) and two case monographs.

The theoretical framework that informs the research questions for the thesis and orients the deductive approach used to generate and analyse the empirical material is presented in Article 1. We adapted Real-Dato's synthesis framework from the discipline of political science to conceptualise the processes of NPGH in public policy terms. This framework establishes the analytical categories constituting NPGH action arenas, set within a multidimensional set of contexts, around which we drew internal (national) and external (global) boundaries for exploring mechanisms of policy change between NPGH and GHG.

This thesis used a retrospective qualitative multiple case study design with two in-depth case studies of NPGH in Norway and Switzerland to answer three research questions:

1) What are the elements of policy design in formally adopted NPGH documents?

2) What characterises action arenas that develop NPGH documents? and

3) How do mechanisms of policy change operate between the system of GHG and the arenas of NPGH?

Data was collected through documentary and interview methods. In 2014 and 2015, I carried out thirty-three semi-structured interviews with key informants from the countries of Switzerland (n=14) and Norway (n=19), using visual techniques (Article 2). Key informants included senior policy actors and experts from the health, development, and foreign affairs sectors as well as civil society actors and researchers. For each case study, a "Context Advisory Group" was established. These groups are an integrated feature of the research design for this thesis as methodological devices to support and validate the construction of the cases.

Article 3 presents the results of the first comparative study, which examines the two formally adopted NPGH policy documents, the *Swiss Health Foreign Policy* and the *White Paper on Global health in foreign and development policy* from Norway. We used Schneider and Ingram's policy design framework to conduct a directed qualitative content analysis of these documents to understand the aims of these policies and the plan to achieve them. This study found that these NPGH aim to create change at the international level and plan to use instruments of health diplomacy and cooperation to modify the global health governance system.

Retrospectively reconstructing the policy arenas that produced these two documents (between 2005-2013), I found that in both cases, government actors from health and foreign affairs sectors (among others) innovated, using strategy and opportunism to build arenas for collaboration to act in and on the global health governance system. To contextualise and construct the two in-depth cases of NPGH action arenas in Norway and Switzerland, analyses were carried out in three stages:

- stage 1 to map action situations in the two national action arenas,
- stage 2 to understand the processes within each action situation, and
- stage 3 to produce a report of each action situation focusing on rules and power.

Rules institutionalised power-sharing arrangements and challenged sectoral cultures in the five situations of the Swiss arena, and they reinforced power asymmetry and sectoral territorialisation in the six situations of the Norwegian arena. The sectors responsible for initiating the NPGH action arena were different in each of the two cases: the health sector being the driver in the Swiss case, and the foreign policy sector in the Norwegian one.

Article 4 presents the results of the second comparative study, which aimed to better understand the relationship between processes for governing global health at national and international levels. Data from the two cases were analysed for the relational structures between the two (national and international) levels of processes for governing global health. We found five forms of interactions between NPGH arenas and GHG: governing bodies of intergovernmental organisations for health, governance of global public-private health partnerships, formal and informal cooperation agreements, global health hubs, and boundary-spanning transnational elites. The circulation of ideas and feedback between different overlapping policy processes within a transnational space for governing global health signifies that an NPGH arena is partly embedded in the GHG system, similarly to the way that the GHG system is partly embedded in an NPGH arena.

Overall, three main findings contributing to better understanding NPGH as a policy process at the junction of health diplomacy and global health governance stem from this thesis: the distribution of roles for sectors varies in multisectoral arenas for NPGH; policy ideas circulate in the interactions between arenas of NPGH and GHG; and GHG materialises as a systemic policy target for arenas of NPGH. As transnational policy arenas, NPGH are *intersectoral policies without borders* that target and interact with actors and institutions in multiple spaces spanning domestic, international, and global arenas for governing global health. This form of transnational governance of global health may bolster the insider status of some state actors in GHG and potentially create conditions for policy transfer through networking and learning mechanisms.

This thesis makes three distinct contributions. First, it contributes in two ways to knowledge on public policy: 1) empirically, it contributes to improve understanding of how the health sector engages with other sectors in intersectoral policy and governance, and 2) methodologically, it contributes to the development of research designs and qualitative methods for comparative health policy research that considers the contextualisation of policy. Second, it makes a theoretical contribution to the conceptualisation of transnational governance of global health, wherein GHG is understood a process that happens *par le bas* through national policy's various transnational interactions as an alternative understanding to that as a process that happens *par le haut* from international institutions. Third, as a thesis anchored in an interdisciplinary research field of health political science, it offers an example of how public policy theories can be used to understand intersectoral policy related to health and global health governance, as well as an example of how the study of global health policy can be used to develop theories of public policy.

Keywords : national policy on global health, global health governance, Norway, Switzerland, intersectoral action, health in all policies, policy process, intersectoral governance, transnational governance

Table of contents

List of tables

Chapter 8

Chapter 9

List of figures

Chapter 7

List of acronyms and abbreviations

AMR – antimicrobial resistance

APP – archives of the policy process

BMGF – Bill and Melinda Gates Foundation

CAG – Context Advisory Group

CS – civil society sector

CSO – civil society organisation

D – development sector

DFID – United Kingdom's Department for International Development

ECDC – European Centres for Disease Control

EU – European Union

FA – foreign affairs sector

FAD – Foreign Affairs and Defence Committee

FCTC – Framework Convention on Tobacco Control

FDFA – Federal Department of Foreign Affairs

FDHA – Federal Department of Home Affairs

FOPH – Federal Office of Public Health

FPGH – Foreign Policy and Global Health Initiative

G20 – Group of Twenty Heads of Government/State and Central Bank governors from major economies

G7/G8 – Group of Heads of State, or Ministers of Foreign Affairs, or Ministers of Finance, or Ministers of Health

GAVI – The Vaccine Alliance (formerly the Global Vaccine Alliance and Global Alliance for Vaccines and Immunizations)

GFATM – The Global Fund to fight AIDS, Tuberculosis and Malaria (also, The Global Fund)

GFF – Global Financing Facility

GHG – global health governance

GHI – global health initiatives

GLOBVAC – Global Health and Vaccination Research

H – health sector

HiAP – Health in All Policies

HRITF – Health Results Innovations Trust Fund

IAD – International Affairs Division

Idag GAP – Interdepartmental Working Group on Health and Foreign Policy

Idag GIGE – Interdepartmental Working Group on Intellectual Property, Innovation, and Public Health

IHR – International Health Regulations

IK GAP – Interdepartmental Conference on Health Foreign Policy

IMF – International Monetary Fund

IP – intellectual property sector

IPI – Swiss Federal Institute of Intellectual Property

IUHPE – International Union for Health Promotion and Education

LMIC – low- and middle-income country

MDG – Millennium Development Goals

MER – Ministry of Education and Research

MFA – Ministry of Foreign Affairs

MHCS – Ministry of Health and Care Services

NCD – non-communicable diseases

NGO – non-governmental organisation

NIPH – Norwegian Institute of Public Health

Norad – Norwegian Agency for Development Cooperation

NPGH – national policy/policies on global health

ODA – Official Development Assistance

ODAH – Official Development Assistance for Health

OECD – Organisation for Economic Cooperation and Development

PEPFAR – US President's Emergency Plan for AIDS Relief

PM – Prime Minister

R – research sector

RBF – results-based financing

RMNCH – reproductive, maternal, newborn and child health

SDC – Swiss Agency for Development and Cooperation

SDG – Sustainable Development Goals

SECO – State Secretariat for Economic Affairs

SGI – Section on Global Initiatives

SHFP – Swiss Health Foreign Policy

SNSF – Swiss National Science Foundation

UN – United Nations

UNAIDS*

UNDP – United Nations Development Program

UNEP – United Nations Environmental Program

UNFPA – United Nations Population Fund

UNGA – United National General Assembly

UNICEF – United Nation's Children's Fund

Unitaid*

USAID – United States Agency for International Development

WHA – World Health Assembly

WHO – World Health Organisation

WHO EB - World Health Organisation Executive Board

WHO/EURO – WHO Regional Office for Europe

WIPO – World Intellectual Property Organisation

WTO – World Trade Organisation

* UNAIDS and Unitaid are the proper names of organisations.

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Hillary R. Clinton said that it takes a village to raise a child, and I would say it takes a community to train a researcher. I do not make this parallel to infantilize the act of shaping and supporting new scholars, but to highlight this aspect of community in the process. Community is an idea and an ideal that is cherished by many public health and health promotion actors, and for me, its significance has permeated every step of my process. I want to use this space to acknowledge that community, and I apologise in advance if I have left anyone out (it is not my fault that there are so many awesome people and groups to thank!).

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Chapter 1: INTRODUCTION

1.1 Foreword – a brief account of how I developed an interest in the object of this thesis

Before I began the MSc in Community Health at the *Université de Montréal* in 2010, I spent the previous decade working for an international professional association whose membership included public health and health promotion researchers, practitioners, and decision-makers from around the world. When I joined the International Union for Health Promotion and Education, the IUHPE, after graduating from the *American University of Paris* with a BA in International Affairs, I was passionate about international cooperation and eager to use it as a means to improve conditions for health, in particular for marginalized or vulnerable populations. Through my professional practice, I was introduced to concepts like the social determinants of health and social inequalities in health that sparked my curiosity about how policies of different sectors shape structural determinants of population health and equity. During my years with the organisation, I learned hands-on about public health and health promotion practice and policy from working on a diverse array of projects and publications through collaborations with individuals and institutions at sub-national, national, regional, and international levels. I was involved in policy dialogues, advocacy initiatives, tool development, and knowledge synthesis and dissemination projects that relied on contributions from actors in different countries and organisational settings. This was a formative experience both in terms of style and substance. I developed competencies for collaborative working arrangements between research, non-governmental, governmental, and intergovernmental organisations. My experience collaborating in these spaces deepened both my knowledge and personal interest in governance and intersectoral action for health, healthy public policy, and health in all policies.

From my perspective embedded in the global headquarters of an international health promotion non-governmental organisation, I witnessed the "global turn" in the institutional discourse of health promotion (1, 2) in conjunction with preparations for the 6th WHO Global

Conference on Health Promotion leading to the *Bangkok Charter for Health Promotion in a Globalized World* in 2005 (3). This renewal and revision of the values, principles, strategies, and commitments for the field of health promotion in the context of a globalized world embraced the development agenda proposed in the Millennium Development Goals. It acknowledged the role of all sectors (including the private and third sectors) in governance of public policy domains that impact health. From my vantage point, having attended the official launch of the report of the WHO Commission on the Social Determinants of Health in November 2008, the *Closing the gap in a generation: health equity through action on the social determinants of health* publication (4) appeared to be a critical lever in accelerating the momentum of this "global turn." It seemed that the Commission's social justice arguments for tackling the "causes of the causes" (e.g. the inequitable distribution of power, money and resources) were compatible with health promotion's values.

The Commission's recommendations for reducing inequities in health suggested actions in interconnected terms between and within countries (i.e. locally, nationally, and globally), and the Commission's results, including the vast resources produced by its knowledge networks, offered additional tools that the field of health promotion could adapt in its approaches to 21st century challenges, including those related to global health governance (5, 6). At that time, I was working on the IUHPE's contribution as a partner with another organisation called EuroHealthNet on a European Union consortium on the social determinants of health. In parallel, the IUHPE established a global working group on the social determinants of health to reflect on and translate the Commission's recommendations for health promotion research and practice. From the desk where I was sitting, it looked like health promotion was being primed for moving into the global landscape, not only due to examples of the diffusion and integration of its practice into public health systems around the world (7, 8), but also given efforts to articulate health promotion approaches with health policy and governance at the international level (9, 10).

During this time, I read two pieces in *The Lancet* that incited me to think about the implicit connection that seemed to be developing between the field of health promotion and collective action on health at the global scale (11, 12). First, I questioned the absence of health

promotion from the comparative discussion of elements between public health, international health, and global health in Koplan et al.'s proposal of a common definition of global health (11). What similarities or differences were there between health promotion and global health defined as "area for study, research, and practice that place priority on improving health and achieving equity in health for all people worldwide"? Indeed, the definition proposed by Koplan and colleagues from the Consortium of Universities for Global Health goes on to specify global health as an area that promotes interdisciplinary collaboration; emphasizes transnational health issues, determinants, and solutions; and combines population-based prevention with individual clinical care (11). This definition neglected two distinguishing factors of health promotion that may have contributed an additional element to the synthesis of public, international, and global health – global health as an area that *creates conditions for healthy living among populations* (not only preventing and treating disease) and global health as an area that *collaborates in policy development outside of the health sector to support environments for health*. I saw an opportunity to conceptualise global health as a field of public policy, as well as one of research and practice, that would include a broader scope of action to promote health.

Second, I was struck by the *Oslo Ministerial Declaration* written by seven ministers of foreign affairs from the all regions of the world who argued that health was a significant foreign policy issue that necessitated a more prominent place on the international relations agenda (12). The Oslo Ministerial Declaration stated a ten point agenda for action underpinned by rationales and values that I discerned as being a unique example of the inter-sectoral approaches for health espoused by the field of health promotion. My questions about how the "global turn" in the institutional discourse of health promotion might bring the field to relate or contribute to this agenda were further prompted by the annexation of the health agenda by these foreign ministers explicitly as being a part of their own.

During this same decade, national policies on global health started to emerge in Western countries that developed and announced national strategies for coordinating state action on global health between ministries and government agencies (13-15). National policies on global health appeared as one way that health and foreign affairs ministries established

intersectoral arrangements for collaborating between departments on matters of global health policy and governance (16-18). Presently, to my knowledge, there are five examples of formal joint health and foreign policy national global health strategies in the European region: Switzerland (19, 20), United Kingdom (21), Norway (22), Germany (23), and France (24). Outside of the European region, two examples of formalised intersectoral strategies stand out. In the USA, the Global Health Initiative was an administrative reform introduced by President Obama in 2009 as a comprehensive global health strategy to restructure the global health work of the US government by consolidating programmes and spending authority through coordination between agencies from multiple sectors (25-27). After the initiative was dissolved in 2012, the US Department of Health and Human Services released its Global Strategy revised in 2016 for 2015-2019 (28, 29). In Japan, the adoption of a Global Health Diplomacy strategy by Prime Minister Abe in 2013 indicated an additional intersectoral approach Global Health Strategy 2011-2015 of its foreign ministry (30-33). While to my knowledge there is no intersectoral national policy on global health in Canada, reports from the Canadian Academy of Sciences and other scholars suggested processes to the federal government for developing an interministerial policy of this kind and indicated benefits in the interest of Canada for developing one (34, 35). In the Canadian context, such policy could build on experiences from intersectoral collaboration between health, development, and foreign affairs sectors for global health research (36), although research has suggested particular barriers to collaboration between these sectors for global health policy (37, 38).

1.2 National policies on global health as a lens to explore public health concerns

In this thesis, I focus on a specific object of multi-sector, inter-ministerial, or cross-government formally adopted national policies on global health (NPGH), acknowledging that state agencies produce strategies on global health which are not formally adopted at high-levels of government, or produce strategies on global health within a single sector which may include intersectoral cooperation arrangements. National policies on global health are "strategies developed at the country level for coordinating a state's action on global health

across government ministries," and they "constitute an intersectoral approach for coherence of a country's policies related to improving health of populations worldwide" (39).[1] The object of NPGH that I explore in this thesis opens a window into three problems of relevance for public health and health promotion in a complex and interdependent world: 1) how intersectorality works in public policy, 2) what kinds of relationships are there between national and global levels of governance, and 3) why does public health need the social sciences, and specifically political science?

1.2.a Intersectorality

First, as intersectoral policy that involves (at least) the health and foreign affairs sectors collaborating on issues of global health, NPGH represents an object that may serve to understand processes of engagement between health and other sectors for integrated governance as a form of Health in all Policies (40, 41). Health promotion strategies are based on the production of health from a socio-political enterprise involving actors from within and outside the health sector (42). Rooted in the history of health promotion's strategies to create health outside of the health sector and system, Health in all Policies, or HiAP, as a policy practice is a flagship proposition formalised after the Bangkok Charter, which gained notoriety globally after it served as the theme of the Finnish presidency of the European Union in 2006 (43, 44). For example, following up on the WHO Commission on Social Determinants of Health, ministers and other government representatives from around the world aimed to support momentum around this policy proposition with the *Rio Political Declaration on Social Determinants of Health* in 2011, which advocated for a HiAP approach and intersectoral collaboration within a comprehensive strategy to reduce social inequalities in health (45). The HiAP approach builds on the strategies of healthy public policy and intersectoral action for improving health (46, 47).

[1] This is an operational definition of NPGH that I proposed at the outset of my dissertation research in a commentary published in the *Journal of Health Diplomacy* (see Appendix A). As a nascent object, the literature did not provide much direction for a clear definition of what were referred to as either country or national strategies related to global health, health and foreign policy, or global health diplomacy. I return to the definition later in the thesis and revise it (see Chapter 5 and Chapter 10) to propose an empirically informed definition of NPGH for researchers and policy-makers.

We know that the role of the health sector varies in intersectoral action for health (48). The role of the health sector varies with the different degrees of ownership holds in Health in all Policies strategies from full ownership as a leader, co-ownership as a collaborator, or no ownership as a contributor or inhibitor (41). These roles play out in strategies for HiAP according to the position of health objectives in relation to those of other sectors, such as whether health sector objectives are central to the activity (core), mutually beneficial with other sectors' objectives (win-win), part of a systematic approach to contributing to other sectors' aims (cooperative), intend to curtail the negative impact of other sectors' policies (damage limitation) (49). Balanced and respective engagement with other sectors in a given context constitutes a challenge for HiAP as an approach in order to abate the risk of "health imperialism" which is the encroachment of the health sector into other sectors' policy and governance jurisdictions and territories of specific expertise and objectives (50, 51). Despite the acknowledgement by scholars and practitioners that governance structures are foundational to implementing other approaches for developing relationships across sectors and integrated collaboration and engagement between health and other sectors (52, 53), empirical knowledge on the practical operations of such collaborations remains scarce (41, 54).

A scoping review of the literature on intersectoral action for heath equity by Shankardass et al. concluded that, among the results included in 128 articles from 43 countries, processes of engagement and negotiation with government actors from different sectors are rarely described (55). Another review on the practice of intersectoral collaboration for health equity published by Chircop et al. found that the most of the policy-focused results from the 64 articles described that collaboration was used but failed to report how the processes of collaboration unfolded in intersectoral public policy (56). Both studies provide evidence that we still know little about the day-to-day practice of intersectoral collaboration on public policy for health and how decisions that mark the process are negotiated (55, 56). Holte et al. show the discursive construction of intersectoral action for health, through various institutional logics, as a "rationalised myth" compounds the challenges for initiating and implementing action across sectors for health (57). The critiques regarding the practice and rhetoric of intersectoral action from the literature highlight the implications for policy practitioners to initiate, implement and sustain intersectoral action for health and the lack of

research to support, inform, or accompany them in these challenges for policy change. As a case in point, Clavier and Gagnon (58) argue that a more nuanced consideration of the interactions between institutions, interests, and ideas in the study of intersectoral action would more adequately emphasize the complexity of policy change, also helping to bridge the gap in this area between the focus on horizontal governance / coordination mechanisms and networks / links between actors from different sectors.

1.2.b Governance across levels

Second, as policy that organises collaboration across sectors for managing the global health work of a national government, NPGH represents an object that may serve to identify and understand national processes of engagement with global health governance. Health as a governance issue builds upon the recognition that health is not only manufactured by the health care system (59) but it is shaped by policies outside of the health sector (47, 60). Governance characterises a set of processes, mechanisms, and structures (61) used by actors from within and outside of government to make decisions on problems or issues of shared interest and to jointly exercise control and coordination of those decisions (62-64). Global health governance (GHG) is generally understood as a set of formal and informal processes, which operate beyond state jurisdictional boundaries, through which state and non-state actors participate in steering and coordinating collective action on health at the global scale (65-67).

Over a decade after the first well-known review of the concept of GHG by Dodgson et al. in 2002 (68), GHG scholars observe a lack of clarity in the meaning of GHG due to a variety of uses of the concept in scholarship and practice (69, 70). GHG is used as an analytical and normative concept referring to processes for health governance in globalised world, the impact of global institutions on health and its determinants, and the arrangements for collectively establishing and meeting global health goals (69). GHG is on the one hand a conceptual lens through which scholars analyse the rules, processes, and institutions for protecting global health and preventing disease, but on the other hand, GHG is a set of ideas through which international practitioners justify different collective action arrangements between state and non-state actors within and between jurisdictions for effective collaboration on health matters that span borders.

Milestone statements and declarations of health promotion have advocated for the field's commitment to working with global health governance, emphasising that health is a core responsibility for all of government but also one that requires interaction with a range of political, social, economic, and civil society actors, including at the global level (4, 40, 71). Leaders from academia and practice have commented that public health actors must critically consider challenges of GHG in their work, but despite their consensus on the political nature of GHG challenges, their perspectives on sources, manifestations, and implications of these challenges (for governments, institutions, systems, and the populations affected by the unequal distribution of power and resources) diverge (72-75). As such, GHG remains an elusive object for public health and health promotion actors given complex challenges such as sovereignty, interdependence, and accountability (76, 77), and some experts critically question what GHG means and what is the role of public health and health promotion in it (78, 79).

There are two problems concerning the role of public health and health promotion practitioners in GHG: an actor problem, the plurality and the proliferation of actors in GHG (65, 70, 80), and a structure problem, to coordinate between actors in an accountable, transparent, and participatory way (68, 70). GHG's managerial focus for cooperation in global health is also coupled with a financial focus in terms of who pays for cooperation (81, 82). The coupling of the managerial and the financial foci lead to a third problem: an issue problem. The knowledge base on GHG (much of it generated by international relations scholarship) generally refers to these three categories of problems: actors, structures, or issues (83-85). The knowledge about GHG produced in the constructivist paradigm critically analyses the discourses and frames used by actors and funders in structures as approaches to argue for (more, better, different) coordination on issues (e.g. globalization, securitization, human rights, innovation). This issue-based approach to the study of the global/international institutions of governance reflects its organisation in practice, as administrators, programmatic personnel, and policy-makers refer to the global health governance of pandemics, tobacco control, access to medicines, anti-microbial resistance, or the "big three" of malaria, HIV/AIDS, and tuberculosis. This issue problem also relates to the actor problem because new actors arise in the institutional landscape of GHG around these issues and the financing of collaboration and action. Within this context, the role of WHO is uncertain, and it seems to

differ according to the issue and norms at hand (86-88).

WHO, as the conventionally recognised international organisation responsible for health, occupies a central place in the GHG debates because the organisation itself has faced challenges to adapt to a more globalised world and to the shifting expectations for its own role in global health and its governance (89-91). An increasingly complex institutional landscape developed within the GHG ecosystem, wherein state and non-state actors participate in decision-making processes over competing global health issues and frames in old (e.g. WHO and the World Bank) institutions and new (e.g. GAVI and the Global Fund) initiatives (92). Within this understanding of GHG as global institutions (whether intergovernmental or public-private), the role of state actors has received less attention even though states exercise particular roles as members of global institutions and global health initiatives.

Beside the more established tradition of research on globalisation and public health practice (93-95), the public health and health promotion communities' interests (and calls to action) in global health governance are relatively new territory. The implications of the understanding of GHG, as proposed above, that happens at the global level within a set of diverse institutions and issue regimes, are that it does not inform us about how intersectoral practitioners and policy-makers from national governments engage in global health governance. Schrecker warns, however, that confining our focus on the complex institution-building and actor configurations at the global level deter much needed attention from the policy processes and agency of state actors and national governments (96). A "mantra" for GHG seems emergent from the calls for public health actors to be vested in the governance of global health because the collective management of health challenges and issues that affect populations around the world is critical for population and public health in the 21st century. Yet, GHG remains a puzzling and ambiguous concept in terms of its meanings, functions, and applications for the field of health promotion.

1.2.c Public policy studies

Third, as a policy that is developed by government actors, NPGH represents an object of public policy whose examination may show how political science in general, and theories

of the policy process in particular, contribute to advancing knowledge about making policies for health in public health and health promotion research. Since the adoption of the *Ottawa Charter for Health Promotion* over 30 years ago (97), researchers and practitioners in the field of health promotion have cultivated a concern with the development of public policy and have invested in exploring public policies as instruments for public health and health promotion (98, 99). The concept of healthy public policy (as a shift from public health policy) created an opportunity for public health and health promotion researchers to draw on theories and methods from policy studies for their toolbox to problematise the role and development of healthy public policy within a broad social agenda (60, 100, 101).

More recently, political science scholars have argued that public policy analyses by the public health and health promotion research community would benefit from incorporating conceptual, theoretical, and methodological tools from political science to enrich policy analysis in public health and health promotion (102-104). For example, political scientists have critiqued public health and health promotion research about the use of evidence for policy-making because many studies do not use the insights of policy theory (105-107). These calls for a political science approach to policy research in public health and health promotion are underscored by reminders to our community to neither silence nor ignore the political dimensions of policy for health and the political determinants of health (104, 108-112).

The contributions of political science to policy research in public health and health promotion have been valuable to define policy for research (104, 113), to interpret complex processes of policy change (114), to propose strategies responding to intersectoral governance problems (115), to identify lessons about joined-up government for Health in all Policies (116, 117), to comprehend the role of ideas in the relationship between public health research and policy (118), and to understand government policy-making processes on the social determinants of health (119). Specifically, theories of the policy process are relevant for health promotion research to advance knowledge and practice regarding the ways that public policies that involve multiple sectors (including health) are negotiated, developed, and implemented (120-122). However, two reviews on the use of policy theories in policy research and analysis in the fields of public health and health promotion show that there is sizeable gap in the use of

theory from political science in this literature (123, 124).

In their review of eleven health promotion journals for articles on the content or process of policy between 1986 and 2006, Breton and De Leeuw found that out of 119 articles meeting their eligibility criteria, 39 referred to a theoretical framework, and 21 of those referred to a framework from political science (123). These results showed that, as of 2006, theories and knowledge from political science had minimally pierced the practice of policy research in the field of health promotion, the implications of which were that research-informed explanations of success or failure of policy advocacy, for example, remained anecdotal without a substantial grounding in appropriate policy theories from political science to understand facilitators or barriers to policy change (123). Nevertheless, the authors noted that the gradual increase in the volume of policy research articles in health promotion journal since the late 1990s was a promising indication of an opportunity to challenge disciplinary preferences of researchers in the field to embrace theories on policy change rather than behaviour change, to include more theory-based policy perspectives in training curricula, and to develop and adapt theories of the policy process for understanding policy change in non-Western political and governance systems (123). In their systematic review of the literature between 2002 and 2012 on health equity and the social determinants of health linked to policy analysis terms from policy theory, Embrett and Randall found only 7 articles that met their criteria; many of the excluded articles did not use policy theory in the conceptualisation or analysis of the health equity and the social determinants of health issue addressed by their research (124). The results showed that the seven studies contributed to the literature by providing examples of how policy theory can be used to explain change or stability in policy for health equity and the social determinants of health, although the authors note that these studies highlighted weaknesses in the application of theories, namely because they often focused on a particular aspect of the theory rather than taking a more comprehensive view (i.e. lacking a consideration of political, social, and economic contexts for policy agenda setting and an examination of interactions between institutions, ideas, and interest groups) (124). Both reviews conclude that the knowledge about healthy public policy would benefit from applying political science theoretical frameworks to better understand how and why public policy for health develops (or not). In this vein, De Leeuw et al. appeal to public health and health

promotion researchers to incorporate insights from "health political science" in their toolbox, which they explicitly refer to as requiring a disciplinary shift from intervention theory to political science theory for public policy research (122). There is a strong agreement among these authors that in order for public health and health promotion researchers to understand the success and failure of public policy for health, as well as the processes of policies at all points in between, the applications of theories from political science constitute a (still relatively neglected) contribution of social science to the development of health.

Finally, I wish to acknowledge the extensive literature that has been produced in the tradition of "health policy analysis" within the field of health systems and policy research (125-128). While the empirical work on health systems and policy within the global health research area increasingly uses social science, and specifically political science, theories, I do not include it as part of the problem for policy studies for public health and health promotion in the context of this thesis for two main reasons. First, it has a distinct focus on health systems (i.e. health services, health systems reform, health systems financing, access to health care, and health care coverage), and while it may include elements of intersectoral action, it falls outside the area of public policy for health as problematized above. Second, it has a distinct focus on low- and middle-income countries in the global south that have a particular set of conditions, challenges, and considerations which are outside the scope of relevance for this thesis.

1.3 How my work connects with these concerns of public health and health promotion

Therefore, the object of NPGH that I explore in this thesis serves as a gateway to address what I see as three broad areas of concern for public health and health promotion policy-related research and practice. Critically, I note that none of the terms "intersectoral," "global," or "policy" appeared among the 25 most frequently used words in abstracts from the top 10 health promotion journals in the results of a bibliometric analysis from a 2013/2014 study on the multidisciplinarity of health promotion research by Gagné et al. (129). One might

speculate whether these kinds of global and broad policy related concerns have not yet become institutionalised as part of the mainstream in the field of health promotion. Nevertheless, I suggest that the public health and health promotion debates in which this thesis positions itself - namely, about the nature and practical workings of intersectorality in policy collaboration between health and other sectors, the interactions of national public policy with global health governance, and the demonstrable value and contribution of using political science theory for research on public policy linked to health - are formidable challenges for the field for which research on NPGH presents an opportunity to make a small contribution.

Concerned with the object of NPGH, this thesis connects directly to core features of HiAP, as public policy "processes driven by people inside government, related to government policy agendas, and coordinated by formal structures of government" (55, 130). In this thesis I explore the processes of collaboration between health, foreign affairs, and other policy sectors of government as national public policy that is an instrument of intersectoral governance of global health. Researchers in public health and international relations have characterised and critically discussed the links between global health and foreign policy fields (65, 131-133), but the literature generally focuses on how global health issues are framed in different sectors' arguments for public policy and global health governance (65, 70, 134-138).

Framing approaches underpin studies of motivations and drivers of national approaches to global health as foreign policy (139), and in assessments of national strategies for global health in particular (140, 141). Frames refer to devices for interpreting or communicating the meaning of a policy problem in a way that makes it understood by or appeal to a particular public or policy community, and frames construct logical links between the interpretation of a policy issue to a select set of possible responses to it (142). Framing research has a discursive and interpretative analysis focus on ideas in policy change, and it does not necessarily produce knowledge on the structures or processes of intersectoral collaboration in public policy for health (143). As analytical tools, frames can be used to show the contested understandings, values, and approaches in global health policy and governance (134, 138). But this thesis does not focus on why or what of national public policy on global health (e.g., frames, priorities) but on how (e.g., policy process) national policies on global health are developed. This is a

small, nascent area of the literature, with two other studies having explored questions related to the development of national strategies on global health in the UK (144) and Germany (145). Within the exploration of intersectoral processes for developing NPGH as public policies in order to understand what is happening (from a public policy perspective) between sectors when global health strategies are elaborated, this thesis is particularly interested in how this process at the national level in government is connected to processes at the global level, or what is called global health governance.

1.4 General objective of the thesis

The general objective of this thesis is to understand the relationship between national policy on global health and global health governance. To this end, the thesis examines an emergent object, national policy on global health (NPGH), conceptualised in public policy terms as a multi-sectoral action arena wherein actors from health, development, and foreign affairs sectors interact in policy situations to make decisions about how to manage the government's work on global health. Within this overall objective to explore interconnections and influences from the global health governance system on NPGH arenas, I pursued three areas of inquiry based on two in-depth case studies of NPGH in Norway and Switzerland.

1. I interrogated the content of the formally adopted NPGH documents from Norway and Switzerland to investigate the public policy elements of their composition.
2. I sought to decipher the features of the intersectoral processes in Norway and Switzerland for developing their respective formally adopted NPGH documents.
3. I scrutinized how change processes functioned between NPGH and the system of GHG.

1.5 Architecture of the thesis

The thesis is presented in ten chapters, including this introduction. The review of the literature in Chapter 2 is organised around the construction of NPGH as the object of study for

this thesis. Because national policies on global health are a relatively recent object for study, I did not conduct a scoping or systematic review related to establishing the state of knowledge on this emergent public policy. Rather, I drew upon literature (conceptual and empirical) from a mixture of disciplinary perspectives (i.e. global health, international relations, and policy studies) to construct this policy object, which lay in the margins between health policy and foreign policy. Informed by studies on global health governance that were somewhat related to the object of NPGH, the literature review problematizes global health and its governance as a public policy issue for national governments in high-income countries. Given the scant empirical foundations and insights for this thesis, the reader can expect a succinct second chapter. However, for this same reason, I needed to be equipped with robust theoretical tools to explore the specific research questions developed along the aforementioned three lines of inquiry.

Chapter 3 contains the first article of this thesis published in *Social Science & Medicine*. This article presents the adaptation of Real-Dato's (146) synthesis framework for the study of NPGH according to the questions asked in this thesis (e.g. regarding the formally adopted policy as an outcome of the intersectoral policy process and the relationship of that process to external influences of policy change). In addition to presenting the theoretical apparatus of the thesis, the third chapter was crafted to show how theory from policy studies informed the conceptualisation of NPGH as an object. This chapter also briefly discusses the challenges of interdisciplinary approaches to research, namely when public health researchers work with political science theories.

Chapter 4 presents the methodological approach and research design for the overall thesis, and more specifically discusses the methods for generating and analysing data to contextualise and construct the two in-depth cases of NPGH action arenas in Norway and Switzerland. The Context Advisory Group established for each case study constitutes a methodological feature for this thesis, and as such the Context Advisory Groups are a significant aspect of the research design detailed in the fourth chapter. This chapter also includes the second article of this thesis, which is a methodological note under preparation for submission to the methods forum in *Global Health Action.* This article presents the

development and usefulness of a diagramming technique for elicitation during key informant interviews. My choice to focus attention in the fourth chapter on the methods for building each of the individual cases in this multiple case study is justified by my use of the same (within/intra-case) methods for the results in both case monographs found in Chapters 6 and 7. The reader should note that the (across/inter-case) methods for the comparative work in this thesis are provided in two articles found in Chapters 5 and 8.

The results are presented in four different chapters (Chapters 5-8). Chapter 5 contains the third article of this thesis published in *BMJ Global Health.* It presents the results of a comparative study of the two formally adopted NPGH policy documents in Norway and Switzerland. I used Schneider and Ingram's policy design framework to conduct a directed qualitative content analysis of these documents. The results of this study led to a revision of the definition of NPGH (see previous footnote in this chapter).

Chapters 6 and 7 are presented in the form of unpublished monographs of the Swiss and Norwegian cases respectively. I intend to pursue the publication of these two monographs as chapters in a book on the comparative study of intersectoral policy processes of NPGH that would also draw on material from other chapters of this thesis. Herein, each monograph is organised using the same layout, containing an executive summary and five sections. The first four sections present empirical results in terms of the elements of the theoretical framework (see Chapter 3 for the theory and Chapter 4 for the definition of the variables). The fifth and final section briefly discusses critical reflections on the case. Each case monograph also includes figures that supply a map of the elements of context for the case country's NPGH action arena which are referred to in the text, and that provide a visual empirical model of the policy action situations which are characterised in the text of the monograph that make up the case country's NPGH action arena based on theoretical model template in Chapter 3. These two chapters solely present results of my analyses of the two cases of NPGH action arena. The reader should refer to Chapter 4 for the data collection and analysis methods I used to produce these results.

Chapter 8 contains the fourth and final article in this thesis, which is under preparation for submission to *Governance*. It presents the results of a comparative study, using the two cases of Norway and Switzerland presented in Chapters 6 and 7, which asked what are the forms of interaction between the processes of the NPGH action arenas and the wider international context, including global health governance. I analysed the data from the cases looking for the relational structures between the two (national and international) levels of processes for governing global health. The chapter discusses findings of five forms of interaction, and it introduces the transnational dimension of NPGH, a point to which I return in the conclusion of this thesis in Chapter 10.

Chapter 9 presents a general summary of the results and a discussion of the overall contributions of the thesis. Returning to the research questions posed, the studies conducted within this thesis led to three main findings that contribute to better understanding NPGH as a distinct policy process at the junction of health diplomacy and global health governance. Chapter 9 also includes a discussion of the methodological strengths and limitations of the thesis, as well as its theoretical contributions.

In Chapter 10, I conclude by speculating on the future of the object at the centre of this thesis, NPGH, and I consider future areas of research. This chapter elaborates on the conceptualisation of transnational governance of global health as the theoretical reflection which culminates from this thesis and which ties together its main findings. The thesis concludes with a #tweesis (= tweets + thesis), in which I propose a thread of tweets about the findings and contributions of this thesis for circulation via my *Twitter* account (@_CatJones_).

Chapter 2: LITERATURE REVIEW

2.1 Global health as a public policy and global governance issue

Health as a governance issue is built on the recognition that health is not only manufactured by a country's health care system, but it is shaped by policies outside of the health sector (47, 59, 147). Challenging national boundaries, the field of global health aims to understand what influences health of populations worldwide and how to improve it (148, 149). Global health is distinguished from international health by its worldwide view, comprehensive scope, concern with equity, and recognition of globalised interconnectedness of health determinants (11, 89, 150, 151). The field of international field health generally refers to disease prevention, health care interventions and services in a developing country that was modelled on the history of colonial and tropical medicine (152). As such, a transition from international to global health has been described as "when the causes or consequences of a health issue circumvent, undermine or are oblivious to the territorial boundaries of states, and thus, beyond the capacity of states to address through state institutions alone," (153)(p.5). The blurred boundaries of an interdependent world, the proliferation of actors in global health, and the recognition of health as a product of multisectoral action contribute to the understanding of global health as a public policy and global governance issue (80, 149, 154-156). My review and analyses of global health definitions (see ***Box 2.1***) identify the transnational dimension, worldwide perspective and social construction of collaboration as arguments for treating global health as a national public policy and global governance issue (see ***Table 2.1***). The way that health problems, issues, determinants and solutions transcend state boundaries constitutes the transnational dimension of global health (11, 21, 68, 153, 157-160). The worldwide perspective defines the interconnectedness between populations for whom health needs, health status and health determinants should be globally governed (11, 21, 77, 89, 161). The construction of collaboration on global health reflect ideas that state institutions are insufficient to manage the health impact of transnational forces (153, 156) and that their consequences are most appropriately addressed by collective action (68, 159-161).

Global health as a public policy and global governance issue is both part and product of the globalisation processes (94, 162). Globalisation is a process in which the speed and intensity of interactions across spatial, temporal and cognitive boundaries increases interdependencies among countries or among actors in different countries (94, 163). As a public policy and global governance issue, global health is situated within the realm of policies of interdependencies rather than that of technical assistance (154, 164), and governance is one means to coordinate interdependence (61).

2.2 Limited empirical foundations of global health governance concepts in public health

Definitions of governance characterise the processes and mechanisms used by public and private actors to make decisions on problems or issues of shared interest and to jointly exercise control and coordination of those decisions (61-64). The emergence of global governance is recognised as a response of international relations to increasing complexity, greater uncertainty and rapid change in the world, primarily due to globalisation (165-169). The conceptual development of global governance is associated with the Commission on Global Governance, whose definition remains a classic reference; it defined governance as a continuous process of managing multiple interests for cooperative action on issues of common interest by individuals and institutions, both public and private, using a combination of formal regimes and informal arrangements (170)(p.2). I propose three features of governance from the governance literature against which I assess the particularities of global governance (see ***Table 2.2***). First, the objective of governance is to steer. Global governance aims to steer policy and orient collective action on transnational issues principally through management and coordination of processes (61, 171). Second, governance suggests the use of collective measures and horizontal processes. Global governance is a collective effort to determine, assess, and act on problems that individual states do not have the capacity to resolve (156) using measures that are found within a matrix of formal and informal processes and arrangements (165, 172). Third, the locus of governance is polycentric. Global governance spans across sectoral and jurisdictional boundaries and involves a wide range of actors, with a particular importance attributed to non-state and civil society actors (156, 165). The

fragmentation of political authority in global governance contributes to the blurring of sectors' responsibilities and the confounding of roles (61, 169).

In the context of global governance, global health governance (GHG) is understood as a set of formal and informal processes and decision-making arrangements, which operate beyond state boundaries, through which state and non-state actors participate in orienting and organizing collective action on health issues that affect populations worldwide (65). GHG can also be conceived as a global platform in which competing normative frameworks vie for policy attention and resources to support an agenda for action (39, 65). A seminal review of GHG identified de-territorialisation, multisectorality and the plurality of actors as key elements (68). Each of these three GHG characteristics, respectively, raises issues relevant for this study: the role of the state and territorial boundaries (65, 68, 80, 156), sectoral strategies/frames and engagement of other sectors in collaboration (4, 65, 68), as well as the roles/responsibilities of actors in GHG processes (70, 156, 166, 173) (see ***Table 2.3***). The issues identified in discussions of GHG characteristics (see ***Table 2.3***) are akin to issues identified more generally with regard to global governance features (see ***Table 2.2***). Global governance modifies the scope and scale of governance, and the diversity of actors in global governance exacerbates challenges for governance processes and mechanisms at the global scale (172). The proliferation of actors challenges collective action at the global level because there is a diffusion of power and fragmentation of authority without accountability or legitimacy at the global scale (61, 156, 165, 169, 171, 172, 174, 175). This provides a background for broaching two problems in GHG research - an actor problem and a structure problem.

The actor problem concerns the plurality of and the proliferation of actors (65, 70, 80). The leadership and authority for health at the global scale have been conventionally a responsibility of international organisations specialising in health, such as the World Health Organization (176, 177). However, the rationale of global governance has created the opportunity for a range of other actors, and in particular those who are not specialised in health, to engage in GHG. Presently, GHG involves actors such the World Bank, the European

Commission, the General Assembly of the United Nations and other groups. Non-state actors such as international organisations, multi-lateral organisations, private foundations, development agencies and civil society organisations are also interested in improving health equity globally (80, 177, 178). The proliferation of actors introduces multiple and varied sources of drivers for GHG (80, 179). This is illustrative of larger trends in international relations and the new roles that non-state actors play in influencing decisions about global issues (156). Focusing the actor problem on the identification, categorisation and coordination of actors neglects proposals for exploring their interactions within GHG (68).

The structure problem relates to a lack of rules and procedures for effective coordination of actors (70) resulting in accountability, transparency, participation and representation issues (68). Health researchers have focused on developing frameworks for critically discussing the value bases for GHG as a foundation for consolidating approaches to collective action on global health (180-182). The strengthening of GHG is often discussed in terms of the organisation and structure of GHG architecture (65, 173). The architecture metaphor reflects a rational, central, hierarchical, technical and authoritative approach to structuring GHG (65). Calls for strengthening GHG architecture, one of the normative concerns within GHG literature, are often associated with the idea that global institutional reform is an appropriate way to do it (6, 70, 77, 182-187). Attention to issues of national or global capacity is generally absent from discussions about management and organisation of collective action on global health (173).

Existing reviews of GHG (67, 68, 70) and related challenges (67, 76) do not provide keys to operationalise the concepts of GHG for empirical research. The paucity of empirical work to support the conceptual definitions and understandings of GHG has left an important knowledge gap regarding what GHG does and how it works, and scholars and practitioners continue to use the term to refer to different meanings (69). The report by the Commission on Global Governance for Health, established to explore and analyse the interrelationships between health and other governance sectors, argues that power asymmetries are embedded in systemic dysfunctions of the global governance system, which thus hinders a more equitable practice of the global interactions across policy sectors that affect health (164, 188). Case

studies on GHG have explored how specific diseases have challenged GHG responses and stimulated innovation for GH (189). Research and secondary analyses have looked at how countries engage in global governance process in different ways (190, 191), for example, regarding policies on access to medicine (192) in Canada (193), Brazil and South Africa (194) or how the foreign global health aid policies of China, India and Japan influence global governance (195).

2.3 Engaging collaboration between health and foreign affairs sectors on policy

Health at the global scale is increasingly addressed through the discourse of foreign policy (93). Foreign policy is any policy adopted by a state in relation to the outside world (including other states and non-state actors) (196, 197). It is the totality of official external relations (including decisions, actions, principles) conducted by a state in international relations (198, 199). Critical approaches to foreign policy analysis question what is "foreign" in an interconnected world where international considerations are increasingly important in many areas of domestic policy (200). Foreign policy is no longer a discrete, technical area isolated from domestic politics; it has become an integrated concern that necessitates a two-way exchange between domestic policy and international relations (201).

The *Oslo Ministerial Declaration* proposed that the international agenda needs a stronger strategic focus on health as a foreign policy issue (12, 202, 203). A series of UN General Assembly Resolutions adopted on Global Health and Foreign Policy has since reiterated this idea (204-207), and they continue to be annually produced in conjunction with the UN Secretary General's report to the General Assembly on global health and foreign policy. Health as a foreign policy issue is the subject of discussion in recent literature (65, 80, 131, 134, 135, 144, 203, 208-213). Relationships between global health and foreign policy have been described with regard to their policy frames, their policy issues of mutual interest, their shared conceptual and practical challenges, and the interactions between the two fields (65, 93, 131, 132, 214-217). The intersectoral links between health and foreign policy mark the point of departure for this thesis' interest in the problem of how global health governance

interfaces with national policy-making on global health. A case study in Norway shows that the development of health as foreign policy is not isolated, but part of a two way process between the global health arena and national policy actors (218). National policies on global health can be understood as part of the response of nation states to the claims generated and commitments produced by global health governance processes.

Global health as foreign policy is being pursued through national policy on global health (NPGH) (16, 140, 144). These policies are defined as coordination mechanisms for intersectoral action. They are inter-departmental or cross-governmental national strategies that outline a country's objectives, means and actions for coordinated policy on global health (219). A review of how global flows impact health proposes that globalisation creates demand from the health sector for intersectoral collaboration with sectors that have relevant administrative mandates and policy instruments (93). WHO and the Public Health Agency of Canada define intersectoral action for health as actions on the outcomes or determinants of health or health equity "undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector" (48)(p.2). Building on earlier ideas of intersectoral collaboration and healthy public policy, Health in All Policies evolved as a policy practice that focuses on action in the policy making process in a more systemic manner (46, 47, 220, 221). It includes an important governance component (53, 221). By extension, as a core feature of HiAP as public policy "processes driven by people inside government, related to government policy agendas, and coordinated by formal structures of government" (55, 130), intersectorality in this thesis refers to the multiple government sectors, ministries and non-governmental stakeholders that participate in the development of NPGH.

Switzerland's *Swiss Health Foreign Policy* has been identified as the first example of an inter-ministerial national agreement adopted on objectives for global health (19, 20, 219). Other examples include the United Kingdom's *Health is global: UK Government Strategy* (21), the Norwegian *White Paper on Global health in foreign and development policy* (22), the

USA's *Global Health Initiative* (222-224), and Japan's *Global Health Policy* (225).[2] The announcements of these policies by Governments are paralleled by increasing discussion of them by commentators and policy makers (31, 215, 219, 226-229). However, thick description of these policies is sparse, and there is a paucity of empirical exploration and analysis of the policy processes surrounding them (144, 218). There are a few notable exceptions. An in-depth study of the UK case, supported by other background case reports, was conducted on global health diplomacy to look at why and how global health is integrated into foreign policy using Kingdon's theory of multiple streams (144, 230). A similar, but smaller study of the German case has been carried out on the motivations for developing its national global health strategy (145). Research working papers have been produced on national approaches and countries strategies on health and foreign policy (16, 140). Grey literature has introduced the cases of Switzerland, the UK and the European Union to support arguments for building the case for a Canadian Global Health Strategy (34, 231). Gagnon's study is the first to use a theoretical framework of the policy process to explore the global health policy-making process at the state level (144, 230). To our knowledge, there is no research on the relationship of these policy processes for development of NPGH to GHG. While researchers express interest in the links between health and foreign policy in terms of national interests and motivations, there is a gap on how the global governance processes may be related to the circulation of policy ideas and how there are incorporated into the policy processes at the national level.

2.4 Relationship between global governance and national public policy – a gap in the public health research

A review of studies obtained primarily from political science databases suggests that there is a reciprocal, and interdependent relationship between the national level of policy-making on issues of global scope and global governance. Studies regarding the policy areas of migration, gender mainstreaming and women's education, sustainable development and the environment, corporate social responsibility, and science, technology and innovation (232-

[2] It is noteworthy that examples such as the European Commission's Communication on *The European Union's Role in Global Health* and Brazil's foreign policies of south-south solidarity are excluded here based on the study's definition of NPGH. However, it is recognised that they may be important to consider within a broader context of policy mobility and GHG mechanisms.

241) offer insight into the relationship between global governance and national policy that can be used to support ideas regarding how GHG and national public policy may be related.

Studies were similar in their aims to understand what is influential in the spread of policy ideas and the uptake of policy across geographical borders, socio-political systems and policy contexts. This research also underlined that global networks matter (233, 234, 242). Specifically, national policy actors who are embedded in global networks can be influential in developing domestic policy and impact policy change (233, 236, 242). These studies have shown that the diffusion of policy ideas is not a top-down phenomenon, but it is part of complex, networked interactions between global and national levels involving state and non-state actors (234). It is necessary to look at national and international factors to explain the global expansion of a policy framework and to understand how global institutional pressure can have differential impacts in developing and developed countries regarding policy commitments (241). The relationship between global governance and a national government's policy processes is a dynamic one, and in particular, their influence on policy is reciprocal. National governments can influence international norms and policy models, and international organisations can facilitate policy learning for national governments (239). The global to national influence is multi-directional because policy development at the national level can also be a factor in international policy innovation (237). When looking at the relationship of global and national levels regarding institutional change in countries, adopting a perspective on process is important because variables are not constant over time; patterns of policy adoption can be influenced by changes within the bureaucracy and by decisions to adopt policies in other countries (242). Global governance plays a role in the spreading of norms, which can influence cross-national learning and national policy development (236, 239).

Research in international affairs and political science indicates that the reciprocal relationship between global and national levels can be explored in terms of how policy ideas move and adapt between these two levels. Jörgens (236), for example, proposes that effective global governance can create conditions for policy transfer. Dolowitz & Marsh (243) define policy transfer as a process for the development of policies which uses knowledge about policies, administrative arrangements and institutions from another time and place, which they

later modified to also include knowledge about ideas in one political setting used in another (244). The concept of policy transfer encompasses the transnational circulation of ideas, paying attention among other things, to the actors who circulate policy ideas and to the transformations that ideas undergo when they transfer (245). Although policy transfer traditionally refers to transfer within a country or between countries, my review of the literature suggests that concepts about the movement of policy are central to the study of relationships between the global and the national policy levels. In addition to cross-national transfer, transnational networks may be an important means of transfer within global governance settings (246). Research in geography has developed on the "transnational geographies of governance" with regard to how policy transfer processes are producing global policy networks and creating new spaces for policy transfer (247). Evans and Davies's three-dimensional model of policy transfer underscores the importance of multiple levels of consideration, in particular the global and transnational level in addition to micro and macro levels (248), by recognizing the role that global forces play in increasing the scope of policy transfer in public policy (249). The analyses of policy mobility as way to explore how global governance relates to national policy-making in the studies reviewed above are generally approached in terms of the type of policy mobility being used for analysis, the substance of what it being transferred and the mechanisms and context for transfer. There is a paucity of information in these studies on the analysis of the instruments of transfer and processes involved. Outcome measures of mobility (a change in policy elsewhere) seem to be prioritized over process measures (how this change comes about) (242, 250).

There is a nascent body of health research that recognises a circulation of policy ideas between the global level and the development of national policy. Research on the spread of ideas on health care financing reform demonstrated that global policy networks are influential global forces and identified a methodological gap in terms of thinking about the global and national levels as units of analysis and how to link them (235). A study on the policy processes related to the emergence of a global policy agenda on health systems strengthening identified a global policy community and recognised the influence on national agendas, particularly as sources of policy ideas (251). A Norwegian case study conceptualised global-country interaction in health as foreign policy development as "interfaces" but concludes that more

research is needed to understand the "interactive, adaptive and reiterative processes" between the global arena and national policy making that uses new approaches to study how countries interact with global governance (218)(p.322). These studies suggest that the relationship is not unidirectional or top-down. This research highlights that policy development at the national level is not independent of the global level influences; however the focus is on the circulation of ideas, rather than on the mechanisms of these interactions for policy development. A knowledge gap remains regarding the relationship between GHG and national public policy processes: research on GHG does not currently incorporate policy transfer as a crucial component or function of global governance.

2.5 Summary of the state of knowledge

This review of the literature has introduced global health as an issue of public policy at the national level and as one of governance at the global level. National policies on global health (NPGH) have appeared as intersectoral policies that aim to coordinate a country's action on global health. Little is known about the policy processes for developing NPGH. Studies in other policy areas suggest that there is external input from global governance that contributes to national policy development on issues of global scope. Global governance literature is useful to contextualise the issues resulting from characteristics of global health governance. Research on GHG has a strong normative focus, primarily on problems related to actors and a need for structural improvements for collaboration. While there is an emerging interest in policy processes of NPGH within state boundaries, there is a dearth of knowledge on their relationship to GHG. The overall objective of this thesis is to explore that relationship. To unpack the relationship between the development of NPGH and GHG, one needs a theoretical perspective on the public policy process and one on governance at the global scale.

Box 2.1 Definitions of global health

Frenk & Moon (77)(p.936)	*Global health should be defined by two key elements: its level of analysis, which involves the entire population of the world, and the relationships of interdependence that bind together the units of social organization that make up the global population (e.g., nation states, private organizations, ethnic groups, and civil society movements).*
Beaglehole & Bonita (161)(p.1)	*Global health is collaborative transnational research and action for promoting health for all.*
Bozorgmehr 2010 (157)	*Global health is a field of practice, research and education focused on health and the social, economic, political and cultural forces that shape it across the world. The discipline has an historical association with the distinct needs of developing countries but it is also concerned with health-related issues that transcend national boundaries and the differential impacts of globalisation. It is a cross-disciplinary field, blending perspectives from the natural and social sciences and the humanities to understand the social relationships, biological processes and technologies that contribute to the improvement of health worldwide.*
Fried et al. (252)	*Global health and public health are indistinguishable. Public health is global health for the public good.*
Koplan et al. (11)	*Global health is 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 recognizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care.*
Janes & Corbett (253)	*Global health is an area of research and practice that endeavours to link health, broadly conceived as a dynamic state that is an essential resource for life and well-being, to assemblages of global processes, recognizing that these assemblages are complex, diverse, temporally unstable, contingent, and often contested or resisted at different social scales.*
HM Government (21)(p.5)	*Global health: refers to health issues where the determinants circumvent, undermine or are oblivious to the territorial boundaries of states, and are thus beyond the capacity of individual countries to address through domestic institutions. Global health is focused on people across the whole planet rather than the concerns of particular nations. Global health recognizes that health is determined by problems, issues and concerns that transcend national boundaries.*
Brown, Cueto, & Fee (89)	*Global health implies consideration of the health needs of the people of the whole planet above the concerns of particular nations.*

Kickbusch (159)	*Global health refers to those health issues that transcend national boundaries and governments and call for actions on the global forces that determine the health of people.*
Smith, Tang & Nutbeam (158)	*Global health refers to the transnational impacts of globalization upon health determinants and health problems which are the beyond the control of individual nations.*
Dodgson, Lee & Drager (68)(p.23)	A global health issue *is one where the actions of a party in one part of the world can have widespread consequences in other parts of the world.*
Lee, Buse, Fustukian (153)(p.5)	*International health becomes global health when the causes or consequences of a health issue circumvent, undermine or are oblivious to the territorial boundaries of states, and thus, beyond the capacity of states to address through state issues alone.*
Institute of Medicine (160)(p.11)	*Health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions.*

Table 2.1 Arguments for global health as a public policy and global governance issue

	Global health dimension	Question	Discussion
OBJECT	*Transnational*	*What?*	Transnational activities are defined as those cutting across national borders, such as the Internet or the movement of financial capital, and they present challenges to the state's capacity to regulate them (94). The transnational dimension of GH refers to the scope of problems and solutions, looking at issues that transcend national borders that influence health (11). The transnational dimension presents challenges for authority, responsibility and legitimacy of GH action. Transnational is not recognised as a common structuring principle or field of operation in social-spatial perspectives, and it may operate within a matrix of territory, place, scale and networks horizontally and/or vertically (254). A re-examination of the concepts of territory, scale and networks for GH policy and GHG through a critical geography lens (255) may illuminate how this transnational dimension may oscillate between the national and global levels and reconstruct spaces for policy processes and global governance (256).
SUBJECT	*Worldwide*	*Who?*	The worldwide dimension refers to the way that GH considers what influences health of populations around the world, over the specific concern with health issues for any given country (11, 21, 77, 89, 161). GH seeks to conceptualise and understand health on a global scale. This understanding can be developed in two ways: the worldwide view as a "network of connections" that increases the density of interdependencies of GH determinants, actions and actors and between populations (163) or the worldwide view as the way a broad range of global actors and structures shape the health of individuals around the world (211).
ACTION	*Collaboration*	*How?*	Challenges for collaboration are related to the social organisation of the global population and the interdependencies of the entities which comprise it - including nation states, private organisations and civil society movements (77). An argument for cooperation can be constructed from the acknowledgement of the social, economic, political and cultural forces that shape global health (157) and the link between health and the assortment of instable, complex, conditional, and frequently disputed global processes (253).

Table 2.2 An analysis of key features in governance and global governance

Features	Governance (G)	Global governance (GG)
***Objective*:** Steering	The purpose of G is to produce policy goals and orient decision-making about collective action (63, 64, 257). G leads to the "creation, reinforcement, or reproduction of social norms & institutions" (63)(p.405). G processes and structures serve a coordination role (62).	GG is actively managing a set of processes that shape formal and informal rule-generation and control mechanisms (171). GG is on a continuum of control mechanisms for "framing goals, issuing directives and pursuing policies" (172). GG articulates collective interests, establishes rules and obligations and medicates differences at the global level (258).
***Process*:** Collective & horizontal	The processes, mechanisms and structures that operate within G are not imposed, but rather produced by continuous interactions amongst actors, based on trust and regulated by the rules negotiated and agreed by participants (62, 63). G utilises governing mechanisms that do not depend on government command or sanctions (257). G processes use of a combination of formal and informal arrangements (64).	GG involves multi-level decision-making and which entails interactions between horizontal and vertical processes (165). The interactions among actors are part of the "broad, dynamic, complex process of interactive decision-making that is ever evolving and responding to changing circumstances" (166). GG does not invoke hierarchical command mechanisms based on central authority because authority is fragmented (61, 172). Horizontal decision-making in GG includes informal arrangements and formal instruments on a continuum from nascent to highly institutionalised processes (165, 172).
Locus: Polycentric	G obscures the boundaries between public, private and third/voluntary sectors (62, 257). Including actors from multiple sectors from within and outside government means that their roles and responsibilities can become less clear (257). G processes create interdependencies between actors (62).	GG processes and relationships engage actors such as States, corporations, citizens and organisations (both inter- and non-governmental) (258). The breadth and inclusiveness of the realm of actors, as well as the diffusion of power and authority across heterogeneous categories of actors is an critical feature of GG (171). Interdependencies distribute power across levels and categories of actors in GG (156).

Table 2.3 Discussion of issues arising from the characteristics of global health governance

Three characteristics of GHG according to review by Dodgson, Lee & Drager (68)	**Issues**[3]
(1) De-territorialisation	*Role of the state & authority* *Territorial boundaries*
The absence of governmental authority at the global level constitutes a challenge for questions of global governance (166). This can result in a disequilibrium between the existence of national sovereignty and the mandate of global collective action to manage interdependence (77). Sovereign states are the cornerstone of the international system as established by the Treaty of Westphalia of 1648, and this principle constitutes the anarchical nature of the contemporary international system (65, 173). State sovereignty can be positioned as an obstacle regarding questions of enforcement in matters of GHG (68). "The role and authority of the state in the 21st century and the interfaces of local, national, regional and global policy" are critical issues in governance literature (185)(p.19). Boundaries of states are both geographical and jurisdictional, delineating the territory of sovereign responsibility for decision-making regarding matters of and concerning the state, and there is a question of sovereignty for GHG with regard to the role of the state within its territory and outside of it. GHG operates within and acts upon the shifting territories of interdependence. Given the transnational dimension of GH (11, 153), GHG addresses factors and includes processes that are not confined to the geographical boundaries of the state (68).	
(2) Multisectorality	*Sectoral perspectives & frames* *Multisectoral collaboration*
The question of sectoral challenges are two fold: how to understand the problems which GHG must address from the perspective of multiple sectors, and how to coordinate action on those problems that involve knowledge, resources and ideas from multiple sectors. Policy coherence for global health issues in sectors such as foreign policy, trade, development and agriculture may contribute to fostering a more intersectoral perspective on health within GHG (185). The sectoral challenge is also linked to the competing normative frameworks found in GHG. Framing policy problems and solutions in different ways can influence the appeal of GHG and action on global health for different sectors. Some of the most common frames include security (65, 134, 135, 181, 210, 215, 259, 260), economic/investment (65, 215), development (134, 260, 261), human rights (134, 181, 260), global public goods (134, 181, 260, 261), foreign policy (132, 215), trade (210, 261), and evidence and social determinants/equity (65). The absence of a theoretical framework for analysing GHG is recognised as a weakness of these GHG frames, and Ruger suggests that global health justice principles may fill this gap (181). The idea of collective action that is associated with GHG needs to be more clearly defined to understand the issues at stake for multisectoral collaboration.	

[3] Related issues have also been introduced for consideration within a set of challenges for the governance of global health proposed by Frenk & Moon [62]. The three challenges they outline, namely the sovereignty, sectoral and accountability challenges, parallel the three features above, and are placed within their conceptualisation of global public health and the functions of the global health system.

(3) Plurality of actors	*Processes* *Roles & responsibilities of actors*
Considering that governance is a determining factor in the distribution of power and resources and in the regulation of societies (185), it may follow that GHG orients societal decisions on GH and determines how power and resources are distributed to implement them. GHG operates on the assumption that GH actors need to be managed and coordinated (70, 182). Theses functions of GHG are associated with a mixture of formal and informal processes employed to engage and interact with GH actors. The plurality of actors is related to a plurality of normative frameworks operating in GHG (65). Frenk & Moon (77) identify two kinds of accountability issues, one for international intergovernmental organizations that are generally accountable to member states and not the populations they serve, and another due to insufficient accountability mechanisms for non-state actors. Authors in health research note that this leads to potential confusion concerning of multiple roles and functions for these actors (70). With regard roles and responsibilities of these actors, there appear to be three kinds accountability issues: processes & mechanisms for accountability, accountability for what, and accountability to whom.	

Chapter 3: THEORETICAL FRAMEWORK

Article 1. Adapting public policy theory for public health research: A framework to understand the development of national policies on global health

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Adapting public policy theory for public health research: a framework to understand the development of national policies on global health

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Authors' contributions to the article:

Catherine M. Jones elaborated the problem and the methods, conducted the review and analysis, conceptualised the framework's adaptations and identified the examples from the literature, designed the figures of the model, and drafted and revised the article.

Carole Clavier contributed to the objectives, theoretical development, and discussion as well as the revision of the article.

Louise Potvin contributed to refining the methods and to the revision of the article.

All authors approved the manuscript.

Research Highlights:

- Presents research process to adapt public policy theory for health policy research.
- Applies synthesis frameworks as new theoretical tools from political science.
- Conceptualises interactions between national and global policy-making processes.
- Proposes public policy develops in system of interactive situations and not stages.
- Contributes to understanding practice of national policy-making on global health.

Abstract

National policies on global health appear as one way that actors from health, development and foreign affairs sectors in a country coordinate state action on global health. Next to a burgeoning literature in which international relations and global governance theories are employed to understand global health policy and global health diplomacy at the international level, little is known about policy processes for global health at the national scale. We propose a framework of the policy process to understand how such policies are developed, and we identify challenges for public health researchers integrating conceptual tools from political science. We developed the framework using a two-step process: 1) reviewing literature to establish criteria for selecting a theoretical framework fit for this purpose, and 2) adapting Real-Dato's synthesis framework to integrate a cognitive approach to public policy within a constructivist perspective. Our framework identifies multiple contexts as part of the policy process, focuses on situations where actors work together to make national policy on global health, considers these interactive situations as spaces for observing external influences on policy change and proposes policy design as the output of the process. We suggest that this framework makes three contributions to the conceptualisation of national policy on global health as a research object. First, it emphasizes collective action over decisions of individual policy actors. Second, it conceptualises the policy process as organised interactive spaces for collaboration rather than as stages of a policy cycle. Third, national decision-making spaces are opportunities for transferring ideas and knowledge from different sectors and settings, and represent opportunities to identify international influences on a country's global health policy. We discuss two sets of challenges for public health researchers using interdisciplinary approaches in policy research.

Keywords: national policy on global health; global health policy; health and foreign policy; global health diplomacy; policy process; theoretical framework

Introduction

The assemblage of health and foreign policy areas is an important theme for public health researchers interested in global health (Labonte et al., 2011; McInnes & Lee, 2012b). Relationships between global health and foreign policy are generally analysed within a realist tradition of international relations wherein economic interests of states and their concern for national security (issues of high politics) explain their choices for taking action on health-related matters of international relevance (Feldbaum & Michaud, 2010; Labonte & Gagnon, 2010). Global health diplomacy is one way of working across these two areas using diplomatic skills and practices to establish and achieve global health goals in multilateral or bilateral negotiations (Katz et al., 2011; Lee & Smith, 2011). Global health diplomacy also has a national dimension because actors from health and foreign policy sectors negotiate within countries to clarify their positions on global health and foreign policy (Hoffman, 2010; Silberschmidt & Zeltner, 2013). National policies on global health appear as another means that countries use to pursue global health as foreign policy (Kanth et al., 2013; Kickbusch et al., 2007; Sridhar, 2009). The purpose of this paper is to propose a framework of the policy process to understand how such policies are developed.

National policy on global health (NPGH) organises and coordinates a state's action on global health across more than one sector of public administration, as part of a coherent approach to policy development and implementation between relevant ministries involved in improving health on a global scale (Jones, 2014). Since these policies for coherence began to appear in 2006 (Kickbusch et al., 2007; Silberschmidt & Zeltner, 2013), this nascent area of research contributes to understanding countries' motivations for (Watt et al., 2014) and barriers to (Runnels et al., 2014) more coordinated efforts to include health in foreign policy. Case studies on Germany, the European Union and the United Kingdom have generated knowledge about the agenda-setting process for these strategies (Aluttis et al., 2015; Aluttis et al., 2014; Gagnon & Labonte, 2013). However, little is known about policy-making practices and processes through which national policy on global health is developed within a country. This knowledge gap is a problem because policy creates conditions for public health interventions, and understanding the policy process is critical to influence policy change for health (de Leeuw et al., 2014). Political scientists make the case for using theories of the policy process to analyse the policy environment and health policy

content (Bernier & Clavier, 2011), to explain relationships between evidence and policy (Fafard, 2015), and to understand how and why policy is structured as it is (de Leeuw et al., 2014). Public policy theories are relevant conceptual tools for public health researchers to integrate social, political and historical contexts into their understanding of the policy process, including the power relations between actors and the role of ideas and knowledge in decision-making (Clavier & de Leeuw, 2013; Fafard, 2015; Smith & Katikireddi, 2013). Although reviews have reported that theory-driven health policy research with explicit uptake of theories of the policy process is minimal (Breton & de Leeuw, 2011; Embrett & Randall, 2014), recent literature contains valuable examples of engagement with these theories to explain health policy change (Carey & Crammond, 2015; de Leeuw et al., 2015) – including change at the global level (Di Ruggiero et al., 2015).

This paper provides an example of work done to adapt theories of public policy for global health policy research. It aims to answer the question of how political science can inform public health researchers' conceptualisation of the processes of national policy on global health. To answer this, we establish two objectives: 1) propose a framework of the process of national policy-making on global health, and 2) demonstrate the adaptation of frameworks from political science for the needs of health policy researchers. We aim to show something generally done behind the scenes – the selection and operationalisation of a public policy framework for public health research. We contribute this as an example to the debate on how public health researchers can move from recognising the relevance of theory from political science for health research to using it. We hope that it will encourage others to explore how heuristic devices and frameworks we use in health policy research are constructed.

Methods

Our first task was to identify an appropriate theoretical framework of the policy process for studying NPGH. We established parameters informed by a literature review on national strategies for global health [starting with (Bozorgmehr et al., 2014; Donaldson & Banatvala, 2007; Gagnon & Labonte, 2013; Kanth et al., 2013; Sridhar, 2009)] and studies in health and social sciences on the relationship between global and national public policy processes and the circulation of policy ideas between these levels (Borrell et al., 2013; Esser & Ward, 2013; Guiraudon & Lahav, 2000;

Hafner & Shiffman, 2013; Happaerts, 2012; Jörgens, 2004; Lee & Goodman, 2002; Lim & Tsutsui, 2012; Ngoasong, 2011; Peppin Vaughan, 2013; Rabe, 2007; Rennkamp & Naidoo, 2011; Sandberg & Andresen, 2010; Storeng, 2014; Sundby, 2014; True & Mintrom, 2001). Three criteria were derived:

1) *Empirical criterion:* The framework should explain policy processes involving actors from multiple sectors because NPGH actors come from health and foreign affairs sectors of government (amongst others).

2) *Theoretical criterion:* The framework should include internal and external influences on mechanisms for explaining change on international policy because factors influencing policy development on issues of global scope within a country (i.e.. global health) are not limited to those within its own borders.

3) *Epistemological criterion:* The framework should emphasize the role of actors' interactions as producers of knowledge about and for the policy process.

We propose that events wherein policy actors govern together are critical spaces for observing how ideas and institutions from national and international arenas influence the decisions those actors make to change policy on global health. This is why we start with Real-Dato's Synthetic Explanatory Framework (2009). Theories of the policy process generally favour interests, institutions, or ideas as explanatory factors for policy change. They also tend to adopt a limited number of models of rationality such as the perspectives of chance or rational-choice (Schlager & Blomquist, 1996). We chose a framework that is part of a trend in policy studies to synthesize frameworks as a way to overcome these shortcomings and strike a finer balance between these three variables (Howlett et al., 2015; Nowlin, 2011). Real-Dato's synthesis assimilates the Advocacy Coalition Framework (Sabatier, 1998), Punctuated-Equilibrium Theory (Baumgartner & Jones, 2010) and Multiple Streams (Kingdon, 1995) using the Institutional Analysis and Development Framework (Ostrom, 2007) as an organising framework. Real-Dato's framework [***Table 1***] emphasizes three important issues in the policy process relevant for conceptualising the development of national policy on global health.

Table 1. Definitions of elements in Real-Dato's framework

Source: Table by author adapted from Real-Dato (2009).

Action arena	A subsystem in which actors interact to make policy-related decisions. It is composed of an ensemble of *action situations* organised by *rules* about the policy process for *actors* to work together on a particular policy issue. Five kinds of rules define and structure action situations concerning which actors have access to them, how decisions are made and what kind of information is used.
Policy design	Output of the policy process within the action arena.
Mechanisms of change	Internal and external pathways explain policy change via how they influence the processes within action arenas as well as the broader conditions and policy environment.

First, the identification of boundary relationships introduces scope to explore interactions between global health policy actors from different sectors, horizontally within a country and vertically within international arenas (criterion 1). Actors developing global health policy at the country-level negotiate policy change *across more than one government sector* (typically involving ministries of health and foreign affairs and the national development agency) and *between levels of action, including the global health policy processes outside of their country* (e.g. Global Health Security Agenda initiative, sustainable development goals negotiations). Second, the framework considers factors outside the national action arena as potential sources of external mechanisms for policy change (criterion 2). In cases of national policy on global health, policy change may be connected to processes and systems of actors in global health outside of the country, such as those of international institutions, multilateral arrangements and non-state actors. Examples include conditions (e.g. Millennium Development Goals), venues (e.g. United Nations) and events (e.g. World Health Assembly) at the global level. Third, the framework emphasizes that actors' interactions (within the scope of relevant institutional structures) provide a foundation for a social explanation of policy change (criterion 3). These interactions are important because they represent opportunities for collaboration or conflict between the foreign affairs, development and health institutions involved in the policy process. Interactions may utilise or create mechanisms of policy change operating within or outside a country (e.g. policy learning from networks).

Our second task was to adapt Real Dato's framework for the NPGH policy process within a constructivist paradigm (Finnemore & Sikkink, 2001) and to integrate a cognitive approach to public policy (Muller, 2000; Sabatier et al., 2000). Cognitive approaches conceptualise public policy as an interpretive rather than a rational process, emphasising the significance of ideas, beliefs, norms and knowledge in problematizing, agenda-setting and decision-making for public policy. This conflicts with Real-Dato's emphasis on material conditions for policy-making, where a set of available actions, their possible results, and the related costs and benefits for participants constitute a range of alternative choices for policy actors who control decisions about them. Our adaptation responds to issues of incongruity between our approach and Real Dato's regarding 1) the rational behaviour of actors, 2) the absence of power, and 3) the limited perspective of external conditions. To adjust for these incompatible aspects:

1) We shifted from a rational choice approach by introducing the significance of ideas, knowledge, and beliefs for actors' policy-making practices. This required replacing the explanation of actors' decision-making behaviour according to their interests and preferences for policy alternatives with attention to what ideas circulate among policy actors, where they come from, how they are framed, and what are the arguments for their use in decision-making. Studies show different approaches to global health policy are contested due to competing frames for understanding what it is, why it is important, which are the relevant instruments for action and who are the legitimate actors to define global health problems and participate in action towards solutions (Labonte & Gagnon, 2010; McInnes & Lee, 2012a). Frames construct rationales for particular policy responses because they symbolically attach to ways of understanding health (e.g. human rights, development) that may persuade specific policy actors (Rushton & Williams, 2012). For example, framing pandemic influenza as either a security or an evidence-based medicine issue produces different justifications and policy instruments, even if both responses may share common policy goals (McInnes & Lee, 2012a).

2) We introduced power into the model by looking at resources and rules. Commentators have argued for better understanding of the sources of power and how different forms of power operate in global health policy (Brown, 2015; Hanefeld & Walt, 2015; Shiffman, 2014). Using Arts and van Tatenhove's (2004) layers of power in policy, we identified two kinds of power relevant to

action situations. Relational power focuses on actors' influences in interactions with different sectors to achieve policy outcomes. Dispositional power focuses on how institutional order influences actors' capacity to act.

3) We expanded the framework's structural definition of external factors to include a broader conceptualisation of context by replacing the material conditions and physical environment with multiple contexts for NPGH. The social, political and economic contexts within the national setting are important in a country's process for NPGH, But it is also important to consider the external context including intergovernmental institutions, international cooperation arrangements, policy and research networks, global health initiatives, and non-state actors that make up the international and scientific and technical context (Hill, 2011; Szlezak et al., 2010).

Results: a framework of the process for national policy on global health

Four elements constitute the pillars of our framework to understand the policy process of NPGH. We start with action situations where actors work together to develop policy on global health in their national setting; a set of these situations comprises an action arena. A national action arena is a decision-making and governing system for national policy on global health composed of actors from institutions within a country who participate in its development processes (henceforth referred to as NPGH action arena). By characterising NPGH action arenas from the ground up, the framework organises inquiry around the micro-processes (coordination, information-circulation, negotiation) between actors within situations organised for the practice of national policy-making on global health. In this way, we conceptualise public policy in terms of spaces of interaction where actors exchange resources and exercise of power for collectively producing policy content, and these spaces are opportunities for researchers to observe the influences, both domestic and foreign, on NPGH.

Multiple contexts for national policy on global health

NPGH development happens within a mosaic of contexts, which we understand as more inclusive than physical environment, conditions and attributes. We adopt Hassenteufel's definition of context as a socio-political construction rather than a material state, wherein context designates what is "outside of the interactions of public policy actors, but is also not independent of them"

(2011, 149) [represented by dotted-line around contexts in Figure 1]. Informed by Hassenteufel's typology (2011, 150), we propose a composite of socio-demographic, economic, state, political, scientific and technical and global contexts are important for NPGH action arenas [***Table 2***].

Table 2. Examples of contexts for national policy on global health
Source: Table and examples by author. Typology adapted from Hassenteufel (2011).

Context	**Definition**	**Example**
Socio-demographic	Age, income, education, employment and health of a country's population.	Health and social policies for population health in the country (e.g. public health law).
Economic	A country's financial situation (e.g. revenue, expenditure, debt, inflation, growth).	Budgets for global health, development and contributions to multilateral organisations (e.g. development aid).
State	Formal and informal rules for public administration and policy.	Institutional arrangements or partnerships between sectors such as health, development, foreign affairs, research and education, and justice (e.g. Memorandum of Understanding).
Political	System that impacts political power, decision-making and governance practices.	Composition of Government, Parliament, elections, political parties, interest groups and civil society (e.g. regimes).
Scientific / technical	Knowledge, interventions, methods, instruments and norms in global health policy.	Research and practitioner communities, global health policy networks, knowledge-translation organisations providing evidence (e.g. national institute of public health).
International	Paradigms, agendas, objectives, and products of multilateral organisations, foundations, global health initiatives.	Participation of a country's government representatives in global health governance or global governance for health (e.g. Executive Board member of WHO).

The ideas of global policy communities who change how global health issues (e.g. AIDS, polio) are portrayed, especially when they are attached to strong institutions (e.g. UNAIDS, UNICEF), can modify the scientific and international context (Shiffman, 2009). International crises overlapping the national and international contexts may initiate development of NPGH action arenas, such as with SARS in China (Huang, 2010). Policy actors at the national level also modify context by using normative frames (e.g. human rights) or technical frames (e.g. results-based financing) as arguments about which institutions should be legitimate participants in a NPGH action arena. In Canada, limited policy frames for global health have been explained as one important barrier to the development of a NPGH action arena (Runnels et al., 2014). Contexts for NPGH overlap with related policy subsystems in the same country (e.g. maternal and child health, health workforce).

National policy on global health action arena

An action arena is a semi-autonomous decisional social space formed by the interaction of actors who coalesce around a policy question within a territorial boundary (Real-Dato, 2009). We define a NPGH action arena as a governing unit where actors interact in situations to design national policy on global health. Nested within the multifaceted macro-level contexts, the micro-processes in policy development practices involving actors from the foreign policy, development and health policy sectors are building blocks of the NPGH action arena, and action situations are the events through which those processes can be accessed and observed. For example, the United Kingdom's NPGH action arena for it's *Health is Global* strategy may be understood to include situations like a cross-government steering group, an inter-ministerial working-group (with representation from health, development, foreign affairs and defence policy areas), and numerous stakeholder workshops with public, private, and third sector actors (Gagnon & Labonte, 2013). Three elements form an NPGH action arena [***Figure 1***]: action situations, actors (circles in situations), and rules (procedural arrangements structuring the operations and boundaries of situations). To understand NPGH processes, we need to know what are the principle action situations where actors interact, which actors participate and why, what resources they contribute, and how those situations are managed.

Our framework assumes that multiple action situations form a NPGH action arena [***Figure 1***]. To illustrate the main components, we isolate one action situation and elaborate on it [***Figure 2***].

We define action situations as purposive activities in which policy actors collectively design policy; they are formal or informal places of interaction between at least three actors involved in producing NPGH content. Action situations include activities such as commissions, committees, working groups, task forces, and consultations, such as the expert panel on Canada's strategic role in global health for example (*Canadians Making a Difference*, 2011). Informed by Ostrom's descriptions (2007, 29-30), action situations are constructs for researchers to observe how policy design is negotiated and decided, what ideas are used for that, how power is exercised, and the consequences of decisions on the policy process. Decision-making processes refer to implicit or explicit guidelines for how actors conduct their work in a situation. Discourse and ideas can change decision-making when they appeal to norms (e.g. health as a global pubic good) and reconcile logics for action (e.g. social justice and technological innovation) to legitimize policy practices that act on a shared global health goal (Harmer, 2010).

The composition, techniques and operations of action situations vary according to the rules and institutional arrangements that organise the actors who participate in them. Rules are a shared point of reference for actors to use in a situation. They determine which actors are involved, their decision-making role, and how information is managed**.** Actors' interpretations or criticisms of rules may result in their modification (Klijn, 2001). Using theoretical proposals about rules in action arenas by Ostrom (2007), Real-Dato (2009) and Klijn (2001), we propose the three kinds: boundary, position, and interaction rules [***Figure 2***]. Rules are important for NPGH action arenas because they play a role in producing the insiders and the outsiders of the policy process (Dupuy & Halpern, 2009). In our framework, actors operate within a rational-bound framework with potential to renegotiate, revise and reinterpret rules for NPGH. Rules define the sources of power by positioning organisations to participate in action situations and assigning roles for actors to use their relational power in their interactions. Public policy evidence suggests that a supportive architecture strengthens collaboration in cross-government health policy interventions, and rules for structural and institutional change can reshape how processes for accountability and information-sharing are managed (Carey et al., 2014). Rules regulate a situation's autonomy because they protect decision-making from the impact of undesired external influences (Real-Dato, 2009).

The NPGH actors are individuals who represent their respective organisations in action situations; they contribute resources from their organisations as ideas for decision-making processes. Actors in NPGH action arenas include diplomats, international development practitioners, health researchers, senior civil servants responsible for foreign affairs, public health, trade, defence, and sometimes, civil society actors (Gagnon & Labonte, 2013; Hoffman, 2010; Lencucha et al., 2011; Runnels et al., 2014). Actors carry ideas in their set of resources, but institutions filter them with rules determining which ideas have access to decision-making processes and how powerful they are (Campbell, 2002). We borrow from Hassenteufel's resources categories (2011, 117-119): positional, material, knowledge and know-how, political, social and temporal. The combined resources actors bring to an action situation (e.g. political support, financial and human capacity, expertise, policy networks, epistemic communities) constitute means for exchange in exercising relational power. The relational aspect of resources is important for interactive situations; action requires the support of a variety of actors who bring different resources [***Figure 2***]. Dispositional power at the organisational level grants selected institutions access to decision-making processes, in which the individual actors may use their resources for relational power to negotiate policy content. Resources may be practical (e.g. funding, dedicated staff and time to participate in NPGH processes), strategic (e.g. mandates, connections to coalitions, links to politicians, or access to relevant policy networks), and technical (e.g. expertise, policy guidance, synthesis, knowledge translation for implementation).

Mechanisms of national policy on global health change

Mechanisms of policy change are devices that support stability of policy or stimulate change in policy. Theories of policy change generally suggest that internal and external factors influence the mechanisms through which change occurs (Hassenteufel, 2011). Our framework proposes that mechanisms of policy change operate within the NPGH action arena and between the global and national action arenas [***Figure 1***]. Adapting Real-Dato's (2009) typology of mechanisms, we focus on how actors innovate for policy change (policy learning) and how actors reorganise relationships for policy change (conflict expansion). These two mechanisms may operate internally or externally, or both.

Policy learning involves the production of policy-relevant knowledge by individual actors and the use of such knowledge in policy decisions collectively (Real-Dato, 2009). Instrumental learning

focuses on the implementation instruments (e.g. programmatic ideas), and social learning focuses on the policy problems (e.g. scope of goals) (May, 1999). Although policy learning is facilitated between actors from different organisations in policy communities who share the same global health policy narrative, it has been shown to be minimal between these networks when their ideas are polarized (Ney, 2012). This is why institutional innovation is important because arrangements that foster policy learning between different communities are crucial to support capacities of individual actors (Shiffman, 2009). However, actors' capacity for policy learning attracts interest of other actors seeking examples of successful policy learning experiences, even if it requires seeking them out in other policy venues (Pralle, 2003). New actors may be brought into the NPGH action arena (e.g. conflict expansion) when actors are unsatisfied with the rules or the consequences of ideas. Real-Dato (2009, 131) considers conflict to be a mechanism through which an action arena's territory expands to connect with previously isolated policy domains. Depending the availability of resources and actors' capacity to mobilise additional resources, conflict expansion is usually a costly mechanism.

National policy on global health design

The content of a national policy document is an important source of data on policy objectives and instruments for action on global health. As the output of a NPGH action arena, one function of policy design is to establish relationships between who benefits from the policy and which agencies are responsible for implementation. Analysed together, the design elements provide a picture of the internal logic of the policy proposal. Informed by Schneider and Ingram's (1997, 73-101) components of policy design, we develop examples of design elements in NPGH [***Table 3***].

Table 3. Examples of national policy on global health design

Source: Table and examples by author. Elements and definitions adapted from Schneider & Ingram (1997).

Design element	Definition	Examples
Goals	The intended change as a result of the policy.	The expected achievements of policy may be technical (improving distribution of health workforce globally or better access to medicines) political (integrating health and foreign policy objectives) or normative (WHO reform, strengthening international institutions, promoting health as a human right).
Targets	The population at which the policy is aimed.	Women and children or vulnerable groups in low-income countries are examples of global health policy populations of interest, but governance structures (e.g. United Nations, European Union) and international organisations (e.g. WHO) are also targets of national policy on global health.
Implementation structures	Agencies responsible for delivering policy.	Implementation structures are generally designated at the ministerial level (e.g. Ministry of Foreign Affairs). The expertise for implementation duties at the operational level is generally embedded in subordinate institutions, departments or special sections within a ministry (e.g. national development agency).
Instruments	The tools that support change.	Instruments for global health policy at the national level may be substantive (e.g. Official Development Assistance for Health) or procedural (e.g. health diplomacy, research funding priorities).
Implementation rules	Procedural standards for policy implementation.	Guidelines for the agencies given responsibility for policy implementation underpin the instruments used by the implementation structures (e.g. agreements for annual work-plans).
Rationales and assumptions	Justifications to legitimize the policy design, and underlying premises.	The right to health is an example of a rationale to legitimize design institutionalising rights-based international conventions. Synergy as rationale legitimises design for policy

		coherence to institutionalise the interdependence of health-related foreign and domestic policy and creating structural changes for how sectors cooperate on shared objectives. The need for international public-private partnerships to act on global health priorities is one example of an assumption. Technical assumptions may come from research and evaluations.

In our framework, policy design is a country's formally adopted global health policy document (e.g. Norwegian (Norwegian Ministry of Foreign Affairs, 2012) and Swiss (Federal Department of Foreign Affairs & Federal Department of Home Affairs, 2012) NPGH). There are limitations to understanding NPGH policy design as the official text of a country's position at the highest level of government at a precise moment because information about instruments for implementation may be lacking, and it excludes consideration of policy processes that have not produced a formal output. However, it provides a unique perspective on the end result of negotiation and trade-offs between policy actors from different sectors collectively deciding on policy content.

Discussion

Our framework for understanding NPGH development has four features. It identifies multiple contexts as part of the global health policy process, focuses on situations where actors work together to produce global health policy, considers these interactive situations as spaces for observing external influences on global health policy change and proposes policy design as the output of the process. We suggest the model can be used to inform research on the practice of national policy-making on global health.

Specifically, the model makes three contributions to the conceptualisation of NPGH development processes. First, the model emphasises collective action between institutions across sectors over that of individual policy actors. Literature on agenda-setting for global health strategies underlines the importance of individual action (e.g. politicians or policy entrepreneurs) and the skills needed for global health diplomats (e.g. leadership) (Aluttis et al., 2014; Gagnon &

Labonte, 2013; Kanth et al., 2013). But this may neglect opportunities and challenges offered by a theoretical perspective of collective work. Understanding of NPGH as a collective production encourages researchers to question which actors are included, which ones are not, and why.

Second, by using an action situation as the starting point to observe policy-making, the framework breaks down the policy process into interactive spaces where groups govern action rather than by the stages when it takes place in the policy cycle. This emphasizes an action-based procedural concept of global health policy development adaptable to policy-making practices in a variety of political systems. The framework assumes that public policy is a dynamic and non-sequential iteration of activities as part of a variety of organised events where actors meet to debate and negotiate global health policy. By materialising the policy process through action situations, public health researchers may find new ways to analyse power configurations within policy-making activities by exploring the mix of actors, resources and rules at play. Action situations are sites for dialogue and disagreement between global health actors.

Third, public health researchers can use action situations as spaces to identify external influences on a NPGH action arena. Action situations are like conduits for the transfer of ideas and knowledge about global health policy from different sectors and settings, with ideational materials flowing in and out of these decision-making spaces. Policy transfer is a process for policy development in which knowledge about policies, administrative arrangements, institutions and ideas from one political setting is used in another time and place (Dolowitz & Marsh, 2000). Global health governance research provides examples of how norms and policy ideas circulate between institutions and actors who operate at the global scale. Other studies show examples of how global health policy and programmes influence national health systems in low and middle-income countries with health interventions. Our model focuses explicitly on the link between the global and the national, interpreting action situations as theoretical sockets through which actors receive and connect to ideas about global health policy from other places. Public health researchers can use this construct to question the influences, both domestic and foreign, on a country's global health policy. What ideas feed the NPGH policy processes, and what are their sources? But also, which ideas are excluded and who decides?

This paper provides an example of work done to move from identifying a policy theory to operationalising it for global health policy research. The task of operationalising a theoretical framework from political science presents two sets of challenges for public health researchers using interdisciplinary approaches in policy research. The first set relates to the ability to work iteratively between at least two sets of literatures. The researcher needs to take into account the characteristics of the field of study and the research object and put them into the framework. For instance, our framework needed to make sense of a policy process characterised by intersectoriality and cross-level influences. Then, the researcher needs to identify relevant theoretical concepts from political science to modify the concepts that relate to those characteristics, while ensuring that the concepts used are coherent with the researcher's ontological and epistemological perspective. As explained above, Real-Dato's framework favoured explanations of actor behaviour derived from a rational-choice perspective, and we chose to integrate a constructivist perspective.

The second set of challenges stems from working iteratively between the abstract (the theory) and the empirical (the policy under study), wherein the researcher faces methdological questions and dilemmas about the relevance of the research for public health action. First, we needed to translate the framework's variables and the relationships between them into observable sets of data, a task that involved linking the adaptation of the model to the specification of methodological rules. For instance, what does an action situation look like on the ground? Is it an international conference? Is it an interdepartmental meeting? Is it a regularly scheduled meeting between three people? Et cetera. For this, we developed general characteristics of actions situations and established criteria we could use in preparing data collection and analysis strategies. This framework was adapted for our research on two cases of NPGH to guide the study's methods, develop an interview guide for informants, elaborate a coding grid for analysis, and orient modelling the policy arena in each case. Though this challenge is not specific to our research, the task was all the more challenging because this particular framework synthesising several theories of the policy process has never been applied to a published case study. Second, we reflected on the use of theory in the fields of population and public health and policy studies. These two fields have different intentions regarding how they relate to action (Clavier, 2012). For example, global health policy literature generally focuses on interventions and programmes to

improve health at the global scale, with a particular concern for health equity. There is an underlying normative goal in public health's aim to improve policy and governance for global health. On the other hand, policy process theories are generally used in the political science discipline with an aim to development theory for the purpose of understanding a wide spectrum of policy processes and action by the State and other actors. Our in-depth process of adaptation stimulates reflection about what field becomes the main target for the results and contribution of a public health researcher using policy theory. We agree that theory development should also be a goal of health policy analysis (Walt et al., 2008), but engaging in a process to adapt policy theory produces a dual sense of responsibility of the researcher to make a theoretical contribution relevant to the discipline of the theory's origin (political science) and a practical or methodological contribution to the field for which his research object is of interest (public health). When using a policy theory-driven approach, this tension may also be visible in the research questions, which have a strong likelihood of being pertinent to either or both fields.

Conclusion

Policy frameworks are useful for health policy analysis within a deductive approach to qualitative synthesis or for comparative research (Walt & Gilson, 2014). Frameworks of the policy process offer conceptual tools for public health researchers to critically question global health policy, to stimulate research questions about how it is developed, and to generate knowledge on opportunities and barriers for global health policy change. We suggest that political science informs public health researchers' conceptualisation of NPGH as a set of micro-processes in interactive activities organised by rules where actors exchange resources and exercise power to negotiate decisions within a governing system coordinated at the national level. We suggest the framework is useful to organise enquiry and analysis of NPGH regarding how policy actors from different sectors work together and in what ways national and global processes in global health policy-making are related.

Figure 1. Framework of national policy on global health policy process

Source: Reinterpretation of Real-Dato (2009).

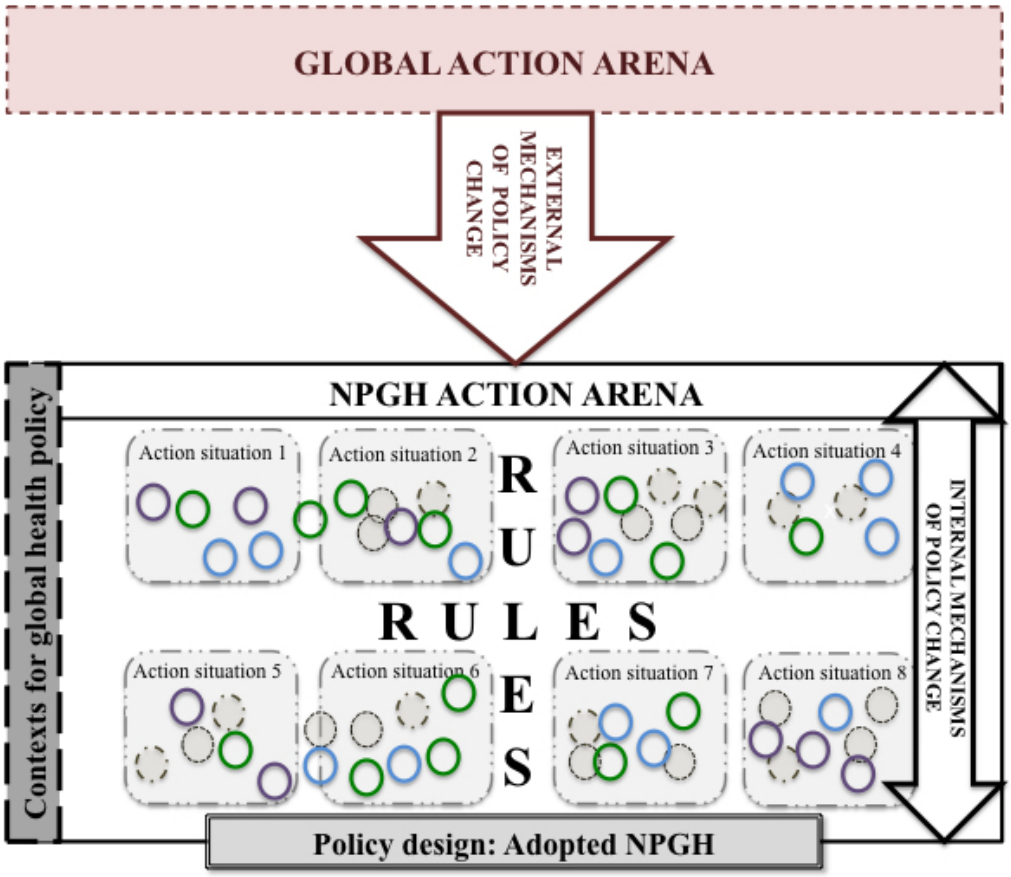
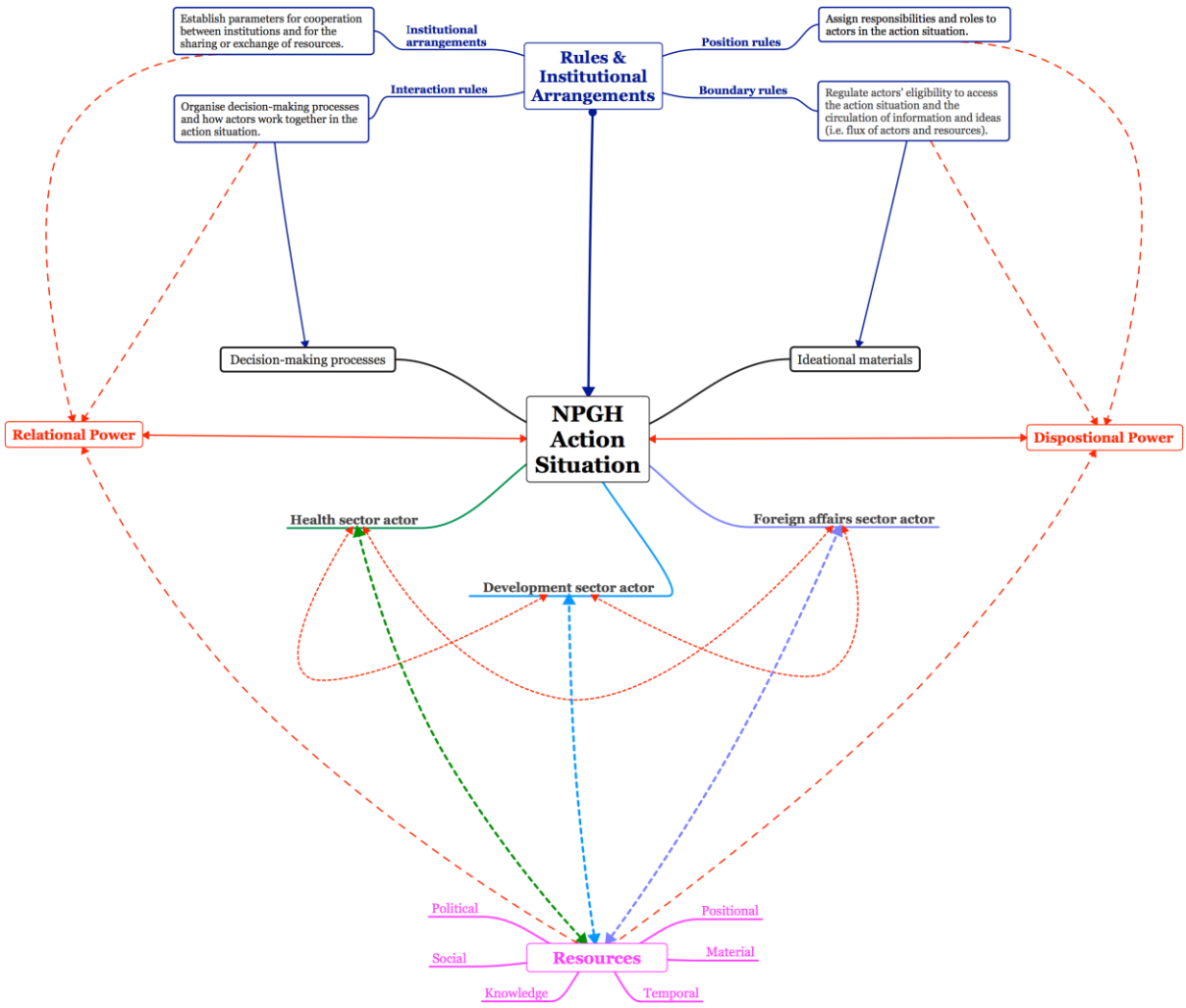


Figure 2. Elaboration of an action situation

Source: Author's model of a single action situation, includes Hassenteufel's (2011) resource typology, definitions of rules and institutional arrangements adapted from Ostrom (2007), Real-Dato (2009), and Klijn (2001), and Arts and van Tatenhove's (2004) layers of power.



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Chapter 4: METHODS

4.1 Research questions

The general objective of this thesis is to understand the relationship between national policy on global health and global health governance. To this end, the thesis examines an emergent object, national policy on global health (NPGH), that I conceptualise in public policy terms as a multisectoral action arena wherein actors from health, development, and foreign affairs sectors interact in policy situations to make decisions about a government's work on global health (see Chapter 3). Within the specific objective of this thesis to explore influences from the GHG system on the NPGH arenas, based on two formally adopted NPGH policy documents, I use two in-depth case studies of NPGH in Norway and Switzerland to answer three research questions:

1) What are the elements of policy design in formally adopted NPGH documents?
2) What characterises action arenas that develop NPGH documents? and
3) How do mechanisms of policy change operate between the system of GHG and arenas of NPGH?

To answer these questions, I carried out the study for this thesis within a methodological approach consistent with the post-positive paradigm that is the dominant standard for research in the field of public health. Following from this paradigm, this thesis deductively models NPGH as social spaces for developing multisectoral public policy on governing global health. Defining NPGH as a policy arena with two important dimensions of interactions for actors – working across different policy sectors, and working at different policy levels – I used public policy theory to direct my data collection and analysis strategies to generate knowledge about two cases of NPGH. The thesis uses a retrospective case research design and data collection and analysis methods to contextualise, construct, and validate units of interactions between actors.

4.2 Ethical review

The study was approved by the Health Research Ethics Committee [*Comité d'éthique de recherche en santé, CERES*] of the *Université de Montréal* on September 8, 2014, and renewed on November 2, 2015 (see Appendix B for certificates).

4.3 Research design

This thesis used a retrospective qualitative multiple case study design (262). I selected the case study research design because in-depth qualitative case studies accommodate a variety of data sources (e.g. documents, key informants) and multiple analytic strategies to examine processes in different contexts (262-264). A multiple case study design allowed me to replicate data collection and analysis methods so that I could interpret findings about the development of NPGH in two countries with the aim of understanding the relationship of those national policy-making processes to the processes in global health governance (GHG) (262). The replication logic for multiple case studies, wherein each individual case selected is conducted separately as a "whole" study using the same data collection protocol, was fitting for the research objective to relate the cases to another system (GHG) through cross-case analysis (262). The deductively constructed cases in this research are instrumental for the comparison of their policy designs and their interactions with GHG (265, 266).

A case is generally defined as a bounded phenomenon or system, with specified physical, spatial and temporal boundaries (267, 268). In this thesis, I define a case as a multisectoral policy process for developing a NPGH document formally adopted by a government at the national level. The State as a sovereign space with a specific political and bureaucratic system within which government actors make policy designates the physical (geographic) and spatial (jurisdictional) boundaries. The temporal boundary of each case is a 7-year period, looking retrospectively from 2012 back to 2006.[4] I consider 2006 to be a

[4] The temporal boundary of 2012-2006 in the research design differs from the temporal boundary of 2013-2005 in the results presented as case monographs for Switzerland (Chapter 6) and Norway (Chapter 7). I decided to extend the boundary for the time frame for each case to reflect and accommodate their empirical realities that

watershed year in the construction of the political and public policy reality for cases as defined for this thesis because of two milestone events. The launch of the Foreign Policy and Global Health Initiative in 2006, and the signing of the *Oslo Ministerial Declaration* in 2007, were significant for more widespread recognition of the problematisation of global health challenges as part of foreign policy agendas to global health and diplomatic actors working at national and international levels (12, 202, 203, 269). In addition, some commentators recognise the *Swiss Agreement on Health Foreign Policy Objectives* between the Federal Department of Home Affairs (ministry with responsibility for public health in Switzerland, mandated to the Federal Office of Public health) and the Federal Department of Foreign Affairs in 2006 (19) as the first example of a national strategy for coordinating a country's global health action across government sectors (13, 140, 219).

4.3.a Study population

This thesis defined the population of cases by the presence of an adopted formal NPGH policy document. For this thesis, a NPGH policy document is an interministerial or cross-governmental national strategy for coordinating a state's actions on global health. Adoption means that a NPGH policy document has been approved or recognised at a high level of government decision-making within a country [e.g. Parliament, Cabinet or Head of Government]. The scientific and grey literature cite a number of national strategies for global health, national strategies for global health diplomacy, and policy statements on health and foreign policy (13, 16, 134) such as those from Switzerland (19, 20), the United Kingdom (21), Norway (22), Germany (23), Japan (30, 33), and most recently France (24). The United States is an unusual case in this population due to the official policy documents on global health produced in various departments, agencies, and offices (health, state, USAID, and the Office of the President), with responsibilities given to each without coordination across.

Noting the characteristics of formally adopted NPGH as policy documents that discuss global health are developed at the national level with more than one policy sector, and adopted at the highest levels of government, I excluded policy statements from this population based

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substantiated this methodological choice, namely related to state and political contexts (2005) and to the scientific and technical contexts (2013) for including action situations with non-governmental actors in the models.

on the following criteria: intersectoral policy documents that discuss global health that are not formally adopted at the highest levels of government, government policy documents that only discuss specific disease issues [e.g. HIV/AIDS], global health policy documents produced by a single policy sector [e.g. global health policy of national development agencies or health agencies], global health policy documents of regional or multilevel policy [e.g. EU Strategy on Global Health], national policy for implementing global health initiatives and public-private partnerships related to disease prevention interventions [e.g. USA President's Emergency Plan for AIDS Relief], ministerial strategies and sector policies of national agencies which impact global health [e.g. trade or economic policy], and national policy related to implementation of international agreements such as the International Health Regulations or the Framework Convention on Tobacco Control.

4.3.b Selection of cases

I selected the cases based on NPGH adopted by Norway and Switzerland from a sub-group of European countries within the population of cases from other high-income countries who have adopted such policies (20-23). I justified the selection of cases according to three criteria for most-similar systems [synchronicity of NPGH policy adoption, acknowledged contributions as a State actor in global health, and analogous engagement in multilateralism] because they relate to a comparable macro-level context for global health policy at the country level (270). The contemporaneous adoption of NPGH in Norway and Switzerland in 2012 established a shared timeframe for the comparative analyses within the thesis in line with the replication logic of the multiple case study design adopted.

Norway and Switzerland have comparable ambitions for global health and its governance. They both work within a challenging climate for governments to find balance between bilateral and multilateral Official Development Assistance (ODA) to increase their international influence on global health (271). Although both are among the top ten richest countries in the world according to their Gross Domestic Product based on purchasing-power-

parity per capita[5], Norway $65,572 USD and Switzerland $56,830 USD, their financial investments in global health through official development assistance for health (ODAH) differ.

Norway has been committed to spending close to 1% of its Gross National Income on ODAH since 2009, surpassing the UN target of .7%, and it was one of four countries with Sweden, Denmark and Luxembourg that surpassed that target in 2013 (272). Norway seeks to increase its international status and develop norms through its policies and partnerships working on global health (and other areas of development related policies) in line with international commitments, while emphasising cross-cutting issues (272). Norway is a founding government member of the Foreign Policy and Global Health Initiative and a founding donor of GAVI, Unitaid, and the Global Financing Facility. In 2006, a Norwegian Forum for Global Health Research was established to strengthen global health research in Norway, improve international research collaborations and build capacity in LMICs.

Switzerland is recognised for the first inter-ministerial (foreign affairs and heath) agreement on health foreign policy objectives in 2006 (13, 19). One of the functions of Switzerland's neutrality is to serve the international system as a host of many UN organisations, other international institutions and NGOs, and diplomatic missions (273). Switzerland's strategic approach to multilateral cooperation is a strength of its development strategy (274). The Swiss Government has made a political priority of strengthening Switzerland's position as a host state and its perception as a global centre of expertise and multilateral diplomacy through the on-going development of *International Geneva* (275). Specifically, *International Geneva* supports projects to catalyse and establish Geneva as a global health hub where actors from multiple sectors can come together to reflect, innovate, and act on global health, including fostering interdisciplinary approaches to global health in academic institutions (276). In this regard, Switzerland is uniquely placed to influence global health within its own borders. In summary, Norway and Switzerland are similar because they

[5] GDP figures for the year 2013 in current international dollars according to the IMF World Economic Outlook Database 2017 (https://www.imf.org/external/pubs/ft/weo/2017/01/weodata/index.aspx).

are both recognised for capacity to influence global health matters given their histories of contributions to health through development cooperation (272, 274, 277, 278).

These two cases are also embedded in a shared international context, with similar strategies for engaging in global governance and multilateralism generally, and for global health in particular. Both countries are active member states of WHO (in Geneva and in the WHO European Regional Committee) and the OECD Development Assistance Committee, the main international normative institutions for health and development, respectively. Both countries are also member states of the Council of Europe, an international organisation concerned with upholding human, social, and democratic rights in Europe. Neither country is part of the European Union, which has become an active global health actor since 2010 (279), but both countries are members of the European Free Trade Association, part of the single market, and have a close relationship with the EU (Norway as part of the European Economic Area and Switzerland through a bilateral arrangements) including on issues related to public health (e.g. ECDC, EU Health Programme). Notably, neither country is part of the group of major economies in whose meetings global health issues are increasingly discussed (i.e. G20, G7).

Some scholars consider the groups of major economies as units of analysis for global health policy research, given the global health policy commitments made by countries in their summits (280, 281). I selected non-member countries because I suggest they offered a rival perspective for exploring what policy plans are being adopted in high-income countries. In this way, Norway and Switzerland are similar because they share a context of relations with international institutions for knowledge and action on global health and development, but they are not formally part of the global groups of major economies or the European regional economic and political union that create a particular constellation of international relations associated with global economic powers.

Although both countries are considered small-developed states according to population criteria (i.e. under 10 million), the category of "small states" is contested because they should not be defined in absolute but relative terms, such as in their relation to systemic attributes at

the international level (282, 283). Small states are also discussed according to their power (e.g. economic, military, diplomatic, institutional) in the international system (284). For example, Norway has sought to increase its international status through moral and normative power by taking on responsibilities and getting involved in international policy processes regarding peace, security, human rights and equality (285). Ingebritsen et al. (286) refer to Norway as one of the Scandinavian "norm entrepreneurs" from the small Nordic countries who contribute to global norms for sustainable development, equity, aid, and international cooperation.

While neutrality has been historically important for Switzerland's power in the international system, some of the functions of neutrality have been challenged by rapid changes in the international context in the past thirty years (273). Switzerland's membership to the United Nations in 2002 and a series of bilateral arrangements with the European Union have increased its opportunities for international influence (273). Switzerland typifies powerful small states behaviour in how it works to influence global politics and international institutions through foreign policy, on peace for example (287). Globalisation and the internationalisation of the domestic policy have given rise to a more (ambitious) foreign policy in Switzerland and a need for coordination between an increasing number of actors an interests, including those of the international community, on policy issues like security and development for example (288). Noting that any discussion of power of small states should be referenced in relation to specific policy issue areas (289), I suggest that Norway and Switzerland are similar because they are both influential state actors in matters of global health, but in different ways.

4.4. Context Advisory Groups

One of the features of the research design for this thesis is the establishment of two Context Advisory Groups. Because the two cases selected for this thesis were unfamiliar empirical or practice settings to me as countries where I had no experience with policy making related to global health, I built Context Advisory Groups (hereafter referred to as CAGs) into the design as methodological devices to support my data collection and analyses for constructing the cases of NPGH in Norway and Switzerland. Below I discuss the rationale,

composition, and roles of the CAGs as an original dimension of the methodological approach for this thesis.

4.4.a Rationale for CAGs

I created the CAG device as part of an overall strategy to improve the validity (*credibility* in qualitative research terms) of the empirical models of NPGH action arenas and the results of the in-depth case studies characterising the processes for the development of NPGH in Norway and in Switzerland. The CAGs are methodological tools that I used to support my comprehensive and systematic consideration of the unique policy-making contexts in Norway and Switzerland to strengthen my data collection and analyses. Neither my doctoral research supervisors, nor I as the doctoral researcher, had experience or extensive networks onsite in the two case countries relevant to the fieldwork I conducted for data collection. For the purpose of this thesis, the national expert members of the CAGs were conceptualised as *context brokers*.

The inspiration for the CAGs came from my own work experience developing and coordinating international projects for over a decade in a non-governmental organisation. There, I experimented with similar advisory tools for projects where experts familiar with the context were consulted for critical feedback to inform decisions about the project orientation and for dialogue about interpretations of results. Acknowledging the methodological challenges of conducting case research in two foreign countries, I organised the separate consultations of the two CAGs in this thesis at critical milestones over the course of the research process.

4.4.b Composition of CAGs

Carole Clavier (thesis co-supervisor in the discipline of political science) and I were members of the Norwegian CAG and the Swiss CAG. In addition, each CAG included one additional national expert member with university and/or research institute affiliations from the respective case country. I identified and invited CAG national expert members from Norway and Switzerland on the basis of selection criteria regarding their knowledge,

experience and research or policy interests related to health and foreign policy, or global health policy and governance (see Appendix C for Terms of Reference). *Dr. Kristin I. Sandberg* is the recruited expert for the Norwegian CAG, and *Dr. Ilona Kickbusch* is the recruited expert for the Swiss CAG. Dr. Sandberg is a Senior Researcher with the Fridtjof Nansen Institute in Oslo, Norway (https://www.fni.no/research-staff/kristin-ingstad-sandberg-article198-818.html). Previously, she served as a researcher from the Institute of Health and Society, Centre for Development and the Environment, University of Oslo, on the team supporting the University of Oslo-Lancet Commission on Global Governance for Health. Dr. Kickbusch is an Adjunct Professor, Interdisciplinary Programmes and Director, Global Health Programme at the Graduate Institute of International and Development Studies in Geneva (http://graduateinstitute.ch/directory/_/people/kickbusch). She has expertise in global health diplomacy and global health governance, and she has served as an advisor to the Federal Office of Public Health in Switzerland on these matters.

4.4.c Roles of CAGs

These CAG structures have an integral part in the research design (and not the collection or analysis methods), and the roles of the national experts reflect this distinction. Members of the CAG were not eligible for selection as key informants. Furthermore, the national expert CAG members did not participate in the development of the research design or the theoretical framework for the thesis. Finally, the specific context-embedded roles of the international CAG members were in no way redundant to the scientific supervision and mentoring roles of the doctoral researcher's supervisors. The national members of the CAG structures were involved as experts because they are global health policy and governance knowledge producers and/or knowledge users in their respective countries, and because they know the key actors and processes in this policy field.

As the doctoral researcher, I served as the chair and convenor of the Norwegian CAG Norway and the Swiss CAG established for this thesis, and I was responsible for their preparation, follow-up, and evaluation. The main roles of CAG members were to:

1) Provide feedback on the modelling of the NPGH action arena for their respective case country.
2) Assist in the identification of relevant archives of the policy process from their respective case country.
3) Contribute to process of identifying key country informants from their respective case country, and to provide strategic or practical advice to facilitate their recruitment.
4) Discuss the case report for their respective country and inform analyses.

The roles of the CAGs were restricted to individual case construction. The CAGs were never used for the purpose of cross-case or comparative work within this thesis.

4.4.d Contributions of CAGs

Over the course of the thesis between September 2014 and April 2017, the CAG meetings were convened at "methodological milestones" in the data collection and analysis process, with each meeting corresponding to a step in the process of constructing the cases. As methodological milestones, the three main CAG meetings (see ***Table 4.1***) were built into the project as checkpoints for quality assessment, relating in particular to quality criteria of qualitative research design, analysis, and reporting such as peer debriefing, triangulation, and trustworthiness (290).

Table 4.1 Three CAG meetings as methodological milestones for each case

Methodological Milestones	**Norwegian CAG**	**Swiss CAG**
CAG Meeting 3 – Reviewing draft case report	April 2017	October 2016
CAG Meeting 2 – Monitoring data collection	April 2015	June 2015
CAG Meeting 1 – Understanding field's context	September 2014	November 2014

The CAGs were consulted mainly via videoconference for the duration of 1-3 hours on three occasions during the project for this thesis, as well as electronically via email exchanges

in between meetings when needed. For each CAG meeting, I prepared the agendas, briefing documents, presentations, analyses in advance and followed-up with minutes, action points and evaluations. The agendas from the Norwegian CAG meetings 1-3 can be found in Appendix D as an example record of the CAG formal processes, but the contents of other documents related to our discussions contain confidential materials, so I have not included them in the Appendices. A process evaluation survey of the first and second meetings was conducted via Google forms for the purpose of improving future consultations and exchanges with the CAG.[6] In addition to the formal documentation of these processes for CAG members, based on the CAG's questions and feedback, I produced reflective notes on the methodological consequences and potential modifications as a result of each CAG consultation.

The main outcome of the *first methodological milestone* (CAG_M1) was a validated a purposive sample of potential country key informants for the first wave of interviews and a confirmed recruitment strategy. CAG members discussed and validated items for a provisional set of action situations (five for the Norwegian NPGH arena and six for the Swiss NPGH arena) and archives of the policy process (five archives of the policy process for the Norwegian NPGH and seven for the Swiss NPGH) based on what I generated from the documentary research phase to prepare for the fieldwork. Using this validated set of action situations, the CAGs discussed actors who participated in those situations, using a preliminary list generated by the doctoral researcher and recommendations of the participants known by the CAG members to produce a purposive sample. The national expert members of CAGs specific knowledge of the policy processes in each case country contributed to confirming an initial map of action situations and their key actors as a basis for data collection with the informant interviews. At this stage, the CAG members also provided feedback on preliminary analyses of the NPGH policy documents and the policy context scan as background for case country profiles.

[6] For example, these surveys were sent to the Norwegian CAG after the M1 and M2, respectively: https://drive.google.com/open?id=1Lpp9f6LSOjdqN4s29FHXvJVxCYwClet2_WJecFnL8xk
https://drive.google.com/open?id=1RKhM05oJDe6gpLVyLmC4rzmrWyudOBRz7i6jsssm98Q

The main outcome of the *second methodological milestone* (CAG_M2) was the prioritisation of a list of actors collected through snowball sampling and validation of the strategy for recruiting informants for subsequent wave of interviews. Based on an update on the data collection completed to date in the field, including an assessment of gaps in the data from actors by action situation and by policy sector, the national expert members of CAGs were invaluable resources for discussing the snowball sample collected in the first wave of interviews. This milestone ensured that the second wave of informant interviews would most appropriately target the policy sector perspectives and missing key actors from the processes that were identified.

The main outcome of the *third methodological milestone* (CAG_M3) was the assessment of the validity, credibility and limitations of the analyses for each case report. Each CAG's review of the draft case monograph was guided by specific questions regarding their general impressions specific critiques, the balance of theory (analytical categories) and evidence (empirical examples) in the case, and the comprehensiveness of the case (any omissions in light of case boundaries). These consultative exchanges collected critical feedback and in-depth discussion of the results of each case study important for exploring rival interpretations since only the doctoral researcher conducted all of the data collection and analyses.

In practice, the CAGs were key methodological devices embedded in the research design for strengthening the reliability and validity of the results presented in this thesis. The CAGs were vital sources of context-relevant advice for constituting the purposive sample of key informants for the first wave of interviews for the cases. In this regard, the first and second methodological milestones were instrumental for the identification of and access to the most appropriate key actors from different sectors that participated in the development of NPGH policy documents. The involvement of the CAGs in the sampling process established a legitimate link to the policy environment specific to each case country, and the transparency about their involvement in the study (as per the roles defined for CAGs) was an asset for the recruitment process. The second methodological milestone was conducive to determining data saturation for each of the cases. Finally, the first and third methodological milestones assisted

in using the CAGs as an audit process to check the dependability and confirmability of the findings. For example, the CAG consultation of the results for the individual within-case analyses of the NPGH policy document designs and of the characteristics of the NPGH action arenas were crucial to the verification of confidence in the results of the case studies for the comparative components of the thesis (see Chapters 6 and 7).

4.5 Constructing the cases

The formal adoption of the NPGH policy documents in 2012 by Norway and Switzerland defines the starting point for the two cases of NPGH in this thesis. Norway's *White Paper on Global health in foreign and development policy* and the *Swiss Health Foreign Policy* were publically available policy documents online in English language versions. I used a retrospective approach to reconstruct the policy processes for developing these two NPGH documents since 2005. The cases were constructed independently as individual studies, with theoretical and methodological replication in accordance with the multiple case study design.

4.5.a The process of policy development in NPGH action arenas

I began the construction of the cases with an outcome: the adopted NPGH documents in Norway and Switzerland. In the terms of the theoretical framework adapted from Real-Dato (146), policy design refers to outcomes of the policy process examined in this thesis. To answer the first line of inquiry, I analysed the content of NPGH documents adopted in the two case countries as a result of a multisectoral policy process. I conceived of NPGH as being the result of interactions between actors from at least three policy sectors, which are generally the foreign affairs, health, and development sectors within domestic public institutions. In the terms of the theoretical framework adapted from Real-Dato (146), each interaction is called an action situation. Action situations are the units of observation. The assemblage of these interactions constitutes the action arena, which is the unit of analysis for constructing the cases. In other words, to answer the second line of inquiry to understand how NPGH were developed in Norway and Switzerland, I identified and studied a series of interactions between

actors from at least three policy sectors (action situations) and how the connections between these action situations (the action arena) led to the development and adoption of NPGH. Because of my interest in interactions between actors (action situations) that collectively (in action arenas) contributed to the development of NPGH in Norway and Switzerland prior to the adoption of these documents, I did not distinguish between agenda-setting, policy formulation, and decision-making stages of the policy cycle for the processes examined within action arenas (291).

Specifically, action situations manifest as committees, working groups, platforms, task forces, or other forms of social groups in which actors from different sectors interact. According to the theoretical framework (see ***Figure 1*** and ***Figure 2*** at the end of Chapter 3), rules and institutional arrangements organise the action situations and structure how the actors work together (e.g. leadership, organisation, coordination) within them. The rules-in-use regulate which actors are included and excluded, the resources they contribute, their participation in decision-making, and how information is managed. According to the synthesis framework adapted from Real-Dato (146), influences on policy change can originate from within or from outside an action arena. For this thesis, as the units of analysis for the two cases, I consider the action arenas for NPGH as the national (internal) and the global (external) arena to be what is outside of that. I assume that this external arena is global governance. To answer the third line of inquiry, taking the perspective of actors from inside the action arenas in Norway and Switzerland based on the in-depth cases of their development of NPGH, I explored how mechanisms of policy change operated between the external arena and the respective action arenas for NPGH. Through the retrospective construction of these two cases, from the moment of the adoption of NPGH official policy statements, and from the ground up through situations for intersectoral collaboration contributing to NPGH development, I organised the data collection and analysis for this thesis with the aim to understand the relationship between national policy on global health and global health governance.

4.5.b Development of instruments and definition of variables

Consistent with the deductive approach adopted in this thesis, our theoretical framework (see Chapter 3) provided the direction for elaborating the methods for the project. I produced detailed conceptual grids of the main variables for each of the four core elements of our theoretical framework [i.e. policy design (Grid 1), action situations (Grid 2), contexts (Grid 3), and mechanisms of policy change (Grid 4)] (see Appendix E). I reviewed public policy literature on each element of the framework to operationalize the model and define variables for data collection and analysis. The variables for policy design (Grid 1) and mechanisms of policy change (Grid 4) are defined in detail in articles corresponding to Chapters 5 and 8 respectively. Below, I define the variables related to the action situations (Grid 2) and contexts (Grid 3) because these variables constitute the two foci for modelling and contextualising the action arenas to construct the Norwegian and Swiss cases of action arenas.

Grid 2 variables (action arenas – policy development)

2.1 Action situation variables		**Definitions**
Actors		The individual and collective actors involved in the policy process for developing NPGH.
	Positions	Specific roles for participants in action situations.
Action - Processes		The interactions, negotiations, dialogue, or exchanges that take place in action situations. The leadership, management, organization, and coordination of interactions among actors in an action situation and the approaches to decision-making.
Results		The products of actors working together within the action situation, and the consequences of the interactions for actors, sectors, or the arena.
Materials		The information available to actors in the action situation for reflection, planning, or other action-processes. The ideas, values, beliefs, information and knowledge actors contribute to and produce through their interactions. These include normative frameworks used for decision-making and models or programmatic ideas used for policy design.
Power		Power is exercised through the use or non-use of resources in interactions within the action situations, and institutional arrangements can determine how power exchanged between actors.
	Relational power	Relational power is power through interactions, based on a relational concept of power struggles between actors / sectors or power struggles in the joint practices and collaborations.

	Dispositional power	Dispositional power is power through position, wherein the rule established order determines the opportunity of actors to act. Dispositional power orders organisations and sectors, in which actors may use their relational power to reproduce, modify or challenge decisions.

2.2 Actor variables		**Definitions**
Spheres		
	State	A government sphere with actors working in legislative, executive and judicial, or other technical agencies of the state.
	Market	A private sphere with actors producing goods and services, primarily (but not exclusively) private corporations.
	Civil society	A public sphere with actors from the third sector/voluntary/civil society organisations such as political parties, interest groups, welfare associations, social movements and religious groups.
	Knowledge-technical	A public or private sphere with actors who are knowledge producers in universities, research institutes, as well as technical assistance organisations that are not in the state sphere.
Resources		Resources are constraints and facilitators for interactions and results in the action situation. Actors use, share, acquire, and produce resources through their interactions. Resources provide the basis for an actor's capacity to interact, using rules to condition power.
	Positional	Resources related to an actor's access to the action situation.
	Material	Financial and human resources (e.g. staff, budget).
	Knowledge	Information, knowledge, evidence (research), expertise and ability to interpret, translate and integrate these resources into strategies.
	Political	Resources of political support / political will from elected officials, bureaucrats, interest groups, coalitions – and other relevant collective actors in the larger political environment.
	Social	Networks, social capital, epistemic or policy community membership, professional associations, communication and exchange.
	Temporal	Time that an actor dedicates to the action situation (also a form of capacity). Also, may refer to the duration of the action situation.

2.3 Rules variables		**Definitions**
Boundary rules		Rules about which actors or materials allowed to participate in an action situation.
	Access rules	Rules regarding the involvement (entry and exit of actors from action situations.
	Flow rules	Rules regarding the circulation of materials (i.e. management and sharing / restriction of ideas, values, beliefs, information, knowledge, normative frameworks, programmatic models).
Position rules		Rules that assign specific roles & responsibilities for actors in action situations.
Interaction rules		Rules about the participation of actors and how they work together

		in an action situation.
	Decision-making rules	Rules establishing or orienting the decision-making processes.
	Power rules	Institutional arrangements and rules for actors' interactions (i.e. rules that influence how actors relate to each other in action situations).

Grid 3 variables (action arenas – policy contexts)

3. Policy context variables		**Definitions**
Contexts		
	Socio-demographic	Information, statistics and analyses about a country's population. Population data on age, income, education, health, work, family, social policy.
	Scientific & technical	The available and accessible knowledge, techniques and instruments for health, public health, global health, and development policy. This includes individuals or organisations who produce knowledge, advice or policy guidance for global health policy, and those who support policy development, evaluation, and implementation for global health and development policy (e.g. research, evaluations, knowledge translation, and policy analyses).
	State	The formal and informal rules for public policy and public administration institutions, including the organisation of the health, development and foreign affairs policy sectors.
	Economic	The economic and financial situation and trends (e.g. aid budgets, taxes, inflation, growth, unemployment, debt, revenue, trade).
	Political	The political system (e.g. government's composition, elections, Parliament, public opinion, special advisors and political appointments or commissions).
	International / global	International events, global initiatives, representation and participation in international organisations, international institutions, treaties and agreements, foreign aid, partnerships.

For data collection purposes, the variables were used with documentary methods to orient data searches and data extraction on context and with interview methods to focus the questions and content for the informant interview guide. The use of these grids with data analysis methods will be discussed later in this chapter in the corresponding sub-section.

4.6 Data collection and generation

I used two qualitative research methods for collecting data for modelling the action arenas and contextualising the action arenas to construct the Norwegian and Swiss cases for this thesis. The *documentary methods* consisted of collecting data from literature reviews of scientific and grey literature; economic, political science, health and development databases; and government and international institution websites. The documentary data collection methods were used to contextualise the cases and produce a timeline for each case and to identify archives of the policy process. I also used *interview methods* to collect data from key informants for each case, supported by graphic elicitation as a visual component to the interview method.

4.6.a Documentary methods

I used documentary data collection methods to build a case study database (262) for the objectives to contextualise the cases and identify archives of the policy process. I designed a context scan based on the definitions of the six variables for contexts relevant for NPGH in each case country. The policy context scans for the Norwegian and Swiss cases were conducted in the second half of 2014 using a three-pronged search strategy to cover a variety of sources including publically available government documents, international reports, and secondary data from scientific and grey literature (see Appendix F). The contextual data from documentary sources were recorded in a database for each case that logged the document name, source, reference and date catalogued. I used the documentary data collection to construct a contextual timeline for each case using *Preceden* (www.preceden.com), a free online tool, to build a chronological map of items for each context domain for each case.

As part of the documentary data collection, I obtained the two adopted NPGH official policy documents from the web. Norway's *White Paper on Global health in foreign and development policy* was obtained from the official website of the Government of Norway (https://www.regjeringen.no/en/dokumenter/meld.-st.-11-20115/id671098/?ch=1), and the *Swiss Health Foreign Policy* was obtained from that of the Swiss Federal Office of Public

Health (http://www.bag.admin.ch/themen/internationales/13102/index.html?lang=en). As part of the data extraction for the analysis of policy design (methods reported in Chapter 5 of this thesis), I also collected data for the case study databases on contexts from the content of each formally adopted policy document, such as: global health activities and communities in each country; the global/public health strategies, treaties, action plans, partnerships and international organisation memberships of each country; and other policy statements and reports related to NPGH in each country.

I identified archives of the policy process from within the dataset on contexts using the criteria provided below in ***Table 4.2***. The preliminary identification of action situations from archives of the policy process was essential to the first methodological milestone for the thesis because I used these action situations to consult with CAG members to identify the actors who participated in them as the procedure for constructing the purposive sample to recruit for the first wave of interviews.

Table 4.2 Selection criteria for archives of the policy process

Characteristics	Criteria applied to each characteristic
Time	Each archive will be a trace or record of at least one action situation that took place at least once between January 2006 and December 2012. Archives retrieved may be documentation produced prior to 2006 and/or continue after 2012. Archives may be preliminary, intermediate or final products of an action situation or communications about or related to an action situation.
Form	Archives may be in writing, either in electronic or paper form. Archives may be either formal or informal in nature (e.g. emails, memos, invitations, minutes, press releases, policy briefs, case studies reports, websites).
Accessibility	Archives may be public or private. Public archives may also be used as sources for data collection for document analyses. Private archives will only be used to identify action situations and actors as potential informants.

The contextualisation of the cases and identification of archives of the policy process from the documentary data collection were instrumental for developing my contextual literacy and understanding of the political and policy-making processes for each case, as a resource for my consultations with the CAGs, and for enriching my discussions with the key informants in the field.

4.6.b Interview methods

4.6.b.1 Sampling and recruitment of key informants

Based on the number of participants in two published case studies on the development of intersectoral global health strategies [fourteen in one case study (144), and six in another (145)] I planned to interview approximately fifteen key informants per case. As previously explained, my strategy for constructing a sample of actors as potential informants relied on the identification of actors in relation to the intersectoral action situations in which they participated. I used two strategies to reflect these characteristics in our purposive samples. First, I used quota sampling to identify potential informants from the range of different action situations. Second, I used heterogeneity sampling to identify actors from all of the policy sectors most involved in the NPGH action arena (i.e. ideally aiming to have at least three key informants per case from each policy sector of health, development, and foreign affairs). I recognised that some informants would be able to inform about more than one action situation in a given NPGH action arena. The characteristics of the samples and informants for each case by sector are found in ***Table 4.3***. A few informants in each case study have multisectoral professional trajectories, having worked in more than one of these sectors between 2006 and 2012 and throughout their careers. I classified their affiliation based on the sector for which they had the most pertinent role in the processes that I studied as the object of this thesis.

Table 4.3 Composition of samples and participants recruited as informants by sector

	Characteristics of ***samples*** by sector	Characteristics of ***informants*** by sector
Norwegian case study	**25** actors identified for recruitment 5 foreign affairs 9 health 4 development 2 civil society 4 research 1 politician	**19** informants recruited and interviewed 4 foreign affairs 7 health 3 development 1 civil society 4 research
Swiss case study	**26** actors identified for recruitment 7 foreign affairs 7 health 3 development 3 intellectual property 3 civil society 3 research	**14** informants recruited and interviewed 4 foreign affairs 5 health 1 development 2 intellectual property 1 civil society 1 research

I recruited key informants in two waves for each case. The purposive sample validated by each CAG was used to recruit informants for a first wave of interviews in each case. I used snowball sampling during the first wave of interviews for each case to identify actors to recruit for the second wave of interviews in each case. At the second methodological milestone, I consulted CAGs about data saturation for the two cases in this thesis. Saturation was defined as: 1) having key informants to generate data on a minimum of three action situations for each action arena, 2) having a minimum of two informants from the main policy sectors in each action area, and 3) having a minimum of one informant from academia and one from civil society. In the data collected in the first wave in Norway and the first two waves in Switzerland, I acknowledged that academics and representatives from civil society were potential outsiders to the main action situations being observed, but they were actors with important perspectives for the NPGH action arena. Their omission from the study was a limitation I did not accept, and therefore made a concerted effort to recruit informants from these categories in the second waves because I considered saturation of perspectives in the data incomplete without them.

I validated the recruitment strategy with each CAG, and they were consulted to advise on issues related to prioritisation of potential informants that was of strategic and practical

value in the recruitment process. I developed a set of communication tools and template documents as package of material for recruitment with text that could be tailored to particular needs, and I established a recruitment management system in Excel to ensure rigorous tracking of recruitment and follow-up with informants who agreed to participate in the study (including their contact information, a log of date of all contact and responses received, and a record of their comments or questions). When it was difficult to find publically available contact information for recruiting informants, CAGs provided email addresses. Informants were recruited by email invitation (see Appendix G), with a summary message and the project information and participation consent form attached (see Appendix H). The invitation explained the process by which they were identified as an actor in the policy process. I used multiple communication strategies for follow-up with informants by email, telephone, and even text messages. I had email and phone conversations with a number of the informants before interviewing them upon their request regarding details or clarification about the study. I recruited 19 informants for the Norwegian case and 14 informants for the Swiss case for interviews.

4.6.b.2 Key informant interviews

I used a pre-interview contact email to prepare the informants for my methodological approach and the main focus of my questions (see Appendix I). Informants received an email reminder between 24-48 hours prior to scheduled appointment for the interview that recapped the details (time, date, location) for the interview and provided informants with three headlines of the issues I wanted to discuss with them. The letter also reminded them of the intended use of the sketch-pad to accompany our discussion for drawing the activities they participated in and get a sense of the connections between them (see Article 2 under *Graphic elicitation – visual methods for interviewing* later in this chapter). I also requested whether informants would be willing and able to share with me any written documentation about the activities we would be discussing (e.g. records, agendas, minutes, notes, interim reports, draft products) as archives of the policy process. Given the cases' retrospective approach, asking informants to recall events that happened 2 – 8 years ago, I implemented this pre-interview process as a reminder to stimulate their reflection prior to our meeting (and many remarked this was helpful to their preparation for our conversation).

Before starting every interview, the informants were given the opportunity to ask questions about the project or clarifications regarding the Informant and Consent Form they had received previously. I reminded informants that they could stop the interview at any time, or request that the audio recording be discontinued and that they have the right to withdraw from the study at any time. In accordance with the ethical requirements of the Health Research Ethics Committee of the University of Montreal, signed consent was received from every participant in person, and I obtained electronically signed and scanned consent forms for those with whom interviews were conducted over the telephone. One informant in the Swiss case did not agree to have the interview recorded, and the consent form was modified on site accordingly. The face-to-face interviews were all conducted in person by the doctoral researcher in the professional settings of the key informants in the case countries Norway (in Oslo) and Switzerland (in Geneva, Bern, Basel). The duration of the interviews ranged from 30 – 90 minutes.

Data were collected between November 2014 and October 2015 from a total of thirty-three key informants from two cases (n=19 for the Norwegian case and n=14 for the Swiss case) using a semi-structured interview guide (see Appendix J). All interviews were carried out in English. In order to construct the action situations in each action arena, I was looking for data from informants about how the situations were initiated / managed / coordinated (rules), to what end (purpose), who was involved (actors), and what resources they contributed (ideational materials, knowledge, capacity). The interview guide had four main sections:

1) Document informant's professional background and their involvement in developing the NPGH document adopted in their country (identify action situations in which they were involved and others they knew about).
2) Examine and map action situations in detail through graphic elicitation (refer to Article 2 on visual methods for interviewing in this chapter).
3) Discuss mechanisms of policy change and sources of influence on the policy process.

4) Explore informant's appraisal, archives of the policy process and snowball sampling.

I designed the interview guide as a table with three columns. The first column from the left contained questions to start the discussion. The middle column contained more specific questions as probes. The last column on the right provided examples to be used for clarification if needed. I navigated interviews using this grid as a guide, but I used it flexibly to adapt to each interview and the flow of the conversation about action situations) as needed. After the first few interviews, I conducted the interviews without the guide by just working with those main headings to navigate the conversation with informants while keeping track of gaps and avoiding redundancies in my questions (also through the graphic elicitation method). I adopted a conversational style of interviewing informed by three interview strategies in this format (292, 293): 1) *object* to make a remark that may counter or contradict a previous point of view developed by the informant, 2) *interject* to directly introduce a new theme, or to integrate the instructions for next steps in the conversation within the framework of the interview to maintain relevance of the discussion for objectives, and 3) *re-launch* to revisit an idea from the informant, paraphrasing or echoing with the intention of seeking clarification. As discussed earlier in this chapter (see sub-section *4.6.a Documentary methods*), the work on contextualising the cases provided me with a context database (which expanded with data collected from the interview methods) from which I could draw upon for details on probing questions with key informants from each case. In some instances, I had communications post-interview with informants regarding follow-up points they raised during the conversation and on which they agreed to respond if I sent a reminder.

4.6.b.3 Graphic elicitation – visual methods for interviewing (Article 2)

Article 2. The invisible in the transcript: Diagraming as an elicitation technique for interviews in health policy research

Catherine M. Jones, Carole Clavier, Louise Potvin

This article is being prepared for submission to the methods forum in *Global Health Action.* Other journals under consideration are *International Journal of Qualitative Methods*, *Health Policy*, and *Methodological Innovations*.

Authors' contributions to the article:

Catherine M. Jones reviewed the literature on visual methods, developed the technique for the interview methods in this thesis, collected data from the methods sub-study, analysed purpose and usefulness of the method, and wrote and revised the manuscript.

Carole Clavier contributed to the literature review, analysis and reflection on the method's purpose and use, and critically reviewed the manuscript.

Louise Potvin contributed to the structure of the paper, analysis and reflection on the method's purpose and use, and critically reviewed and revised the manuscript.

All authors approved the manuscript.

Title:

The invisible in the transcript: Diagraming as an elicitation technique for interviews in health policy research

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Key messages

This paper presents the development of a diagramming technique and discusses its usefulness as a graphic elicitation tool for interviewing policy actors as key informants.

We propose three functions of the diagramming technique for interviewing and fieldwork in health policy research.

A large sketchpad is a low-tech, low-cost tool to visually support semi-structured interviews with policy and decision-makers on health policy processes that is adaptable to a variety of health policy research settings, including low and middle-income countries.

Health policy and systems researchers should explore how to integrate visual elicitation techniques more systematically as part of their formal methods when conducting interviews with policy actors and elites.

Abstract

In contrast to the development of knowledge on photo, video, art-based, and other media elicitation techniques in qualitative *health* research, regarding qualitative *health policy* literature, little is known about graphic elicitation in interviews with policy and decision-makers to study policy processes. This paper presents the development and application of a diagramming technique as a visual method to support data collection using schemas drawn (either by the interviewer, the informant, or collaboratively between them) during interviews with high-level policy actors. We developed the diagramming method for interviews with senior civil servants and experts in a retrospective study on the development of national policy on global health in Switzerland and Norway. Equipped with an artist's sketchpad, the interviewer suggests mapping out policy activities and situations together with each informant in terms of their purpose, participants, organisation, and resources using the drawings to explore what influenced action situations and their interconnections. We discuss the purpose and usefulness of the technique from a researcher's perspective with illustrations of sketches produced in four interviews from the study. Based on our use of a diagramming method in 25 face-to-face interviews with key informants about complex policy situations, we derived three main functions of the method, which helps researchers to *focus*, to *engage*, and to *reflect*. The results of a sub-study on the method, conducted with partial data, suggest that the technique also appears to be useful from a participant's perspective as an interactive approach using visualisation to explore policy processes being discussed. While some informants saw opportunities for using the content of the sketches, others remained cautious about their subjective nature and limits of dimensionality. We suggest health policy researchers should explore experimenting, formalising, and integrating graphic elicitation in interviews with policy makers in low, middle, and high-income countries.

Keywords: qualitative research, key informant interviews, policy actors, visual methods, elicitation techniques, diagramming

Introduction

Visual methods have emerged from social sciences (e.g. visual sociology and anthropology) as way to produce or analyse data as non-verbal, non-numerical representations of an empirical reality. They are commonly used for representing and synthesising the findings of quantitative and qualitative analyses, but visual methods are increasingly used as data-generating devices that produce an image (photo, video, diagram, map), in particular in qualitative health research (Prosser and Loxley 2008, Bell 2010). Visual methods for data collection involve the use of existing images and/or images produced by a study participant or researcher, which are interpreted by the researcher and/or participant as a manifestation of meaning for the purpose of addressing an empirical question (Prosser and Loxley 2008, King, Bravington et al. 2013). This paper presents the development and application of a diagramming technique as a visual method to support data collection using schemas drawn (either by the interviewer, the informant, or collaboratively between them) during interviews with high-level policy actors.

Visual methods in qualitative research

Visual methods include the *use of data in the form of existing images and/or images generated by the participant or researcher to address an empirical question, whereby the research and/or participants interpret these images as expression of meaning* (King, Bravington et al. 2013). Elicitation techniques in qualitative research aim to redress challenges for interviewing by stimulating ways to access key informants' tacit knowledge (Johnson and Weller 2001). Among a variety of elicitation techniques, some are visually based such as photo, video, and graphic elicitation. Specifically, graphic elicitation techniques engage participants in drawing representations of a concept (either on their own or with the researcher). In qualitative research, graphic elicitation techniques like concept mapping, participatory diagramming and timelining have been used to frame participant's experiences, generally in work using grounded theory or phenomenology (Crilly, Blackwell et al. 2006, Bagnoli 2009, Wheeldon and Faubert 2009, Sheridan, Chamberlain et al. 2011, Wheeldon 2011, Copeland and Agosto 2012, Buckley and Waring 2013).

In qualitative *health* research, the literature focuses on the use of photo, video, or arts-based techniques to elicit participant's knowledge about the needs of individuals or communities and their beliefs, behaviours, or lived experiences regarding health, disease, or vulnerability (Guillemin 2004, Catalani and Minkler 2010, Padgett, Smith et al. 2013, Mitchell and Sommer 2016) and particularly for research with children and young people (Darbyshire, MacDougall et al. 2005, Drew, Duncan et al. 2010, Johnson, Sharkey et al. 2011, Alexander, Fusco et al. 2015). In the health literature, examples of the use of graphic elicitation in interviews appear to be scarce, with some exceptions in organisational science, for example exploring inter-professional collaborative practices in health care settings (Umoquit, Dobrow et al. 2008, Harris and Guillemin 2012, King, Bravington et al. 2013). However, with regard to qualitative *health policy* research, little is known about how graphic elicitation is used in interviews with policy and decision-makers to study policy processes (Umoquit, Tso et al. 2011). The objective of this paper is to present a diagramming method used to generate representations of complex policy situations from decision makers and experts who had been involved in those situations. Specifically, working through examples of its application, we aim to derive purposes for which this method is useful.

Development of the method

The technique was elaborated as a support for interviewing senior level civil servants, policy actors and experts who served as key informants in a retrospective study on the development of national policy on global health in Switzerland and Norway. Development of the technique was informed by the theoretical framework of this study which conceptualises policy as an arena for interactions between actors in action situations organised by rules (explicit and implicit) about who participates, how they work together, and with what resources (social, financial, and ideational materials like information, evidence, norms) (Jones, Clavier et al. 2017). The study sought to answer questions about what characterises the policy process in those arenas. Key informants from the health, development and foreign policy sectors had participated at various stages in the policy development. During the interviews, they were to retrospectively report on the actors, interactions and actions involved in those policy arenas.

Informants were notified in advance of the plan to use visual methods during the interview. At the beginning of each interview a large (42 cm by 30 cm) sketchpad and pencils were placed on the table between the interviewee and the interviewer. Participants were not obligated to use the sketchpad. Most of the time the interviewer diagrammed throughout the interview, in a few cases the informant did, and in some cases the diagram was co-produced by the informant and the interviewer.

The initial approach used the technique to help gather specific data during the interview about *action situations,* which were the units of observation in the study. The interview grid addressed questions such as:

- How did you become involved in the development of (*name of adopted policy*) in (*informant's country*)?
- What kinds of activities were you involved in during that time related to (*name of adopted policy*) development in (*informant's country*)?
- I would like to hear about each one of the activities (e.g. working groups, committees, forums, initiatives) you consider to be most significant in more detail. Could we go through them more in-depth one by one?

For each *action situation*, the interviewer suggested mapping them out together in terms of its purpose, participants, organisation, and material support in order to also use the drawings to explore what influenced action situations and their interconnections.

Purpose and usefulness of the method

In this study, we used this diagramming technique as a graphic elicitation method to support data collection in Norway and Switzerland during 25 face-to-face interviews conducted in English about policy activities. All but one of these interviews were audio recorded. Graphic elicitation was introduced into the interview guide to equip the interviewer with a tool to support having a conversation with informants by drawing *action situations*, but as we carried it out, it became integrated as part of the interview process itself. The Health Research Ethics Committee of the *Université de Montréal* provided ethical approval for the main study and the sub study about diagramming (Certificate of Ethical Approval 14-083-CERES-D1). Informed consent was obtained from all participants in accordance with ethical guidelines.

Figure 1 was produced during the first interview for the study in Norway, the first time the technique was used. As the informant told the interviewer about participating in the action situation of the policy writing group, the interviewer used the sketchpad to keep track of the actors identified from various policy sectors and to explore their roles and how they worked together in that action situation. The diagram also served to discuss how the policy writing group related to processes within each sector that were contributing directly to it and to other situations in the broader political context.

Figure 2 was co-produced with the informant during the interview. In this diagram, the action situations (like the writing group, the consultation process with civil society, high-level cross-ministerial forum, and the public hearings in parliamentary committees) are positioned in a timeline. This map accompanied a discussion about the role of key Norwegian actors in those situations and how they changed over time and in relation to other processes in the Norwegian and international context.

Figure 3 is a diagram drawn by an informant from Switzerland. The map depicts a set of situations such as the interdepartmental conference on health foreign policy, two interdepartmental working groups (one on health and foreign policy and another on public health, innovation and intellectual property), and a quarterly executive group breakfast meeting. The map was used to support data collection on how key actors worked within these processes formally and informally.

The diagram in ***Figure 4*** was entirely drawn by an informant from Norway. The map shows the trajectory of a number of global health initiatives supported by the Norwegian government in the first decade of the millennium as part of a context for the construction of the Norwegian global health policy arena. The discussion of this map underscored the key experts and policy actors (including politicians) from the different policy sectors who strategically organised opportunities and used their networks to connect the disparate streams of the Government's global health work and investments.

Based on our use of a diagramming method in support for interviewing key informants about complex policy situations, we derived three main functions of the method that help researchers to focus, to engage, and to reflect.

First, the technique helps focus the discussion. Over the course of the interview, the sketch develops an externalised representation of the exchange between researcher and informant. The diagramming technique produced a visual trace of the study's units of observation (*action situations* usually taking the form of boxes). In this way the sketches become a materialisation of interview guide combined with data. This record supports other interview strategies (i.e. probing) because the image is used to elicit responses from informants when asked to expand, react, reflect, comment, compare, or contradict a representation. The diagram is used as tool for the researcher to bring back the conversation to a question of interest, to ask informants to talk in more specific detail about what they did, how, why and with whom in a complex environment composed of several action situations by pointing to the particular situations on the page (« here, in the (*name of situation*) »). A semi-structured interview is a plan, but the interview process can stray from that plan, and diagramming is one effective way to focus the conversation. It is a way to encourage the informant not only to tell the researcher about what happened, but also about their own personal action and responsibilities within each *action situation*.

This relates to the second function of engagement. The challenge for policy actors to talk about what they do in their work during research interviews is well documented in the literature. Pinson and Sala Pala (Pinson and Sala Pala 2007) emphasize that it is the role of the researcher to help actors "verbalize" their own practice. Diagramming as a graphic elicitation technique offers a different way to have a conversation with informants**.** It helped to elicit a detailed account about situations in the policy arena. But these tools for interaction with the informant also demand a different and deeper kind of engagement on the part of the researcher during the interview. The latter needs to achieve a balance in the management of note taking, diagramming, listening, and adapting accordingly. This means that the researcher must also pay special attention to the conversation to specify which situations or elements are

being referred to on the drawing especially when demonstrative pronouns are used in the discussion.

Finally, the method serves a reflexive purpose. The diagrams produced (however brief or elaborate) are useful to the researcher as materials for reflection while "in the field" collecting data. The sketches provide snapshots of previous interviews (in particularly how they related to the study's units of observation). Even when they are not analysed in detail, they provide visual sources/forms of data for reflection and prompts for field notes, which are beneficial to the researcher when considering issues related to saturation. It also prompts the researcher's thinking about where to adjust or refocus questions in subsequent interviews to complement gaps in the data or in the understanding of a situation from different informants' perspectives.

Informants' reactions

The tool also appeared to be useful from a participant's perspective. While carrying out the first few interviews for the study in both countries, we noted that informants' reactions were generally positive. Based on these initial reactions, we developed an interest what the informants thought about the method and added a question at the end of the interview guide about it as a sub-study: *What did you think about this tool for our discussion on the activities and processes for developing national policy on global health in your country?*

Study participants generally responded that they found the diagramming technique and use of the sketchpad to be a beneficial tool to aid the interview process. There was a sense that visualisation (e.g. drawing images, diagrams, maps) helps to bring different elements of the policy process together, and consider and discuss the linkages (or absence of) between them. A Swiss informant, health sector told us this was "very interesting, and I actually like to draw, and to work with papers like that, because it really helps you bring things together." Schemas produced served as entry points to discussing the importance of individuals and the dynamics within those processes. Among the participants who expressed their support or appreciation of the technique, a Norwegian informant from the foreign affairs sector highlighted that although it is very subjective as a technique, because "some people take up information that way, and others need to have it structured differently," its strength was the "interactive angle to try to

understand it" through discussion during the interview. However, its appeal was not uniform to all participants, as a Swiss informant from the foreign affairs sector noted: "Visual aids are useful, but I prefer talking things out."

In addition to reactions about the methodological approach, participants also commented about the visual data produced by the interview process, which is the content of the diagrams and form of the schemas. Trying to capture a complex process in a two-dimensional diagram on a sketchpad left many things invisible. For example, it is difficult for a drawing to capture the will and commitment of individuals working together in a process. "The graphic here, it's very good to visualize it, but then at the end, as I said, it's not so strict. It's always the exchange, and the people that work on it. For me that is essential," said one Swiss informant from the foreign affairs sector. Static schemas are not necessarily representative of the dynamic process that informants spoke about. In addition, the map's depiction of *action situations* struck one Norwegian informant from the development sector as de-contextualised from the political and administrative apparatus. *"*Regarding the map, this is useful, but might be a bit difficult to follow unless the general process is already known. You might think in terms of structuring more according to administrative and political set-up, as this may be more familiar to many. " One Swiss informant from the intellectual property/justice sector commented on the potential instrumental use of such an image as an overview visual summary of the process to share with others. "I never established this chart. If I had this chart, I could go to the Graduate Institute and say to the other developing country negotiators, 'Look, that's how we do it in Switzerland.'…This is great, yeah. Because such a thing can then be distributed to somebody else and say, "Here, inspire yourself. You don't need to do it the same way we do it. Do it differently, but here's an example."

Limitations

The technique was not useful for supporting conversations in all of the interviews. The method worked well with informants who were very knowledgeable about the policy process, either because they held a key position or were actively involved in situations. Interviews with actors who were excluded from key situations, but who were still knowledgeable about the

policy arena more broadly, sometimes, but not always, produced less visual material to use for elicitation.

The material and ideas from which we drew to discuss the usefulness of this method were collected through a process of reflection on the application of the technique in the field and a question to informants. The question about the method was added later to the interview guide and was not asked systematically to all participants, nor what is answered by all of them. Conducted with partial data, the analysis of the usefulness of the method is an exploratory effort that we undertook to capitalize on potential to developing understanding and preliminary knowledge about this technique for interviewing policy actors.

Conclusion

This paper presents the development of a diagramming technique and discusses its usefulness as a graphic elicitation tool *for* interviewing. The analysis of these diagrams as visual data collected using this method, as a product of the interview process, would require separate consideration and is out of the scope of this paper. It is nonetheless important to note that visual traces of data generated with graphic elicitation are a companion to the interview transcript, and verbal and visual records of an interview should not be separated for analysis.

Although key informant interviews are among the standard methods of data collection in qualitative research on health policy, the methodological musings above stem from our interest to encourage reflection by researchers on how they do interviews with policy actors, and think about techniques to support such conversations with actors about what they do in policy. The use of an artist's sketchpad for applying this diagramming technique is an example of a low-tech, low-cost tool to support semi-structured interviews with policy and decision-makers on policy processes that is also relevant for policy research in resource poor settings. We think there are opportunities to integrate such techniques more systematically as part of the formal health policy and systems research methods when conducting interviews with policy actors and elites, including in low and middle-income countries.

Figure 1. Sketch from interview with Norwegian informant, development sector

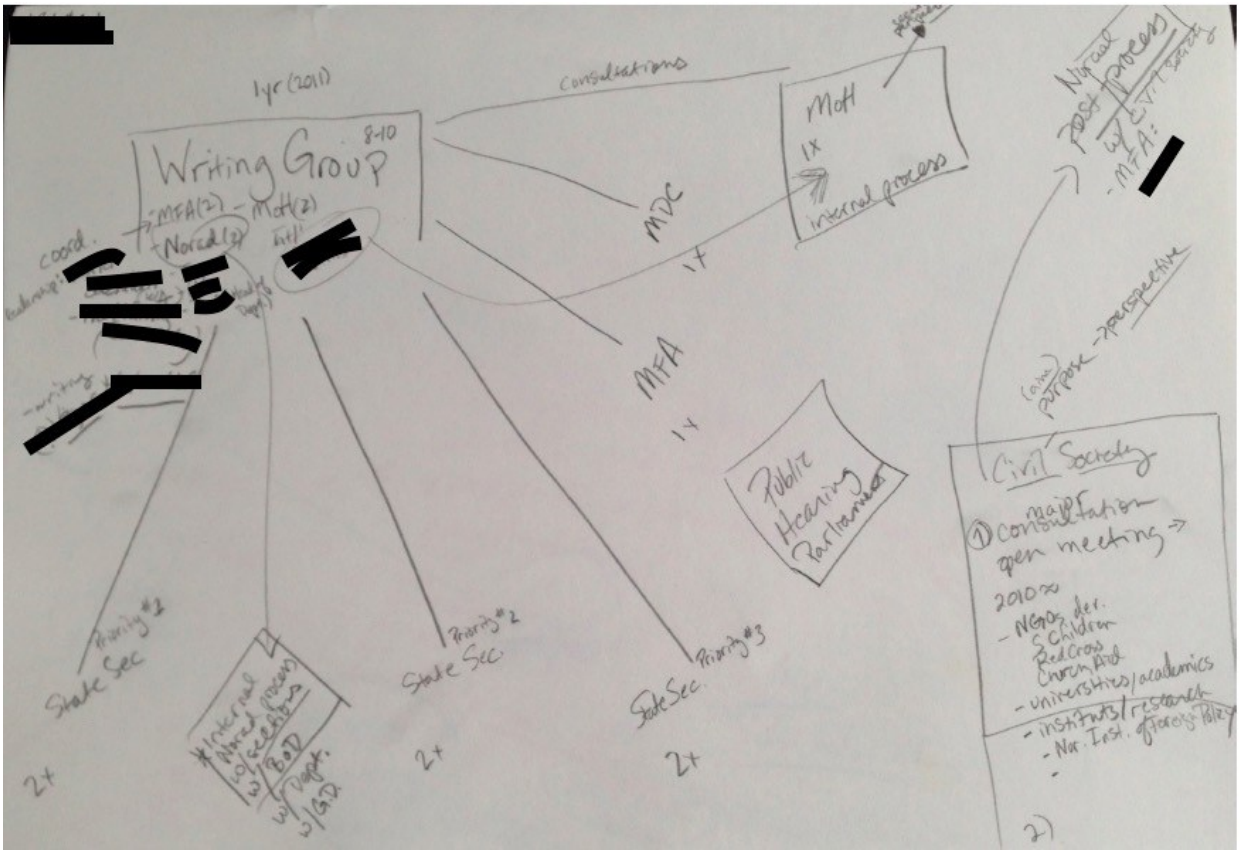


Figure 2. Sketch from interview with Norwegian informant, foreign affairs sector

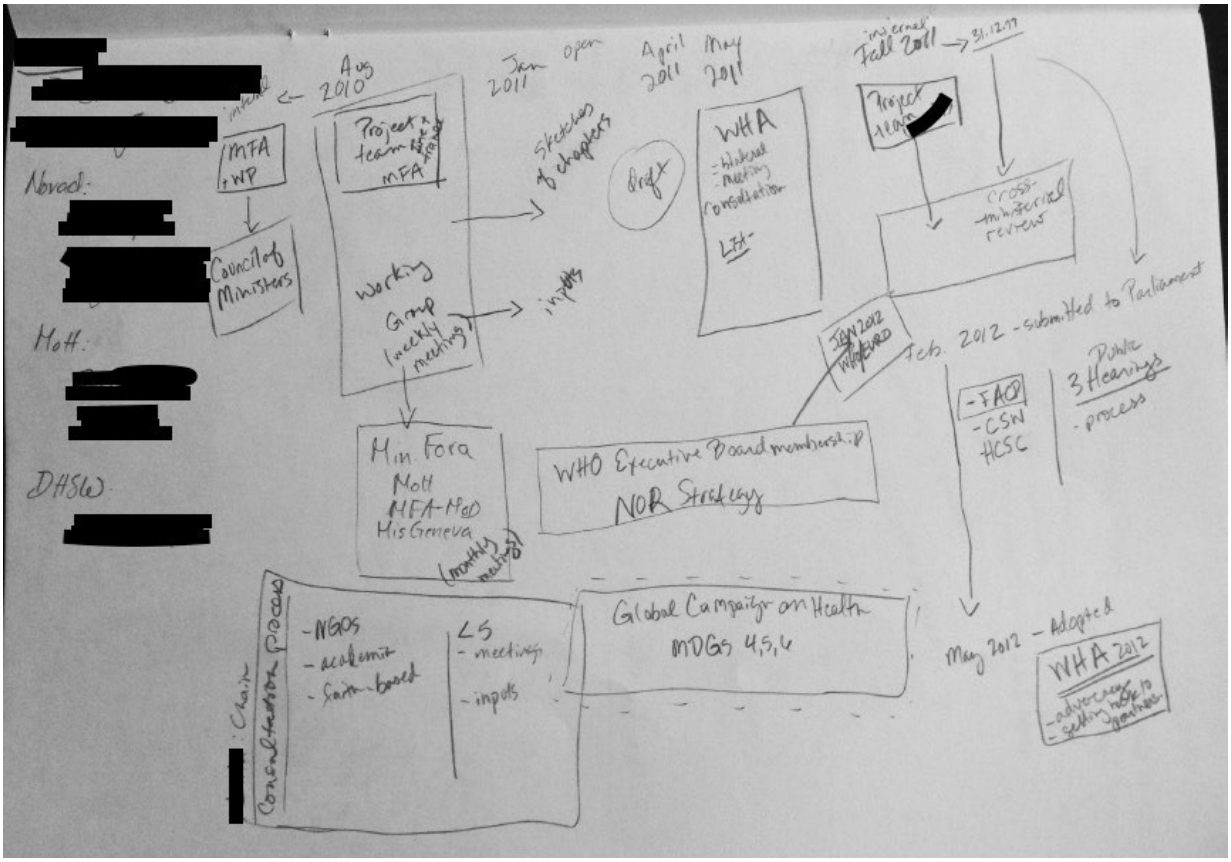


Figure 3. Sketch from interview with Swiss informant, intellectual property and justice sector

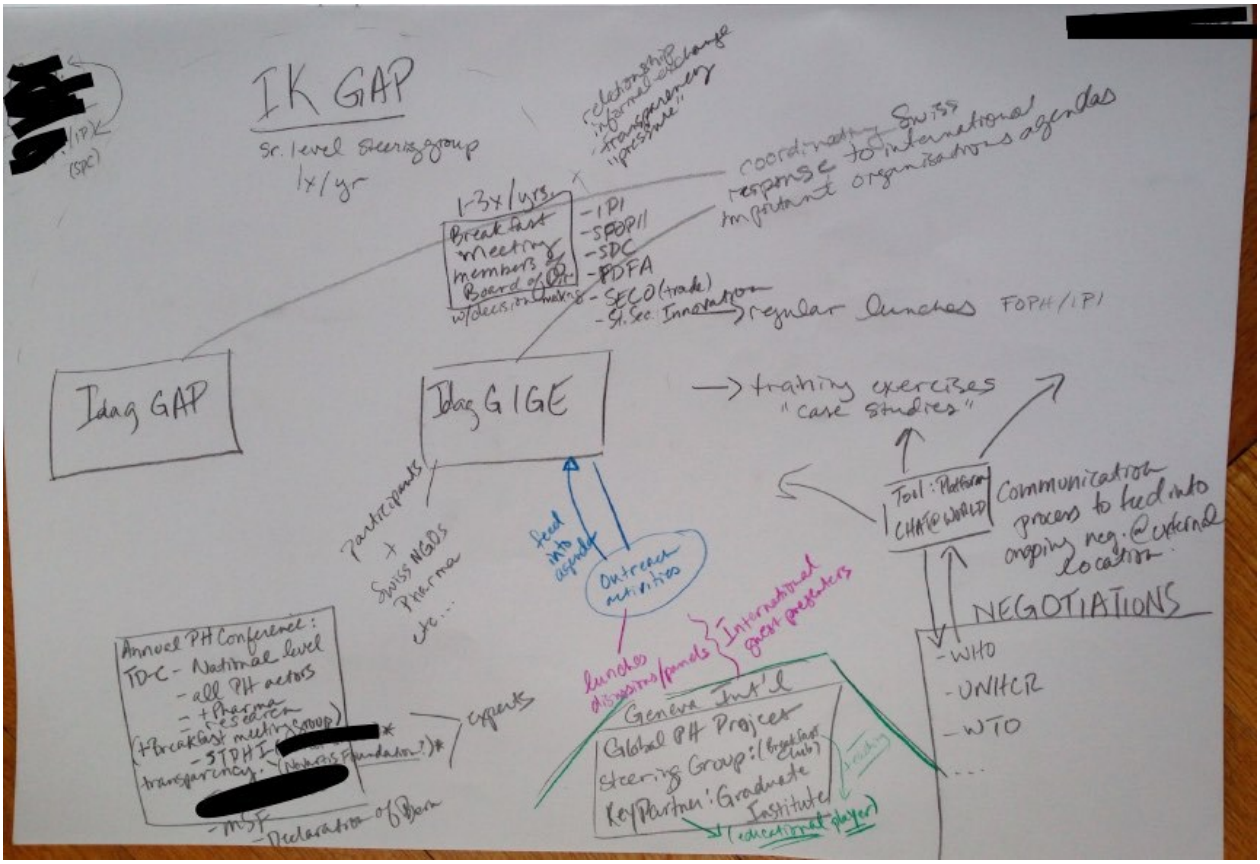
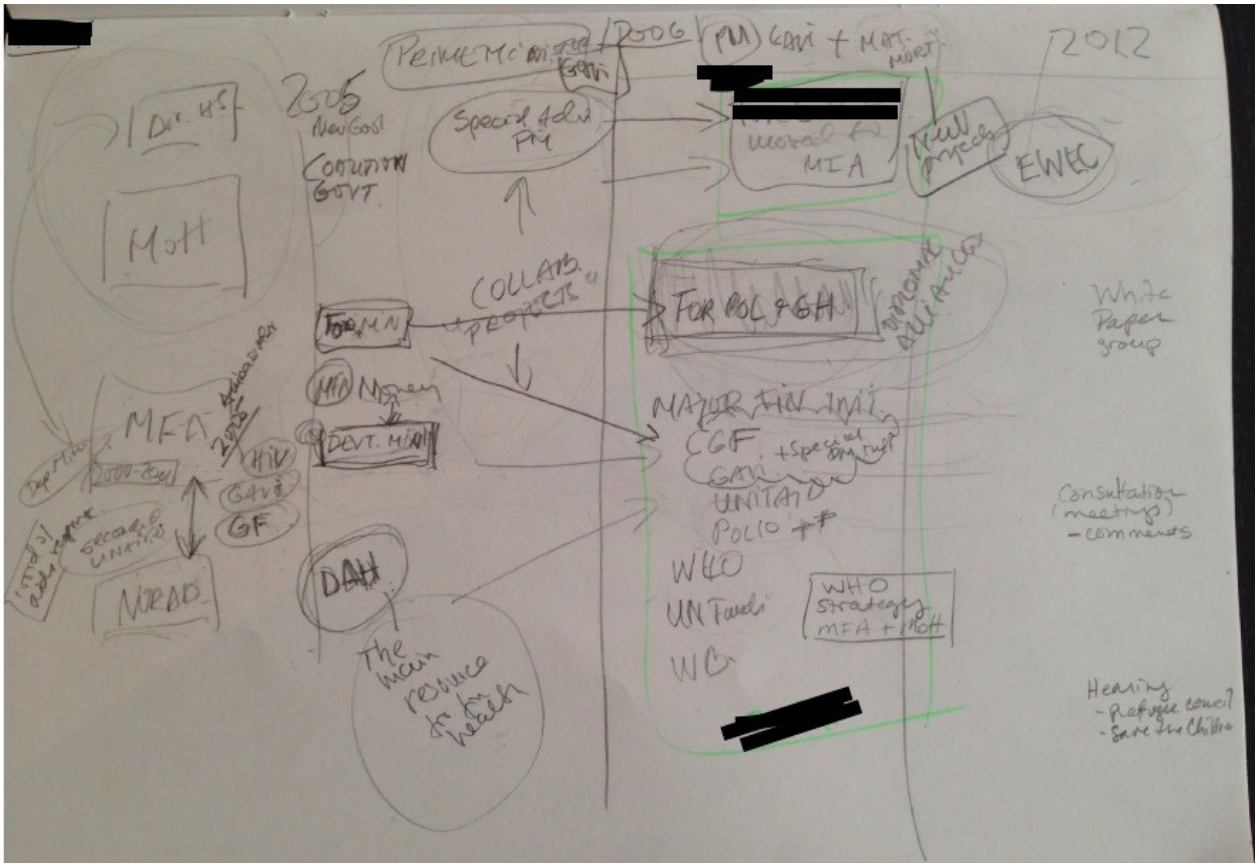


Figure 4. Sketch from interview with Norwegian informant, foreign affairs sector



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4.7 Data management and audit trail

A neutral code was assigned to each one of the thirty-three key informants, starting with NI (Norwegian informant) or SI (Swiss informant). This identifier was associated with all data generated from that key informant in the data management system. Face-to-face and telephone interviews with thirty-two key informants were recorded with a digital audio recording application with each participant's consent. All audio-recorded interviews were downloaded in .mp3 format and transcribed verbatim. The interview and field notes taken with a *SmartPen* (www.livescribe.com) were subsequently transferred via *My Script for Livescribe* (v1.3.0.977 liv) to electronic files for inclusion in my project database. I took a picture of the mapping exercise done with informants on the artist's sketch pad and catalogued it as an Adobe file with the informant's unique identifier. An overview of the data collected from each informant interview can be found in Appendix K. Every informant received an electronic copy of their verbatim transcript for participant checking, providing them with an opportunity to make corrections if they desired, and a picture of the map (in .pdf) drawn during the interview.

I inventoried the data collected from informants in the processes in an Excel sheet created for each case (Norwegian and Swiss fieldwork data inventory respectively) to record the following:

1. Field data: for each key informant I recorded the duration of the interview, the number of pages of the transcribed interview, the codes for picture of the map drawn during the interview, and the corresponding interview notes and field memos I took.
2. Materials collected from key informants: for each key informant, I recorded in two columns the policy documents and materials collected a) at the time of the interview, and b) in the follow-up after the interview.
3. Follow-up from field work: for each key informant, I recorded the follow-up questions for further information and materials we discussed and agreed on during the interview, informant's responses to follow-up questions, date of all follow-up correspondence and replies, transcript edits and approvals, archives of the policy process provided, responses to question about visual methods.
4. Archives of the policy process: the archives of the policy process collected during the

preparation for the field and interaction in the field were compiled in one place together, with an APP code, the phase collected and informant ID if relevant, the document attributes (name, date of publication, source, reference, language), the relationship to action situations in the model, and when it was inventoried.

5. Policy documents and other materials: a complete record of all materials (policy statements, commissioned reports, strategic plans, etc.) collected from the informants that during and post-interview that they thought would be useful as contextual background for the NPGH action arena, with informant(s) who provide it, the name and date of the document.

6. Table on informant's use of visual method: for each key informant, I recorded related notes from my field memos, my reflections on the visual images produced, notes made during the data inventory and cleaning procedures, and the informant's response to the visual method question (when available).

Separately, I created a data source tracking sheet to systematically record the data inventory, cleaning, modification and importation processes for data collected from interviews and my memos from both cases as part of the audit trail record. All of this data was uploaded and stored in the *MAXQDA12* (release 12.3.2) qualitative analysis programme (www.maxqda.com), which I used to code data for analysis.

In addition to interview notes, I also kept a journal in *Day One,* an online multi-device application (http://dayoneapp.com), where I recorded photos and memos from the field. Within 24-hours after an interview (with two exceptions), I wrote about each interview for at least one hour. This process developed over the course of the fieldwork for each case to include a variety of reflections about the interviewing process, my challenges and opportunities interacting in the field, about each case individually and about comparative aspects between them (similarities and differences that arose when debriefing with myself about a specific interview). The field notes usually contained my thoughts about the interview and the relationship of the data collected to the entire case and what I already collected from other informants, focusing on what was new from this informant, or what they said that challenged or supported what other informants told me. I noted new questions emerging from

the interview, and in particular I tried to highlight any of the tensions the informant raised about the action arena (regarding contextual elements, between policy sectors interacting, or between political and technical ideas). I used these opportunities to push myself to think about how what the informant said related to the overall objective for this thesis and to explore the relationship between the global arena the NPGH action arena. For face-to-face interviews, I included my reflections on the participant's interaction with the graphic elicitation.

4.8 Data analysis and interpretation

I used different methods of analysis for the studies conducted within this thesis to answer each of the three research questions announced at the beginning of this chapter. In relation to the first and third research questions, I report on those analysis methods in Chapter 5 and Chapter 8 respectively. The remainder of this methods section reports on the data analyses I carried out for each of the in-depth case studies to characterise action arenas of NPGH in Switzerland (Chapter 6) and in Norway (Chapter 7) in response to the second research question. To answer this question, the theoretical framework oriented my analytical strategies consistent with the two foci of modelling the action arenas and contextualising the action arenas.

I began analysing data as I began collecting it, with action situations. As the units of observation for the cases studies, action situations are the building blocks with which I constructed the action arena for each case. I adopted an iterative analysis process for data immersion (263, 294). Saldana's methods for first and second cycle coding informed this process (295). I constructed the action arenas for each case by assembling the action situations in multiple rounds of data analysis and interpretation using the definitions of variables and coding grids developed from our specification of Real-Dato's synthesis framework for this thesis (see sub-section *4.5 Constructing the cases* in this chapter). As the first step to delineating the empirical action situations, I defined them as formal or informal purposive activities (i.e. working groups, committees) in which three or more actors interact to collectively produce results or resources for the action arena (e.g. policy design, collaboration

arrangements). I elaborated a set of methodological rules to build models of the action situations from the data according to the criteria in ***Table 4.4***.

Table 4.4 Criteria for action situations

Characteristics	Criteria applied to each characteristic
Time	Each action situation must have taken place at least once between January 2005 and December 2013. Action situations may have been established prior to 2005 and/or continue after 2013.
Space	Each action situation must have taken place in an identifiable spatial setting (either formal or informal, physical or virtual, such as video or teleconferences).
Purpose	Each action situation has an identifiable and specific purpose established (i.e. mandates, goals, objectives). [It is noted that the understandings or interpretations of the purposes of situations by actors involved may differ from the communicated or documented established purpose].
Interactions of actors	Each action situation is composed of at least three actors. (Although two actors may interact, our model does not consider that two actors sufficient to constitute an action situation.) Actors are always embedded in action situations. Actors are individuals. Each actor may participate in more than one action situation.

I analysed the material in three stages of analysis: stage 1 to map the action situations in the action arena, stage 2 to understand the processes within each action situation, and stage three to produce a detailed descriptive report of each action situation focusing on rules and power.

4.8.a Analysis stage 1

I reviewed all the data collected from interviews with the objective to construct preliminary model of action situations and their key actors as the first step of our analysis. Before initiating the data coding process in detail, for each informant I listened to all the recorded interviews, reread the transcripts, reviewed the interview and field notes, and analysed the sketched maps produced. I cross-checked our initial inventory of possible action situations resulting from the documentary data collection which served for consultation with CAGs to validate the purposive samples with the action situations I recorded from the interview data. One of the benefits of the graphic elicitation technique was a visual trace of the action situations I observed. The sketch maps produced during the key informant interviews

were not coded like the data in transcripts because the images and text in the sketches were not stand-alone data. In our analyses, all sketches resulting from the graphic elicitation for face-to-face interviews were considered as a pair with the corresponding informant transcripts and notes, as recommended when using elicitation techniques (296-299). Iterative approaches to analysis between the images and interview text are necessary for validating findings identified across the visual productions (298). In stage 1, I analysed the maps produced during informant interviews in conjunction with the transcripts and our notes and memos as a summary of the interview to extract data on variables of action situations, actors, and contexts to start building a model of the main action situations (using the criteria in ***Table 4.4***) for each case in *MindNodePro* v1.11.5 (https://mindnode.com). I devised a colour code to map actors from different policy sectors in situations [**health = green**, **foreign affairs = purple**, **development = blue**, **civil society = red**]. Separately, I initiated a contextual map in *MindNodePro* to synthesize data collected from informant interviews related to the six contextual variables with the data collected from documents (see ***Figure 1*** in Chapters 6 and 7). I used this mind-mapping programme as a tool for data analysis to produce 1) visual representations of analyses for modelling the action arenas, 2) maps for contextualising the action arenas, 3) visual aids for coding data, and 4) to present results. The first stage of analysis resulted in a set of empirical action situations for each case that I used to organise the deductive exploration and coding of interview data from transcripts for modelling the action arenas.

4.8.b Analysis stage 2

I deductively coded all the verbatim transcripts for the main variables of action situations, policy design, and contexts. In this round, I especially focused on the micro-processes of the action situations, and I coded all the data for action situations under the parent codes for each of the empirically named action situations established in the first stage [10 Norwegian action situations (NAS) and 5 Swiss action actuation (SAS)] (see Appendix L for complete coding system). I created a generic category for other action situations to code any emerging action situations in the transcripts I had not identified in the maps. In addition to the coding tree architectures I developed within the *MAXQDA12* programme for this project, I used a coding map as a visual aid with a single page overview of all the key variables to help me ensure a comprehensive approach when coding the data on action situations.

After the detailed coding of action situations, policy design, and contexts for each case, I focused on coding the interview data for the relational variables for arenas that intersect with but are outside of the action situations such as power, influences on policy change (internal and external), and rules and institutional arrangements. In this process, I created some new codes for emergent themes such as policy coherence, WHO/WHA, and research-policy links (see Appendix L). After coding for all the variables in each transcript, I produced an analytic memo for each informant interview with analytical commentary on data for contextualising and modelling the action arenas.

The second stage of analysis resulted in the production of action situation analysis templates for modelling action arenas. I designed these method templates for two purposes: 1) to assess the materiality of action situations analysed for the cases, as defined by the criteria for the four characteristics of action situations in ***Table 4.4*** of this chapter, and 2) to provide an overview of the triangulation of data collected on the action situations for the cases (i.e. from both documentary and interview methods, and whether initially validated by the CAGs). The triangulation of data on action situations was important for modelling the action arenas, because I decided to exclude any action situations that were only identified by data from documentary methods or CAG expertise but not verified by data from interview methods. For those action situations on which I collected data from interview methods, it was important that I had informants who participated directly in them and not only informants who were aware of them but did not participate directly. A mix of these two kinds of actor positions in relation to action situations was useful to understand different perspectives for analysing rules for relationships between action situations in the arenas. I produced templates for 5 Swiss action situations and 7 Norwegian action situations because 3 of the formerly identified 10 situations in coding process were collapsed into another larger situation (see Appendix M). The complete lists of the archives of the policy process (APP) collected for each case that are identified in these templates and referenced in the results Chapters 6 and 7 can be found in Appendix K.

4.8.c Analysis stage 3

I generated reports on the coded segments of the data in *MAXQDA12* for each action situation. Based on the operationalization of the theoretical framework (see sub-section *4.5.b Development of instruments and definition of variables* in this chapter), I used a table of questions to guide my analysis of each action situation (see Appendix N). These questions included some of the probes developed for the interview guide (see Appendix J). I used this table to organise my analysis of how the main variables for action situations related to rules and power. After reorganising the data for each action situation from a coded segment report according to questions in this table, I produced detailed descriptive analyses reports for each action situation. This descriptive document for each of the action situations also contained an initial overview of the position, boundary and interaction rules identified from the processes. The resources of actors in action situations and the rules that structure the action situations were derived through the analysis of the processes of interactions of actors in situations, and the analysis of power (as another key relational variable within action arenas) was conducted by exploring the interplay between the two variables of rules and resources within and between action situations. I revised the models of action situations for each case in *MindNodePro* building on that done in the first stage of analysis to reflect the main action situations [**grey boxes**], their actors [different colours for each policy sector specified in analysis stage 1], rules [**dark blue**] and power [**orange**] relationships (see empirical models of action arenas in ***Figure 3*** at the end of Chapter 6 for Switzerland and ***Figure 2*** at the end of Chapter 7 for Norway, with breakdown figures of each model by action situation in ***Figures 3.1-3.5*** in Chapter 6 for Swiss case of NPGH and in ***Figures 2.1-2.6*** in Chapter 7 for Norwegian case of NPGH).

In this analysis of action situations, I worked between visual mapping and writing as a combined strategy for clarifying my analysis of the foundational units of my two cases. Throughout the first two stages of analysis, I wrote memos to record thoughts on my understanding of the action situations individually and as a group, and what these relationships meant in terms of the characteristics of the arena as a whole. I refined the analysis working

back and forth between the visualisation and the narration of the action situations' operations and connections for modelling the action arenas.

Using the detailed analyses of each action situation as a foundation, I constructed the action arenas around them. I reviewed the 30 pages of the analytic memos I produced after coding each transcript in the second stage of analysis to highlight analytical avenues to include and elaborate the drafts of the case monographs. From reports generated for the coded segments specifically related to power, context, policy design, influences, and the emergent themes (e.g. WHO, policy coherence), I used this data to complement and contrast the analytical avenues I developed from the previous iterations of data exploration, coding, and reflection. I focused on how rules shape power relations, what is used for policy development, and mechanisms for policy change such as policy learning.

I revised the contextual map for each action arena that I initiated in the first stage of analysis with fine-tuned scan of all contextual data gathered from interview methods (including archives of the policy process and other policy documents and materials), in particular that related to the political, state, international, and scientific/technical domains that informants underscored as important for contextualising the case. I completed the context maps with basic political, economic and socio-demographic context data from the documentary methods that was not covered by the data from interview methods (see ***Figure 1*** in Chapters 6 and 7).

The outline for the five sections of each case monograph on action arenas for NPGH in Norway and in Switzerland correspond to four main elements of the theoretical framework for action arenas (Sections 1-4 of case monographs) and a section on critical reflections (Section 5 of case monographs) about the arena (for the case monographs see Chapter 6 for Switzerland and Chapter 7 for Norway in results section of this thesis). Based on the analyses of the action situations for each case (Section 2.2 of the case monographs), I derived the position, boundary, and interaction rules for the action situations and the action arena (Section 2.3 of case monographs). The characteristics the action arena (Section 2.1 of case monographs) are a synthesis of the modelling of the arena from analysing action situations embedded in a

contextualisation of the action arena (Section 1 of case monographs) constructed from an analysis of the socio-political specificities of these cases, included their international dimensions. The outcomes of action situations (Section 3 of case monographs) were the results of action situations and products of interactions between actors from different sectors, including but not limited to the NPGH policy documents that were officially adopted. The mechanisms of policy change operating between the global health governance and the national action arena (Section 4 of case monographs) is the intra-case analysis of sources of influence from outside the country (see Grid 4) responding to the third research question for each case. The comparative analysis for responding to this question for the thesis, and not just for each case, is detailed in Chapter 8. The results of my analyses of the cases were collated according to the sections described above into separate case monographs for the Swiss (see Chapter 6) and Norwegian (see Chapter 7) action arenas.[7] In the third methodological milestone for the thesis, I consulted each of the CAGs about the results presented in draft monographs for the respective cases, as discussed previously in this chapter as part of the research design.

[7] A notable difference in the presentation of results between the two case monographs is that individual knowledge elites are named in the results from the Norwegian case study. The two individuals named as knowledge elites in the Norwegian case monograph served in roles as public servants and actors in government agencies. This characteristic distinguished them from the knowledge elite individual in the Swiss case monograph who was never part of the Swiss federal government administrative apparatus. Their involvement in the Norwegian action arena as actors and representatives of the Norwegian government in international forums and institutions, as well as the data from informants that conveyed their integral roles in the history of global health in Norway, made these two figures inseparable from the context and the fabric of the case itself. Their presence in the results of the case was critical to it being recognisable to Norwegian actors. Otherwise, the other individuals named in both case monographs are politicians and senior public figures. The results related to the knowledge elites were made anonymous in Chapter 8, since that article is being prepared for an international scientific journal and individual's names are not relevant for the research question of the second comparative study.

Chapter 5: RESULTS of comparative study 1

Article 3. Are national policies on global health in fact national policies on global health governance? A comparison of policy designs from Norway and Switzerland

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Are national policies on global health in fact national policies on global health governance? A comparison of policy designs from Norway and Switzerland

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Authors' contributions to the article:

Catherine M. Jones designed the study, conducted data collection and analysis, and wrote and revised the manuscript.

Carole Clavier and Louise Potvin contributed to refining the study methods and provided overall supervision for the project.

All authors critically reviewed and approved the manuscript.

What is already known about this topic?

- The adoption of global health strategies by some governments in European countries over the past decade represents a formalised approach to health and foreign policymaking at the national level.
- Case studies on the development of the UK's and Germany's global health strategies have contributed to understanding the motivations and interests for their production in those countries.
- Little is known about the content of these documents regarding what they propose to do from a public policy perspective.

What are the new findings?

Based on a comparative analysis of formally adopted national policy on global health (NPGH) documents in Norway and Switzerland:

- Actors at the international level that make policy are targets for countries to influence change related to global health;
- Health diplomacy is an instrument countries use either domestically or internationally for supporting the desired change related to global health; and
- The specification of rules for implementing NPGH varies between these policy documents.

Recommendations for policy

- Actors in the global health governance system are the target population intended to benefit from change as a result of implementing NPGH.
- When policy instruments are unfamiliar to or outside of the mandate of actors in the health sector, the implementation of NPGH may exclude structures from the health sector unless rules specifically include them.
- An empirically informed definition of NPGH is proposed for researchers and policymakers.

Abstract

Background: Since the signing of the Oslo Ministerial Declaration in 2007, the idea that foreign policy formulation should include health considerations has gained traction on the United Nations agenda as evidenced by annual General Assembly resolutions on global health and foreign policy. The adoption of national policies on global health (NPGH) is one way that some member states integrate health and foreign policymaking. This paper explores what these policies intend to do and how countries plan to do it.

Methods: Using a most-similar systems design, we carried out a comparative study of two policy documents formally adopted in 2012. We conducted a directed qualitative content analysis of the Norwegian *White Paper on Global health in foreign and development policy* and the *Swiss Health Foreign Policy* using Schneider and Ingram's policy design framework. After replicating analysis methods for each document, we analysed them side-by-side to explore the commonalities and differences across elements of NPGH design.

Results: Analyses indicate that NPGH expect to influence change outside their borders. Targeting the international level, they aim to affect policy venues, multilateral partnerships, and international institutions. Instruments for supporting desired changes are primarily those of health diplomacy, proposed as a tool for negotiating interests and objectives for global health between multiple sectors, used internally in Switzerland and externally in Norway.

Conclusion: Findings suggest that NPGH designs contribute to constructing the global health governance system by identifying it as a policy target, and policy instruments may elude the health sector actors unless implementation rules explicitly include them. Research should explore how future NPGH designs may construct different kinds of targets as politicised groups of actors on which national governments seek to exercise influence for global health decision-making.

Keywords: Norway, Switzerland, comparative policy analysis, policy design, national policy on global health

Introduction

The Oslo Ministerial Declaration[1] signed by seven ministers of foreign affairs encapsulated ideas about how expanding the scope of foreign policy to strategically include global health on the international agenda is an important step towards improving collective action and multilateral cooperation on transnational policy issues (eg, development, environment, security) related to health. Although foreign policy and health academics and practitioners continue to reflect on the relationship of these two policy sectors and the implications for practitioners engaged in global health diplomacy fields,[2-5] there is little in the literature to advance knowledge about what countries are doing to develop and manage policy at the interface of the fields of health and foreign affairs.[6-11] Appearing in some high-income and middle-income countries over the past decade,[10 12-15] national policies on global health (NPGH) are one way for countries to coordinate and integrate health and foreign policymaking. This paper explores the general question: what do NPGH propose to do and how do they plan to do it?

We define NPGH as policies that *aim to organise and coordinate a state's action on global health across more than one sector of public administration, as part of a coherent approach to policy development and implementation between relevant ministries involved in improving health on a global scale.*[16] Within a knowledge base about countries' motivations for integrative approaches at the national level of policymaking to develop their strategies on health and foreign policy,[10-13 15 17] it is unclear what such policies intend to do about global health. The transnational dimension of global health is important because the social, political, and economic causes, impacts, and consequences of a health problem or solution are not contained within countries' borders.[18-20] Some researchers suggest that the foreign policy sector plays a significant (even dominant) role in agenda-setting, establishing priority interests and funding of country's work at the interface of health and foreign policy.[21 22] But little is known about which sector's expertise and what kind of policy tools are used for NPGH which seem to develop at the junction of at least three policy sectors (health, development, and foreign policy) and two policy levels (domestic and international). For example, research in Canada shows that barriers to integrating health into foreign policy decision-making processes include health actors' lack of diplomatic expertise (eg, knowledge of international law,

negotiation skills) and diplomatic actors' lack of health expertise (eg, knowledge of health impacts of other policies, health systems).[23 24]

By questioning what NPGH intends to change and how it plans to accomplish this, we aim to better understand the multilevel and multisectoral empirical characteristics of such policies. First, NPGH requires domestic actors to collaborate to improve health globally, but it remains unspecified where change is expected (internally at the national level, or externally at the international level). Second, NPGH demands that the health sector collaborates with the foreign affairs and the development sectors, but we do not know whether the goals and methods of intervention will be those of the health sector or of another sector. To this end, we study NPGH with tools of health political science, a field of research that uses theories from political science in health policy research to generate knowledge about policy change in matters related to public health.[25]

In policy science, policy design is generally conceptualised either procedurally (design process, policy formulation/experimentation, crafting policy) or substantively (outcome of design process, policy content, instrumentation).[26 27] Schneider and Ingram conceptualise policy design as the elements comprising the content of public policy.[28 29] Content includes the plans, principles, and underlying discourses for a policy in their instrumental and symbolic forms, which reflects in part the politics and contexts that produced it. They propose six elements of policy design: goals, targets, instruments, implementation structures, implementation rules, and rationales and assumptions. Goals and targets are about what the policy wants to do. Goals are what will be achieved; they refer to the intentional, explicit change expected as a result of the policy. Targets are for whom the change will impact, they refer to the groups for whom the policy intends to stimulate change in capacity or behaviour. Instruments are about how it will be done. Policy instruments refer to the tools and methods to support the intended changes of the goals and targets. Implementation structures and rules are about who will do it. Structures refer to the agencies responsible for policy delivery and implementing action. Rules refer to the procedures and criteria for implementation structures to work with policy instruments. Rationales and assumptions refer to the reasons for the policy. Rationales legitimise the substance of the other elements of policy design, and assumptions support the linkages between them. Rationales and assumptions justify policy design as a whole: the course of action proposed, the tools for doing it and the relevancy of the

actors responsible for delivering it. This framework allows us to analyse the content of NPGH according to a set of attributes[30] rather than according to sector-affiliated labels, also known as adjectival policy[31] (ie, health policy, foreign policy, development policy) or policy titles (ie, health as foreign policy).[29] Specifically, we ask whether the texts of NPGH documents adopted in different jurisdictions present any similarities in core constitutive elements that may exemplify the logic of NPGH designs.

Methods

We conducted a comparative study of the content in cases of NPGH policy design from two countries. In this study, we define a case of NPGH policy design as a formally adopted policy document at the highest level of government.

Case selection and construction of comparability

Using three criteria (synchronicity of NPGH policy adoption, acknowledged contributions as a state actor in global health, and analogous engagement in multilateralism), we selected cases of NPGH policy design adopted in 2012 by Norway and Switzerland from a group of four countries in Europe who have adopted such policies.[32-35] We use a most-similar systems design because these criteria relate to a comparable macro-level context for global health policy at the country level.[36] The contemporaneous adoption of NPGH in Norway and Switzerland establishes a shared timeframe for comparison. Norway and Switzerland are also similar because they are recognised for capacity to influence global health matters given their histories of contributions to health through development cooperation.[37-40] Both countries are active member states of international normative institutions for health and development (i.e. WHO (Geneva and European Regional Office) and Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee. For example, in 2012, representatives from Norwegian and Swiss governments served on the WHO Executive Board. Neither country is part of the group of major economies in whose meetings global health issues are increasingly discussed (ie, G20, G7, G8)[41], nor of the European Union (EU), which has become an active global health actor since 2010.[42] However, both have a close relationship with the EU (Norway via the European Economic Area, Switzerland through bilateral arrangements), especially on public health issues (eg, European Centres for Disease Control

(ECDC), EU Health Programme). Although considered small developed states based on population criteria (ie, under 10 million), these two middle powers[43] have comparable ambitions for global health and its governance within a challenging climate for governments to find balance and create synergies between bilateral and multilateral development aid in their search to increase their international status and influence on global health.[44] Informed by Sartori's[45] questions, we compared the NPGH policy designs from these countries to examine what these adopted policy documents convey about the intentions of these two high-income countries to work intersectorally on global health, to explore similarities or differences in their design characteristics, and to improve understanding of NPGH components towards an empirical definition of this emergent policy object.

Materials

In line with other studies on health and foreign policies that identify a single policy document as a country's policy framework for its national global health strategy[10 15], in 2014 we downloaded publically available English language versions of adopted NPGH policy documents from government websites of Norway[33] and Switzerland[34]. Noting the characteristics of NPGH documents as policies that discuss global health, are developed nationally across more than one policy sector, and adopted at the highest levels of government, we excluded intersectoral policy documents discussing global health that are not formally adopted at the highest levels, government policy documents addressing specific disease issues (eg, HIV/AIDS), and global health policy documents produced by a single policy sector (eg, global health policy of national development agency). We excluded images and illustrations from our analysis.

Data analysis

We manually coded text of the two policy documents using Schneider and Ingram's six elements of policy design[28] to conduct a directed qualitative content analysis.[46] We analysed each NPGH document's design architecture individually, replicating the framework's application to each text to interpret the empirical expressions of the theoretical design elements. We submitted each case's analysis for discussion with experts in two independent Context Advisory Groups established respectively for each case in 2014 as a strategy to reduce

bias. Each group included CMJ, and CC and one experienced global health policy/governance researcher knowledgeable about their country's NPGH context. These consultations aimed to identify significant omissions from our understanding of their country's policy design, and they were independent from the comparative analysis conducted for this paper. Taking the separate analysis of each individual document, we subsequently analysed them side-by-side to explore the commonalities and differences across elements of NPGH design.

Results

Norway's *White Paper on Global health in foreign and development policy*[33] (approved by the Norwegian Parliament on 29 May 2012) is a 47-page document organised around three priority areas until 2020: mobilising for women's and children's rights and health, reducing the burden of disease with emphasis on prevention, and promoting human security through health. Each area is divided into sub-priorities, listing a total of 70 commitments of the Norwegian government. The *Swiss Health Foreign Policy*[34] (approved by the Swiss Confederation's Federal Council on 19 March 2012) is a 42-page document that presents 20 objectives for a 6-year period under three areas of interest: governance, interactions with other policy areas, and health issues. Both documents convey the intention to strengthen connections between different policy sectors in their country for improving consistency in the government's global health work, but the designs differ in the problematisation – which is political in the Norwegian design and administrative in the Swiss design. An overview of the comparison shows that their contents contain common types of targets, but there is variation across the other five elements of design (see ***Table 1***).

Table 1 Comparing policy design elements in Norwegian and Swiss NPGH documents (Source: Authors)

	Norway[33]	Switzerland[34]
Targets	Global health governance system: policy venues, institutions, networks and partnerships for collective action on global health	
Goals	Integrate policy levels: incorporate international and Norwegian domestic objectives related to global health	Orchestrate policy sectors: institutionalise collaborative working processes for global health between multiple sectors in Switzerland
Rationales and assumptions	Norway can impact global health governance building on history of political leadership contributing to global health improvement	Administrative innovation can strengthen Swiss interactions in the global health governance system
Instruments	(*External*) Global health diplomacy—international co-operation/relations	(*Internal*) Global health diplomacy—interministerial co-ordination/dialogue
Implementation structures	Ministry of Foreign Affairs, Norwegian Agency for Development Cooperation	Federal Department of Foreign Affairs, Federal Office of Public Health, Swiss Agency for Development and Cooperation
Implementation rules	Political	Administrative

Targets

The Norwegian and Swiss policies aim to act on the global health governance system by influencing change in policy venues, international institutions, networks, and partnership structures where decisions about global health policy and programmes are made. The main targets for the Norwegian policy are international policymaking arenas where political and economic support are mobilised for global health such as United Nations agencies (e.g. WHO, UNICEF, United Nations Population Fund (UNFPA)), the World Bank, Global Health Initiatives (GHI) (eg, Global Alliance for Vaccines and Immunizations (GAVI Alliance), the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM)), financing mechanisms (eg, Unitaid, Health Results Innovations Trust Fund (HRITF), Global Environment Facility (GEF)), and multilateral partnerships (eg, Every Woman Every Child, Global Campaign for Health Millennium Development Goals (MDGs)) [see ref. [33] sections 3.2, 5.2 and pp. 18, 20-23, 25-29, 31-37, 44]. The principle targets for the Swiss policy are international institutions and governance bodies such as the OECD, the Council of Europe, WHO, and EU agencies [see ref. [34] pp. 18, 19, 21, 22, 24, 27, 29]. These targets are systemic and international. Both NPGH aim to impact institutions and groups of actors who make decisions about collective action on global health in which their governments have vested interests and participation.

Goals

The foremost policy goal in the Norwegian policy is to improve the continuity of domestic and international policy objectives on global health, including a synthesis of health objectives into foreign and development policy [see ref. [33] pp. 5, 7, 15, 16, 36-38]. The document's account of a composite history of Norwegian leadership and political, technical, and financial contributions to global health is presented to solidify global health policy as an important domestic issue [see [33] pp. 7-9 and section 3]. One of the intended results is to integrate Norway's commitments to the health-related MDGs (MDGs 4, 5, and 6) into their foreign policy and technical health framework [see ref. [33] pp. 9, 10, 15-23]. The goal is to integrate the political and technical aspects for understanding and developing Norway's global health work at the national level among actors involved from different policy sectors and parliament, and with its partners at the global level [see ref. [33] pp. 8, 37, 46, 47].

The principle goal of the Swiss policy is to systematise an intersectoral approach to global health work across sectors within the Swiss Federal Administration. The intended result is the normalisation of interdepartmental collaboration across agencies responsible for public health, foreign affairs, development and intellectual property to make decisions about Swiss positions on matters of global health, propose instruments for institutionalised dialogue about global health across government ministries, and to standardise the procedures for intersectoral collaboration and joint decision-making on global health issues, positions and policies [see [34] pp. 7, 14 , 15, 33-35].

Rationales and assumptions

Norway's history of leadership and contributions to global health as an important state actor are the cornerstone of the rationale for its policy [see ref. [33] section 2]. Examples of Norway's development aid, its global health projects, and its role in initiatives like GAVI and the GFATM [see ref. [33] pp. 7, 12, 20- 23, 34, 44] or the Foreign Policy and Global Health Initiative [see ref. [33] pp. 11, 36, 38, 43] serve to justify the logic for continuity of Norway's political leadership in global health and the path dependence of its programmes in this domain. The Norwegian policy is premised on the assumption that there is a need to combine national responsibility with global collective action for improving health on a global scale [see ref. [33] pp. 5-7, 13, 24, 25, 43]. An individual's right to health is a responsibility of national

governments and health systems to ensure, but collective action at the international level is needed to support countries with limited capacity.

The underlying assumption of the Swiss policy is that working responsibly with governance of the evolving global health architecture necessitates administrative devices for structured intersectoral collaboration at the federal level [see ref. [47] p. 18, 19]. The Swiss rationale is that the institutionalisation of dialogue to improve opportunities for coherence across policy sectors in the Swiss context will increase the credibility of Swiss negotiations on global health policy positions in international settings [see ref. [47] p. 9, 10, 13-15]. The arguments rely on the experience of a previous agreement between the Federal Department of Foreign Affairs and the Federal Department of Home Affairs on Swiss health foreign policy objectives [see ref. [47] p. 7, 3-35] to demonstrate the success of tools for interdepartmental cooperation on matters of health and foreign policy.

Instruments

The Norwegian policy proposes instruments of international cooperation like official development assistance, multilateral arrangements, partnerships, political networks, and global health diplomacy to achieve desired changes [see ref. [33] sections 2, 5.2]. Norway strategically uses diplomatic techniques to stimulate and support change in international policy settings and to demonstrate leadership and capacity for global health stewardship at the highest levels. Examples include the Oslo Declaration of Foreign Ministers in 2007, the Prime Minister's establishment of the Global Campaign for the Health MDGs and the Network of Global Leaders in 2007, negotiation process for the Pandemic Influenza Framework, health diplomacy for ratification and implementation of the Framework Convention on Tobacco Control, promoting norms of rights-based approaches to health (gender equality, sexual and reproductive rights), supporting capacity-building internationally for implementation of WHO global strategies, frameworks and codes of practice, or via membership on Boards of UNAIDS or Unitaid [see ref. [33] pp. 5, 7, 9, 11, 21-22, 28, 29, 32, 36, 41].

The Swiss instruments for achieving desired changes are coordination tools for improving interdepartmental cooperation to strengthen coherence. Communication-based instruments (ie, e-platform CH@WORLD) support information sharing across the entire Swiss public administration and the co-production of policy guidance [see ref. [34] pp. 33, 34]. These

processes are carried out in bodies such as the high-level Interdepartmental Conference on Health Foreign Policy (for oversight), an executive support group (for strategic decisions), and two interdepartmental working groups on health foreign policy and on public health, innovation and intellectual property (for operational issues) [see ref. [34] pp. 34-35]. A coordination office, staff secondments from Federal Department of Foreign Affairs to the Office of Public Health, and global health policy training for diplomatic service personnel are examples of instruments to institutionalise practices that strengthen links between health and foreign policy sectors and build capacity for fostering a deeper understanding between these sectors on the ground [see ref. [34] pp. 33, 35].

Implementation structures

The foreign affairs ministry and development agency in each country have responsibilities for implementation; however, clarity about the role of health sector agencies in implementation differs. In the Norwegian policy, the Ministry of Foreign Affairs is the main implementation structure [see ref. [33] pp. 8, 25, 43, 46, 47]. Although the Ministry of Foreign Affairs and the Ministry of Health and Care Services are joint signatories of the document, the implementation roles within and between those ministries are indeterminate, and the relationships of departments, sections, and subordinate agencies in those ministries and between them regarding implementation duties for Norway's NPGH are unclear [see ref. [33] pp. 8, 46].

The main implementation structures for the Swiss policy include the Sectoral Foreign Policies Division of the Federal Department of Foreign Affairs, the Federal Office of Public Health from the Federal Department of Home Affairs, as well as the Swiss Agency for Development and Cooperation [see ref. [34] pp. 7, 34, 37]. The Sectoral Foreign Policies Division (Transport, Energy and Health Section) is the primary coordination office for the Swiss NPGH, working closely with the Federal Office of Public Health and the Swiss Development Agency [see ref. [34] p. 33].

Implementation rules

Both documents state that no additional resources are specifically allocated for implementation; the policy is carried out with the currently budgeted resources available. The

Norwegian policy's rules are unspecific. They authorise foreign policy and development actors in the Ministry of Foreign Affairs to implement existing international commitments for global health based on an approved vision up to 2020. In that time frame (extending five years into Sustainable Development Goals agenda), the document's section 6 "Perspectives on the future" explores the challenge of further developing "a coherent Norwegian global health policy" [see ref. [33] p. 46] that encompasses use of policy instruments, including those from other sectors, for a range of problems with health consequences (eg, urbanisation, climate change). Ambiguous rules for implementation in the Norwegian design render decisions about implementation procedures for using selected instruments for specific targets to the discretion of senior government officials and politicians.

The rules for implementation in the Swiss policy are administrative because they provide the procedures for working across federal departments (ie, ministries). The rules define how the coordination of the interdepartmental structures is part of a collaborative process for overseeing implementation of policy-related activities (e.g. rules for good governance, see ref. [34] p. 13). Two interdepartmental working groups submit an annual implementation report to the Interdepartmental Conference on Health Foreign Policy, the highest decision-making body for Swiss NPGH (under the Federal Council) [see ref. [34] p. 34]. While the implementation of specific initiatives under the policy may be the responsibility of individual agencies, the implementation rules require that information and progress are shared regularly with the other federal agencies and relevant stakeholders. Administrative rules for extensive consultation and large-majority consensus are also deeply engrained in the overall Swiss policymaking context.

Discussion

Exploring the multilevel and multisectoral characteristics of NPGH, we used a policy design framework to assess whether NPGH documents adopted by Norway and Switzerland shared similar design elements. The results of this comparative analysis indicate that NPGH expect to influence and affect change outside of their borders, by targeting the international level. Methods and instruments to support desired change are primarily those of health diplomacy, as tools for negotiating interests and objectives of multiple sectors on global

health, for use and adaptation internally in the case of Switzerland and externally in the case of Norway.

These results have two implications for public health. First, the global health governance system encompasses the population of actors intended to benefit from changes as a result of NPGH because the Norwegian and Swiss governments aim to influence the capacity and behaviour of this system with NPGH. These are not target populations or beneficiaries of health and social policy as generally understood by people working in public health. Policy targets in both designs include groups of actors who comprise the system of global health governance, ranging from the traditional normative institution of WHO to contemporary actors like the multi-partner GHI evolving since 2000 (eg, GAVI, GFATM). A plurality of actors representing competing normative frameworks vie for policy attention and resources to support respective agendas for global health action in the global health governance system.[48] The proliferation of actors who operate in the system leads to overlapping roles and functions that create accountability issues.[49] Leadership and authority for health at the global scale that were conventionally a responsibility of international organisations specialising in health (ie, WHO) have been challenged by the ascent of non-state actors and GHI in the global health governance system.[50 51] Although private philanthropy has historically played a role in international health agenda-setting, scholars have expressed concerns about the influence of foundations and private industry actors in the global health governance system in the 21st century, including their relationships with governments, public-private partnerships and international organisations.[52-54]

Both NPGH designs portray WHO, UN agencies, the World Bank, health-related multilateral organisations, and GHI and public-private partnerships (eg, organisations in the Health 8) as key institutions for health and arenas for political mobilisation to support technical advancements in global health. Schneider and Ingram propose that groups targeted by public policy are depicted in normative terms because policy design contributes to the social construction of policy targets.[55] The social construction of a policy target refers to whether a group is depicted as deserving or undeserving, and policy design links the behaviour or capacity of targets to the achievement of the policy's goals.[56] The NPGH policy designs we analysed reinforce the normative underpinnings of global health governance as a system of indispensable actors operating at the international scale, and endorse the system of global

health governance as a group of actors meriting state's attention. The NPGH designs construct targets that governments cannot neglect in international negotiations for health, which supports the theoretical proposition that policy designs convey messages to "target groups about how government behaves and how they are likely to be treated by government."[57] By establishing this systemic target for NPGH in their designs, countries participate in the construction of a transnational population of legitimate and powerful global health actors as the beneficiaries of NPGH, potentially also contributing to constructing other states or international civil society organisations as contenders or dependents with less political power to act in that system. Furthermore, these countries are also insiders in the institutions of that system, and the designs confer advantage to those decision-making bodies where the country is a member and intends to influence decisions on global health.

Second, the implementation of NPGH may be elusive to health sector actors. Although both NPGH designs construct similar target populations, different instruments to reach them relate to who is responsible for implementation and according to what rules. Policy instruments are technical and social devices representing knowledge about how to coerce or enable a change in the target population.[58] They have symbolic importance for communicating the nature of the relationship between the targets and the implementers. In Norway's design, the Ministry of Foreign Affairs is the main implementation structure with authority, legitimacy and expertise to use political mobilisation and health diplomacy as instruments to affect desired change in the international system. In Switzerland's design, the instruments are structures for interministerial collaboration, with multiple implementation agencies cutting across sectoral divides because the rules about consultation and collaborative approaches impose shared responsibility at the federal level for NPGH. In neither case are the instruments specific to the health sector or to public health. Global health diplomacy is an instrument used at international and national levels.[59] This means that health sector actors may be challenged to work with unfamiliar policy instruments unrelated to their area of expertise (eg, global health diplomacy) or be excluded from the implementation structures even if they were involved in developing NPGH with other sectors. Public health actors seeking to influence health and foreign policy are encouraged to discern ways health is framed in global health policy.[60] A combination of a lack of familiarity, understanding or experience with diverse

policy frames and instruments may limit public health actors' participation in implementation unless implementation rules in designs support a clearly defined role for them.

Limitations

These results and their implications for public health must be considered within the methodological and theoretical limitations of our analysis. The narrow concept of policy design we used confines the scope of policy content to texts of adopted NPGH strategy documents. This is an incomplete picture of content as theorised by Schneider and Ingram. Symbolic forms of content could be collected through interviews and other materials, but our analysis focused on single policy documents from two countries. Our deductive approach to using Schneider and Ingram's policy design elements also imposed limits. By applying generic categories of design elements to explore the content of NPGH documents, we might have omitted issues of focus in global health policy. For example, our analysis excludes discussion pertaining to the meaning of global health in NPGH and global health priority topics promoted by states for attention in the system of global health governance (eg, health systems, vaccination, universal health coverage, access to medicines, maternal and child health, global health security). Research has explained why certain policy issues receive political attention over others in the global health agenda[61 62], but such questions were not part of the framework we adopted to explore the architecture of these NPGH documents. Finally, the framework did not equip us to acknowledge the composition of policy sectors. For example, *health* and *foreign affairs* sectors are not homogenous groups of actors or expertise; diverse sub-groups compose each sector (eg, foreign policy sector includes humanitarian affairs, economic development, human security, and health policy sector includes hospitals and healthcare, insurance, drugs, public health). One caveat of conducting directed qualitative content analysis of policy documents is limitation for understanding the policy processes, negotiations between sectors and sub-sectors, and trade-offs in the content's production.[63] Further research on development and implementation of NPGH is needed to contextualise their elaboration and use. Aware of these limitations, we suggest this policy design framework is a theoretical tool for public health researchers to do comparative analyses of content in policy documents across jurisdictions at any level.

Conclusion

Global health policy and governance research generally focuses on how different frames of global health construct policy problems and legitimise the knowledge, actors, and resources associated with their solutions.[64-66] Our comparative analysis of Norwegian and Swiss policy documents to better understand what NPGH propose to do suggests that these policies contribute to the construction of global health governance through its constitution as a system of policy targets. Formally adopted NPGH in Norway and Switzerland designate the actors in this system that the country considers as legitimate and authoritative groups for making decisions that impact health on a global scale and with which state actors must interact to influence these decisions. Based on these findings, we modify our definition of NPGH to: *a policy that connects a country's work on global health across more than one government policy sector, in which the health sector may not have a leading implementation role, with the aim to act in and on the global health governance system.*

While there is no consensus on the understanding and use of the term global health governance in scholarship or practice,[67-69] our findings support a conceptualisation of global health governance that is multisectoral, taking place in multiple sites and on multiple levels.[66 70] This leads us to question the empirical salience of conceptual distinctions between global health governance and global governance for health[69] as systems targeted by NPGH because the two designs target alike actors for whom health is the main objective and actors for whom it is not. NPGH targets actors making decisions related to global health, whether they are specialised in health or not, (eg, intergovernmental, private/public, state/non-state, and hybrid: see ref. [71,72] for thorough presentation). For example, the amalgamation of public and private actors in the global health governance system may be of concern for NPGH designs when policy targets that include financing mechanisms (ie, GAVI, GFATM) are combined with those that do not, or when governments target transnational public institutions similarly to private or hybrid actors. In this study, we found that NPGH designs designated different actors in the global heath governance system as targets for government attention without transparent analysis of institutional arrangements or explicit questioning of normative or evaluative bases for targeting them. Noting pressing questions regarding legitimacy and accountability of philanthropic and hybrid actors operating in the global health governance system,[73-76] we think

future research needs to explore how NPGH designs may construct different kinds of targets as politicised groups of actors on which national governments seek to exercise influence.

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Chapter 6: RESULTS of the Swiss case study

Case monograph of the Swiss national policy on global health action arena

Case monograph of the Swiss NPGH action arena

Table of Contents

List of tables and figures in the Swiss case monograph

Table 1 and ***Figures 1-4*** in the Swiss case monograph are located at the end of Chapter 6 in this order.

* ***Figures 3-4*** use the following colour code for actors from different policy sectors in the five main Swiss action situations [**in dark grey boxes**: **civil society sector = red**, **development sector = blue**, **foreign affairs sector = purple**, **health sector = green**, **intellectual property sector = brown**] with rules [**in dark blue**] and power relationships [**in orange**].

→ Please note that all highlighted text cross-references material in this chapter.

List of acronyms and abbreviations for the Swiss case monograph

APP – Archives of the policy process

BMGF – Bill and Melinda Gates Foundation

EU – European Union

FDFA – Federal Department of Foreign Affairs

FDHA – Federal Department of Home Affairs

FOPH – Federal Office of Public Health

FPGH – Foreign Policy and Global Health Initiative

GFATM – Global Fund to fight Aids, Tuberculosis and Malaria

GHG – global health governance

GHI – global health initiatives

IAD – International Affairs Division

Idag GAP – Interdepartmental Working Group on Health and Foreign Policy

Idag GIGE – Interdepartmental Working Group on Intellectual Property, Innovation, and Public Health

IHR – International Health Regulations

IK GAP – Interdepartmental Conference on Health and Foreign Policy

IPI – Swiss Federal Institute of Intellectual Property

MDG – Millennium Development Goals

NCD – non-communicable diseases

NGO – non-governmental organisation

NPGH – national policy on global health

OECD – Organisation for Economic Cooperation and Development

PEPFAR – US President's Emergency Plan for AIDS Relief

SDC – Swiss Agency for Development and Cooperation

SDG – Sustainable Development Goals

SECO – State Secretariat for Economic Affairs

SHFP – Swiss Health Foreign Policy

SNSF – Swiss National Science Foundation

UN – United Nations

WHA – World Health Assembly

WHO – World Health Organisation

WHO EB – World Health Organisation Executive Board

WHO/EURO – WHO Regional Office for Europe

WIPO – World Intellectual Property Organisation

WTO – World Trade Organisation

Abbreviations for citations from data:

Letters in parentheses designate the sectoral classification of informant next to citations from the data collected in interviews included in this chapter:

Civil society sector (CS)

Development sector (D)

Foreign affairs sector (FA)

Health sector (H)

Intellectual property sector (IP)

Research sector (R)

Executive summary

In 2005, actors from the health and foreign policy sectors in Switzerland began innovating and experimenting with instruments for interdepartmental cooperation on matters of foreign policy concerning global health and its governance. The Federal Office of Public Health of the Federal Department of Home Affairs and the Political Directorate V of the Federal Department of Foreign Affairs Health worked together to develop the first interdepartmental agreement on health foreign policy in Switzerland in 2006. In 2012, the formal adoption of the *Swiss Health Foreign Policy* (SHFP) by the Federal Council represented a government level institutionalisation of Swiss national policy on global health (NPGH) arena that had been constructed between the health, development, intellectual property, and foreign policy sectors.

The Swiss arena for NPGH was established to make Switzerland more credible, and therefore more powerful, in the global health governance (GHG) system. It was founded on a core belief that interdepartmental collaboration would improve processes and produce more credible outputs and coherent positions for the international arena, and that this coherence would improve the influence and perception of Switzerland as a state actor in GHG. The Swiss government aimed to improve their credibility in the GHG system by reducing the contradictory positions or statements between actors from different policy sectors representing Switzerland in various global health policy venues and institutions. The Swiss arena resulted from the 'bottom-up' arrangements developed by senior civil servants, with strong leadership and vision from individual actors in the health sector, to share power across several relevant sectors having joint responsibilities for cooperating to make decisions on Switzerland's action regarding GHG. Although the Swiss arena for NPGH excludes civil society actors from the decision-making processes, it includes an annual information exchange process for sharing news and networking between government actors involved with the *Swiss Health Foreign Policy* and global health practitioners, researchers, educators, professionals, and industry representatives.

Between 2005 and 2013, I observed five main action situations comprising the Swiss NPGH arena, stratified in a hierarchy of authority. The NPGH boundary and interaction rules organise actors at similar levels of seniority in the federal administration into intersectoral action

situations. The political action situation (situation 1) is responsible for setting the political vision and arrangements for monitoring at the agency director and State Secretary level. The administrative-technical action situations at the bottom (situations 2-3) develop the operational elements and manage the decision-making and coordination processes for the arena, including a mix of executive, advisory, and technical officer levels. A strategic action situation (situation 4) at the senior executive level between the two levels manages the strategic directions and governance of the administrative-technical situations. Two administrative-technical situations (situations 2-3) have been the mainstays of the Swiss NPGH action arena, because the work of the middle-senior level civil servants serves as the cornerstone of the policy process where the exchange of information, planning, policy advice, and negotiations are most concentrated. A core group for each administrative-technical situation is responsible for leading, managing and coordinating interdepartmental action. Theses groups are composed of four policy sectors: public health, foreign affairs, development, and intellectual property. Health is an important boundary sector connecting all of the action situations of the Swiss NPGH action arena. A practice-technical action situation (situation 5) lies outside the purview of the public administration hierarchy and operates as a platform for information-sharing in the arena between global health practitioners, researchers, policy-makers and administrators; the stakeholder platform (situation 5) does not have any direct influence on decisions made within the other state-actor-centric situations of authority (situations 1-4).

The position and boundary rules in the Swiss arena configured the dispositional power of the core groups for the two administrative-technical situations. The boundary and interaction rules regulate the exchange of resources and the relational power between actors in the two administrative-technical situations. Position rules for rotating co-chairs in the formal meetings (situations 2-3) reinforced power sharing between actors in the core group. The interaction rules required structured discussion about agenda items based on the detailed preparation of the materials by the core group, and the rule of large majority governed the relational power of actors in decision-making. Micro-level instruments in institutional arrangements, such as secondments and other resource exchange tools, were also used for relational power adjustments, especially between the health and foreign affairs sectors.

In addition to the content of the policy design of the formally adopted Swiss NPGH, I found that the interactions between the actors in the Swiss arena produced four outcomes for intersectoral, interdepartmental collaboration – routines, models, trust, and partnerships. The administrative-technical action situations (interdepartmental structures) at the formal and informal levels facilitated and improved intersectoral collaboration because interaction between policy sectors was institutionalised. The learning from this institutionalisation was especially useful for the FDFA to show other sectors as a model of successful interdepartmental cooperation on foreign policy matters. The interaction rules for dialogue and transparency, in particular in the strategic and administrative-technical situations, produced interactions that created relationships of trust and confidence between federal departments (ministries), as well as better understanding and appreciation of the others' issues, interests, and instruments. Finally, the interactions between sectors in the Swiss arena also produced more resources through new projects and partnership agreements among Swiss actors and external actors that increased the relational power of some actors who were not a part of the core group.

The Swiss NPGH arena and the GHG arena interacted through two mechanisms. Elite networking was the first mechanism of interaction between the two levels. Switzerland's foreign policy to make Geneva a hub of multilateral diplomacy for health supported networking between health and foreign policy actors at high levels within and between state and international actors in GHG. The translational boundary spanning contributions of an elite actor from outside of the Swiss government facilitated and strengthened interactions between the Swiss arena and diverse GHG actors, which stimulated the circulation of new ideas and resources between the two spheres of action. Policy learning was the second mechanism of interaction between the two levels. Swiss actors learned about policy when they participated in the governance and management bodies of international institutions (such as WHO) and through informal interactions with other governmental actors (such as the Glion meetings or constituencies in Geneva) and institutional partners in global health. The mechanisms of elite networking and policy learning circulated ideas between the two arenas and created a transnational arena that was reflective of Switzerland's NPGH interests in influencing the GHG arena.

Section 1: Contextualising the development of Switzerland's NPGH action arena

1.1 Placing the Swiss government on the global health governance map

The interviews conducted with key informants about the Swiss case of a multisectoral, interministerial policy arena for the Swiss government actors to govern matters of health and foreign policy commonly evoked a shared sentiment among actors: pride. Most informants interviewed for this study expressed a strong sense of pride and honour in Switzerland being the first country (in 2006) to have approved an interdepartmental agreement on shared objectives between the ministries of health and foreign affairs (in Switzerland, the Federal Department of Home Affairs and Federal Department of Foreign Affairs) for a *Swiss Health Foreign Policy*. The scientific and grey literatures have also commonly referenced the Swiss case as the first country to adopt a policy of this kind, seeking a more coherent approach to collaboration between sectors at the national level for the governance of global health.

Since before the end of the 20th century, the executive and legislative branches of government in Switzerland have been developing strategies and implementing measures to support policy coherence for development goals (1, 2). Specific efforts to improve coherence and cohesion between departments at the strategic and administrative levels with regard to development policies were mainly coordinated by the Swiss Agency for Development and Cooperation (SDC) and the State Secretariat for Economic Affairs (SECO) focusing on the consistency of Swiss policies in other areas with development policies and priorities. The *Swiss Health Foreign Policy* provided a high-level coordination mechanism for health, development, and foreign policy sectors (among others) to address incoherence by systematising interdepartmental consultation on Swiss positions regarding global health issues in global governance.

The specificities of the political context of Switzerland should not be neglected in this contextualisation (see ***Figure 1***). Federal departments in Switzerland have a high degree of

independence in their internal decision-making processes. Switzerland does not have a single elected Head of State because the cabinet collectively shares the executive authority of the Swiss government; the presidency rotates annually between the seven Federal Councillors who are elected by the Parliament. The political system in Switzerland is highly decentralised, with few areas directly under the authority of the federal-level executive. Principles of concordance, collegiality, and consensus are fundamental to politics and policy-making. Some Swiss political scientists have referred to the Swiss political system as a 'negotiation democracy' in which internationalisation processes have redistributed power among domestic policy actors towards strengthening those who have direct access to international arenas (3).

Switzerland is a relative newcomer to some venues in the global governance system, having joined the United Nations as a member in 2002. But, building on experiences in WHO, actors in the Swiss public administration had ambitions for Switzerland to become a more prominent and powerful actor in the GHG system. I found that the inception of the Swiss NPGH action arena was located at the intersection of concomitant changes in the health and foreign policy sectors that sparked innovations by actors within the Swiss public administration to modify rules for informal intersectoral collaboration, a precedent to the more formalised action situations discussed in this chapter. In the following sub-sections of this contextual background for the Swiss NPGH arena, I present an analysis of the internationalisation of health in Swiss public policy from the perspective of the health and foreign affairs sectors as an introduction to the origins of their collaboration to construct an arena for NPGH in Switzerland and to produce the *Swiss Health Foreign Policy*.

1.2 Swiss foreign policy – seeking influence in the international system

Strengthening Switzerland's position in the world was one of the three priorities for the Legislative Programme for the 2003-2007 term, adopted by the Swiss Federal Council in February 2004 (4). The implications of this priority for Swiss foreign policy were a reconciliation of Swiss development objectives (poverty reduction, humanitarian aid, peace building, environmental protection) and economic interests as part of a system of Swiss values (justice, good governance, human rights). Nearly a decade later, the OECD/DAC peer review in 2013 (2)

reported significant progress in this area with the Dispatch for International Cooperation 2013-2016, and the Sustainable Development Strategy of the Federal Council 2012-2015, as evidence of approaches and comprehensive strategies for improving policy coherence for development.

The political initiative to strengthen the dimensions of collaboration and coherence in foreign policy to improve Switzerland's international position and promote Swiss interests was informed by a review for the status report on foreign policy presented to the Swiss Federal Council by the FDFA in May 2005. This FDFA report provided the Swiss government with analyses on the notion of coherency of interests across different policy sectors, to improve coordination between them on foreign policy matters, and reduce fragmentation of approaches to Swiss relations with other countries, regions and international organisations [see APP 24].[1] Specifically, two measures were adopted to support more coherence and credibility in the international system. First, building on experience from the first two rounds of bilateral agreements with the European Union, a systematic approach to creating strategic foreign policy documents for cooperation with priority state partners was instituted. Second, agreements between the FDFA and other policy sectors were introduced to improve intersectoral consultations and cooperation on matters of international significance (such as health, research, or environment) as a response to the internal challenges for coherence within the administration. Following this decision in May 2005, by the month of July a Health Desk was created in the Political Division V (now Sectoral Foreign Policy Division), of the FDFA's Directorate of Political Affairs. This marked a new orientation for the development and practice of foreign policy wherein Swiss foreign interests would not only be focused on structural priorities, such as partner countries or institutions (like the USA or the European Union), but also around foreign policy issues of intersectoral relevance, such as health.

The annual reports on Swiss foreign policy to the Federal Council testified to move towards prioritisation of multilateral engagement as the most effective way for Switzerland to have influence on the global system. As of 2010, to "exert influence on the international context"

[1] All references indicating [see APP #] refer to archives of the policy process for this case. These are listed in Appendix K of this thesis in a table under the heading archives of the policy process (APP) for modelling the action arena of the Swiss case of NPGH.

[see APP 5, ch. 8] was an explicit goal of Swiss foreign policy, with the caveat of balancing state sovereignty with participation in international cooperation. These foreign policy directions conveyed that Switzerland had interpreted globalisation as a positive force [see APP 5, ch. 8] offering increasingly diverse opportunities to "make its interests known... and to integrate them in international decision-making processes." The FDFA reports also recognised that similar forces had also contributed to changes in the GHG architecture, which had gained new actors such as the Bill and Melinda Gates Foundation, the Global Fund, and PEPFAR [see APP 25, section 3.3.4, and APP 5, section 4.8]. During this time, Swiss foreign policy changed focus towards optimising strategic participation in relevant multilateral discussions, especially those whose purpose was global governance – to collectively set and monitor agendas for political action at an international level. As Switzerland did not want to engage in political alliances, its focus on interacting in multilateral fora meant that it could have concurrent access to a broad range of actors to practice diplomacy based on its interests.

1.3 Swiss public health – building capacity for diplomacy in global health governance

In the 1990s, Switzerland was in the global spotlight with regard to public health controversies, due to its pioneering intersectoral approach to harm-reduction based drug policy and the scandal regarding Nestlé's practices of marketing formula for infants in the global south. As a country rooted in traditional principles of autonomy and neutrality in the global system, the international reaction to these public health related policies and commercial practices substantially transformed how the Swiss health sector, which began to re-evaluate the interconnectedness between Switzerland and the rest of the world. However, according to informants in the study, health as such was not yet on Switzerland's foreign policy radar.

> That's where we started: a) out of a position where we felt that our freedom of action within the country is limited, and b) with the understanding that without allies we are lost. We felt that having the World Health Organization here in Switzerland, and the other health organisations, was an asset we were very proud of, and that we should try to engage with them. (H)

Under the leadership of the Director of the Federal Office of Public Health (FOPH) from 1991 to 2009 who had extensive international experience, the GHG vision of the health sector came into focus. During this period, the FOPH underwent a metamorphosis based on the

realisation that Swiss public health needed to connect with international institutions and other countries to be less isolated from partners. WHO was targeted as a starting point for this transformation, and WHO and GHG served as a proxy for the world stage on which Switzerland could play a more important role.

> The starting point of the Swiss Health Foreign Policy, and the really disturbing point, was that particularly in the context of the World Health Assembly, representatives of different branches of the Swiss government had very different views on things. It crystallised around the question of Nestlé and baby food. (H)

The experiences of the FOPH in the Swiss mixed delegations to the annual WHA underscored the need for intersectoral collaboration across the Swiss federal departments (ministries) in order to have an impact and a powerful presence in multilateral decision-making on health. For example, the health sector proposed that the Swiss ministries needed to discuss together and exchange before meeting in the venue of an international organisation (e.g. WHA) to reduce the risk of presenting an incoherent position from the Swiss government perspective. This seemed particularly important given Switzerland's relatively low power in international debates and negotiations on global health matters at the time, compared to high powered donors (like the USA or the UK). The vision of the FOPH leadership crystallised during Switzerland's seat on the WHO Executive Board (1999-2002) where Switzerland was actively contributing to the WHO governance reform (e.g. chairing a committee of independent international experts on tobacco industry practices against WHO at the request of WHO Director General Brundtland). This experience stimulated ideas for strengthening collaboration between sectors at the national level to improve the impact and perception of Switzerland's international presence in GHG.

> In the late 90s/early 2000s, we started having inter-ministerial meetings before the WHO Executive Board and the WHA. Then we formalised that more systematically, "Let's meet two or three times a year to discuss all the pending issues." We (the FOPH) were those who were reaching out to find consensus when we represented Switzerland in health-related agencies. That was a difficult thing. We really didn't know what could be points of common interest. Some were obvious – one of which continues to be obvious, we all had an interest in strengthening *International Geneva*, to have good conditions for the organisations in Geneva to work, and to attract other partners. But apart from that, it was pretty difficult at the beginning to figure out what could be of mutual interest. (H)

International Geneva was an integral part of Swiss foreign policy to improve the multilateral diplomacy of Switzerland, including rational approaches for investment,

partnerships, and legal frameworks to continue shaping Geneva into a global governance capital, of which GHG was a significant component. The adoption of the MDGs by the UN General Assembly accelerated the rise of health issues attracting global attention and discussion in international agendas (which was also evidenced by the high-level UN meetings on HIV/AIDS). New institutions appeared on the global health landscape in Geneva that were unfamiliar to the state actors in pre-millennium period, which introduced new GHG arrangements to the range of international institutions and multilaterals for countries to relate to.

> There was this multiplication of organisations, like the Global Fund and GAVI, and most of them were created for governance questions. We were confronted with these questions of how to deal with these new institutions, particularly because they were created in order not to have huge governing bodies of 194 countries, but a small, streamlined group that could decide rapidly. UNAIDS was created because of the governance questions within WHO, and so it was taken outside. So, the question of how do you structure internationally, how do you divide the work, was on the agenda almost every year. And then the questions about coherence within programs between the organisations and how countries related to them were a challenge. (H)

Swiss foreign policy directions saw multilateral relationships as a way to maximise the potential for Swiss impact on the global arena (see previous sub-section of this chapter). The proliferation of new actors and institutions in global health expanded the opportunities for Switzerland to have an influence on international policies and agendas in GHG.

In 2003, the International Affairs Division (IAD) of the FOPH was established to create a unit of international expertise in the ministry to engage and liaise with international and European institutions on matters of public health and health-related policy. The IAD was responsible for managing and leading the international dimensions of public health and health policy issues, and for making the appropriate connections and contributions to matters of global public health on behalf of Switzerland, with country partners and in international organisations, in particular WHO. The person hired as Head of the IAD remained in this position until 2012. As discussed later in the characteristics of the Swiss arena for NPGH, this person was instrumental in its construction (see Sections 2.1.b-2.1.d of this chapter). To ensure the diplomatic expertise to support this work, one year later in 2004, the first career diplomat was recruited as Deputy Director of the FOPH IAD as a secondment from the FDFA (see Section 2.3.c of this chapter). Since the inauguration of the IAD, the FOPH has used it to entrench its capacity for international work on matters of health and GHG by anchoring it in diplomatic expertise for negotiation. A diplomat held the position of Deputy Director until 2015, and a diplomat has been the Director of

the Division since 2013. Since 2011, the Director of the IAD of the FOPH has special diplomatic status as Ambassador for Global Health.

Global health crises such as SARS and H5N1 were noted by informants as important events that were influential factors supporting arguments for improving the collaboration on foreign policy relating to health matters between the FDFA and the FOPH in the FDHA. Events such as these were external shocks to the Swiss context that underscored the vulnerability of the Swiss health system because of its geography and its reliance on many foreign health workers, and thus reinforced the ideas that were already gaining momentum in the FOPH about coordination needs between health and foreign policy sectors. The geographic position of Switzerland (surrounded by five countries) and its status as a global diplomatic hub made it particularly sensitive to these crises, thus Switzerland made a 5 million Swiss Franc solidarity donation to WHO towards the development of global pandemic plan. The need to coordinate on virus sharing, vaccinations and garnering support for the International Health Regulations were part of the FOPH's justifications for integrating health and foreign policy objectives, as Switzerland wanted to respond more systematically to these crises, to increase their legitimacy and credibility as a key player in GHG.

> The Director of the Division of International Affairs anticipated that diplomacy for health and foreign policy was an important subject. This was helped, at the end of 2003, by the SARS crisis in Hong Kong that spread. You could see that there were some issues on international health that should be discussed. That was a tipping point. There were other specific events that made us more aware of how interdependent the different health systems are and how you cannot only count on yourself to fight an epidemic. We realised that our health services are very much dependent on the health workforce from abroad, because we have so many border workers that come from France, Germany, Italy to work in our hospitals. You have to cooperate with other countries to deal with health emergencies more efficiently. You cannot do it by yourself. The International Health Regulations were also something that inspired the FOPH to think about this opportunity of having a health voice internationally. (FA)

Since the FOPH had been developing the international dimension of the public health sector's work and increasing the health sector's capacity for engaging in health diplomacy, they had also been thinking about the need to make connections between the foreign policy and health sectors regarding Switzerland's representation and engagement in the GHG system. When the political decision was announced in 2005 to develop interdepartmental collaboration with the FDFA on sectoral policies (such as health), the FOPH proposed an agreement on health foreign

policy as a pilot for this new type of institutional arrangement. The leadership in the FOPH had been preparing for such an opportunity and was positioned to be the driver for the original interdepartmental agreement between the FDFA and the FDHA adopted in 2006 (see Sections 2.1.b-2.1.d of this chapter).

> We decided in a discussion with our minister at the time to propose health as an intersectoral issue for multilateral action of Switzerland. Normally the leadership for these processes was clearly left to the Ministry of Foreign Affairs. We suggested that the government agree to give this group [later the IK GAP] the mandate to shape a paper on health foreign policy. The Federal Council for Home Affairs took it to Federal Council, and they agreed it was a good idea. The FDFA was very enthusiastic to pilot this. (H)

> It was clear for me. You don't try to do your own foreign policy. There is only one Swiss foreign policy. (H)

When the mandate to pilot interdepartmental cooperation on health foreign policy was authorised, the FOPH was equipped with expertise (in health and diplomacy) for the task of negotiating the rules for the Swiss NPGH action arena.

1.4 *Swiss Health Foreign Policy* - from interdepartmental agreement to Federal Council policy

Once the 2006 *Agreement on shared health foreign policy objectives* between the FDFA and the FDHA was approved, progress updates were presented in the FDFA's annual foreign policy reports to the Federal Council. In 2007 the agreement was reported as the first of its kind between the FDFA and another policy sector [see APP 6, section 3.4]. The shared objectives were established with the aim of promoting Swiss interests, and the instruments to achieve them were intended to facilitate the coordination of actors from multiple related sectors. The internationalisation of many policy sectors translated into a need for cooperation, in particular with respect to health and development due to the influence of the international agenda on development policy (since the adoption of the MDGs). Since Switzerland became an official member of the UN in 2002, it has invested in making the UN a significant venue for its multilateral relationships, and has been especially interested in UN reform. The Swiss government recognised the increasing "global" responsibility for international development that has become embedded as a shared task for global governance [see APP 6, section 3.6.1].

The 2010 report on foreign policy announced the projected renewal of the *Swiss Health Foreign Policy* in 2012 [see APP 5, section 4.8, and APP 4, p. 2801]. Specifically, the report acknowledged the three purposes of the initial agreement – to oversee the coordination of national and international health policies, to increase the efficiency of international cooperation in health matters, and to strengthen the role of Switzerland as a host country for headquarters of key international organisations and businesses in the health sector [see APP 5, p. 1152]. In 2010, Switzerland wished to extend this focus on coherence to the global level. The Swiss government saw its main priority within the WHO as being reform for better coherence across the UN system with regards to actors from other sectors who influence health, and it intended to contribute to this goal during Switzerland's term on the WHO Executive Board (2011-2014). The development of *International Geneva* as a global hub of competence for global health remained a key priority for *Swiss Health Foreign Policy*, including *Campus Santé* and agreements with major global health actors. The Swiss government aimed to centralise the health actors in Geneva in order to promote more exchange and coordination between them to "contribute to the consolidation of the global health institutional architecture and improve tools for governance" [see APP 5, p.1155] (see Section 3.5 of this chapter).

> It was a long and iterative process to develop this health foreign policy. The elaboration of the second one was much easier and more interesting from the point of view of the foreign affairs sector because we could show other ministries that developing such a policy can work very well. It has advantages for synergy when Swiss delegations work in different international organizations related to health. We have a clear approach across the board, and that's important. It's even more important for a country like Switzerland. (FA)

The Swiss Federal Council adopted the second version of the *Swiss Health Foreign Policy* on March 9, 2012. This rest of this chapter presents my analyses and the findings from the case of the Swiss NPGH action arena between 2005 and 2013, including its characteristics, the action situations which comprise it, its outcomes, and mechanisms of policy change. The chapter concludes with some critical reflections that emerged from the informant interviews and analysis.

Section 2: What characterises the Swiss NPGH action arena?

2.1 Characteristics of the Swiss NPGH action arena

As briefly described in the previous section, the first decade of the 21st century was a period of innovation in the Swiss public administration that raised the profile of global health to the national policy agenda and instrumentalised health as a means of improving the Swiss government's position in global governance. Between 2005 and 2013, actors from the health and foreign affairs sectors experimented with and refined instruments for interdepartmental cooperation on matters of foreign policy concerning global health and its governance. The FOPH from the FDHA and the Political Directorate V from the FDFA Health worked together to develop the first interdepartmental agreement on health foreign policy in Switzerland in 2006. In 2012, the formal adoption of the *Swiss Health Foreign Policy* by the Federal Council represented a government level institutionalisation of the Swiss NPGH arena that had been further elaborated between the health, development, intellectual property, and foreign affairs sectors.

The Swiss NPGH action arena is a multisectoral governance arrangement that evolved from the intention to establish Switzerland as a credible actor in the GHG system. I characterise the construction of the Swiss NPGH arena as a bottom-up policy process from within the public administration, driven by the health sector. The FOPH had the foresight to use the informal links it had been developing with other sectors for WHO-related work as grounds for being the first sector to respond with a proposal for operationalising the political decision to improve Switzerland's international position through foreign policy collaboration and coherence announced in the FDFA 2005 status report. The *Swiss Health Foreign Policy* produced in the Swiss NPGH arena resulted from processes that were designed to share power horizontally across the core sectors involved, but the health sector remained the constant source of impetus. According to many informants, this was largely attributable to the leadership and negotiation skills of one key actor who was the Head of the IAD at the FOPH, a position later sub-titled Ambassador of Global Health. Ultimately, the Swiss NPGH is an arena for interaction of government actors at the federal level (with marginal interactions with civil society reserved for information sharing), and as such the arena reflects the strata of authority for decision-making

embedded in the Swiss system. Below, I expand on each of these six distinguishing aspects that characterise the Swiss NPGH action arena.

2.1.a National device to produce global credibility

The Swiss NPGH arena was constructed to respond to the policy problem of how to make Switzerland more credible, and therefore more powerful, in the GHG system. It was founded on a core belief that interdepartmental collaboration will improve processes and produce more credible outputs and coherent positions for the international arena, and that this coherence would improve the influence and perception of Switzerland as a state actor in GHG.

> The more we collaborate with other ministries, the more we can make our foreign policy and defence of our interests powerful. When you don't coordinate, then in the international organisations you send mixed signals because everyone says something different and it's difficult. This makes our position much stronger, and this is especially true for small countries. You are listened to, if you have a clear position, a fact-based position, but also coherent position. You cannot allow yourself to change your mind the second day. If you are a big country you can change your position more easily because you have the power to impose a certain view at a certain moment. If you come from Switzerland, you better try to be coherent in your position in order to bring it forward. (FA)

The Swiss hypothesis of power through credibility means putting forward a coherent discourse on Swiss positions in the GHG system to avoid contradictions between actors from different policy sectors representing Switzerland in different global health policy venues and institutions.

> This should make Switzerland more credible, more powerful, because people should start to understand there is no use in saying, "We don't discuss IP, Public Health and Innovation in WTO, we prefer to do that in WHO because in WHO, we like the guys from your delegations better." This might be, but they will sing the same song always. (IP)

This belief that intersectoral coordination to achieve more consensus within the public administration on matters of health and foreign policy will lead to a stronger, more credible position is one of the reasons that actors invest their institutional resources in the Swiss NPGH arena. It is important for the Swiss government to speak with a consolidated voice on their positions and to be interchangeable in terms of representing Switzerland rather than just representing their department or office.

> In the end what we all want is to have a coherent and credible Swiss foreign health policy – not "It's my ministry's position." When you speak to different forums on the outside, about what we think, as a small country, it's even more important to be credible, and that people see, "Oh, the

> health minister said that, but we also heard it from the foreign minister, interesting." I think that that gives us more credibility and influence. (FA)

> Before, you knew exactly who was speaking: Trade, Development Cooperation, Health. We were starting to speak with one voice (about foreign affairs). (H)

This idea of improving processes for a more credible Swiss contribution to the GHG system was a strong theme across the informant interviews with actors from different sectors in the Swiss administration. I found that the Swiss arena was a coordination mechanism to ensure that all relevant sectors interacted when Switzerland needed to respond to external stimuli (e.g. to take a stance in global governance on a particular issue) to produce the most coherent position possible.

> It's not a tool to promote health only. It's a tool for policy coherence. It's not how do the others work for us, but how do we work together. (H)

2.1.b Bottom-up policy arrangements from within the public administration

The bottom-up approach to the development of the Swiss NPGH arena is another characteristic reported on by many informants. In one respect, the gradual development of the Swiss NPGH as a pilot policy arena did not deviate from the Swiss standard procedure for rolling out national health projects and programmes, as noted by one health sector informant, which consisted in trying something out for 4-6 years, and then deciding whether or not to continue based on its outcomes. In another respect, the coherency processes developed for the Swiss NPGH arena were within the general norms of Swiss processes for broad consultation across the public administration giving opportunities for departments' interests and perspective to be heard on issues (e.g. on the international cooperation messages of the SDC). What distinguished the Swiss NPGH arena was the progressive formalisation of rules from implicit to explicit, leading to the construction of a policy arena with a set of situations used as coordination instruments that were certified through the adoption of a policy document.

> It is a policy that has been designed and progressively developed in a pragmatic way, in a bottom-up way. Of course, you need the approval of the government; you need the interest of your ministers. But the substance has been designed, developed within the offices in charge. And there is an important part of personal willingness, personal interest to develop, to continue to develop it. But there is also the fact that you have some kind of structure and a document, and therefore more sustainability. (FA)

The dedicated work of the actors from the different sectors who were initially committed

to the Swiss NPGH from its early stages created a record of performance, from which the collaboration was able to gain momentum, and then build a large majority as a core group with an initial trio of health, foreign affairs, and intellectual property (later joined by development) was strong enough not to be opposed.

> So, in a way, this democratic process was so powerful because it created this situation where no one could oppose internally. The three had a discussion agreed to change the rules of the game. From now on, each of us will consult with the other on everything. That's how it started. From there, others had no choice but to join, because with three ministries on board out of four who are in charge for the whole thing, they could no longer follow the old rules of the game. The three were strong enough. So, that was the most important thing, and out of this you can create whatever you want. (IP)

2.1.c Horizontal power sharing between sectors, but health sector driven

Related to the characteristic of the bottom-up nature of the development of the *Swiss Health Foreign Policy* for NPGH, the horizontal power sharing across the core group of sectors involved also characterised the Swiss NPGH arena.

> The strategy helped to coordinate the policy of Switzerland on health subjects in a better way, bringing together the different federal offices concerned in economics, in public health, in development. And I think that was an important issue, that it's perceived as a horizontal task, considering health as a transversal objective. (H)

Although the health sector was the main driver behind the construction of the Swiss arena for NPGH, the position and boundary rules-in-use helped to make the collaboration appealing to other sectors, because the health sector was interested in building up areas for co-responsibility and sharing a variety of institutional resources for governing global health, as a process of learning from and bargaining with each other to find common positions that are acceptable to all.

> All the issues in the *Swiss Health Foreign Policy* belong to different departments. They don't belong really to the Foreign Affairs, but with our missions in Geneva, in Vienna, in New York for the UN in general and in embassies all over the world, we contribute to make this policy active. Ministries usually want to deal with international level at first by themselves. If they can, they use their own channels. Sometimes they don't inform Foreign Affairs of their external activities, and this is typical for every country. What was instrumental for the *Swiss Health Foreign Policy* was the vision of the FOPH actors, "We can multiply the challenges we are facing, we can multiply our force and our strengths by using the network in Foreign Affairs by collaborating with the Ministry of Foreign Affairs." From the Foreign Affairs perspective, we saw this as a very good idea, and the Secretary of State of the Foreign Affairs clearly said, "Yes, that's a good idea. Let's try." We acted as an interested party because we wanted to have the process. We wanted also to have the possibility to influence the process. I don't think there was problem with having the health office as a driver of that. I think on the contrary we saw more the opportunity to cooperate with someone, yes. (FA)

2.1.d Institutional arrangements that rely on individuals

The institutional arrangements and rules of the Swiss arena for NPGH were designed by a handful of individuals in the public administration who worked with each other in an iterative fashion to overcome the institutional barriers for collaboration which are not uncommon in system without a single formal head of government, where agencies and departments have a great deal of independence. The single most significant individual mentioned almost unanimously by the informants was the Head of IAD for the FOPH between 2003 and 2012. Many informants noted that his perseverance, networking capacities, personal leadership, and negotiation skills were "crucial" to the development of both versions of the *Swiss Health Foreign Policy*, and the Swiss arena for NPGH at large. The Swiss political system with a coalition government provides civil servants with policy-making context for flexibility and room for initiative within their departments. The Head of the IAD was particularly skilled at using social and political resources, such as networks and personal relationships with other senior executive staff, to broker and build the relational power of the FOPH within the existing institutional order to advance the idea of the Swiss NPGH.

> He was the founder of everything at the beginning. Without him, it wouldn't have worked. He showed openness. He understood that by being frank and open, in the short run, he might lose influence, but in the long run, he would enhance it. And that's what happened if you look at what he did. He was a bit of lame duck on the international level, because in the beginning he was absorbed by the national level in order to be transparent with the other sectors in the administration, who then said, "Now we have seen everything, now we understand, now we cooperate." Then he could go back to acting as a bridge builder in the WHO processes, and have his deputy continue to work with the other sectors in full confidence. And this gave him more legitimacy. He served quite often as chair in WHO processes, and he knew that in order to be a strong bridge builder, you need to know that your country will not leave you in the rain. In the long run, I think public health people gained. (IP)

2.1.e Federal government agenda, excluding civil society actors from decision-making

The boundary and interaction rules for the Swiss arena of NPGH created a distinctly separate space in the form of an annual stakeholder platform for the government actors to engage with civil society (including a mix of private industry, NGOs, research centres, professional associations, etc.) and exchange information relevant to priorities for the *Swiss Health Foreign Policy*. Some non-state actors from the research and knowledge generation community were

consulted electronically to provide comments on drafts of the policy document in 2011, and were also involved in special sub-committees on projects on specific policy questions (e.g. migration of health personnel). However, overall the Swiss NPGH was characterised by civil society actors as a multisectoral policy arena that is by and for the Swiss government to coordinate matters of health and foreign policy in the governance of global health.

> I understand that it's primarily an instrument for the administration. So, it's not our duty to tell them they should do it like this or like this. It's not very clear for us how civil society or stakeholders are included. On some issues we are included, on others we just don't know. There is not a very structured way now beyond this annual meeting. (CS)

Civil society organisations, and the research community (including academics) are "outsiders" when it comes to the interactions in the Swiss NPGH action arena. The interaction rules excluded their access to decision-making in arena, although boundary rules for some situations give them access to share relevant knowledge, practice, and ideas (situation 5), or produce analyses or participate as implementing partners on projects of the arena (situations 2 and 3). Informants from NGOs and the research community felt that they had very little opportunity to influence or participate actively in the Swiss NPGH action arena.

> I think one aspect to be considered is definitively what non-governmental actors do play. I have a feeling they are in a relatively distant position for the moment. It's mainly a government driven agenda. I see it as a small, mainly governmental driven process with limited participation of other stakeholders. But these processes always involve the same question, if you open it too much it gets, obviously, always very complicated, also, and time consuming. (R)

According to these boundary rules, the actors with resources needed for engaging in the GHG system were "insiders" of the decision-making within the Swiss NPGH arena, while actors who conducted research and interventions with populations to improve global health and equity (more often engaging with health policy and systems) were "outsiders".

The exclusion of civil society, as representative of the 'public', from decision-making in Swiss policy-making on GHG raised questions in the analysis due to the Swiss tradition of direct democracy in making federal laws. However, there are few laws of this kind since many sectors are decentralised for policy competencies at the cantonal level. While the *Swiss Health Foreign Policy* is not a law, the questions raised by civil society actors in this study take issue with what is the socially acceptable participation of Swiss civil society in the country's multisectoral arrangements for governing global health.

2.1.f Stratified arena of multisectoral collaboration

Lastly, I characterise the Swiss NPGH action arena as a stratified policy process divided into political, strategic, and administrative-technical layers of authority for decision-making. These layers of the Swiss action arena corresponded to levels of responsibility of staff in the Swiss public administration: the connection to the political vision and arrangements for Federal Council monitoring at the Director of agency and State Secretary level, the strategic orientation and decision-making at the Senior executive level, and the operational and administrative coordination at the junior policy advisor or desk officer level. These strata were a consequence of rules-in-use that state actors collaborate (horizontally) across sectors with their equivalent level of counterparts in the administration hierarchy.

The administrative-technical situations, Idag GAP and Idag GIGE (situations 2 and 3), are the cornerstones of the Swiss arena for NPGH. The focus of the Idag GAP has more breadth in terms of a wide range of cross-cutting issues related to governing global health and foreign policy issues, and that of the Idag GIGE has more depth in terms of specifically dealing with intellectual property and relationships between public health, research and development, trade, patents, and access to medicines. Both situations report directly to the highest political level situation in the arena, the IK GAP (situation 1). The only decision-making executive body above it is the Swiss Federal Council. A strategy level situation, the Executive Support Group (situation 4) acts as an intermediary level buffer between the administrative-technical situations and the political one. Situation 4 ensures that the fewest number of problems or unresolved concerns rise to the political level by resolving tensions and disagreement through dialogue among senior executive members of the administrative apparatus. As per their boundary rules, situations 1-4 are the authoritative government situations reserved exclusively for federal administration

There is also a practice-technical situation, the Stakeholder Platform (situation 5), a multi-stakeholder situation for which the boundary rules are more inclusive of non-state actors, and which operates outside of the stratified authoritative space of situations on the political, strategic and administrative-technical levels. This situation serves as a communication and networking instrument for information exchange between global health practitioners, researchers, and other policy-makers and administrators.

An iceberg of intersectorality

I positioned the five action situations (4 authoritative, 1 multi-stakeholder) of the Swiss NPGH arena into formal and informal categories, which I conceptualised as an iceberg of intersectorality (see ***Figure 2***) with the formal meetings being the most "visible" parts of the iceberg to the researcher as an observer. All five situations are visible in the formal part of the arena. But there is also a substantial part that is less visible consisting of many informal interactions within situations 2.a and 3.a (core groups). The decision-making in the political and strategic strata is integrally related to support of a core group of actors from public health, development, foreign affairs, and justice (intellectual property) policy sectors on the informal side of the administrative-technical layer because intersectoral core teams manage each of the two administrative-technical action situations. A core group of actors from different sectors shared the positional power with responsibility for each administrative-technical situation. The health, development and foreign affairs sectors are the core group for situation 2, and the health and intellectual property sectors are the core group for situation 3 (see Section 2.2.d of this chapter). As one moves higher up the strata to the levels of the strategic and political situations, the cross-government characteristics of the arena appeared more strongly because the core groups are less distinguishable as a separate entity than in the lower levels of the process (as reflected in the position, boundary and interaction rules for situations 1 and 4). The periodicity of interactions between sectors seemed highest in the informal part of the administrative-technical level, both among senior and junior staff.

I found the central (boundary) position of public health most clearly at the informal level of the Swiss arena (c.f. situations 2.a, 3.a, and 4). The FOPH acts as a link between the action situations because the health sector is the only actor that interacted with all the other sectors in the Swiss NPGH arena at the formal and informal levels. This finding of public health as a bridge between sectors in the Swiss arena may have historical and contextual explanations. Firstly, actors from the FOPH initiated the informal processes to develop the first interdepartmental agreement in 2006 as a pilot case for experimenting with interdepartmental objectives for integrating foreign policy and other policy sectors' goals for policy coherence at the federal level (see Sections 1 and 2.1.b-d of this chapter). Secondly, there is not a central ministry of health *per*

se in Switzerland since health is a decentralised responsibility at the level of the cantons. This means that with regard to population and public health in Switzerland and the Swiss health system, the FOPH (located within the FDHA) works very closely with the Federal Conference of Swiss Cantonal Health Ministers (Directors), among other national and cantonal actors, on matters of public health in Switzerland. Whereas the federal level does not have responsibility for the daily questions of the health system, it does for public health questions of international scope and international health issues that impact public health and health systems in Switzerland.

2.2 The action situations of the Swiss NPGH action arena

I observed five main action situations in the Swiss NPGH action arena between 2005 and 2013. ***Figure 3*** presents a model of the Swiss NPGH action arena according to its constituent parts – action situations, actors, and rules. The ordering of the action situations in the text below corresponds to their numbering within ***Figure 3***, and ***Figures 3.1 - 3.5*** zoom in on the five individual action situations. Over this period of time, there was an on-going process of formalisation of the actions situations in the Swiss arena that were experimented with and established through the development of the interdepartmental agreement between the FDFA and FDHA on shared objectives for *Swiss Health Foreign Policy* (5). In 2010, a process of evaluation and revision of the first agreement which sanctioned situations 1 and 2 developed into the Swiss Health Foreign Policy adopted by the Federal Council in 2012 (6) that formalised situations 3-5 and recognised all five of the main situations presented below as parts of the apparatus for coordinating the arena. The main situations are multisectoral, and hierarchically structured to correspond to the level of authority of the actors representing the different sectors (see previous section of the chapter). The two administrative-technical situations have more informal sub-situations that are on-going (***Figures 3.2 - 3.3***) that maintain the functioning (preparation, communication, and follow-up) for the formal parts of situations 2 and 3 (e.g. which meet physically at least twice a year).

2.2.a Situation 1 – Interdepartmental Conference on Health and Foreign Policy (IK GAP)

The IK GAP *(**Figure 3.1**)* is a high-level political decision-making body (just under the highest executive level of government) that reports directly to the Federal Council. The main purpose of this situation is to monitor progress and achievements related to Swiss arena overall with regard to the development and implementation of the *Swiss Health Foreign Policy*. The actors in this group discuss policy topics as part of decision agendas and "ratifies" high-level orientation of Swiss interdepartmental collaborations on governing global health; this situation does not review information items nor does it treat any matters of operations at the level of technical detail. This group oversees the mandates and progress made by the Idag GAP (situation 2) and Idag GIGE (situation 3), reviewing annual reports from both groups and a mid-term evaluation of the *Swiss Health Foreign Policy* (every three years). One important task of the IK GAP is to solve any outstanding issues that were not previously resolved by the members of the Executive Support Group breakfast meeting (situation 4).

> Instead of going to the Federal Council, which is a cumbersome process because you have to respond to many criteria before you really can approach this level, the alternative, softer, way is that you try to bring decisions to the IK GAP. The IK GAP sometimes decides and says, "This is not within our competencies. We really have to bring it to the Federal Council." But in most of the cases, this is a convenient way of accelerating processes, because it "only" has to go to the IK GAP. (D)

Before 2006, before working towards a more formal and sectorally inclusive configuration of members for the IK GAP, the FOPH initiated more regular coordination with other relevant sectors prior to sending Swiss delegations to governance bodies of intergovernmental organisations such as WHO in order to separate the political and technical "battles" related to Swiss positions in such international institutions.

> It was very good for the Secretary of State for Health, the Secretary of State for Foreign Affairs, and the Secretary of State for Economic Affairs to meet regularly. Because it seems to be that when you are lower in the hierarchy, sometimes fights are much more fierce, then you have to regularly update. It was important then that, when it came to the level of the state secretaries, one tried to calm down these tensions, appease it a bit and try to find a solution which corresponds to what the Swiss interests are. (H)

This interdepartmental group became the IK GAP. The IK GAP meets once a year and is jointly chaired by the Director of the FOPH, the Secretary of State for Foreign Affairs, and the Director General of the SDC. The actors in this political level action situation include representatives at the State Secretary level and other Directors of offices and agencies from six of the seven Federal Departments, and a representative from the Swiss Conference of the Cantonal Ministers of Public Health. Upon adoption of the policy document in 2012, membership of this group expanded to include other actors, such as Swissmedic, a regulatory and implementation organisation. The group served as a formal annual check-in for the interdepartmental work. The yearly meeting of this high-level political group incentivises and catalyses the lower level of situations to meet interdepartmental objectives and respect the regular processes of collaboration.

> But it helps to know that once a year we have the IK GAP, because I think in the daily business you could just sometimes forget, and collaboration would be ad-hoc. Then you risk having one ministry or office saying, "We can deal with this," and not inform the others, which we experience in other policy sector fields. Here you have this structure, and you have to fill it. You still need the goodwill of the people wanting to do it -- if the collaboration wouldn't work, it would force people to need to work together. We do it anyway, but it's kind of there to safeguard, and it's helpful. (FA)

2.2.b Situation 2 - Interdepartmental Working Group on Health and Foreign Policy (Idag GAP)

The Idag GAP *(**Figure 3.2**)* is an interdepartmental group that meets formally 2-3 times per year for a half-day. The position rules distributed a shared dispositional power between the core group of three sectors who co-chair this situation: IAD of the FOPH, the Health Portfolio at the SDC, and the Sectoral Policies Division, Section on Environment, energy, transportation and health, of the FDFA. Although a coordination office is maintained in the Sectoral Policy Division of the FDFA, the "substance (of it) is really something of all three" sectors combined (FA). In addition to the core group, the boundary rules give access to senior public administrators (with technical expertise in their fields) from other government sectors such as the Swiss Federal Institute of Intellectual Property, the State Secretariat for Education and Research, the State Secretariat for Economic Affairs, and representatives from the Swiss foreign missions [Geneva (WHO) especially, but occasionally New York (UN), Vienna (drugs), Brussels (EU)]. Representatives from other stakeholders such as Swissmedic and the Swiss Conference of Cantonal Health Directors are also invited to attend. The attendance of the formal bi-annual

meetings ranges from 10-15 people, even though the situations full membership consists of about 25 actors.

As the first pillar of the Swiss arena, the purpose of the Idag GAP is to develop positions on behalf of the Swiss federal government related to technical questions often linked to WHO processes and resolutions. In the formal meetings, interaction rules required updating other branches of the Swiss public administration on work related to global health in each of the offices represented and discussing on-going collaborative activities initiated between actors in the Idag GAP.

> It's at the level of the technicians, specialists for specific topics, which have a platform within these committees when it comes then to specific questions on technical matters. This is quite a nice institutional setup to discuss these matters and to also develop some common positions for specific technical questions, which have to be taken in many, many cases in relation with processes, resolutions, etc. of the WHO. (D)

The products of this situation often took the form of policy and position papers that support exchanges at the political level between state secretaries and directors of agencies (in situation1), including briefing documents for ambassadorial visits received by the Federal Council on matters related to *Swiss Health Foreign Policy* and providing input to other policy domains (e.g. international cooperation). The interaction rules provide for the establishment of subcommittees for special studies or projects for discussing priority topics identified by the Idag GAP for Swiss positions. The boundary rules for these subcommittees give authority for terms of reference to include ad-hoc participation of civil society actors and research centres (e.g. Swiss Centre for International Health). The sub-groups report back to the Idag GAP. For example, the Idag GAP produced a policy paper on the International migration of health personnel to Switzerland [see APP 22] to inform the Swiss implementation of the WHO Code of Practice on recruitment of health personnel based on a project commissioned to collect studies from the Swiss Health Observatory [see APP 19], the Swiss Tropical and Public Health Institute [see APP 18], and the Swiss Conference of Cantonal Health Directors [see APP 20].

Consensus was the fundamental decision rule for producing positions within the formal Idag GAP meetings where a majority is necessary for action to be approved and carried forward.

Rules for consensus were applied at all stages of administrative-technical situations' processes, even in the informal forms (see Section 2.2.d of this chapter).

> To illustrate how we work, it's very much through what we call consultation and coordination, to consolidate our Swiss position. So, I always call these the three Cs. We work on the basis of cooperation, but not in the sense of controlling. Which means that with all of that, we need to have added values. So, whenever I come to the discussion, I come with my hat of public health and I expect my colleagues from the foreign office to come with their hats for defence of Swiss interests. When I see people from trade, they come from their economic perspective. When I see someone from Swissmedic, they come with their hat of quality assurance of medication. And this is where the added value brings the richness to that conversation. So, any Swiss document, declaration, or position that we need to consolidate, we'll actually then circulate it. Because we need to have all those perspectives ("hats") converging to something that is actually the Swiss thing that we want to promote. To give you very clear example, we agree that every person in the world should have access to drugs. At the same time, we also agree that we should make sure that intellectual property rights are also protected. It's not a contradiction in itself. (H)

The boundary rules for ideational materials permitted actors to contribute any resources that support action on priorities decided by the Idag GAP; resources generally took the form of expertise, approaches and networks. These resources also represented a set of ideas corresponding to the institutional mandate of the different actors and to which they also have a firm commitment to follow. For example, a representative from the SDC carries the lens of poverty reduction as a frame for understanding global health problems, whereas a representative from SECO approaches the Idag GAP deliberations from a political economy perspective, and the FDFA from the angle of maintaining strong international relations with other countries and institutions through diplomacy. The boundary rules and interaction rules work together to construct a sort of marketplace within the situations, where the Idag GAP collectively identified and decided the needs for expertise, for funding and for knowledge (boundary rules), and the Idag GAP discusses relevant resources from the different policy sectors (interaction rules). When they had a need for knowledge, the activity was generally outsourced to qualified stakeholders in the research, practice, or knowledge generation communities (e.g. research centres and institutes) commissioning knowledge production on topics (like the subgroup for the study on Migration and Human Resources for Health) from Swiss Tropical and Public Health Institute or the Swiss Observatory to synthesise knowledge for decision-making. Informants from the knowledge production community did not necessarily see themselves as active participants of situation 2, but the interaction rules of situation 5 supported these types of links for project development. One

researcher noted however, that there is not a "systematic invitation of more research" (R) by the situation when making policy decisions. The interactions between actors in the situation who are not members of the core group seemed to fluctuate with the demand for expertise for different kinds of objectives. This appeared to construct a two-tiered system of (active/passive) participation of actors depending on how the actor's institution would be affected by a decision and to what degree that issue was part of their own work plan and mandate.

> At the beginning frankly, we had the impression that this is more about public health. There were a lot of discussions after about political aspects, around priorities regarding World Health Organization, governance, et cetera, things that really did not necessarily affect us in our day-to-day work. (H)

2.2.c Situation 3 - Interdepartmental Working Group on Intellectual Property, Innovation, and Public Health (Idag GIGE)

The Idag GIGE *(**Figure 3.3**)* is the second administrative-technical situation that is parallel to the Idag GAP (***Figure 3.2***) in the hierarchy of the NPGH action arena that also formally convenes on a bi-annual basis. According to the position rules for this situation, the core group of the Federal Office of Public Health and the Swiss Federal Institute of Intellectual Property shared dispositional power as co-chairs. The boundary rules allowed access of the same actors as in situation 2, but the most active ones in addition to the core group are the Swiss Agency for Development and Cooperation, the State Secretariat for Economic Affairs, and Swissmedic.

As the second pillar of the Swiss arena, the purpose of the Idag GIGE is to develop positions on behalf of the Swiss federal government related to technical questions often linked to WHO, WIPO, and WTO processes and negotiations.

> It is all about the governance. How can it be that on issues related to intellectual property innovation, the Swiss position in WHO is blue, in the WTO is red, and in the WIPO is green. This is not coherent. This is bad for the reputation of Switzerland. Of course, it's always good for those in the lead in these organisations because they have mini-victories, but in the long run it is damaging the credibility of Switzerland. (IP)

This purpose of this situation is more specific than situation 2, and it is less concerned with the cross-cutting issues of global health and development that are addressed in the Idag GAP. Its boundary and interaction rules concerning actors and ideas related to intellectual property, quality

and access to medicines, patents, drug research and development reflected the specific aims of this situation.

> I think intellectual property (IP) is an important issue on the international level. The items discussed in this field of IP, innovation, and public health are like a huge book, and two chapters are devoted to IP. One is the chapter "IP as a barrier." The other chapter is "IP as a stimulus for new innovations." So, you have these two chapters and you cannot say anymore, "WHO is where the health family discusses with your Ministry of Health. Health is health, and IP should not be here." That's what happened before. (IP)

One of the underlying aims of the Idag GIGE was to contribute to changing perceptions about how intellectual property fits into a public health framework, which necessitates both sectors to have a good understanding of the other's values, issues, and strategies.

The interaction rules for the Idag GIGE allowed it to establish sub-groups when needed to develop policy positions or other products. For example, to improve efficiency of Swiss diplomacy at the UN in New York, the Idag GIGE tasked a sub-committee to elaborate guidelines for negotiators on topics related to the framework of intellectual property rights in public health. The vignette in the box below, edited from the transcript of an informant in the intellectual property sector, describes in detail how sub-groups worked in practice.

The e-government platform (CH@T world) connects everyone in the Swiss government and public administration with access and capacity to react and contribute to consultations on Swiss policy. Each individual is subscribed to policy topics based on their competence and interest/mandate of their agency, and this generates get an automatic email notification any time a new comment is made to conversation topics in their subscription list. There is also a function for uploading documents being shared with all the partners that are relevant to that consultation.

Whenever there were references to intellectual property rights, TRIPS agreement, or access to medicine in multilateral discussions, at the UN for example, the Swiss diplomat from the foreign ministry negotiating on behalf of Switzerland consulted the capital through the e-platform. The negotiators on site need a fast and clear cut answer on basically how they should approach, how they should negotiate, and what should be the stance and why. There were discussions within the administration in Bern about what input we should give and what should be the official position. Often in the context of IP and public health, we ended up having long discussions online between different actors of the public administration who had diverging opinions.

To respond to this, the Idag GIGE formed a sub-group tasked to develop general guidelines for our negotiators who are not specialised in this policy area. A core group was formed with representation from the Sectoral Policies Division of the FDFA, from the FOPH and from IPI, which was lead and coordinated by the FDFA. We made a proposal with an

introduction to the topic, basic guidelines on what the Swiss position should be and how flexible the negotiator could be. The paper also included concrete examples of past negotiations and qualified those examples as good outcomes and less optimal outcomes.

Once agreement was reached on the level of the core group, the circle was enlarged to include Department of Human Rights, State Secretariat of Economic Affairs, and the State Secretariat of Innovation, Education and Science to fine-tune the text. It was time intensive; the whole process took about one year – that is the time that was needed. I'd say it wasn't a very efficient process, but it led to a lot of exchange and principled discussion on the topic. I think it furthered understanding amongst the different stakeholders of the main issues, the objectives, and the basis for the position from each department. That kind of forced us together to work something out.

The final result was a 10-page paper (in German and in English) with all the examples, and an executive summary of 1.5 pages. After negotiators tried working with it, we got some positive feedback. I think it has facilitated work. Before, when such a case came up on our online network, if you made a comment, there might be 100 other people reading, and if there are differences of opinion, you're back and forth and you're filling up people's email boxes, which can be extremely inefficient. Since we got these guidelines in place, it's been a lot smoother and straightforward. (IP)

2.2.d Informal core group for Idag GAP (2.a) and Idag GIGE (3.a)

Informal processes among core groups for coordinating the Idag GAP and the Idag GIGE

The "core group" teams served as the operational support units of the administrative-technical action situations. One informant from the foreign affairs sector refers to these informal situations as the "inner circle" (FA) of actors in the Swiss NPGH area. The position rules established intersectoral co-chairing for the formal situations 2 and 3, but outside of the formal situations, the actors in these two core groups worked closely (and frequently) together because they are responsible for the leadership, management, and coordination of the administrative-technical level of the Swiss arena. The core groups in situations 2.a *(**Figure 3.2**)* and 3.a *(**Figure 3.3**)* are further divided into two levels, with interactions between senior staff (meeting about 6/year) and between junior staff (meeting as needed between formal meetings) from the different sectors. Coordinating intersectoral processes requires a lot of work, as one informant noted it is not a "natural process." Rules support the work of coordination, but the investment of human resources is required (personnel and personal time is needed to make these processes work).

> The fact that we have these regular meetings helps, but in the end, it depends a lot on people. The initiative of certain people is important because otherwise it will just die. (IP)

The junior policy staff that co-managed with their counterparts from other sectors to prepare materials for action situations 2 and 3 carried out most of the informal administrative support. This included preparing draft agendas, reporting on progress, planning and organising the meetings and ensuring communication and follow-up. They applied boundary rules to collect ideas about what is current or forthcoming on the agendas of relevant international institutions, hot topics in international conferences, and any urgent issues that are of relevance to situations 2 and 3.

> We discuss, sometimes we disagree, but usually we find an agreement on topics that are relevant or important to discuss. We then come up with the agenda, it usually passes through (the consultation with senior staff), and then we invite the whole group. Then we prepare the guidelines for our chairs to lead the meetings, take minutes, and if we have external actors that come in, we do the outreach and coordination with them. (IP)

The informal interactions of the core group are mechanisms through which external ideas flow into the Swiss NPGH arena. These ideas were usually related to content areas or priority topics on which Switzerland would be expected to engage and respond in international institutions or other multilateral venues.

The interaction rules for senior staff in situations 2.a and 3.a were very open ended, primarily aimed at maintaining an open dialogue between sectors. The senior level public administrators shared updates, exchanged information and sought advice on matters related to global health policies and governance.

> In a formal way, you have to develop a common position – where we consult each other and where we are interested to know what the other actors think and what kind of a position they would have. Then there's the more day-to-day business, where depending a bit on the needs and opportunities, we meet more frequently on specific issues. (D)

In addition to benefits for the work in the Swiss arena, some informants mentioned that this regular dialogue also contributed to developing collaboration on matters related to their own institutional activities related to global health outside of the remit of direct oversight by situations 2 and 3 because they could build on the relationships and information constructed in these situations. The core group of actors from the Swiss NPGH action arena are also the same actors in the intersectoral group responsible for implementing the Federal Council's official mandate to the FDHA for the Swiss delegation's participation in the World Health Assembly.

> Coordination is a lot of extra work, but it is shaping policy. Shaping the process means that we need to pre-discuss internally and to decide, and it empowers the delegations acting on the international level. When we do this here, the delegates have a clearer mandate. (IP)

The informal interactions of the core groups influenced the agenda setting for the formal sides of these action situations. The detailed preparation of situations 2 and 3 by the core group created a streamlined and structured space for the interaction rules (for decision-making) to be applied efficiently during the formal Idag GAP and Idag GIG meetings. In this manner, the core group exercised a lot of power over the scope of the interactions in the administrative-technical formal situations 2 and 3. This approach has been critiqued however as restricting the reflection of the actors in the administrative-technical situations with meetings that are too infrequent, short and framed in advance without opportunity for reflection, debate, or dialogue amongst actors because time is allocated only for progress reports. However, one informant noted that these processes are improving.

> I find the meetings are more and more productive. I think it really has evolved from more providing information to exchanging information, exchanging views and joint discussion. The discussions are constructive. (H)

2.2.e Situation 4 – Executive Support Group

The Executive Support Group *(**Figure 3.4**)* is a strategic situation that spans the technical and the political levels of the Swiss arena. This situation serves as a bridge between the two, mostly to resolve issues before they take on a political dimension that would necessitate a lengthier process. Its purpose is to make strategic adjustments, troubleshoot, and ensure appropriate linkages between the relevant aspects of the work of their agencies. The situation was held as a "breakfast meeting" among executives from the public administration (Director of Offices or Ambassador level) to have "meta-level discussions"(IP) and discuss "thorny issues" (H) between actors who have sufficient knowledge of the technical aspects and are also well-informed of the political implications and able to make decisions about what issues necessitate action at a higher level or not. One informant described the situation as central to arena at large, "where the real stuff is developed and where the absolute key to success to the whole thing is happening, which is trust-building."(H) The Executive Group met about five times a year to focus on any lack of consensus in either of the interdepartmental working groups or issues which junior staff (situations 2.a and 3.a) have flagged up critical for attention, but it also has an advisory function for collective reflection and counsel from colleagues regarding particular challenges within an agency. There is an implicit understanding that taking problems to the IK

GAP or the Federal Council should be averted, so actors are motivated to solve problematic concerns at this strategic level with other actors who have authority but who are closer to the issues than those higher up politically.

> This group might say, "This is a problem, we solve it now." And then they solve it, and it's solved because if these six say it's like this, then it's done." Or it could go to the government for decision. That's how you can escalate, if there is a need. (IP)

The strict boundary rules for this situation restrict access to senior level public administrators (no alternative replacements or proxies allowed), so that there is an equally shared capacity to make strategic decision on the spot. Participants include the senior members of the Swiss Agency for the Protection of Intellectual Property, the FOPH of the FDHA, the Sectoral Policy Division of the FDFA, the SDC, the SECO, and the State Secretariat for Innovation and Research.

While there is an agenda, when an actor has the floor to speak, any item s/he wishes to raise is up for discussion. The interaction rules establish an obligation to share one's opinion and analysis with the group on the issues raised because every actor must speak in response to problems on the table for resolution.

> If you are forced and someone says to you, "Now, you have the floor, what is your opinion?" Then you will say something. If you are hidden in your office, you will not send me an email today. You have no obligation to do that. So, it is a transparency mechanism. It's also pressure. If five have presented something, number six cannot say, "I abstain." (IP)

These boundary and interaction rules were intended to ensure open participation, and informants from this situation expressed that the rules of the Executive Support Group have contributed to trust and confidence-building that is both an ingredient and a product of the Swiss arena through strengthening relationships between the sectors mainly via relational power between the senior level actors, especially since the membership of situation 4 overlaps with the core groups of situations 2 and 3.

2.2.f Situation 5 – Stakeholder Platform

The Stakeholder Platform *(**Figure 3.5**)* is a situation held approximately on an annual basis (every 12-18 months) since 2010. The situation was officially sanctioned as integral part of the Swiss NPGH arena with the adoption of the *Swiss Health Foreign Policy* in 2012 that

formalised stakeholder dialogue in the Swiss NPGH policy design. The core group of the Idag GAP (situation 2) has positional power for this situation because it sets the agenda, decides the programme, and invites stakeholders to participate. The purpose of this situation is to share information between actors within and outside of the Swiss public administration about the *Swiss Health Foreign Policy*. The interaction rules for the Platform support dialogue and exchange of ideas between actors, but they exclude the possibility of direct participation of civil society in decision-making related to the Swiss NPGH arena.

> But the aim, it's exchange, it's information and this is already good. Basically, this was the first thing we wanted, that we really know what the frame of this health foreign policy is doing, but it's not a place where you get influence on it, decision-making on this. (CS)

The Swiss administration informs non-state actors about what it is doing (e.g. priorities, achievements, expectations) and stakeholders can comment, question, critique, and make specific requests. The boundary and interaction rules are used to organise the Stakeholder platform meeting around particular policy topics or themes of interest to the Swiss arena. This took place in interactive panels to allow Swiss state actors to outline the administration's approach to these issues and allow stakeholders to present and discuss their activities in those domains (e.g. neglected tropical diseases, health personnel migration, Ebola).

> This dialogue is very helpful to kind of inform both sides of what the current thinking is, of what the current issues are. So, both sides can take into consideration what is being discussed. (H)

The number of actors in a formal meeting of situation 5 ranges from 40-100 people. The boundary rules for participating in the Stakeholder Platform provide access to a heterogeneous group of actors working outside the Swiss public administration whose day-to-day work is related to Swiss public health, global health, or international health cooperation. The actors include civil society, private industry, professional associations, scientific institutions, academia and education, lobby groups, NGOs, and the Swiss Ministerial Conference of Cantonal Health Directors (e.g. Doctors without Borders, Swiss Tropical and Public Health Institute, University of Geneva, Novartis, Nurses association, Public Health Switzerland). It is a particularly important situation for the FDFA because the SDC and FOPH have more regular and close contact with implementing actors and networks as part of their institutional mandates and operations. One of the results of the stakeholder platforms is the sensitisation of government actors to the strengths, weaknesses, opportunities, and challenges from the perspective of implementing agencies and

NGOs, as a way to "take the temperature of stakeholders" on different issues for the Swiss arena. While the purpose of these meetings is not policy development, the exchanges and learning can contribute to ideational materials for policy development discussions in situations 2 and 3.

> We present what are we doing in this foreign health policy, and what are our expectations. They (civil society) also tell us what they're doing. The stakeholders are quite heterogeneous, so they're not all working in the same field or sector. They could be from the private sector, or could be somebody from an NGO, either working on Swiss health policy, or in development cooperation. So, between them they don't have a common position where they could say to the Swiss government, "This is our position." But we want to hear their concerns. When you develop a policy position, it is important to know where there's some sensitivities, where to be careful. We don't guarantee that we take their positions on of course. It's still the government's position. But it's also important to get in touch with the people that work on the ground, or that have good ideas, and maybe have different kind of networks (e.g. research). So, I would say it's fruitful inspiration. And for them it's also important to see what is the government doing. Where are things heading? They could maybe say, "You should talk to them", or, "In our view, this is going down the wrong direction." You don't have position or something that comes out of it. It's really more about having an open exchange. (FA)

Although the Stakeholder has been recognised by participants as a useful mechanism for information sharing, there appeared to be a lack of clarity about the rules of engagement from the perspective of the civil society organisations for the Swiss arena. In addition to the annual platform, there are ad-hoc meetings with certain stakeholders related to themes and priority areas identified by the administrative-technical situations (situations 2 and 3). This raises questions about the relationship of Swiss NPGH to the work of civil society organisations and global health practitioners (see Section 5 of this chapter).

2.3 The interplay of rules, resources and power in the Swiss NPGH action arena

Position, boundary, and interaction rules structured the individual action situations (see ***Table 1***), and actors used them to lead and coordinate, to organise the actors participating and materials used, and to manage interactions and decision-making (see ***Figure 3***). Through the analysis of the rules in use for individual action situations, the inter-relationships between the action situations, and the data on the particularities of the Swiss system, I derived a set of rules for the Swiss NPGH arena (see ***Figure 4***).

2.3.a Configurations of power

Position and boundary rules for the core groups

While boundary rules for the Swiss NPGH arena gave access to a multisectoral representation of actors from the public administration, the position rules of the Swiss arena created a smaller core group of four sectors (see ***Figure 3***) that were jointly responsible for the two administrative-technical situations considered the pillars of the arena (see Sections 2.2.b-d of this chapter). The shared dispositional power between these four sectors had a unique configuration for situation 2 (H, D, FA sectors) and situation 3 (H, IP sectors). As a unit with joint responsibilities for the Swiss NPGH arena's intersectoral operations, the core group also oversaw the application of the boundary and interaction rules in the arena, which also includes the power to modify/restrict/reinterpret the rules for the formal parts of the in the administrative-technical situations (see Section 2.1.f of this chapter). I found that the sectors with the dispositional power in the core group also had power over exchanges of relational power (what resources actors contributed to rule-based decisions). The actors from sectors who are not core group are not necessarily passive participants, since the interaction rules required the same opportunity for discussion and consideration of any divergent opinions in the decision-making process, but they were more removed from the agenda setting processes for the situations which could be said to take place 'backstage' in the informal side of the arena (situations 2.a and 3.a).

The positional power of the core group is mainly expressed in the administrative-technical situations through its guardianship of the agendas for the meetings. According to the position rules, the core groups were responsible for the surveillance of the GHG institutions' agendas and multilateral partnerships of interest to Switzerland to identify the key topics on which the government needed to position itself, and prepare any material necessary for the formal parts of the situations to do that. With the preparation of the agenda, documents and issues in advance by the core group in the informal side of the arena, most of situations 2 and 3's time was spent on information update and review of progress, and there was little space for emerging new ideas and collective reflection (see also Section 5.2 of this chapter). Since the ensemble of the core group represents most of the sectors involved in the multisectoral arena, as issues shift from the informal to the formal side of the arena, the margin of possibility for actors to change policy and

influence new directions is reduced, although not entirely diminished (due to the interaction rules).

The progressive construction of the core groups

The core group of the Swiss arena for NPGH developed gradually, from the bottom up, and largely due to the initiative of a boundary spanner from the FOPH (see Sections 2.1.b-d of this chapter). The group began with the building the relationship between the FOPH (in the FDHA) and the Political Division V (in the FDFA), and continued with building that between the FOPH and the IPI. These were the main sectors that were initially very heavily invested in the idea of the intersectoral collaboration for governance of health and foreign policy matters, and their interactions were key in building trust and understanding between sectors to that were instrumental for producing the policy content and institutionalising the collaboration instruments of the Swiss arena for NPGH (see Sections 3.1-3.4 of this chapter). There were some political barriers hindering the involvement of the development sector in the early phases of establishing the NPGH arena's pillar situations (2 and 3) for developing of the first document until about 2008/9, after which time the development sector was integrated as a sector in the core team. Some changes in the context regarding leadership in the Federal Council and in agencies as well as institutional reform and restructuring of the SDC (see ***Figure 1***) and the trust-building outcomes (see Sections 3.3-3.4 in this chapter) that generated more interest from development that facilitated the elimination of those barriers for them to join the co-ownership of the core group. As one informant from foreign affairs explained, it was an instance where "political commitment" was missing from a key agency because there was a lack of interest and lack of trust on the part of the development agency, which has sufficient financial independence from the FDFA under which it is situated that it remained reticent regarding any opportunity to collaborate in the *Swiss Health Foreign Policy*. The first edition document of the Swiss arena only had the formal agreement of the Director of the Federal Office of Health and by the State Secretary of the Foreign Department.

> The actors in the development agency were very independent in their policy-making because they aligned their work to their budget. They are theoretically integrated in the FDFA, but they were very independent. We came very far at high levels in the FDFA and the FOPH, and often we were still waiting for comments from people from on the development side. They were dealing with other matters, or they were not interested, and they took this collaborative exercise as more of a risk than an opportunity. For the first edition, the results were, political commitment from foreign

> affairs and from health, and development people just took note of that. Also, other ministries they understood that this could be interesting, that there could be synergies, but they didn't really commit themselves to that. So, it took all time it took to bring them really on board. (FA)

> It was difficult initially to figure out what could be part of mutual interest because our major partner and ally was the SDC. The problem was that they always had millions and millions of dollars, and we had none. The SDC had a budget of billions, and the FOPH had a budget of $1 or $2 million. They didn't want us to interfere with their priorities. Depending on the period, health was high in the agenda, then it was low again, then it was more development, or democracy, and then the MDGs. They had their money and their mandate, and they didn't want to have that coordinated too much. They were the like the rich brother, and we were the poor brother – that was the difficulty in that configuration. (H)

By the time the deliberations began in 2010 for the second document (that was adopted by the Federal Council in 2012), the SDC was an equal partner in the multisectoral core group and actively participated as such in accordance with the position rules. At that time, a decision was made that the SDC would be responsible for the evaluation of the *Swiss Health Foreign Policy* in preparation of the second version, but due to a lack of resources available, the core group opted for a self-evaluation. The lack of structure to the evaluation process was a surprising finding in the Swiss case of NPGH. Switzerland has a strong tradition and practice incorporating evaluation into policy projects (including a percentage of the budget for this purpose) that are generally conducted 12-18 months before the end to feed into decision-making about the next period. But the evaluation processes had not been pre-defined or budgeted. "Evaluation in this sense was not considered to be one of the key processes. So, it had to be somehow a bit discussed and invented on the spot."(D) There was a favourable consensus among partners that the multisectoral cooperation of the NPGH arena had been productive for Swiss governance in global health, and as one informant from the health sector said, "It was clear, we wanted the next one, except the evaluation which was a pure disaster, and obviously, it was not good."(H) Despite the lack of resources, the 'self-evaluation' was conducted, and while many key informants spoke about that step in the process, I had no access to the evaluation report for the first version as part of our effort to collect archives of the policy process, whereas I did receive a copy (for information, not for sharing) of the mid-term evaluation of the second version of the *Swiss Health Foreign Policy*.

2.3.b Sources of power

One of the reasons for the lack of resources for the mid-term evaluation of the first edition of the policy arena's intersectoral governance arrangements may be due to the fact that the *Swiss Health Foreign Policy* has no attributed resources. "It's doing more with the same existing resources. It's not contradicting each other all the time in the Swiss representation towards outside for more coherence at international-national levels."(H) Actors who constructed the arena made an explicit choice to separate governance arrangement and financial arrangements for Swiss intersectoral collaboration in the governance of global health (see also Section 5.2 of this chapter). Because the action situations in the Swiss NPGH arena were run without additional financial resources, other types of resources take on significance in the action situations (knowledge, social, political and temporal), especially in the core groups.

I found that differences in resources between sectors were a source of tension in the effort to construct the Swiss arena for NPGH. As mentioned in the previous section, the SDC's budgetary independence seemed to increase its relational power relative to the other actors in the Swiss NPGH arena. The SDC's financial autonomy stems from a unique allocation mechanism every four years (rather than annually) for approval of foreign aid budget by Parliament (through the Dispatch on international cooperation), which gives the development agency discretion and freedom with regard to planning expenditure of its multi-billion Swiss Franc budget against broad objectives related to its mandate. When there were funding needs within the Swiss NPGH, the SDC held increased relational power because other actors see it as a potential funder of projects and ideas arising from the Idag GAP or Idag GIGE (see also Section 3.5 in this chapter).

> At the level of the Idag GAP, resources play also a role in terms of who can bring in expertise and money actually in order to defend and to take position on a certain topic. The development cooperation generally has the advantage that not all our resources are really all the time planned. We are an important actor because we are a potential financier. This gives us some leverage within the whole setup. Because we have some resources available, they have come to us and asked, "Would it be possible that you finance this and that?" Within this setup, it gives us some bargaining powers. From that point of view, I think resources are naturally very important and set somehow also a part of the game. (D)

While these conversations may take place between individual actors, the interaction rules for joint decision-making and management within the action situations mitigated the inequitable weight of material resources over other kinds of resources that boundary rules would favour. The

Swiss case demonstrated that material resources were not the most important source of influence (in absolute terms) in a multisectoral arena when rules exclude budgets from constituting dispositional power. For example, the FOPH became the central connecting actor that "drove" the development of the arena that produced the *Swiss Health Foreign Policy* (see Section 2.1.f of this chapter), even though it has a smaller budget with limited funds for WHO compared to SDC's budget for international cooperation and development.

The boundary rules for the action situations ensured the necessary sectoral representation so that actors with access to the main situations in the Swiss arena brought diverse types of resources to contribute from their institutions that the administrative-technical situations could mobilise for its interdepartmental deliberations. Taking the SDC again as an example, the organisation had a worldwide network (social resources) in health that has been built up through its bilateral work with countries in the global south, and a broad range of technicians (knowledge resources) with expertise and knowledge about health system strengthening, access to medicines, and neglected tropical diseases. The FDFA brought its network of contacts in strategically important embassies and missions (political and social resources) and negotiating skills (knowledge and positional resources). Other non-core group actors like Swissmedic, for example, had narrower focus and therefore highly specific knowledge and social resources for regulatory systems.

2.3.c Sharing of power

Rotating co-chairs – horizontal management and distribution of power

The position rules for the Swiss arena of NPGH distributed power between four main sectors that formed a core group (see ***Figure 4***). The position rules were established to uncouple power from sectoral (ministerial) territory. These rules created power sharing arrangements within the core group (situations 2.a and 3.a) that were also applied to the administrative-technical situations (situations 2 and 3) where the core group acted as a unit to share power as co-chairs.

> The co-chairing is an interesting feature. Some other sectoral policies failed because of disagreements about who would chair. We deliberately went for co-chairing arrangements. (H)

The co-chairing rules regulate sharing of organisational and leadership responsibilities between the actors from the sectors in the core groups of the Idag GAP and the Idag GIGE in the informal

side of the arena (see Sections 2.1.f, 2.2.d, 5.2 of this chapter). But within the formal side of the arena, the rotation rule for chairing the meetings of the Idag GAP and Idag GIGE (see Sections 2.1.f, 2.2.b, 2.2.c of this chapter) determines a circulation of the formal convening and chairing responsibilities to preside over individual meetings.

The core groups shared the power for planning, framing, and organising formal meetings of the administrative-technical situations, but the power to hosted and run the meetings alternated between actors in the core groups. For example, if the Idag GIGE is holding a formal meeting at the FOPH, then the IPI will preside, and vice-versa.

> Actors in the Idag GIGE may come to the Institute of Intellectual Property with the perception now we're with the good guys and some come with the perception of now we're with the bad guys, it all depends from where you come. This perception is immediately destroyed if the Public Health person comes and chairs, or if the Intellectual Property person chairs the meeting at the FOPH. We separated power. (IP)

The rules-in-use for the rotating co-chairing between the core group actors created processes of reciprocity between the sectors. The rotating co-chairing rule aimed to share power among the core group through their interchangeability as authority figures and communicators for the administrative-technical situations. I found that the rotation of chairs appeared to serve as evidence of trust (see Section 3.4 of this chapter) and a means for its authentication by the non-core group members of the Swiss arena. Rotation rules established the expectation among core group actors that chairs would consider the other sector's interests and items as their own, and show equal support in handling issues that were outside their institutional mandate. This required a great deal of learning within the core groups, so that when a given sector presided over a meeting, the chair was as versed in the issues and stakes as if it came from their own sector. The rotation rule constituted an intentional strategy to support understanding between sectors of their respective instruments, issues, values, and priorities to more efficiently lead to compromise (interaction rules).

Interaction rules for joint decision-making – relational power to decide (or limit decisions)

The rules-in-use for interaction in the Swiss arena for NPGH were encapsulated by the requisite of consensus for decisions, or the "Swiss way" of doing things.

> Everything is joint decision. Everything is consensus based – we're in Switzerland. We build up consensus. Working through dialogue, that's the way we operate (H)

One of the reasons that the *Swiss Health Foreign Policy* was applauded by many of the informants as a notable achievement at the federal level seemed related to the challenges of applying rules for consultation, compromise, and consensus (or *Swiss C's* as one informant referred to them), which are deeply ingrained in the Swiss political context (see ***Figure 1***), within a such normative policy on multisectoral governance.

> That's very Swiss. This kind of consultative processes is technically handled in a very participative way, with key actors being invited to take a position. This also reflects the kind of a Swiss compromise. You have always to do a little bit right to everybody. Typically, for example, you cannot neglect the pharmaceutical industry here. (R)

The Swiss arena for NPGH reflected and reproduced the Swiss context and the obligation for (large, if not full) consensus to move ahead with any decisions. However, the position and boundary rules for the Swiss arena cannot override the interaction rules. Once issues are identified for decision, all voices and inputs are considered in the process towards consensus by discussion. The interaction rules organised the decision-making processes so that every actor with access to them must be heard, and when there are conflicts, the concerns of all parties must be taken into account and considered equally, regardless of their sector of origin. However, some actors from civil society questioned whether some of these conflicts were muffled by the silent power of economic government actors (e.g. State Secretariat for Economic Affairs), who in a liberal economy "really say what is going to happen." However, many actors saw conflicts as a predictable part of the process of multisectoral/interministerial cooperation, and they saw security in having a rule-based process to work through tensions and reach compromise through for dialogue between government actors in the Swiss arena for NPGH.

> You can discuss as long as you want, but at the end of the day, we have a mechanism to take a decision. Sometimes our position, specifically when it comes to developing countries, has a higher priority. In other issues, the tobacco debate for instance, our leverage is clearly less, even though tobacco is addictive and a huge problem in developing countries. There are many Swiss economic interests in that. We are fighting for some common position, but we really have also to compromise. Tha''s the nature of the process. I don't want to say that now with our policy everything is fantastic. We naturally have power games. We have controversial interests. It's clear that the interests sometimes of the Swiss pharmaceutical industry is not 100% aligned with the interests of our development policy and the values of our development policies. You have all these fields of tension, but at least you have a well-established process for how you discuss these issues,

> where you discuss it, and what are the different roles of discussing and how you come to a common and joint position. I think this is one of the big advantages. (D)

> Of course, there are some potential conflicts. Take for instance, access to quality of therapeutic products. The position of the Swiss Development Cooperation is not always the same as the position of the Federal Institute for the Protection of Intellectual Property. But each office within the process of designing this policy, need some concession on their initial position, in order to take that into account, the point of view of the other. And the goal does take into account the legitimate concern of these two partners. That's not by chance that we mention not only access, but also quality. (FA)

Actors carried their institutional mandates into the Swiss arena as part of their sectoral identity and resources, with the understanding that a compromise must be found on each item for decision (interaction rule) even if there was not unanimous agreement with it. The institutionalisation of rules (see Section 3.2 of this chapter) and trust-building between sectors via individual actors (see Section 3.4 of this chapter) together bolstered actors' participation and compliance because of the defined structure (rules) of the cooperation in the two mainstay administrative-technical situations (see Section 3.1 of this chapter). In the Swiss arena for NPGH, it was inconceivable to negotiate power on an ad-hoc basis rather than a deliberate basis on which all agree to follow if concerns of actors involved must be recognised as legitimate.

Tools for relational power adjustments – resource development and exchanges

In addition to the rules for action situations in the Swiss arena for NPGH, there were several more specific institutional arrangements and tools that promoted the development and exchange of resources in a network of actors from the sectors in the core groups. One tool was that of secondments and rotations between the health and foreign affairs sectors.

> We were actually quite innovative. We started offering positions for people in the foreign affairs to come to join the FOPH for a short term. In the beginning, we had a hard time to convince someone to come, but then it became an attractive post for diplomats coming back to Berne to work with the health sector on diplomacy instead of being at a desk job in the FDFA. (H)

These secondments were arrangements intended to bridge the sectoral "cultural" divides and improve the understanding between sectors about their issues and working methods.

> I think the secondment aspect is important, because you do not have a secondment if you do not have a sufficient level of confidence. First one has to build up the coordination, and you can build up the confidence step-by-step. The instrument of the secondment is certainly a way to build up confidence. (FA)

The secondment tool gave the actors from health and foreign affairs sectors an "insider's" perspective into each other's operations and practices. The secondments improved relational power of both sectors by serving as nodes to connect the networks of each sector. The secondments equipped the health sector with the skills and policy instruments of the foreign affairs sector that it needed for using diplomacy in GHG.

> If you go into climate negotiations, you don't need to be an environmental scientist. If you go into cultural diplomacy, you don't need to be an artist. We had enough doctors and health experts in the ministry. We wanted people with expertise in diplomacy. (H)

Since the establishment of the IAD at the FOPH, a trend developed around hiring career diplomats rather than medical doctors or public health experts. The foreign affairs sector used learning from their experiences with the secondments in FOPH as power sharing arrangements for transferring these tools to other areas for collaboration with other sectoral policy areas (see Section 3.3 of this chapter).

Aside from the frequent interactions between actors in the core groups on the informal side of the Swiss arena (see Sections 2.1.f and 2.2.d of this chapter), some of them also attended other sectors' internal (sectoral) team meetings. For example, one informant from the foreign affairs sector reported that for several years the person in charge of health issues within the Sectoral Division of the FDFA took part in the weekly meetings of the Division of International Affairs of the FOPH, for which "here again, you needed a certain level of confidence of trust."(FA) This was another micro-level institutional arrangement and tool for developing and exchanging resources for improving relational power between the health and foreign affairs sectors. Increasing the interactions between actors were investments in calibrating the relation power between sectors to ensure better mutual understanding when dealing with contentious issues for decision-making in the action situations.

> If you can establish good working relationships with the people who are shaping those policies or driving those policies in the other department, you acknowledge the differences and that those differences can be bridged and overcome. It's a positive circle because you're bound to meet and bound to discuss through this institution that we created and that increases interaction, and that's usually quite conducive to better understanding. And the more you see each other for informal exchanges, this also establishes good working relationships for being able to find a consensus and work together on current topics. (IP)

The electronic platform *CH@TWorld* is also an important tool for relational power when consulting on Swiss positions for global governance (see boxed vignette in Section 2.2.b in this chapter). The foreign affairs sector relies heavily on this tool, not only for consultations on GHG issues, but to define common positions with multiple sectors in the Federal Departments on many issues in the UN context. The Division of International Organisations in the FDFA manages most of the coordination of the UN negotiations on the platform to give instructions to the negotiators on site (whether in Geneva or in New York) based on the outcomes of the consultation.

> This is a really transparent way to work because everyone sees what the other ministry or office is proposing, and where are the differences. If there are big differences, we'll try to settle them first with a phone call. If that doesn't work, we'll set up a meeting. And then we also have the possibility of going up the hierarchy. At the end, if we would not find a solution or a tactic, it would have to be the Federal Council that decides. (FA)

The Swiss arena for NPGH used a range of tools outside the formal action situations to adjust the relational power between sectors for improving the applications and use of interaction rules within the formal action situations.

Section 3: What are outcomes of Swiss NPGH action arena?

This section discusses what results from the interactions between sectors in the Swiss NPGH arena based on the analysis of what action situations produce.

3.1 Policy design – interaction produced content

The interactions between sectors in the Swiss arena for NPGH produced policy content of two versions of the *Swiss Health Foreign Policy* (the first version being an agreement between the FDFA and FDHA in 2006, and the second being a policy adopted by the Federal Council in 2012). The *Swiss Health Foreign Policy* was referred to by many of the informants from different sectors as a "coordination document" for the Swiss administration.

> It's a coordination paper about how the different departments within the administration have an effect on global health issues. This document reflects how they want to coordinate this. It helps that these different actors really know from each other what they are doing. It helps to bring some issues in a coherent way forwards towards international organizations – WHO, Global Fund. (CS)

The choice to produce a policy on governance processes, rather than issues, for collaboration between departments (ministries) on Swiss government action in governing of global heath was a

deliberate choice. As one informant from the health sector contrasted the Swiss policy documents (2006 and 2012) to that of the UK, for example, it was noted that the Swiss thought "it's better to have something thinner, and then policy papers developed separately."

> The policy describes the key processes. Within these key processes, somehow the roles, procedures, etc. are quite clearly described which is helpful because they do not need to be re-discussed every time. It's very clear that the processes are in place and that everybody somehow has been following it. (D)

For instance, having these processes in place facilitated the preparation work on the strategy development for Switzerland's WHO Executive Board seat (2011-2014) since "already having the overall health foreign policy, it was not necessary to have a huge process for that (WHO EB) one, because you go on with what you're doing anyhow."(H) These processes were also used to guide the work of situations 2 and 3 in the development of the policy briefs and policy papers on specific topics (as discussed in Section 2.2 of this chapter). Multiple informants from the core group mentioned that the processes that outlined policy content of the *Swiss Health Foreign Policy,* which underwrite the rules for the operations and procedures of the action situations, are valuable because of their adaptability to a diverse range of themes and topics. "It's important because it gives structure to the cooperation. In other areas, good or bad cooperation depends on the people. When you have such a more structured framework, you are obliged to cooperate better."(FA) This means that when global health emergencies arise (e.g. as with Ebola in 2014), a structure for multisectoral governance and decision-making is in place to be tailored to the issue at hand.

The adoption of this document by the Federal Council in 2012 was a milestone for the Swiss arena because it validated the working processes described in the paper. "We have objective legitimacy because the government has approved this whole thing."(IP) Considering the political and policy-making context of Switzerland as a decentralised country where decision making at the national level is limited, the adoption of this policy content at the federal executive level of government was considered a major achievement. "There are relatively few of these kinds of policies in Switzerland. So, in that sense, I consider that as a very valuable and a good document. I think they set a certain normative framework which such a policy document has to do."(R) Nevertheless, the content for some actors outside of the administration appears to

camouflage underlying tensions and power issues. As a document that reflects "the minimal consensus of quite a broad range of actors"(R), "it's not a document that really brings fundamental contradictions out of the negotiating room and on the table."(CS)

> It's very important to have this coordination document to know how they find their position, but there are conflicts that cannot be written away by this document. (CS)

3.2 Institutionalisation – interaction produced routines and expectations for intersectoral collaboration

The interactions in the Swiss arena for NPGH have produced a set of routines and expectations that resulted in the institutionalisation of the rules for the action situations.

> The main aspect of success is that it provides a common basis for cooperation mechanisms in the Swiss administration between offices involved in health aspects. And I think this is really the important part -- that you have coordination, cooperation between the different offices that is institutionalised based on the foreign health policy. This provides a more efficient, a more consolidated, more professional, more efficient way of working in this area. And when you go to meetings, you have positions that are agreed and consolidated within the administration. This strengthens to the positioning of the Swiss foreign health policy. And it's still quite a unique instrument. Such a complicated policy, and yet it is accepted and kind of lived by the different parts of the administration. (H)

Over time, these processes became a way of working for the sectors involved in the Swiss arena for NPGH, especially those in the core group. The core groups have been instrumental in this institutional process because the two administrative-technical situations are considered as "the major pillars, established forum of discussions and of finding consensus on fresh topics."(IP)

> Interministerial collaboration is a challenge because you have all these technicians within the ministries with different agendas, and so the coherence issue is a tricky one. With the policy we have in place now, we have quite clear processes, committees, platforms for how this collaboration should be structured. (D)

The institutionalisation of the multisectoral collaboration for the core groups has transferred the rules for the structural environment of the Swiss NPGH arena into their own institutional practices as part of the regular methods for working with each other on health matters.

> Everything is coming bottom up. We are meeting every six weeks to have lunch together, where we kind of do our shopping list together, would you have and we just exchange it, and we get everything on the table and we say, "What's going on with this? What is important? What's that?" (H)

> In terms of daily work, those two groups are the ones driving it, and where it's happening. Sometimes the lines can get to be blurry, and sometimes work just happens between the actors that are part of one of those groups, and so sometimes there might not be exactly clear lines. But the coordination and oversight are a given, even if it is informal. If there are topics of common interest, they will be discussed debated in those two groups and it's not going to be done in some other group and without either of those two groups being aware or being informed about it. (IP)

While this manner of working with regular exchanges and collaboration between the foreign affairs, health, and development sectors appeared integrated at the time the field work for this study was conducted in 2015, this was not the case at the start of the processes leading up to the first interdepartmental agreement in 2006 where actors were working towards abolishing some silos. The reflection of the informant below crystalized the difference between then and now, and how the institutionalisation of these collaborative rules takes time.

> In general I have a very positive appreciation of what has been done because during the deliberations for the first edition, it was really difficult to manage the different (sector's) responsibilities, and there were few who saw the opportunity of collaborating in a positive light. But this was a very important process. I think people got to know each other, people got to know that there were other actors in the field that had something to say, that they had expertise, and that they could help achieve goals together. (FA)

I found that a "de-politicisation" of the Swiss arena was also an indication of the deeper institutionalisation of the Swiss NPGH rules. By de-politicisation, I refer to the loosening or relaxation of boundary rules for the political level situation (IK GAP) that are less restrictive in terms of access to actors who are not from the State Secretary level. For instance, an informant from foreign affairs noted that Deputy level personnel are increasing being sent to participate in their place. It is difficult to situation this finding in the timeframe of the study but it appears to have begun in the period around adoption (which also corresponded to changes in the Federal Council and leadership of the FDFA and FDHA, as well as senior staffing changes in the FOPH). Furthermore, there appeared to be a shift in the responsibilities of the administrative-technical situations (Idag GAP and Idag GIGE) around the time of the adoption, which initiated a process of the strategic and political levels gradually giving more authority to the core groups.

> In the beginning it's like, "Okay, we have to organise the next IK GAP." The less we organise the IK GAP at that level, it means the better we work together at lower level. We even take decisions ourselves, and then we inform our directors and they say, "Yeah, just do it."(H)

3.3 Demonstration – interaction produced validation of a model and tools for adaptation

The interactions of the actors from different sectors in the Swiss arena for NPGH produced a model of intersectoral collaboration for the FDFA use as an example for working with other sectors on policy that has international elements or links with global governance institutions. "We're saying, 'Look at this, how it works.' It's really a success for us." (FA)

> The process was positive within the FDFA because we had people working on humanitarian affairs or human rights which are typical international issues who realised that there are other sectoral policies, like health, that are also important (international issues) for Switzerland. This important for foreign affairs but also the other experts saw that a more coherent approach sometimes needs compromises in the long run. Then we used also this foreign health policy in a certain way like a model because, in a way, it was the most developed way for foreign affairs to collaborate with other departments. (FA)

From the perspective of the actors from the foreign affairs sector, the interactions in the Swiss arena produced relevant experiences used for policy learning to show other ministries that there were available frameworks for working between the ministries on policy goals of common interest.

> This exchange, or placing foreign affairs people in different ministries for a few years, was also part of the structure for developing the *Swiss Health Foreign Policy*. This kind of secondment or personnel exchange is one of the examples that we're interested in replicating with other ministries. We have diplomats in economic affairs and in environment, but we don't have them in all departments or offices. With the Swiss Federal Office of Energy we have an agreement for a partial secondment. A diplomat is being fully paid by the Department of Foreign Affairs but works 50% in the Swiss Federal Office of Energy and 50% in the Department of Foreign Affairs on energy issues. (FA)

The foreign affairs sector wished to use the results from the multisectoral collaboration for Swiss policy on governing global health as an exemplary case for advocating for more systematic, structured interdepartmental collaboration with other relevant sectors. The test case of their collaboration with the health sector for GHG was particularly appealing to the foreign affairs sector because it was not ad-hoc (see Section 3.2 of this chapter). The informants I spoke with from the foreign affairs sector expressed that generally other ministries only want to collaborate with foreign affairs when a need is identified from within their sector, and it is decided to "let the foreign affairs" into their domain.

> For us, this is definitely an example. We think that would be ideal if we could expand that in the other sectoral policies and establish collaboration in the other fields where sometimes it's not that easy. And this structure helps a lot. We are trying; we have some other (provisional) agreements now. We have to see that we live up to it, and then see how we could take this model and use it also for other ministries. (FA)

Sectoral policy areas define territories for ministries, but as soon as anything crosses a border, there is a foreign policy dimension involved. The interest of the foreign affairs sector in bridging these sectoral territories at the technical level and collaborating on solutions together with experts from the other ministries is to prevent issues from escalating into problems that require resolution at the political level. I suggest that the interest of the foreign affairs may also be to extend the idea of improving the credibility of Swiss positions into global governance of policy domains other than health (see Section 2.1.a of this chapter).

3.4 Perception – interaction produced trust and transparency between government sectors

The interactions between actors from different sectors in the Swiss arena of NPGH produced better understanding of the approaches, perspectives, interests, and values of the sectors through the development confidence and trust between the individual participants representing those sectors. The development of trust in the Swiss arena was not only necessary to strengthen the relationships between the actors, but also to recruit and convince other sectors to fully participate. Trust was essential to the bottom-up approaches used to form a critical mass of actors from different sectors to ensure that Swiss arena had the large majority to change the rules of the game (see Section 2.1.b of this chapter).

> The deliberation of the first document had to build confidence. We had to show that at least the political division of the FDFA and FOPH lived up to this engagement. The other sectors witnessed that we were not deviating from the engagement, and we were always consulting the others to see what they thought about different topics, for instance, access to medicine and intellectual property. These were the typical subjects where you have very diverging views among different actors. We were always trying to find a compromise. This process was very useful because it built trust, and that worked. You never know how it will end, but it came out well so that we could elaborate the second document, where additional relevant stakeholders participated actively and saw the interest of having it. I think that the main achievement is that we can use our network in foreign affairs better for health issues because there is now a kind of sensibility for health issues in the FDFA. (FA)

Many informants reiterated the significance of building trust among the actors in the

Swiss arena for NPGH as a necessary supplement to the building structures for cooperation. Several actors from the action situations emphasised that structures (rules) support intersectoral collaboration, but that individual people need to trust and invest in the process with "genuine interest" and readiness for building good relationships to help make those structures work.

> Swiss Foreign Health Policy establishes a clear political will that we work together and that we converge together, and so the networks are in place. What is important here is not the structure, it's the people that know each other by name and work together, and know how they work together well and how they can actually call each other to get things done. … I think at the end it comes down to exchanging information and to have this transparency to collaborate. Even if you had the structure and people would not want to do it, it wouldn't work. (FA)

> The fact that we had these institutionalised meetings made us talk. We got together, and just the very fact of having to discuss with each other improved our relationships, understanding, and trust in each other, and of course, also the concrete cases where we had to work more intensely together. Having regular meetings helps, but in the end, it depends a lot on people. (IP)

The rules for transparency were one of the main ways for building trust among the actors in the Swiss arena. These rules were strictly applied in informal and formal parts of the arena, especially within the core groups (situations 2.a and 3.a) and the Executive Support Group (situation 4), even before having institutionalised this situation. These situations relied on rules for transparency and openness to build trust so that the senior staff actors could communicate that trust to their respective teams at the junior level to operate along the same lines. Trust was built horizontally across sectors, but it had to be transferred vertically within institutions. When there is mistrust, the relationships between sectors resemble an "arm wrestling match" rather than a mutually beneficial cooperation, as one informant from the intellectual property sector explained. The trust building outcomes of interactions have been reinvested back into the Swiss arena for NPGH as resources, because having established trust between sectors at the national level frees up time and other resources to use more efficiently in the global arena for improving the position of Switzerland in the governance of global health.

> When I talk to other countries about this, they say, "Look, we would like to do this too, but you know the guys from the Ministry of XYZ, you simply can't trust them. They simply don't understand these general frames, and then it doesn't work." But I say, if it doesn't work, it means that you have, on the national level, all your energy absorbed in internal discussions that are unproductive (*or overtly protective of sectoral plans and instruments*). Trust means you need to show me the content of your back office, and I will do the same thing here. This is critical because

otherwise it's about dominating and about being more important. But the three sectors here at the beginning said "Look, we need to create solution together, and we want it to be holistic." (IP)

3.5 Cooperation – interaction produced mechanisms for new partnerships and projects

The interactions in the Swiss arena for NPGH also generated new resources and initiatives with Swiss stakeholders through different mechanisms for partnerships that build up on the cooperation established within the action situations. Because the boundary rules for the flow of ideational materials in the two administrative-technical situations are externally oriented, giving priority to the items on health-related agendas of global governance institutions, the Idag GAP (situation 2) in particular has developed into a situation that generates ideas and resources from actors for projects from different sectors related to Switzerland's ambition to increase its credibility and prominence on the global health stage. Although these projects may not have necessarily originated in these situations, some have been adopted by the information agendas as part of the activity report updates that are considered relevant to the situations' actors and work. The situations in the Swiss arena for NPGH, which are increasingly institutionalised (see Section 3.2 of this chapter), set up an infrastructure of key actors who routinely interact and have developed strong working relationships across sectors at the technical and strategic levels. The different sectors can benefit, draw from and exchange resources when they wish to collaborate or consult when developing their own specific activities and projects in line with the priorities of their individual agencies.

Such projects include 1) the Global Health Hub project as part of *International Geneva*, which is chaired by the FDFA; 2) the Swiss contributions to strengthening lab systems and antimicrobial resistance as part of its participation in the Global Health Security Agenda (USA initiated multilateral initiative related to supporting implementation of WHO International Health Regulations); and 3) the partnership to strengthen regulatory systems in sub-Saharan Africa to improve access to health interventions, led and managed by Swissmedic and the SDC (who report back to the Idag GAP on the development of initiatives under this partnership) and supported through a Memorandum of Understanding between the FDFA, FDHA, and the Bill and Melinda Gates Foundation.

For instance, the Global Health Hub project is financed by the FDFA and implemented by the Global Health Programme at the Graduate Institute. The principle behind the project is similar to that of the Swiss arena: build a platform for multisectoral dialogue between actors to improve interactions in Geneva among international institutions, public-private partnerships, NGOs, and government representatives. The Steering Group for this initiative is the same as the core group for the Idag GAP (situation 2.a) plus the State Secretariat for Education, Research and Innovation.

> It‘s quite a new project, but it shows that we develop also this kind of collaboration and ideas. Even if the funding comes from the ministry of foreign affairs, it‘s not something that we (in foreign affairs) are going to decide unilaterally, because we need to collect the ideas of others. We want to push the intersectoral links (between international organisations) to bring actors and knowledge from different sectors in Geneva together to have an impact on the health agenda. (FA)

The modification of an individual institution’s mandate that accommodated new resources and roles also altered relational power in an action situation. The relational power of Swissmedic (the Swiss federal agency for the authorisation and supervision of therapeutic products) in the Idag GAP presented an example of this transformation. For example, the revision of Swissmedic’s mandate allowed the institution to align its work more with general global public health issues regarding international cooperation than they were previously authorised by a more specific mandate. The adoption of the *Swiss Health Foreign Policy* in 2012 couple with the change in Swissmedic’s institutional framework were instrumental to designing their implementation rule in projects emergent from the Memorandum of Understanding between the Swiss government and the Bill & Melinda Gates Foundation to improve regulatory systems for access to health interventions and therapeutic products in resource poor countries.

> Within the working group, we are seen now more as an active and relevant player to support the goals and the objectives of the health foreign policy. It goes both ways. We benefit from the health foreign policy as a basis for our work, but enabling us to be engaged in this project also allows us to strengthen our position and be more actively engaged in this initiative. (H)

These examples showed how the Swiss NPGH contributed to reshaping Swiss context for action on global heath by establishing a multisectoral governance arena for following up on projects resulting from modified arrangements within institutions as well as between them. Shifts in resources of the institutional actors changed their relational power in the action situations,

especially among actors who are not in the core group, although they did not impact the dispositional power (see Sections 2.3.b and 5.3 of this chapter).

Section 4: How mechanisms of policy change operate from the GHG arena to influence the Swiss NPGH arena?

Following an analysis of the contexts, characteristics, and outcomes of the NPGH action arena in Switzerland in between 2005 and 2013, I revised the theoretical and empirical idea with which I had begun: that external factors/forces (from a global arena) exert influence on internal policy change (in a domestic/national arena). The Swiss case of NPGH illustrates how mechanisms of policy change operation through interactions of the NPGH arena and the GHG arena. These interactions construct a transnational arena for global health policy and governance, which shares elements of both the national and global contexts. It is through the operation of two mechanisms of policy change, namely the processes of policy learning and elite networking, that the transnational arena emerged as a zone for circulation of ideas and feedback between the NPGH and the GHG arenas.

4.1 Mechanisms of policy change: interaction and circulation of ideas in the transnational arena

The transnational arena was a platform for the communication and exchange of policy design. I found that the Swiss government used the adoption of the *Swiss Health Foreign Policy* by the Federal Council to validate (internally in Switzerland, and external transnationally) its model and cooperation instruments for coherency in GHG through the institutionalisation of consultation, compromise, and consensus for Swiss policy on health and foreign policy. The structure (rules) of the Swiss arena had been tested and evolving since 2005, and transnational arena was the emergent mechanism for transparency, in Switzerland's role as a legitimate and significant state actor, for showcasing to external actors the credibility of its directions and decisions in the GHG system.

4.1.a Elite networking

As a global health hub, or the international health capital, Geneva acted as a major intersection for actors from the Swiss arena to connect and network with other actors related to health and foreign affairs, even those which who may not be traditionally associated with GHG. The networking processes in Geneva between state and non-state actors (including the private industry sector) were opportunities for the Swiss arena to interact with actors in (and interested in) GHG. But as part of the foreign policy strategy for *International Geneva,* these networking aspirations were also part of the policy design and instruments of the Swiss Health Foreign Policy for increasing the position and influence of Switzerland in the GHG system. One of the goals of the Swiss arena is to support more intersectoral collaboration between international institutions within the UN system and other actors (see Section 3.5 of this chapter).

> We were the first one to design such a health foreign policy. We have a very particular political system, and you cannot transplant such mechanics directly into another country. What is important is the idea of having a cross-sectoral approach, and that's a challenge that each country faces. We were aware that we couldn't work anymore in silos – development silo, the economic silo, the environment silo, and the scientific silo. We had to gather the various actors on each of these issues. And that's also another challenge for our specific goal on the development of Geneva as a centre for multilateral diplomacy. And we think it is very important World Health Organization works more with other international institutions present in Geneva, works more with the private sector, with the academic institutions, and scientific institutions. The idea is also that the international institutions have more contact with other actors in Geneva benefit from the presence of some well-renowned academic institution, some important research centre, the presence of some important companies. (FA)

Furthermore, informants reported that their networking interactions in Geneva often took place with other state and international actors in the Swiss mission in Geneva which organised many events and meetings with partners on GHG issues and also connected indirectly to the whole network of diplomatic missions abroad. This is one type of fusion of health and foreign affairs networks that the government actors from these two sectors who built the Swiss arena from the ground up had envisioned (see Sections 2.1.c-2.1.d of this chapter), that reinforced the capacities and reach of each other's own sectors.

In addition to the key boundary spanner within the arena from the FOPH (see Section 2.1.d of this chapter) who was an internal mechanism for policy change, the Swiss arena for NPGH benefited from the networking processes of a transnational boundary spanning elite actors

whose networking was highly conducive to the interactions and circulation of ideas between the Swiss NPGH and the system of GHG. This elite actor, with a political science academic training, was a world-renowned expert and advisor in public health, global health, and governance. The boundary spanning capacities and extensive personal and professional networks which grew from over 35 years of international experience in scholarship and policy, many of which were grew from working in international institutions like WHO or being a senior advisor to these institutions, were made available to the Swiss arena as early as the brainstorming stages of the Swiss Health Foreign Policy in the early part of the 21st century. Although this person served in an advisory capacity in some instances to the Swiss government or the FOPH, the connective abilities for supporting interactions between the Swiss arena and the GHG arena were mainly derived from the "outside" transnational expert status of the boundary spanner removed from any particular government affiliation. Many informants referred to the Director of the FOPH, the Director of the Division of International Affairs of the FOPH, and this transnational boundary spanning elite as the visionary "trio" who had the acumen to develop the ideas of global health diplomacy for health and foreign policy in the Swiss context. As one informant from the health sector relayed, "health diplomacy was a concept we crafted together." In the period of this case study (2005-2013), the Swiss arena for NPGH was able to learn about conceptually and empirically from innovative experiences in other countries, and network with actors outside of its reach, thanks to the interactions with the global health arena via this boundary spanner, whom informants often referred to as a "facilitator" for the Swiss NPGH.

> She wrote articles and she was in steady contact with the FOPH. She was also going around the world, having conferences on global health policies and the global health issues. We got the feedback from that side. She was our intellectual partner. (FA)

The transnational elite also founded the Global Health Programme at the Graduate Institute in Geneva, and has served as the Director since 2008. This organisational affiliation of the transnational elite within an institution for academic and professional training has multiplied the opportunities for interaction between the Swiss arena for NPGH and the GHG arena with learning and networking processes orchestrated for transnational and intersectoral boundary spanning (see Section 5.2 of this chapter).

> The Graduate Institute in general, and the Global Health Program in particular, is a main educational player of the *Swiss Health Foreign Policy*, but an independent one, of course. So, this

> is not a player explaining the Swiss position, but a player raising awareness of people on the importance of the issues. (IP)

The prestigious career and awards in the fields of public health and global health, the vast international experience in various academic and policy institutions, and the personal and professional networks of this transnational elite were available to the Swiss arena, and the inauguration of the Global Health Programme at the Geneva Institute installed these ensemble of these global networks as resources for Swiss NPGH. In addition to the circulation of ideas between the Swiss arena and GHG facilitated directly by the transnational boundary spanning elite, indirectly the global health diplomacy training offered by the Institute is another way learning supports further capacity for interactions between these two spheres because diplomats now have a core module on health in their curriculum.

4.1.b Policy learning

In addition to elite networking as a mechanism of interaction, which facilitated the circulation of ideas, instruments and other resources in the transnational arena, policy learning is another mechanism of interaction in which knowledge about policy ideas, instruments and processes is shared between actors in the transnational arena. The governing bodies and management arrangements for international institutions, informal clubs with other OECD countries, and close working relationships with the global health actors in Geneva were forms of interaction between the actors in the Swiss arena and those outside to share experiences and learn lessons for policy change.

The governing bodies of WHO, both at the global and regional office for Europe level, were policy learning zones of interaction between the Swiss arena for NPGH and GHG. As discussed earlier in this chapter (see Section 1 of this chapter), the experiences of the FOPH leadership in WHO governing bodies were formative for the Swiss arena. The Swiss government's representation and participation in the governing bodies of WHO stimulated reflections on the needs and potential benefits of foreign affairs as a policy sector collaborator for advancing and strengthening the Swiss international health interests. During the 1990s in particular, WHO/EURO meetings of the Regional Committee regularly focused interactions

between member states on topics related to intersectoral collaboration and coherence as strategies for health equity and healthy public policy.

> We were formally, and probably more informally, always talking about policy and coherence, and needing some in WHO EURO, and of other officials complaining of the lack of coherence. That was particularly true in the context of European projects on environment and health or traffic because the WHO Regional Office for Europe tried a couple of times to have meetings where they invited Ministers of Health, Ministers of Environment, and Ministers of Foreign Affairs. I only remember one on environment and health which was really successful and where both ministries came. It was always a debate, but it makes sense, and I think that is still a big issue for WHO in Geneva. In Geneva, there are only the health people. Foreign Affairs is there, but not too much, and other ministries are not at all. So, in the *Swiss Health Foreign Policy*, we always said that this notion of co-ownership of processes is necessary in order to be successful. I think that came from my knowledge working at the WHO European level in a couple of processes, and also follow up to the to the Rio process were international meetings were starting to discuss policy coherence. So, when it came to the Swiss experience of policy incoherence, which was so disturbing, we said, "Let's try to correct for it." (H)

The interactions in international institutions provided opportunities for Swiss actors to collect and exchange ideas, strategies, and instruments for the Swiss arena. These interactions reflected that instruments and rules to respond to challenges of intersectoral collaboration for governing health were similarly needed at the national and international levels. Governing bodies of WHO, and particularly WHO EURO before the turn of the 21st century, created spaces of interaction that promoted the sharing of models, learning between member states, and adoption of core WHO institutional practices (i.e. management by objectives, intersectoral action for health). The decisions, reports and resolutions produced by these governance bodies (in which the Swiss were actively participating) were circulated back into the Swiss arena for NPGH as subject matter for the administrative-technical situations. The actors in the informal core groups (see Sections 2.2.d and 5.2 of this chapter) were vehicles for the circulation of these ideas because they were usually the same members of the sectorally diverse official Swiss WHO delegations to the WHA, and they were also responsible for agenda-setting and planning the formal side of the administrative-technical situations.

> We realised up here (at the executive level) that we were mostly driven in these discussions by upcoming events, or issues from outside, because we really didn't have an agenda internally. We didn't have a strategic plan, we just had the next meeting. WTO is coming up, what's on there? WHO is coming up, what's on there? (H)

The Swiss interactions in GHG were integral to creating the topics for the Swiss arena to deliberate. For instance, the WHO Commission on the Intellectual Property Rights, Innovation and Public health (chaired by a former Swiss president Ruth Dreifuss) produced a significant agenda for the Idag GIGE (situation 3). In the opinion of one informant from foreign affairs, the lack of Swiss "own" topics for taking leadership on priorities and action on topics that it designs, that do not come from agendas of international institutions or public-private partnerships for global health, was a weakness of the Swiss arena. Amidst the dense system of actors in GHG and international policy venues where health is debated as a component of foreign and development policy, the Swiss NPGH action arena was reactive to the circulation of policy agenda ideas from organisations in the UN system, and in particular those of WHO (i.e. global strategies, codes of practice, etc.) that affect Swiss interests (whether humanitarian, health, development, economic), which included the MDGs; pharmaceutical research and development, intellectual property and access to medicines; and health workforce migration (with exception of Framework Convention on Tobacco Control which Switzerland has still not ratified).

The Idag GIGE (situation 3) expanded interaction and boundary to include outreach sessions once a year for learning from actors outside the Swiss arena. These took the form of discussion seminars or policy dialogues, and they were designed to hear about different experiences and learn from external actors prior to a formal Idag GIGE meeting to inform the decision-making process (interaction rules) of the group with diverse perspectives on the topics on their agenda. For example, when a topic involved divergent, conflicting perspectives to be considered, these tensions were first introduced through structured interaction with experts representing the different ways of thinking from outside the Swiss arena.

> The SDC organised a lunch with a critical perspective towards intellectual property, and IPI organised a lunch with supportive thinking about intellectually property. So, it's like every family invites the guest who tells the family that you are the greatest guy. (IP)

These learning-oriented activities were mechanisms for interacting with actors from the GHG system to share ideas and innovations related to access to medicine debates. The World Intellectual Property Organisation Research, Medicines Patent Pool, Drugs for Neglected Diseases Initiative, Médecins Sans Frontières, and Access to Medicine Index were some of the organisations and NGOs that were invited to present in these activities. In addition, these events

aim to facilitate networking between relevant international initiatives and pharmaceutical companies (e.g. Medicine Patent Pool and Roche).

The actors in the Swiss arena also interacted with other state actors from the GHG system in informal networking and learning. Between 2004 and 2011, the FOPH organised an annual meeting in the Swiss village of Glion for OECD countries prior to the WHA.

> Basically, at the time we were creating the first agreement on *Swiss Health Foreign Policy*, the only other country in a similar formal process was the UK. The UK colleagues and us, we were comparing notes quite a lot. At the time (2005/2006), these were the available experiences to be connected. But on an informal basis, a lot came out of the Glion discussions with a selection of the countries from the OECD. The Division of International Affairs at the FOPH started also to invite peers from OECD countries to our annual retreats, just before the WHA in Glion, near Montreux. Participants were heads of international affairs in ministries of health from US, from Canada, from UK, from Germany, from Australia, from Japan, from Sweden, etc. Out of the 30 OECD countries, and usually about half of them came. There was a lot of exchange. Some of them had a paper, but not many tools. Some of them had the tools of collaboration quite well in place, but they hadn‘t formalised it as a government decision paper. Some said, “It doesn‘t work yet,” or, “We would like to have such a thing, but what‘s your experience with that?”(H)

The informal “off the record” meeting (Chatham House rules) produced ideal conditions for interactions between various state actors to share experiences and “compare notes” on their cooperation strategies for working with other sectors on health and foreign policy related to GHG. The two informants I interviewed who participated in these meetings relayed that they were valuable learning and networking mechanisms for the FOPH to use for the Swiss arena.

Finally, the learning processes in the regular exchanges between actors from the Swiss arena with other global health actors in Geneva produced interaction between these two governance spaces for global health. This overlapping of the national and global arenas in Geneva was a particularity for mechanisms of policy change operating in the Swiss case, where the constant interactions for learning and networking between Swiss and external actors from GHG blurred the boundaries of the Swiss arena.

> If you ask me what was the most important driver for change within how we behave in this *Swiss Health Foreign Policy* setup, then I would say the practice in Geneva because there, we associate with one actor for such a topic, with another actor for such a topic, etc. Then somehow, everything is brought together within the WHO. There, we take positions, we learn if we were successful and why we were not successful, what should be changed in the future to be more successful. This is our learning field, and that’s why we are also somehow very proud to have all these actors in

> Geneva and because this is an incredible opportunity for Switzerland to influence the global thinking on global health. (D)

The *International Geneva* policy initiative of the FDFA has been dedicated for many years to ensuring that optimal conditions are met for international institutions, permanent diplomatic mission, as well as since 2000 the increasing number of public-private partnerships for global health, product development partnerships, and global health networks to thrive. The Swiss arena for NPGH has benefited from learning and networking interactions with these key actors thanks to their proximity as well as to the strategic vision to use global health and the GHG arena to demonstrate Switzerland's power for multilateral diplomacy. This is helped when Geneva is your "playground" as one informant referred to the networks available to the actors in the Swiss arena.

> Switzerland is in a kind of a specific position. I would say the *Swiss Health Foreign Policy* actors are generally heavily involved in trying to actually play the game in Geneva with these different kinds of health actors, but also – and most importantly – with how other countries together with us articulate in different constituencies towards these actors in Geneva. We have policy dialogue with these different actors, be it on the UN side, on the private side, on the foundation side, and with public-private partnerships too. This is successful learning by doing process, in the *Swiss Health Foreign Policy and* in the interaction with other countries. We communicate these positions on a regular and systematic basis communicate to the other Idag GAP members, where we pre-discuss our positions that we are going to take in some different constituencies, where we mobilise specific technical knowledge when it to specific questions which will go beyond our own capacities. That's how we learn and how we move forward. (D)

The circulation of ideas between the Swiss national arena and the GHG arena arena in the "global health capital" took place through learning processes of policy dialogues where Swiss arena actors interacted and networked with various global health actors.

Section 5: Critical reflections on the Swiss NPGH action arena

Based on the findings presented in this chapter from the Swiss case of a multisectoral arena at the national level for the governance of global health, I discuss questions and concerns raised in key informant interviews. I present them below in the form of reflections around three sets of questions about content of the *Swiss Health Foreign Policy*, the rules of the Swiss arena for NPGH, and the goal of policy coherence. I considered these areas relevant dimensions of

empirically based critique on the theoretical dimensions of policy design, the interaction of actors, and the Swiss context for NPGH.

5.1 Critique of content

The critical perspectives on the content of the *Swiss Health Foreign* Policy document adopted by the Federal Council in 2012 related to the short-term vision of the priority areas named in the paper, the lack of operational value for implementing partners like NGOs, and the disconnect with research priorities for global health in Switzerland. I noted that informants from the civil society and research sectors, who were mainly excluded from the decision-making processes and deliberations on the policy content, raised these questions. As discussed in Section 2.1 of this chapter, the Swiss NPGH is characterised as an arena of the federal government, with boundary rules that reserve access to interact in decision-making processes to actors in the public administration from different sectors. Noting this characteristic, the critiques of the informants from civil society and research communities raise issues that the government may wish to consider in future iterations of the Swiss NPGH.

First, the document was analysed as having a very short-term perspective, lack of vision for the future, and no adequate anticipation of future challenges, targets and priority agendas on the global level in terms of global governance for health and development.

> The document makes a lot of references to the MDGs. The MDGs come to an end 2015. But this was not reflected in this document. You can also say, was not very much anticipating what is happening at the global scale. In 2012, one knew the SDGs were coming. The Swiss working group was already set up at the time being, although the processes had not really started, but it was established. But the Swiss Health Foreign Policy doesn‘t anticipate that very much. At that time one also knew already that the whole question about universal health coverage was coming on agenda. It’s not anticipating such things. It’s more reflecting what happened in the debates and the period may be 2008 to 2012. Maybe that can also be a lesson to be learned for the future and something that can be thought through in a next *Swiss Health Foreign Policy*. (R)

> From our perspective, there should be a clear vision, like health for all, or the human right to health. Yet, as it is, a vision isn’t really there. (CS)

These critiques revealed that some members of the global health research and practice community in Switzerland thought that the principles and values mentioned in the policy document were insufficient to lay out a clear vision for the direction and the ultimate aim of the

intersectoral coordination processes within the Swiss arena for NPGH in the GHG system. Furthermore, the lack of any explicit mentioning of the forthcoming global agenda items like the SDGs and UHC was interpreted as an error, because it left a gap in terms of the period covered by the policy (2012-2018) and the pressing GHG issues of the day which were already clearly emergent. This particular lacuna appeared puzzling however, given the results of the Swiss arena for NPGH producing policy about process and not about issues (see Section 3.1 of this chapter), which would suggest that the policy issues mentioned could have been expanded to embrace those on the near horizon.

Second, the policy content was not assessed by the non-state actors as operationally oriented enough to be useful for implementing agencies in research and practice communities. Granted, these communities were not the audience intended for the policy's use. But the critique offered a valuable reflection about the content of policies for governance that may differ from the content of policies for programme elaboration in terms of the level of operational details regarding implementation.

> While I consider it as a very useful document, I think at the same time it also reflects a compromise of many different actors, some more influential than others. But nevertheless, it covers quite a broad range of topics and areas. It sets some priorities for governmental actors, what is on their agenda and what they have to do. And I think here it's useful. But when you look what is an agenda, topic-wise, for Switzerland in the area of global health, international health? You find here a little bit of everything, but not really saying, "Health systems are a prime thing for us," or "Access to medicine" – you find everything. It is setting general priorities, but operational priorities are far from that. But that's too generic for us to use it on a day-to-day basis even if it could be of importance for us. I think the interconnectivity between this and how or where are the funds is not sufficiently strong. (R)

This leads to the third critique about the policy content of the *Swiss Health Foreign Policy* from the civil society and research community informants. The content of the policy document appeared to be detached from the research priorities and funding for global health and development in Switzerland. Since the *Swiss Health Foreign Policy* is not supported directly by any funding as a governance mechanism (although indirectly funds circulate between actors for specific projects), one informant hypothesised that the limited interest from NGOs and other civil society groups may be because these groups saw no opportunity to connect their work to it and seek funds on that basis. However, from a knowledge development perspective, the informant

considered the biggest missed opportunity was a more explicit connection of the *Swiss Health Foreign Policy* content to the *Swiss Programme for Research on Global Issues for Development* (r4d 2012-2022), which is co-founded and implemented by the SDC and the Swiss National Science Foundation (SNSF). The SNSF is a major funder of research on development in Switzerland and abroad, but their programmes are not reflected in the policy content.

> As an institution that does research, we do not find a lot of overlap between what is in the SHFP and what is stated in the Research for Development program. For example, the call from the SNSF public health program last year, with an overall funding of 50 million Swiss francs, sought research projects on universal health coverage and social determinants of health – two aspects you don't find much in the SHFP. The SHFP is more important in terms of what the governmental actors push, in terms of policies and strategies. But it's not underpinned, necessarily, with research funding priorities. As an institution, we are looking at funding channels priorities because more than 80% of our funding is external. So, they are other documents that push us much more in scrutinising global health, than the SHFP. (R)

From the perspective of these informants, the content of the document was neither entirely political nor technical. Government actors were the intended users of the policy content to structure their intersectoral cooperation on matters for governing global health, but some civil society and research informants evaluated the content as lacking an overarching vision for Switzerland in GHG. Public administrators used the content as a guideline for their collaboration practices with other sectors. What is a technical matter for administrators (how to collaborate between ministries) is not a technical consideration for practitioners working in the field (how to work with programmes and populations). Although, the policy content was developed for government actors, the absence of explicit linkages to Swiss priorities for research funding on global health and development within more comprehensive approach to GHG were questioned.

5.2 Critique of rules

The sources of the critique of content discussed above came from those actors "outside" of the decision-making action situations of the Swiss arena for NPGH. In the course of my fieldwork and interviews with Swiss key informants, I noted few critical perspectives from "inside" the decision-making spaces of the Swiss arena for NPGH. These observations made me question the reasons for an apparent lack of critique from actors during the interviews. There appeared to be a kind of avoidance, or discipline rather, among participants to censure deep reflexivity about the processes in which they participated. There was a positive tone in terms of

describing what was accomplished in establishing such a normative policy for intersectoral governance at the federal level in Switzerland which, acknowledging the political and policy contexts, is a notable feat. However, when probed about the dealing with differences of opinion, tensions, or conflicts, the actors emphasised the significance of compromise towards a majority consensus. I noted that the interaction rules for the Swiss arena for NPGH are embedded in the rules of the Swiss political context at large (namely, that of collegiality). I do not wish to convey that informants were unwilling to discuss challenges of the intersectoral collaboration; but the conversations on these issues were focused more on their resolution as an outcome than learnings or pitfalls. Some data were collected on the critique of interaction rules in the Swiss administrative-technical situations (in particular the Idag Gap); however, I was not authorised to quote them. I summarise some of these critiques below, because in my analysis, they offered an opportunity to present a counter perspective the dominant ones in the results.

The interaction rules for the Idag GAP (situation 2) limit dialogue and discussion between actors in the formal meetings to agenda items prepared by the core group (situation 2.a). The trend of these meetings has been for them to function as a coordination mechanism for follow-up where actors report on on-going work, react, or prepare in response to external agendas (multilateral agendas). As a constructive framing of the critique, the informant suggested that more time for interactions that are reflective, strategic, creative, future-oriented, and vision building would be a desirable modification to the rules from the perspective of this informant. Secondly, the interaction rules (consult, compromise, consensus) for actors to produce more coherent positions for credible impact on the international level may also produce some secondary consequences. For example, inclusivity may lead to consensus, but a weaker one (i.e. there may be agreement, but on a weaker policy position). Rule-obligated consultation also invites disagreement that must then be negotiated in order to identify points of compromise before making a final decision. These interaction processes slow down international cooperation, when partners need quick replies, because Switzerland needs more time. More generally, this critique about complex and slow procedures for interdepartmental collaboration on matters of foreign policy was also found in reports from the Parliamentary oversight of the administration [see APP 12] and the Management Commission of the National Council [see APP 13], which suggested that the Federal Council consider adapting some procedures that would improve the

flexibility and capacity of Swiss reactions in some instances. Many of the informants pointed out, this level of intersectoral coordination requires a lot of work, but it also takes time because agreement takes time if you want it to be legitimate.

5.3 Critique of coherence

In this chapter, I began the presentation of my findings on the Swiss NPGH action arena with its characteristic as international "credibility" producing device for Switzerland (see Section 1.1.a of this chapter). The interaction rules for consensus between government actors in the Swiss arena for NPGH produced legitimate results for the public administration. But I would like to question what lies in between the consensus positions and the goal of improving credibility. It is this question that led to the selection of the critique of coherence as the last area of reflection I address on the Swiss case.

Coherence is a term that is abundant in the data I collected. As a goal for Swiss foreign policy announced by the FDFA, coherence appeared in the policy context for the Swiss arena for NPGH as the paradigm underpinning the FOPH's initiative to propose the FDHA as the first sectoral policy/departmental partner of the FDFA in this call for intersectoral collaborative frameworks on matters of foreign policy. According to the findings, coherence in the Swiss arena of NPGH was an intended outcome, an expression of what would be considered the result (or even the quality) of good collaboration between sectors. But informants rarely defined this frequently used normative concept about agreement in the interviews, from which I derived some different assumptions about *coherence of what* that I discuss below.

Most of the informants from the core groups considered coherence to be agreement about processes (and decisions).

> As long as you don't have any governance process and coherence procedure, you will not defend your interests properly on the international level. (IP)

> We should make the assumption of incoherence. You never get full coherence, because full coherence would mean total deadlock, because you would spend all the 100% of your time coordinating. So, it's always that tension of how much coherence is useful, and where is coherence simply blocking action. (H)

> The Sectoral Policy Division of the FDFA had a very clear goal for the second edition of the Swiss Health Foreign Policy – to make sure that as many actors that are important in this field work together so that we have a coherent and a strong foreign health policy. We didn't have a stake in the technical goals that are spelled out in the policy, so we were in a position where we could really develop ideas for compromise between the parties. (FA)

Coherence of processes for the Swiss actors meant finding a balance in the rules to arrive at sufficient consensus on positions, but also offering some room for flexibility and autonomy to decide when there was a need go back to a situation for approval of a change of course (also see trust and transparency as outcomes of interaction Section 3.4 of this chapter).

Other informants considered coherence to imply a better agreement between the content of policy papers from different sectors and their policy objectives related to health and foreign policy. Related to the discussion of the critique of content (see Section 5.1 of this chapter), the Swiss arena for NPGH was not developed with the purpose of improving coherence between the government policy and the programmatic work in the field of global health funded by the Swiss government and grant organisations and implemented by Swiss actors (state or non-state). These reflections about coherence of objectives concerned questioning the duplication or fragmentation at the government actor level between the *Swiss Health Foreign Policy* and the Health Policies of the SDC (2003-2010, 2013-2020). Some informants expressed what they thought was a lack of coherence between the Swiss policy on international health and the *Swiss Health Foreign Policy*, as well as the Swiss development policy (in the form of the Message on International Development voted on by Parliament every 4 years). One of the explanations why there is not coherence between these documents is that the Message for International Cooperation is what determines the budget allocated to the SDC and SECO for international cooperation and development policies and programmes because the development policy arena remains a discrete arena with separate rules, and the boundary rules do not include it as such as part of the materials for governance of the Swiss arena for NPGH. The *Swiss Health Foreign Policy* is not a document that engages the SDC or any other actor in a financial commitment or joint budgeting practices. Some informants from the foreign affairs sector expressed optimism that the adoption of the SDGs might provide new impetus for coherence between objectives in development policies and other sectors in Switzerland (note: interviews were conducted in 2015 before September and UNGA adoption of SDGs).

The issue of budgets and fiscal divisions between sectors (between departments) and agencies and offices (within departments) relates another critique of coherence. One informant suggested that in the Swiss context, the logic of coherence should not be about joint budgeting or agreements on budget sharing practices.

> It was key to say that the coherence measure is not about sharing the resources, and possibly that's different in Switzerland than in others, because here you have seven equal bosses. If you have one boss (*head of state*) and he says, "Here are your hundred million with which you can do that policy," that works. But if you have seven bosses, you'd better have the coherence tool and the resources separately. (H)

The coordination of financial resources was kept outside of the boundaries of the Swiss action situations to separate decisions about Swiss positions for global governance from questions about financing. By excluding decisions about money from the arena's purpose, the rules neutralised the importance of material and financial resources from constituting dispositional power in the arena, even though it remained a hidden source in relational power (see Sections 2.3.a-b of this chapter). In the Swiss case of a multisectoral arena for collaboration on Swiss participation in governance of global health, the separation of resources from coordination arrangements for was considered by some an advantage for coherence of processes between policy sectors, and by others a limitation for coherence of objectives between policy sectors.

Table 1. Position, Boundary, and Interaction Rules for the five action situations in the Swiss NPGH action arena

Situations	***Position rules***	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 1 – **IK GAP** (political)	Co-chairing arrangements between FDFA, FOPH, and SDC (as for Idag GAP but higher authority level). Meeting organised by the FDFA.	Participants are Secretary of State level. Excludes the Federal Department of Finance (*and therefore also excludes this potential power lever from entering to relational processes*).	Content of meeting agendas for high-level decision-making on health and foreign policy. Issues brought forward from the Idag GAP or Idag GIGE.	Staff in the corresponding department unit briefs their official representative with an official in advance so that information items are not discussed and all attention is focused on critical decisions.
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 2 – **Idag GAP** (administrative-technical)	Rotating co-chairing among the three leaders of core group from public health, development and foreign affairs for sharing ownership and positional power.	Participants are senior public administrators from relevant offices & divisions in different sectors (from all ministries except finance) identified as relating in some way to issues of global health and its governance (international dimension of the state sector agencies is underscored for access). Reserved for technical experts. It is	The international agenda and key problems/issues defined by the global health governance system are items of importance on its agendas. Needs assessment about what is missing to meet the group's agreed objectives, part of making rules about which resources from different actors are brought in.	Interaction and exchange for making decisions requires ample opportunity to hear all points of view, including divergent opinions as legitimate concerns for the group before decision. Leadership for tasks or products on specific topics is given to individual agencies (relational power) that are part of the Idag GAP based on their relevant resources (e.g. expertise,

		accessible to specialists in the public administration. Participants must be able to engage in discussions about specific technical questions. Closed to NGOs and civil society, except to consult on documents or projects as needed. Stakeholders are contributors but not participants.		networks). The Swiss "C's" (i.e. consult, consolidate, compromise, majority consensus). Compromise is an important rule because it is key step to consensus.
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 3 – **Idag GIGE** (administrative-technical)	Rotating co-chairing amongst the two leaders of core group from public health and intellectual property – sharing ownership and positional power.	Participants are senior public administrators from relevant offices and divisions in different sectors identified as relating in some way to issues of public health, innovation and intellectual property. Reserved for technical work. It is accessible to specialists in the public administration. Participants must be able to engage in discussions about specific technical	The international agenda and key problems/issues defined by the global governance systems related to health (WHO, WIPO, WTO) are items of importance on agenda. Access is given to the ideas and knowledge of other (international) experts to present projects and experiences from which it is considered that the Idag GIGE can learn from on topics of interest where there is an overlap between IP, public health and innovation (such as	Interaction and exchange for making decisions requires ample opportunity to hear all points of view, including divergent opinions as legitimate concerns for the group before decision. Interaction rules for how actors work together in the Idag GIGE aim to break down the dichotomous (good/bad) approach to intellectual property debates. The group works

		questions on IP, access to medicines, research and development, public health. NGOs and civil society are excluded from access to the formal meetings of the Idag GIGE; however, they are included in outreach strategy for networking and learning from external (and international) experts.	pharmaceutical companies, WTO, WIPO, WHO, NGOs, etc.) during lunch seminars regularly held prior to formal meetings to stimulate reflection on key issues for decision.	according to consensus by discussion on principles, and these exchanges are iterative until resolution is reached (if possible). Email consultations can replace physical meetings to expedite the process.
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 4 – **Executive Support Group** (strategic)	Rotating host agency arrangements between the participating departments and offices.	Participants are senior level public administrator (Ambassadors, Deputy Directors, Directors) with decision-making authority. Participants cannot send a replacement to attend in their place, no junior level staff is allowed to stand in for a member of this situation.	Open-ended, no fixed agenda. Actors bring any problematic issues, challenges or questions they have to the table.	During *tour de table* everyone must speak opinion on issues, no abstentions from commenting. This expectation that all present must speak up publically creates an informal pressure for open communication. When an actor has the floor, they can raise any issue they wish to discuss.
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 5 – **Stakeholder**	Core group from Idag GAP responsible for	Invited participants include all	Themes proposed annually based on current priorities	Open ended dialogue between the administration

Platform (practice-technical)	organising and preparing this event. The FOPH provides the leadership for drafting the agenda and the preliminary programme of the formal meetings.	Swiss stakeholders (outside of public administration) related to global health, international cooperation, or other areas of research and practice related to topics covered by the *Swiss Health Foreign Policy*. Excludes actors and content uniquely related to health care implementation in Switzerland (such as the individual cantons).	(i.e. neglected diseases, health personnel).	(state actors) and external partners (non-state actors). Organised to exchange ideas, knowledge, and practice; network; and raise awareness of important *Swiss Health Foreign Policy* issues and how they relate to non-state actors. Explores different perspectives through interactive panels. Stakeholders not consulted on policy change, and not provided an opportunity to directly influence Swiss government positions.

Figure 1. A mapping of the elements of contexts for the Swiss NPGH action arena

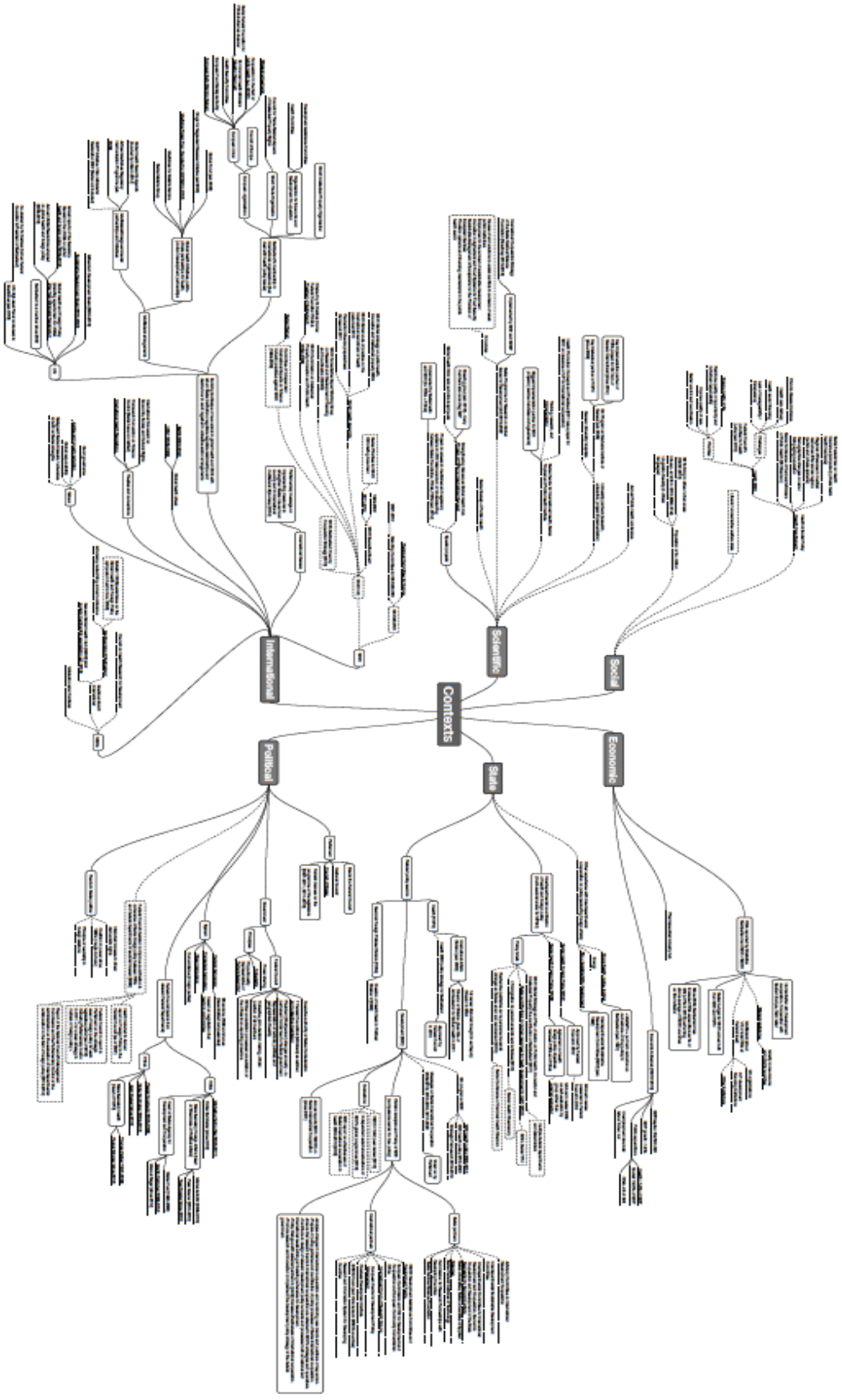


Figure 1 (contd.) – Close up of international and political contexts of Swiss case

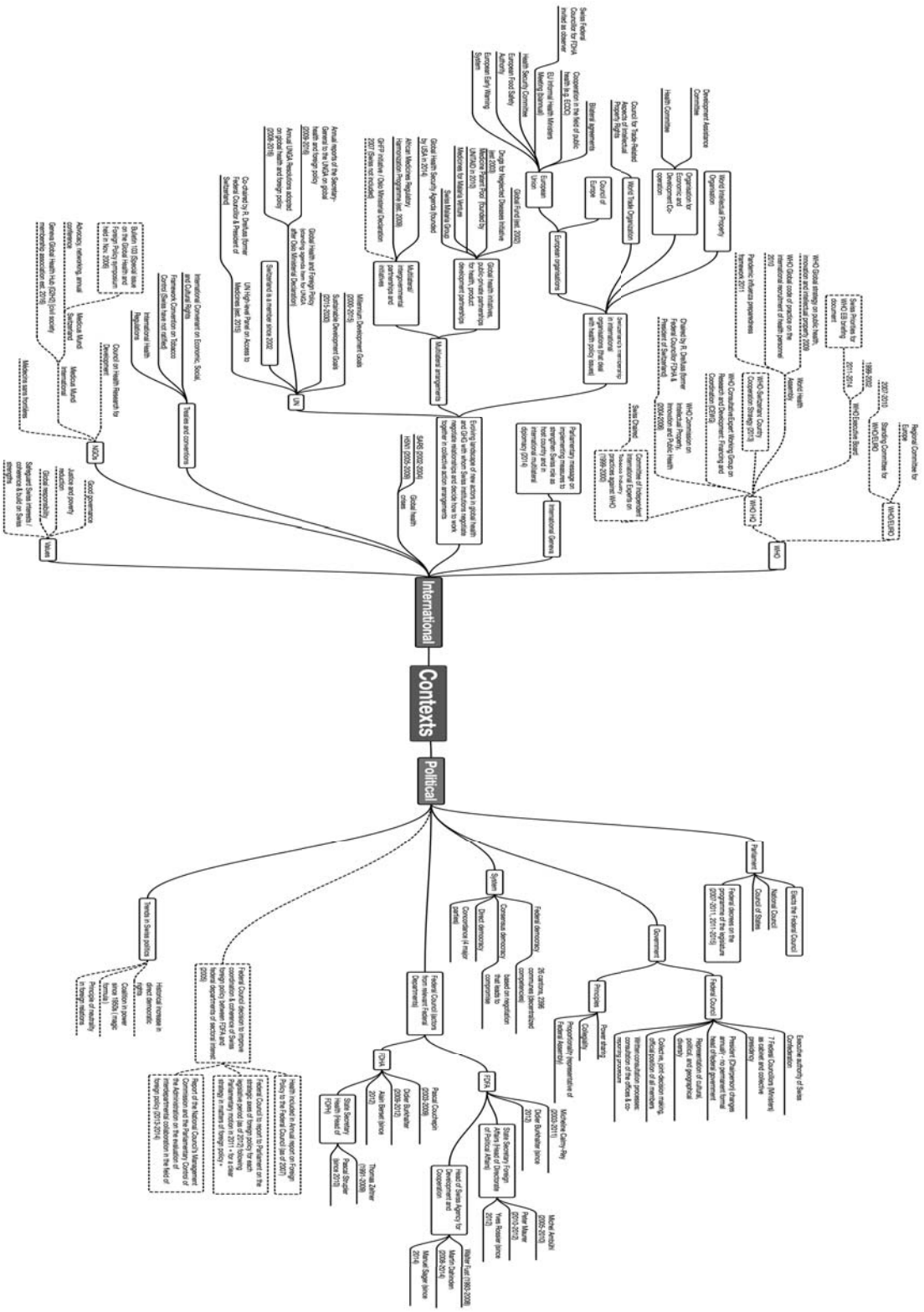


Figure 1 (contd.) – Close up of scientific and state contexts of Swiss case

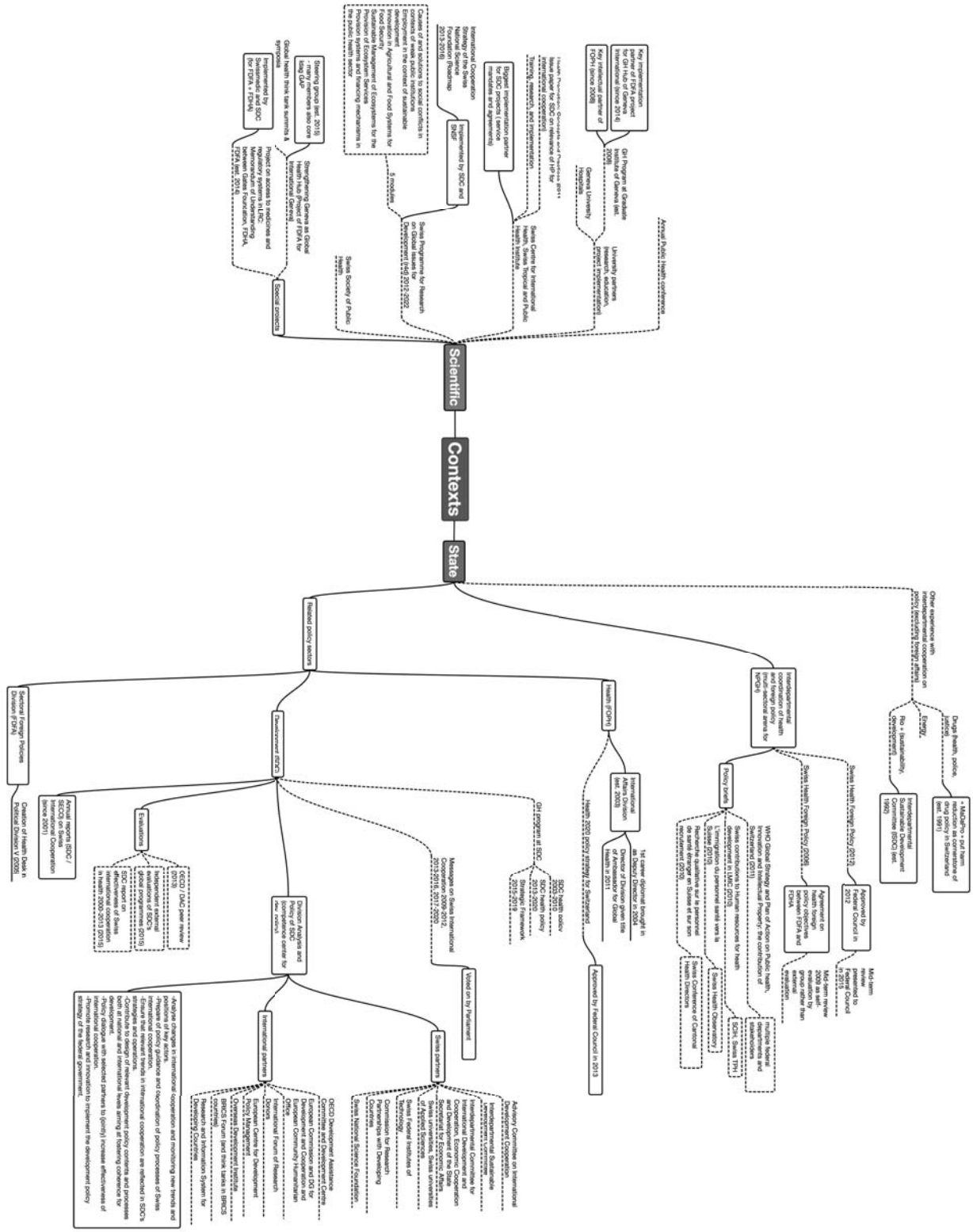


Figure 1 (contd.) – Close up of social and economic contexts of Swiss case

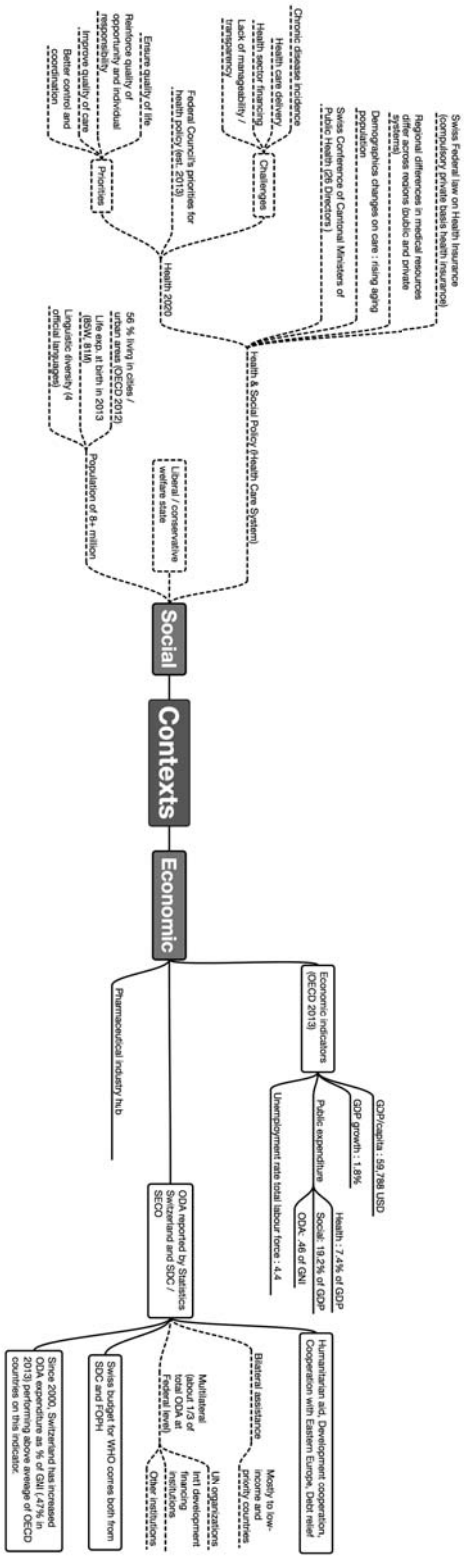


Figure 2. The Swiss NPGH action arena iceberg

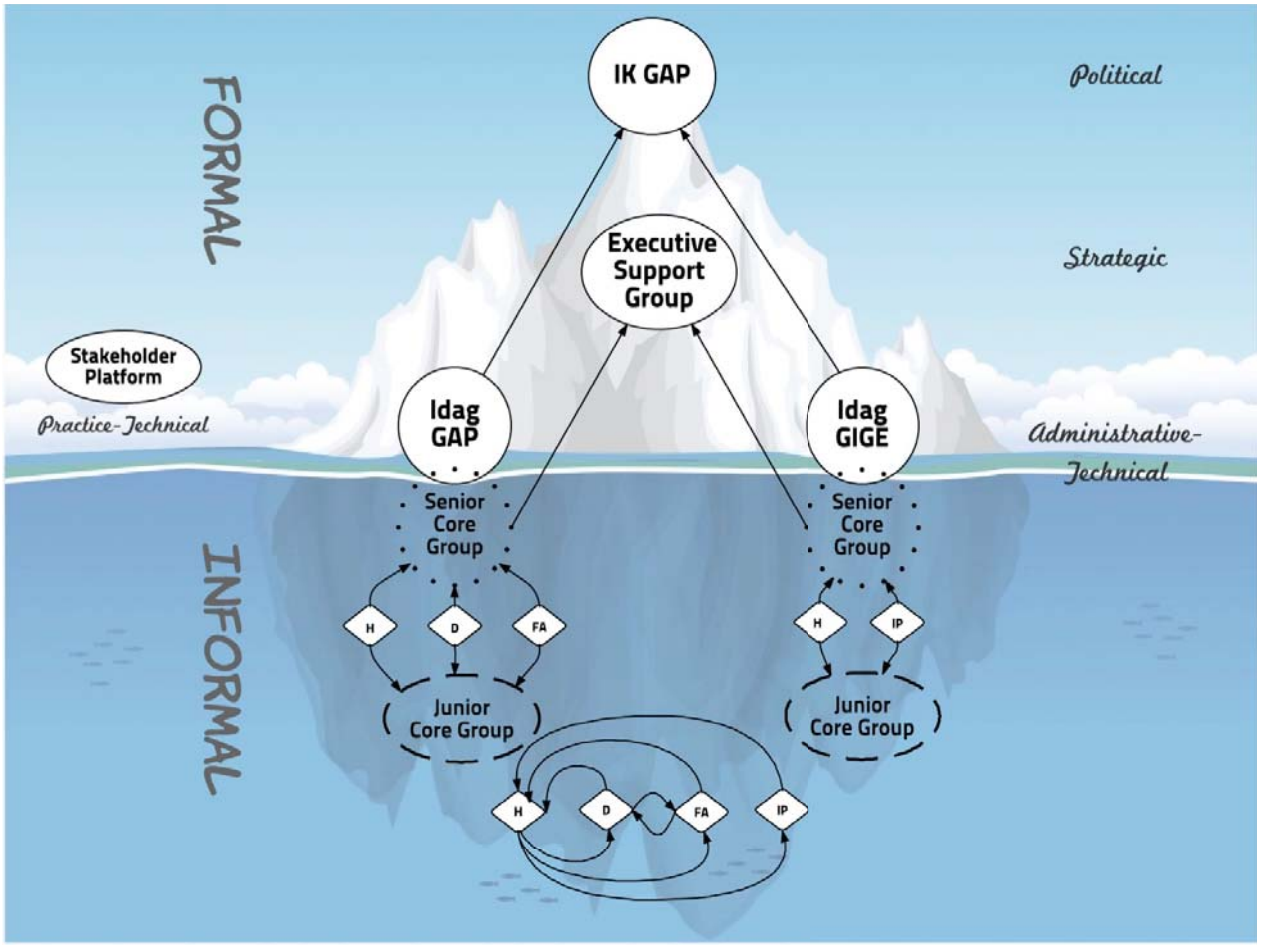


Figure 3. Model of the Swiss NPGH Action Arena

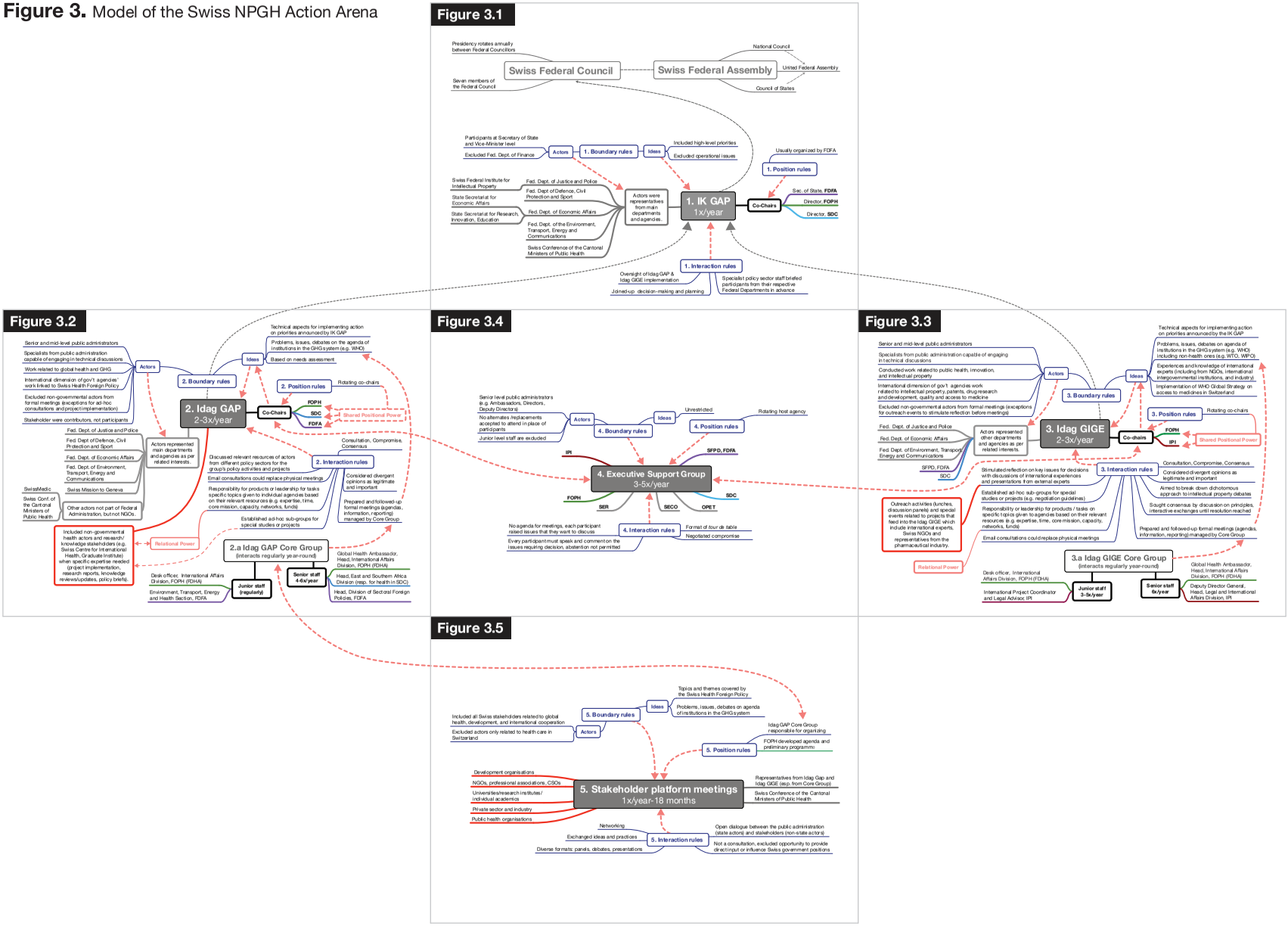


Figure 3.1 - Interdepartmental Conference on Health and Foreign Policy

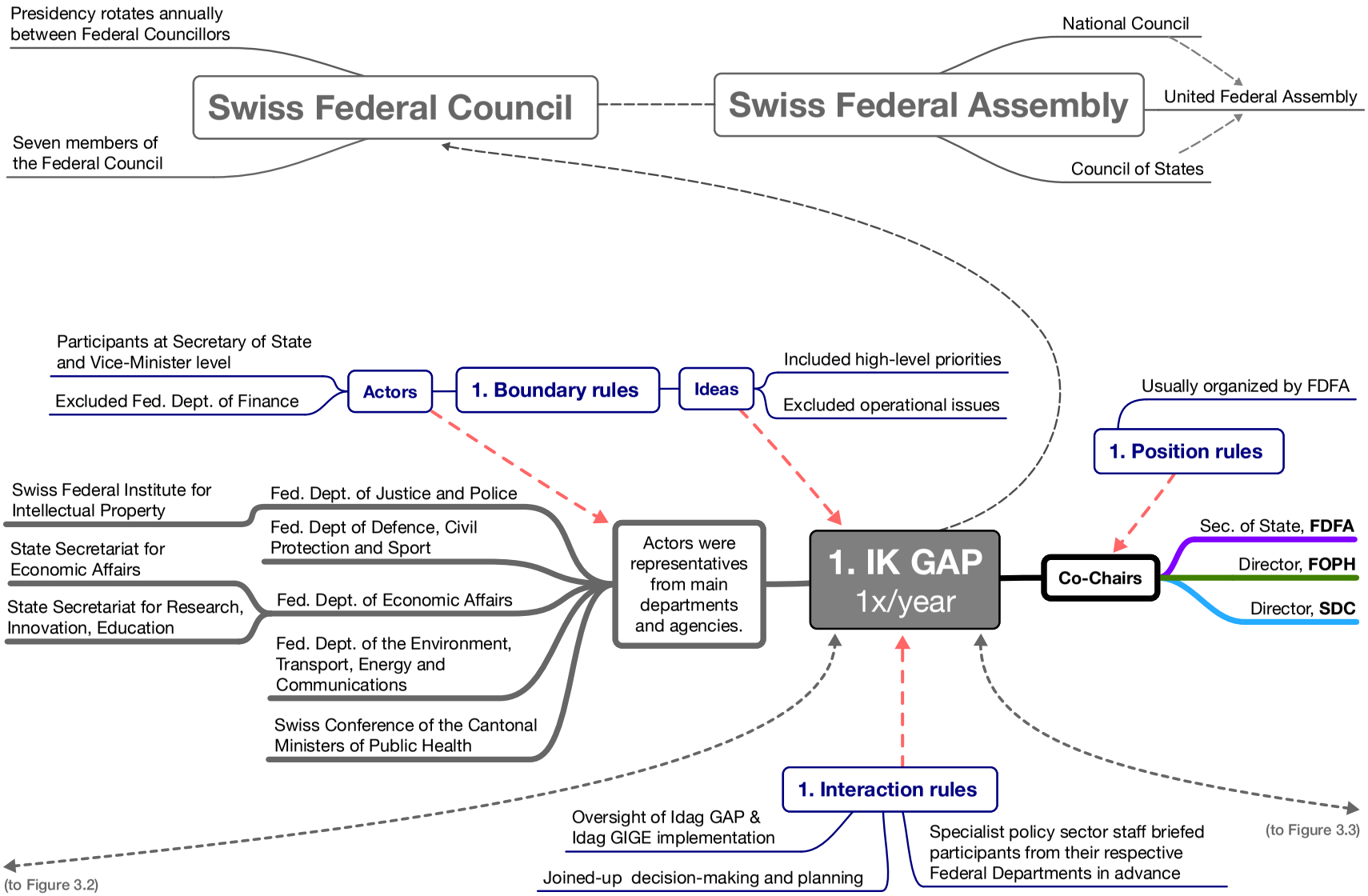


Figure 3.2 - Interdepartmental Working Group on Health and Foreign Policy

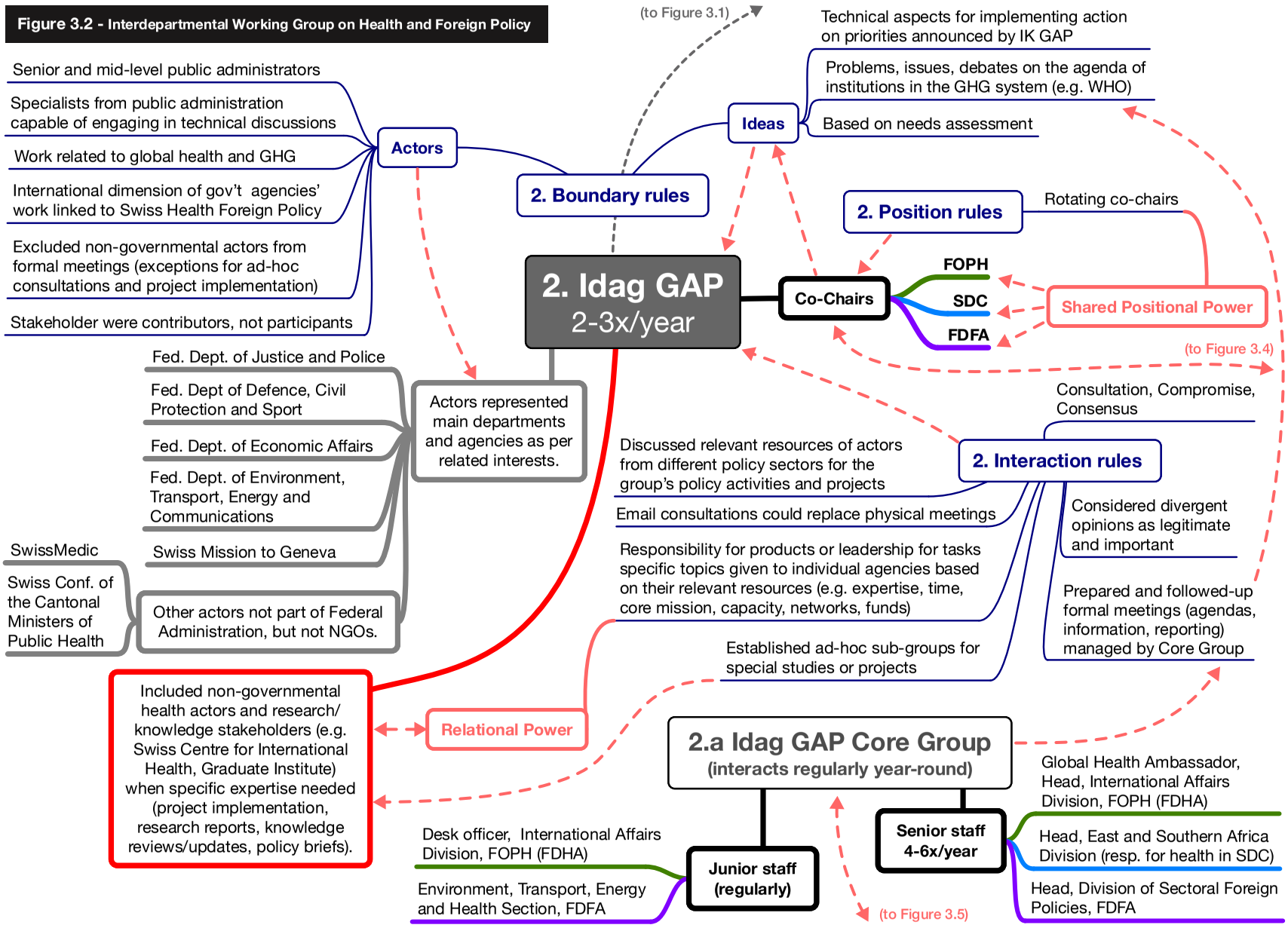


Figure 3.3 - Interdepartmental Working Group on Intellectual Property, Innovation, and Public Health

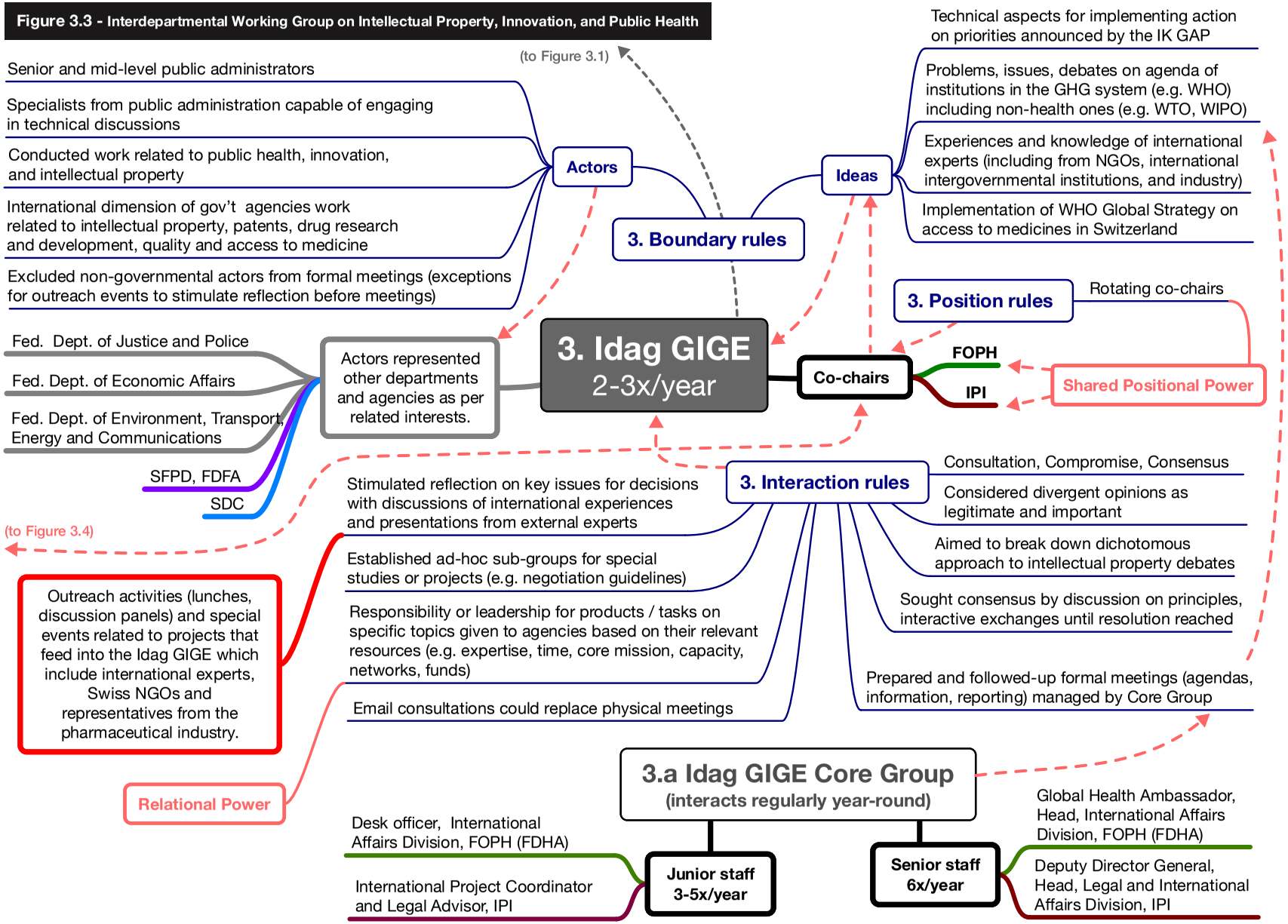


Figure 3.4 - Executive Support Group

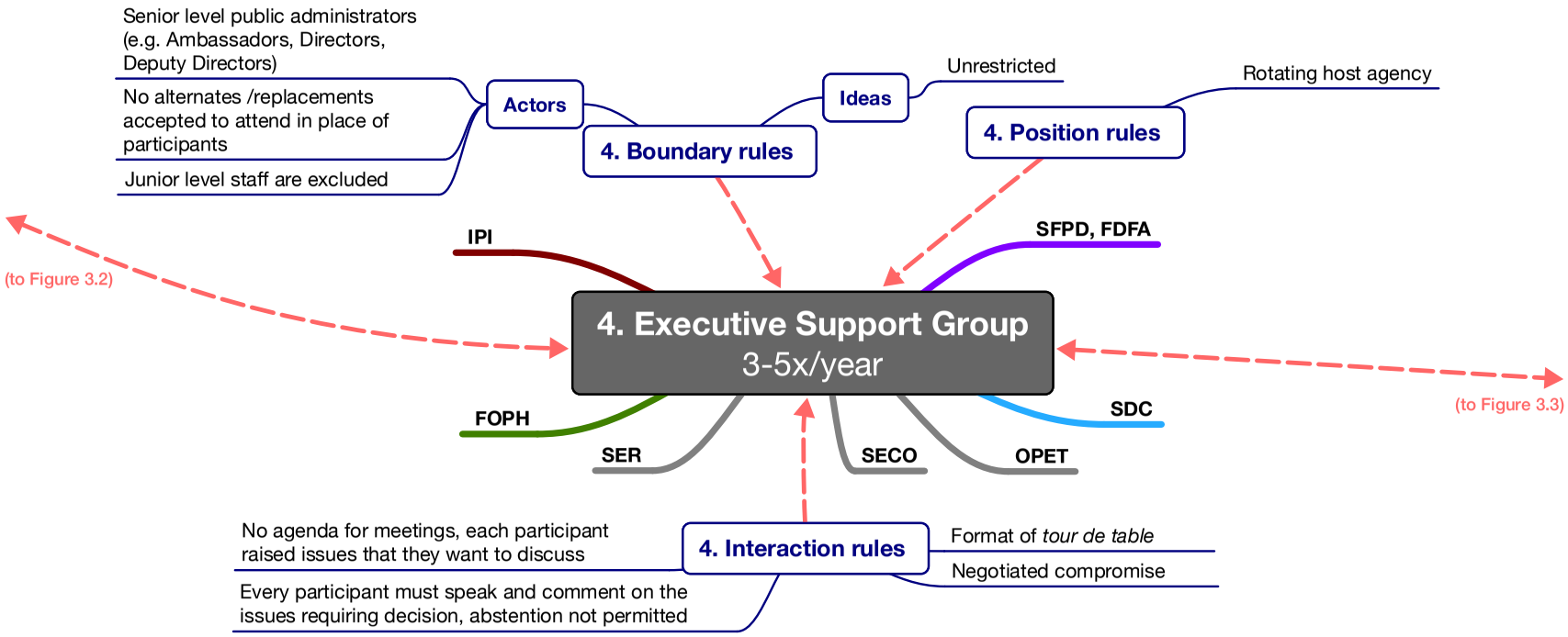


Figure 3.5 - Stakeholder Platform

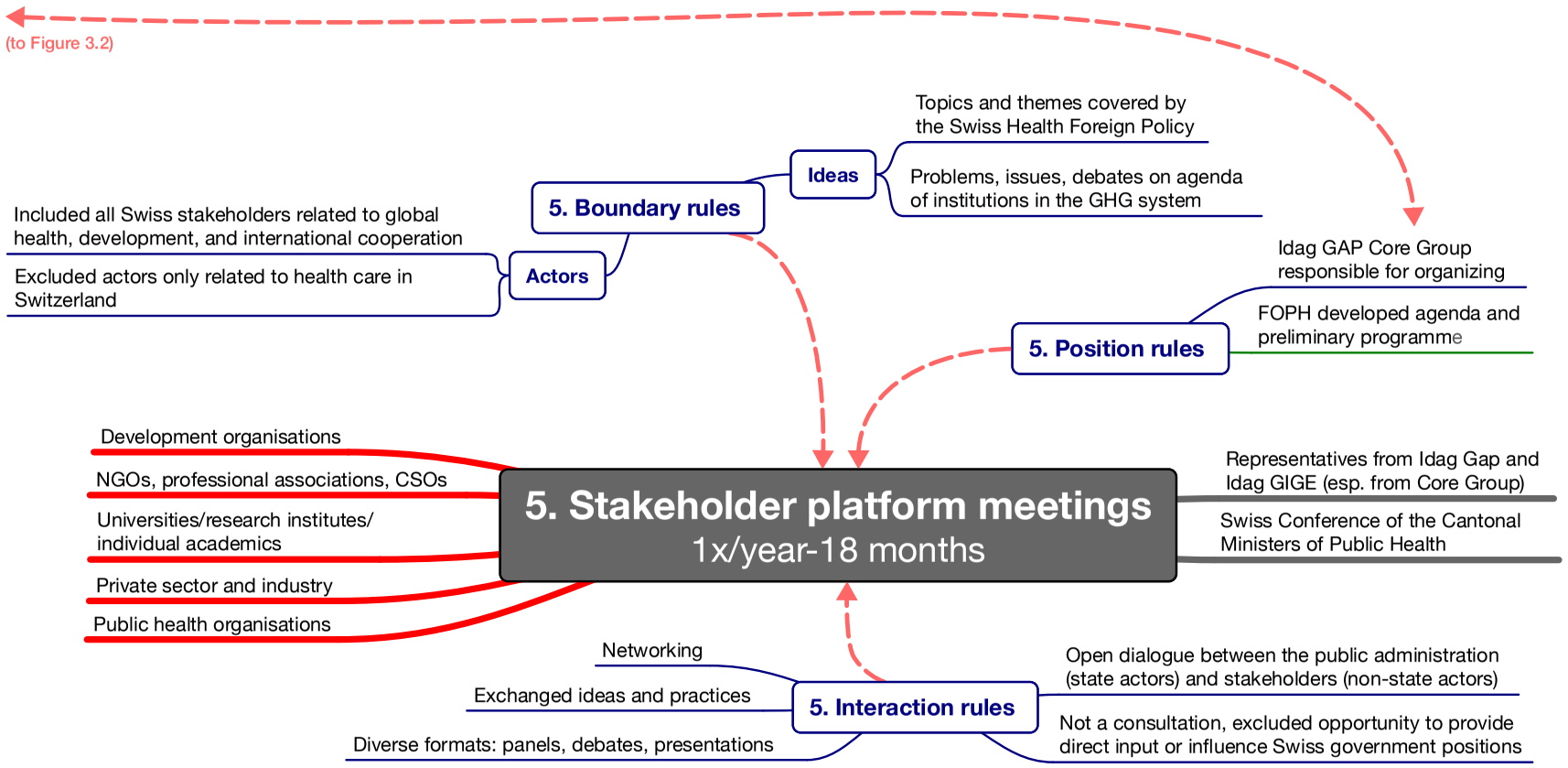
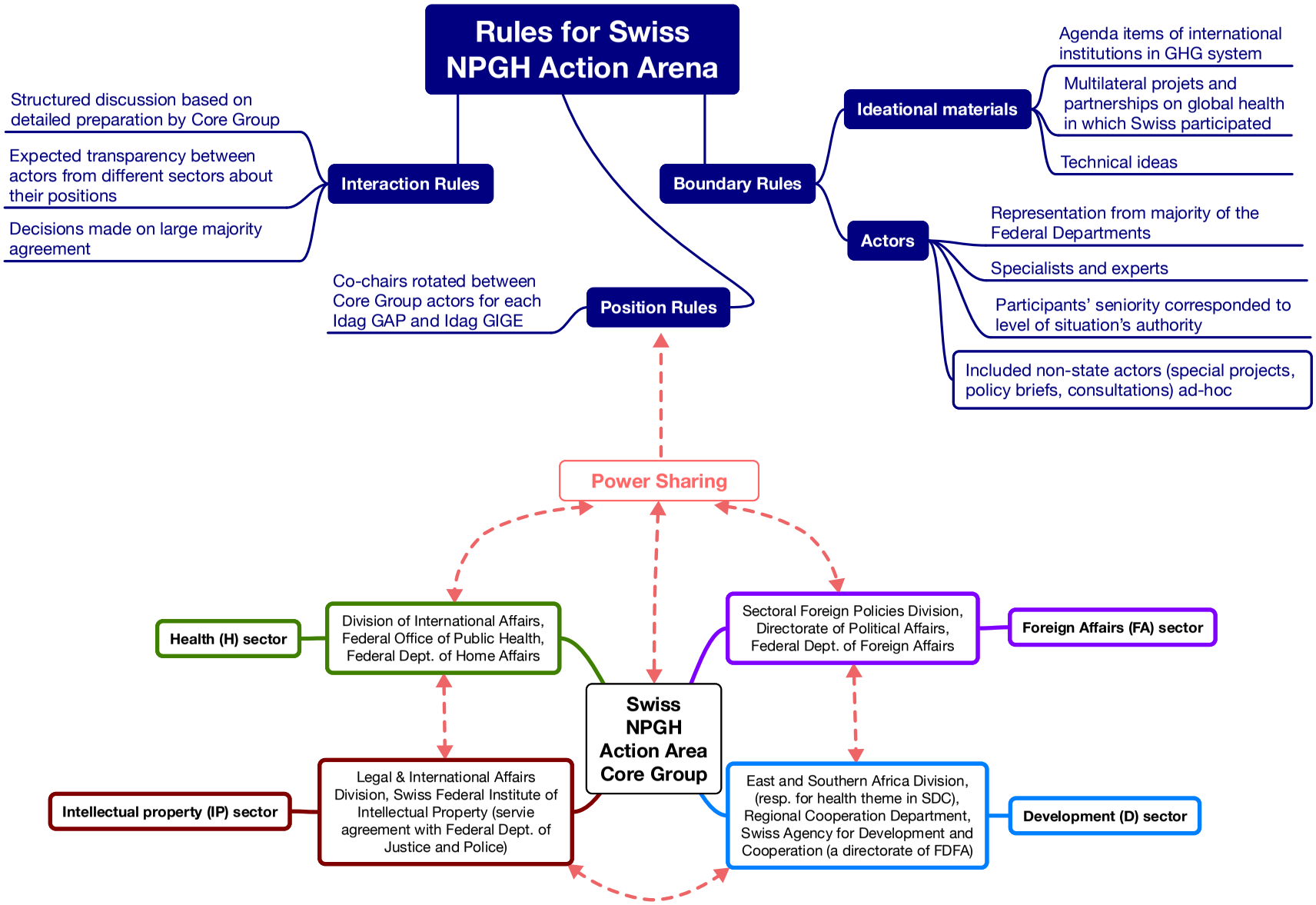


Figure 4. Rules for Swiss NPGH Action Arena



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Chapter 7: RESULTS of the Norwegian case study

Case monograph of the Norwegian national policy on global health action arena

Case monograph of the Norwegian NPGH action arena

Table of Contents

List of tables and figures in the Norwegian case monograph

Table 1 and ***Figures 1-3*** in the Norwegian case monograph are located at end of Chapter 7 in this order.

***** ***Figures 2-3*** use the following colour code for actors from different policy sectors in the five main action situations [**in dark grey boxes**: **civil society sector = red**, **development sector = blue**, **foreign affairs sector = purple**, **health sector = green**] with rules [**in dark blue**] and power relationships [**in orange**].

➜ Please note that all highlighted text cross-references material in this chapter.

List of acronyms and abbreviations for the Norwegian case monograph

APP – Archives of the policy process

BMGF – Bill and Melinda Gates Foundation

CSO – civil society organisation

DFID – United Kingdom's Department for International Development

FADC – Foreign Affairs and Defence Committee

FPGH – Foreign Policy and Global Health Initiative

GAVI – Global Alliance for Vaccines and Immunizations

GFATM – Global Fund to fight Aids, Tuberculosis and Malaria

GHI – global health initiatives

GHG – global health governance

GLOBVAC – Global Health and Vaccination Research

MDG – Millennium Development Goals

MER – Ministry of Education and Research

MFA – Ministry of Foreign Affairs

MHCS – Ministry of Health and Care Services

NCD – non-communicable diseases

NORAD – Norwegian Agency for Development Cooperation

NPGH – national policy on global health

NIPH – Norwegian Institute of Public Health

ODA – official development assistance

ODAH – official development assistance for health

OECD – Organisation for Economic Cooperation and Development

PM – Prime Minister

RBF – results-based financing

RMNCH – reproductive, maternal, newborn and child health

SDG – Sustainable Development Goals

SGI – Section on Global Initiatives

UN – United Nations

UNDP – United Nations Development Program

UNEP – United Nations Environmental Program

UNFPA – United Nations Population Fund

UNICEF – United Nations Children's Fund

USAID – United States Agency for International Development

WHA – World Health Assembly

WHO – World Health Organization

WHO EB – World Health Organization Executive Board

Abbreviations for citations from data:

Letters in parentheses designate the sectoral classification of informant next to citations from the data collected in interviews included in this chapter:

Civil society sector (CS)

Development sector (D)

Foreign affairs sector (FA)

Health sector (H)

Research sector (R)

Executive summary

Between 2005 and 2013, actors from the health and foreign policy sectors used a combination of strategy and opportunism to construct the Norwegian national policy on global health (NPGH) arena as a zone for intersectoral collaboration on policy relating to global health governance (GHG). The Norwegian NPGH action arena functioned like a workshop in which foreign affairs experts crafted policy design by piecing together global health instruments and investments comprising the Norwegian government's commitment into a politically coherent form. Senior civil servants in the public administration worked on directives from politicians to formulate policy content that was both technically sound and politically acceptable, and not in conflict with other policy. The formal adoption of the *White Paper on Global health in foreign and development policy* (hereafter referred to as the White Paper) in 2012 served three purposes for the Norwegian Government, as: 1) an acceptable demonstration of its fiscal responsibility to Parliament, 2) a symbol of the ratification of its global health aid legacy, and 3) a validation of its role as a key state actor in the GHG arena. The incentive for accountability to Parliament is one factor that explains the development of a White Paper, which launched multiple situations in the arena, to rationalise an inventory of global health work managed by the Ministry of Foreign Affairs into a single, intersectoral framework. The collaboration of the health and foreign policy sectors (along with their respective subordinate agencies) to produce the White Paper capitalised on previous experiences between the two sectors in developing Norway's WHO strategy for its term on the WHO Executive Board.

The processes in the Norwegian NPGH are structured by rules that support unilateral dispositional power for the leadership, coordination, and management of the NPGH by the foreign affairs sector, with the health sector in a supporting role. The Norwegian NPGH operated using rules made by the foreign affairs sector for situations to exchange the resources and practices of the three key sectors in Norway involved in global health and its governance. WHO is the only institution related to global health for which institutional arrangements support intersectoral coordination between the Ministry of Foreign Affairs (MFA) and the Ministry of Health and Care Services (MHCS). From 2008-2013, the WHO Executive Board Strategy Group provided an opportunity to develop and strengthen collaborative practices between these policy sectors. This was a foundational situation of the NPGH action arena, but one reserved

specifically for WHO affairs. It is an outlier of the NPGH arena due to power sharing between the two sectors, rather than power asymmetry favouring the foreign affairs sector as found in the other situations.

An ideational border between the health and foreign affairs sectors marked the respective territories of global health claimed by each sector. Informants from the health sector perceived the NPGH arena to be dominated by development assistance for health and disease prevention and treatment (based on an international health and development aid model), and not sufficiently integrating an understanding of global health policy as action on the interdependence of a comprehensive range of determinants (social, economic, political, and commercial) and distribution of health on a global scale. The definition of "global health" and determination of the scope of policy were divisive topics, on which informants differed depending on sectoral perspectives. It was a challenge for the health sector to argue for health issues such as mental health and other non-communicable disease to be included in White Paper because they are not part of the framework for development aid for global health. During the time of this case study of Norway's action arena for NPGH, informants acknowledged that other complex global issues regarding climate change and food security were emerging as problems for which intersectoral collaboration in the arena would be needed to find innovative policy approaches together (but the post-2015 work in Norway on the sustainable development goals had not yet begun in 2012).

The interactions of actors from health, development, and foreign affairs sectors in the NPGH arena generated tensions, connections, and reflections – all of which represented learning that reinforced links at the Ministerial level between the MFA and the MHCS, facilitated communication, and fostered understanding of each sector's different policy ideas, issues, values, and approaches to global health. Actors from each sector who participated in the NPGH arena increased their familiarity with the policy goals, instruments, and practices of the other sectors through regular and mainly informal discussion and debate. From the perspective of the health sector (as "specialists") this seems to be particularly important, given the periodic mobility of actors within the foreign affairs sector (as "generalists") every 2-4 years, to build capacity for intersectoral collaboration around policy issues impacting global health. The MFA and MHCS tried to maintain these connections (although with weak formal institutionalisation) to cultivate a

sustained role for the Norwegian Government as an influential state actor in the GHG arena at large.

The Norwegian government occupies a niche role in the GHG arena because it was instrumental in starting and supporting many of the newest institutions and partnerships in the landscape of the GHG arena. The decisions of the Norwegian government regarding disbursement of official development assistance for health, which has included these new kinds of multilateral organisations since the year 2000, established a basis for the rationale underpinning NPGH. The Norwegian NPGH arena focused on bringing a foreign policy approach to health within a broader approach to collective action with multilateral partners at the global level. Collective action on global health in the Norwegian NPGH arena concentrated on the multilateral (more than bilateral) level of cooperation, finance, and governance to use development aid to prevent and treat infectious diseases and specifically to improve the health of women and children.

Within this multilateral approach, the Norwegian NPGH arena and the GHG arena interacted through two policy change mechanisms: elite networking and policy learning. Two senior scientists and global health champions in Norway who are internationally renowned experts were important boundary spanners between the national and global levels, and their individual and professional networks were valuable resources for the Norwegian arena. Norwegian actors learned about policy (organisational, social, and policy learning) when they participated in the governance and management bodies of international institutions (such as WHO), global health initiatives (such as GAVI), and other partnerships (such as trusts and commissions). These elite networking and policy learning mechanisms circulated ideas between the two arenas within a transnational arena that reflected Norway's interests in influencing the GHG arena.

Section 1: Contextualising the development of Norway's NPGH action arena

1.1 The golden age of global health in Norway (2000-2010): the rise of a Norway as a leader for global health among state actors

The Institute for Health Metrics and Evaluation refers to the first decade of the 21st century as the "golden era" of global health because of the dramatic increases in donor commitments and global health investments. During this period, Official Development Assistance for Health (ODAH) experienced a phase of "rapid growth" leading to a peak of $28.2 billion in 2010 (1). Since 2009, Norway is one of the few OECD countries that allocate about 1% or more of their gross national income to official development assistance (2). While bilateral assistance remains an important component of the Norwegian development cooperation budget, it has become more thematically focused than nationally focused, aside from a select group of priority partner countries. Multilaterally administered bilateral assistance, and multilateral assistance (to UN agencies and other multilaterals) is a significant part of Norway's ODAH. In 2012, the Norwegian Ministry of Foreign Affairs reviewed 30 multilateral organisations,[1] and the results show strong Norwegian participation in the governance and funding of many of these organisations. For example, in 2012, Norway was one of the three largest donors to the United Nations Population Fund, the United Nations Environment Program, UN Women, UNICEF, GAVI, the Central Emergency Response Fund, the Office of the High Commissioner on Human Rights, and Unitaid; one of the five largest to the United Nations Development Programme, the United Nations Relief and Works Agency for Palestine, the UN Office for the Coordination of Humanitarian Affairs, and UNAIDS; and one of the ten largest to the WHO, GFATM, Food and Agricultural Organization of the UN, UN Habitat, International Fund for Agricultural Development, Consultative Group for International Agricultural Research, UN High Commissioner for Human Rights, and UN Office on Drugs and Crime. This Norwegian spending on global health is one indicator, among others, of the trajectory of the Norwegian government's involvement in global health activities and their governance. The *White Paper on Global health*

[1] Available at https://www.regjeringen.no/en/topics/foreign-affairs/the-un/review-mulitilateral-org/id737780/

in foreign and development policy adopted by the Norwegian Parliament (*Storting*) in May 2012 summarised the legacy of the Norwegian government's global health work during this decade (3).

> That's really where Norway is an interesting case in many ways. I think it's more interesting the way we've been working on global health in general, than the White Paper itself. (D)

Norway focused its approach to global health (from the development aid perspective) on influencing the global health governance (GHG) system as an innovator, as a funder, as an advocate, and as a trusted partner.

> Norad has done a great job internationally on global health. And by being smart in setting up new initiatives like GAVI and by thinking differently and working on the priorities MDG 4 and 5 politically. They [MFA + Norad] have managed, of course in partnership with others, to get other funders to come with their money. That's the way Norway has operated, and it has expanded the cake when it comes to development internationally. (H)

During the first decade of the new millennium, Norway contributed to modifying the institutional landscape of the GHG system and played a substantial role in introducing new instruments and mechanisms for funding to deliver therapeutic products and interventions to improve the health of those in low- and middle-income countries. The Norwegian approach to global health and development policy during this "golden era" helped change the way that global health interventions were funded, in particular those related to MDG 4-6.

The Norwegian government financial commitments to GAVI (est. 2000) and the GFATM (est. 2002) were successfully achieved in advance for a long-term period. Publically announced decisions by Jens Stoltenberg in 2005 brought the Norwegian government's total contributions to GAVI since 2000 and the International Finance Facility for Immunization as of 2005 to approximately $1billion USD until 2015 for vaccinating children in poor countries. In 2007, he announced an additional $1billion USD from the Norwegian government to be spent between 2008-2018 for reducing child and maternal mortality. Although these funds came from the budget of the Ministry of Foreign Affairs, their approval was confirmed through different arrangements with the Parliament that fixed high levels of contributions through grant agreements guaranteeing Norwegian contributions to GAVI and multiple partnerships for women's and children's health until 2020.

> You just have to read the spending decisions to see that. And the GAVI contribution keeps growing and the Global Fund contribution keeps growing, and that's where the focus remains. And that's tied down for many years into the future as well. (FA)

The vision of the Ministry of Foreign Affairs for changing the GHG arena has aimed to mobilise more resources for vaccines, prevention and treatment of infectious diseases, and for maternal and child health in low-resource settings. It was a founding member of Unitaid (est. 2006 by the governments of Norway, Brazil, Chile, France, and the United Kingdom), of the International Finance Facility for Immunization (est. 2006 with the governments of Norway, the United Kingdom, France, Italy, Spain, Sweden, Australia, the Netherlands, and South Africa), the Health Results Innovation Trust Fund (est. 2007 with Norad, DIFD, and the World Bank), the Reproductive, Newborn, and Maternal Health Trust Fund (est. 2013 jointly by WHO, UNICEF, UNFPA, with significant funding from Norway and a select few other countries), the Global Financing Facility (est. 2015 with governments of Norway, Canada, USA and the World Bank).

The appellation of Norway as a "leader" in global health is a title that actors in the Norwegian development policy sector acknowledged as an external recognition of the Norwegian government's accomplishments in global health.

> Being a leader in global health is not something that one assumes, but it is given. It's not something that one declares oneself, but it's something that is identified by others. And it was never the intent that, "Oh, we want to be a global leader, and therefore, let's do A, B and C." So, the fact that Norway punches above its weight and Norway is a global leader – this is something that others have iterated. This is something that we humbly note. That is just something that has come with the territory of doing the right thing. (D)

1.2 Individual scientists and politicians integral to the contextual fabric for Norwegian NPGH

However, the roots of Norway's political leadership role in global health reach back to former Norwegian Prime Minister Gro H. Brundtland. Norwegian researchers and practitioners recognise Dr. Brundtland as a powerful political voice for Norway's support of reproductive and sexual rights and health at the International Conference for Population and Development in 1994. As Director General of WHO from 1998-2003, she represented what Norway aspired to achieve

in international institutions with efficiency and health diplomacy to advance intersectoral policy and collaboration on public health, sustainable development, and global health research. Her term as WHO Director General marked a milestone for Norwegian innovations for GHG. During this time, a circle of political and health actors from Norway were all in Geneva. Jonas Gahr Støre, a Norwegian politician in the Labour party, served as the Chief of Staff to Dr. Brundtland in WHO. He had already worked as a special advisor in Prime Minister Brundtland's Office years earlier. Dr. Tore Godal, a distinguished Norwegian immunologist, with a research career which began in Ethiopia working on leprosy, had been working at WHO in Geneva since the 1980s, first as Chairman of the WHO committee for research in immunology of leprosy and tuberculosis and later as the Director of the UNDP, World Bank and WHO Special Programme for Research and Training in Tropical Diseases. He was instrumental in the research on treated mosquito nets that modified the WHO strategy for malaria prevention, from which emerged the launch of the inter-agency Roll Back Malaria Partnership. Dr. Godal became a Special Advisor to Dr. Brundtland in WHO.

The turn of the century was a watershed moment for Norwegian involvement in global health, which initiated some of the activities in which Norway was involved due to the circle of Norwegian political and knowledge elites working in Geneva and in Oslo. Prime Minister Jens Stoltenberg [also a leader of the Labour Party from 2002-2014] was the Norwegian signatory to the MDGs in the year 2000. Dr. Sigrun Møgedal, a medical doctor working in community health and primary health care in Nepal for 20 years in the 1970s and 1980s, was the State Secretary for International Development at the Norwegian Ministry of Foreign Affairs during the Stoltenberg Government I (between 2000-2001). She was instrumental in accomplishing the work of the Norwegian government to make HIV/AIDS a political priority internationally, including the Declaration of Commitment by the UN and recognition of HIV/AIDS as a human security issue during Norway's membership on the UN Security Council in 2001. In addition to the MDGs, new global health partnerships such as the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to fight Aids, Tuberculosis and Malaria (GFATM) were also created around this time. Norwegian scientific and political actors were pivotal in establishing these new partnerships that modified the institutional landscape of the GHG system. For example, Godal's leadership was critical to the processes of negotiating Bill Gates' financial contribution to

establish GAVI, and Godal was the first Executive Director of GAVI at the secretariat in Geneva until 2004. Stoltenberg and Møgedal were also more active in Geneva after a change in government following the 2001 elections. Dr. Møgedal was seconded to UNAIDS as a Senior Policy Advisor until 2004, while a member of the GAVI Board. Stoltenberg served as a member and Chair of the GAVI Board, which galvanised his political commitment to vaccination as an effective public health intervention for saving lives, and to the improvement of maternal and child health, as part of his platform for global health policy in the Stoltenberg Government II as of 2005.

This elite circle of Norwegian political actors (Stoltenberg and Støre) and health scientists (Godal and Møgedal) all returned to Oslo in 2005, bringing with them ideas and experience in raising the political profile of health issues in international policy arenas in Geneva and around the world. The Stoltenberg government II (Red-Green coalition with the Labour, Socialist Left and Centre parties) remained for two terms until 2013 when it was replaced by a Centre-right (Blue-blue) coalition of the Conservative and Progress parties. During the Stoltenberg government II, Godal was appointed Special Advisor on Global Health to the Office of Prime Minister Stoltenberg (an position that was later transferred to the Ministry of Foreign Affairs). Støre was the Minister of Foreign Affairs until 2012, and then Minister of Health until the change in government. Møgedal was appointed the Norwegian HIV/AIDS Ambassador, the senior expert advisor on the Foreign Policy and Global Health Initiative, a Senior Advisor for global initiatives at Norad, and in 2010 left the development and foreign affairs sector to serve as a Senior Advisor at the Norwegian Knowledge Centre on Health Services.

> When Jens Stoltenberg became Prime Minister [in 2005], he had already been a board member of GAVI, taking with him that sphere and all the success of putting money into vaccines and saving children. That's a very politically easy message to sell. We have given that amount of money, and this many children have been saved. He saw that and at the same time, it's also a good low-hanging fruit in terms of political issues. So, when Stoltenberg became Prime Minister and Støre became Minister of Foreign Affairs, they both were quite dedicated to the issue of global health. So that was an easy sell. Tore and Sigrun had already facilitated that work and that process. (FA)

Jonas Gahr Støre, Norwegian Minister of Foreign Affairs at that time, was a member of the UN Commission on Information and Accountability and the Co-Chair of the UN Commission on Life-Saving Commodities, both of which were intended to support Every Women, Every

Child. These commissions served as political networking activities related to the Global Campaign for the Health MDGs which added an additional locality to the chain of places where Norwegian and global policy processes were interacting in the GHG arena. The UN General Assembly at the UN Headquarters in New York became a significant place for Norwegian global health policy processes to interact with other actors with global health policy interests related to the MDGs.

> That's when it started with all the parades at the UN General Assembly. Look at what's happening in the opening week of the general assembly over the last five, six years. It has started to become a parade ground for leaders of the world that show their commitment to global health. They largely do that with promising money or appearing together with prime ministers from somewhere, so that's where the Every Woman, Every Child comes in. Norway was very instrumental in creating some of these. This was very much in Tore's work. (FA)

Furthermore, Foreign Minister Støre implemented strategic approaches for how to make health a policy topic for foreign affairs and diplomacy, which he pursued through the network of the Foreign Policy and Global Health Initiative (see Section 2.2.g of this chapter).

The launch of the Global Campaign for the Health Millennium Development Goals in 2007, in which Prime Minister Stoltenberg played an active role as a founder of the Network of Global Leaders (along with the Presidents of Chile, Tanzania, Liberia, Senegal, Mozambique, Brazil, Indonesia, and the Prime Ministers of the United Kingdom and the Netherlands), served as a platform for Norway in global governance. The Global Campaign and the Network of Global Leaders were umbrellas for the high-level political advocacy for health MDGs in the UN system and connections with the members of key groups (e.g. Health 8, the G20, G8, et cetera).

> Norway initiated the Network of Global Leaders and the Global Campaign and we were, at that stage, very, very active in it, and that was quite important at the time. That Network was very important not only for the Prime Minister, but it was also an instrument that led us into the global arena as a wider group, the Ministry of Foreign Affairs, Ministry of Health, Norad, and the Directorate of Health. We were all, all of a sudden, very active on the global arena much more than earlier, and got involved in much more of the global processes and we were part of the GAVI Board, the Global Fund Board, the different boards and then the PMNCH – was Partnership for Maternal, Newborn and Child Health – was initiated also with Norway as a driver, and I think we were chairing that at some stage as well. (D)

> We started in 2006/2007. This was the Prime Minister's global campaign together with 10 or so other heads of state. Their sherpas met in order to push issues. The Prime Minister set it up to develop a report every year. One called for consensus, a technical consensus for maternal and child health, and later it was broadened to be the reproductive, maternal and newborn and child health,

> and it did costing. So, this is the global campaign. And Every Woman, Every Child is the initiative for the campaign. It's called two things. We have a contract, for example, with the UN Secretary General's office, the UN Foundation, and the partnership for maternal, newborn, and child health in order to strengthen the collaboration to the Every Woman and Every Child campaign. That's how we keep it alive. We're in that office very often with Tore Godal. Tore Godal is key! (D)

The Global Campaign of the Network of Global Leaders contributed to the Global Strategy for Women's and Children's Health launched by the UN Secretary General in 2010, supported by a multi-stakeholder movement called Every Woman, Every Child.

> Norway's involvement in GAVI and Global Fund and the development of the global strategy for women and children's health, which came in 2010, are absolutely key. Norway was a very big part of the development of the global strategy for women and children's health, which was the UN Secretary General's strategy. We were also part of the writing group there and there were two commissions related to that. One was the UN Commission on Information and Accountability, and the other was the UN Commission on Life-Saving Commodities for Women and Children. The Reproductive, Maternal, Newborn, and Child Health Trust Fund (RMNCH Trust Fund), tries to deliver on the recommendations from the Commission for Life-Saving Commodities. … So, Norway has a sense of accountability around what it has promised or pledged to. We are a big part of some of the portfolio and the priorities that are identified there –around the Global Fund, GAVI, the RMNCH Trust Fund, the RBF Trust Fund. (D)

The Red-Green (centre-left) coalition Government between 2005 and 2013 established a unique political context for Norway's ascension as a key state actor in global health on the international scenery. The PM had already demonstrated a strong commitment to the MDGs during the Stoltenberg I Government in 2001, and both the Labour Party and the Christian Democrats (in Government 2001-2005) had a strong interest in global health. While this gave impetus and underlying political commitment for increasing Norwegian budgets for global health expenditure, the negotiation of these details was also complex in terms or working out the precise division of responsibilities within the MFA for these budgets. The MFA is the line ministry for global health spending, but during this government (until 2012 whether there was a Cabinet shuffle), the Minister of Foreign Affairs was from the Labour Party and the Minister of Development from the Social Democrats. These political realities necessitated some negotiations and flexibility to accommodate the distribution of responsibilities between the PM office, Minister of FA and Minister of Development who all had interests in global health and a desire to have influence on decisions about the disbursement of those funds.

The direct implication of Prime Minister Stoltenberg in global health (supported by Godal in the role of Special Advisor for Global Health in the PM's office) was a strong signal to actors in GHG of Norway's interest to further build its capacity in the niche role that it had developed within global health and aid architecture, for example in the 1990s working with global governance of HIV/AIDS (i.e. UNAIDS). This particular political context in Norway, and in particular this "gallery" or "circle" of actors are cornerstones of the streams of activity that constituted "golden decade of global health in Norway" from 2000-2010 described by multiple informants, when many things were quickly happening and the Norwegian contributions to a variety of international initiatives were growing (see ***Figure 1*** for a map of the contextual elements). One informant from the development sector noted that in this context, as integration increased between foreign policy and development policy in matters pertaining to global health initiatives, sometimes the lines of roles and responsibilities blurred. The idea to produce a White Paper proposed a way to clarify that work, by taking stock and identifying who was doing what within the public administration.

> We had been working on global health issues – particularly the health MDGs for quite some time. Some of these were produced long before we started working on the White Paper. We saw the need from Norad's side to have a better foundation of where we're headed, because it was, to a high degree, the work headed by Tore Godal, who was a special adviser to Prime Minister Stoltenberg, and he was actually sitting in the Prime Minister's Office, not the Ministry of Foreign Affairs at that time. So, the Ministry of Foreign Affairs had quite a lot of ownership of the whole global health policy, but they hadn't written it down anywhere and it wasn't really clear exactly to everybody what type of priorities this had within the Ministry of Foreign Affairs. Also, since it was with the Minister of Foreign Affairs and not with the Minister of Development Cooperation, I think it was needed from that perspective to have it based more in the Ministry of Foreign Affairs, but we also needed to make sure that Ministry of Health was equally involved. So, I think internally, within the Norwegian system, it was important to have some kind of a document saying that and then the White Paper was the answer to that. (D)

Section 2: What characterises the Norwegian NPGH action arena?

2.1 Characteristics of the Norwegian NPGH action arena

As described in the previous section, the first decade of the 21st century was a watershed for Norway's investments and political commitments in global health policies, programmes, and governance arrangements. The NPGH action arena was elaborated to bring those together under a coherent rational policy framework. The Norwegian action arena for NPGH was an intersectoral policy arena that developed from the intention of the Ministry of Foreign Affairs to connect the dots between, one the one hand, diverse global health initiatives and partnerships that it supported through its development assistance for health, and on the other hand, the knowledge and expertise for international health cooperation that is coordinated in the health sector under the remit of the Ministry of Health and Care Services. The *White Paper on Global health in foreign and development policy* produced in the Norwegian NPGH arena resulted from highly-regulated interaction between the three main policy sectors involved (health, development and foreign affairs) as part of a sense-making exercise of actors in the public administration for politicians (in the executive and legislative branches of government). I found the following aspects as characteristic of the Norwegian NPGH action arena.

2.1.a Sectoral territorialisation of global health

A lack of clear, unifying definition, or agreement, about what is global health and what is the scope of global health policy between the participating government policy sectors characterised the Norwegian NPGH action arena. The bifurcation of approaches to global health in the NPGH action arena represented the sectoral ideas and instruments used by health and foreign affairs sectors to improve the health of populations outside the jurisdictional borders of Norway. The health sector promotes a holistic and systemic view of global health, which necessitates longer-term horizontal actions across sectors within and between countries to positively impact public health and health equity of populations on a global scale. The foreign affairs sector promotes a targeted and issue-specific view of global health, which necessitates shorter-term vertical actions, often coordinated by multilateral organisations, to improve health of

selected population groups (usually women and children) in the poorest, low-income, and middle-income countries in a way that can produce quick and measurable results. Development assistance and aid strategies, supported by results-based financing as a key instrument for global health policy, overrode the systemic approaches traditionally supported by the health sector which also rely on partnerships with health sector actors in other countries (public health policy communities and NGOs) and exchanges with other public heath institutes.

> It is important to be aware that there has been some kind of tension between a very results-based focused strategy from the Minister of Foreign Affairs and his senior civil servants and others in the development community, who have been more used to sector-wide approaches and kind of horizontal approaches to development, and the health ministry and the agencies under the health ministry, who had more of a health system approach to the thinking about global health. There were tensions in that sense -- there were potential disagreements about priorities, the main thinking, and things like that. A lot of the approach by the Minister of Foreign Affairs' thinking in global health over that period focused on multilateral initiatives – vertical in the sense that they focused on specific interventions, and results-based financing or incentives-based transactions oriented approaches to the relationship between a funder and a recipient -- so in many ways a very new public management approach to global health. (H)

The pervading dichotomous approaches and corresponding instruments divided the ideas in the action arena along the two sectoral boundaries, which co-existed rather than integrated.

> They (MHCS) have their very clear priorities, which correspond more to what the health challenges are in Norway. And we (MFA) have our development perspectives, with MDG four and five mostly, which is not really that important to them. Non-communicable diseases, mental health, and pandemics so on – that's the Ministry of Health's priorities. It's still like that, but we have the development perspective, so that was a challenge here. (FA)

While different sectors agreed on some important goals, this agreement did not usually extend to the details about how to best and most sustainably achieve them.

2.1.b Power asymmetry

The position rules underpinned the division of these two territories of global health in the Norwegian NPGH action arena. The Ministry of Foreign Affairs exercised dispositional power in a majority of the situations, and throughout the NPGH action arena, because the rules allocated the highest position to the sector with the fiscal responsibility for global health. This translated into an asymmetrical power dynamic within the arena because the MFA, who manages all of the global health related budgets for official development assistance for health (including bilateral and multilateral assistance), could regulate the impact of relational power exercised by the

MHCS using rules operating in the NPGH arena that governed the flow and use of resources, including global health knowledge and expertise. Because the NPGH arena's rules allocated more positional power to the sector with fiscal accountability for global health, over a sector with the duty for knowledge production and policy-making on health, this reinforced the territorial lines related to approaches to global health (see Section 2.1.a of this chapter). Norway has a centralised system of decision-making and management of funding for multilateral organisations, which means that the Ministry of Foreign Affairs is in charge of the budget and acts as the lead competency ministry for all relationships with multilateral organisations. WHO is the only multilateral organisation with which the MFA and the MHCS share a joint-collaborative ministerial competency (e.g. the MHCS is responsible for matters related to WHO, even though the WHO budget is decided within the MFA). Rules gave most (if not all) power for decision-making in the NPGH action arena to the MFA, with the exception of the WHO Executive Board Strategy Group (situation 6), in which there was more balance between the two because rules reinforced power sharing arrangements between health and foreign affairs. As the main driver for the *White Paper on Global health as Foreign and Development Policy,* the MFA could allay the relational power of other sectors in the action arena and use the existing parallel system of institutional arrangements within sectors and between the sub-ordinate agencies in different sectors to support the collection and exchange of knowledge and expertise to supplement the processes engaged in the action situations.

> When developing the White Paper, it was a matter of updating the latest evidence, numbers and researcher findings in the area. Norad has close ties with the Ministry of Foreign Affairs and also with the research institutions in Norway. So, we're funnelled very much into each other, so that is taken care of. (D)

Social resources such as policy communities (i.e. RMNCH partnership) and diplomatic networks of actors who are part of the Norwegian foreign affairs and development policy sectors seemed to have more weight through the boundary rules applied to materials in the NPGH action arena (see Section 2.3 of this chapter).

2.1.c Dependant on key individuals who are boundary spanners

Sigrun Møgedal and Tore Godal are two Norwegian senior scientists and global health champions who are internationally renowned experts and advocates. While neither of them directly participated in the main action situations, their status as "insiders" to the policy process in the NPGH action arena was earned through their roles in senior positions as strategic advisors

or decision-makers in government, in the public administration, and in the civil society and academic community (see Section 1.2 of this chapter) as well as their frequent interactions with key political and administrative actors in the Norwegian action arena and in global health policy and governance at the international level (see Section 4.2 of this chapter). According to most of the informants, the international careers of these two medical doctors by training developed in such a way that they are the two most highly esteemed global health envoys for Norway. Both individuals bring their international experience, knowledge and networks to bear on the development of the NPGH action arena, and they have both been embedded in the development and foreign affairs policy government sectors during significant portions of time during the period of this case. The combination of their comprehensive package of international experience (in the field on the local level and in international institutions), their in-depth knowledge and understanding of Norwegian politics and foreign policy making, their personal and professional networks, and their cutting-edge strategic and analytical skills which make them valuable resources for the NPGH action arena as well as an integral part of its overall context (see influential individual Norwegian knowledge elites in ***Figure 1*** map of contextual elements in the NPGH action area). I found that these two individuals were inseparable from the fabric of the history of the Norwegian case, and inseparable from the development of the Norwegian government's global health activities during the first decade of the millennium. It is noteworthy to mention that our data also pointed to an upcoming next generation of boundary spanning individual emergent from the health sector in Norway.

2.1.d Informal routinisation and limited institutionalisation of interaction

Action situations observed in the Norwegian NPGH action arena are time-limited, and none were found to formally exist after 2013. However, informants reported that interactions between these two sectors continue to take place on a regular, but informal, basis. The data conveyed a sense from the informants that policy learning between the health and foreign affairs sectors as an outcome of their interactions in the arena has resulted in improved understanding and openness to other sectors' issues and approaches, fostered more willingness to engage in intersectoral conversations, and sustained a rationale for maintaining them.

> We had a couple of strategy meetings in Geneva (after the adoption of the White Paper), where we pulled together all the people in the Ministry of Foreign Affairs, and Ministry of Health, and subordinate agencies for general discussion on: What are the key topics now? What are the

> priorities? What about the comments from the Parliament? Are we following up? What will be our priorities in global health in terms of the sustainable development goals? In that sense, we use this as a platform and we try to continue the reflective process. (H)

> Ministries of Health are national and their links with international are limited. The White Paper might have bridged the [health and foreign affairs] Ministries closer together, in the sense that it was a joint White Paper. The Ministry of Foreign Affairs is the one handling all the aid money, which pays for all the health work abroad. And the Ministry of Health is the one with the scientific knowledge but it does not work internationally, in the sense of supporting other nations in doing better health, primarily. This is always difficult because the Ministries of Foreign Affairs, they are not Ministry for the topic, they are the procedural Ministry for dispatching aid. So, to have that link, if that link is successful, I think it makes a much, much stronger government. (H)

The WHO interministerial forum, with the purpose of supporting intersectoral collaboration for Norway's participation in the governance of WHO as the main international institution for global health, is the only action situation in the arena that I found had endured. This is also due to the action arena's antecedents in producing the White Paper addressing the division of WHO portfolio responsibilities between the two sectors.

2.1.e Exclusion of civil society actors and academics

The Norwegian action arena involved non-state actors in consultation and information gathering from the Norwegian context, such as non-governmental organisations that work in global health, universities and institutes doing global health research or practice. But they are excluded from any decision-making processes related to policy-making on NPGH. Civil society organisations, and the research community (including academics) are "outsiders" when it comes to the interactions between the health and foreign affairs sectors in the Norwegian arena for NPGH. The interaction rules limited their access to decision-making in the arena, although boundary rules for some situations gave them access to share their relevant ideas and analyses as resources. Non-state actors were generally outsiders to any interactions related to the reflection and decision-making processes, but they were included as participants in situations within the arena with boundary rules designed to give them an opportunity to be heard (see Sections 2.2.b and 2.2.c of this chapter). Overall, informants from NGOs and the research community thought that they had little opportunity to influence or participate in the NPGH action arena; this contrasted the reports from academics who conveyed that matters related to global health research or health policy in Norway are generally subject to more collaborative actions between

the MFA, MHCS, and MER, in which academic actors are more actively involved. However, I noted that national franchises of global NGOs and other historically powerful Norwegian NGOs have other ways to influence policy internally through their advocacy efforts directed at individual members of Parliament and to each of the political parties.

2.2 The action situations of the Norwegian NPGH action arena

I observed six main action situations in the Norwegian NPGH action arena between 2005 and 2013. Within this timeframe, most situations were concentrated within a period of two and a half years between 2010 and 2013 (with the exception of the Norwegian WHO Executive Board Strategy Group). ***Figure 2*** presents a model of the Norwegian NPGH action arena according to its constituent parts – action situations, actors, and rules. The ordering of the action situations in the text below corresponds to their numbering within ***Figure 2***, and ***Figures 2.1 - 2.6*** zoom in on the six individual action situations. The main situations are multi-sectoral. Three intra-sectoral situations (***Figures 2.1.a - 2.1.c***) are sub-situations that comprise the work done within each of the health, development, and foreign affairs sectors to organise and coordinate their respective sectoral resources that were contributed to the NPGH action arena.

2.2.a Situation 1 – Policy Writing Group

The purpose of the Policy Writing Group (***Figure 2.1***), hereafter referred to as the Writing Group, was to elaborate the text of the *White Paper on Global health in development and foreign policy*. Composed of senior and mid-level public administrators, policy advisors and experts from foreign affairs, development, and health policy sectors, the Writing Group discussed the development of the document's content and ensured the quality of the evidence and information used.

Once the decision by the Council of Ministers approved the MFA's proposal to develop the White Paper for Parliament, the Deputy of the Global Health Initiatives section of the MFA was given the authority to lead a team within the ministry for this purpose and to coordinate the project through phases of the interministerial clearance process before the Government's approval for submission to Parliament. The MFA owned that process from start to finish, housing

the White Paper Project Team that lead, organised, and managed the Writing Group. As the line Ministry for the White Paper, the MFA gave access to the other two sectors (using boundary rules for actors) by inviting participants to the Writing Group, and the foreign policy sector hosted all of the meetings and kept all records of the process. The Policy Writing Group was a small group composed of 8-10 individuals (3 foreign affairs, 3-4 development, 3-4 health). Although the Ministry of Health and Care Services (and occasionally other health sector agencies) collaborated closely in the process, many informants from the health sector shared the same perspective that the Ministry of Foreign Affairs drove the development of the White Paper in the Writing Group.

> We didn't have much debate about the priorities; the debate was kind of presented to us as almost *fait accompli* from the Ministry of Foreign Affairs, this is what they wanted. So, this was mainly an in-house exercise between the Ministry of Foreign Affairs and the Parliament. (H)

> We were called in for a meeting in the Ministry of Foreign Affairs explaining that we're going to be the writing group, and here is the skeleton of how it's going to look. So, for every item, there was a brainstorming on 'the Government will' in the first meeting: the Government wants to do this and it wants to do that. We sat there brainstorming and writing those up those very quickly, and many of them are still in there. That's the reality of how things work sometimes, because a lot of this is driven by politics more than by evidence, of course, and a lot of it was basically what we were already doing, so that was easy. A major chunk of those 'the Government will' action points were already formed at that stage in the very few first meetings. (D)

> It was very clear the Ministry of Foreign Affairs was in the driving seat. (H)

The authority for the process to assemble the White Paper lay with the MFA due to its purview for the financial administration of ODAH. However, the MFA did not have sufficient capacity (manpower or expertise) to develop the policy document entirely in-house without seeking supplemental social, scientific, technical and knowledge resources from Norad, as their sub-ordinate agency for development, and from the MHCS as the line ministry for health and public health policy.

> We had to spend that half-year enlarging and broadening that area, so that this would include all of the members of the working group so everybody was on the same page: what's the status, what's today's situation in terms of money and agreements and long-term obligations, and where were we heading. We continuously had to calibrate towards Sigrun and Tore because they were still very much out there on the frontlines. (FA)

The MFA initiated the Writing Group to create a space for dialogue between actors from the MFA and the MHCS to finalise the White Paper with the input of resources and approaches

from both sides. The MFA controlled the timing and degree of participation of the members of the Writing Group, which fluctuated as the inclusion of the actors from sectors other than foreign affairs expanded and contracted over the course of its fixed term process. The periodicity of the Writing Group's meetings and the size of the group varied over the duration of about one year between the fall of 2010 and the fall of 2011. The Writing Group was established in the summer (July/August) of 2010 by the MFA, and regular meetings were held in the fall of 2010 with MFA, MHCS, Norad (approximately 1x/week). In the initial phase of work of the Writing Group (fall 2010 – spring 2011) the process mostly included both ministries and Norad for consultations, followed by an intense writing period to draft in January-August 2011, with the diplomat "policy writer" recruited in April 2011 specifically for writing-up the final draft of the policy paper, at which time the group reconvened in late spring for final meetings to consult on the revised text.

The MFA structured and coordinated the interaction processes of the Writing Group. The Writing Group situation served as a centralised hub for the MFA to collect information and ideas from the key actors representing the three main governmental policy sectors involved in the NPGH. The members of the Writing Group were expected to share the work and resources that were internal to each policy sector (compiling input on drafts of sections, contributing new text to fill in missing parts of the outline, doing quality assurance, backing up with examples and research) (see ***Figures 2.1.a - 2.1.c*** corresponding to internal sectoral processes as sub-situations 1.a – 1.c of the Writing Group below). The MFA invited input from other sectors within a framework of pre-determined priority areas. As one informant from the health sector stated, "This had to be in line with the Ministry of Foreign Affairs thinking, on maternal and child health, and the MDGs." As the curator of the Writing Group, the MFA set the boundary rules for the information, ideas, and resources admissible for the Writing Group's process. Using development aid as the organising principle for including policy ideas, the boundary rules favoured resources especially related to the health-related MDGs.

> And with each part being quite technical in character, and with the politics blended in, the organising principle was the three main priorities which emerged from the MDG process primarily and reflected the priorities we had at the time in terms of development money. (FA)

The contributions from actors in the Writing Group corresponded to the kinds of resources germane to their respective sectors. Informants identified resources as being divided

across sectoral lines of interests, values, expertise, approaches, and instruments. The types generally fell into the following groups for a) the foreign affairs sector and b) the health sector : a) results-based financing, innovation, development, women and children (i.e. sexual and reproductive health rights), vaccination, short term wins, vertical programmes; and b) strengthening norms, public health and health systems, institution building, NCDs and mental health, global health which includes a focus on North and South, not just developing countries, horizontal approaches to health systems. The development sector lay somewhere in-between. While Norad falls under the institutional order of the MFA, as the technical and implementation arm of the MFA, actors working in the development sector share a number of approaches, such as intersectoral and horizontal approaches to health and education, the with the health sector – including principles of consultation and participation.

All the participants in the Writing Group did have the same perception of its processes. Actors from the foreign affairs sector tended to see the process as being one that was inclusive and that was successful at drawing on the knowledge resources of different sectors to build on the foundations of the White Paper together. Actors from the health sector generally considered that there was not enough brainstorming about what the White Paper could have become, rather than focusing on filling in the blanks of policy content with the appropriate corresponding evidence, practice, programmes, and ideas. Informants from some health policy sector agencies perceived their contributions were minimally influential, in terms of low relational power for materials and issues considered for inclusion. For example, some informants from health sector thought the health sector had more impact on the WHO strategy (see Section 2.2.f of this chapter), which is a situation where the health sector had more positional power. While some informants described the Writing Group as an "open process" others were critical about the approaches to engaging members of the Writing Group and wider consultations (see Section 2.2.b of this chapter) with regard to who was excluded and how processes were designed and used. There seemed to be a sense that there was lack of transparency about process to a broader community of interest (not just to other government actors, but to the global health research and practice community in Norway). While applauded for being an intersectoral process (boundary rules), some informants in health, development, and research sectors critiqued the interaction rules, having seen a shortcoming of the consultations being their insufficiency to qualify as participatory processes.

The Writing Group process was occasionally slowed down due to capacity gaps in the foreign affairs sector, but according to some informants from the health and development sectors, there was also a need to accommodate more discussion on content.

> It was initially intended to be carried out within a period of a few months, but then it was delayed. So, it took more than one year to develop the paper itself. And there were many reasons for that, but mainly capacity issues, and also the fact that there was a need to have more discussions. (D)

By the summer of 2011, when the document was being consolidated and finalised for clearance, the process was streamlined and the Writing Group consisted primarily of the core team in the MFA (3 members of the White Paper Project Team). Between April – August 2011, the Writing Group was internal to the MFA, and was reduced to one individual who was tasked with drafting the final version of the policy document. The policy writer reported to and collaborated with the other two members of the White Paper Project Team, and he interacted closely with actors from the health policy sectors through individual consultations.

The rapid writing up process by someone who had not been previously involved was in some ways beneficial, because the policy writer had distance from the on-going debates, which allowed new opportunities and fresh perspectives for their exploration when he renewed consultations on issues as needed directly with the individual actors from the different sectors in the Writing Group. In this stage of drafting, the policy writer used the positional power of the MFA to connect more directly with the health sector to reinforce the relational power of the health sector in the final phase of the Writing Group, holding strategic one-on-one meetings to work through ideas and content issues with members of the Writing Group from the health sector.

> He (the policy writer) picked up the phone a lot more than what was the case before, just to address our comments because the White Paper was not ours, it wasn't the Ministry of Health's paper, it was the Ministry of Foreign Affairs. So, in that sense you can comment and you can provide inputs, but you also have to accept that a lot of things will not be taken into account. But he did a great job in coming back to us for all the comments that we had come in with. 'So, what does it actually mean? How can I reflect this in some way? Maybe not here. Can I propose to put it here? I'll work it into the sentence... So, it's in the paper. Pull it up here, in terms of the structure…' (H)

> We really tried consciously to structure the text in the way that reflected both of those cultures and both of those mentalities, and not just because we thought it was necessary to bring everyone together and get the text that everyone can buy into, but also because we thought it would make the text better, which I think it did. (FA)

> He managed to draw better on the health side, when developing the final version that was approved. Because otherwise, it would have been a much more mediocre product, in the sense [that] it would be about development aid. I think that was really his contribution. (H)

The policy writer was a key individual to the successful completion of the Writing Group because he was highly skilled at working on complex policy issues in a consultative way. As a diplomat, he also had the personal skills and professional resources required for this (as reported by multiple informants) – a good negotiator, a good writer, knowledgeable about the audience and the rules for White Papers in Parliament, politically savvy, intelligent and committed.

It was in the final stages of the drafting that the final section of the White Paper emerged as a significant piece content of this policy document, to capture how Norway worked on global health policy and communicate that as a key message of the White Paper. This section was not originally planned in the outline of the White Paper as conceived by the MFA for the basis of the Writing Group's work. The diplomat who was recruited to the Writing Group as the policy writer proposed the last section.

> The intention of that part of the paper was to describe the way we wanted to do global health policy. So we had a chapter on the knowledge base and we had a chapter on political mobilisation, where we tried to capture our way of working, which was an important point in itself. We thought we needed to make a separate part about that to describe how we were working with the issue, because we have quite a lot to say about that – the Norwegian government global health policy was pretty innovative. We had a central part of the development of major new initiatives, and it was really a revolutionary way of doing development policy. And we haven't done that in any other field in that way, so that was a key message in itself in the White Paper. (FA)

Due to the policy writer's work to interact with members of the Writing Group from each of the sectors, he analysed that the summary of the Norwegian government had been done was insufficient to capture Norway's innovation. In this way, one result of the Writing Group was the acknowledgement of the rapidly changing landscape for intersectoral action on global health that was emerging and the clarification of the Norwegian approaches to working in this context. While this result did not indicate a clear action plan for dealing with those shifts, it left "an open door to a more horizontal policy process" on global health.

The main product resulting from the process of the Writing Group was a document that was signed by three ministers (of foreign affairs, of international development, and of health)

from two ministries (MFA + MCHS), that was agreed to by all of the ministers in Government, and that was later formally adopted by the Norwegian Parliament as the *White Paper on Global health in foreign and development policy*. There was consensus among many informants that this document is essentially a product of the MFA. For this reason, some informants from the health and research sectors did not think the White Paper was representative of the traditions of global health in Norway in a comprehensive way, noting that long-standing partnerships and capacity building efforts which Norwegian researchers and practitioners developed in the global south over the past 20-30 years were absent, as one consequence of the dominant MFA development aid perspective presented in the document.

Intra-sectoral processes of the action arena

Processes internal to each sector for coordinating its resources for the Policy Writing Group

The Policy Writing Group acted as a hub for exchanging knowledge-resources brought by actors from three sectors. Each of the participating policy sectors carried out internal intra-sectoral processes that collected, debated, and organised the ideational materials that were transferred by the actors representing those sectors to the Policy Writing Group. The intra-sectoral situations mobilised, convened, and analysed resources, which alimented the actors from each sector in the Policy Writing Group to exercise relational power to the degree afforded by the collective use of the Writing Group's rules. The rules for each sector's internal processes are intrinsic to each sector, but they also acknowledged the higher order of rules operating for the NPGH arena overall. Essentially, the intra-sectoral situations constituted the resources for the relational power dynamics that played out in the Writing Group situation.

Situation 1.a – Foreign affairs policy sector (intra-sectoral processes)

The idea for the White Paper was first initiated in an internal meeting at the MFA, with the Section on Global Initiatives (SGI) and the Minister of Foreign Affair's office in 2010 to discuss global health activities, which had been burgeoning, and for which they had no comprehensive catalogue.

> I wouldn't say it came out of nowhere, but we had been consolidating all of the things we were doing on global health because it was really a mix. There was no consolidated menu on that. There were two-three people working on that in the MFA; we are everywhere and we are nowhere. So, we needed to get this structure together. Where are the funds going? What was the background for

> those decisions? What political prioritisation were those funds and those agreements based upon? And when we started mapping that out, and we got some sort of grip on all the activities that were going on in order to be able to steer it, and in order to be able to provide the reporting of the results back to the Parliament. It was quite a lot of money. At the most in the global health unit itself, we were responsible for 3-4 billion Norwegian Kroners, and that was not including all the funds going to UN organisations as core funding where we knew that big percentages of that to UNICEF, UNFPA, WHO were also part of the global health funding from Norway. We were summoned to a meeting with Jonas Støre, the Minister of Foreign Affairs about a completely different issue, I think, and he was commending us on how we'd been able to get the two strong persons working together and how everything was playing out nicely. And he said that we should now go out and communicate what we'd been doing. This is actually a success story. We need to communicate that. That was when [the Head of the SGI at the time] said, "Well, why don't we make a White Paper?" That was how that came up. It wasn't more strategic than that. It was based on five years [2005-2010| of struggling to get all of these people and funds and everything put into a system where we could say to the Parliament and the auditor general, "We have some sort of control. We know where the money is going to, we have all the agreements placed up. All the issues fit nicely together in a political prioritisation." (FA)

The global health expenditure from the MFA involved a complex set of funding instruments, which also required a lot of coordination with two key global health actors from Norway (see Section 2.1.c of this chapter and refer to influential knowledge elites in ***Figure 1***). The Minister supported the idea of a White Paper as policy to communicate what the MFA had been doing to the rest of Government, to Parliament, and to the international community of global health actors. The MFA wanted to find a way to position the Norwegian Government's global health expenditure within a broader strategic framework for global health policy that involved multiple sectors.

As the lead ministry for the development of the White Paper, the MFA was the nerve centre for most of the action area (such as the Writing Group, the CSO consultation, and the high-level Ministerial Forum steering group situations), and the foreign affairs internal process made decisions about what to do with the input that the foreign affairs policy sector received from others. All of these internal and intersectoral processes were under the responsibility of the Section for Global Initiatives. The official name of the section was Global Initiatives and Gender Equality, and that section was responsible for global health, migration, gender and other specialised project issues as well as the WHO liaison and the FPGH (as of 2010). The Deputy of the section led the White Paper Project Team within the MFA and managed the entire process

connecting with the other action situations, and supported by a trainee for one year doing her diplomatic training rotation through this office with no experience in terms of health content. As of the spring of 2011, the main responsibilities transferred to the policy writer.

The SGI team members who were not part of the Writing Group were involved in the White Paper's development through internal discussions. It was a small team and the White paper was the topic of many internal discussions between the end of 2010 and 2011. They also participated in sessions with NGOs or researchers, because the Global Health team had internal resources that were valuable to the process. For example, a woman's and children's health team (MDG 4&5), headed by Tore Godal, who was the special advisor to the PM, worked very closely with Norad on this area. There was also a team working on HIV/AIDS (MDG 6). A combination of internal resources from the global health team was used to different degrees because the internal processes were less formal and because they were built also on the daily routines and working relationships between these actors who were accustomed to collaborating within their institution.

Once the policy writer arrived in the spring of 2011, internal checks and validation activities were conducted often in the final phase of the document's elaboration prior to going through a Cabinet wide review and to the Council of Ministers, before submission to Parliament.

> We had a checkpoint with the politicians, along the road, and there were at least two state secretaries actively involved in foreign policy, one from the Labour party and one from the Socialist party. And of course also, the UN Department was kept in the picture at regular intervals. We also were in touch with the Mission in Geneva, who played a specialist role on part of the second chapter, on global health preparedness stuff, the pandemic framework, and all of that, which was big at the time. People like Sigrun played into it, and Tore, we discussed it with him regularly as well. (FA)

The internal processes for the MFA were organised for the White Paper project to be tailored to the hierarchy of authority and corresponding mandate for areas of responsibility within the ministry. The senior managers of the section connected with their teams and the two main experts in global health, reporting back to the state secretaries, and ultimately to the Ministers. Because this was a coalition government, the internal processes necessitated particular attention to ensure that decisions were respectful of all parties of the Government's concerns, priorities, and visions.

Situation 1.b – Health policy sector (intra-sectoral processes)

Two actors from the MHCS who were in the Writing Group connected to the internal health sector processes with opportunities for all departments in the MHCS to contribute comments and text, and to ensure that the MHCS's submissions to the MFA reflected as best as possible the full array of health sector reflections for the White Paper, and in particular on items pertaining to research, mental health and health personnel. The internal process was coordinated by the International Department at the MHCS, who was responsible for channelling the health sector input back to the MFA for the Writing Group. When text was available for comment (approximately 6-8 times during the development of the White Paper), it was sent to all of the MHCS department heads, and they decided whether it needed attention from there department, if so, whether it was a priority and were resources and capacity available to do it, and if yes to the above, who should have responsibility in their department for that.

The MHCS process for collecting input from other health sector agencies was informal. Agencies included the Norwegian Directorate of Health, the Norwegian Institute of Public Health, the Norwegian Knowledge Centre for Health Services, and the Food Security Agency. The International Department at the MHCS coordinated with the relevant head of international or global health in each agency as the contact for communicating White Paper positions. Meetings were held to share the scope, agenda, structure and highlights of the White paper among all health actors in Norway, including researchers and NGOs. The process was a one-way collection of input from the actors in the health sector feeding back ideas to the MHCS, but without necessarily involving dialogue about decisions or follow- up. This is likely because the MHCS was not responsible for the overall process of the White Paper.

The resources and ideational materials contributed by the health sector were one of source of tension in the overall process of the underpinning the White Paper's development in terms of the boundary rules for ideational materials. The main tensions related to the vertical multilateral initiatives (MFA) versus horizontal (MHCS) approaches, which represented different ways of engaging in/acting on global health (see Sections 2.1.a and 3.2.b of this chapter). Collectively, the input from the health sector influenced a shift the focus to include more than women's and children's health and communicable diseases, such as some of the more globally shared

challenges (like NCDs, security, etc.). Even up to the final hours (before the final Ministerial Forum steering group validation) the internal health sector processes managed to convince the MFA to add a few sentences into the policy content on mental health and stigma.

> I had a talk with the Ministry of Foreign Affairs more or less the day it was supposed to be presented for the ministers -- it wasn't yet the council but it was a week or two before. There's all these procedures, it needs to be forwarded to the various ministries for comments, and then it comes back, and then you do another round... but it was one of the last rounds where we managed to get in I think two sentences, just through a reflection and now there's one point saying that the government will put stronger focus on mental health illness and stigma or something. But even so, this was commented after the launch by few organisations, that the text around mental health illness was weak. (H)

The capacity (human resources, knowledge, and practice) of the health policy sector in the Norwegian government is larger than the foreign affairs or development sector; there are more subordinate agencies in the health sector than in the other two policy sectors. There seemed to be homogeneity in terms of the perspectives on the development of the White Paper from the health sector, but with so many more actors and from different agencies, it was difficult to assess from the data the contributions from the different parts and to what extent they were synthesised by the MHCS who was the main sectoral actor in the Writing Group.

Situation 1.c – Development policy sector (intra-sectoral processes)

Although Norad's membership in the Policy Writing Group broke the institutional norms against participating directly in policy-making, the agency wide approach to policy review was a regular institutional practice, as a rule for all white papers requiring technical expertise from the development agency. Informants in the development sector confirmed the extensive internal processes within Norad to contribute to the White Paper. The Director of the Department for global health, education, and research coordinated an agency-wide process within Norad, signing off on the inputs before they were forwarded to the MFA for the Writing Group. The process entailed senior level input, including the participation of the Director General in some internal consultation meetings, as well as getting feedback on the White Paper from the Norad Board of Directors. The White Paper was circulated to all of the departments in Norad offering them opportunities for input. It was important for the Norad internal consultation to include input from across the agency and not only the health section, to include a diverse range of resources from the

development sector. Norad's Global Health team (Head + 12 staff) located within the Department for global health, education, and research held a more in-depth process of internal consultation to ensure contributions from staff who had expertise and knowledge on specific topics, but all of them also contributed to the overall package of content and the connections between the policy areas in the document.

2.2.b Situation 2 – Civil Society Organisation consultation

The CSO consultation (***Figure 2.2***) aimed to collect input from non-governmental organisations and members of the research community who had an interest in contributing their expertise and ideas to the White Paper's development process. The MFA hosted and organised consultation. Two face-to-face meetings were held for this purpose in mid-October 2010 and late May 2011, in addition to the possibility for non-state actors to submit written proposals electronically. The 1st meeting was chaired by a member of the White Paper Project Team from the Section on Global Initiatives, and the 2nd meeting was chaired as a panel by 2 state secretaries, one from health and one from foreign affairs. The MFA invited a wide range of non-state actors and civil society groups including academics, health professional associations, faith-based NGOs and church networks, research institutes, youth organisations and other actors who were not a part of the Writing Group (including actors from the private sector) to share their input on the White Paper.

> Another loop which is important for all these White Papers – and they did that for the White Paper on Global Health – there is request for input from civil society, academia, private sector and so on, and that generated a lot of input – from NGOs, from the universities and so on. (D)

Over 70 organisations and groups were invited to the meeting in October 2010, but only 30-40 organisations took part because the policy development process coordinated at the MFA did not have funding to ensure inclusive participation of actors from civil society and academia from all over the country. Those who participated were either based in Oslo or had travel funds to attend the meeting. Participating organisations included: Norwegian Red Cross, Norwegian Cancer Society, Norwegian Church Aid, Organisation against Lung Disease and Tuberculosis, Save the Children, Norwegian Institute of Public Health, University of Bergen Centre for International Health, Norwegian Knowledge Centre for Health Services, Norwegian Institute of Foreign Policy, Fridtjob Nansen Institute, members of the Norwegian Forum for Global Health

Research (and other global health scientists), and specialist NGOs (e.g. diabetes, addiction) and other professional associations.

> It's sort of blurred to me because I'm in so many meetings where you gather ten NGOs and the MFA speaks, and you're a little bit back and forth, and it's not necessarily very productive. We submitted something in writing with other NGOs on getting more human rights language into the report. That was one of the key concerns there, and we also submitted individually, in writing, on more of the substance we have been talking about here prior to the launch of the White Paper and before it went to Parliament. I think maybe we submitted two or three even formally or informally. We also had some contact with [White Paper Project Team], I remember. There was a meeting, or two, or three. (CS)

At the first outreach meeting in mid-October 2010, the MFA shared a draft concept paper. No documentation was provided for the 2nd meeting in late May 2011, announced as a public consultation, but an update was presented to the participations on the process, reviewing the main outline of the White paper and giving a last opportunity for civil society to comment. There were also some closed and informal meetings in addition to the two bigger forums. The meetings were not structured in an interactive format for exchange on any particular questions or concerns regarding the development of the White Paper.

> Then normal procedure is just that the Minister would introduce, there is a round of comments around the table, and there is some type of summary at the end, and they all go home happily. (H)

Approximately 100 different inputs were collected in writing and from the CSO consultation meetings, and they were "very professional and thorough" according to an informant from the development sector.

While the boundary rules of the Writing Group process restricted the resources and information allowed to a development aid policy approach to global health, the CSO consultation process expanded those boundaries significantly to include a wide array of perspectives and resources from actors working on all facets of global health. The consultation process welcomed all ideas that related to any aspect of the global health agenda, even though it was unclear what would be done with them and how they would be processed.

> There were a couple of times when we asked them for input, but not on specific text components of the draft, but rather the gist of it saying that, "This is how we foresee the White Paper and would welcome any important ideas or suggestions to that". (FA)

The rules for handling information, and understanding and incorporating those ideational resources and materials were not clear, but no input of any kind was turned away or discoursed.

> It was seminars, internal meetings, but it was not a very open consultancy. We were always asked to come and reflect on it, and we were very seldom getting a draft to say, "Could you contribute to this draft?" The consultations were not very formal. Sometimes they asked some of us to come to the ministry for closed sessions to discuss. Of course, when they asked for something, we came. We know them personally, but it was not a systematic, planned process involving both of the sides from the Ministry of Foreign Affairs and Ministry of Health. It was too few consultations, in my view…. it was not transparent, because they had not told us who were invited for some consultations or how many other consultations they had. (R)

Participants did not receive a clear rationale for the MFA's consultation. There were no clearly defined expectations, roles and responsibilities on behalf the CSO actors or on behalf of the Government in terms transparency about the decision-making process, what would be done with the contributions of the non-state actors, and how they would be reviewed, analysed, and incorporated in the policy content. The CSO consultation process was generally not perceived as "participatory", but rather an opportunity for the MFA to assemble non-state actors who had a stake in global health work and who wished to be heard by the government for this purpose of collecting their insights and ideas about policy content.

> They were part of the process, but not as much as they should have been according to what most people would think was the right way. In many ways, I think it was insufficient to say it was a good process with the civil society. (D)

> The civil society in Norway is quite active in making comments on things. I don't think they were part of conceptualising the paper, but they were part of the hearing. There are strong civil society organisations… like Save the Children, like the Refugee Council, and some of these would make use of these opportunities to go with their comments, but it wasn't anything like a participatory process. (FA)

From the perspective of informants who were not from the foreign affairs policy sector, the rules did stimulate interaction or dialogue, but they created a mechanism for the MFA to collect input from civil society resources. The perceptions of the process differed greatly among informants between the participants from the different sectors, which seems to be related to the cultures of the policy sectors. The use of "participatory" consultations for policy-making is not a common recourse for the foreign policy sector, where decisions are usually made internally and expediently, relying on strategic consultations with identified experts when needed. In the development and health policy sectors, participatory consultations or dialogues with key stakeholders outside of Government is a practice recognised as a key principle and value for

developing policies and programmes. The consultation was intended to take note of key points from the perspective of actors who are working in the field of global health. This was not a power sharing arrangement or participatory policy-making exercise, but the situation served as a platform for expressing ideas. The CSO had little relational power; they were "heard" but had the impression of having little influence.

> When it comes to the role of research of in global health, I would say that compared to all other areas of Norwegian development assistance, health is the area where research has a prominent place, more than in any other area of development. Even though researchers in the global health field out there don't get much –they get much more than others, in terms of funding for research. But that doesn't mean that researchers have any role in policy-making. The policy process, that's another issue. The normal procedure is to have some kind of involvement. It's more that people have an opportunity to voice their viewpoints, maybe more than a dialogue about actual formulation of policy. They hold a meeting where people could say whatever it is on their mind, but not the ministry coming forward saying, "Hey, we're thinking about this policy. What do you think about that?" I've not experienced that. (R)

While the process generated ideas, and that seemed to help the MFA team get a sense of the diversity in the field of global health action in which Norwegian actors were working.

> There was lots of interest, lots of comments, and mainly good things. What we drew from that was that we were on the right path, but we also tried to take the input from that into the work. It's mainly reflecting some sectoral interests, and not having their stuff included. In any case, it was kind of a big event. It also took quite a lot of time to organise. (FA)

It is unclear from the data how this was used/or not used for drafting policy content and what were the criteria for those policy choices.

> Again, we are back to the political-- the politicians are very afraid of involving outsiders of the ministries into their writing process, but they are very open for listening to others and questioning and listening. (R)

By reaching out to the global health actors, one of the results of the consultation process was that the MFA built a larger basis of support for policy work on global health. For example, the consultation process increased acceptability of the policy document's content to politicians because it created opportunities for the non-state actors to be heard prior to the public hearing in Parliament.

> We've gotten a lot of comments and I'm still getting calls and emails, and stuff like that, because everyone wanted to influence the paper. That was also something we tried to work in. We took a pragmatic approach to that. Some of it was good, things we hadn't thought of and could build on, but beyond that, what you want to do is try to include as much of it as possible as long as it doesn't contradict anything or hurt in any ways. If you can, on a pragmatic basis, include an input,

it's always better to do so. You try to include, but it's a government policy document, so in the end if someone thinks something different than the government, of course it doesn't go in there. But generally speaking, you try to include as much as possible of those perspectives because it also gives you a broader basis, and it matters to the way it is received, and it's kind of the way we work also. We don't just sit around in the ministries and figure things out. And if we can integrate as much as possible, the thinking and activities out there on the civil society side, we have a broader basis for policy and we'll be more efficient in getting results, so there is always this bias to try to include as much as possible that perspective, and really build from there. (FA)

When we talked to them, it wasn't a matter of disagreement or challenges in terms of what to prioritise or not. It was more an issue of getting the gist out of it, the snapshot because the area was already so much agreed upon and there was so much money in there and advocacy in there. It was more to make all of the partners see, "What is it that we really need to pin down when advocating for this area because we all know that there is a very large and substantial amount of work being done on all kind of levels, in all kind of different countries and forums, but if we are to sell this to more than just the Parliament, what is that we really want to pinpoint and from that point what is it that we want to push forward to take it even further?" (FA)

2.2.c Situation 3 – Public hearing of the Parliamentary Standing Committee on Foreign Affairs and Defence (FADC)

The Norwegian Parliamentary Standing Committee on Foreign Affairs and Defence met to hold the public hearing (***Figure 2.3***) on the White Paper in the spring of 2012. The process began once Parliament received the White Paper from Government in February 2012, and it took approximately two months to complete. The purpose of the FADC public hearing was to hear statements from experts and interested organisations outside of government about their views on issues they thought were important to have on the official record related to the White Paper. Individual experts and representatives of groups participated in the hearing process in two ways; experts submit statements for the FADC's consideration and they respond to questions from the FADC in person. Invited experts delivered statements for no longer than 5 minutes each in a formal hearing. The committee is obligated to hear from the experts, but public hearings are not necessarily interactive as a format. CSOs use hearings as opportunities to address issues in policy that they consider may not have been given adequate attention. The hearing was also concerned with the process of developing the White Paper.

MFA actors were not being put on the hearing stand because we'd submitted the paper, but a lot of the NGOs referred back to the consultative forum, so a lot of the hearing discussion was actually about process – which was also quite interesting, because the committee is always concerned

> about whether the papers have been inclusive, whether it's been transparent, whether the policy resonates in the broader community. (FA)

About 15-20 experts from CSOs and special interest groups participated in the FAD Standing Committee public hearing, mostly large NGOs like Save the Children, Red Cross, and the Forum for global health research. Organisations invited to the formal FADC hearing also contributed written statements about the policy [see APP 9-11, 20].[2] From the data, it is difficult to decipher reasons why some CSO issues get traction and others did not in the hearing process. For example, some statements did seem to appeal to a practical consideration by the committee, such as the committee's interpretation of points raised by the Forum for Global Health Research on global public goods.

> The point that we made was that even though health has certain aspects of a global public good, it draws attention away from the fact that health is also about distribution. If health is a global public good, it's a thing that everybody can enjoy. That rhetoric undermines some of the real big focus on health inequality to the world. I don't think that was the intention in the White Paper, but we just drew the attention to that issue. But I think the committee members saw that this was a point of philosophical interest rather of practical interest. And we didn't have a big conversation with them anyway. They asked a few questions about it. That was the end of it. (R)

While others, such as those related to mental health, had a broader appeal and support due to the advocacy work of issue-based NGOs.

> The lobby group behind mental health -- they knew exactly where to push and had the right sort of people involved in Parliament. (D)

From a civil society actor perspective, the process of the public hearing was more receptive to input than working directly with the MFA in the consultation process for example.

> Parliament was much more open than the MFA in the writing process. Not that they were not open, but I think Parliament were more open for integrating input from the civil society. I'm not saying they (MFA) were not. They were taking issues from civil society, but I think when we worked through Parliament, there was a great opening there. (CS)

The elected officials in the legislative branch are generally more approachable and responsive than senior bureaucrats or political appointees in the executive branch, because achieving wide support in parliament is more conducive to sustainable backing for policies. Some large NGOs possess financial, human, knowledge, and social resources to analyse politics and policies for adapting and targeting different perspectives related to their message.

[2] All references indicating [see APP #] refer to archives of the policy process for this case. These are listed in Appendix K of this thesis in a table under the heading archives of the policy process (APP) for modelling the action arena of the Norwegian case of NPGH.

> Norway is generally good on working on children and women's rights and giving priority to that. But as the world looks today, there are some key shortcomings in the way this is dealt with nationally and globally and within global health. The key challenges like inequities, fragile or inaccessible primary health care, and malnutrition are not really dealt with in a proper way, and the fact that several of the vertical initiatives in which Norway's been involved does not necessarily create or enable comprehensive integrated health services neither for women or children. Those structural issues were more our angle. We were pressing at a formal level for more references to child rights convention and all the human rights instruments. Then in terms of the thematic issues, we were focusing on getting more language on health systems strengthening, human resources for health, universal health coverage and, as I said, nutrition. Now these are issues that would anyway be touched on in such a Norwegian White Paper, but I think we influenced it to ensure that – especially after it went through the Parliament – it is more substantial in there than what it would otherwise have been. …I think in hindsight, we were quite successful in getting more language on these issues. And also, that the Parliament has more focus on it. But in terms of actual action, the influence has not been that strong, because it's more in the narrative. It's not really in the recommendations. (CS)

The completion of the FADC hearing process resulted in the production of a recommendation / opinion to Parliament for its debate on the White Paper. The FADC officially released and submitted its opinion to the Storting on May 16, 2012 [see APP 3]. It its opinion, the FADC endorsed the White Paper, fully supporting that it be passed, and called for a stronger emphasis on mental health and part of global health policy in Norway. While the FADC owned the formal opinion, there were two other committee meetings (health and social welfare), both of which also supported the FADC's opinion. Overall, there was little disagreement on salient points.

> The White Paper was different from other White Papers because when it was adopted by the Parliament, the question came up from Parliament members that: 'We normally ask the question, how are you now going to implement it? How are you going to fund this, but that's already here. So now the only thing we can ask for you to do is come back to us with the annual budget and report on how we're actually following it up.' (FA)

The FACD hearing process highlighted some issues that are important for a broader support of the policy in the parliamentary debate [see APP 4]. The recommendation of the committee made the policy narrative more comprehensive to allow for more coalition support and cross party buy-in, not only for the vote on the White Paper in Parliament but also for follow-up on global health policy in the future.

> That's interesting because a specific Government put it forward, with a constellation of political parties, and then when they change, the new political scenery is not necessarily then bound by the old government, which was a different political constellation. … But that is where the committee

> hearings come in, and that's very important, because if the Parliament, with all the different party politics consents to the report, then it becomes a much stronger tool. Then it's independent of the different political parties that were actually initiating it while in government. And that was pretty much the case in this, and it is in many of the White Papers. I think they received quite broad support from the Parliament. In which case, you can discuss how or to what extent they bind the new government. (H)

2.2.d Situation 4 – Ministerial Forum

The Ministerial Forum (***Figure 2.4***) operated as a steering group that provided for high-level checkpoints with relevant state secretaries and ministers to ensure ongoing political agreement and satisfaction throughout the process (from fall 2010 to fall 2011). Specifically, the Ministerial Forum was essential for cross-sector agreement between the health and foreign affairs ministries first, to develop a White Paper, (in the summer of 2010 before securing Council of Ministers support resulting in establishment of the White Paper Project Team in MFA), and second, to finalise the White Paper (in the fall of 2011 before requesting Council of Minister's support to send the White Paper to Parliament). Before officially initiating the White Paper's development within the MFA, the concept of the policy document had to be formally validated by the Cabinet (Council of Ministers).

> All White Papers have to be approved by the Council of the Ministers. When the idea was approved by the Minister of Foreign Affairs, at that point we also had a Minister of Development, so the formalities were that we had to do the internal formal process of getting the documentation on the idea, purpose, and timeline on a general level approved by the two ministers, and then the more formal note and decision document to the Council of the Ministers, which is quite a cumbersome process. It involves that we consult with the other ministries who then consult with their ministers. So, when the document is actually put forward for the Council of Ministers, it's more or less agreed upon – more or less. That was one formality. In the decision document to Council of Ministers, we had briefly elaborated on the purpose or the need for the White Paper, anticipated approach and then of course a timeline. And due to the -- I wouldn't say smooth surface of cooperation between the two ministries -- there was quite a bit, unusually again, on how we would process the work on the White Paper. After having that formal decision from the Council of Ministers, we established that project team. (FA)

Before submitting to the White Paper to the Government Conference (PM + Cabinet) and the Council of State (Cabinet, PM + King), the White Paper had to be cleared and approved by all of the ministries, but first and foremost in the MFA and MHCS before being released and sent

out to all the others. Then each ministry had time to comment on the draft before it goes forth to the Government Conference and Council of State.

> There were of course several Ministries that felt that they had the ownership of the document and … because there are so many stakeholders in that area. (FA)

At the completion of the Writing Group, a similar process took place with the text of the White Paper before sending it to Parliament.

> Up to Christmas 2011, we were writing and we showed that we had all the formal institutions and directorates' support, getting the last of our conclusions in the document. At that point of time the Council of Ministers processes takes longer, because then the different line ministers had to read the White Paper. They are given an opportunity comment on the White Paper, and a lot of ministries are then trying to get their piece of work into the paper. The Ministry of Finance is worried about the budgetary consequences, and that was again where the White Paper was untraditional because the Parliament had already approved quite a lot of the budgetary consequences long-term, multi-year contributions up to 2020. So, we already had the annual budget and could refer to the annual budget and decisions by the Parliament. So, the Ministry of Finance was one of the more easy line ministries to have on-board in that process which is very, very rare because they are often the one that will sit down at the very last minute to make sure that every word is sort of in the right way done. So that also was the internal processes on the bureaucracy side with the ministers and the Parliament. (FA)

The White Paper went through the final Ministerial forum's clearance process at the end of 2011, and then went to Government Conference and then Council of State before its formal submission to Parliament in February 2012.

The three relevant ministers from MFA (the Minister of Foreign Affairs and the Minister of Development) and MHCS (Minister of Health) as well as three relevant state secretaries (deputy ministers) constituted a high-level cross-ministerial forum that served as a Governing/Steering Group for the White Paper process. The White Paper Project Team located in SGI in the MFA coordinated the situation for cross-sectoral interactions at state secretary and minister level. The intra-sectoral processes at the MFA analysed and presented the results of Policy Writing Group and the CSO consultation to the responsible ministers and state secretaries, giving the political level regular updates and opportunities to give feedback throughout the durations of the policy document's development (see situation 1.a in Section 2.2.a of this chapter).

> A positive effect of a wide consultation is the involvement of a broad set of actors. However a challenge might be that the process will take a long time. When Norway was preparing the White Paper, Norway had three ministers involved : minister of health and care services, minister of foreign affairs and minister of development. The two latter ministers represented two different

> parties in the Government, and every clearance required that the two parties had a common position, which again could sometime take time. With the new Government (from 2013) there is one minister of foreign affairs who is responsible for both foreign affairs and the development and aid portfolio, and therefore can make a rapid decision. (H)

The Ministerial Forum met about once a month, and this process was generally consistent throughout the White Paper's development. Otherwise the White Paper Project Team provided updates to individuals without convening the entire group. Sometimes members of the Writing Group also met with State Secretaries. These interactions were intended to maintain a flow of information to the political level about the status of the White Paper's development, connecting the administration to the politics so tensions or conflicting issues could be dealt with accordingly.

The materials provided to the Ministerial Forum were drafts of the Writing Group's products, as well as updates from the consultation process with state, academic and civil society stakeholders inside and outside of Norway. The boundary rules for information in this action situation were skewed towards the use of political resources, because these were the resources with which the actors in this situation were most invested, familiar, and concerned. The "Government will" action bullet points and agreement to them was a deterministic product from this situation, wherein essentially each of the main priority areas also corresponded to the areas of responsibility for state secretaries.

> At the end of the day, the politicians come in and say, "This is what we want." Then it's a political thing and then it becomes a political paper [from the Government]; once you reach that stage it becomes a political document. And then it turns into getting the political priorities into it. (H)

Most importantly, this situation galvanised agreement across the Government (based on demonstrated agreement of the two collaborating ministries) for the final version of the White Paper.

2.2.e Situation 5 – Follow-up process

The same two ministries (MFA and MHCS) who signed the policy document initiated a follow-up to the White Paper (***Figure 2.5***). After the formal adoption of the by the Parliament, the three state secretaries (in particular those from the MFA) requested a follow-up report and an evaluation of the action points (i.e. the "Government will" points agreed upon in the Ministerial Forum). Norad coordinated this situation, working in close partnership with the NIPH. There were two parts to this process. First, the follow-up aimed to better capture what Norwegian actors

(state and non-state) were doing in the field of global health (advocacy, practice, research). This aimed to connect with the civil society actors in Norway in a more meaningful and purposive way than during the CSO consultations for feedback during the development of the White Paper. They scanned the main actors working in global health (broadly defined) in Norway and asked them to report on their main activities. In this situation, Norad invited NGOs and other civil society actors to share what they were doing in global health to provide an overview of their piece of the Norwegian global health puzzle, as a compendium to the goals, objectives and instruments in the design of the adopted policy document.

> It was important for the Ministry of Foreign Affairs it to see that all these actors were involved and for them to actively use and engage with them. They wanted some kind of a table, like a two-pager showing what everybody was doing, and we thought, "Okay, that's not sufficient because these agencies need to be able to show what they're doing more clearly and you can't do that in just a few lines. That wouldn't be fair to them in many ways." So, we initiated the larger process for that. We tried to get them more engaged, even though it was a bit later, by asking them what they're doing in this area, and how they see the White Paper and how they follow it up. It was a way of engaging. It was a process in itself, and many of these institutions and civil society agencies got much more involved and had more ownership in the White Paper afterwards due to the fact that we made this. So, the process, not the document itself, but the process of producing that was quite important and it made up, at least partly, for the lack of involvement [of CSOs in the writing process]. (D)

While politicians recognised that there was a need to include the Norwegian actors more visibly in terms of the Norwegian contributions to global health action, the methodology was unclear. Actors were not asked specifically to report on projects and programmes as they might have been accustomed to doing for public-funded accountability procedures, but they were asked to report on their global health activities in broad terms. The participants did not receive precise instructions about what level of detail to provide nor any criteria or guiding principles to use in their report, so content and structure of each contribution depended on the organisation's scope of activities.

> The method we discussed with the Ministry of Foreign Affairs was probably too laborious and was not useful enough because what one tried was to say was, "Let's go out and ask each actor in Norway how it contributes to global health." Then, we'll compile them. Well, that was impossible because, I mean, it was too different. To compile all of the actors' responses in a coherent way that was interesting or relevant was difficult because when you go to an NGO and you ask, "What's your result?" -- the NGO response was super-detailed about in one project in one itsy-bitsy village. (D)

It was an open-ended and adaptable process, which produced a great deal of diversity across the submissions according to the capacity of the organisation.

> So, you had a lot of people reporting, "We took part in meetings" another reported, "We had one activity. It was 250 million dollars and we did something very big in Africa." So, it didn't level when people reported on it, which became a methodological challenge because those writing the report knew that they had to somehow consolidate this data and make an analysis of what you should actually draw from this. You had organisations reporting on lots of activities, which were in total very minor, when it came to how much money was involved or how much actually output was involved. Whereas others reported hardly anything and you knew that they had a budget of several hundred million Kroner, and they had done massive amount of work in the field. So, it was a methodology question that made the way that we tried to make the follow-up report very difficult. We should have structured it differently. And I think I say "We" because we were in the group that designed on it. We should have been able to think it better in a way. (H)

The process did not include an exchange with participants about an action plan to work with civil society on any particular recommendations to follow-up on the formally adopted policy document.

The report *Norwegian actors' engagement in global health* was the main publically accessible result [see APP 2]. It was released at an open house launch of at the Literature house near the port of Oslo at the one-year anniversary of the White Paper's adoption (May 2013). The publication presented a collection of different stories of what Norwegian government and civil society actors were doing in global health arena, including 49 different contributions from Ministries, directorates, government agencies and NGOs. Each organisation submitted a statement of their work, but the results of the process did not include any cross-analysis of the state of the art in global health work in Norway, trends, or emergent themes or gaps. Since no overall assessment was provided, the links between the work of individual organisations and the Government's work as reported in the White Paper were questionable and unclear. Nevertheless, this type of engagement with the civil society actors was a step towards countering the sentiments about their lack of inclusiveness in the policy making process for the White Paper.

The second branch of the follow-up process focused on preparing an accountability framework as part of an evaluation process of the "Government will" recommendations. This effort intended to support evaluation and monitoring on the actions recommended, to track what was being done or progress made. Informants reported significant challenges regarding this work, because the recommendations had been made without any reference to indicators of change

or impact. This work was mainly undertaken by a small group of actors in Norad and NIPH, but it was unsuccessful and never got published or publically shared, although the data suggest that perhaps it is used internally in the MFA.

> The three state secretaries from the Minister of Foreign Affairs and Health wanted us to have an evaluation of its recommendations given in the paper. Then we started to read it and we understood that this could have been done much, much better. (H)

> We looked into ways with the Ministry of Foreign Affairs on how to create a kind of an accountability framework which we developed on most all the points in order to be able to say, "Okay, this is how it's followed up. These are the investments that have been done in relation to the different cabinet action points" – the 'Government will' – there was more than 70 of them. Our recommendation was to compile them in logical groups because some of them overlapped, and then to see what Norway is doing, and then to see if there was any way possible to link activities and funding to results in any way. It was very obvious that it was broader than health. It was the security element, health in diplomacy, health in development -- health in more of global health perspective. It was very much apparent in its framework. And I think that it's important to have such a framework. That could have probably been better thought of up front. Although a lot of the things that got included in there were because they were, in themselves, very result-focused so they land very well in the accountability things like GAVI, investments to GAVI or through a fund. We could have used GAVI's results framework. So, there were ways of looking at it. But there were other things that were more difficult to monitor. So, we asked the Ministry of Foreign Affairs and when looking at an accountability framework, should we include the comments or should we not include comments (from the Parliament decision) -- which is a delicate matter because the comments from Parliament are not necessarily the 'Government will'. (D)

2.2.f Situation 6 – Norwegian WHO Executive Board Strategy Group

Due to cooperation between the Nordic countries to maintain a permanent presence on the WHO Executive Board, a Nordic country can calculate in advance when to begin preparing for elections. Candidate countries and representatives are first discussed and cleared through the WHO EURO Regional Committee. With a seat for Norway on the WHO Executive Board on the horizon for 2010, the Norwegian Government produced a strategy in 2009 to communicate what Norway wanted to accomplish during its tenure on the WHO EB.

> When we went to that global health meeting in May 2010 we had lined up a campaign for our board member, where we were consolidated across the Norwegian line from diplomatic missions, to NGOs, to faith-based organisations, to the two ministries and directorates and researchers. (FA)

The purpose of this action situation was to bring together the health and foreign policy sectors to discuss the policy position of Norway in relation to the WHO portfolio, and how

Norway could have an impact during its WHO EB term from 2010-2013 (***Figure 2.6***). To capitalise on this opportunity to influence the governance of WHO at a high level, the Norwegian MFA and the MHCS collaborated (under the leadership of the Ministry of Health) to develop a strategy with a dual purpose: *firstly, to define the overall objectives and priorities of Norwegian WHO efforts, and secondly, to provide the basis for a clear, coherent Norwegian WHO policy, thus enhancing the consistency of Norway's approach in WHO forums as well as in the UN* [see APP 23].

The development process for preparing the strategy began in 2007/2008, approximately 1.5 years before taking up the EB seat in May 2010 (at the 127th session of the WHO EB). Between 4-6 official quarterly meetings were held before reaching agreement on the final strategy, with monthly meetings when needed to maintain were active and open channels of communication and frequent interaction outside the formal meeting (informants spoke about lots of correspondence in between meetings to make progress). The strategy was officially released after the Norwegian Board term had begun, signed by the Minister of Health, the Minister of International Development, and the Minster of Foreign Affairs on September 1, 2010 (the same three ministers who signed the White Paper in May 2012). Once the WHO EB term was active, the situation remained active until the end of Norway's terms on the WHO EB in 2013, with monthly meetings of 6-10 people, chaired by the Director General of the Directorate of Health (the elected Norwegian EB member), with 3-5 people from each of the two sectors participating (depending on the issues on the agenda). The strategy document outlined these rules for processes giving the Directorate of Health the task to coordinate the management and decision-making for the Norwegian WHO EB seat, including the coordination, collaboration, information exchange with other sectors. It should be noted that since then, the coordination and secretariat of WHO affairs for the health sector has since been moved from the Directorate of Health to the Ministry of Health, and the former Director General of the Directorate of Health is the Secretary General of the MHCS.

The WHO EB Strategy Group is an outlier situation in the Norwegian action arena because it is the only one where the position rules give the health sector the power to coordinate,

with leadership from the MHCS. According to informants from both sectors, this situation struck good "balance" between health and foreign affairs sectors in terms of reflecting their mandates.

> From the beginning the WHO strategy was a more open discussion. The result of this White Paper was more predefined than it was in the WHO strategy. It was a more real discussion, much more anchored in the health and foreign policy climate in Norway. The balance between Health and Foreign Affairs was much better than for the White Paper. (H)

The interaction and boundary rules recognised that WHO is a venue for which the relational between the MFA and the MHCS is subject to negotiation. The idea behind the joint cooperation of the health and foreign affairs sectors to develop the WHO strategy was to benefit from combining their skills, resources, and perspectives regarding Norway's vision for reforming and strengthening WHO.

> It was quite formalised at that time because of the WHO Board membership. We established monthly meetings at a high level with the Norwegian board member. Not too big, not too small. It was very good. The Directorate of Health was given the task to coordinate on behalf of all. That was efficient. They have a big global health team. Much more capacity than we have. (FA)

The WHO EB elected representative for Norway had extensive experience in global issues related to health and with WHO, and he was supported by experts in the Directorate of Health and the MHCS.

The goals for the WHO EB strategy (including 5 objectives for Norwegian engagement in WHO and 6 priorities for Norway's WHO EB term) emerged from discussions between sectors in the situation, with each sector contributing its respective resources. As a result of these interactions, differences in the sectors' priority issues and approaches to policies for improving global health came to the forefront, and the borders separating the territories of global health ideas between the two ministries became more visible.

> If you look at that, it's quite revealing for the split because the priorities on this (MHCS) side at that time, already shifting to NCDs, whereas, this (MFA) side would maintain infectious disease and the MDGs. And that became a sort of a polarisation in a way. In terms of the WHO Strategy, they (MFA) largely acted with development assistance for health type money, so it's not a commitment for a big-global effort where the ministry is interested in more than development assistance. It's when it comes to what WHO does in conflict areas or the diplomatic aspects of health collaboration, but not the financing of Norwegian international health that's largely been development assistance. It's not a consolidated piece that makes it clear that this is Norway as Norway, and not what these people (MHCS) say in the health assembly, and what these people (MFA) say in the health assembly, and where these people (MFA) are largely interested in the development finance. (FA)

The "split" created an opportunity for the two sectors to acknowledge these differences and to begin a learning process in the persisted in the development of the White Paper. The WHO EB strategy group situation produced interactions that helped to build understanding between the two sectors about the sectors' issues and priorities and their methods of working.

> As in all policy making, there's also a gallery of personalities. In relation to health and global health, it's very clear, some very important dynamics brought by the Ministers themselves, and in particular, Jonas Gahr Støre. But this was a useful exercise ahead of the White Paper exercise, because it basically brought some of the issues around WHO to the table, but also, for example, the NCD agenda and other agendas that had not been part of the MFA and Norad focus at the same level. (D)

As part of the regular institutional arrangements between sectors for WHO affairs, Norway had cultivated intersectoral cooperation between health and foreign affairs to prepare for the annual World Health Assemblies. Although the WHO EB strategy group built on those historical arrangements, it also coincided with the pinnacle of Norway's leadership roles in global health financing and diplomacy in its "golden decade" of global health work mostly undertaken by actors from the foreign office. The WHO EB seat triggered the establishment of closer links between the MFA and MHCS, and when formalised as an action situation, this allowed for installing more open dialogue at the director and senior advisor levels between the two ministries. The processes of the WHO EB strategy group that began in 2008 were building blocks that facilitated the multi-sectoral interactions (see Sections 2.2.a, 2.2.4, and 2.2.e of this chapter) for developing the White Paper that began formally in 2010.

> One of the reasons why the White Paper was easy to write and collaborate between Ministries was that Norway was sitting on the Executive Board of WHO. And before taking that seat, Norway developed a strategy on their priorities. That kind of work was also the first of its kind. That strategy was from 2010 to 2013 but was developed in 2008 and 2009. That means that they have already started, even though it was very WHO focused, but they have started across the Ministries to work together on a higher level and a lower level. This was an important contributor to this process, and why we could develop a joint White Paper. (H)

2.2.g Boundary Situation – The Foreign Policy and Global Health Initiative

Building Norway's capacity for global health diplomacy

While the MFA's global health work that used development assistance to make progress on the MDGs was more visible in part due to fiscal accountability for these expenditures, the MFA had also been working with other types of arrangements, without budget lines, to integrate a foreign policy analysis of global health policy.

> One has to be able to continue to capture these opportunities and make sense of the flexibility and strategic work is as important as pouring money on specific things. (FA)

The Foreign Policy and Global Health Initiative (FPGH) was a strategic initiative to work closely with a small network of other foreign policy ministers and their teams on foreign policy with a health focus (***Figure 2.4***). The FPGH initiative experimented with multilateral collaboration through a diplomatic network between governments to work on governance of global health. The FPGH initiative was classified as a boundary situation to the Norwegian NPGH action arena because while it aims were multisectoral (better integration of health and foreign policy objectives), the composition its actors were not (project of the foreign affairs sector with other foreign ministries).

The MFA built a diplomatic network to strengthen relationships for foreign policy collaboration and to raise the profile of health as a foreign policy issue at high levels of global governance, such as the UN General Assembly). The FPGH initiative is widely recognised for its first main product, the Oslo Ministerial Declaration, published in the Lancet in 2007 (4). The development of this initiative began in 2005 when Jonas Gahr Støre, Norwegian Minister of Foreign Affairs, asked Sigrun Møgedal to develop a concept paper for a group that would unite Ministers of Foreign Affairs in an alliance to apply a foreign policy lens to health and explore the connections and policy implications (benefits and challenges) of the links between health and foreign policy. He was developing this with Philippe Douste-Blazy, the French Minister of Foreign Affairs at the time, and later elected Chair of the Board of Unitaid in 2007. The other five partnering countries were recruited (Brazil, South Africa, Indonesia, Thailand, and Senegal) with a strategic interest in capitalising on strong foreign policy relationships and opportunities.

> This is where a person who is a really smart foreign policy thinker was able to get that group

> together. We agreed that each of these ministers would appoint a senior person to work on that agenda. That's how it started as a background for this Lancet declaration and the ten-point agenda. We had several meetings. We were pretty much in the lead from Norway at that time. It was a very dynamic period of creating that document and having it agreed and negotiated in all seven of the capitals. (FA)

Initially coordinated strongly by the Norwegians, the FPGH initiative quickly incorporated a shared power base with a rotating chair and secretariat, which moved annually across the seven capitals within the respective Ministries of Foreign Affairs. The FPGH initiative aimed to use foreign policy scenarios and foreign policy partners in this network in a strategic way to promote and advance thinking about the interconnections between health and foreign policy at different levels and venues of policy-making and governance. The FPGH initiative was interested in creating opportunities for dialogue about the health impact of foreign policies among concerned actors within and between countries.

> The Minister of Foreign Affairs worked really well with the Prime Minister, but also, he had his own interest in making these things work. The FPGH initiative didn't cost money. This is a diplomacy thing, so it had to do with alliances, whereas, these global health initiatives and mechanisms had to do with money. So, the FPGH was a turf on its own that we used when we saw that it was smart. Having contacts with the seven, of course, when at the same time sitting on boards, it's very easy to use a platform of trust to collaborate with others. That was beneficial, but since it didn't take money, it was never in competition with any of the others, but what was decided then was to make sure that there wouldn't be a conflict over use of money. (FA)

Relationships of trust solidified in the FPGH initiative were valuable to partners in other GHG settings (i.e. UN, WHO). The MFA leveraged the learning and networking from the FPGH to improve its effectiveness as actor on Norway's behalf in negotiations within health fora.

> This made a very strong basis for digging into something that the Ministry of Foreign Affairs had not done before on this level. Not to say that they've not done anything before because Norway has been supportive. For instance, the establishment of GAVI and the UNAIDS and all the different funds have been getting part of the money through the Ministry of Foreign Affairs for a long time prior to this. So, it's not that it is new as such, but the level is new. … [for example] -- The story from 2007 when Indonesia refused to share samples of H5N1 virus with the World Health Organization (WHO) is an important example to understand the context of the foreign policy and global health (FPGH) initiative. Norway played a very important broker role in that process, when the Norwegian ambassador to the UN together with the ambassador of Mexico in Geneva co-chaired the WHO process that led to the establishment of the Pandemic Influenza Preparedness (PIP) Framework, which is a unified mechanism for the sharing of pandemic influenza viruses in the case of a pandemic. (H)

This is one example of how Norway used this transgovernmental diplomatic network to

support a more multifaceted role in GHG that added diplomacy to its résumé as a trusted aid donor. The FPGH initiative's structure facilitated interaction and exchange among the seven country partners at multiple levels (between their Ministers of Foreign Policy, between their senior diplomats in charge of advancing the technical aspects of the FPGH initiative, between their Ministers of Health, and between their ambassadors in Geneva and New York). These took place formally in the annual meetings between the Ministers of Foreign Affairs in New York every September, the annual meetings between the Ministers of Health ever May in Geneva, and the frequent exchanges between the high level sherpas of the Ministers of Foreign Affairs to make health visible in foreign policy fora where it wouldn't normally be. One of the FPGH initiative's most notable achievements was the production of an annual UNGA resolution on FPGH and report to the UN Secretary General. These were not policy changing devices, but the annual reports and resolutions concretised commitments taken among the group of seven and put them on a visible, high-level platform. Every year a topic was selected for the FPGH to focus on in these global statements, but the group brought these topics back into their respective countries where the Ministry of Foreign Affairs worked to reflect that priority in their own foreign policy agenda. This required the SGI team to connect and collaborate with other policy sections in the MFA.

> We were using our experience from Global Health and Foreign Policy initiative, because we wanted those kinds of issues to be part of the White Paper. We did not want to be development policy, we also wanted it to be foreign policy. That was very clear from the beginning. And that involved connecting health to all the different parts of the ministry, like the humanitarian section, for example. This year, the focus for the UNGA resolution and for the work in the initiative has been security of health workers, so we worked really closely with the humanitarian section, which also has this as a priority. And then if it was environment and climate, as it was one year, then we do it together with our colleagues working in the climate section. … so that's how we tried to work. (FA)

These findings support those of Sandberg *et al.* (5), that the FPGH initiative functioned as a unique "club" for talking about disagreements and complex policy issues and for collectively reflecting and openly discussing in a group of trusted peers from around the world.

> The design was pretty unique with these seven countries across regions and alliances, developed as an initiative without having a permanent secretariat. You didn't have a structure, a server, or a website based in one country. It was based on people, based on trust, based on mutual interests. It was a place where people could come together and disagree, which is often not the case where you meet and when there is so much consensual base. But this was a place that you could meet and

> actually solve some of these questions, air disagreement and have discussions on definitions; it was a really good place to talk things out, and we used this forum to talk about definition of words and issues such as global health security. (H)

The processes for the high-level collaboration between the seven ministries of foreign affairs was sustained even when there was a change of government in the counties because the senior bureaucrats of the diplomatic core were the actors responsible, which contributed to building the capacity of the partner countries for working on health and foreign policy issues in global and domestic arenas. Although the MFA maintained ownership of the FPGH initiative, the high-level collaboration between ministries of foreign affairs was eventually replicated in parallel between the ministries of health between partner countries, with coordination of the initiative moving over time (since 2013) into their realm of leadership in Geneva through the support of their permanent missions. As the new operational base, the FPGH initiative's coordinating across the seven permanent missions also involved WHO as an observer.

Norway's leadership and work with the FPGH for the UNGA, including collaboration with WHO on the annual report to the UN Secretary General, contributed to building up the country's reputation as a strong state actor in global health diplomacy.

> There's a lot of experience from the FPGH initiative in the White Paper. This whole part, this third area, promoting human security through health, is all related to that initiative and the work that we try to do within the initiative. We were using our experience from the FPGH initiative because we wanted those kinds of issues to be a part of the White Paper. (FA)

This kind of leadership in global health diplomacy rooted in the Ministry of Foreign Affairs was connected to the GHG system at large via the United Nations General Assembly, which worked in tandem to the leadership role in global health funding for maternal and child health that it also played in New York via the Global Campaign for the Health Millennium Development Goals and later for Every Woman, Every Child and its global strategy. Similarly, the Ministry of Foreign Affairs work with the GHIs and global health financing mechanisms (such as GAVI, GFAMT, UNITAID, etc.) in Geneva was conducted side-by-side to the diplomatic work in the more traditional international institution of WHO.

2.3 The interplay of rules, resources and power in the Norwegian NPGH action arena

Position, boundary, and interaction rules structured the individual action situations (see ***Table 1***), and actors used them to lead and coordinate, to organise the actors and materials used, and to manage interactions and decision-making (see series of ***Figures 2***). Through the analysis of the rules in use for individual action situations, and the inter-relationships between the action situations, I derived a set of rules for the Norwegian NPGH action arena (see ***Figure 3***).

The Norwegian action arena was an inter-sectoral one with actors from the MFA and MHCS (and their sub-ordinate agencies), but the rules concentrated positional power for the arena in the MFA. As the line ministry, the MFA shared access to the arena with the health and development government policy sectors, but retained the ownership by making and enforcing the boundary rules regulating the flow of actors and materials in the arena and by using interaction rules that sustained its leadership for decision-making within the arena.

The MFA served as the gatekeeper for what resources are considered and how they are used, with three exceptions: the WHO EB strategy group (see Section 2.2.f of this chapter), the public hearing by the Standing Committee for Foreign Affairs and Defence in Parliament (see Section 2.2.c of this chapter), and the follow up process led as a joint-project by Norad and the NIPH (see Section 2.2.e of this chapter) [also refer to ***Figures 2.3, 2.5, and 2.6***]. The WHO EB strategy group is an outlier situation because the MHCS had the positional power, and a balance was achieved in the relational power dynamics between the two sectors to include appropriate resources and equally participate in decision-making for the WHO EB strategy. The dichotomisation of the two sectors' approaches to global health matters that had materialised as complementary in the WHO WB strategy group proved more challenging to resolve through attempts to integrate them in the Writing Group process. The two ends of this spectrum refer generally to sectoral differences in terms of which ministry funds global health for development (MFA – i.e. MDGs) and which ministry has a stake in global health, regarding the determinants

of health of populations on a global scale (MHCS – i.e. systems and population approaches to health and disease and NCDs).

> The MHCS have their very clear priorities, which correspond more to what the health challenges are in Norway. And we have our development perspectives, with MDG four and five mostly, which is not really that important to them. Non-communicable diseases, mental health, and pandemics so on – that's the Ministry of Health's priorities. It's still like that, but we have the development perspective, so that was a challenge here. (FA)

> The strong focus on the health MDGs that was guiding this, maternal and child health, and HIV/AIDS in particular, was not as much owned by the Ministry of Health. They were already moving much more into NCDs and had that perspective much stronger. They wanted NCDs to be much more recognised in the White Paper than it was at one stage. It was quite deliberate by the Ministry of Foreign Affairs that we needed to keep up the focus on the health MDGs in particular, not necessarily as opposed to NCDs, but to keep a focus was important. The different NCDs were brought in gradually, but not as much -- you see from the headings, they're not really included there, but mental health is mentioned. (D)

The fiscal responsibility of the foreign affairs sector for global health expenditure translated into dispositional power over the health sector within the Policy Writing Group and throughout the action arena.

> The critical part was that we actually had it lined up with all the budgetary implications and all the work that was being done there. That White Paper without all the work that had been all laid down, would never been a White Paper because we would still be in this process of discussing in between areas of responsibility, who was in charge of what, and who is taking which decision. (FA)

The budgetary commitments of the MFA for Norway's ODAH regarding maternal and child health and family planning up to 2020 influenced the position rules for the MFA's ownership of the White Paper process, which also established the MFA's relational power based on financial resources (which could not be renegotiated) against the knowledge, scientific/technical, and social resources of the MHCS (which were perceived as challenging the prioritisation and distribution of resources for global health).

> Norway has taken pride in having 1% (of GNI) finance for ODA. If you can imagine sitting in a budget conference and fighting over money, and then if you are a development/foreign affairs minister, you will just get 1% without a fight because it's a matter of principle. Then the others that sit around the table are pretty irritated because they have to fight for small pieces. So, if you're saying to the Ministry of Health that you need to carry more of the responsibility for international collaboration on global public goods, knowledge, some of the things we need to do in research, they would say, "You'd better find the money there (in the MFA)," because they don't want to spend their money on international issues. And that's the downside when you have a

> budget construction where everything you should do becomes development assistance. It means that when you talk about health promotion, for instance, which belongs here [MHCS], then have very little power and influence here [MFA]. (FA)

> Processes like this bring us closer together and try to reduce the imbalance between Health and Foreign Affairs side. The main challenge is that the Ministry of Foreign Affairs is funding WHO, they're funding the Global Fund, they're funding GAVI, so they have the financial power while the Ministry of Health has more of the technical power, but it's less. The processes leading up to these documents are very important, maybe more important than the document itself, to create a kind of collaborating atmosphere between the Health side and the Foreign Affairs side because the balance between Health and Foreign Affairs is a bit skewed because of the financing. That's the way it is in Norway, but it's the same in other countries as well, that the Foreign Affairs are funding most of the global health initiatives. (H)

This source of power comes from the position rules established for the action situations when the idea for the White paper was initiated by the MFA and approved by the Council of Ministers. The foreign policy sector held the ownership of the idea and its realisation because the White Paper was a political and an administrative project of the MFA, essentially made for demonstrating accountability for large sums of money already dispersed or committed.

Participation in the Policy Writing Group (see Section 2.2.a of this chapter) and the CSO consultation (see Section 2.2.b of this chapter) required an invitation by the MFA [also refer to ***Figures 2.1 and 2.2***]. In granting access to the arena, the MFA sought to achieve a mixture of generalists (usually from the MFA) and specialists (usually from the Norad, the MHCS, or its subordinate agencies) with experience in international relations concerning health matters. But the relational power dynamics between the two ministries inhibited the capacity of the health sector to fully contribute their resources because the boundaries rules for ideational materials reinforced the dichotomisation of approaches associated with the two sectors, while favouring the foreign affairs sector's instruments for health and development. The boundary rules for ideational materials privileged the consideration of resources related to multilateral global health initiatives and partnerships in which Norway participates (led by MFA, and some with direct PM involvement), and particularly those related the work of state actors on the health related MDGs. By excluding any working definition of global health from rules to guide the selection criteria for considering other kinds of resources in the action arena, the interpretation of the relevance of resources was decided by the MFA.

Political resources had significant value in the NPGH arena, especially in negotiations of relational power within the MFA between a Minister of Foreign Affairs and a Minister of International Development from two different parties in the Stoltenberg II coalition government of 2005-2013. The power dynamics were also present in the application of boundary, interaction and decision-making rules that favoured the development policy content based on ideas in line with Norwegian politics for global heath and development that were being pursued by the MFA during the Stoltenberg II Government, rather than content based on ideas in line with Norwegian politics for health and the determinants of health. The MFA established a consultative process to collect feedback from non-state actors (see Section 2.2.b of this chapter); yet, there was a lack of transparency regarding how feedback from consultations were reviewed and used by the MFA.

> It is political. I think the research community should be more demanding, and I think that the research community should be allowed to present some premises for global health policy the same way the research community does for domestic health policy. I think the policies in global health are shaped without researcher input. They come after and want proof that what they're doing is working. (R)

The boundary rules accentuated sectoral differences, and the political and administrative boundaries established by the MFA to keep the White Paper focused mainly on areas of development aid limited the consideration of the broader resource contributions of the other sectors.

> The health side was able to influence some of the content, for instance to shift a bit of balance in the document from not only MDG four and five and maternal health, also looking into the non-communicable diseases and the changes in the burden of disease in sub-Saharan Africa from communicable diseases to non-communicable diseases. In a way, the health side had some influence, but from my perspective, the White Paper was mainly a product from the Ministry of Foreign Affairs. (H)

> We were invited by the Ministry of Foreign Affairs, because they have the global health portfolio, while, of course, the Ministry of Health also has a stake in global health. We do not put as much money into it, so their main issues are the development side. They put their funds into women and children's health, which of course is a good case, and something we wish to support from the Ministry of Health as well. They feared that their own funds for all other good cases would fall apart if NCDs moved in, because they had such a hard priority on women and children's health, vaccination and so on. (H)

The MFA monopolised the positional power for the Writing Group, and when it came to drafting the final version of the White Paper, informants from the health and development sectors confirmed that the "MFA held the pen."

> We thought that from our side we might have more technical influence on what is written there by doing it, and yet we saw that we were sort of a little bit like second-grade citizens [chuckles] within the Writing Group because it was really the two Ministries that were the important parts here and we were more technical people, which in many ways is fine, but, as a writing team, a writing group, it became a bit unclear exactly what the role is within that. (D)

The rigidity in the application of these rules put some strain on the process from MHCS not having its "perspectives sufficiently brought to the table" as one informant from the development sector remarked. Some relational power shifted with the arrival of policy writer because he was skilled at reaching out to the health policy sector and establishing a dialogue to hear and understand their concerns. There was a specific effort to gather information from the MHCS in the early part of the Writing Group process (October 2010), and later (spring/summer 2011) during the finalisation of the text, there was a more concerted effort to also include the NIPH and Directorate of Health in addition to the MHCS. The boundary rules for materials and resources were less strict rules when applied to the health security section (i.e. the third priority area of the White Paper) because the direction in terms of the past priorities and practices of MFA in this area was scantily defined. This section on promoting human security related somewhat to the work that had been done by the FPGH initiative (see Section 2.2.g of this chapter). It was included, but it was not a threat (unlike NCDs) to the MFA priority issues for global health because diplomatic networks were not competing for financial resources.

Outside of the NPGH action arena, these sectors engaged in other forms of relational power (both within and between health and foreign affairs/development sectors) through exchanges of resources defined in the form of Memorandums of Understanding (i.e., MFA and Norad, Norad and academia, Norad and Directorate of Health, MHCS and Directorate of Health). Although these institutional arrangements underpinned working relationships between actors from the sectors represented in the Writing Group, the agreements for technical support for their work outside the NPGH arena were not considered part of the set of rules that influenced relational power between them within the NPGH arena. There was a notable exception in the NPGH arena to the standard rules for policy making and White Papers. According to informants from the

development sector, the Writing Group was the only time when the rule that Norad only provides technical and policy guidance to the MFA was broken.

> We have decided in Norad that we don't want to be part of the writing team in the Ministry of Foreign Affairs since we are not in policy-making phase but more in the advisory and implementing phase. In the past few years, we have provided substantial inputs to White Papers, but we haven't been the ones writing the White Papers. And, to be totally frank, when it came to the global health White Paper, we were part of the writing team. Then we went more hands-on than we are today. (D)

> Normally Norad is not part of the writing group. We normally are providing input in terms of commenting and so on, because this is really the Ministry's responsibility. It's quite rare that we get directly involved like we did there. I think one of the reasons is that we've had a lot of discussions and seamless collaboration with the Ministry of Foreign Affairs, which meant that the roles have been less clear and we worked more as a team with the special section called Global Initiatives Section Four: Global Initiative and Equal Rights, which has been built up gradually after this strong involvement in global health, but it was mainly focused on the global health initiatives. Since we had that type of section in the Ministry of Foreign Affairs that we worked so closely with, it was much easier for us to make one writing group out of that. As far as I understand, that hasn't been done to that extent before. We had the relationship already. We were questioning the model quite a lot, whether that would be the right model. (D)

> But then, although we were represented on the Writing Group we could also have our independent expert opinion because we are a technical department with autonomy to have our technical opinion. So, we don't need to be a part of the writing group because we can still be on the outside and provide input. (D)

Informants perceived cultural differences in interaction rules for the NPGH arena regarding participatory practices for debate and discussion in multisectoral collaborative policy-making. It appeared that different kinds of rules for interaction in general may be indigenous to each sector, and tensions arose when they are confronted within an intersectoral process with different rules. The interaction rules used in the NPGH action arena (such as in the Writing Group and the CSO consultation) restricted interactive processes for decision making on agendas. This is explained in part by the political resources prioritised through the Ministerial Forum situation that produced a list of recommendations to start the process of developing the White Paper. The interaction rules limited the use of situations as opportunities for collectively producing ideas that challenged the overall outline and points that had been politically agreed upon.

> It's a very different thing if you create something and have people comment on it, than if you start with blank sheets and discuss what are the priorities. That's why we need to look at that White Paper process for what it's worth and for what it was meant to do. I'm pretty sure it was meant to make sure that the global health engagement over eight years would be somehow presented, so that it made sense and served as basis for building agreement on health as an important effort to be continued regardless of Government change. As you see now, it is being continued, but not with a lot of heart. (FA)

Section 3: What are outcomes of Norwegian NPGH action arena?

This section discusses outcomes resulting from the interactions between sectors in the NPGH action arena based on the analysis of what action situations produced.

3.1 Policy design – interactions produced content

This paper was widely referred to by many of the informants as a "political document" because of its purpose to consolidate the legacy of the Stoltenberg II Government. The *White Paper on Global health in foreign and development policy* was a politically acceptable way for the Stoltenberg II Government to report to the Norwegian Parliament about the international activities related to global health to which the Government and Parliament had committed significant funds.

> We didn't have those political priorities summarised in one document. We had the annual budget – where in bits and pieces you could read about where all the money was and where the priorities were, but there were no separate chapters saying that we were actually spending 5-6 billion Norwegian kroner on global health each year. And we also have a lot of influential positions in different boards including GAVI, Clinton Foundation, and Global Fund. All the agreements were there, all the board places were there, we had rolling systems with the board representation regarding GAVI, the Global Fund, the UN organisation, WHO. (FA)

The White Paper was the first of its kind on global health to be discussed in Parliament. The formal adoption of the White Paper by the Norwegian Parliament in May 2012 politically validated the global health policies, streams of work, and funding commitments that the Government established to pursue the health-related MDGs 4-6.

> The White Paper formalised a lot of things and got a bigger buy-in from the national level. Norway has been much more globally active than what was known at national level. The White Paper was a part of making more issues known and getting Parliament behind a lot of this, which

> is important because we have so many political parties, that it's good for Parliament to understand some of those issues and to provide a stronger base for that… it was important to have the White Paper because it establishes a national ownership across political boundaries, and then it had an important function across Ministries. The White Paper is very important for politicians because it gives them a base at national level to do the international work. Norway's international role has not been that well-known within Norway. (D)

> First and foremost, it's a status report to the Parliament on where are we and what are we doing, and it's a mechanism for having a broad political consensus and support for the ongoing priorities. So, it's a process for making global health efforts visible to and comfortable to the Parliament. (H)

> The Ministry of Foreign Affairs had quite a lot of ownership of the whole global health policy, but they hadn't written it down anywhere and it wasn't really clear exactly to everybody what type of priorities this had within the Ministry of Foreign Affairs, also since it was with the Minister of Foreign Affairs and not with the Minister of Development Cooperation. It was needed from that perspective to have it based more in the Ministry of Foreign Affairs, but we also needed to make sure that Ministry of Health was equally – or almost as equally – involved. Internally, within the Norwegian system, it was important to have some kind of a document saying that, and the White Paper was the answer to that. (D)

The White Paper captured the Norwegian government's work in global health, health diplomacy, and GHG to make it more visible to a domestic audience of politicians as well as to an international audience of global health actors. The document synthesised an era of global health policy and governance work and the approaches Norwegian state actors used to modify the landscape of the GHG system and to raise the profile of global health as a political issue for intersectoral action in the Norwegian arena and in the global arena.

> First of all, to think that there is a linear relationship between the White Paper of 2012 and what we did beforehand is a little bit stretching it with hindsight, because that paper was put together when one thought we were doing great things: *let's put it together so we can have it on paper, and have it discussed and cleared in the Parliament*. It served its purpose to show what that government in that period tried to achieve. So, it's okay to look at that paper as sort of the end point that can be documented, but a lot of the things we did before were not done with the intention to end up in the White Paper. And it was more of different pieces building on the past and capturing new opportunities, which was driving that period. (FA)

> What we often see is that White Papers are the policy document of politicians saying what they want to do. So, in that concept, this White Paper was already putting up to the Parliament what we've been doing for quite a while, and with a lot of funds already being dispersed and already being made into agreements for a very long-time. None of that had been put together in one piece of paper in one place, and that's where that White Paper comes out quite un-traditionally with regard to other White Papers, because all the work was done. (FA)

> It was a consolidation of what we were already doing, because global health work had been going on for a while, and it had a very high political priority. It was partly political mobilisation. It was a lot of that, building alliances and using our Prime Minister and our Foreign Minister and others to play a very visible international role and promoting global health as a high priority. And, at same time, it was a lot of money going into some very key initiatives, and that had been going on for a while. Writing the White Paper was very much about putting it all together in one place, because that had never been before, systematising on paper what we were already doing. There was also very broad political support from all the parties, and we knew that. And there weren't very many new things put in there. It was consolidating and systematising it, which was needed, because very few people had that overview and could see it all together and what it was about. (FA)

> It sums up an era of Norwegian global health policy, because it's so dominated by these MDG-related aims, and the approach that had been there. But it also points towards the transition into the next era with that last chapter. (FA)

The "non-traditional" features of the White Paper as a summary of efforts that are underway left some global health researchers and actors in the health sector in Norway disappointed because it lacked a clear direction for the future, only providing a snapshot of what the Government had been doing. Some informants would have preferred a policy document that was more operational and concrete for the health sector and its agencies–with an implementation focus.

> The WHO strategy has expired, and the White Paper is very, very high level and not so tangible. So, we want an anchor document, a bit more like an action plan, for the next years, and one that is not only for WHO, but for global health in general. (H)

> Then again, for all the good things it says in here, it does not necessarily convert it into too much practice. (CS)

> Policies need to be things that can be done in a way. You need to make it doable. (R)

Nevertheless, the document is being used as a reflection and planning instrument. It is a discussion starter about policy and programme direction in Norad, and for the development community to look at the broad set of commitments as a compass for their work.

> It has a lot of weaknesses. It's quite wide, and it's sort of listing a number of areas, but it is still a useful instrument. We are even using it in Norad to argue where to go, because Norad also covers a number of different areas. The fact that we have a White Paper is important, and it is being used actively with all these weaknesses and some strengths. (D)

From the perspective of actors in the health sector, the White Paper was not a comprehensive global health policy, but a foreign policy or Norwegian global health aid strategy because it reported on the ways that Norwegian ODAH was being used to support new forms of international collaboration through a variety of partnerships in GHG.

The NPGH arena was not constructed for or by the development of the White Paper, but it was built over more than a decade of internationally focused investments and partnerships on global health. The strategic and political savvy to combine people, networks, and resources is a hallmark of the Norwegian way of working in the GHG system.

> In the end, what really matters for your ability to do deliver anything is the way in which you work with it. And especially for a small country with, financial speaking, more resources than countries of our size usually have, because we have an extremely high GDP and this 1% GNI ambition for ODA. So this combination of being small and flexible, combined with the sort of basic political realities that are shaping our actions, by which I mean special advisory position on global health who is directly relating to both the Prime Minister and the foreign minister, then combined with this big bag of money and the role we have taken in setting up the Global Fund and GAVI, and basically as strategists of considerable global impact on solutions in the global health field -- this is not normally the picture for us. It's something that was possible because of the confluence of priorities and processes, and the right people with some extraordinary capabilities, and with total political backing from a government that was there for a long time. That was really far more important than choosing three thematic areas that we thought were very important. And that brought some lessons in the way we were working with global health issues too, which we felt should really be an emphasised part of the paper, and something that would also be useful both for Parliament and for others at large to see what we were thinking around. (FA)

The White Paper was the product of the Norwegian action arena for NPGH at a moment in time within an ever-changing dynamic for GHG.

> The politicians on the MFA side and ourselves from the development side, we wanted to have a White Paper that provided a very clear direction on the unfinished business for the MDGs, while gearing up towards the new health challenges, but not basically losing the focus for the past five years on the MDGs. There was both an influence internationally from what we have been doing for the MGD6 in terms of the big infectious diseases and HIV/AIDS, but also from the domestic environment, thanks to the Ministry of Health and Care services, with the focus on NCDs, and with a very interesting link to WHO and the international processes. (D)

Policy and decision-makers from the health, development and foreign affairs sectors acknowledged that the national arena needs to be able to adjust to the tectonic shifts in the GHG arena due to changes outside of Norway and how national policy processes on global health interact with international ones.

> The world is moving very quickly away from even this White Paper thinking. One has to somehow listen. (FA)

> If I look now on the issues I'm working with and the challenges they bring, I can't go to that document to find the solutions, because the landscape that shaped this document is no longer there. It's totally different. (FA)

3.2. Tension – interactions produced conflict

3.2.a Political versus technical

One conflict produced by interactions between actors from different sectors in the action arena is the tension between what belongs to the political realm and what belongs to the technical realm when it comes to NPGH. The summary of Norway's global health work as adopted in the White Paper conveyed a post-hoc coherency of policy decisions that were made in the first decade of the millennium. As one informant expressed, the document symbolised the MFA's aspirations to articulate the various commitments and initiatives in a way that constructed logical connections between global health expenditure decisions and an overall strategy.

> You see that when you have this dynamic in a little government like Norway, we need to like each other to make it work. Right? And as long as you keep at it, you can do that, but it's not obvious that it sticks together. So, then what is the White Paper? I think it was an effort, initiated by the Foreign Minister, to show that these pieces actually were driving an agenda that could be coherent. It's not just pieces, but it has to do with ambition to make it work. (FA)

Deciphering between what is political and what is technical oriented the formulation and use of boundary rules for situating global health issues in the arena, and position rules for deciding who is responsible for them within the administration.

> How do we arrange and prioritise within the big bag of global health issues? Is HIV/AIDS just a global health issue? Is it more a political issue? Is child and mother health, is that just pure health or is it also political… right? You had all those kind of discussions going on outside the box of the specific health issues related to it -- very much trying to position both of those two agendas within the foreign policy area. (FA)

The division of resources between technical and political domains influenced the relational power between the ministries of health and foreign affairs.

> What we did out in the world was pretty much decided in the Ministry of Foreign Affairs, apart from the WHO affairs. Dialogue between different sectors is possible when you wanted political solutions, not so easy for technical solutions. So, when these guys [MHCS] went to a World Health Assembly, one would divide jobs and responsibilities between MHCS and MFA, and not

much of a dialogue across what was a national interest and what was a global interest. (FA)

Conflicts over details in the White Paper's content that were classified as part of the technical domain were resolved by going up to higher levels of authority in the more political domain. The renegotiation of relational power at higher levels to resolve clashes over approaches required diplomatic finesse more than knowledge about the policy problem or solution in order to reach agreement on policy content with which everyone is satisfied.

> What you get from the process in a document such as this is more important in a way than the sort of basic aims that predefine basic aims and priorities, because you can always find ways of bringing that in -- things can be expressed in many different ways and approached from many different angles -- and something that might seem as a conflict doesn't necessarily have to be solved. Surprisingly often, it can be solved. This was one of the lessons I took from working with the health ministry people – you could sort of take it up to the next level and find a better way of putting it that reflected both perspectives. I know if you do that as a consistent practice, it becomes a bit of an exercise in sophistry. Which it shouldn't be, so there are limits. But often it turns out the oppositions between views were a bit too simplistic. You could actually acknowledge those things and come out with something better and more meaningful. (FA)

> This is very political. This is really political ideology and in a way, it's hard to have that sort of discussion in a process that partly was seen and run as apolitical. I guess that's the challenge in a way. Of course, white papers from governments should reflect the political ideology of the ruling party – but this White Paper could have been written by almost anyone. The social left party had the Development Minister during this period and a lot of that health portfolio was taken from the Development Minister to the Foreign Minister due to his personal interest and engagement in global health, which was great absolutely. But it's quite interesting to look at the difference of perspectives in this White Paper, compared to the general White Paper on development. (H)

From perspective of some foreign affairs informants, the policy document drifted towards a presentation that was too technical during its development in the Policy Writing Group, while from the perspective of some health and civil society informants, the framing of issues as technical matters depoliticised debates and masked tensions, for example, those around results-based financing as an instrument and Norway's support for them.

> To what extent Norway supports some of the global mechanisms, and how much of that should be result-based financing? That's created a lot of disturbance because I think most people would say that there is mixed empirical evidence for what RBF works for, and does not work for, within health. A lot of evaluations and serious academic work on it point in different directions. RBF is a lot of different things, and sometimes when it's used with careful do no harm mechanisms, it can create positive processes. It can also, in other instances, if you misunderstand the context, really create perverse incentives and destroys systems. We're talking about a lot of different things when

> we talk about that. So that's also a hot potato currently, so to speak. The argument is often that results-based financing is good to show to politicians because then they can show that there is efficiency, and how the money is being used. Of course, the problem is that if you have a model that confirms a few outputs that you would like to see, and it's not measuring, for instance, the breakdown of confidence or system-wide variables, you're not necessarily getting anywhere in a 10-15 year perspective. These are key issues there, which probably need more political discussion instead of being considered a technical field. (CS)

The "political" and "technical" categories hid another layer of tension about the definition of global health and which sector should have the knowledge, capacity, and resources to look after what Norway is doing internationally that impacts health, its determinants, and its distribution around the globe. In this dichotomous separation, opportunities to explore how intersectoral collaboration in the arena could address the political and technical sides of these issues together remained ignored.

> Most thinking about global health from the Minister of Foreign Affairs side and from Norad side is about aid efficiency and results -- and of course it's rational. Maybe key actors in the Ministry of Foreign Affairs have also put that results-based financing framework on themselves to more easily to see the clear impact. If I get money from the minister where can I deliver most impact in two-four years' time? But what they need to do is to focus on how we should use the money that we allocate to health internationally from the Norwegian side. And whether that is a responsibility of the Foreign Ministry or of the Health Ministry I am not sure, because I have argued that this should be more of a responsibility for the Ministry of Health. But the Ministry of Health does not take it up because the Minister of Health focuses on patients in Norway. That's because they can be kicked out of office if they aren't paying attention to the interests, debates, and tensions here in Norway. This is partly related to this vertical versus horizontal approach, but it's really about the concept of global health and global health governance because the White Paper is a global health aid strategy. (H)

> There are tensions in all political work and diplomacy. Not everybody has the same interests, and there are things you can do but normally, it's a matter of pragmatic solutions. For instance, if you think about coherence and health in all policies, it's not obvious that policies are coherent, and it's not obvious that you want to make them coherent because when they are coherent, it narrows the space. To make it coherent, you actually limit your number of choices. If you do that by design, it is one thing, but if you do that without knowing what you're doing, it's another thing. There is a pretty dynamic tension between what you want to make coherent and where you want to keep the possibilities for alternative action and flexibility. (FA)

3.2.b Vertical approaches versus horizontal approaches

A second area of tension that arose in the interactions between actors from different sectors in the action arena concerned the differences in their approaches and goals. These differences are broadly described under categories of *vertical approaches* (using results-based performance indicators for health-related development programmes in low and middle income countries, focusing on health MDGs targets) and *horizontal approaches* (using systems-thinking for population health, often with an equity focus, to act on a broad range of determinants – social, economic, political, and commercial – and conditions of health).

Many conflicts over the more "technical" dimensions of debate in the arena for NPGH were seen as differences of perspectives between policy experts in different sectors, and not explicitly acknowledged as political choices (such as the disagreement between the health and foreign affairs sectors about the place of NCDs in global health policy).

> They are very eager for non-communicable diseases to become part of the development agenda. We had lots of discussions on that for many years. That's not something that we spend money on today, and maybe we will post-2015. But that was their main concern in the working group, how to lift that whole area up and make it more visible and prominent. We had long technical discussions on how NCDs are developing in the world, to what extent they are a big burden for developing countries or not. We discussed very heavily at that time, because evidence was not that clear. We disagreed a lot on the evidence. That was a difficult discussion. (FA)

> Our interest is different. We want to strengthen the norms. That made the foundation for the tensions in the initial phase of the White Paper, because for example, we had the NCDs as an agenda which has been pushed by the Ministry of Health, because we see it nationally, we see it in neighbouring countries, and we see the trends. This is something that will come along. It might not be in sub-Saharan Africa next month, but it's still rising there, especially tobacco-related, but also others. The NCDs was one of our major pushes, the second was health systems. We wanted something more institutional. You can't only do the vertical initiatives, get results after the five years and then you pull out totally, it doesn't work like that. And of course, the Foreign Affairs Ministry knows it, and the people there, but they're much more used to doing hard priorities and putting all the funds in one pocket. We wanted text that was more horizontal, more cross-cutting. That's an example, but NCDs was the hardest case. (H)

By successfully arguing for the inclusion of some non-traditional global health issues from the MFA perspective (like NCDs and mental health) that did manage to be mentioned in the final adopted text, the MHCS proved to be a strong ally of the MFA because these were points that civil society and other health organisations criticised as lacking from the content. To this end,

including something helped the MFA to show that they considered the non-MDG health issues in the NPGH action arena's processes.

> The process was a little devilled by well-established conflict lines between the Ministry of Health and the Ministry of Foreign Affairs, and especially the development side of the Ministry of the Foreign Affairs regarding priorities – which came down to the basic divide in between the Health Ministry having most of the expertise, and the Foreign Ministry having the money. But it's not traditionally a completely negative picture either, because there's a lot of cooperation. The fact that we were on the Executive Board of the WHO at the time had established some processes, which made things work much better. But there were some unresolved issues centring particularly on the role and weight of NCDs in global health priorities. They had seen for some time the picture that is now generally acknowledged that the burden of disease, including in developing countries, is increasingly moving in that direction, and that needs also to cause a corresponding shift in policy. (FA)

The acknowledgement of these tensions generated opportunities for actors to challenge them and explore alternate frames and scope for future conversations and interactions between sectors.

> A limitation in the White Paper from our (MHCS) perspective is that it has an emphasis on development aid, obviously, because that's the major tool where you already had health in the Foreign Office. But at the same time, what is good about the White Paper is that it highlights health as something more than development aid. The link with security, for instance, is very interesting. In that way, the White Paper is forward looking in pointing out, that health is actually becoming relevant in more spheres than the traditional when you think, "Foreign policies, health, that must be development aid." Strategically, the White Paper shows a bigger picture, which is very positive and which made it easier for us to communicate with the Foreign Office. (H)

3.3. Connection – interactions produced relationships

Action situations also strengthened connections between actors from the ministries of health and foreign affairs. The interactions between actors from the MFA and MHCS improved working relationships based on better understanding of each sector's ideas, instruments and approaches. Constructive exchanges for learning energised and motivated people to work together on global health.

> I got a very good introductory course to global health. It developed in a positive way, and it produced a good result. You could see it was pulling different parts of the system together which was also a very rewarding experience, and there was a lot of really, really good people involved – in the foreign ministry, in the health ministry, and in Norad also. It was inspiring working that way. (FA)

These relationships were useful to create a stronger shared commitment and accountability for NPGH among actors from health, development, and foreign affairs sectors.

> In developed countries, there is a large difference in the view of health from the Ministry of Health vis-à-vis the Ministry of Development or the Ministry of Foreign Affairs, and it's very useful to have them together because they have each their arenas where they play their role. For example, the Ministry of Health sits at the World Health Assembly. However, in our case, we go together. The Ministry of Foreign Affairs is part of the delegation that goes to the World Health Assembly and prepares the WHO Executive Board. That has been really important to have them together. Absolutely. I could be critical, and I could say that maybe the Ministry of Health didn't own the White Paper as much as the Ministry of Foreign Affairs. However, was it useful that they were a part of it? Yes. Was there more collaboration in the realm of developing of that document and its aftermath than there would have been without it. Yes. There's a sense of accountability around it … so there's commitment. (D)

> It opens a door for a better cooperation, in order to provide the input and the knowledge that the Foreign Office needs to address the different elements. It doesn't mean it solved everything, but of course it puts the highlight on it, which is positive in itself. (H)

The development of the White Paper formalised communication channels and practices about global health work in Norway between government policy sectors that enhanced the expectation for intersectoral collaboration on global health and for continuing to develop links between foreign policy and health. The interactions created increased familiarity of actors and approaches between sectors that improved the quality and results of their discussions and helped understand and manage tensions. The actors were more sensitised and aware of the issues on the other side of the table, and in return the interactions gave actors a sense of being heard as well.

> You try to deal with tensions in the easiest way possible. That is, you need to establish enough meeting places where you can talk things through. But I think, there was much more tension 10 years ago, than there is today. (H)

> This is the usual stuff that comes out of people feeling that there are other institutions who don't really understand and acknowledge their issues -- which then causes people to read things in a negative way and to be overly sensitive – which is a sign that the right conversations haven't been going on in the right way for too long, then you get that kind of friction. (FA)

> If you know much more about what the other people are thinking and doing in their daily work it's much easier to avoid conflicts or resolve tensions when they come up. So, it's pulled the ministries closer together definitely. (H)

The relationships between actors from the health and foreign policy sectors were founded on what they learned about the policy goals, ideas, instruments of the other sector, but also on what they learned about the processes of collaboration in the public administration. The learning about the rules and institutional arrangements operating in each sector enhanced actors' trust and capacity to use processes more adeptly.

> There are benefits to that method being more broadly understood by other institutions and people who are also involved. If there's a common understanding of the basic principles that should drive the way we're working, then in the end that becomes institutionally embedded on an instinctual level, which makes things flow more easily. That's something you need to establish, get people to reflect around, and be able to point to: *it says here*. Within a certain subculture, in a certain ministry, you can get that instinct established, because you have the key figures for working on that basis, and people who are drawn into it learn to think in the same way. But you also need to spread those models and principles to a broader basis. I think that was what we attempted to do. (FA)

> We learned through that process to pin down and to elaborate on how the working processes had been developed. The working process between the Ministry (MFA), international fora, and the line Ministry for health (MHCS) because we were very much in that sphere of how do we cooperate, how do we do the dialogue with line ministries on all different levels – from ministers at the top to portfolio managers at the very bottom. (FA)

The connections produced from interactions in the NPGH area also supported continuity of the relationships and learning between actors in the health and foreign affairs sectors.

> There are benefits with being small because the same actors are present in many other arenas. You're more forced to see with a broader perspective and to see more connection possibilities. We find the same actors in different arenas, so they are able to make more connections. (D)

The mobility of actors in the foreign affairs sector, where it is common to rotate posts every few years, was a challenge for actors in the health sector. The interactions in the NPGH arena embedded some of the learning that grew from the relationships developed in the individual action situations.

> We've seen a rapid development of the understanding on global health. Yes, in part because of the White Paper, but it's not the most important process. The Minister of Foreign Affairs has this system of rotation, and so we have new actors working with us for three or four years. At the end of that period they know a lot about global health, WHO, reforms, and budgets. Then they leave again. (H)

> An ambassador sits for only four years. But if a meeting is institutionalised, then you can secure that the successor also attends those meetings, because that's the way it's done. That creates the

link, and that helps. For those of us working here in Oslo to have the ambassador and the delegation present at those meetings, that's a reality check. They know something about the landscaping in Geneva that we only touch upon because they're there continuously. (H)

Going back to our cultural differences in terms of long-term work, we know that from the Ministry of Health perspective, this is typical. They shift their people quite often, so from an individual standpoint, maybe one person opposes something, but the next person that comes in has heard a lot more about it, and does not fear it as much. As time goes by it becomes part of the jargon like any other health issue. We need to work with the Ministry of Foreign Affairs over a long time period in order for them to understand. (H)

3.4 Reflection – interactions produced thinking

The interactions between sectors in the NPGH action area also developed an environment for intersectoral collaboration conducive to reflection on global health policy. The learning from the reflection processes initiated by these interactions was valuable for both the MFA and the MHCS.

The cultures of those two ministries are very different, which is a big part of why they sometimes have a problem communicating. The culture in the foreign ministry emphasises action, with short informal processes for visible deliverables on results defined by politicians. We are used to complex things moving quickly all the time, so you just have to jump in there and do something on the basis of what you have. Whereas in the health ministry, you have a culture that is more academic – it's knowledge-based and expertise-based, so what you tend to get is long, thorough discussions over something. People know what they're talking about, and they know how to get something useful out of disagreement. Debate is encouraged and seen as a necessary part of policy forming. We're not as good at that in the MFA. This was also part of the situation, because that tends to generate a wrong kind of response to disagreement from other ministries and in contentious areas – you get this sort of territorial instinct. But we did take the time to have those discussions properly in this process, and that helped a lot. It enriched the text a great deal because when we wrote that final part, it was with one eye on the foreign policy side and another eye on the kind of knowledge base and the orientation from the health side. (FA)

We learned a lot more about how the Ministry of Foreign Affairs is thinking and working. We weren't making a new course for global health. It was more institutionalising the existing system, with some discussions, for NCDs and the overall perspective, about what are we trying to achieve. It made a sensible, useful platform for discussions on global health, and it also made more of a reflective environment so we would understand more about what the thinking is in the Ministry of Foreign Affairs, and the Ministry of Foreign Affairs people would understand more what is the international health scene from the Ministry of Health angle. If you know more about what the other people are thinking and doing in their daily work it's much easier also to ease the tensions and avoid conflicts. It has definitely pulled the ministries closer together. It wasn't like everything shifted after the launch of the White Paper, but good forces got better. (H)

The thinking and questioning emergent from the interactions in the arena was a formative outcome for actors, especially those from the foreign affairs sector, because the sector's culture was not accustomed to prioritising reflective learning in policy processes.

> The last chapter of the White Paper is very much on competence building, research, and how to maintain that work in the bureaucracy – which is quite demanding because you're always moving on. There's always something waiting in your inbox so you don't really get the time to sit down and elaborate and think, "Okay, we did this. What are we taking out of that process and feeding back into the next one?" (FA)

> That whole lateral process was really key. That's how you need to understand the approach to process, also to understand the results that came out of it, because the people who sit down and write the first concept haven't often got a lot of time. They haven't thought everything through, so it's not as if everything is already there, the politicians have even less time, and even less predispositions to thinking things through from every possible angle. They see something, they respond to it, and they don't think about it for weeks. A lot of it emerges gradually in the process. The thinking and the content, it's a thought process – a collective thought process. (FA)

Section 4: How mechanisms of policy change operate from the GHG arena to influence the Norwegian NPGH arena?

Following the analysis of the contexts, characteristics, and outcomes of the NPGH action arena in Norway in the between 2005 and 2013, I revised the theoretical and empirical idea with which I began: that external factors/forces (from a global arena) exert influence on internal policy change (in a domestic/national arena). The Norwegian case of NPGH illustrates how mechanisms of policy change operated through interactions of the NPGH arena and the GHG arena. These interactions constructed a transnational arena for global health policy and governance, which shared elements of both the national and global contexts. It is through the operation of two mechanisms of policy change, namely the processes of policy learning and elite networking of actors who have status inside and outside of Norway, that the transnational arena emerged as a zone for the circulation of ideas and feedback between the NPGH and the GHG arenas.

The rationale for Norwegian NPGH aimed to connect the pieces of various Norwegian government activities that targeted the GHG system. The Government cultivated Norway's leadership role in global health as a state actor (and through key individuals acting on behalf of

the state) by working as a funder, a convenor, an advocate, and a trusted partner, to influence the system of GHG. The Norwegian Government epitomised a donor country exemplar in global health by developing niche roles as a state actor since the late 1990s to start global health partnerships (mobilising ideas and networks), to support them (using political and technical support through representation on Boards), and to secure funds for them (using leverage with other state and non-state actors) (see Section 1 of this chapter).

> Norway got involved in almost any global health issue related to, in particular, maternal and child health, and all these processes for new financing mechanisms, like UNITAID. Things were moving so quickly that it was almost impossible to map out exactly what our global health activities looked like at each stage because things were moving continuously. At one stage, I tried to sort out on a map how Norway related to all the different types of mechanisms: global funds and global health initiatives that were not funds, and innovative financing mechanisms and trust funds, and all that was being created. Everybody laughed, but a few weeks later it was stuck on everybody's wall because we needed to have something to map things out and understand what the different things were. (D)

Norway's own financial commitment to global health was only one way by which Norwegian actors assessed the Government's global health work. Norway's political commitment in the GHG arena was also expressed through their leadership of process within GHG.

> Another measure is how many boards and committees Norway is represented on – how many processes we're going to not only enter, but to lead on, that's another measure of political priority. (D)

The Norwegian Government's leadership and stewardship roles in the evolving landscape of the GHG arena created of feedback loops between the governance arrangements of global health partnerships and initiatives and the Government's approach to global health policy.

4.1 Building blocks of the transnational arena: multilateralism as an instrument *for* and level *of* policy

During the period in which the Norwegian government expanded its involvement in the global arena (especially concerning maternal and child health), the creation of new global health institutions correlated to the increase in use of the term "global health" in the development and foreign policy community in Norway.

> We didn't define *global health* in the White Paper because that required a whole exercise. Global health is broader than traditional aid. … Global health is global challenges that no country can solve alone. That's why you need collaborative action. (H)

> *Global health* as a term has made things difficult. The whole world is interlinked and global health affects everyone. Global health is not something that the poor countries have to deal with, and we don't need to do anything. We're actually in it together. But how people perceive it is very different. A lot of people perceive it as, "Well, it's something to do with poor countries and aid can take care of it." (H)

> We've been talking about this whether it's global, or international -- the jargon was international health earlier on, but it's turned into global. All the small coordination units are now suddenly called global health coordination, rather than international health coordination. (H)

Previously, international health in Norway referred to working in developing, or low and middle income, countries principally through bilateral arrangements between Norway and another country. One informant from the development sector emphasised that now "we work a lot through multinationals, and we work a lot at international level, with less presence in country at bilateral level." The new vocabulary represented a new way of working on another scale; global health policy was shorthand for working at the global level, with multiple partners on shared issues of policy interest.

> As we discussed this more internally, we realised that we need to make sure people understand that we work in a different way now, that we don't work so much bilaterally anymore. Currently in health, we have a bilateral involvement in three to four countries. Early on, we were involved more in sector-wide development programs in a number of countries, but we realised that our capacity to do that type of work bilaterally was very low. It's the embassies that are running and managing the programs. So, we work in a very different way than we used to, and we see that we can make a difference at the global level. The focus really became global. That's the key to it, that we can influence at the global level, and there we could reach much further and have some kind of a larger influence than we can at the bilateral level. In that sense, global means something. It means a level. We deliberately did not get into the discussion in the writing group to define it. I wanted to push a little bit more for that because I thought this could guide us, but I think weren't at that stage when we wrote it. But it's become increasingly more important as a concept, and now everybody is using it. For us, the starting point was much more that it is at global level. (D)

> Norway has been key in identifying platforms for dialogue, platforms for partnership, and also looking critically at how to use ODA strategically. This will be an increasing role in the future looking at what is the function of ODA and how can ODA be helpful. Around 2006, we identified innovation as being a key part. … Norway has a number of channels of investment just like many other countries. How these channels intersect at country level and how well they contribute to supporting each other or not… we're unsure on that. Norway has taken a decision by design not to be present bilaterally in countries and has assessed that we're probably too small. It would just make more noise, so it's better to join forces and have fewer but bigger actors come to country level and support countries in their development plan. However, our channels are focused on what

> we would say are critical areas, but what might be presumed at a country level on being a lot of parallel, vertical initiatives coming at country level. However, we have been always very clear and very strong in all of the global initiatives to insist on a health system's strengthening platform that goes beyond the health sector and interfaces with other sectors. (D)

The increasing use of multilateral arrangements as global health policy instruments in addition to bilateral arrangements was a gradual change for Norway. Before this, the Norwegian development aid tradition relied on Norad dispersing aid directly to countries in the global south and building the relationships with them. Norwegian non-government actors from research and civil society perceived consequences related to this shift in development policy which neglected strengthening partnerships at the country level, reduced resources for Norwegian researchers and practitioners to build capacity in those countries, and limited opportunities for cross-sectoral collaboration on the ground.

> There has been a shift in Norwegian development aid policy from being large bilateral funding through Norad, with a country focus. Now almost all the development aid funds go through the multilaterals, for instance, UNFPA for reproductive health, or these other funding mechanisms. So very little is left for Norwegian actors to work in developing countries, and there aren't many Norwegian actors in those big international organisations. (R)

> There's no bilateral partnership. There should be an action plan including partnership for capacity and institutional development in the weak countries. Norway, having developed strong country partners, has not really implemented global health as a task for country partnership. Surprisingly, but they have put a lot of effort into GAVI and these things, but not at the country level. (R)

> That's a constant challenge that, if you reduce willingness and presence for bilateral work, there are a lot of ways of working more holistically that you exclude. (CS)

> If we look at the way Norway works and operates, it is fair to say that it's been going in a more focused way, both in terms of areas and instruments – for example, results-based financing versus broader health financing – and more international/global, rather than working bilaterally, even if that also has been always a part of the overall approach. With some exceptions, this White Paper focused on the use of ODA; when one looks at which areas have received the most attention, it's much more the ODA-fuelled initiatives. There has been huge success in areas where aid has been able to push the envelope -- innovate, leverage, all the buzzwords. We have some very good examples, and health is one of the areas that can show the most success. But it's a selective global health policy. It doesn't take into account thinking now across health and international affairs in terms global security in general, although it mentions it. (D)

The construction of the Norwegian arena built on existing work by government actors for strengthening financing mechanisms and partnerships in the institutional landscape of GHG (i.e.

GAVI, GFATM, UNITAID, Health Trust Fund) for health-related aid. Norway's multilateral cooperation focused on vaccination, infectious disease prevention and treatment, and maternal and child health for global health aid priorities. The organisation and coordination of these initiatives operated independently in MFA and Norad, and the post-hoc relationships between them within the Norwegian arena were formed through interactions among actors from the different policy sectors.

> The White Paper served its purpose to show what the government in that period tried to achieve. It wasn't a paper that created direction. The global health funding initiatives were what created direction. The Global Fund and GAVI were made on the logic of those policy processes, not to make them serve anything beyond that. (FA)

Norway's increasingly multilateral approach to development aid with new institutional actors in the first decade of the 21st century only provided a partial picture of the Norwegian arena for NPGH that interacts with GHG. Other interactions between the NPGH arena and the GHG arena were taking place through Norwegian government cooperation in more traditional international institutions (e.g. UN agencies like WHO, UNICEF, UNDP, UNPF) and in diplomatic alliances (e.g. FPGH initiative) to make health a policy and governance issue for foreign affairs at domestic and international levels.

4.2 Mechanisms of policy change: interaction and circulation of ideas in the transnational arena

The transnational arena was a platform for the communication and exchange of policy designs. I found that the Norwegian government used the adoption of the White Paper to validate (internally in Norway, and externally outside of Norway) its leadership role as a state actor in the transnational arena, in which it aimed to influence other actors and the GHG system itself.

> The purpose of that White Paper was less giving the tone from a Government in position on what they wanted to do, which is normally what White Papers are about, than it was a piece of paper stating what we had been doing, and also as one piece of paper that we could sell internationally. That was why we had the English translation of it very, very soon after the Norwegian one because we knew that the purpose and the value of that White Paper were actually more abroad. (FA)

But the Norwegian Government was an actor and a subject of the GHG system, with the intention of influencing but also to be influenced by other actors in the system. The Norwegian Government in this way acts on global health both as a state actor (Norwegian actors acting on behalf of Norway as a government and donor country), and as part of the transnational "we" (Norwegian actors working together with other members of institutions and networks constructed through their work in the GHG arena). Norway played a central role in the design, creation, and viability of new networks, multilateral financing mechanisms, and other public-private global health funding partnerships. The new partnership instruments and global health funding mechanisms created for making progress on the health-related MDGs, and in particular those under Prime Minister Stoltenberg's political umbrella and the MFA engagement to advance maternal and child health, catalysed much interaction between the NPGH arena and the GHG arena in the period of this case study.

> It's more a sort of circular because we were a big actor in setting up those funds. From that perspective, they were partly created as tools for our political priorities. We didn't just orient towards them after they already existed. Their creation reflects the priority that was already there. And so now that they are there and are doing quite well and giving good results, they are still our priorities. The fact is that we've been part of the history of these mechanisms, and the fact that we have a lot of political capital invested in them and that they're delivering quite well, and our politicians that are from a new government are stepping into the same kind of commitment role for those as before. It's pretty much a mainstay of our other development side of our activity, and seems destined to remain so for a foreseeable future. So, it's continuity. (FA)

The transnational arena is polycentric, and it spans geographical, jurisdictional, and institutional boundaries. As context in this case was defined as multifaceted concept (see ***Figure 1***), the circulation of ideas populated and shaped a shared context for the transnational arena. The contexts in the transnational arena converged through this circulation of ideas in between sites where the Norwegian actors interacted with other actors from the GHG system, in cities such as Oslo, Geneva, New York, Seattle, Washington D.C., and London. The transnational arena appeared from those interactions between the Norwegian arena and the GHG arena through mechanisms of elite networking and policy learning.

- Oslo is the Norwegian capital and the hub for the arena for NPGH where Norwegian government actors developed, coordinated, and managed governance of global health processes, principally actors of the foreign affairs sector (multiple sections of the MFA),

the development sector (Norad), and the health sector (multiple departments of the MHCS, with support from the Directorate of Health, the NIPH).

- Geneva, often referred to as the 'global health' capital, is the city in which the headquarters of the main international institutions for health (including the global health initiatives and financing mechanisms) such as WHO, GAVI, GFATM, UNITAID, UNAIDS, PMNCH are located. The Permanent Missions to Geneva of sovereign states, represented by their Ambassadors, health attachés, and other diplomats, were also dimensions of the Geneva site, in particular related to global health diplomacy and negotiations related to health policy concerns in global governance venues.
- New York is the site of the World Bank and UN General Assembly. It was the meeting place of other high level political networks for maternal and child health (Network of Global leaders, Every Woman, Every Child Global Campaign and Global Strategy, UN Commissions), and the work of the FPGH initiative for special reports to the UN Secretary General that were coordinated with WHO.
- Seattle is the location of two important actors in the transnational arena with which the Norwegian government collaborates (i.e. Bill & Melinda Gates Foundation, Institute for Health Metrics and Evaluation).
- Washington D.C. (USAID, World Bank) and London (DFID) are other capitals where national agencies for development and cooperation and institutional partners were located.

4.2.a Elite networking

The Norwegian case of NPGH illustrated the transformational role of individual actors, such as politicians, but especially scientists in the public administration who have extensive international experience and wide-reaching networks.

> What made it possible to become a leader in global health? It was new ideas and networks. It was a Prime Minister and it was money. All those ingredients were essential. (FA)

> The White Paper is summing up many years of policy, and many years of activities, and many years of networking. (FA)

In the Norwegian NPGH arena, there was a group of elite actors who were critical for networking and circulation of ideas in the transnational arena, specifically, Tore Godal, Sigrun Møgedal, Jonas G. Støre, Gro H. Brundtland, and Jens Stoltenberg. They were scientists and

politicians who had a history of working either in global health (as doctors in their early careers) or as public servants (in national or international agencies) committed to policies for improving health and its determinants. They had close working relationships with each other, in Oslo and in Geneva.

> Stoltenberg, who was at the time heading the Labour Party, was asked to join the GAVI board [in 2001], and he had worked very closely with Dr. Brundtland when she was the Prime Minister of Norway. Tore Godal was actually one of her close colleagues from early on. They studied together at university. So, you had these three people in Geneva – Stoltenberg going back and forth – and the fourth one was Jonas Gahr Støre, who was Dr. Brundtland's right hand in WHO. He was also one of the leading people in the Labour Party in Norway. So, it's that circle. (D)

The politicians from the Labour party such as Jonas G. Støre and Jens Stoltenberg owed much of their traction to the political legacy of Gro H. Brundtland (in Oslo and in Geneva), with regard to artefacts of her prestigious political reputation as an advocate and leader for more cross-sectoral commitment to policies that improved health, in particular to understand how other policy sectors (i.e. development, foreign policy, environment, finance) impact health and vice-versa.

> The history of this goes a way back. It didn't start in 2000. But that made it possible. Don't underestimate the role of Gro Harlem Brundtland as the previous Prime Minister for a period in WHO, and how that sent sort of that collective commitment in that party. It's sort of a legacy being built. And those of us that were involved in different ways, we've not been groomed for this through that party or anything, but we've been part of a network that could carry such a project. (FA)

> The FPGH initiative was a forerunner in a way because -- it's politics, it's personalities, and it's where they come from. You've got Jonas Gahr Støre in office at the Ministry of Foreign Affairs, who is very capable and very well versed in global health. He saw this field more so than his predecessors in foreign affairs and international politics. And that's why, when he picked up on this as a political agenda, what could we do from the Norwegian side in the policy and politics arenas for global health, one of the first things that came after was the Oslo Ministerial Declaration. (H)

However, the informants attributed most of the successful networking that laid the foundation for the NPGH action arena to the two Norwegian senior scientists (Møgedal and Godal) who are world renowned experts and well connected to the international networks of global health actors (see knowledge elites in ***Figure 1***). They are both medical doctors with experience in developing countries and with experience in Norwegian government and

international institutions. Their careers spanned the history (in Norway and internationally) of the evolution from tropical medicine, to international health, to global health as a policy and governance field. Their work "on the frontlines" at the cutting edge of global health research, practice, and policy formed the basis upon which the Norwegian Government raised the profile of Norwegian global health work through multilateral partnerships, first by investing in newly emerging institutions like GAVI at the turn of the century, and second by building on the momentum sparked by Stoltenberg's firm commitment to support the MDGs.

> It's fair to say that it's been a combination because all of us who have carried this have been inspired elsewhere. It's not that we have been sitting in Norway cracking out smart things on our own. You can go back to the 1993 report of the World Bank. Before that, selective primary health care, we were part of a debate, which is still with us in a way, about sector programs, the health system reform discussions. Before that, we have been working with tropical disease research and leprosy, with NGOs and the public sector in the 1970s, with the dream of Alma Ata and all the rest of it. And then we came into the millennium period with these new goals, but even the MDGs were not really driving Norwegian action until towards the end. The specific initiatives were driving it – UNAIDS, the GAVI, the Global Fund, UNITAID, and the ideas around what you could do with new types of money. All of this has shaped people involved, and Norway is a very small country. We've had these unique opportunities to be exposed and be part of it -- just imagine what happened when we created these things. It was a golden opportunity. (FA)

While both of these knowledge elites have different political party affiliations, policy communities and networks, and strategic approaches to their work, they have been working for the past 40 years with key international partners and forging Norwegian connections to the institutions for global health policy-making. There was wide support in the data and agreement from informants across all sectors regarding the significance of these two individuals in particular, Sigrun Møgedal and Tore Godal, and regarding their utility to political elites (such as Stoltenberg and Støre, and Høybråten) and to the senior civil servants in the bureaucracy who capitalised on these networks to move government policy forward. Each one had direct contact with relevant ministers, and they regularly briefed administrators in the MFA and Norad who were responsible for providing support if they needed it. The administrators were responsible for making connections between the strategic efforts of these two knowledge elites and the practical considerations for policy development and implementation by the administration.

> They were building networks, maintaining and linking people working on different layers, not only as medical doctors, but also knowing how to pull on the good people around them. That political networking, that map of individual persons that I've given you, before they came in into position and while they were in position, the political background tied around two person: Sigrun Møgedal

> and Tore Godal. That's a pretty important piece of that puzzle that you're going to spell out. Because without that, we wouldn't have been where we are with the White Paper right now, because we wouldn't have had that political commitment to it in this ministry. We might have had a White Paper on Global Health, but not driven from the Minister of Foreign Affairs but from the Minister of Health. (FA)

> Tore is very important. I wouldn't say that everything in health revolves around him, because that's not true. But he's been very influential in terms of the direction, and also the impact of Norwegian global health policy – first, by virtue of his scientific approach and his medical institutional experience, including at the international level. Second, because he is very strategic. Not only within this field, but at across fields. And third, because he became the special advisor on global health to the Prime Minister when he came back to Norway, first in the Prime Minister's office and then from within the Ministry of Foreign Affairs. (D)

The two experts worked with a complementary dynamic – in terms of their strategies, expertise, and contacts. The combination of their resources provided the MFA with access to a comprehensive repertoire of the relevant and powerful actors and ideas circulating in the transnational arena. While both are strategic and effective networkers, they differed in their foci and methods. Møgedal was described as a complex systems thinker, and an advocate of community-based and horizontal approaches related to social and political solutions for health and equity, who directed attention to work on cross-cutting issues related to gender, health workforce, and HIV/AIDS. She was seen as having an inclusive perspective and a broad base of contacts and collaborators beyond donor or financing institutions (including many NGOs and civil society networks). Godal was described as a focused, high-level outcomes-oriented thinker and negotiator, as well as an efficient communicator who was instrumental in connecting with institutions and funders. He was seen as advocate of results-based financing, usually related to technical and medical solutions for individual clinical interventions (including prevention and treatment), and he directed attention to specific initiatives such as GAVI, and maternal and child health partnerships that were also important to the Prime Minister.

> Tore is a campaigning person, pulling out the best opportunities, identifying the politicians and the money, putting together the one pager with three bullet points that's very easily sellable. Sigrun is more the one building brick after brick after brick, laying the foundation. She helped make that platform work dynamically, making sure we got the youngsters coming in, making sure that people were introduced to international cooperation, whether it would be networking with NGOs or working as a board member in faith-based organisations. He worked with the top people, hooking them up with other major events like UN General Assembly and the Gates Annual Meeting in Seattle. We took advantage of each of their networks promoting how they did their work. With this combination as our foundation, making sure we had the people and the institutions

> coming in, also being out there at country level working at in embassies, providing basic feedback from the results on the ground -- that was a constructive cooperation without fighting over boundaries or responsibilities. When we managed to get the two of them to see that, and when we found that balanced combination with the two of them – and that was before the White Paper – then it really started working. All of this was within the Ministry of Foreign Affairs, and then of course Ministry of Health, Norad, the social directorate, our delegation of permanent missions abroad, particularly New York and Geneva, church networks, heads of NGOs, media contacts. When we got all of that puzzle together around these two persons, in the period between 2007 until 2012, it started rolling and then the idea of the White Paper came up. (FA)

Møgedal and Godal brought diverse resources and ideas from their different professional experiences and networking together for the public administration to cement them in the global health policy work of the MFA (see Section 1 of this chapter and ***Figure 1*** for further details). Møgedal had been State Secretary for International Development, Norwegian AIDS Ambassador, and a lead expert for FPGH, and she had also served on Boards of GFATM, GAVI, Global Health Workforce Alliance, UNITAID and Global Forum for Health Research. Godal had a long career in WHO Geneva as a Director in the Tropical Disease Research unit, and he was a special advisor to Dr. Brundtland during her term as WHO Director General. He was the first Executive Director of GAVI from its inception to 2004, and he left that that to become the Special Advisor on Global Health to the Prime Minister, where he led the Norwegian government's work on maternal and child health). He had also been an advisor to the Bill & Melinda Gates Foundation. The Norwegian arena for NPGH drew upon the direct links that Møgedal and Godal had in the UN system, in WHO, in global health initiatives, and in foundations (e.g. Gates, Clinton). Møgedal and Godal were not only Norwegian actors, but they were transnational actors deeply embedded in GHG arena in which they had invested years of their careers in an ongoing exchange of ideas with others actors worldwide who shared their passion to improve health of populations in the poorest, low-income and middle-income countries.

> None of us lives in a vacuum. I'm not functioning behind the desk to come up with good ideas, I work better together with others, so the whole shaping of the Global Fund, UNAIDS, GAVI, all this has been part of a golden ten years of working together for health, and it's been key players around the world that have been carrying a lot of that, and you can sort of have a range of people that we all know. It's a small circle, but we all know each other. (FA)

Non-state actors, and specifically private philanthropical foundations like the Bill & Melinda Gates Foundation (BMGF) were also part of the elite networking in the arena. The ideas

for new structures in the institutional landscape to which Norway was committed necessitated alternative approaches to financing that relied heavily on private investment and sources other than development aid budgets of donor countries.

> One of the breaking points that came out of the White Paper was that the importance of global health and the foreign policy became clear to a lot of our partners in WHO – from developed and developing countries. It became clear that in terms of raising the huge amount of money that is needed to fight malaria, tuberculosis, HIV/AIDS, to educate and advise, it's really not possible to just draw from public budgets. So, the issue of public-private partnerships with the World Bank, private sector money, Gates and those kind of advocacy people, not just putting money in there but also putting it on the agenda is also one of the successes of the White Paper. We've been doing it for quite a while. We had some complicated structures to refer to on paper but just the mere fact of putting it in White Paper and having the non-traditional partners, in terms of not being governments – actually advocating and saying that, "We have a piece in this paper. We're actually part of that White Paper," was one of the successes of the paper too. (FA)

As a result of networking within the transnational arena, the special relationship and interactions between Norwegian government actors and actors from the BMGF flourished in the golden era of global health with the development of the global health funding initiatives like GAVI and GFATM. The idea for the Global Vaccine Alliance (now GAVI Alliance), which grew from discussions between international institutions, donor countries, academics, and the pharmaceutical industry, received much support from WHO through the collective work of Godal and Brundtland. Godal, who became the first GAVI Executive Director, was instrumental in securing the initial contribution of Bill Gates ($750 million USD). Since then, the two remained connected as part of an elite network that interacted regularly in the transnational arena, and close ties were strengthened over the following years around common interests to advance the health related MDGs, and in particular for maternal and child health. This shared interest in improving maternal and child health between the Norwegian government and the BMGF advanced in formal settings, such as the Network of Global Leaders and Every Woman, Every Child campaign and strategy lead by the UN. The benefits of elite networking also meant accessing funds for specific projects, under the arch of more formalised partnerships. For example, the Norwegian Government was supported with a special project funding from BMGF of over 1 Billion Krone for "innovative catalytic approaches" that was implemented through partnership agreements with India, Tanzania, Pakistan, Nigeria, and Malawi to make rapid progress on maternal and child health MGD targets. The position created for a Special Advisor on Global Health in the PM's office captured opportunities from networking in the transnational arena to advance policy goals

for maternal and child health, but also required negotiation of institutional arrangements between the PM's office and the MFA to work with these funds managed through the MFA.

This example demonstrated the importance of the relationships between scientists and politicians within the network of actors in the Norwegian arena, and how they interacted with those between scientists and private philanthropists (as well as more traditional donors) in the transnational arena. This has raised questions among some Norwegian actors about how the BMGF may influence the spending of Norwegian government funds in particular directions.

> The text in the budget is what convinced the current government to follow up and pay for in that budget period. That's where you can read what you really do. Why did it increase? A lot of the mileage has to do with these two. Why do we put more money in polio? Because Gates wants us to put it there. We've done things here (Polio +) and we've done things with GAVI, but they have not necessarily been held together as a way of thinking about an immunisation strategy. We're funding UNICEF that does other things, and WHO does their immunisation work, which is different, but the big money doesn't go to international institutions. (FA)

Elite networking sustained dialogue between Norwegian government actors, especially from development and foreign affairs sectors, and the BMGF for circulation of ideas and instruments for global health. According to informants from the research sector, this has influenced the arena.

> Norwegian global health politics have been influenced by the health MDGs, and they have been influenced very much by the Bill and Melinda Gates Foundation. Norway openly collaborates with the Bill and Melinda Gates Foundation, and Prime Minister Stoltenberg was putting money in the same bag as them for these initiatives. That was official, and they were on television shaking hands. So, this is no secret. (R)

> There is a close connection between Bill Gates and Norway. But exactly how that relationship works, I am not in a position to say. I think Norway is important to Bill Gates. When Norway elected a new government in October 2013 – the right-wing government – Melinda Gates and her crew came to Norway to talk to Norwegian organisations. They were interested in how this would change the way Norway supports the global health agenda. They are eager that Norway will continue supporting global health, and they see Norway as an important collaborator to their mission. It's funny how strongly they have shown that Norway's global health initiatives are important to Gates. (R)

Maternal and child health interests of the Norwegian government were also interconnected with those of other state actors in the transnational arena, specifically aid agencies

such as DFID and USAID. Many informants underscored the close alignment of Norwegian development aid in the MDG era of global health policy to USAID and American policy.

> The major influence has been the political alliances through the various initiatives in particular around women and children's health, the UK, the US, and other governments like France. It's been a key objective from Norway's side to engage with the US government because they are intellectually and scientifically strong. They have resources on the scientific side, but also, if the US is not joining, you cannot move things internationally, particularly in aid. They account for half of health aid. We see that the political networks have been extremely important in terms of shaping some of the thinking and then also some of the private sector and foundations. Bill Gates, he is a major partner in some of the undertakings, so a very strong connection. The White Paper reflects this active engagement internationally, with both public and private partners. (D)

> The people who work on female genital mutilation in Norad are extremely welcoming of anything that comes from the research environment, and they have very interesting and fruitful discussions about the way forward and issues at stake, and they consult a lot. Whilst on maternal and child health there's been barely anything. They operate in complete isolation from the researchers. So, it's really a big variation in responses to the researchers' knowledge and the policy making. I don't know why, but I think maybe it's because some of those decision makers pick up things from the big world instead of the Norwegian world. Their alliances are normally with big actors and not with the local ones. There is a lack of communication between what happens domestically and what happens internationally. It is really easy to see that this is the case and that something should be done about it. I that people who work in the foreign affairs and Norad, they meet more with people in the big world, in the development crowd rather than in the science crowd. (R)

Elite networking of the two transnational knowledge elites operated within the gap between the political and technical divide separating the roles of the health and foreign affairs sectors in global health. The rules used in the Norwegian arena for NPGH generally concerned political resources over technical ones (as discussed in Section 2 of this chapter). The bureaucracy, namely actors in the Section on Global Initiatives of the MFA, had the responsibility to connect the science and the politics through the synthesis of networking by Møgedal and Godal.

> The two directorates in global health – Norad and the Directorate for Health – have strong ties and formalised agreements with research institutes and think tanks, Norwegian and international. We managed through the White Paper and through that process of getting the team together to learn how to pull on all the work and the competence that the two directorates had and in the interaction areas with the research institutes. So, when the two of them were out there on the frontline pushing the edge all the time, they always had with them the latest research. What we managed to do with the White Paper was to make sure that the Directorates talked to the bureaucrats, us, in terms of how to feed that research material to the two in front and at the same time to make sure we anchored it with the political side here. So, institutionalising the way they had been working

> on the global health within the line Ministry is perhaps the most important output of that White Paper, and it doesn't say that explicitly because that's the internal, sort of learning and internal experience we made on that paper actually. (FA)

Through these two knowledge elites, Norwegian actors from MFA and Norad multiplied and strengthened their international networks, which increased their relational power respective to that of the health sector in decision-making situations in the Norwegian arena for NPGH. The elite networking elevated global health as part of political capital that can be spent in Norwegian arena or the global one. The extensive international networks of these two key actors were valuable assets in the global health work of the Norwegian Government; each one is a pillar of the Norwegian NPGH action arena.

> In the White Paper, we managed to spell out the importance of those personal networks, but without pinpointing the two of them. The last chapter in that White Paper tries to map out more broadly the long term working and foundation of the policy that emerged. (FA)

4.2.b Policy learning

Mechanisms of policy learning were found in governance bodies and management arrangements for international institutions and public-private partnerships for global health in which Norway participate where transnational actors share experiences with policy ideas, instruments, and processes and learn lessons for policy change. The World Health Assembly and the WHO Executive Board are the two main governing bodies of WHO at the international level; the WHO European Regional Committee is the governing board for the activities of WHO EURO. Institutional arrangements were in place in Norway between the health and foreign affairs sectors to review and discuss agenda items before each of the three WHO governance meetings annually. But before the WHO EB strategy group was established in 2008, there were no overarching vision or objectives to orient Norway's engagement in WHO at the global level and no explicitly documented working methods to guide the intersectoral collaboration between the MFA and MHCS to achieve them.

> We have the WHO Forum three times a year, prior to the World Health Assembly in May, the Executive Board meeting in January, and the European Regional Committee meeting in September. The director general in the Ministry of Health leads these forums, and the Ministry of Foreign Affairs, NORAD, the Directorate of Health, the Norwegian Institute of Public Health, and the Norwegian Medicines Agency participate. We go through the main topics on the agenda for these WHO meetings, and we agree on which agency takes responsibility to develop so-called hand papers on different issues. We go very strategically through the agenda to prioritise items,

> and prepare them so that those people going to the meetings are well equipped when it comes to the background for the topic and the current questions, and also with the Norwegian position, and some speaking points for that for each of the agenda items. (H)

The Norwegian WHO EB strategy group developed a more institutionalised dialogue between the MFA and MHCS between 2008-2013 within a strategic framework that focused on what Norway wanted to achieve in WHO. Informants reported the normalisation and standardisation of intersectoral processes between the health and foreign policy sectors in Norwegian government are not present for any other external institution related to health other than WHO. For example, the MFA does not participate in any regularly held meetings with the MHCS related to representation on Health Committees for the EU or the OECD, nor does the MHCS participate in any regularly held meetings with the MFA related to its issues pertaining to other global health institutions.

Identifying the need for a more routine dialogue between the health and foreign affairs ministries and for other organisational changes to improve intersectoral collaboration in the public administration were among lessons learned by Norwegian government actors in WHO governing bodies. Changes in the WHO and WHA contexts for decision-making and governance required different approaches by member states to organise their representation and participation in the governance bodies. The circle of Norwegian political and knowledge elites who had worked in WHO Geneva also possessed knowledge and lessons learned from their interactions and observations at the intersection of health and foreign policy [see APP 5]. The politicisation of the decision-making body of the traditional international institution responsible for health produced more demand for countries to work intersectorally, coordinating between their health and foreign policy ministries for intergovernmental negotiations regarding resolutions, conventions, frameworks and regulations. The Norwegian WHO strategy document underlined this challenge facing the WHO in the juxtaposition of the political and technical aspects of its mandate [see APP 23, pp.25-26].

The work of member states in WHO Geneva increasingly required a balance of diplomatic and political acumen as well as scientific knowledge and technical know-how to navigate alliance building between actors and to influence decisions on the institution's work. The collaboration

between the health and foreign affairs ministries in Norway was analysed as an essential process for developing knowledge, skills, and capacity to impact negotiations in this increasingly complex setting, in which alliances and power were also shifting with geopolitical changes and the political economy of health. The BRICS countries and emerging economies were seen to be increasingly persuasive in this setting because they disrupted some of the traditional alliances, and this changed how countries interacted in those negotiations and diversified the range of expertise and know-how needed.

> There was this idea that it's either foreign policy or health policy, which in the case of WHO is no longer correct. The two spheres have really been blurred. It is much more is politically driven than traditionally considered, when questions were meant to have a medical or scientific answer. Over the last 15-20 years, we've had more ministers present in the World Health Assembly, which is good in the sense that it shows that this is more important. But the downside of that is that when you have more politicians, you have more bickering, you have more negotiations. You get a totally different perspective from new voices and countries in WHO, which are stronger and more outspoken than before, and very tricky to move. In that playing field, what used to be simple is suddenly complex. Things that used to be easy, suddenly get another dimension that was not there before. We see very clear division lines now that were less prominent before. And in that setting, it's crucial that our two ministries are able to work very tightly. (H)

The interactions and learning from the governance of WHO continued to generate reflections in the Norwegian arena for NPGH about the substance of global health policy epitomised in the two sectoral perspectives. From that of the MFA, global health policy was development aid policy for the health MDGs and for maternal and child health in developing countries. From that of the MHCS, global health policy was public health policy, generally with a focus on globally shared challenges for all countries, and specifically related to non-communicable diseases, the social determinants of health, and health systems. While the multi-sectoral interactions in the Norwegian arena did not achieve consensus about a comprehensive and integrated perspective on global health policy, it initiated communication, awareness, and rapport between actors from these two ministries. The policy learning in the WHO governing bodies generated reflections in the NPGH arena about how Norwegian government processes should adapt to the evolving contexts for GHG.

The policy learning in the Norwegian arena for NPGH supported by interactions in the governance of WHO also benefitted Norwegian intersectoral collaboration on health in other global governance settings. For example, the foreign affairs sector learning about the burden of

NCDs and the intersectoral approaches that this policy problem required better equipped the preparations of the Norwegian diplomats leading up to the intergovernmental discussions on NCDs at the UNGA in September 2011. The time and energy invested in debate and dialogue (and often "difficult conversations") between health and foreign affairs in the WHO EB strategy group and the Policy Writing Group was beneficial and pertinent for the high-level meeting on the prevention and control of non-communicable diseases at the 65th session of the UNGA. The NCD agenda taken up by the UN created an opportunity to use the policy-oriented learning and raise awareness of NCDs as a policy issue of global concern among world leaders (not as a development issue, but as a health issue affecting populations in countries around the world).

> The Ministry of Foreign Affairs had to take account of all these processes going on within the UN system because they have to take positions. The Ministry of Foreign Affairs is very influenced by the external pressure on which topics are coming up. Someone needs to sit down and understand what it's about. With the development of the White Paper and the high-level meeting on NCDs and all the follow-ups of that within WHO system, they know a lot more what NCDs are about. They're not necessarily throwing money at it, but at least they know the agenda, and they're not struck in fear as soon as someone mentions NCDs, as was the case a few years back. (H)

The Norwegian government also used WHO governing bodies as mechanisms of policy learning to showcase its ways of working and share its experiences with NPGH as a policy model for other countries. For example, the Norwegian MFA consulted with partners in international institutions and other countries in Geneva during the WHO Executive Board in January 2011 and the World Health Assembly in May 2011.

> What we realised at that point in time [January and May 2011] was that this was ground-breaking work, that everybody was more in the mode of listening to us, than the other way around. We didn't really get much of feedback from the partners [during consultation meetings in Geneva], except that they thought it was very exciting and very cutting edge work. (FA)

The Norwegian government used the WHO EB and WHA as learning platforms for the White Paper, to share its learning about ways of working on global health policy from the previous decade, and to serve as a manifesto of its commitment to this up to 2020 for its partners in GHG. The Norwegian government used the White Paper as a window to the arena for NPGH, visible to the WHO member state delegations and other GHG actors, to certify Norway as a global health leader and authenticate its status in the GHG arena.

> Our partners never experienced anyone writing that sort of White Paper – bringing global health into the sphere of the foreign policy. We had all the work we'd already been doing and all the

> long-term support to the different organisations – GAVI, Global Fund, NGOs, faith-based organisations, followed-up with the campaign on maternal and child health that had been running with the Prime Minister fronting that. The range of activities and work we've been doing being summarised into the White Paper, pulling global health into the foreign policy area was new to most of the people we talked to. It came out in May 2012 just before the next WHO annual meeting in Geneva. We went to Geneva with the executive summary in English so we could go back to partners we consulted with a year earlier and provide it. We didn't foresee the value of the White Paper before we were there; it became clear throughout the process. In May 2012, lightning struck for us about the effect and the magnitude of the White Paper being adopted by the Norwegian Parliament, referring to why we considered Norway being a proper member of the WHO because of that massive global health effort that's been snapshotted in the executive summary pinpointing to where we wanted to move forward, pushing the edge. (FA)

The Norwegian representation on the WHO Executive Board between 2010 and 2013 facilitated the visibility of the work in the Norwegian arena for NPGH to GHG actors. The 65th Session of the World Health Assembly in May 2012 was an opportune mechanism for the Norwegian delegation to validate its policy innovation by highlighting the design and process of NPGH as an example for others countries. During this meeting, on May 23rd, the Norwegian Minister of Foreign Affairs presented the White Paper and the arena for NPGH as Norwegian policy developed during its term as a member of the WHO Executive Board that supported WHO Director General Chan's efforts in foreign policy and health. The White Paper was discussed only days later as the first of its kind on global health in Norway's Parliament.

> It was very much planned, and this is Tore Godal on his best. He is brilliant at pinning down a timeline in terms of: where the advocacy points are, were we can sell it, where we can get publicity, where we can make our boss shine, and where we can also push the substance. *This is the forum. We need to back up the head of the WHO in her approach on saying that global health is actually about global foreign policy*. Norway has to be there. That was also during the timing when Norway had a board member in the WHO. So, the board member saw that they could actually pull on us. (FA)

Connections through elite networking mechanisms ensured that the launch of the White Paper on February 15, 2012 in Oslo (after sending it to Parliament for the public hearing) was an event for the document from the Norwegian arena to receive attention and acclaim by important actors in the transnational arena. In addition to the Norwegian politicians leading the arena (see Section 2.2.d of this chapter), the Special Advisor on Global Health, and academics from Norway and abroad, the launch featured prominent figures in the transnational arena such as Richard Horten, Editor of The Lancet, and Margaret Chan, WHO Director General. Later that

year in June 2012, the Norwegian government hosted high-level political conference "A World in Transition: Charting a New Path in Global Health" which brought together experts and politicians, including the Foreign Minister of Norway and Foreign Minister of the USA.

The governing boards of global health initiatives and partnerships were also mechanisms of policy learning, and the interactions of Norwegian representatives with these bodies also contributed to the circulation of ideas to and from Norway. The use of elite networks to help place Norwegian politicians into roles on the GAVI Board supported policy learning about global health policies that was helpful to Norwegian politicians in Government or Parliament. For example, Dagfinn Høybråte, a member of the Christian Democratic party, was a former Minister of Health in 1997-2000 and 2001-2004 during the time between the Stoltenberg I and II Governments. In 2006, Høybråten was elected as a member of the Board of GAVI in 2006 (replacing Jens Stoltenberg who became PM in 2005), and he served as the Chair of the GAVI Board from 2011-2015. During this period, he was also member of the Parliament's FADC from 2006-2013, and the spokesperson for the public hearing and the committee's opinion on the White Paper (see Section 2.2.c of this chapter). At that time, he was also the Vice-President of the Norwegian Parliament. Having politicians from Norway in board positions boards strengthened ties to learning about programmes for policy between the national and the global levels. Elite networking supported politicians to learn about global health policy in ways that were useful to developing the White Paper in the Norwegian arena for NPGH, especially for the coalition government.

> Dagfinn played a crucial role in ensuring that you get a cross-spectrum support in the Parliament for this White Paper, but in doing that, he also had a lot of power in ensuring that other perspectives than what were initially presented in the White Paper from the Green-Red government, became substantial. They wrote about 20 pages of comments from the Parliament, which is officially then a part of the White Paper. (CS)

The FPGH initiative at the boundary of the Norwegian arena and the GHG arena was also a mechanism for policy learning because the dialogue between the seven strategically selected country partners improved their understanding of health issues in foreign policy terms from the perspective of different regions of the world. The relationships between senior level actors in the diplomatic core of these seven countries (and in their corresponding missions in Geneva and New York) were valuable social and political resources for influencing agendas and circulating ideas

in institutions of the global arena. This learning also improved the capacity of the Norwegian MFA in global health diplomacy in New York (UN) and in Geneva (WHO).

4.3 Implications for policy change

These results suggest that the interactions between the Norwegian arena for NPGH and GHG created a transnational arena where mechanisms of elite networking and policy learning operated. This convergence of Norwegian and global contexts in the transnational arena is a particular case because Norway as a state actor played an active role changing the institutional landscape in the GHG arena. I found that the diffusion of context and circulation of ideas is not analysed well in terms of internal or external influences in one direction or another between policy arenas at different scales. The transnational arena is characterised by interaction for policy change at different levels.

> There is an intimate interrelation between the organisational innovation that was happening in the global health field in the first decade of the 2000s, and the nature of the challenges we were facing. GAVI, Global Fund, UNAIDS – all these new things that were set up that completely changed the landscape in that field away from the WHO / UNICEF kind of model that dominated the development side of the health field previously. This is really an under recognised thing, because it's the only major field of development where the main decisions have shifted out of the UN system, and into a set of ad-hoc organisations where you have foundations, non-state actors, and even the private sector, really, very much part of running the show together with big donors on the basis of a highly strategic model which has delivered dramatic and demonstrable results. (FA)

The Norwegian government's participation in the founding and governing these new institutional forms created seamless pathways for ideas, instruments, and experiences to circulate (directly and indirectly). The influence of the ideas and policy learning were not necessarily directly perceptible, especially when they were informal.

> We were so involved in the different global processes, that we had a very strong sense of the issues that were discussed in the different fora. As far as I know, there was no direct influence from outside on that. But indirectly, when we discussed with our partners in GAVI, in Global Fund and so on, we did not necessarily talk about the White Paper as such, but of course they influenced our general discussions and our take on it. People knew that we were writing this, so they might have used opportunities to engage and try to say, 'Why don't you make sure that this is in there.' (D)

The transnational arena we observed emergent from the inter-level interactions seemed to

reproduce the sectoral differentiation within the Norwegian arena for NPGH and the fragmentation of the GHG arena. The first cleavage was the definition of global health policy – as a worldwide policy concern versus global health policy as aid for health interventions and services in developing countries. The second was the heuristic distinction between what is political (relating to money or interests) and what is technical (relating to research/knowledge or practice). These two discontinuities in the Norwegian arena for NPGH appeared to divide the sectoral cultures of health and foreign affairs (see Sections 2.1.a and 3.2 of this chapter). Each policy sector connected to their field's policy beliefs, norms, and expertise that framed global health and defined the scope for global health policy.

> It's not a very strong link, but there is a link also to the EU on this, with how we work in global health in general. The link is there because global health has a problem of definition. In the sense that you make global health something which will also involve health in Europe, then you link up with EU. If you think global health is mainly about Africa, then that's something else. (H)

> The health ministry is not only doing global WHO type of health, but we're doing a lot of more cooperation with our close neighbours and part of the northern dimension, for example, with the Arctic Council, the EU funds. Norway is paying a lot of money to be part of the EU system through the EEA agreement, and we also have a lot of money in that for health. So, the landscape looks slightly different from the Ministry of Health than from the Ministry of Foreign Affairs, which is mainly global, international, at least on the their (MHCS) global health portfolio, and very focused on developing countries that (MFA) side. (H)

WHO affairs are formally the competency domain of the MHCS because WHO requires the scientific/technical health expertise of member state representatives in official capacities of the heads of their delegations. However, WHO is the only international institution for health in which the MFA and the MHCS have institutionalised intersectoral collaboration to bridge their sectoral definitions of global health and to link the political and technical perspectives on health.

> The responsibility for WHO as an organisation is divided between the Ministry of Foreign Affairs and the Ministry of Health. That's quite a struggle. Who is going to be in the board seat? Who is going to present it to Parliament? Which of the Norwegians from the two ministries are we to advocate and promote for international positions in the WHO? It's always been a tug of war. The money's here (in MFA), because this is where the development budget is for voluntary contributions and the funds for the obligatory assessed contributions to the international organisations sit here. But the responsibility for the subjects themselves – health, as such – is with the line ministry (in MHCS) of course. (FA)

> WHO is the major organisation when it comes to the cooperation between the two ministries (MHCS + MFA). First of all, they [MFA] finance the organisation. The larger majority of that

> funding is voluntary contributions, which means that it's development aid. Our (MCHS) minister is responsible in Government for Norwegian positions in WHO. When it comes to finalising our positions, they are cleared in both ministries in parallel. But, you have a number of health related scientific issues coming up in the World Health Organization, for which clearly, our services are the best to reflect on and provide input, and that's our very important share in it. (H)

The rules used to delineate the lines and methods of cooperation for WHO between the MFA and the MHCS appeared based on the heuristic for appointing the political dimension to the former and the technical one to the latter (+ Norad). However, these modalities were not transferred formally and systematically to their intersectoral collaboration related to other global health institutions (see Section 2.1.d of this chapter).

Section 5: Critical reflections on the Norwegian NPGH action arena

Related to the implications for policy change discussed above, some informants from the health and research sectors raised questions concerning the ramifications of a transnational arena that reproduced sectoral approaches to global health policy and governance. The first set of questions related to consequences of sectoral territorialisation at the national level (in the Norwegian arena for NPGH) on the interactions within the transnational arena. The present division of responsibilities for global health in Norway left many GHG issues unattended to, in a sort of no man's land.

> There are many systemic issues for global health that are currently falling between these two (ministerial) chairs. These are issues related to intellectual property, trade, research and innovation, and all of the broader economic drivers and systemic issues internationally which are linked to health and health outcomes. And we do not seem to have a very clear policy or politics about them. The Minister of Foreign Affairs is dealing with it in a way because they're dealing through other sectors, such as our positions and preferences in trade agreements. My point is that we haven't contextualised those more clearly in a health perspective. With the NCD agenda, it's even more important because you not only have an issue in the international system for medicines, vaccines, technologies, and sharing of benefits, but it's also now a question of food, nutrition, tobacco, alcohol, all the *bad* products and how do you nurture a good marketplace internationally on those issues. Those are global health governance issues -- where maybe the Ministry of Health has not had the sufficient capacity or interest, and where the global health section in the Minister of Foreign Affairs focuses first and foremost on where should we put our money. These areas are not easy. They cannot be solved by money. They need to be solved by political negotiations, agreements, and

> conventions. Having seen the UN system and the extreme slowness of many difficult negotiations, I understand why you want to shy away from that and go with where you can actually deliver results because these other complex issues will never be solved. There will always be debates, discourses, and discussions on different interests, so it's always about shifting things somewhat in one direction instead of in another direction. (H)

Informants questions how Norwegian resources (political, financial, and technical) could be used to leverage support for intersectoral governance for global health that would aim to manage and regulate the economic and commercial interests at the global level. This would necessitate health diplomacy to influence politics as well as civil society support, because as one informant from the health sector pointed out, one cannot influence institutional structures (ministries) alone to be instrumental. One informant from the foreign policy sector recognised this complexity, and expressed some optimism regarding the foundations for Norway's intersectoral governance practices and methods, while also acknowledging rapid changes in the GHG arena.

> We're getting completely different types of challenges -- NCDs, emerging diseases, air pollution and climate-related problems, and escalating problems with humanitarian crises with big health consequences. These things cumulatively make communicable diseases and maternal and child health look more and more marginal as factors in the global burden of disease and years of life lost. And none of these things can be addressed with vertical initiatives, because they are inherently multi-sectoral, and all of them are controlled by sectors other than health. It's in the hands of people like transport, industry, finance -- people who regulate taxation and emissions. If you want to get big results in those fields, you are essentially in the situation where you have to persuade other parts of authorities, nationally and globally, to do things that make no sense from their perspective, because it is necessary to get good results in our view. Which is a totally different kind of challenge, and that's why also we wanted to have that third part in the White Paper- to say a bit about how we have to work to make that kind of thing function. You have to have a good knowledge base, you have to have a focus on building good tailor-made political processes globally, and you have to approach it as a task of advocating for health concerns and demonstrating the health benefits to other sectors nationally, globally, academically everywhere. It's a much more indirect and complex approach. In that sense, I think we were on the right track with that final part. (FA)

> I think the White Paper was (a precursor). In terms of global action, Norway is in the middle of preparing for what the sustainable development goals are going to look like. The work that we've done on the White Paper and global health has helped us learn that you need to work across institutions. The sustainable development goals process that is currently happening here now is reinforcing that we need to work across. We don't exactly know how to do that. (H)

The second set of questions relates to what informants with experience in public health and public health research considered to be a concerning divergence between political values for

global health and political values for health in Norway. Norway is internationally known for its commitment to reducing social inequalities in health for the Norwegian population, but there are concerns that when it comes to global health, strategies for acting on the social determinants of health and for equitable health systems were overshadowed by competing values in the arena for NPGH. Informants from the research sector especially expressed concern about these contrasts and how they related to the populations for which sectors are responsible and the sectoral divide – that is between the Norwegian government's work for health of populations in the global south (responsibility of MFA) and the Norwegian government's work for health of populations in Norway and in circumpolar regions (responsibility of the MHCS).

> This foreign policy in global health is completely at odds with everything else we're doing in politics for Norwegians. Why should we do something else in foreign policy? The Public Health Act is really important and something to be proud of, and the public health traditions in Norway are very rich. Linking back to global health engagement, we are not using any of this public health material and knowledge and capacity that we have in Norway. (R)

> Our health system in Norway is extremely strong – well-funded and well-functioning. It has its difficulties, but it's a rock-solid piece of work. But do we promote health systems in the global nature? No, we don't. We don't research it systematically. We don't make policies systematically. We may mention health systems, like we should do some health system strengthening, 'blah blah blah', but are we going for that as a core way forward? No, we don't. We're bypassing it sometimes. (R)

> The White Paper didn't really represent the traditions and the processes of global health in Norway. (H)

Informants suggested that Norwegian politicians used international development models rather than Norwegian public health models as sources of policy ideas and instruments for global health. Due to these preferences by Norwegian politicians and bureaucrats, particularly in the MFA, it seemed Norwegian researcher thought that the knowledge they could provide for policy development was often overlooked. Informants expressed their impression that the Norwegian global health policy and development aid was about quick and easy wins more than support for systems and structures.

> During this period, there has been a very strong trend in general on the value for money when it comes to development aid. Healthcare, due to its compatibility with other development areas, has been successful in benefitting from the new money coming into development aid. I think this is because they have sold simplistic messages to policy-makers and politicians: by giving this dollar, you can save this life. (H)

> You have the issue of political visibility because you have the long term and the short term. It's easier to gain goodwill if you give money to vaccines and medicines rather than investing money in prevention. It's easier to say Norway, we've vaccinated X-amount of children in Africa last year. That's more fancy than to say Norway, we invested X-amount of money in prevention and lifestyle diseases in Africa last year. (H)

> It can look a little bit like – regardless of whether you have a more left or a more right government in place – that the structural issues and those issues related to systems strengthening and general resources for health – such as nutrition / malnutrition – it's not really addressed in practice, despite the fact that both sides could be sympathetic to that having a larger place. It remains more of rhetoric, less action in practice. (CS)

In this era of multilateralism, where governments can easily pour money into global initiatives, the comment of one informant from the research sector said, "It is hard to know and to say what the Norwegian government stands for today, what does it want to do in global health?"

The third area of concerns from global health and public health researchers in Norway related to whether research and expertise from outside of Norway should be understood as political resources, rather than technical ones, in the arena for NPGH.

> They use researchers, but maybe not so much Norwegian ones. The health department in Norad uses foreign researchers in various parts of the system. But research is highly specialised; you might not find a Norwegian researcher for the exact policy question you are trying to address. It's fair for them to look at the global pool of knowledge more than just at the Norwegian one. I think that can play an important role because Norway is all the time trying to leverage support from other donors on their initiatives. So, if you have a leading American researcher supporting the Norwegian argument (this is just my own thinking about it), I guess that would have more power supporting this as a good idea, than if you had a Norwegian researcher on there. (R)

Informants from the research community voiced concerns over potential consequences of interactions in the transnational arena for Norwegian global health research funding and priorities for knowledge production on global health in Norway (e.g. scientific / technical context of the arena). The interactions with networking and learning in the transnational arena circulated ideas that were linked to calls for research through programmes funded by the MFA and the Norwegian Research Council (like GLOBVAC), the main Norwegian funder of global health research with low and middle-income countries.

> When the White Paper came out, all the researchers were interested to see where the politics is heading. The research funding will be shaped according to the White Paper, and part of the research budget has been going out to American institutes for some reason. (R)

For example, one way this impact is observed related to how global health research funding calls were earmarked in line with work of the MFA, rather than research objectives and questions related to community health, primary health care, and health policy and systems in low and middle income countries.

> GLOBVAC asked us for "game-changers", game-changing ideas. If I would be critical about their choice of strategy, there is too much looking at new types of things we can do to get to where we want to go, instead of doing the hard work of strengthening the basic things that people need -- like a good health system that's functioning and a good health information system on the ground. Instead they talk about innovation and game-changers, and that is fuelled a little bit by the close connection with the Norwegian government and Bill and Melinda Gates Foundation. Bill Gates, though he funds a lot of global health issues, he's very interested in innovation, gadgets, and things like that, and Norway wants to be an active partner. There's an alliance between the Americans-Gates-Norwegians in maternal and child health and global health centred around innovation and gadgets. I wonder whether you lose some important aspects of doing the right things in impoverished environments and understanding how they function thoroughly when you are looking for technological solutions to the issues rather than structural solutions. You see a big emphasis on the commodities list, the essential life-saving commodities for a child or newborn, which came out of the blue. Why commodities? Yes, commodities are important, but they need to be linked up with skills and with access to services. I felt that the emphasis on commodities is another kind of isolating elements, instead of understanding the complexity, and that's what irritates me. (R)

I found such concerns expressed by informants from research to be a cautionary indication of ways that the power asymmetry (see Section 2 of this chapter) between the MFA and the MHCS in the arena for NPGH also impacted the Norwegian scientific and technical context.

> I think the tension in our area has been around target-oriented health interventions that are working along those vertical axes for specific diseases where the emphasis has been extremely strong. That tension exists in Norway and I think that tension is substantial. Those who are more in the field are more concerned with equity, rights and coverage at the level of needs, than with target-oriented health services. We have seen that a few people have influenced a lot of the work that's been done in global health in Norway on the development side, such as Tore Godal and the former Prime Minister who were very vocal in the GAVI initiative and the establishment of the Global Fund initiative. Of course, they have a lot more power than little researchers with policy interests have in this field. Our global goals are the same, improvement of maternal and child health parameters and the millennium development goals. There was a big wish to move forward on this, but there was a disagreement on strategic approaches, absolutely. (R)

> The White Paper did not give any real partnership announcement for Norwegian partners. While there are very good teams working on global health in Norway, they are doing this very much in spite of the follow-up of the White Paper. The White Paper was strong on thinking and perspectives, but the follow-up has been very weak. It has increased the Norwegian multilateral

> funding, but it has completely missed in securing the involvement of Norwegian bodies and knowledge community in Norway. It has reduced the follow-up on partnership with higher education and research (in the south), which are the only bodies that can secure the future of global health in the regions affected. The Ministry of Health is not talking about global health to the Norwegian community. The Ministry of Education and Higher Research is not really putting up the agenda. The Ministry of Foreign Affairs has been lifting it, but mainly through its profile towards WHO, GAVI, and some other institutions. (R)

As a contrast to this critique of the arena for NPGH, informants commented positively about the global health strategic initiative group which identified research priorities and an action plan within the *Health and Care in the 21st Century* process in 2014 that the MHCS undertook with other ministerial partners and that some researchers I interviewed identified as an exemplary intersectoral and participatory process.

Table 1. Position, Boundary, and Interaction Rules for the six action situations in the Norwegian NPGH action arena

Situations/*rules*	***Position rules***	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 1 – **Policy Writing Group**	MFA was the line ministry responsible. MFA staff led and coordinated all White Paper activities, managed in the SGI section. Position of policy writer created for a diplomat to draft and finalise text at the end of the process. Criteria for positions favoured diplomatic expertise, international institutions, budgeting, and foreign policy experience over experience in the health areas of the policy content.	Included representation from MFA and MHCS. Participants from the ministries were senior level (i.e. Dept. heads, deputies, senior advisors), with experience or professional focus on international relations, international institutions, or global health. Participation was permanent standing membership of individual representatives from the respective agencies (no alternates allowed). Excluded non-state actors. Practical selection criteria for actors from sectors other than foreign affairs (other than expertise in the global health domain) was that they have experience with national policy processes and were available with the potential to	Ideas for consideration related to reporting on high-level priorities for development aid expenditure and budgetary commitments. Current practices and past priorities for Norwegian development aid to support targets for health-related MDGs 4-6 guided selection of materials. Bring health policy perspective into foreign policy framework. Excluded direct input and expertise from some health research driven (government funded) processes in Norway where global health policy is being debated and evaluated (i.e. Forum for Global Health Research). Included private sector visibility in the White Paper as long as it was related to the priority areas.	The Writing Group was a hub for collecting input from the actors on behalf of their sectors. The subordinate agencies for development and health interacted with the Writing Group under rules for checking quality control, which required their expertise to ensure up to date scientific evidence and statistics. The use of rules that were generally applied to White Papers processes also necessitated reviewing existing policy materials (policies, white papers, strategies, etc.) to prevent any contradictions in the content. The Writing Group did not operate under rules for collective decision-making. The MFA was the final decision-maker, although exercised this role by consulting and

		incorporate this process into their workload. *A regular rule in use broken for NPGH*: MFA's subordinate agency Norad included as an actor for capacity reasons because White Paper Project Team needed Norad for specialist knowledge.	Politicians' perspectives and political priorities were given access to the group for consideration alongside those of actors in public administration. Setting out a future vision for global health policy was excluded (but this rule was modified by the policy writer in the final drafting round by adding the final section on contexts & approaches).	negotiating with the other sectors involved. The *Government will* bullet points (agreed at the political level - in situation 4) guided decision-making about the direction and scope of the policy document. These points were used to signpost brainstorming activities to develop corresponding content under related sections. In the final writing phase, the policy writer applied policy-writing rules for making the text less technical.
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 1.a – **Foreign Affairs (***internal*)	Deputy of SGI managed White Paper Project Team in MFA.	Special advisor on Global Health to the Prime Minister. Other sections in the MFA's Department for UN and Humanitarian Affairs. Ad-hoc inclusion of members from other departments in discussions. Ad-hoc inclusion of staff from Permanent Missions of Norway and Embassies in discussions.	Included expertise and materials from groups and teams within the MFA & foreign service (related to health MDGs and security, pandemics, and WHO). Excluded ideas from expertise about intersecting issues not formerly treated as part of GH policy (e.g. trade, economic development)	Collected inputs from different departments and sections in MFA for the Policy Writing Group. The coordinator had oversight and decision-making regarding the application of boundary rules for internal briefings and exchanges within MFA. White Paper was regular item on agenda of SGI team meetings between mid 2010 and end

				2011. Consultations with other departments and sections within the MFA and exchanges about decisions for the White Paper were informal, spontaneous, and fluid as needed (determined by the Coordinator of White Paper Project Team). The White Paper Project Team coordinator had regular meetings with key actors (influential scientists and foreign service actors).
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 1.b – **Health** (*internal*)	Core team represented the MHCS one the Policy Writing Group. Dept. of International Affairs was responsible for process issues and ensuring the transfer and support of health sector contributions to this group; consulted, communicated, and coordinated inputs from relevant organisations from the health sector about White Paper.	Other relevant departments within the MHCS. Public agencies that were sub-ordinate institutions to the MHCS with relevant expertise and experience in global health research, policy and practice. Sub-ordinate institutions that worked on health only at the domestic level were excluded (e.g. issues on supervision of health services,	Horizontal and systemic approaches to global health issues. Consideration of impact of policies from other sectors on health (i.e. NCDs). Global health policy conceptualised more broadly than health MDGs.	Although health sector inputs were centralised through MHCS, there was no coordination of supporting or reiterating the inputs and key messages across the health sector. Informal process for MHCS collected input from other agencies in health sector. No structured / facilitated interaction or dialogue between actors from within the health sector.

	Dept. of Public Health was responsible for substantive contributions to this group regarding the content of the White Paper.	patient issues, biotech, medicines, radiation protection). Contact person in the health sector agencies was either from the International Affairs or Global Health Dept. (unless otherwise specified).		
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 1.c – **Development** (*internal*)	Head of Dept. on Health, Education, Research coordinated agency-wide internal consultation process across Norad, ensured input received from all 10 Norad departments, and approved all inputs before they were sent to MFA. Head of Global Health section managed internal consultation within GH team and oversaw how the feedback is sent back to MFA via Norad representation on Writing Group.	Agency-wide participation: all departments consulted.	All White Papers with content related to Norad expertise went through an agency-wide consultation as defined by Norad's five functions (technical advice, quality assurance, evidence, policy guidance, implementation support). Diversity, inclusivity, relevance - broad ideas and materials collected related to White Paper contents. No materials from development agency experts excluded or discouraged. *A regular rule in use broken for NPGH:* Norad did not provide MFA a background briefing on problem	Input collected from Departments after distributing texts at various stages with a template for feedback. The White Paper was an ad-hoc agenda item discussed at various stages in section meetings, department meetings, and the Norad Board of Directors meeting. Two of Norad's representatives on Writing Group did not hold positions in the intra-agency consultation process, but they were responsible for interacting with other Writing Group members and supporting the arguments of Norad's input into that process.

			and state of the art before MFA initiates development of a White Paper.	
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 2 – **Civil Society Organisation Consultation**	Chaired by line ministry (MFA).	Inclusivity for access offered to full range of CSOs as participants in consultation. Open invite extended to about 80 Norwegian actors from global health research & practice community and all major NGOs working in global health. Representatives of relevant Ministries and subordinate agencies were invited to attend consultations. Participation was voluntary and resources were not available to support attendance or facilitate contributions.	No ideas related to global health were excluded from submission to the MFA White Paper Project Team. Pragmatic approach to inviting suggestion of materials from CSOs: when possible be inclusive b/c it is good for quality and acceptability of policy.	All participants (whether present or not at the physical meeting) were invited to submit comments and input in writing to MFA. Rules provided for the MFA consultation to collect CSO input. Not conducted as process for dialogue, interactive exchange, brainstorming, collaborative problem-solving. Decision-making rules were vague. No clear criteria for how CSO actors' feedback would be assessed to determine which materials and ideas would be considered for the policy and which would not. The decision-making rules here were made at political level - to align CSO comments with political vision for Norwegian government action on global health.

				Rules for linking consultation to policy process (i.e. to Writing Group) subject to cultural differences between health and foreign affairs sectors Re why and how to engage with CSO for policy development. Government outreach to CSOs for comment and consultation on development of White Papers was conventional but not mandatory. Materials shared with CSOs about policy content / process were minimal.
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 3 – **Public hearing of the FAD Standing Committee in Parliament (*Storting*)**	Storting's (Parliamentary) Rules of Procedure outlined composition and duties of committees. Committee elected a Chair and Vice-Chair. Committee elected a spokesperson for each item of business who is responsible for preparing the committee, information collection, oversight of issue	Each committee's membership reflected the distribution of political parties as found in the overall Storting, to the extent possible. Committee may request to hear from actors representing ministries, NGOs, or private individuals to collect information. Organisations or individuals may request to appear before the	FAD Standing Committee was responsible for matters of foreign affairs, development cooperation, and agreements between Norway and other states or organizations. Committees only considered matters referred to them by the Storting.	Committee hearings must be public. Process to convene public hearing began when Parliament sent White Paper to FAD committee. Participants may submit written statements to the committee in advance of the hearing. A time slot was reserved for each participant to deliver his or her

	until recommendation adopted, and formulating the committee's recommendations in writing.	committee to present their views.		statement at the hearing. Common practice for committee members to discuss the issue in Parliamentary Party Groups or their Steering Committees. Other committees reviewed White Paper but not responsible for issuing official opinion. After the hearing and committee deliberations, the Spokesperson wrote the recommendation (including summary and proposed decision) and submitted to Storting. A committee's recommendation generally determines the outcome of the vote in the Storting. Generally accepted that the opinion on the decision is also part of the White Paper (even though the text of the policy paper is not modified after the decision by the Storting).
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 4 –	Managed by White	Main participants	Ideas that made	Exchanges focused

Ministerial Forum	Paper Project Team Coordinator in MFA.	are from the political level (Ministers and State Secretaries/Deputy Ministers). Sometimes members of the Writing Group participated in meetings to brief State Secretaries. May also include one or two members of a Minister's senior staff or senior advisory, but otherwise excluded any public administrators from the three policy sectors. Frequently included input from actors in the Norwegian Mission to Geneva.	connections between Norway's global health investments and the politics that underpinned them. This was a space reserved for discussions about the White Paper's content from a political perspective. Consideration of high-level priorities, in particular those germane to the political legacy of the coalition government. Excluded matters and questions of a technical nature.	on finding political solutions and agreement between Coalition parties. Decision-making focused on consolidating the political platform for global health.
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 5 – **Follow-up process**	Led by NORAD & NIPH at the request of the three State Secretaries. Report jointly published by MFA & MHCS.	Invited all Norwegian institutions and organisations who deliver on global health in some way to contribute.	Showed Norwegian actors' (across policy sectors and those outside of government) activities in global health. Methodology for report unclear. No guidelines (criteria, principles, or organizing framework) for structuring submission of materials. Gave Norwegian non-state actors visibility,	Planning and decision-making centralized within the Editorial Team. Editorial team exchanged with individual actors, but no interaction between participants. Open-ended process produced a lot of diversity across submissions from CSOs & other non-state global health actors.

			recognized their contribution, and highlighted broad range of resources invested by Norwegian actors in this field.	
	Position rules	***Boundary rules (actors)***	***Boundary rules (materials)***	***Interaction rules***
Situation 6 – **WHO Strategy Goup**	Development of the strategy was led by the MHCS and the Directorate of Health, but with close involvement of MFA and Norad. Secretary General of the MHCS Chairs the WHO strategy group. Directorate of Health was the secretariat for the WHO Forum established by the strategy, and was responsible for preparing instructions for each WHO meeting. The MHCS and MFA shared the power to approve decisions for the strategy and its implementation (with each round of instructions for WHO meetings three times/year).	WHO Strategy Group was composed of representatives from the MHCS, MFA, Directorate of Health, and Norwegian Mission in Geneva . WHO Forum was made up of representatives from MHCS, MFA, Directorate of Health, Norwegian Medicines Agency, NIPH, Norwegian Board of Health Supervision, Norwegian Food Safety Authority, Norad, Norwegian Knowledge Centre for Health Services, and Permanent Mission of Norway to UN in Geneva.	Strategy content emerged from discussion between the two sectors. Criteria for including ideas in the WHO EB strategy: What do we believe (what are our core values)? Based on our experience, what do we think we can do contribute? How does this fit with our political priorities? Strategy included key alliances and countries for cooperation to meet objectives (e.g. Nordic countries, special partners countries with shared global health goals and interests – the Netherlands, UK, France, USA, and the FPGH (boundary situation).	Dialogue meetings with stakeholders (including non-state actors) held once a year in January with aim to improve transparency and communication with the public and actors affected by WHO deliberations. Rules also built on successful examples of interactions and collaborations that existed previously (i.e. annual preparations for the WHA). Rules promoted discussion and dialogue, interaction rules foster working group environment with shared ownership. Even though the boundary rules targeted the inclusion of high-level decision makers to validate priorities, they were increasingly included towards the end of the

				process (bottom-up development). Open and transparent processes at high levels between the two ministries for discussions to set priorities for Norway WHO engagement.

Figure 1. A mapping of the elements of contexts for the Norwegian NPGH action arena

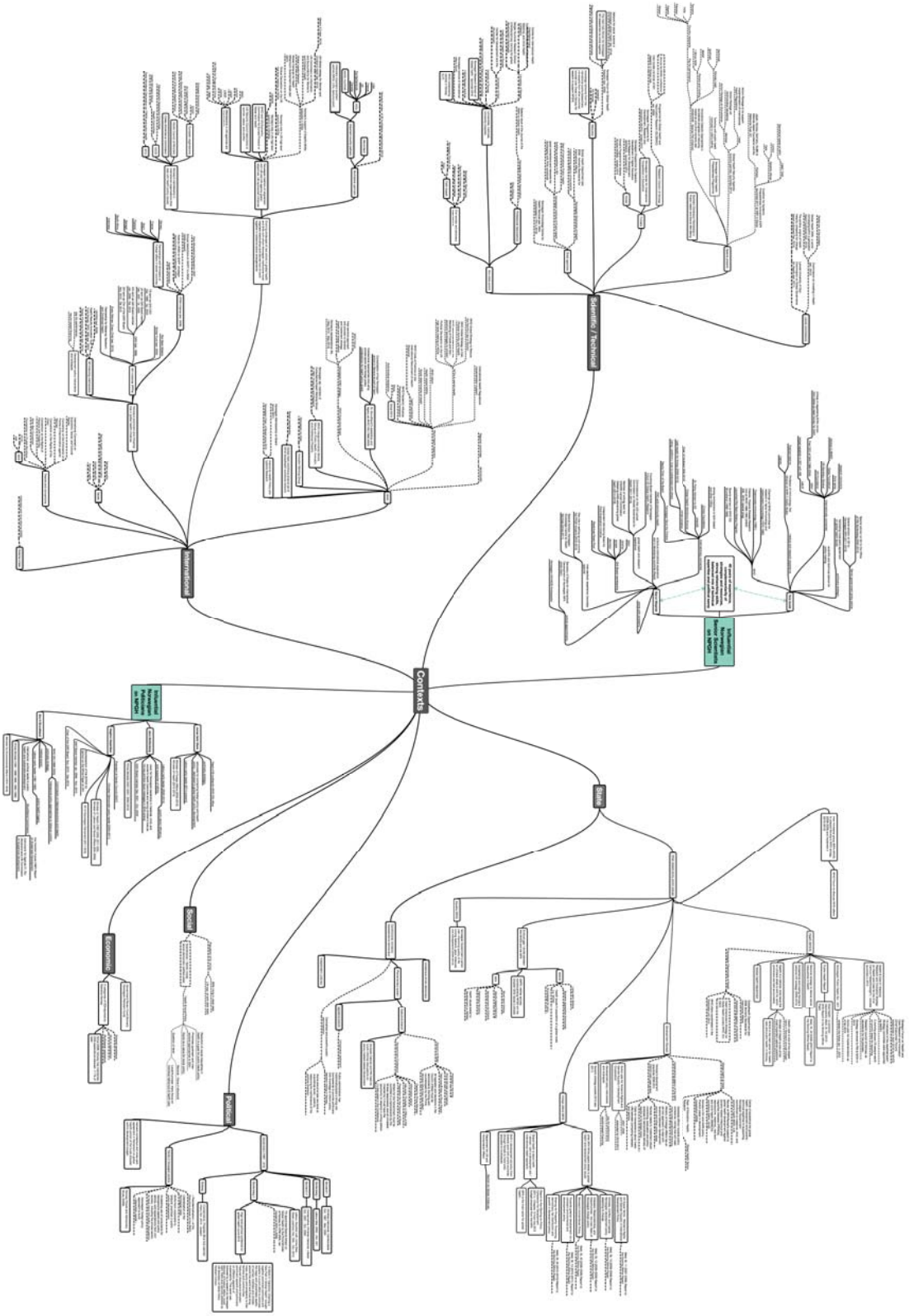


Figure 1 (contd.) – Close up of scientific and state contexts of Norwegian case

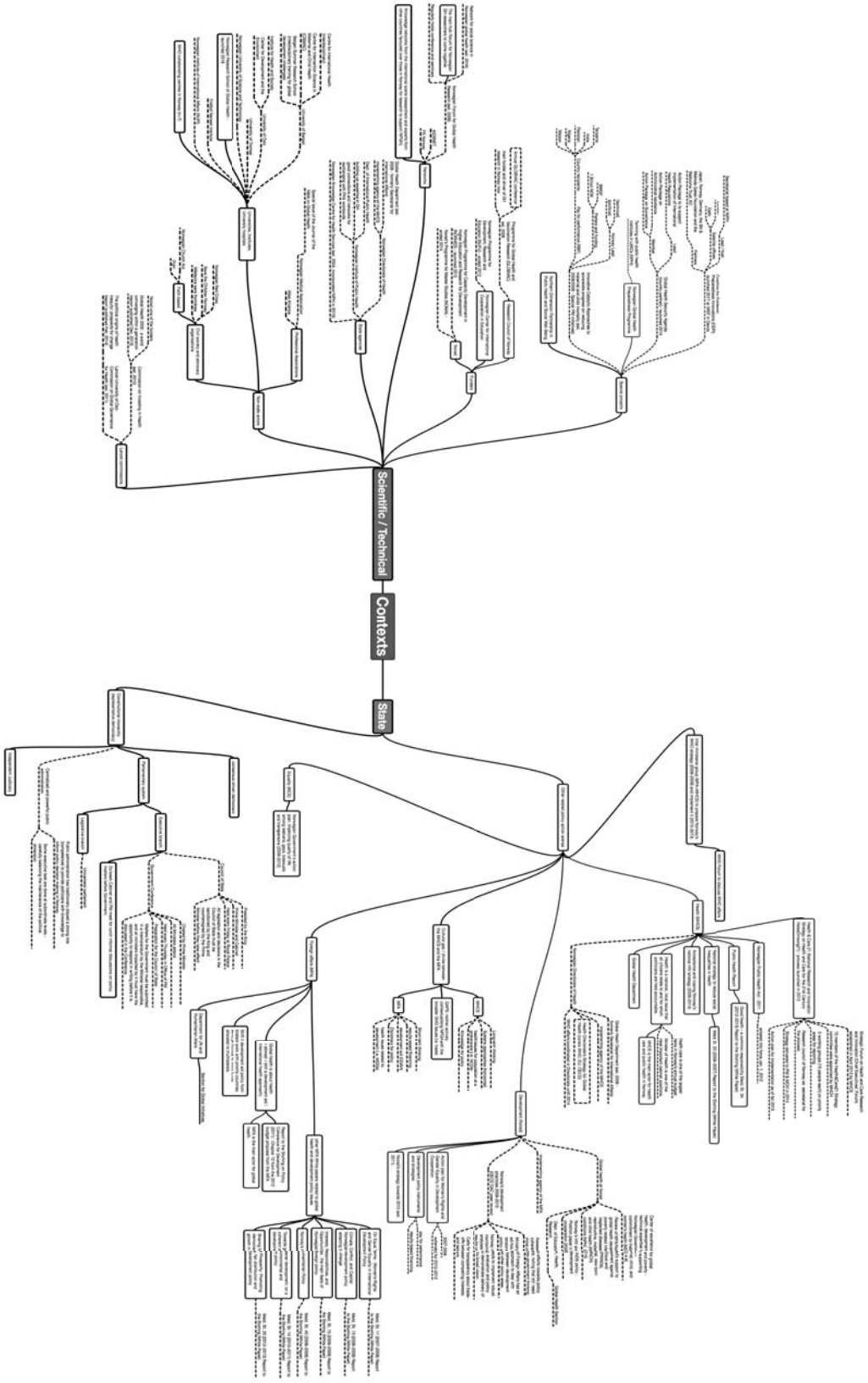


Figure 1 (contd.) – Close up of international context of Norwegian case

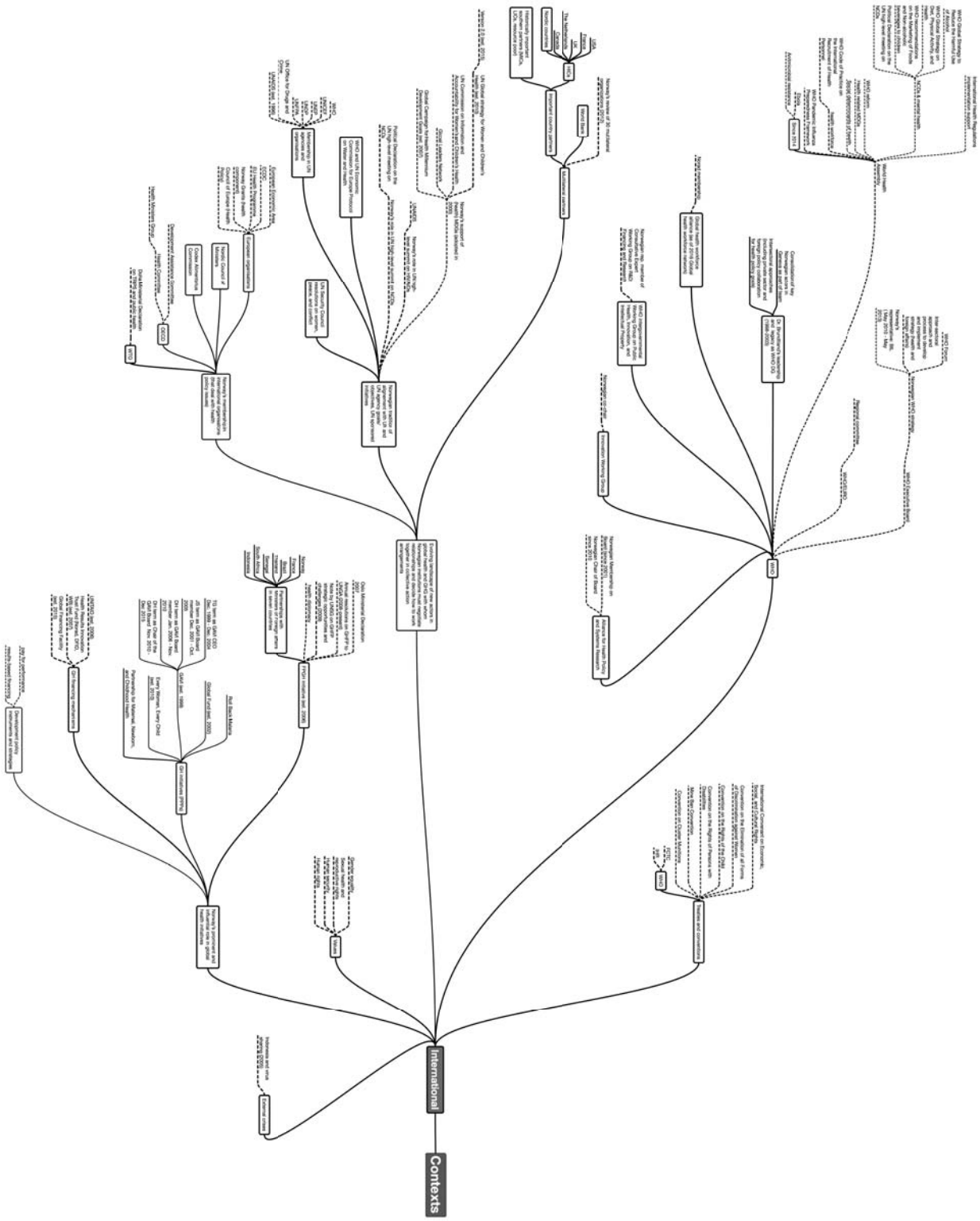


Figure 1 (contd.) – Close up of social, economic, and political contexts of Norwegian case

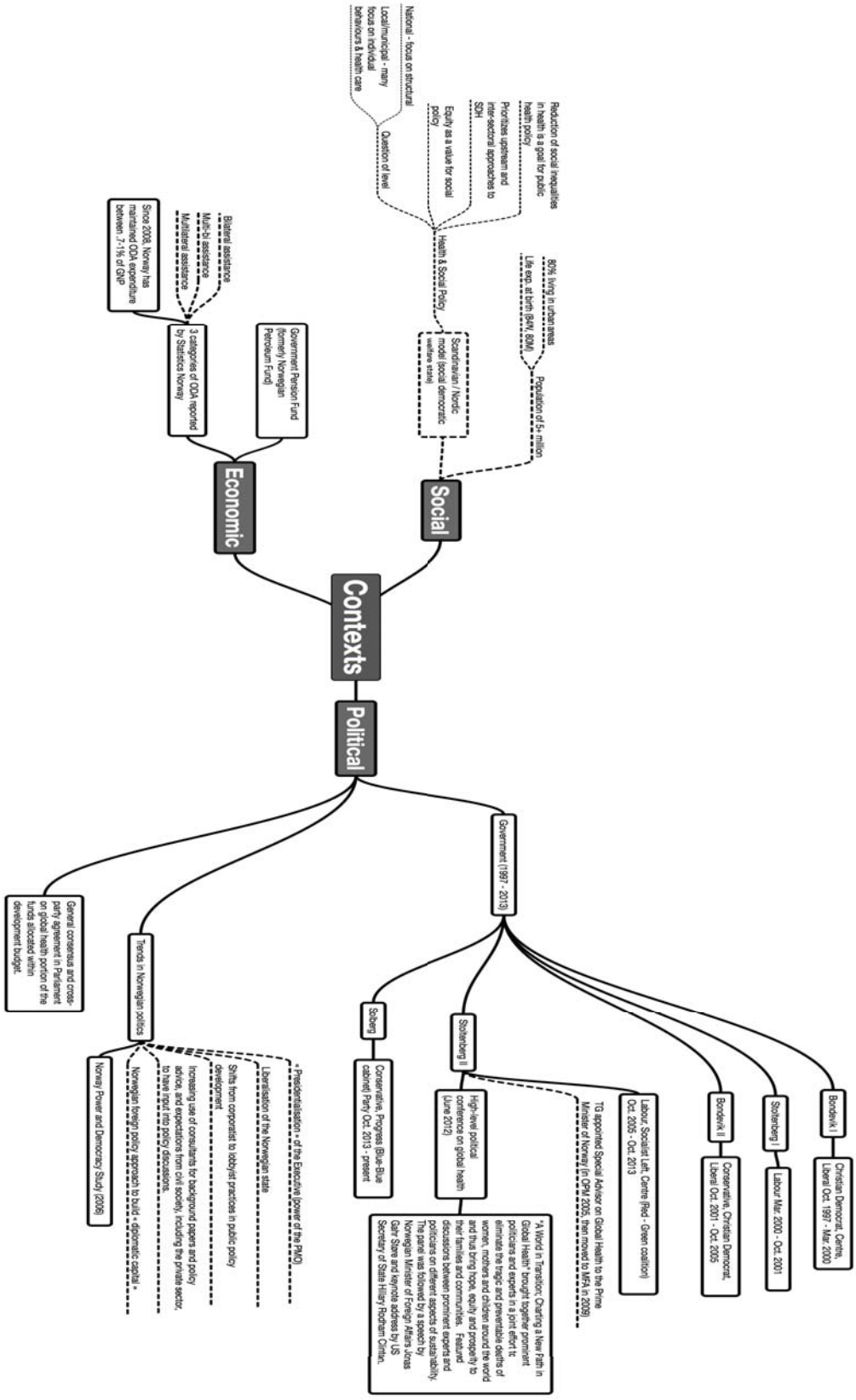


Figure 1 (contd.) – Close up of political and knowledge elites in context of Norwegian case

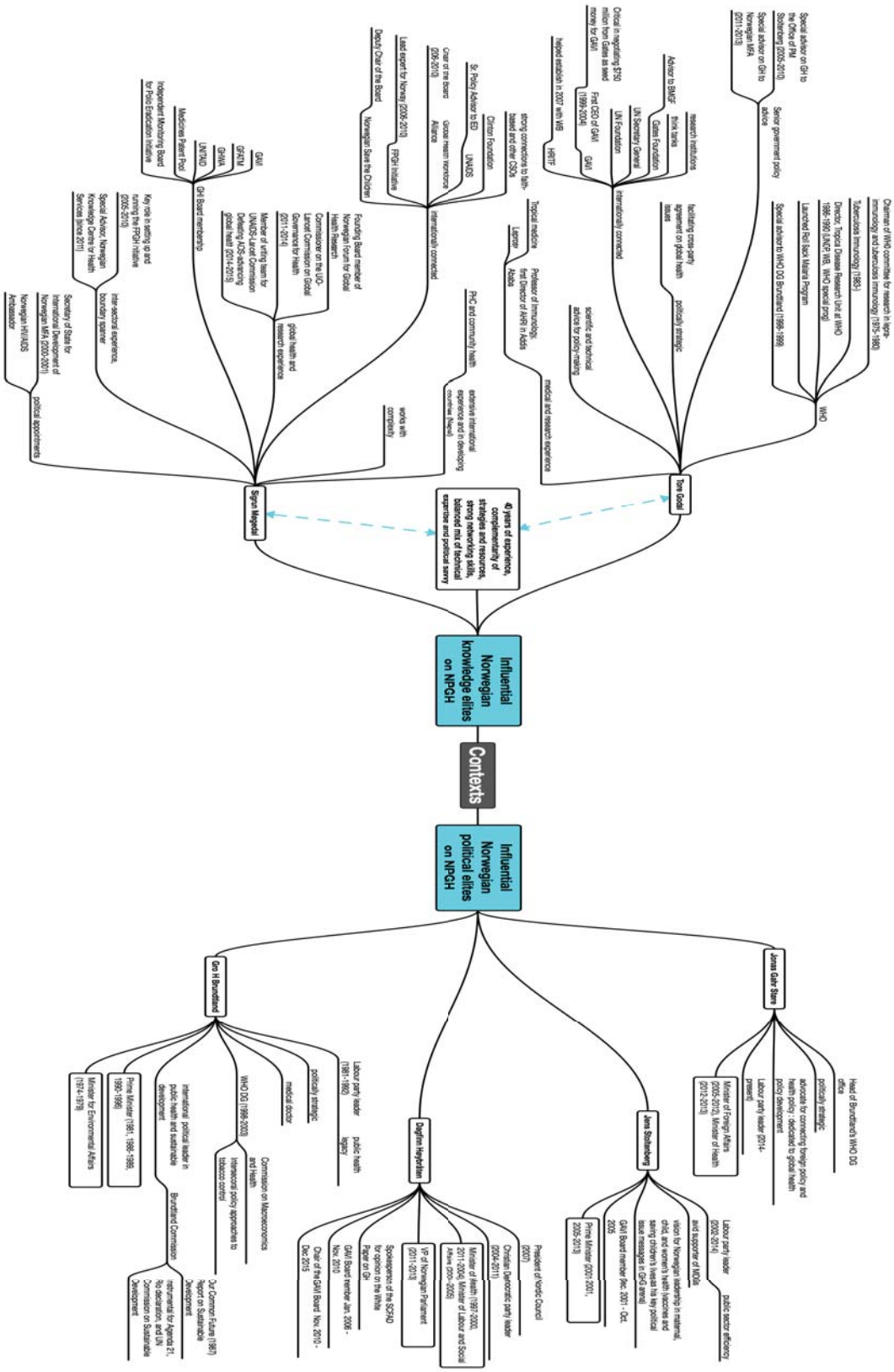


Figure 2. Model of the Norwegian NPGH Action Arena

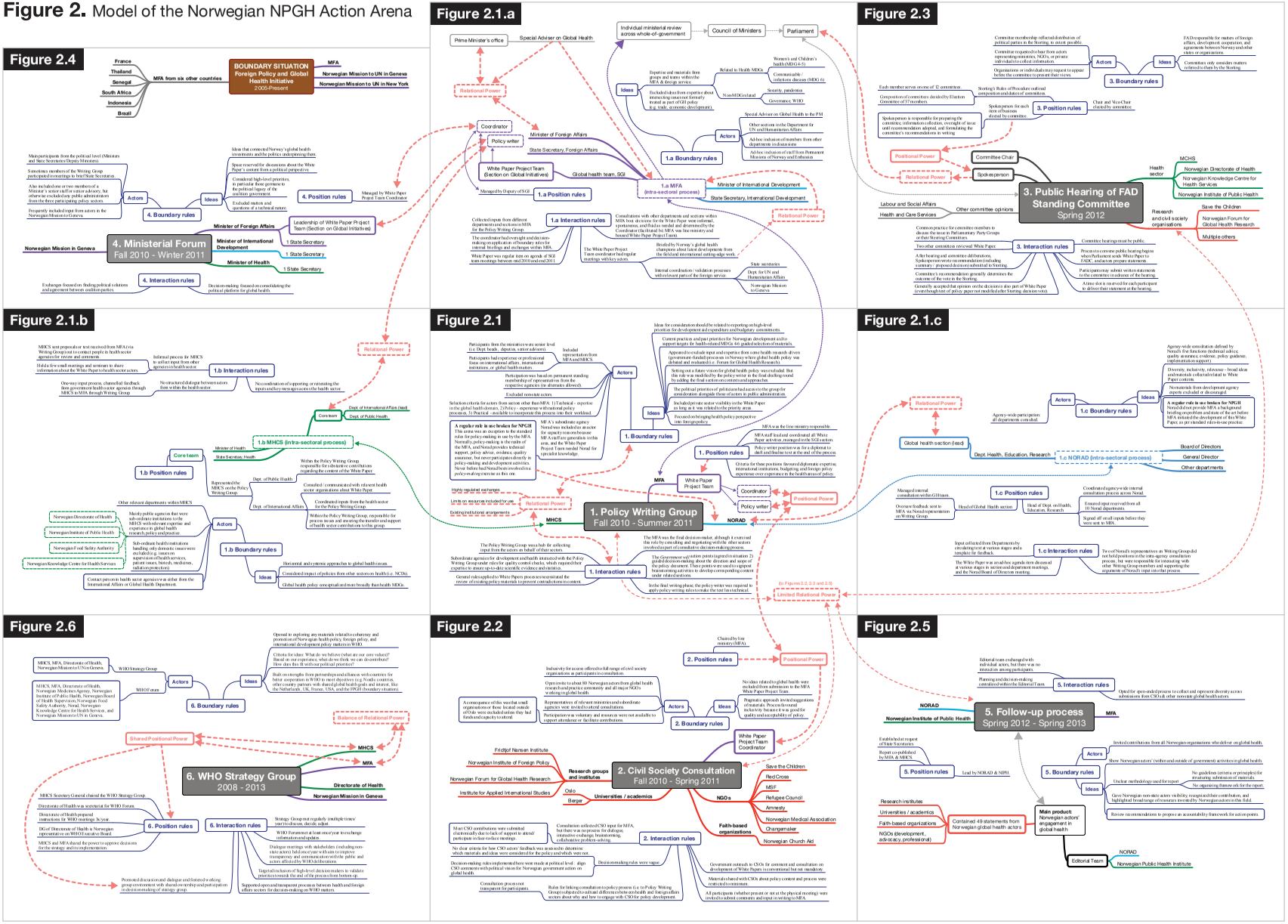


Figure 2.1 - Policy Writing Group

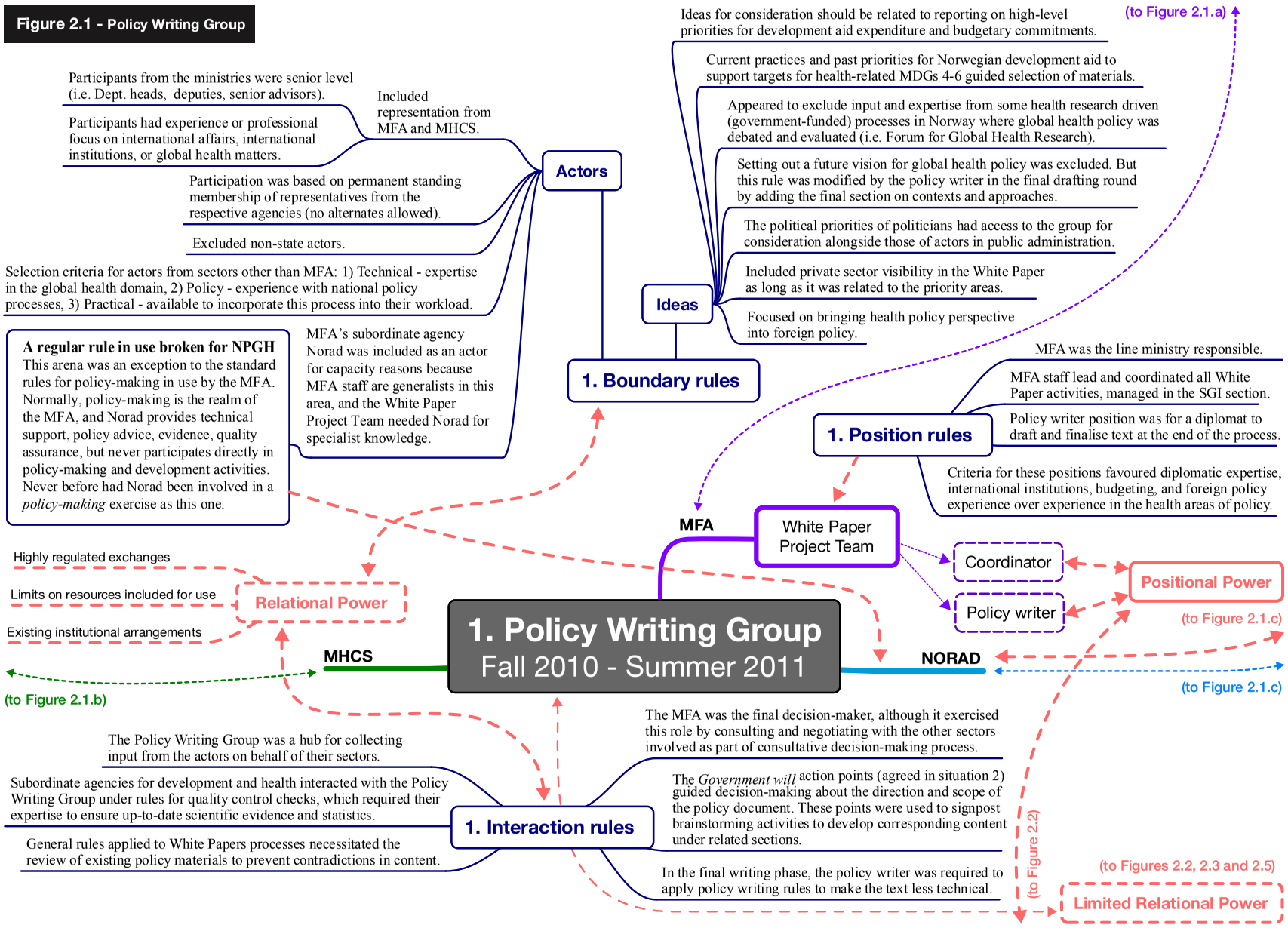


Figure 2.1.a - Internal processes of foreign affairs for Policy Writing Group

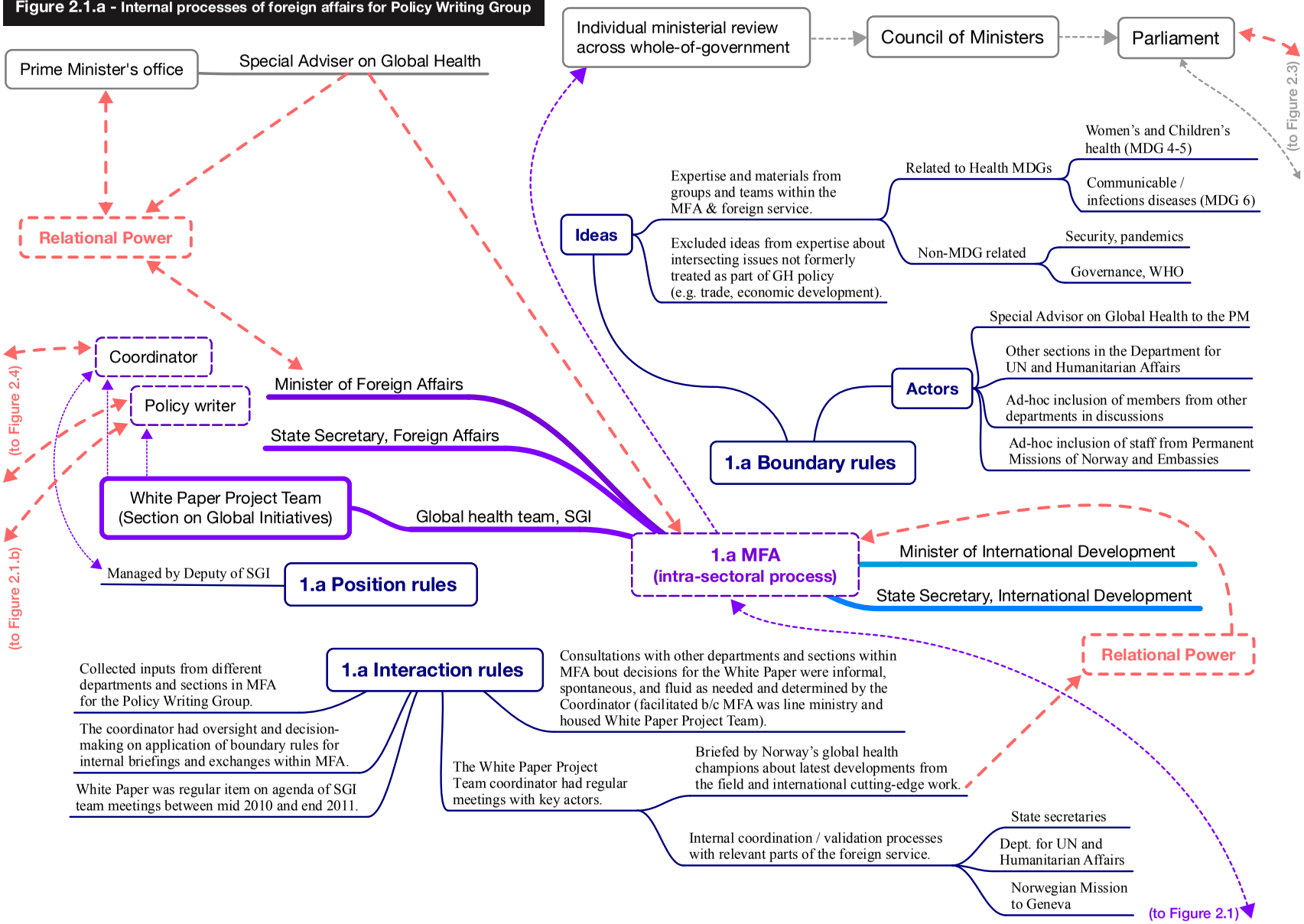


Figure 2.1.b - Internal processes of health sector for Policy Writing Group

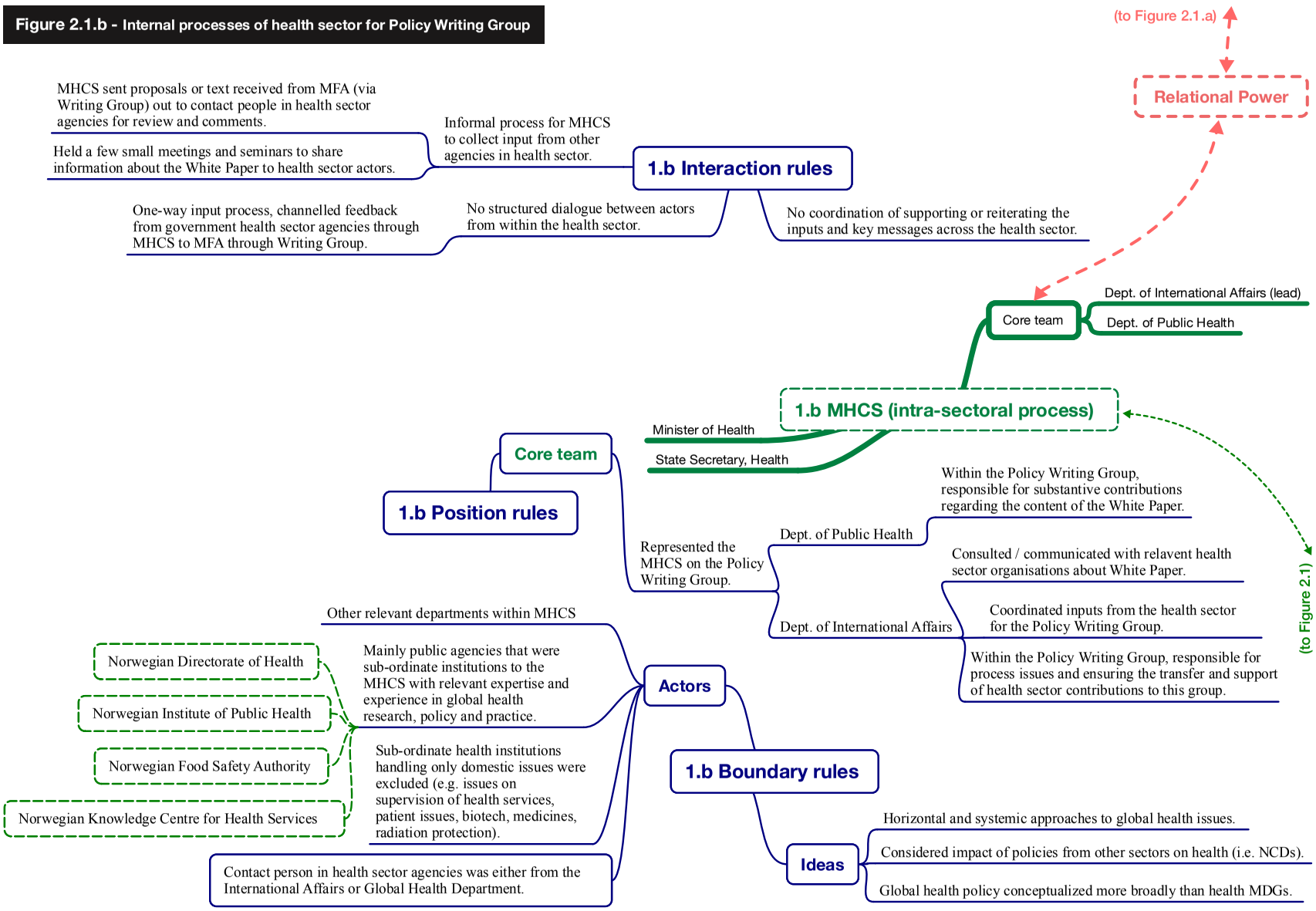


Figure 2.1.c - Internal processes of development sector for Policy Writing Group

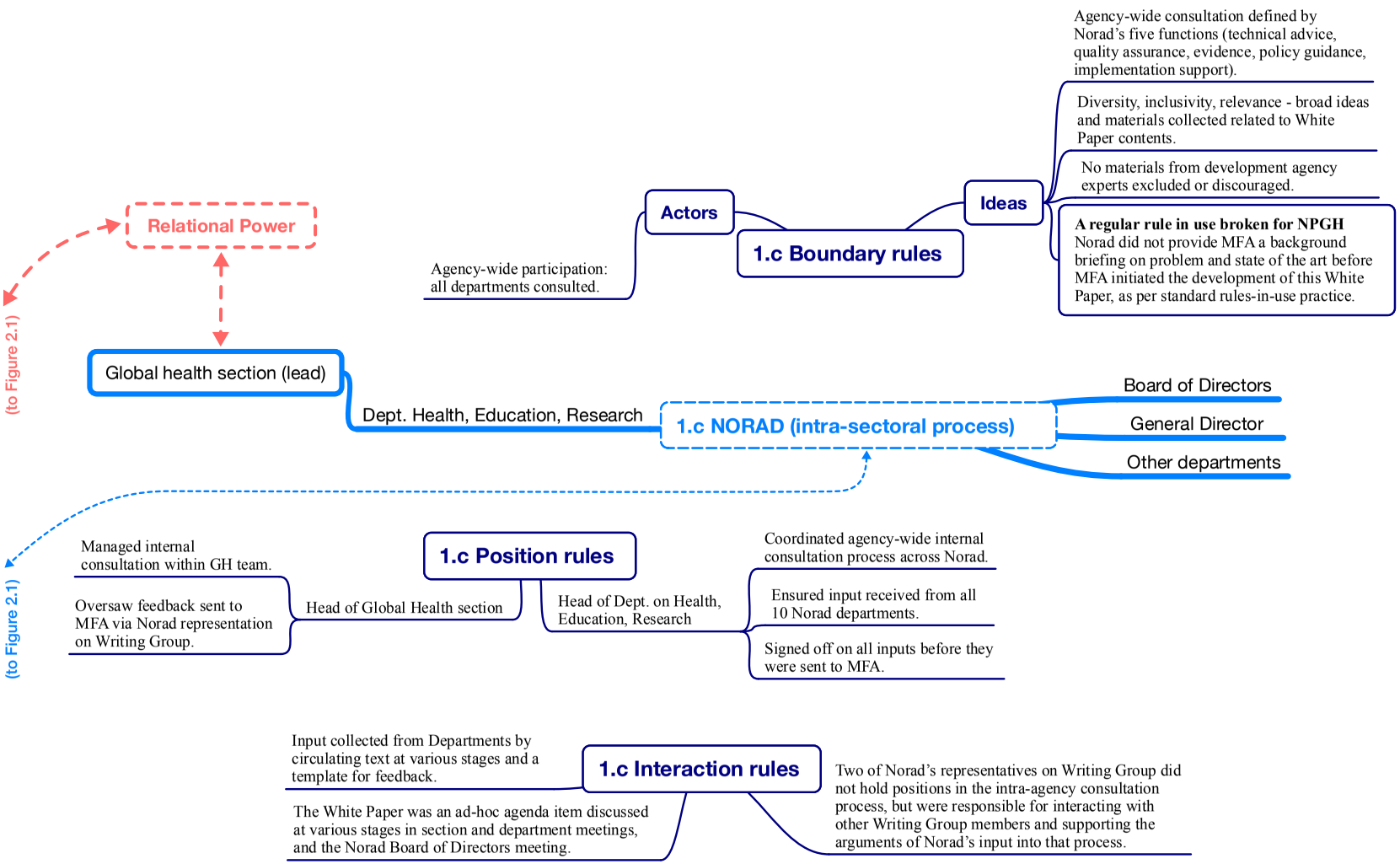


Figure 2.2 - Civil Society Organisation Consultation

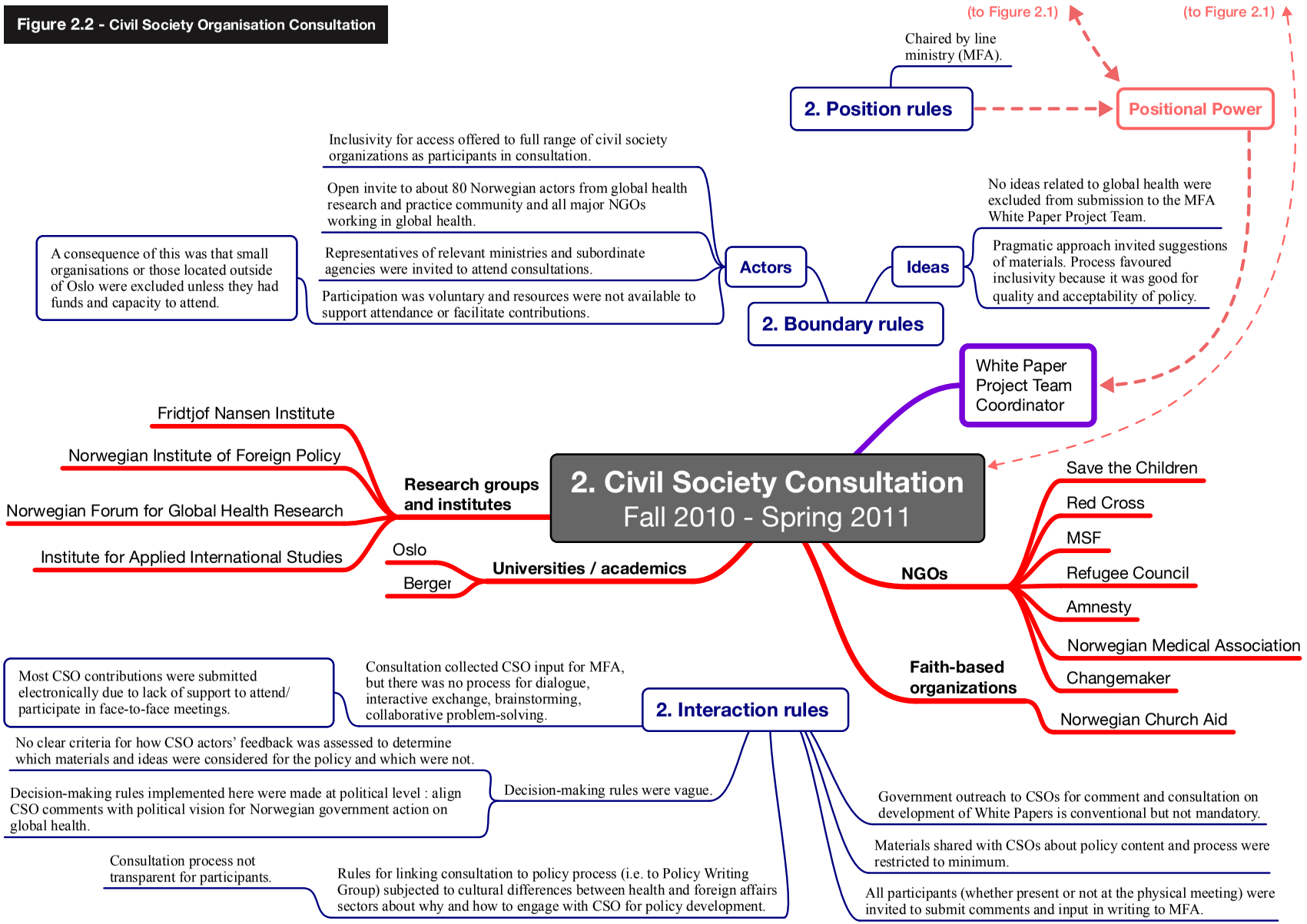


Figure 2.3 - Public Hearing of the Parliamentary Standing Committee on Foreign Affairs and Defence

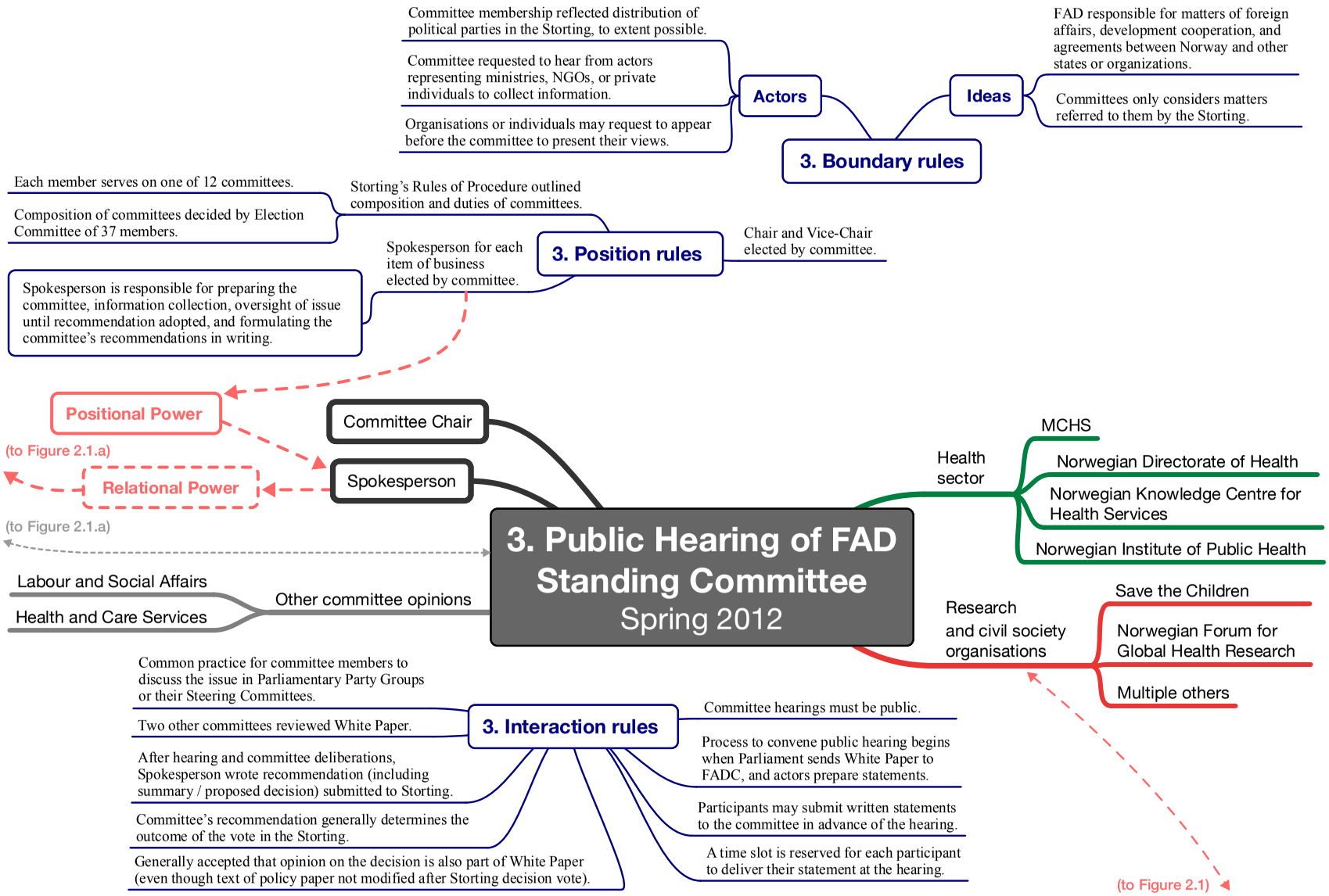


Figure 2.4 - Ministerial Forum

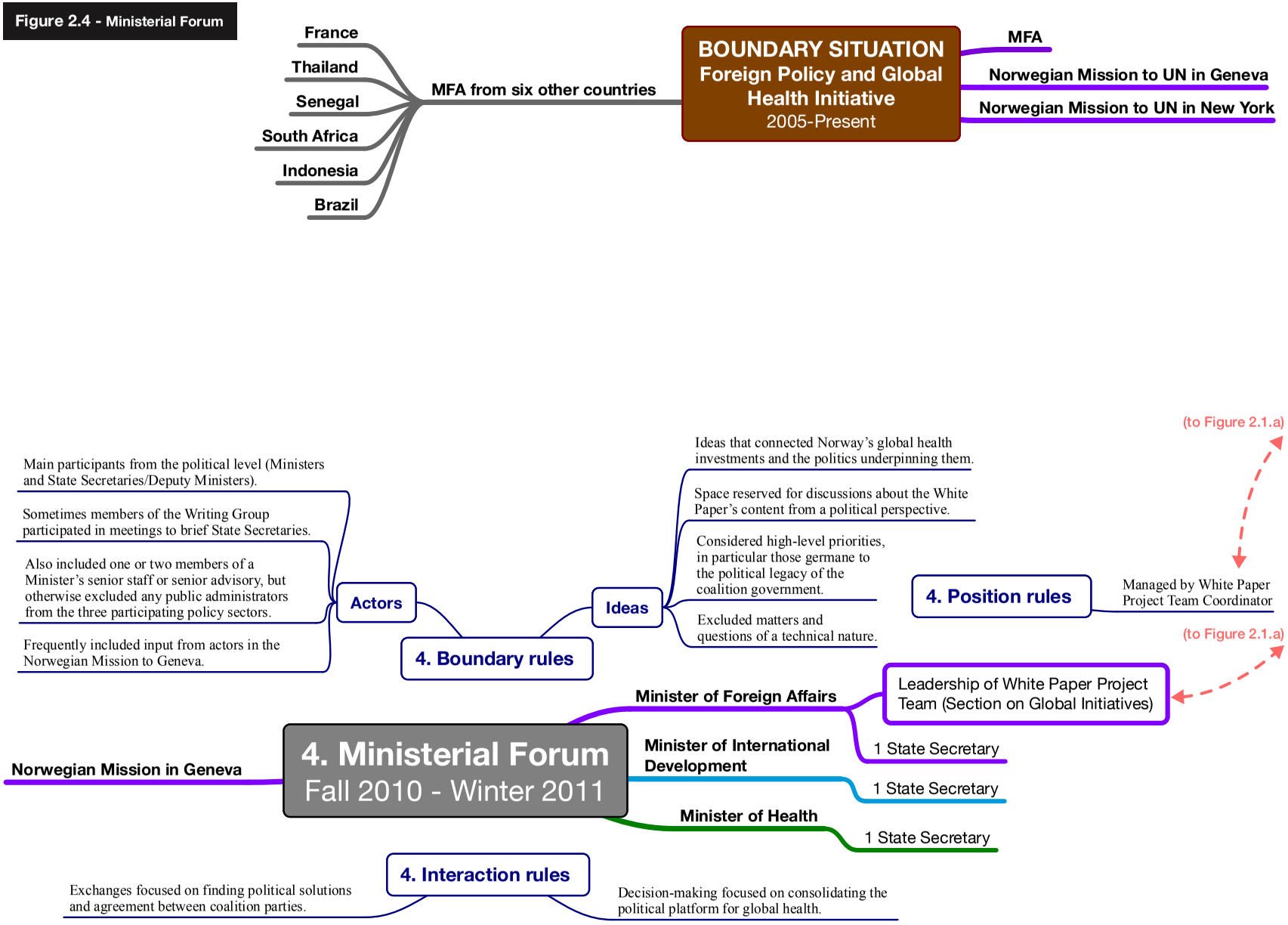


Figure 2.5 - Follow-up process

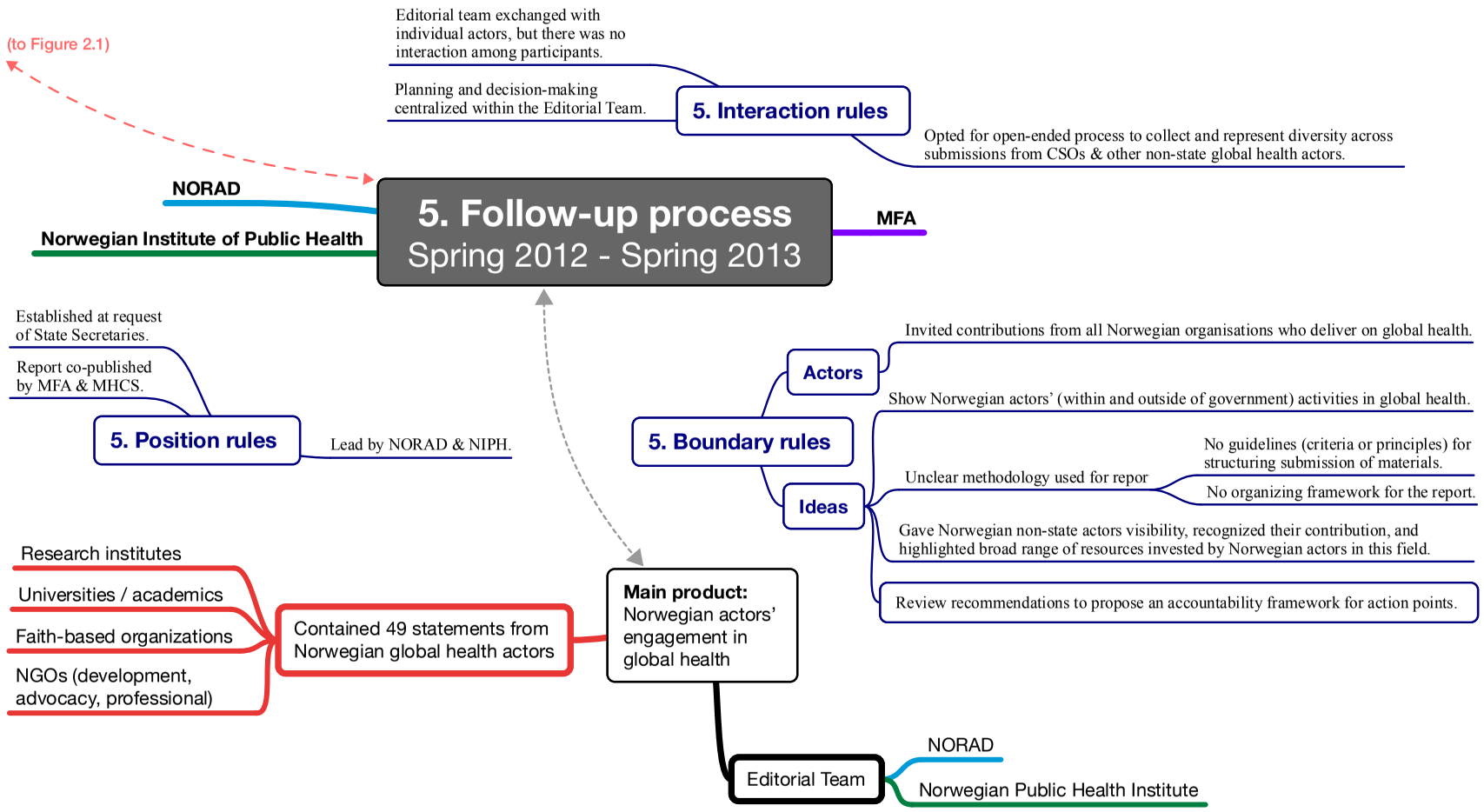


Figure 2.6 - WHO Strategy Group

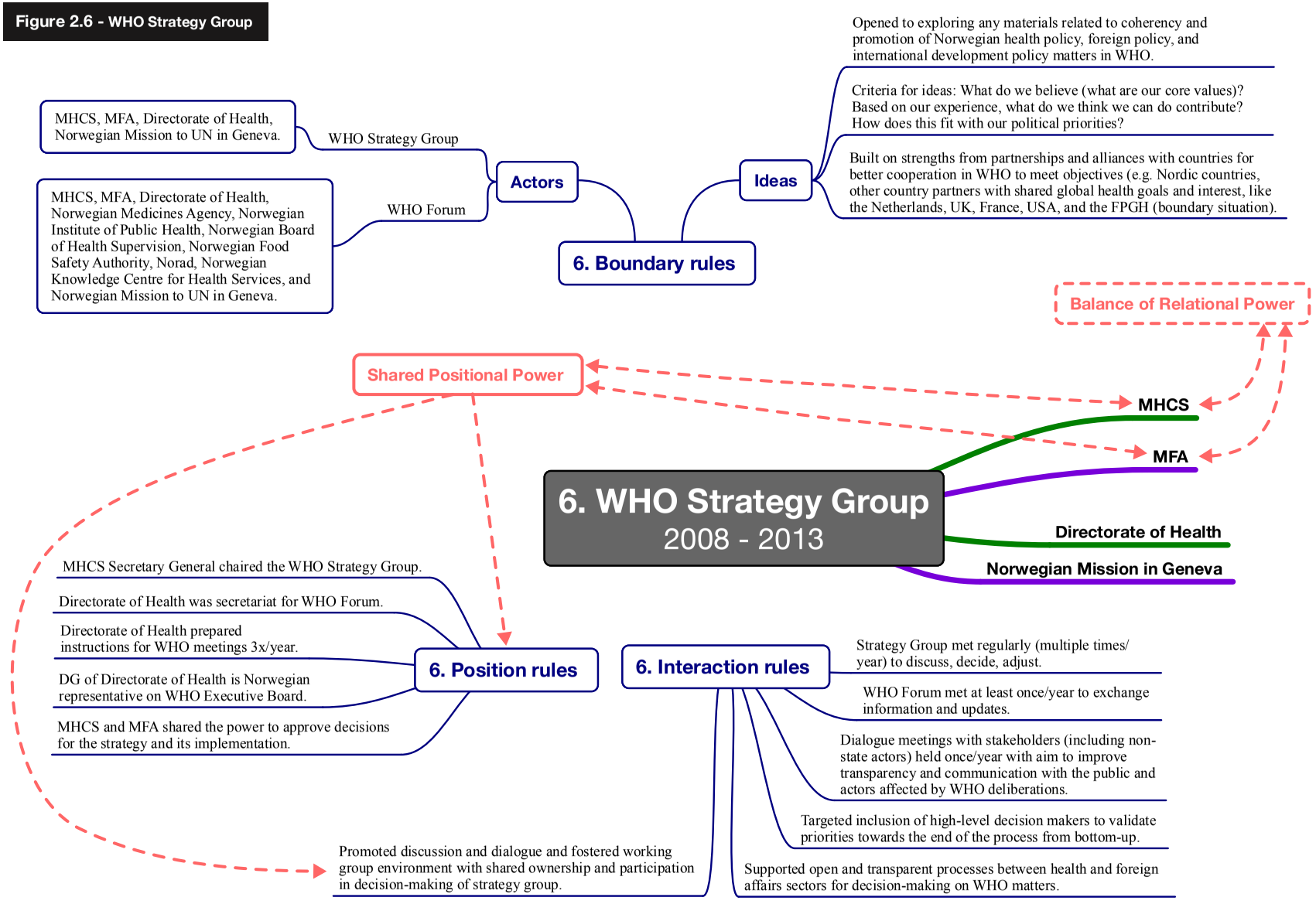
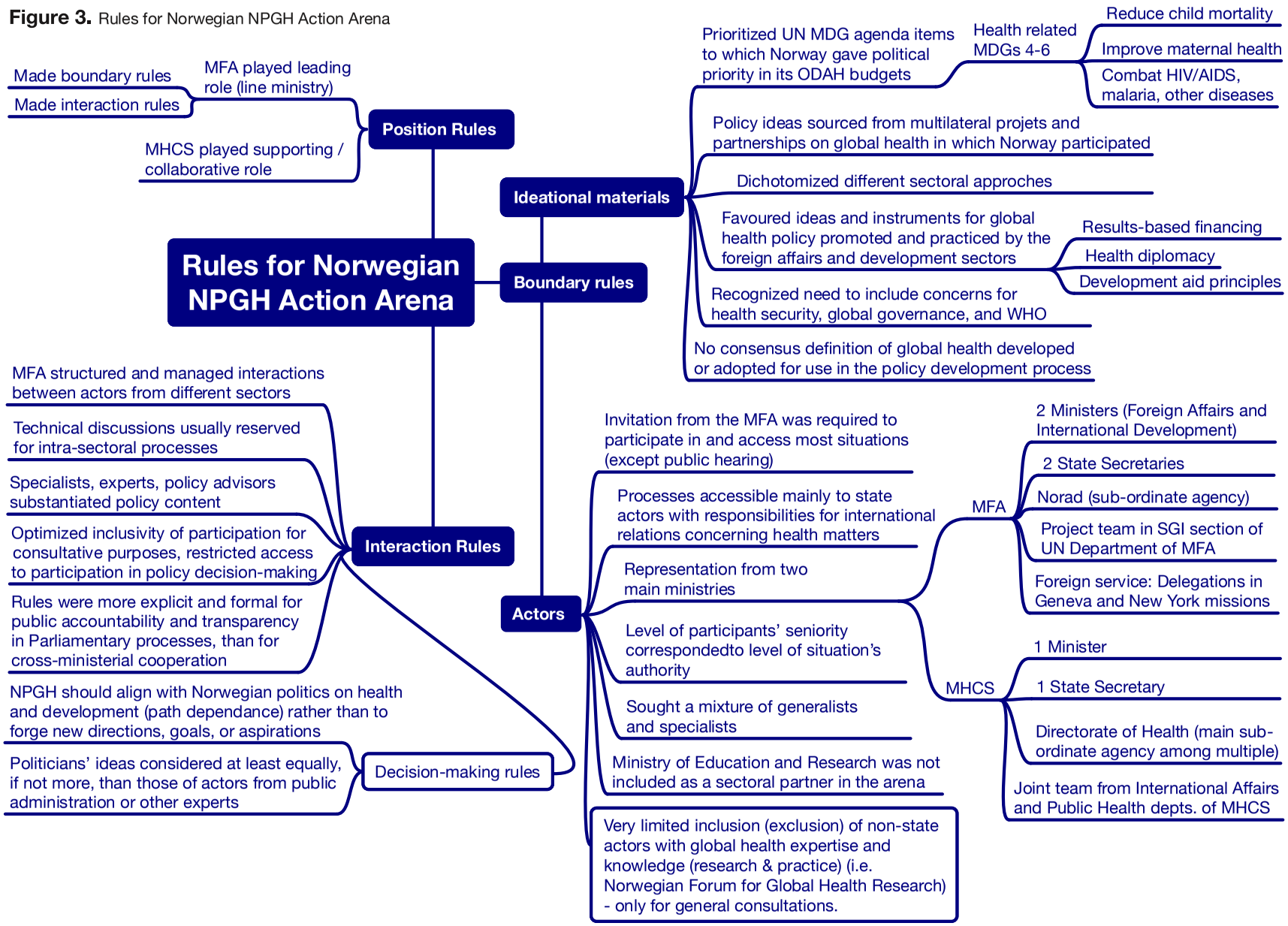


Figure 3. Rules for Norwegian NPGH Action Arena



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Chapter 8: RESULTS of comparative study 2

Article 4. Policy processes without borders – forms of interaction between arenas of national policies on global health and global health governance

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This article is being prepared for submission to *Governance.*
Other journals under consideration are *Globalization and Health, International Journal of Health Policy & Management, Global Health Governance*, *Global Policy, and Journal of Comparative Policy Analysis*.

Authors' contributions to the article:

Catherine M. Jones designed the study, collected and analysed the data, and wrote and revised the manuscript.

Carole Clavier contributed to methodological and theoretical approach, and critically reviewed the methods, results and discussion sections.

Louise Potvin contributed to refining the results, and critically reviewed the methods and discussion sections.

All authors approved the manuscript.

Title:

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Abstract

National policy on global health (NPGH) arenas are multisectoral governing arrangements wherein rules structure cooperation of health, development, and foreign affairs sectors in policy action situations for decision-making about a government's work in global health governance.

Aiming to explore the relationship between national and global processes for governing global health, this paper asks: in what forms of interaction between NPGH arenas and global health governance are learning and networking processes present?

In a multiple case study of Norwegian and Swiss NPGH arenas, we collected data on intersectoral policy processes from semi-structured interviews in 2014/2015 with 19 and 14 informants/case respectively. Adapting Real-Dato's synthetic framework, we analysed each case separately to produce monographs as comparable constructions of NPGH arenas.

Analysing both NPGH arenas for relational structures linking external resources to internal policy arena processes, we found five forms of interaction wherein mechanisms of policy learning and elite networking operated.

The five include institutions, transgovernmental clubs, and connective (hubs / boundary spanning) forms of interaction. Interactions involving both state and non-state actors are formal within institutions and mostly informal in connective forms.

These interactions circulate ideas and soften arenas' boundaries. We argue that national policies on global health are characteristic of the transnational governance of global health.

Keywords: national policy on global health, global health governance, transnational governance, interaction

Introduction

National policies on global health (NPGH) are public policies on global health matters that involve collaboration between health and foreign affairs ministries. Descriptions of multisectoral global health strategy documents produced by high-income countries have appeared in scientific and grey literature exemplifying the disposition of global health diplomacy and policy formulation to integrate heath and foreign policy (1-3). A comparison of NPGH documents adopted in Norway and Switzerland showed that these policies target the international level and aim to affect actors in the global health governance system (4). Global health governance (GHG) is a set of formal and informal processes, which operate beyond state boundaries, through which actors participate in steering, coordinating, and financing collective action on issues impacting health and disease internationally or globally (5-7). Diverse state (governmental and intergovernmental) and non-state (NGOs, philanthropic foundations, think tanks, academics, corporations) actors comprise the GHG system (7-9). The literature generally treats questions related to the roles of non-state and intergovernmental actors in GHG, which means that we know less about how states engage more directly in processes of the GHG system. Global health scholars and practitioners should acknowledge potential interdependencies between global/foreign and national/domestic public policy processes pertaining to GHG. Based on two in-depth case studies of Norwegian and Swiss NPGH arenas, this paper aims to explore the relationship between processes at national and global decision-making levels on matters of global health.

NPGH arenas are multisectoral governing arrangements wherein actors from health, development, and foreign affairs sectors interact in policy action situations to make decisions about the government's work on global health and its governance (10). In-depth case studies show that position, boundary, and interaction rules-in-use for micro-processes in individual policy action situations regulate power between actors from different sectors in the NPGH arenas.[8] Rules-in-use at the level of NPGH arenas establish ranks or relationships between different policy sectors interacting on behalf of the state in global health. For example, the

[8] Readers should refer to Chapters 6 and 7 in this thesis. For the submission of this article to a scientific journal, we plan to include an executive summary of each case monograph as supplementary material.

rules in the Norwegian NPGH action arena designate a leading role to the foreign affairs sector and a supporting one to the health sector, except in matters concerning WHO affairs (Chapter 7). Alternatively, the Swiss NPGH arena depends on a core group of four sectors that share power in action situations, with public health as a sector linking them in the arena (Chapter 6).

Based on Real-Dato's synthetic framework, external mechanisms of policy change are positioned as a directional force from the global arena on the national one in our NPGH arena model (see (10) downward pointing arrow in Figure 1). The literature on how ideas impact policy change informs our selection and understanding of potential mechanisms by which the global arena influence national NPGH policy arenas (11, 12). We define mechanisms as "relational concepts" to understand how levels of NPGH and global arenas relate (13). According to Hassenteufel and Palier (14), relational analysis seeks to connect the internal {national} and external {global} levels rather than place them in opposition with one another. We selected policy learning and networking as mechanisms because both suggest that the circulation of ideas and instruments between actors may explain processes *for* policy change as well as outcomes *of* policy change. The former process is cognitive whereas the latter is strategic.

Policy learning is a cognitive process by which ideas are mobilised for policy change. Policy learning refers to the use of past and current experiences to inform ideas and policy-relevant knowledge of actors for decision-making at the collective choice level (15). Policy literature proposes various types of learning such as political, social, policy-oriented, or government learning and lesson-drawing (16). Learning objectives support different kinds of change for doing policy, such as procedural (operational adjustments for organisational changes), instrumental (instruments and lessons for programmatic changes), or systemic (policy goals and frameworks for paradigmatic change) (16-19). This literature also distinguishes intentional from reactive learning (16). For Hall (20) learning is deliberate, based on questioning previous policy successes or failures and learning from their consequences to adjust policy objectives and tools; whereas for Helco [cited in (21)] learning is stimulated by

the social context and broader policy environment, which incites a process to adapt and respond to external shifts.

Networking processes among actors from different government jurisdictions, international institutions, and epistemic communities contribute to the circulation of policy ideas and instruments. (22, 23) Elite networking often occurs within policy communities (e.g. bureaucrats, experts and policy professionals from inside or outside government) and between governments that share a particular issue of policy or professional interest. (24) Elite networking is a means of disseminating policy ideas because it connects actors with shared identities and concerns to policy learning. (24, 25) Although networking transports ideas between structures and across levels, institutions and political context mediate whether and how ideas are considered in policy. (12, 26)

Through these two processes of change (learning and networking), we aim to understand the relationship between NPGH action arenas and the GHG. Specifically, this paper asks: in what forms of interaction between NPGH arenas and GHG are learning and networking processes present?

Methods

To answer this question, we designed a multiple comparative case study of policy arenas that led to the adoption of NPGH in Norway and in Switzerland in 2012. Criteria for selection of case countries are detailed elsewhere (4). The study received ethical approval from the Health Research Ethics Committee of the *Université de Montréal* (*CERES* Certificate of Ethical Approval 14-083-CERES-D1). Informed consent was obtained from all participants in accordance with ethical guidelines.

Data collection

We used purposive and snowball sampling to build a sample of relevant actors in each case as key informants. The sample was discussed and validated separately by case-specific Context Advisory Groups both consisting of two authors (CMJ, CC) and one researcher with expertise

on global health policy and governance for the respective case country. Based on similar studies (27, 28), we intended to recruit approximately 15 informants per case, including actors from the foreign affairs, health and development policy sectors. CMJ conducted semi-structured interviews with 19 informants from Norway and 14 from Switzerland between November 2014 and October 2015 (see ***Table 1*** for informants by country and sector). We asked informants about intersectoral policy situations and decision-making processes for NPGH during the period 2006-2012 before the formal adoption of policy documents. In addition to questions about how actors worked together in policy situations, we asked about influences on processes to develop NPGH, and specifically, whether anything from outside of the respective countries exerted influence (i.e. If so, what? Where from? Who brought it to the attention of actors? How was it used?). We used diagramming technique for graphic elicitation in the interviews conducted face-to-face. With one exception, interviews were recorded (36+ hours of audio) and transcribed verbatim (543 pages of transcripts). Each case was analysed separately to produce two monographs (Chapters 6 and 7 of the thesis).

Table 1. Informants classified by actor's sphere and sector for each case of NPGH

Actors' societal spheres (policy sectors)	**Key informants**	
	Norwegian	**Swiss**
State actors (development)	3	1
State / public actors (health)	7	5
State actors (foreign affairs)	4	4
State actors (intellectual property/justice)		2
Civil society actors (health)	1	1
Public actors (global health research)	4	
Private actors (global health research)		1
	19	**14**

Data analysis

These monographs provided a comparable construction of the two NPGH arenas to explore the mechanisms of learning and networking for similar or different forms of interaction with GHG (29, 30). We organised our material on mechanisms of policy change related to *external sources of influence* (e.g. institutions, ideas, instruments) *on the internal policy process* of

NPGH. Mechanisms of policy change are relational concepts that are not deterministic because they are mobile and work differently in different contexts (13). Because we understand policy context as a composite of physical environment and ideational elements, it includes the social, scientific and technical, and political fabric within which actors work. As such, contexts are elements of NPGH arenas, but they also span across boundaries of sovereign jurisdictions and geographical national borders. This has two implications for our analysis: we did not analyse outcomes of mechanisms operating in the cases, and we looked for mechanisms of learning and networking in contexts that were relevant from informants' perspectives for understanding their government's work in global health, whether inside or outside the national arena.

Informed by Hassenteufel and Palier's (14) distinction between a unilateral analysis (seeking to understand how external factors impact NPGH arenas) and transnational analysis (breaking with internal and external as opposing categories to understand the interactions between them), we searched our data for the relational structures that appeared to forge a connection between NPGH arenas and GHG. We use an interpretive schema of interaction to explore the zones that connect national and global level actors where learning or networking mechanisms operate. We examined the resources (e.g. knowledge, information, programmes, networks, frameworks) from outside the NPGH arenas reflecting on their provenance, their proponents, and their prioritization. We also recognised learning when resources were linked to experiences and lessons for modifying policy practices. We highlighted data pointing to significant international meetings, institutions, actors, initiatives, and partnerships in which informants signalled participation of actors from NPGH arena.

Results

Analysing two NPGH arenas (hereafter referred to as the Norwegian arena and the Swiss arena), we found five forms of interaction [F1-F5] between NPGH processes and the international context wherein mechanisms of policy learning and elite networking operate.

F1 Governing bodies of traditional intergovernmental institutions for health

We found policy learning processes operating in the interactions between the Swiss and Norwegian NPGH arenas and GHG when countries participated in the governance of international institutions responsible for health, namely WHO. The World Health Assembly (WHA) and the WHO Executive Board (EB) were zones of interaction in both cases. Learning within the NPGH arenas' interactions with WHA's decision-making context for WHO governance appears linked to reflective approaches of member states to re-organise and implement changes regarding their participation in the organisation's governing bodies. During the 2000s, the politicization of the WHA stimulated learning about organisational change for delegations to include more senior politicians and increase icons of authority. From these interactions in the WHA, the NPGH arenas learned that more diplomatic skills for negotiating were needed in the WHO delegations, in addition to the traditional technical and practice skills related to knowledge about health and development.

> There was this idea that it's an either/or thing. It's either foreign policy or health policy. Which in the case of WHO is no longer correct. The two spheres have really been blurred. When you realize things from a scientific point of view are clear and not problematic, you suddenly get a totally different perspective from new voices, new countries in WHO, which are stronger, more outspoken than before, and very tricky to move. In that playing field what used to be simple is suddenly complex, and needs negotiations. In that setting, it's crucial that our two ministries are able to work very closely. … What I mean is that it is much more politically driven than was traditionally considered (when questions were meant) to have a medical or scientific answer. Over the last 15-20 years, we've had more ministers present in the WHA, which is good in the sense that it shows that this is actually more important than it was considered before. *Norwegian informant (H)*

Governmental learning processes in the interactive zone of the WHA prompted innovations in foreign affairs administration, like health expertise for diplomatic posts and earmarked WHO liaison staff in permanent missions to the UN. In the Swiss arena, this learning supported transformations in the political division of the Federal Department of Foreign Affairs (creation of health sector desk), nomination of health-dedicated personnel in the Swiss Mission, development of health diplomacy training for health attachés in embassies, and establishment of an Ambassador for Global Health title in 2011.

> When I started, the missions in Geneva had no one who was specifically trained in or assigned to health. Now, that is almost standard. *Swiss informant (H)*

In the Norwegian arena, the multisectoral cooperation on health is reflected in the Norwegian Mission with diplomatic councillors for WHO matters from both health and foreign affairs ministries.

Procedural changes in NPGH arenas were supported by learning that to engage effectively in intergovernmental negotiations in WHO, policy processes needed to emphasize coordination between health and foreign policy ministries. Learning from Swiss interactions in WHA revealed that without "any governance process and coherence procedure, maybe you will not defend your interests properly on the international level." The ideas for inter-departmental cooperation instruments in the Swiss arena were fostered by Swiss actors deliberate learning from the conflicts between sectors in WHO governing bodies.

> The starting point of the Swiss Health Foreign Policy, and the really disturbing point was particularly in the context of the WHA, that representatives of different branches of the Swiss government had very different views on things. It really crystallized around the question of Nestle and baby food. *Swiss informant (H)*

The interactions of the national and international contexts in matters of WHO governance triggered learning to improve coordination between sectors on issues for decision in the WHA. These constituted learning processes for the Swiss and Norwegian NPGH arenas to reflect on how they wanted to organise the sectoral dimensions of cooperation in the delegations, and to establish rules about preparing and administering WHA-related decisions. Representation of sectors on the delegation was insufficient; preparation, discussion, and coordination between them were necessary to manage the onsite demands during the WHA. The NPGH arenas in both cases held multisectoral information meetings before each WHO governing body meeting (WHA, EB) in addition to specific delegation meetings.

> We have the WHO Forum prior to the WHA in May, the EB meeting in January, and the European Regional Committee meeting in September. We go through the main topics on the agenda for these WHO meetings, and we agree on which agency takes

> responsibility to develop (briefing) papers on issues. We go very strategically through the agenda, give priority to some items of the agenda, and prepare them so that those people going to the meetings are well prepared when it comes to the topic's background and the current questions, and also with the Norwegian position. *Norwegian informant (H)*

Similarly in the Switzerland, learning in this interactive space encouraged processes for defining united positions in advance, rather than a collection of sectoral ones. This represents a dramatic shift from the processes for preparing WHA before the coordinated approach was built up through the Swiss arena.

> We did not even have a preparatory meeting here in Bern before the WHA. We just went to Geneva, and we met in the hall with the different parts of the delegation before the assembly started. And then, sometimes we figured out that we had major issues where we disagreed, and that was very difficult because then someone had to call the home office representative of the Minister of Foreign Affairs about what to do. *Swiss informant (H)*

From the perspective of the Swiss arena, the WHO governing bodies are interactive devices for policy-oriented learning focused on agenda-setting and implementation priorities. The governing bodies validate and circulate global norms for national adaptation. As one *Swiss informant (FA)* said, "of course the WHO agenda strongly influences the priority topics" that are deliberated in formal meetings of interdepartmental groups of the Swiss arena. The agendas of policy action situations in the Swiss arena also included topics from international institutions for which health is not the focus, such as World Intellectual Property Organization. Policy questions circulated to the Swiss arena through interactive zones of WHO governing bodies. Pressing issues on the global agenda that necessitated action by the Swiss arena influenced the number of formal meetings of action situations (i.e. an urgent need in WHO governance for Switzerland to position itself catalysed more interaction within the Swiss arena). The Swiss arena sought to align with member states based on shared policy positions and approaches rather than historical voting blocks by engaging in issue-based networking in WHO governing bodies.

> If you analyse the Swiss coalitions in which Switzerland was in the last ten years in

> WHO - so since we started [working on the SHFP] in 2005/2006 - you will see Switzerland with Kenya, Switzerland with Thailand, Switzerland with Norway, Switzerland with the US, and so on and so forth. So, it's not a pattern. *Swiss informant (IP)*

In addition to the annual WHA, the WHO EB generated frequent interactions between NPGH arenas among a smaller group of member states and the WHO secretariat. The WHO EB, composed of representatives from thirty-four member states, formally meets biannually. Representatives from Norway and Switzerland were serving terms on the WHO EB between 2010-2013 and 2011-2014, respectively. In both cases, WHO EB membership augmented learning and networking processes. The WHO EB gave member states a unique platform in addition to the WHA to showcase their contributions and priorities and to connect with other actors with similar interests and ideas.

The Norwegian arena established a WHO strategy group in 2008 to prepare joint health and foreign policy objectives for its WHO EB term and methods to achieve them. The Norwegian term from 2010-2013 increased visibility and facilitated access of the Norwegian NPGH arena's work to international actors. The Norwegian NPGH arena strategically used the 65th WHA in May 2012 to announce its official policy document (*White Paper on Global health in foreign and development policy*), having consulted with select partners about its content during the EB and WHA meetings of 2011. The 2012 session was the last WHA held during Norway's term on the WHO EB, and it coincided with Margaret Chan's appointment for a second term as WHO Director General following her nomination by the EB. As a form of interaction, the WHO EB supplied opportunities for strengthening networks with counterparts and allies, and for embedding social learning from Norway's NPGH work in WHO by promoting Norway's policy on GHG.

> The magnitude of that White Paper being adopted by the Parliament became clear to us throughout the process, referring to why we considered Norway a proper member of WHO because of that massive global health effort and pointing to where we wanted to move forward. We said, "This is the forum, we need to backup the head of the WHO in her approach on saying that global health is actually about global foreign policy." Norway has to be there. *Norwegian informant (FA)*

F2 Governance of global public-private health partnerships

Norway's involvement in establishing key global health initiatives and its representation on their governing boards was a significant form of interaction between its NPGH arena and the international context, and one which was not mentioned by Swiss informants. Global health initiatives use public-private partnership models to advocate, fund, and/or implement interventions for disease-specific programmes. Networking between political and knowledge elites in international institutions was formative for interactions in public-private partnerships for health where learning increased political capital in the Norwegian NPGH arena.

> Jonas Gahr Støre (who later became) Minister of Foreign Affairs was Gro H. Brundtland's right hand in WHO. At the same time Jens Stoltenberg's appointment to GAVI's board (2001-2005) was facilitated. So when Stoltenberg became the Prime Minister (again in 2005), he had already been a GAVI board member, taking with him that sphere, and taking with him all the low-hanging fruits of success from putting money into vaccines and saving children. *Norwegian informant (FA)*

The involvement of Norwegian politicians in the governance of global health initiatives like GAVI connected policy learning directly to the political context of the Norwegian NPGH arena.

Using elite networking to help place Norwegian politicians (like Jens Stoltenberg and Dagfinn Høybråten) into such roles also supported global health policy learning that was useful for Norwegian politicians once back in Government or Parliament. Høybråten, elected as a Board member of GAVI in 2006 (replacing Stoltenberg who became Prime Minister in 2005), was Chair of the GAVI Board from 2011-2015 during which time he was also a member of the Parliament's Foreign Affairs and Defence Standing Committee from 2006-2013 and its spokesperson for the public hearing and committee's opinion on the White Paper in the Norwegian arena.

> Høybråten played a crucial role in ensuring a cross-spectrum support in the Parliament for this White Paper, but in doing that, he also had a lot of power in ensuring that perspectives other than those initially presented in the White Paper from the Green-Red government, became substantial. *Norwegian informant (CS)*

The interactions between the Norwegian arena and governing boards of global public-private health partnerships are also carried out by knowledge elites. The complex relationship of the Norwegian arena to interactive zones in the governance of institutions such as Global Fund, UNAIDS, GAVI was intensified due to the role of Norway in their establishment. Participating directly and intentionally in modifying the GHG institutional landscape, the Norwegian arena created new forms of interaction with the international context of global health.

> It's more circular because we were a big actor in setting up those funds. From that perspective, they were partly created as tools for our political priorities. We didn't just orient towards them after they already existed, and then their creation reflects the priority that was already there. And so now that they are there and are doing quite well and giving good results, they are still our priorities in that way. *Norwegian informant (FA)*

F3 Formal and informal cooperation arrangements (transgovernmental clubs / bilateral relationships)

Formal and informal cooperation arrangements were forms of interaction for learning used by Swiss and Norwegian NPGH arenas. An annual retreat hosted by the Swiss Federal Office of Public Health (FOPH) in Glion prior to the WHA (2004-2011) constituted the most informal form of interaction that combined elite networking and policy learning. The Head of International Affairs at the FOPH initiated this meeting between senior international affairs administrators from Ministries of Health and other health officials and experts from OECD countries to facilitate exchanges of policy ideas and experiences. It created a space for policy-oriented learning about GHG between health actors from high-income countries. For example, the idea for a WHO Committee C proposal emerged from Chatham House rules discussions in Glion.

> On an informal basis, in terms of what are the issues - a lot came out of the Glion discussions with a selection of OECD countries assembling in this little village every year for about six/seven years. There was a lot of exchange and some said, "It doesn't

> work yet," or, "We would like to have such a thing, but what's your experience with that?" In that, we found some of them had a paper, but not many tools. Some of them had tools of collaboration in place, but they hadn't [officially] formalized it as a government decision. *Swiss informant (H)*

The Norwegian Ministry of Foreign Affairs (MFA) was a founder of the Foreign Policy and Global Health (FPGH) initiative, a more formal diplomatic arrangement for cooperating with six other ministries of foreign affairs (France, Senegal, Brazil, Indonesia, South Africa, Thailand). The FPGH initiative functioned as an interactive zone between the Norwegian arena and MFA counterparts to collectively reflect on complex policy impacting health from a foreign policy perspective. As put by a Norwegian informant (FA), it was "a turf on its own that we used when we saw that it was smart … which is as important as pouring money on specific things." The FPGH espoused a "platform of trust" that protected a space for discussing issues for GHG among peers in countries from northern and southern hemispheres. By networking with actors who were not based in health ministries, it created opportunities "to make sense of flexibility and strategic work" for dialogue about health and GHG in the foreign affairs policy communities within and between countries.

> The design was pretty unique with these seven countries across regions and alliances, developed as an initiative without a permanent secretariat and no website. It was based on people, trust, and mutual interests. … It was a place where people could come together and disagree, which is often not the case, (because usually) there is consensual basis for meeting…[the FPGH] was a place to air disagreement and have discussions on definitions; it was a really good place to talk, and we used this forum to talk about definition of words and issues like global health security. *Norwegian informant (H)*

The policy learning from this FPGH initiative enhanced the Norwegian arena's understanding of health issues in foreign policy terms, and this learning was used to support action in institutions for GHG. One policy-oriented learning outcome of the FPGH was an annual UN General Assembly resolution on FPGH and reports to the UN Secretary General which concretised commitments taken among the group of seven and increased their visibility on a global platform. Every year a topic was selected for the group's focus in these global statements, and FPGH members brought those priority topics back into their domestic policy context where the MFA worked to reflect them in their own foreign policy agenda.

> That involved connecting health to all the different parts of the MFA. This year, the focus for the UN General Assembly resolution and the work in the initiative has been security of health workers, so we have to work really closely with the humanitarian section, which also has this as a priority. And if it was environment and climate, as it was one year, we do it together with our colleagues working in the climate section. *Norwegian informant (FA)*

The learning from this zone of interaction also contributed to building the content of the Norwegian arena to include foreign policy components in addition to development ones, like around the area of promoting human security through health.

The most formal cooperation interactions of the Swiss NPGH arena with the international context happened in the form of bilateral and mini-lateral arrangements with other countries. Swiss NPGH actors had frequent bilateral discussions with countries (especially the UK) that were developing similar national strategies or experimenting with health diplomacy policy instruments related to GHG. Bilateral relationships with countries with which Switzerland shared approaches or values regarding global heath policy issues produced opportunities for lesson learning from examples of other's successful and challenging experiences.

> Allies in international relations normally start with saying, "I'm friendly. I have good relations with other ministers." So, that's how you start [bilateral friendships] - some by coincidence, some by purpose. We always maintained good relations with the Netherlands because the Netherlands has a very similar health system and drug policy, and for many cultural reasons, we are kind of connected. It's not a tradition of Switzerland to have papers of mutual understanding, but we did one with the Netherlands and with China. So we entered in a couple of more formal collaborations where we negotiated what are the issues of mutual interest, and then we said, let's work on these, and let's meet on a regular basis. We did the same with Germany and Austria. *Swiss informant (H)*

F4 Global health hubs and global health governance metropolises

Sites like Geneva and New York function as interaction zones for NPGH arenas and the international context where policy ideas circulate through elite networking processes among state actors, and non-state actors, including scientists and private foundations. Geneva, often

referred to as the 'global health' capital, hosts the headquarters of the institutions for global health, including for partnership initiatives and financing mechanisms. Both of these cities are hubs for interaction that provide access to global health elites and a range of experts from international organisations, policy networks, think tanks, or NGOs.

Geneva places the GHG capital in the Swiss NPGH arena's backyard. Swiss actors reflected on the embedded nature of the their national arena in the global one. Swiss actors are in a continuous networking and learning process with other actors from around the globe to discuss ideas and exchange lessons.

> If you ask me what was the most important driver for change in how we behave in this Swiss Health Foreign Policy setup, then I would say the practice in Geneva because there, we associate with one actor for such a topic, with another actor for such a topic. Then somehow, everything is brought together within WHO. There, we take positions, we learn if we were successful and why we were not successful, what should be changed in the future to be more successful. This is our learning field, and that's why we are also somehow very proud to have all these actors in Geneva and because this is an incredible opportunity for Switzerland, actually, to influence, also the global thinking on global health…. It's with UNAIDS, it's WHO, it's the networks of PDPs. Quite a lot of issues on global health governance are organized by the missions in Geneva. That's our playground somehow. *Swiss informant (D)*

One way the Swiss arena optimised this hub was via working lunch seminars. The Swiss Interdepartmental Working Group on Intellectual property, Innovation and Public Health holds these before its formal meeting with the purpose of bringing in international experts to present alternative policy options that stimulate discussion and inform decision-making processes of the group. These policy dialogues are forms of interaction designed for the Swiss arena to learn from experiences of external actors, such as the Medicines Patent Pool or Drugs for Neglected Diseases Initiative, aiming to use this learning for its work with Swiss pharmaceutical companies and for developing Swiss positions on GHG agendas.

Both Geneva and New York were hubs for interaction between the Norwegian arena and GHG. It is through interactions in Geneva that networking between Norwegian political and knowledge elites and private actors, such as the Bill and Melinda Gates Foundation,

flourished. The small "circle" of political and knowledge elites from Norway that had worked in Geneva made their networking be of service to the NPGH arena, including putting the issues of "public-private partnerships with the World Bank, private sector money, Gates" on the agenda. New York interactions linked the FPGH initiative to the global governance system at large via the UN General Assembly. But New York was also an important zone of interaction where elite networking interconnected the national and international political contexts of GHG.

> Look at what's happening in the opening week of the General Assembly over the last five, six years. It has started to become a parade ground for leaders of the world that show their commitment to global health. They largely do that with promising money or appearing together with prime ministers from somewhere else. That's where *Every Woman, Every Child* comes in. Norway was very instrumental in creating some of these. *Norwegian informant (FA)*

F5 Boundary spanning transnational communities

Boundary spanning refers to forms of interaction that cut across structural boundaries of organisations, professions, sectors, cultures, socio-economic contexts, and jurisdictions (31, 32). Boundary spanners in Norwegian and Swiss NPGH arenas were not participants in the main policy action situations. These individual agents are valuable resources for NPGH arenas because they work across sectors and scales (national/international) and foster the NPGH arenas' connections to significant transnational actors.

In the Norwegian arena, two knowledge elites were central for boundary spanning. Both were medical doctors with experience in developing countries, and well-renowned in global health expert networks. Their careers span the history (in Norway and internationally) of the evolution from tropical medicine, to international health, to global health as a policy field. Their work "on the frontlines" of global health research, practice, and governance, contributed directly to building the international profile and presence of Norway in GHG, simultaneously constructing pillars of the Norwegian arena. They are attributed with much of the networking that laid the foundation for the Norwegian arena, working for the past 30 years with key

international partners and forging Norwegian connections to the institutions for global health policy-making.

> The Global Health White Paper is summing up many years of policy, many years of activities, and many years of networking. And in that White Paper, we managed to spell out the importance of those personal networks, but without pinpointing the two of them. *Norwegian informant (FA)*

Their careers spanned working in the field in resource-poor countries to political appointments to international institutions. They brought resources and ideas from their networks together in the NPGH arena.

> I wouldn't say that everything in global health revolves around him, because that's not true. But he's been very influential in terms of the direction, and also the impact of Norwegian global health policy – first, by virtue of his scientific approach and medical institutional experience, of course at the international level. Second, because he is very strategic. Not only within this field, but at across fields. *Norwegian informant (D)*

Each had direct contact with relevant ministers and they regularly briefed administrators who were responsible for providing them support when needed and for connecting their strategic efforts and practical considerations for NPGH development and implementation.

> They were building and maintaining networks and linking people working on all different layers, not only as doctors, but also knowing how to pull on the good people around them. ... I mean that political networking, that map of individual politicians, before they came into position and when they were in position, the political background tied around these two persons. That's a pretty important piece of that puzzle. Because without that, we wouldn't have been where we are with the White Paper right now, because we wouldn't have had that political commitment to it in this ministry. *Norwegian informant (FA)*

In the Swiss arena, one boundary spanning knowledge elite was critical for connecting Swiss state actors to epistemic and policy communities at the international level. This boundary spanner was a significant knowledge broker and partner of the Swiss arena on whom the arena relied for expertise in health diplomacy and foreign policy. Her personal and professional connections built through her career and years of experience in policy, academia, and

international health institutions like WHO, made her an asset to the Swiss NPGH as a "facilitator".

> She wrote articles and she had a lot of contact (with FOPH). Apart from our steady contact with her, she was also going around the world, giving conferences on global health policies and the global health issues. In a way we got the feedback also from that side. She was our intellectual partner. *Swiss informant (FA)*

She bridged the Swiss NPGH arena and the external context, in particular to the epistemic communities. The establishment of the Global Health Programme at the Graduate Institute in Geneva constituted a fundamental networking and learning arm for the Swiss arena, as many Swiss health attachés for embassies and diplomats were then being educated there. The development of the "health diplomacy" training established the Graduate Institute as a key stakeholder of the Swiss arena for policy discussions and dialogues with international experts in Geneva about GHG issues.

Discussion

Our results show that the relationship of influence between GHG {external} and NPGH {internal} levels of policy is one of interaction between international and national processes rather than a global causal force exerting influence on domestic policy arenas. The relationship of interactions between GHG and the national arenas of Norwegian and Swiss NPGH supports the hypothesis of a multidirectional circulation of ideas, procedures, instruments that state actors used in their own policy on intersectoral collaboration on global health. Through the mechanisms of learning and elite networking, these interactions constructed interdependence between the NPGH arenas and the GHG arena.

These interactions are part of an apparatus of transnational governance of global health where actors learn and network, within an evolving context for collective action among them. Our findings show that they take at least five forms varying in terms of their degree of formality, the actors involved, and their ontological status (see ***Table 2***).

Table 2. Characteristics of the forms of interaction between NPGH and GHG

Forms of interaction	**Types**	**Actors**	**Ontologies**	**Mechanisms**
	Formal / informal	*State actors / non-state actors*	*Institutions / networks*	*Policy learning / elite networking*
F1	formal	state	institutions	learning
F2	formal	both	institutions	both
F3	both	state	clubs	mostly learning
F4	both	both	hubs	both
F5	transversal	both	articulations	both

Forms of interactions between NPGH arenas and GHG

Governing bodies [F1, F2] are formal forms of interaction between NPGH arenas and the international context that take place according to the conventions of the institutions being governed. Mandated as the international authority for health, WHO is the most representative institutional form in GHG. There is knowledge about the WHA as an interactive form (33-35), but little about the WHO EB. Similar to previous studies (27, 28), our findings suggest that learning processes related to WHO EB [F1] are common to all four cases. These countries all had EB seats while constructing their NPGH arenas: the UK (2007-2010), Germany (2009-2012), Norway (2010-2013), and Switzerland (2011-2014). As in Norway, the UK developed a separate institutional strategy for WHO (27); whereas Switzerland was the first high-income country to develop a country-cooperation strategy in partnership with WHO. In spite of sub-optimal governing practices (36), public-private institutional forms of interaction [F2] have been shown to offer their members commensurate access to information from the secretariat and to have accountability policies for monitoring (37, 38), shown to be lacking in WHO (39, 40).

The non-institutional forms of interaction [F3, F4, F5] include a mix of formal and informal types. We found that among interactions that involve state actors [F1, F3], those that take place in smaller groups of networks or "clubs" of countries were of particular significance because they are established on trust between participants. Based on our findings, formal and informal clubs [F3] should not be neglected among state actors as an interactive form with

implications for GHG. Research has previously highlighted formal diplomatic clubs (e.g. G7/G8, BRICS bloc) as forms of interaction between national and international spheres with opportunities to exchange ideas and learning for GHG between their members (41-44). Following the uptake of global health as a priority under the German G20 Presidency in 2017, and Argentina's commitment to its continuation, expansion of formal economic and diplomatic clubs as interactive zones for GHG seems possible. In contrast to formal arrangements between governments, literature on informal ones [F3] is scarce. Sandberg et al. (45) found the FPGH quasi-formal club experimented with practicing diplomacy as "complex relationship management outside of institutions" which "revitalizes the role of states" in GHG. In the UK and German cases, similar kinds of arrangements were mentioned as consequential interactions for developing their strategies, such as the UK's special relationship with the USA (27), and German actors interactions with OECD countries during the WHA and other UN agencies in Geneva (28).

Interactions that involve both state and non-state actors [F2, F4, F5] are formal within institutions [F2] and mostly informal in the connective forms [F4, F5]. These connective/intersectional forms [F4, F5] are ontologically different than the other structures (i.e. institutions, networks) in our findings, and they are rarely discussed in these terms in the GHG literature. As cities [F4] or transnational knowledge elites [F5], these two forms of interactions were found to be important axes for consolidating learning and networking of institutional forms [F1, F2] with specialized attributes and individualized approaches to learning and networking processes. In particular these forms of interaction seem critical to the networking and learning that takes place outside of institutions or formal networks with non-state actors (epistemic communities, NGOs, thinks tanks, private philanthropic foundations, or corporations). Boundary spanning, a term from organisational science and studies of administration (public or business), generally refers to practices for reaching across diverse structural divisions to benefit collaboration between organisations and improve management of complex problems. Recently, researchers and practitioners have argued that boundary-spanning approaches are needed in global health practice for more inclusivity with regard to working across contexts as well as structures (e.g. professional, sectoral, or geographical) (46). We refer to boundary spanning [F5] as a form of interaction in our findings in a particular way

that goes beyond work in or across organisations. It is rather the work of senior transnational elites whose accomplished careers have spanned different sectors, international organisations, academia, policy, and practice building their own personal and professional networks around the world. They are respected by the politicians and public administrators in the NPGH arena who entrust them to bring their contacts, knowledge, ideas, strategies, and know-how to the arena and be an integrate part of the arena's links to the international context. They are skilled networkers and strategists (not necessarily working in government), dedicated "reticulists" and "entrepreneurs of power" (32) with many years of international experience and thick address books, who broker learning and relationships between policy makers, funders, institutions, and epistemic communities.

The implications of these findings are that focusing only on the formal types of interactions in institutions for GHG neglects to capture the force of networking processes in informal types for connecting national and international contexts through engagement/exchanges with diverse actors corresponding to criteria/questions defined by the NPGH arena. The learning produced and shared for GHG and NPGH in informal interactions [F3, F4, F5] is complementary to that produced and shared in the formal ones [F1, F2, F4] in part because our results suggest the networking mechanisms seem more kinetic in the informal kind. This may be due to the flexibility or autonomy that informality affords NPGH actors to interact with actors from different sectors within GHG. Our findings showed that the mechanisms of policy learning and networking were both operating in most forms [F2-F5], although policy learning was the only mechanism in data related to interactions in WHO governance [F1]. The procedural and instrumental foci of learning in the WHO governing bodies was a mixture of deliberative based on analyses of the experiences of their delegations and reactive to the shifts in the policy environment of WHO which was also linked to systemic perturbations of public health crises (e.g. SARS, swine flu). Learning and networking processes appeared to be more interconnected in the other forms of interaction [F2-F5] in particular when networking processes are employed in informal interactions to improve access to and reach of learning processes, experts, or policy communities [F4, F5]. Institutional actors in the international system are targets of NPGH arenas, but it is reductive to see them as the only zones of interaction for learning and networking between policy processes for GHG at the national and

global level.

Transnational governance of global health

Given the interactions between the national and international levels, NPGH arenas appear to have less clearly defined boundaries as a policy process. These interactions redefine the boundaries of the two arenas such that, we argue, they are largely overlapping with each other. The transnationalisation of national policy on global health is such that it is also a part of the global health governance system, in the same way that the global health governance system is in part embedded in a NPGH arena. Conceptually, transnationalisation pertains to relationships between actors (organisations, institutions, corporations, communities) and sectors (environment, finance, health) that function outside the traditional frameworks of international relations. Transnationalisation refers to frames of reference (e.g. policy regimes, identities) that relate social and geographic spaces across multiple localities, diverging from ideas of national and global spaces as concentric spheres (47). Interactions between state and non-state actors from different levels of policy and governance are characteristic of the transnationalisation of public policy (48).

The transnational dimension of NPGH is supported by our findings on the formal and informal interactions of these national arenas with institutions, groups, and individuals within and outside of the state and international system. The interactive zones of NPGH with the international context reveal some aspects of the state's interpretation of the GHG system. From the perspective of the NPGH interactions, the GHG system is not only a institutional arena with normative functions, even if those are conspicuous components of it and institutional actors are main targets of change intended by NPGH policy designs (4). We found that governments also interpreted the GHG system as a socio-political arena for exchanging ideas between state and non-state actors, demonstrating relevance of health and foreign policy sector collaboration, and reaffirming status as state actors intrinsic to the system. However, NPGH arena's interactions across different structures in the transnational space, including but not limited to formal institutions, diversifies the content and reach of the learning and networking produced which NPGH arenas may recirculate in other interactions with GHG system. Theoretical approaches that emphasize interactions in GHG seem

appropriate to further explore implications of NPGH as transnational spaces for governance of global health.

The NPGH arenas are policy spaces for government actors, politicians or public administrators, to make decisions about adjustments and adaptations as a feedback to the learning and networking processes across forms of interaction. These forms of interactions spanning various actors, conventions, sectors, and structures correspond to understandings of GHG as polycentric governance of health matters negotiated in a globalised world that combines scales, mechanisms, and actors (6, 49, 50). While our results focus on the forms of interaction, we cannot discuss the transnational nature of the NPGH without referring to the agents within these interactions. Stone identifies three types of "transnational policy community" individuals who circulate and exchange ideas, procedures/practices, and instruments (51). The "internationalised public sector official" operates in institutions and networks [F1, F2, F3, F4] based on authority from their official positions within their state. The "international civil servant" works in the secretariat of international organizations and global public-private partnerships [F1, F2, F4]. The "transnational policy professionals" are the policy and practice pundits (i.e. consultant, foundation officer, scientific expert, NGO executive) [F2, F4, F5]. For instance, transnational policy professionals impact the circulation of policy learning through networks and modify the geographies of governance. (52, 53) The boundary spanning transnational knowledge elites identified in our two cases [F5] have been some combination of these types during their careers. We would add to this the "transnational capital class" of corporate elites (54) that interact with NPGH and the GHG system in global public-private partnerships and product development partnerships (i.e. pharmaceutical industry) [F2, F4] (see (55, 56) for examples). State actors in NPGH arenas use boundary spanning transnational knowledge elites as resources to help them analyse and strategize to navigate the complexity of the GHG system [F5]. Boundary spanning transnational knowledge elites are significant actors in the circulation of policy ideas between NPGH arenas and GHG through meta-networking to link the salient learning and relationship-building from the diverse interactions in those translational spaces back to decision-makers and policy practitioners in national institutions.

NPGH interactions with GHG illustrate these intersectoral national policy processes are interconnected to an array of elements of the GHG system. We suggest that state actors are a significant part of NPGH arenas' transnational interactions, in particular when the interaction is outside of institutions for learning from other governments [F3]. For example, research has shown transgovernmental networks in the Anglosphere used by internationalised public sector officials for policy learning and transnational governance on social, welfare and other regulatory policies (57, 58). A transnational space of global health governance accommodates a range of actors with which state actors develop their specific interests and instruments for global health work within a set of mechanisms that facilitate the exchange of experiences, ideas, and resources with other actors. Through these transnational interactions we propose that states with NPGH become integral actors in the GHG system recognised in their own right, not only as members of institutions, or as development donors. The intersectoral collaboration between health and foreign ministries with their development agencies that countries develop within their NPGH action arenas is a resource to improve their capacity for influence in the transnational arena for global health governance. Indeed networks across state institutions and the reconfiguration of responsibilities of state agencies to include governance of issues at the international level are examples of ways that global governance transforms internal governance arrangements (e.g. NPGH) to perform GHG as part of the domestic arena (59). From the current data on cases of NPGH in a select number of high-income countries, the internal/domestic resources for such transformations to construct a NPGH arena is likely one not afforded by mid- and low-income and resource poor countries.

Limitations

We note that the exclusion of other mechanisms of policy change, such as conflict expansion and venue shopping, are limits to the study's findings regarding the forms of interaction. These types of mechanisms affect change in public policy process (often in agenda setting or prioritisation processes) through framing strategies to modify a policy image in order to render the policy issue more appealing or meaningful to a different audience or to propose a different set of instruments for addressing it. We excluded these mechanisms because they are generally associated with the global governance of particular health or disease issues (i.e. HIV/AIDS, pandemics, antimicrobial resistance). Related to this point, global issues networks were absent

from our data and results. Such networks have been shown to be influential in advocating around particular issues in global health policy and practice, including helping raise political priorities (60-62). These networks may represent other forms of interaction between national and global processes governing global health. However, given the focus of our study on the intersectoral NPGH arena, such interactions with issue networks may be either via national civil society organisations who are observers in NPGH, or through sectoral arrangments specific to particular health institutes or subordinate agencies, or in intersectoral arrangements at the programmatic/operational level (rather than policy governance level).

Conclusion

With the objective to better understand the relationship between processes on global health governance at the national and global levels, this paper sought to answer the question: in what forms of interaction between NPGH arenas and GHG are learning and networking processes present? The formal and informal interactions between NPGH arenas and GHG construct an interdependent relationship between the policy processes within NPGH arenas and GHG system. These ties are formed through the through the circulation of ideas in policy learning and networking processes between state and non-state actors in institutions and networks of various kinds. Based on our findings, the characterization of NPGH arenas as transnational governance of global health introduces a nuanced perspective to understand the role of intersectoral governance arrangements of states not only as actors inside or outside GHG, but as actors of GHG.

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Chapter 9: DISCUSSION

Anchored in an interdisciplinary research field of health political science, this dissertation draws on theories and concepts from the policy sciences to explore the processes, rules, outcomes, and power that characterise the national policy arenas in which multiple sectors interact to coordinate global health strategy on behalf of a country's government. In order to discuss the results of this thesis, I first return to its research object of interest as the point of departure. This thesis explores an emergent object, national policies on global health (NPGH), conceptualised as multisectoral action arenas wherein rules structure interactions of actors from health, development, and foreign affairs sectors in policy situations to make decisions about the government's work on global health. The general objective was to understand the relationship between global health governance (GHG) and national policy on global health (NPGH).

I started with the national strategies on global health adopted by Norway and Switzerland to retrospectively reconstruct the intersectoral policy processes that produced their respective policy documents. There are multiple types of policies made at the national level of government that focus on global health issues, problems, or programmes impacting population health on a global scale. For example, individual ministries (such as health or foreign affairs) as well as national development agencies, public health agencies and other national or federal government institutions have their own global health strategies. I did not consider policies and programmes on global health research or practice that are managed by single sectors within the scope of our definition of NPGH, although our theoretical framework considers these elements as part of the policy context for NPGH. In this thesis, I am interested in a particular sub-set of global health policies at the national level that involve at least both the health and foreign affairs sectors. I acknowledge that this definition excludes the work done within sectors relating to the governance of global health because I only looked at where sectors worked together, and as such, this definition does not represent the sum of a country's policy on global health or global health governance. The multisectoral policy dimension that I imposed on the definition of this object had theoretical and empirical bases from two main

sources: first, from the literature on integrating health and foreign policy in matters of global health, and second from the policy documents that emphasised the collaboration of these sectors for this purpose.

To understand these precise kinds of NPGH, the thesis explored and characterised the rules-in-use that regulated the functioning of intersectoral processes within these policy arenas and the cooperation (or contestation) between the sectors working together in developing these policy papers from our two cases, with a focus on questioning the influences on those processes from outside of the country. It should be noted that little is known about these kinds of NPGH. To my knowledge there are only two other case studies about intersectoral processes producing national global health strategies of this nature. These studies are situated within a broader literature on health and foreign policy that spans a diverse array of research from international relations, policy studies, and health sciences within the global health diplomacy and global health governance fields of inquiry. Given this delimitation of a precise sub-category of multisectoral policy arenas within the larger group of national policies on global health and for which a small available knowledge base exists, I draw on knowledge from these wider fields to discuss the main findings of this thesis.

9.1 Summary of results

Inspired by Real-Dato's synthesis framework, this thesis sought to understand how rules were used to organise action situations that made up the policy arena in two cases of NPGH and how they structured the dynamics of cooperation between different sectors in an NPGH arena (Chapter 3). The arena also includes a set of contexts for NPGH of a social, political, scientific, ideational, and economic nature. The model underlying my work represents a conceptualisation of public policy as collective policy-making in socially constructed spaces of interaction between actors, on which influences may come from foreign or domestic sources. For this, I borrowed from Real-Dato's framework the distinction between internal (national) and external (global) boundaries for exploring mechanisms operating between NPGH and GHG. The model assumes that policy design is an outcome of an arena's processes, which is why I used the formal adoption of a NPGH policy document at the highest

levels of government as the starting point for the retrospective qualitative multiple case study design of this thesis. Starting with these outputs of the arenas, I used Schneider and Ingram's policy design framework to assess the similarities and differences in the design elements from the content of NPGH policy documents adopted by Norway and Switzerland.

Within the general objective of exploring the relationship between global and national processes for governing global health, the specific research questions were:

1) What are the elements of policy design in formally adopted NPGH documents?
2) What characterises action arenas that develop NPGH documents? and
3) How do mechanisms of policy change operate between GHG and NPGH arenas?

Below, I summarise the results of this thesis according to the design of NPGH as found per the official policy documents, the characteristics of the intersectoral working processes in the arenas that produced them, and the relationships of influence between these arenas and GHG.

9.1.a What are the elements of policy design in formally adopted NPGH documents?

Our analyses of Norway's *White Paper on Global health in foreign and development policy* (approved by the Norwegian Parliament on 29 May 2012) and the *Swiss Health Foreign Policy* (approved by the Swiss Confederation' s Federal Council on 19 March 2012) showed that these formal documents signified the intentions of these two governments to reinforce connections for integrating approaches between health, development, and foreign affairs sectors in matters of governing global health. The formal adoption of the Norwegian document served three purposes for the Norwegian Government: 1) to demonstrate its fiscal responsibility to Parliament, 2) to ratify its global health aid legacy, and 3) to validate its role as a key state actor in global health governance. For its part, the Swiss document represented an institutionalisation of instruments for interdepartmental cooperation at the federal level on matters of foreign policy concerning global health and its governance. The most striking result from the comparative analysis of the NPGH policy documents was its indication that they

targeted actors in the global health governance system, such as global public-private partnerships and international organisations, where decisions about policies and programmes that impact global health are made (Chapter 5).

9.1.b What characterises NPGH arenas?

Retrospectively reconstructing the policy arenas that produced these two documents (between 2005-2013), I found that in both cases, government actors from health and foreign affairs (among others) innovated, using strategy and opportunism to build arenas for collaboration between these sectors to act in and on the global health governance system. I found that both NPGH designs included global health diplomacy as an instrument for their arenas at different levels of negotiations and policy-making on global health, either domestically or internationally. In contrast to the similarities regarding the targets and instruments in their designs, there was more variation across the other elements such as rationales, goals, implementation structures, and implementation rules.

9.1.b.1 Inside the Swiss arena for NPGH

The rationale for constructing the Swiss arena for NPGH was that intersectoral collaboration between federal departments and their agencies responsible for health, development, foreign affairs, and intellectual property would improve Swiss decision-making processes related to global health governance, because these would facilitate more credible outputs and coherent Swiss positions on the agendas in the global arena. Coherency was a founding principle of the Swiss arena because it was argued as a means to achieve powerful status in GHG and to improve the influence and perception of Switzerland as a state actor.

The Swiss NPGH arena was comprised of five main action situations (***Figures 2 - 3***, Chapter 6), stratified in a hierarchy of authority wherein rules organised actors in intersectoral situations at comparable levels of seniority in the federal administration. A political action situation at the top was responsible for setting the political vision and institutional arrangements for monitoring at the agency director and state secretary level. Administrative-

technical action situations at the bottom (including a mix of executive, advisory, and technical officer levels) managed the operational elements and decision-making and coordination processes for the arena. A strategic action situation at the senior executive level functioned between the two to manage the strategic directions and governance of the administrative-technical situations. The two administrative-technical situations were the cornerstones for the Swiss arena because this was where exchange of information, policy advice and negotiations between middle-senior level civil servants from different sectors were most concentrated. The health sector was instrumental in establishing the administrative-technical action situations, but a core multisectoral group for each administrative-technical situation was responsible for leading, managing and coordinating. A practice-technical action situation lies outside the realm of the public administration hierarchy and operates as a platform for information sharing in the arena between global health practitioners, researchers, policy-makers and administrators.

The position rules in the Swiss arena supported power sharing through the use of rotating chairs for formal meetings between actors from the sectors in the core group. The interaction rules for the Swiss arena required structured discussions about agenda items based on the materials curated by the core group. More specifically, the decision-making rules for the Swiss arena stipulated consensus, which meant that any decision must have large majority support. Some informants reported that these rules could also produce unintended consequences. For example, wide inclusivity may lead to consensus agreement, but on a weaker position. Also, the compulsory duty to participate and the criteria of transparency in consultations on proposals in action situations invites disagreement that must be negotiated in order to find compromise before making a final decision. This can slow down the processes on urgent matters.

The interactions between policy sectors were routinized in the administrative-technical action situations. Institutionalising the cross-government monitoring at a high political level supported the lower levels of the public administration to organise, manage and implement processes. In pursuit of the objective to speak with one (coherent) voice on behalf of Switzerland in the GHG system, the Swiss arena helped to build relationships of trust across

federal departments (ministries). This outcome was strongly supported by the boundary rules to include representation in situations from a majority of federal departments and the interaction rules for open and candid interactions. Finally, the Swiss arena also created more resources through decisions about new partnership agreements among Swiss actors and external actors that increased the relational power of some actors who were not a part of the core group.

9.1.b.2 Inside the Norwegian arena for NPGH

The Norwegian government's budget and spending on official development assistance for health since the turn of the century necessitated accountability to Parliament for its global health funding decisions. This is one factor that incentivised the development of the Norwegian NPGH document to rationalise an inventory of global health work managed by the Ministry of Foreign Affairs (MFA) into a single, intersectoral policy framework. The Norwegian action arena for NPGH was mainly concerned with Norway's influence on global health governance from a development aid and foreign policy perspective.

The Norwegian arena was comprised of six main action situations (***Figure 2***, Chapter 7) and operated using rules made by the foreign affairs sector for the interactions between health, development, and foreign affairs sectors. The rules gave positional power to the foreign affairs sector for the leadership, coordination, and management roles in the Norwegian arena, with the health sector in a supporting role, except in matters concerning governance of WHO affairs. The rules structuring the interactions of actors from health, development and foreign affairs sectors in policy situations within the Norwegian arena appeared to reinforce a divide between sectoral cultures (e.g. ideas, approaches, strategies, instruments) of actors from the health and foreign ministries, which seemed to support dichotomisation rather than integration of their respective roles and contributions to the governance of global health. This ideational border between the sectors of health and foreign affairs marked respective territories of global health claimed by each sector. Informants from the health sector perceived the Norwegian arena to be dominated by development assistance for health and disease prevention and treatment (based on an international health model), to the neglect of approaches to global

health promoting action on range of interdependent determinants (social, economic, political, and commercial) of health on a global scale. It was a challenge for the health sector to argue for health issues such as mental health and other non-communicable disease to be included in NPGH design because they were not part of the framework for development aid for global health.

Also, rules limited the relational power of non-state actors (i.e. professional associations, NGOs, researchers) making them outsiders to the decision-making processes even though their resources and knowledge were valuable to government actors in the Norwegian arena. Senior politicians and scientists were key influential individuals within the Norwegian arena, even when they were not participants in action situations. Knowledge elites acted as boundary spanners between different contexts within and between national and international levels of global health policy and governance. Actors in the arena were required to formulate policy content that was technically sound and politically acceptable, interpreting inputs from many sources and connecting them to an existing set of practices within the bureaucracy of the foreign affairs sector, which housed the core team for NPGH.

The actors from different policy sectors in the arena learned more about each sector's different policy ideas, instruments, and approaches to global health. This seemed particularly important from the perspective of health sector actors in order to build longer-term capacity for intersectoral collaboration around policy impacting global health due to high mobility in foreign affairs sector where individuals rotate in and out of positions every few years. Although the main policy situations observed in the period of study are now inactive, actors reported that learning outcomes persist and support on-going dialogue as well as informal and ad-hoc interactions between sectors in the Norwegian arena (although with weak formal institutionalisation) to cultivate a sustained role for the Norwegian Government as an influential state actor in GHG. WHO is the only international institution of global health governance for which the Norwegian Government has regular institutional arrangements in place to support intersectoral coordination and sharing responsibilities between the MFA and the MHCS.

9.1.c How do mechanisms of policy change operate between GHG and NPGH?

Analysing arenas from both cases for relational structures and mechanisms linking external resources to internal policy arena processes, we found five forms of interaction wherein mechanisms of learning and networking operated (Chapter 8). The five include institutions (intergovernmental organisations and global public-private partnerships for health), closed networks (transgovernmental clubs), and connective (centres of activity as hubs and transnational elites as boundary spanners) forms of interaction. Interactions involving both state and non-state actors are formal within institutions and mostly informal in connective forms. Interactions between state actors are formal in the governing bodies of intergovernmental institutions for health and both formal and informal in bilateral or multilateral cooperation agreements such as transgovernmental networks. The formal and informal interactions of the Norwegian and Swiss arenas reshaped their boundaries and constructed an interdependent relationship between the national arenas for NPGH and GHG. These relationships are formed through circulation of ideas, procedures, instruments for policy on global health and its governance in learning and networking processes within these interactive forms.

9.2 Contributions to health diplomacy and global health governance literature

Overall, the studies conducted within this thesis led to three main findings that contribute to better understanding NPGH as a distinct policy process at the junction of health diplomacy and global health governance.

9.2.a Finding 1 - Distribution of roles for sectors varies in multisectoral arenas for NPGH

Rules structure the terms of cooperation between health, development, and foreign affairs sectors in action situations within the multisectoral governing arrangements of policy

arenas for decision-making about a government's work in global health governance. However, the contributions of these sectors to the arenas vary according to the distribution of roles in interactions within the intersectoral policy situations. Based on the results presented in the two NPGH case monographs (Chapters 6 and 7), the thesis has shown different ways that rules regulated the access of health and foreign policy sectors' actors to action situations and their ideas (boundary rules), established the positions they hold in those situations (position rules), and organised their methods of collaboration and decision-making processes (interaction rules). These findings complement what is known from two other cases of similar multisectoral policy arenas in the United Kingdom (144) and Germany (145), but they also illustrate some points of concern in debates about alliances between these two policy sectors in policy matters of global health and its governance.

Many experts agree that when it comes to cooperation between the health and foreign affairs sectors on matters of health (particularly regarding health security), foreign policy concerns and interests tend to prevail (131, 133, 135, 214). Inter-agency (bureaucratic approaches) and intersectoral coordination mechanisms (such as arenas of NPGH) are a means to reconcile these two perspectives, recognising that ministries of health and foreign affairs are not traditionally administratively structured with the capacity to work across these two sectors (133). For instance, the USA and Canada are among the countries for which we have examples (from previous administrations than those at present) of the architecture for collaboration between health and foreign policy sectors on global health that lacks rules for intersectoral coordination mechanisms (38, 301, 302).

As shown in the cases of the Norwegian and Swiss arenas of NPGH, rules designed leadership within action situations. Two similar cases in the literature, those of the UK and Germany, found that the inter-ministerial groups for developing national global health strategies were led by the Department of Health and the Ministry of Health respectively (144, 145). This contrasts my findings of the Ministry of Foreign Affairs taking a leading role in the Norwegian arena, except in matters concerning governance of WHO affairs, and the shared leadership between the core group of actors from public health, foreign affairs, development and intellectual property policy sectors in the Swiss arena. Looking across the four cases (see

Table 9.1), Switzerland is the only case with power-sharing arrangements for the leadership of processes, even though the configuration of a core team was found in all cases consisting of at least the health, foreign affairs, and development sectors. Regarding rules for implementation, the health sector was only explicitly included in the implementation structures in the Swiss and UK cases.

Table 9.1 Comparing roles of sectors in four processes of developing national global health strategies

	Formal adoption (yr)	*Sectoral Leaders*	*Sectoral collaborators*	*Sectoral cooperation (consultation) [internal]*	*Implementers*
Cases of processes					
Germany (145)	Cabinet (2013)	H	H, FA, D*, D**	All other ministries (workshops with academics and civil society stakeholders)	"*ambiguous*"
Norway (Chapter 7)	Cabinet + Parliament (2012)	FA	FA, D*, H	All other ministries, sub-ordinate agencies of health ministry (NIPH, Directorate of Health, Norwegian Knowledge Centre on Health Services), consultations with research and civil society organisations	FA, D*
Switzerland (Chapter 6)	Cabinet (Federal Council) (2012)[9]	H, FA, IP, D*	H, FA, IP, D*	All other federal departments and specific agencies such as Swissmedic	H, FA, D*
United Kingdom (144)	Cabinet (2008)	H	H, FA, D*, Def.	Lancet, LSHTM, RCSE, Nuffield Trust (workshops with academics and civil society stakeholders)	H, D*, FA, Def.

H = Ministry of Health, FA = Ministry of Foreign Affairs / Foreign and Commonwealth office, D* = national agency for development and international cooperation (Norad, SDC, DFID, GIZ), D** = Ministry of Economic Cooperation and Development, IP = Federal Institute of Intellectual Property, Def. = Ministry of Defence

The use of rules in arenas of NPGH served to constrain or share power between actors from different sectors, not only in terms of their positions in the situations, but also in terms of the ideas and instruments allotted for taking action. This thesis found that health diplomacy is an instrument for NPGH used at different levels of policy-making (international and state

[9] The first iteration as an interdepartmental strategy in 2006 was not adopted by the Federal Council.

level). The literature on global health diplomacy underscores the origins of this form of diplomacy in the practices and techniques used for negotiations between governments in international relations that have been increasingly adopted by different kinds of actors in processes to reach agreement on collective action on global health at different levels of governance (219, 303, 304). Global health diplomacy has been defined as "*policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilise health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve other political, economic or social objectives*," (304). The use of global health diplomacy as a tool is linked to the efforts to integrate health into foreign policy discourse and raise the profile of health in foreign policy negotiations, which may explain why some argue for the theorization of the practice of global health diplomacy to engage more with international relations theories (93, 305). While Gagnon and Labonté (144) characterised the policy process of developing the UK's global health strategy as global health diplomacy, my study shows that global health diplomacy is one policy tool used by actors in NPGH arenas among others (e.g. financial instruments of development aid for health, partnership and cooperation instruments).

The relationships between the distribution of the roles for leadership and implementation between sectors in NPGH arenas, and the instrumentation of the NPGH (mainly using tools from the foreign affairs sector) raise questions about the degree to which arenas for NPGH integrate sectoral approaches and tools for governing global health. The implications of using foreign affairs sector instruments for NPGH (as discussed in Chapter 5) are that the health sector may be excluded or marginalised from implementation of strategies and policies emergent from NPGH when they are not equipped to use tools of health diplomacy. While the scientific and grey literature suggests that health training of diplomatic personnel (for Permanent UN missions in Geneva and New York, for health attachés in embassy posts, and for delegations to the WHO) is a key capacity building measure for global health diplomacy (303, 306-308), there is less consideration in the literature for diplomatic training of health sector personnel. The differences in capacities and skills between the health and foreign affairs sectors have been shown to constitute barriers to their collaboration (37). I do not think that differences in diplomacy capacity hinder collaboration because this thesis

shows that rules can create mechanisms that provide conditions for intersectoral collaboration on governing global health. In fact, I found that actors from different sectors recognised the differentials in their capacities (and their relative strengths and weaknesses).

Nevertheless, it seems that favouring instruments of diplomacy for governing global health through multisectoral arrangements at the national level may segregate health sector actors from the front lines of GHG to supportive roles, given their skills and competencies associated with research, analysis, and knowledge development for health policy. If the preferred instruments for governing global health through multisectoral arenas are those of the foreign affairs sector (e.g. development aid, health diplomacy), there is potential for power asymmetries in the arena to favour foreign policy approaches in state action on global health, which generally sidelines health equity objectives for those of foreign policy in such matters (131, 135). A number of academic and professional training programmes have been established specifically to build capacity for global health diplomacy in both sectors, aiming to improve the knowledge of international relations among health professionals and that of health issues and determinants among the diplomatic core in the foreign services (14, 306, 307). These kinds of training may help to redress some of the knowledge and structural barriers to cooperation for global health diplomacy between actors in these two sectors (37).

9.2.b Finding 2 - Policy ideas circulate in the interactions between arenas of NPGH and GHG

As part of the comparative approach framing this thesis, I explored the relationship between global health governance and the two arenas for NPGH in Norway and Switzerland through mechanisms of policy change. Specifically looking for mechanisms of learning and networking, we found five forms of interaction between the GHG system and the multisectoral arenas at the national levels.

I think it is important to situate NPGH arenas within the literature about GHG actors. Broadly defined typologies categorise actors in global health governance according to their public and/or private, state and non-state, and "old" or "new" status, and within these broad categories a matrix of possibilities exist: UN agencies intergovernmental institutions, public-

private partnerships for health, funding mechanisms, philanthropic foundations, NGOs/civil society organisations, development banks, research and academic institutions, and state/government actors (83, 84, 92). In the global health governance literature, state actors (specifically high-income countries and members of the OECD's Development Cooperation Committee) are generally discussed in terms of their roles as donors, whether their contributions as governments take the form of bilateral or multilateral aid (82, 309-311). Official Development Assistance for Health (ODAH) from state actors as traditional donors was key to develop and sustain action on global health in the era of the Millennium Development Goals that stimulated increases in and a redistribution of health-related development aid, including more discretionary funds to international institutions typically earmarked for vertical programmes - or what Sridhar and Woods refer to as "Trojan multilateralism" (312). Even contextualised within an evolving mosaic of an overall basket of funding from new institutional forms and non-traditional donors (313, 314), 73% of all ODAH is from governments (315). However, Ottersen et al. (316) have shown that the criteria for allocating ODAH are rarely explicit and transparent (in particular among bilateral funders) and that many funders lacked criteria specifically related to health or health needs. Moon and Omole's critical review of ODAH advances financing and governance-oriented proposals to reform development assistance in the post-2015 era of the Sustainable Development Goals (315).

As actors in the GHG system, governments are global health funders both directly and via multilateral aid. The findings of this thesis depart with views on the roles of states as financiers of global health to explore their roles as governors of global health, in particular through understanding ways multisectoral arenas interact formally and informally with learning and networking processes in GHG. While the proliferation of new partnerships and funding mechanisms has produced a diversity of actors in the expanding landscape of global health governance (70, 317, 318), I agree with those scholars and practitioners who suggest that role of the state is not diminishing (or being diluted) relative to that of other actors in the system, but that countries should rather be considered with regard to their interactions with other actors in the system (68, 319). This finding also supports the work of McInnes et al. (85) who empirically define GHG as *a process of change and adaptation and as an arena where*

actors, institutions and ideas interact. Taking this stance, I discuss how the five kinds of interaction resonate in the literature from the perspective of their ontological forms.

9.2.b.1 Institutions

The findings regarding the interactions of national and global arenas in the form of institutions (within governing bodies of intergovernmental organisations for health like WHO, and with governance of global public private partnerships for health, like GAVI) complement the work of Chorev (90) and Clinton and Sridhar (92) on the governance of global health institutions. These studies use political and organisational sociology (90) and principal-agency theory (92) to explore the relationships between institutions (such as WHO in both, but also World Bank, GAVI, and GFATM in the latter) and their members. Both found that institutions have internal strategies to negotiate their levels of autonomy in terms of acting on their organisational objectives and/or in interests of their members. The convergence between my findings and theirs lies in the identification of governing boards and governance structures of intergovernmental organisations and public-private partnerships for health as spaces for interactions between national arenas and GHG. In both studies, the governance practices of the institutions are described in-depth in relation to their development historically, and analysed in terms of the levers of influence of members (principals) on the organisations' (agents') behaviours. Although increasing, decreasing, or withholding voluntary contributions to WHO is one way that (high-income) countries from the North exert financial influence on WHO, its governing bodies such as the WHA, but in particular the Executive Board because of direct interaction with the Director General and secretariat, provide a means for procedural influences on the organisation (90). As Clinton and Sridhar show (92) show, funding and governance arrangements work in tandem in terms of how money is raised, who has a seat at the decision-making table, and most importantly what are the accountability and transparency policies for those decisions.

In this thesis, I have shown that when representatives from countries with multisectoral arenas for NPGH interact on those governing boards, they circulate ideas between the national and international spheres. They transform the learning and networking that happens in these interactions into resources for their respective NPGH arenas. In this regard, our findings also

substantiate the example of China's general involvement in global health governance. For example, Chan et al.'s findings that learning through interactions within the intergovernmental institutions such as UN agencies has informed its own participation in multilateralism and quest for credibility and status in global governance institutions through health security (191). Nevertheless, knowledge about the formal interactions between state (and non-state) actors in the governing bodies of international institutions (whether intergovernmental or public-private) is scarce.

9.2.b.2 Clubs (closed networks between government actors)

The interactions of national and global arenas in the form of clubs constitute a finding from this thesis that complements analyses regarding the role of "summit diplomacy" in GHG. Closed membership networks of multilateral groups such as the G7/G8 have been shown to provide a form of interaction for member countries (whether represented by health ministers, finance ministers, or heads of government) that informs a state's commitment to global health, but does not necessarily improve compliance to collective decisions related to global health governance (320). Similar analyses of the BRICS summit health diplomacy reveal that the BRICS health ministers' forum, and other health-related BRICS groups, are key sites of members' international interactions related to learning related to global health diplomacy practices and as hubs of global health governance networking (320). While the G8 has been shown to act as a form of interaction for learning and networking about global health between state actors from the world's largest industrialised democracies, which has produced agreements such the group's endorsement of the Global Fund, its performance as a group in governing global health has been criticised as one that has neglected to deliver on health equity globally and one that may contribute to the fragmentation of the GHG system (281, 321) [see also (280) for in-depth analyses of G8 and global health governance). The nascent literature on G7/G8/20 forum diplomacy places a focus on these groups as actors in GHG that act either in competition with, parallel to, or in support of existing international institutions, such as those in the UN system, with health-related mandates. The interactions in these high-profile closed intergovernmental 'summit' groups are formal, and they are increasingly so in terms of the procedures for transparency of documentation (including sharing preparations, briefings, and decisions) through summit host's websites. However, our findings on

interactions in transgovernmental clubs, like the Foreign Policy and Global Health Initiative, suggest that those of an informal nature which take place outside the more traditionally visible high-level groups ('under the public's radar' so to speak) should not be neglected when exploring the transnational governance of global health (see Chapter 8).

For instance, one of the important features of the Foreign Policy and Global Health Initiative was the flexibility and quasi-informal practices that were built around diplomatic relationships based on trust between members (see Chapter 7). These findings about the Foreign Policy and Global Health Initiative as a transgovernmental club corroborate those of Sandberg et al. (322) about how the interactions of state actors from the foreign affairs sectors in seven countries supported their health-related negotiation processes in other venues, wherein the initiative functioned to bridge different national and global arenas in matters of health and foreign policy. I argue that evidence from other policy fields also supports claims that transgovernmental networks, informal and formal, circulate policy ideas for shared policy dilemmas and facilitate coordination to manage transnational policy challenges (323, 324). Although the literature does not provide much confirmation about closed and highly informal networks such as the Glion annual meetings (see Chapter 6) of OECD countries before the World Health Assembly in the first decade of the 2000s, Aluttis et al.'s study mentions interactions of this nature as influential in the German process for developing their national global health strategy (145).

Much of the literature on the European Union (EU) and global health focuses on the role of the EU as a global health actor in the GHG system (279, 325-327). Even though neither of the cases of NPGH for this thesis came from EU member countries (although both are member states of the Council of Europe), I think that questions related to multi-level or regional organisations as forms of transgovernmental networks should be considered as forms of interaction between national and global arenas governing global health. For example in the EU, there are mechanisms such EU Member States Expert Group on Global Health, Population and Development or the Global Health Policy Forum. Regional intergovernmental governance organisations have developed frames of health as an intersectoral issue in foreign policy (328). Policy learning is disseminated within regional governance networks such as the

Association of Southeast Asian Nations to member states to share ideas for better governing global health policy at the regional and global levels (329, 330).

9.2.b.3 Connective (open networks with government and non-government actors)

The interactions of national and global arenas in the connective form of hubs or boundary spanning are rarely discussed in these terms in the global health governance literature. As shown by Hoffman and Pearcy's (317) study mapping global health architecture, most global health actors' headquarters are in the USA or Switzerland. The findings in this thesis about the connective forms of interaction through hubs for global health governance (New York and Geneva), and through the articulation of national and global arenas through boundary spanning transnational elites, offer new perspectives on the circulation of ideas in open networks. This finding suggests alternative explanations for how individuals affect policy change in national multisectoral arenas of national policy on global health, such as those of policy entrepreneurs, street-level bureaucrats of global health governance in public administration, and key actors from policy communities discussed in the UK and German cases of global health diplomacy (144, 145). Our findings confirm those of Sandberg and Andresen (218) who found that a few key individuals domestically and internationally renowned and well-networked in global health diplomacy are transformative in connecting health and foreign policy. I observed this within the Norwegian national arena through their capacity to interact with and articulate the national and global arenas. I agree with the authors that such a "reliance" on a handful of boundary-spanning transnational elites may render the policy arena vulnerable to change.

However, two points are particularly striking about this finding in terms of interactions between multisectoral policy arenas and GHG. First, the individuals from our case countries who are renowned international scientists, experts, consultants, and politicians acquired a particular status as a boundary-spanning transnational actor as they move between the national and global spheres of governing global health and between sectors, institutions, and global health networks. Second, their unique privileged status is institutionalised in the arena even if their individual positions and affiliations change, because they serve as conduits for the

circulation of ideas and learning between the levels through their personal and professional connections with other elite transnational actors (both state and non-state).

These observations about boundary spanning networking practices which operate at the intersections of GHG hubs and the dense personal networks of transnational elites from the national arenas might explain why formal global health networks are absent from our data analysis on interactions between national and global spheres. Global health networks (specific issues / policy networks) have been shown to be instrumental for agenda-setting, i.e. framing and prioritising global health policy problems and solutions (331, 332). The interpretation of our findings thus presents a challenge when compared with the global health and global health governance literature, which tends to be organised according to governance regimes or issues (i.e. disease, vulnerable group, risks/substance) for global health governance, rather than as a regime complex made of competing clusters of institutions, law, rules, financing mechanisms, and norms (67). Our findings indicate that questions about how to proficiently involve multiple sectors in the organisation, coordination, and implementation of a national government's strategy for participation in and influence on global health governance have become a policy problem for which arenas for NPGH were constructed to address. I further discuss the implications of this in relation to third finding in the next section.

9.2.c Finding 3 - Global health governance materializes as a policy target for arenas of NPGH

The problematisation of the global health governance system as a target for national policies produced by multisectoral arenas of health and foreign policy collaboration was the most unexpected finding that emerged from this thesis. The materialisation of the systemic target of actors in global health governance as policy objects for change in the NPGH designs of Norway and Switzerland (Chapter 5) and the circulation of policy ideas via the interaction of the national mutlisectoral arenas of NPGH with the global health governance system (Chapter 8) construct an interdependence between the collaboration of health and foreign policy sectors in countries and state action in and on global health governance.

The challenge of discussing this particular finding with the literature, and specifically against two other documented similar cases of developing national strategies in the UK (144) and Germany (145), is that neither case offers a theoretically based analysis of the strategies' contents. To our knowledge, this thesis is the first deductive analysis of NPGH documents in public policy terms [I do not consider Bozorgmehr et al.'s (333) analysis of the German document's strengths, weakness, and opportunities as public policy analysis because there was no theoretical underpinning for it]. Nevertheless, our findings do not contradict those of Gagnon and Labonté (144) or Aluttis et al. (145) which suggest that these national global health strategies highlight the breadth of challenges for governing global health and situate national contributions relative to the global challenges. What this thesis has added to this literature is an understanding that multisectoral arenas for NPGH are constructed to support state action in and on global health governance. As discussed earlier (see Finding 1), the distribution of roles between sectors in these arenas varies. This suggests that it may be more appropriate to speak of collaboration between health and foreign affairs in governing global health than integration of those sectors' policy objectives related to global health. In our two cases of national arenas, collaborations between actors from ministries of health and foreign affairs produce a shared representation of the complexity of the global health governance landscape from the perspective of the country on the national scale.

These results illustrate the dual realm of global governance as both a technical and administrative domain (primarily in the health sector's domain or responsibility) and a political dimension of international "cooperation and contestation" (primarily in the foreign affairs domain of responsibility) as synthesized by McInnes et al. (85). As a form of transnational governance of global health (see Chapter 8), the Norwegian and Swiss arenas for NPGH used officially adopted policy content to communicate their ideas about representation, participation, and contribution to the GHG system and signal their processes for managing the relationships and interactions with other actors in the system. As discussed above, the transnationalisation of NPGH was found in the policy process (circulation of ideas from interactions with GHG). However, I also found it in the policy content because NPGH designs target a set of actors in the GHG system for which a state desires to render visible its

coordination and decision-making process between government sectors of health and foreign affairs.

9.3 Limitations and strengths

The main limitations to this thesis result from two interrelated methodological choices. The first is my methodological choice to commence the retrospective reconstruction of the two arenas of NPGH with the formally adopted policy documents defined as the output of the policy processes that were the object of study. Using a specific outcome of these multisectoral processes as the starting point for the study is however both a source of strength and weakness of the thesis. It is a source of strength for this series of studies because it provided a concrete end point for which I studied a process that reached a state of completion. Although starting with the policy designs (the NPGH policy documents) as the tangible output of an arena was a methodological choice, it was theoretically informed by Real-Dato. Some political scientists, like Daigneault (334), agree that the choice to start with a readily observable phenomenon, such as policy documents, statutes, and other procedures provides a practical approach to materiality in the study of public policy and policy change. The weakness of this methodological choice is that the models of the NPGH action arenas I constructed were only made of 'productive' or 'viable' situations that were considered to have successfully contributed to the development of the two policy documents that initiated my inquiry. This choice limited the inclusion of data for the action situations in our models of the two national policy arenas, thereby reflecting their composition to consist of situations that collectively contributed towards the production of the respective policy document as the outcome. I acknowledge that this choice excluded 'failed' situations or situations in the arena that informants considered were not established for purposes related to the selected policy documents, such as special intersectoral projects as part of other inter-institutional arrangements and other spin-offs. I have shown in the context mapping in each of the case monographs (***Figures 1*** in Chapters 6 and 7) that there were aspects of intersectoral work (and sectoral policies on global health) that were not explicitly tied or directly leading to these two policy papers, but which informants considered significant for understanding the wider socio-political and technical environment of which the action arenas on NPGH were a part. While these were not systematically analysed, I acknowledge that the constellation of contexts for

NPGH arenas intersect with the sectoral and intersectoral work in global health that was not treated as materials within the situations analysed for this thesis.

Related to the above, I should mention that I do not consider the status of the selected outputs as intrinsic to the considerations regarding this limitation of their use as the starting point. The criteria for selecting the two specific documents I used for this purpose are presented in Chapter 5 of the thesis. The policy documents were adopted and approved at high levels of government (executive and/or legislative), by the Federal Council of the Swiss Confederation and by the Norwegian Council of Minsters and the Norwegian Parliament. While these formally adopted documents present to the world outside of their countries a representation of their efforts to collaborate between sectors for a coherent national strategy on global health, the interpretation of the status and meaning of the documents within the countries is different (as discussed in the two case monographs), but neither of them constitutes law or action plans. Different forms of government and political systems also explain the varying status of these two papers in their own national contexts. I have argued that regardless of their differences in internal status (regulatory/political weight) in their respective government systems, it is their formal adoption at levels above the individual ministries involved that constituted our entry point to explore the intersectoral arenas and the processes leading to the development of these policies on global health governance.

The second limitation of our findings results from our methodological choice to select cases of NPGH from countries that are not among the major global geopolitical powers, nor members of the European Union. This choice may have negative implications that limit the generalizability of our findings to other significant state actors that are top donor countries in global health who are members of the G7 or the G20, or members of regional political and economic governance arrangements. Nevertheless, both of the countries for our cases are members of numerous multilateral/intergovernmental international institutions that are part of the landscape of global governance of health and development. Acknowledging this limitation, the thesis has shown that in lieu of traditional sources of geopolitical power (economic and military), these two state actors use health and foreign affairs collaboration to situate themselves on the international stage as major actors in the global health governance system.

The findings of this thesis are relevant to cases of other state actors and the instrumental use of global health governance as a means for acquiring political and diplomatic capital in the global arena.

Accepting that the findings of this thesis should be considered within the aforementioned limitations, I suggest that they should also be weighed against two related strengths. First, the Context Advisory Groups (described in Chapter 4 of the thesis) established for each case study were strong methodological tools for rigour and reducing researcher bias. The Context Advisory Groups acted as a strategy to increase the trustworthiness of the findings. Specifically, two criteria for judging the rigour of qualitative research are the credibility (internal validity) and dependability (reliability) of the findings. The Context Advisory Groups served to validate the most relevant actors for recruitment as informants from the purposive and snowball sampling and to aid in accessing the main actors from each of the situations. The preliminary analyses of the content of the adopted NPGH policy documents and of the case studies were discussed with each Context Advisory Group separately, as a variation of the peer debriefing strategy in qualitative research. These methodological steps taken with the Context Advisory Groups serve to counterbalance a potential critique regarding the absence of member checking with key informants on the analyses for the case studies because they only received their transcripts and photo of the interview sketch for verification. As experts from the case countries with their own knowledge and experience of these processes, the Context Advisory Group consultations were critical check points to exchange about the cases, respond to their questions and critiques, and collect their opinions on our own understanding of the case and its context, and reduce the risk of significant omissions. The use of the Context Advisory Groups was a strength of the thesis as a strategy for rigour within each case, independent of the comparative elements of the study.

Second, the use of public policy theories from the discipline of political science constitutes one aspect of the strength of the thesis. In Chapter 3, we presented the development of a theoretical framework adapted from the political science literature to conceptualise NPGH in public policy process terms. As such, the thesis aims to enlist in the interdisciplinary literature that is growing between political scientists and public health researchers around what

some refer to as "health political science" (122), which acknowledges what political science can bring to public health and health policy research (102, 103) and why health politics constitutes a different sub-field in political science with specific considerations (335). The commentators discussing this idea argue that public health researchers need to expand the theoretically-based understandings of the policy-making making process to explore policy change and governance in matters related to health. In this thesis, through the use of a relational theory of policy, I focused on interactions within NPGH arenas and between these arenas and global health governance, which led to findings that challenge thinking about the governance of global health in structural or institutional terms. The theory falls within our broader conceptualisation of public policy as a collective enterprise between actors, which I adopted over conceptualisations of public policy as actor behaviour or as discourse. While reviews have shown minimal uptake of the use (and in some cases misuse) of policy theories in health promotion research (123) and research on social determinants of health and health equity policy (124), the literature in the field of health systems and policy research in low- and middle-income countries generally engages with a broader set disciplinary perspectives and theories from political and social sciences (127, 336).

Noting that much of the scholarly work to advance knowledge on health and foreign policy, global health diplomacy, and global health governance has been conducted and interpreted using concepts and positions from international relations theory (305), I briefly expand this discussion about my choice to use public policy theory as a strength of the thesis. Indeed, similar to the conversations in the literature noted above regarding interdisciplinary complementarity between public health and public policy theories, international relations is another field within political science wherein international affairs scholars have reflected on contributions of its theoretical approaches applied to the study of global health policy (65, 211, 337, 338). International relations theories broadly fall into three large categories of realism, liberalism, and constructivism applied to understand the relations between states and with international actors, and the operations of power, interests, and norms in the international system. These theories explain international affairs based on definitions that classify what is in the realm of the domestic and what is in that of the international, with the unit of analysis typically being either a state, an international organisations, or occasionally individuals. I

started with a research object defined as public policy with the multisectoral arena as the unit of analysis, rather than an object of international relations with the state as the unit of analysis. I selected and adapted policy theory to explore how health and foreign policy sectors were developing policy together on global health. This approach contributes to the literature in a different way, starting with public policy interactions between sectors in countries to explore how they interacted with GHG, rather than starting with the international rules, institutions and norms. In our opinion, the public policy and international relations theoretical perspectives are complementary, because public policy theory allowed us to look inside of the state at how intersectoral collaborations are functioning to develop policies on global health governance, whereas international relations theory (in particular liberalism / neoliberalism and constructivism) may provide supplementary tools and explanations for understanding cooperation and politics in global health governance.

9.4 Theoretical contributions

In this thesis, theory played a role in the conceptualisation of the research object as well as its empirical construction. I adapted a theoretical framework from the political science literature to model NPGH in public policy process terms. I began with Real-Dato's synthesis framework from the policy sciences because I sought a theory about public policy that would help me explore the interactions between actors from health and foreign affairs ministries (intersectoral dimension) and the relationship between global and national policy making processes (interlevel dimension) assuming that the former exerts some kind of influence on the later. Chapter 3 presents the method for selecting and adapting this policy theory for the object of interest for this thesis, NPGH as multisectoral policy arenas. Real-Dato's own theoretical synthesis of the Multiple Streams Theory, Advocacy Coalition Framework, and Punctuated Equilibrium Theory, set within the overarching framework of the Institutional Analysis and Development Framework was developed within the field of public policy and public administration in the discipline of political science. Although it has been cited in 17 articles from the scientific literature in English (according to a Web of Science citation report conducted on June 20, 2017) and over 50 additional publications in other languages and dissertations (according to a Google scholar citation report from June 20, 2017), to my

knowledge Real-Dato's synthetic framework has not been operationalized for empirical study in a particular policy field or issue. The synthesis of multiple frameworks in public policy is one means of innovation in the policy sciences to breakdown the conventional barriers between the most well-established (and dominant) theories of public policy and find synergies between them (339-341).

Through this thesis, I have shown that Real-Dato's framework is a relevant theoretical tool for studying intersectorality in a particular policy process. Zooming in on the action situations, the theory uses rules to explain the power dynamics between sectors that play out in the intersectoral spaces of a national policy arena. Through the regulation of actors working together in these situations, the theory focuses on the social properties of actors' interactions rather than the individual properties of actors or their behaviours, beliefs, interests. Accordingly, through the regulation of materials and other resources accessed by action situations in their decision making processes, the theory sheds light on the synergies or discordances regarding policy ideas from the perspective of sectors with complementary (but distinctly different) skills, capacities, and instruments. The significance of the respective institutional affiliations and contexts of actors from different sectors reveals itself through the interactions between them. Because the theory looks beyond institutions, it also presents advantages for international comparative public policy research because it can accommodate institutional variation and incorporate the consideration of context (342, 343).

Since Walt and Gilson published the seminal health policy triangle (125), the elements of content, actors, context and process have circulated as an adaptable general organising framework for the field of health policy analysis (344), and by extension global health policy analysis (345) within the health sciences. Both of the other main case studies of intersectoral collaboration on national global health strategies (144, 145) used the policy triangle to organise data collection and analysis, and in one case this was combined with Kingdon's multiple streams theory for analysis and interpretation of results (144). I think that the policy triangle should be regarded in light of its contribution to public health research in the 1990s for raising awareness about the significance of using social science concepts in analyses of health sector and health system reforms, particularly in LMICs. However, the triangle as a

model for health policy analysis does not offer a theory about the relationships between the four variables it underlines. In this thesis, situating the intersectoral policy arena embedded within a broader set of multiple contexts is one of the notable modifications that were made to the theory for looking at how rules organise the way actors work with each other and with which ideas from different sectors. In this regard, Real-Dato's theory (in terms of what he borrowed from Ostrom's Institutional Analysis and Development Framework) focused on a materialist/structuralist view of the policy environment that I adjusted to include a more comprehensive typology of policy context (from Hassenteufel's sociology of public action) that covered the state, political, social, scientific/technical, economic, and global dimensions. This modification to the theory adds a layer of context in which actors situate themselves, their institutions, the policy arena, and the national policy context within a broader global one. The inclusion of these facets in the theory illuminate the construction of context by the actors in the arena who act as policy artisans and contextual interpreters working together to craft and structure their representation of the complex landscape of the global governance system from their vantage of national perspective. The modification of the model to conceptualise (and inventory) the contextual fabric that underlies the national and global arenas constituted a theoretical advancement of this thesis, wherein context is neither a material state, nor a static condition of background for a national policy arena, but an evolving set of socio-political constructions that are part of the national and global arenas as well as their transnational interactions. Through this modification, I argue that for multisectoral arenas targeting global governance, context is not a theoretical dimension reserved to contained categories within internal or external boundaries, but it is permeable – as part of both a reason for and a result of policy change. Nevertheless, as the theoretical framework for this thesis is not a dynamic model, it did not provide any guidance to consider and account for changes in context over time within the analysis of the policy process of the arena.

By directing attention to action situations (wherein actors from various sectors work together), the theory took us out of institutional structures to help us see into what happens between them. As intended by Real-Dato and supported by public policy theoretical commentators (346), the theoretical framework helped us see the micro-processes of intersectoral policy-making, that is the leadership, coordination, and management of purposive

situations intended to involve actors from more than one sector in the design and governance of policy. Specifically the theory opens up these intersectoral spaces and gave us tools to examine the rules that structure the operations of these collective enterprises on a policy problem of shared interest in order to understand who is participating, why, how, and with what resources (material, ideational, political, or social). Equipped with the theory, I could see what happens when actors from different sectors work together in spaces created for the purpose of collective decision-making processes on policy issues of global scope. My use of this relational theory of public policy for the thesis allowed me to bring together ideas and institutions as categories of explanation in public policy by looking at the interactions of actors in regulated and structured types of intersectoral work for policy on governing global health. By focusing on interactions and collective policy-making and governance processes between different sectors, the theory is not necessarily blind to the influence of key individuals, in so much as the rules accommodate and mediate the particular influence of individuals and their role is seen through the perspective of institutions in the arena (whether bureaucrats inside the action situations or transnational knowledge and political elites outside of them).

I demonstrated in the case monographs (Chapters 6 and 7) and in the comparison of the two arenas' relationships to GHG in Chapter 8 that mechanisms of policy change operate in forms of interaction between the national and international levels rather than dichotomously inside or outside of an arena. This empirical finding challenges the traditional theoretical distinction in public policy of endogenous and exogenous factors of policy change. The modification of the theoretical framework to include a zone of transnational forms of interaction that overlaps the national and global arenas, where the boundaries of arenas are softened by the circulation of ideas exchanged through policy learning and networking mechanisms operating in the interactions between the two arenas, constitutes a theoretical contribution of this thesis.

Chapter 10: CONCLUSION

In this thesis, I introduced national policy on global health (NPGH) as a public policy object for public health and health promotion research. Informed by Real-Dato's synthetic framework, I conceptualised this public policy object as a multisectoral action arena to explore the policy processes for developing formally adopted national policy on global health documents in Norway and Switzerland. As discussed in Chapter 9, the results of this thesis contribute to knowledge on the policy processes in high-income countries to develop official national global health strategies of an intersectoral nature. The thesis used public policy theories from the discipline of political science to analyse the content of two such policy documents (see Chapter 5) and to understand the characteristics of the multisectoral arenas that developed them (see Chapters 6 and 7). The results shed light on the design of these policies and revealed specifics about the micro-processes (i.e. rules-in-use) underpinning the operations of intersectoral collaboration on NPGH and its governance in Norway and Switzerland. These insights have implications for government actors from health, development, and foreign affairs sectors in countries that are questioning or considering the development of an official NPGH document together across sectors.

The knowledge gained from the cases of the Norwegian and Swiss action arenas provides examples of two different approaches to developing formal intersectoral strategies and policy statements, and each case poses an alternative pathway for organising and advancing intersectoral work. Namely, these pathways refer to the sector of origin for the arena's stimuli and the degree to which sectors are ranked by their individual and collective responsibilities for coordination and decision-making. For example, in the Swiss case, the health sector took the lead for initiating the process, and in the Norwegian case, the foreign affairs sector drove it. The rules of the Swiss arena favoured power sharing through the joint coordination and collective responsibility of the arena by a core group of sectors. This contrasted with the rules of the Norwegian arena that restricted the coordination and responsibility to the purview of the foreign affairs sector, which maintained authority over the

situations for its collaboration with the health and development sectors. The use of rules that limited the participation of civil society and academia through select situations in the arena was common to both cases. Based on the learning in this thesis from the two cases from Norway and Switzerland, and building on that from two other cases in the literature of the development of similar formal intersectoral policy statements on global health in the United Kingdom and Germany, I suggest the following list of questions that national governments should explore when considering the development of a formal document between sectors on global health and its governance:

- Are there any existing institutional or bureaucratic arrangements (formal or informal) in place for collaboration between the health and foreign affairs ministries and/or their subordinate agencies and institutes?
- Where is the national development agency located in the current institutional order of the foreign affairs apparatus? How technically, politically, and financially independent is it?
- Has the country recently served a term, or will it serve one in the near future, with a representative from its government on the WHO Executive Board?
- Who are the transnational boundary spanning elites in global health and global health governance from the country?
- How do the country's Permanent Missions and delegations to international organisations (especially those in Geneva, New York, and Paris) reflect sectoral interests, skills, and capacities of health, development, and foreign affairs sectors?
- What are the expectation, desirability, and acceptability of involving actors from the global health research and practice communities, and other civil society stakeholders, in policy processes for global health governance?

I propose that answering these questions would support a baseline assessment of factors related to initiating action situations for developing NPGH.

The problem for this thesis was formulated in relational terms, in that there is little known about the relationship of GHG to the policy processes for developing NPGH. This is a problem, because research has shown that policy processes within countries are not independent of global governance processes when dealing with policy issues of global scope,

such as climate and sustainable development (237, 238, 347, 348). This problem was the genesis of the general objective for this thesis, to explore the relationship between global and national processes for governing global health. Within this objective, I pursued three areas of inquiry addressing the content of the formally adopted NPGH documents from Norway and Switzerland (first comparative study), the features of intersectoral policy processes in Norway and Switzerland for developing their adopted NPGH documents (two case studies), and the rapport of influence between the system of GHG and NPGH arenas (second comparative study). I approached this objective from a policy studies perspective to interpret the internal workings of the collaborative processes that engaged different sectors for developing these policies. This thesis contributes a better understanding of how national intersectoral policy development on global health and GHG are related. Overall, I found that questions about how a national government influences GHG became policy puzzles for which NPGH action arenas were developed to address. By exploring specific action situations, I observed interactions between institutions, ideas, and interests through actors from several key policy sectors (including the health sector) engaging in work together on coordinating a government's strategy for GHG. I argue that this is significant for public health and health promotion because it is one example of how governance mechanisms at the global level and policy-making processes at the national level interact, and may be reshaping each other in the process.

10.1 Transnational governance of global health

Based on in-depth case studies of arenas that developed national policy on global health in Norway and Switzerland, this thesis argues that the multisectoral arenas are emblematic of the transnationalisation of governing global health. By transnationalisation, I mean interconnected processes that span across different levels and institutions of policy decision-making and governance of global health, including those within countries (national), between countries (international), and above countries (global). Transnationalisation constructs groups of actors working together across different levels of global society. Using the cases of Norwegian and Swiss arenas between 2005-2013, this thesis showed how action arenas for NPGH are intersectoral "policy processes without borders" that interact with actors

from GHG in a variety of forms. These interactions in networking and learning processes (that took place through institutions, transgovernmental clubs, hubs, or transnational boundary spanning elites) circulated ideas between the respective national arena and the GHG system. The circulation of ideas from interactions between the two levels constructed relationships between the two levels (a global arena and a national arena). I observed that transnational spaces of governance were forged through the interactions of a national arena with actors and institutions from different parts of the GHG system around shared agendas of concern (e.g. issues, diseases, conventions). As a system, state actors in the form of the national action arenas do not engage with GHG in its entirety because the GHG system is an amalgamation of actors (intergovernmental, state, and non-state) using "formal and informal institutions, rules, and processes… to deal with challenges to health that require cross-border collective action" (67). As discussed in Chapter 8, the formal and informal kinds of interactions, in addition to those with institutions and public-private partnerships for global health, were significant for defining the transnational space of governing global health relative to each national arena. In particular, the informal ones (networks, hubs, and boundary spanning elites) were critical to support the flow of ideas between arenas. These findings constituted the basis for reflecting on the theoretical contribution of this thesis to understanding transnational governance of global health as a potential conduit and space for policy transfer.

As a result of these findings, I revised the theoretical idea on which this thesis was premised from Real-Dato that external factors/forces (from a global arena) exert influence on internal policy change (in a national arena). Both cases of arenas for NPGH in this thesis illustrated how mechanisms of policy change operated through interactions of the NPGH arena and GHG. It was through the mechanisms of policy change, namely the processes of policy learning and elite networking, that the transnational arena emerged as a zone for circulation of ideas and feedback between the NPGH and the GHG arenas. The relationship between GHG and each national arena in this thesis was not found to be one of causal force, external influence, or exogenous pressure for national policy change. Rather, what appeared from the forms of interactions within the transnational spaces for governing global health was a relationship to policy change of a reflexive nature between national and global processes through learning and networking with and from other actors. The flow of ideas between actors

in the transnational interactions that overlaps the national and the global levels also created a space for the convergence of shared elements of international and scientific contexts across these analytic scalar boundaries.

This theoretical contribution has implications for empirical research and for governance and policy practitioners. The thesis has shown that transnational spaces for governing global health exist, and that these spaces can be identified by the interactions of actors from a multisectoral arena at the national level and actors from outside of their country. For actors in policy and governance of global health, this implies state actors seeking to develop national policy on global health may wish to engage in or diversify non-institutional forms of interaction with other state and non-state actors to support that learning and networking for sharing experiences and developing policy ideas and instruments that will contribute to their participation in global health governance. In particular, the development of organised dialogue between actors from health and/or foreign affairs from a group of different countries constitutes a valuable source of learning and networking in transnational interactions that can be used in national processes and for collaboration between alliances in other global governance venues. For researchers interested in global health governance, this implies that the feedback and interactions between national intersectoral policy processes and global health governance processes are empirical objects that may be outside of the realm of traditionally defined conceptual elements of global health governance, such as institutions. I illustrated elsewhere that applying different theoretical perspectives to a process for developing national policy on global health could discern different elements of GHG (see Appendix A). This thesis has demonstrated that the targets of national policies on global health and the forms of interaction between the national arenas and GHG show us how these multisectoral approaches interpret and define GHG from a perspective of state actors.

The theoretical and empirical implications of this contribution suggest a diffusion of governance of global health and its contexts that are also embedded in national policies, which leads to questioning ways the transnational governance of global health stimulates policy change at the national or global levels. Many definitions of GHG qualify health issues *for* governance as transnational, meaning that GHG is collective action between states, non-state

actors, and intergovernmental bodies on issues that are not confined to national borders and which cannot be resolved only by state institutions within their borders. In this thesis, I suggest that the transnational quality applies to the work and practice *of* governing global health, meaning that from the viewpoint of state actors in NPGH, GHG is an ensemble of interactions in transnational spaces of governance where they learn and network. From this stance, the integral roles of high-income state actors multiply from being participants, funders, and implementers of global health governance but also as its designers, proponents, and influencers. As such, arenas for NPGH are one manifestation of the transnationalisation of governing global health in national policy-making that targets the GHG system. This thesis has advanced the idea that NPGH are public policies that exhibit transnational governance of global health because they are relational policy arenas with processes that target and interact with actors and institutions in multiple venues within a polycentric socio-political space spanning domestic and global policy arenas. As such, the contribution reiterates the definitional parameters with which the thesis began, that action arenas for NPGH have two important dimensions of interactions for actors - *working across different policy sectors* and *working at different policy levels*.

10.2 Speculation on the future of national policies on global health

Before addressing the potential future avenues for research, I would like to return to NPGH as the main object of interest for this thesis. An operational definition of this object was provided in Chapter 1, and a footnote directed the reader's attention to an empirically based revision of that definition in Chapter 5 following a comparative study of two NPGH policy documents. In this concluding chapter, I suggest a final revision, defining NPGH as: *a transnational and multisectoral policy arena, in which the health sector may not have leadership role, wherein rules structure interactions of actors from health, development, and foreign affairs sectors to make decisions about the government's work in and on the global health governance system.*

With few studies (and few empirical instances) of the development of these official intersectoral policy statements on global health and its governance, one might ask: will these

intersectoral and transnational objects endure? National policies on global health are situated within a field under development at the crossroads of health and foreign policy studies and global health governance. These objects emerged during an era of the MDGs and international agreement on global development targets, a series of high-level forums and declarations on aid effectiveness, the negotiation of two international health treaties (FCTC and IHR), and the burgeoning of public-private partnerships and financing mechanisms for global health that were rapidly integrated into the landscape of health and development institutions of global health governance. Global health governance is an increasingly significant arena for international relations, and reflecting on findings of this thesis I propose that the development of NPGH might be a non-economic, non-militaristic (soft) strategy for states seeking to otherwise rearrange or maintain the balance of power within the international system. As the thesis has shown, this strategy uses rules for a formalised alliance between the health and foreign affairs government sectors that takes the form of a national action arena to strengthen their impact on global health governance by officially registering and communicating their ambitions, intentions, and collaboration processes in a formal way visible to the outside world. This type of alliance necessitates inter-ministerial coordination, because each ministry requires competencies from the other (health policy and diplomacy) for complementarity and to work effectively in global health governance.

These findings also provide an empirical basis for developing critical perspectives on policy coherence as a goal for health and foreign policy that are currently lacking in global health governance literature. Speaking with "one voice" through a formally adopted NPGH policy document on behalf of multiple sectors from a country may constitute a procedural or structural coherence for targeting the global health governance system, but creating arenas with mechanisms for multisectoral cooperation for integration do not necessarily lead to coherence among policies for impact on shared goals (e.g. objectives, instruments) [see (349) for analysis of policy coherence concept]. The issue of coherence is generally discussed in terms of how arguments are framed for global health diplomacy in global health governance (134, 350). Policy frames are notably absent from our findings because our methods reconstructed multisectoral collaborative processes (not discourses) for a particular global strategy document, even though frames have been shown to have ideational power for policy

change and shaping debates in global health governance institutions in particular in studies on specific regimes or issues in global health governance (e.g. access to medicines, HIV/AIDS, pandemics) (85, 138). I consider that frames constitute part of the resources and ideational materials that belong to different sectors within arenas for NPGH that circulate in learning and networking interactions between the arenas and global health governance.

Since the data was collected for this thesis, the world has undergone a period of political change in leadership of some traditional global powers such as the UK and the USA, which has stirred up many questions regarding the stability of financial and political commitments in the governance of global health and development. Such changes are reminders that the seats for main actors around the global health governance table, so to speak, are not permanent. These shifts may create opportunities for balancing strategies of opportunity for other countries to secure their place as global health influencers. For example, one can look at the national policy on global health documents adopted by Germany in 2013 (23) and France in 2017 (24) in the context of the development of their roles as states in global health and its governance but also in relation to the changing international climate (351, 352). The policy documents were a materialisation of processes in the arenas studied for this thesis, but reports in grey literature from epistemic communities in France, the Netherlands, Canada, and Brazil suggest that while a formal paper may be an ideal outcome, the necessary tool for integrated approaches to strengthen global health and its governance is an interdepartmental coordination mechanism between the ministries of health and foreign affairs and the national development agency (and potentially other sectors).

10.3 Future areas of research

Suggested areas of research arising from this thesis are related to empirically testing hypotheses generated by my dissertation research and to the potential application of the theoretical framework to other national intersectoral policies on issues of global governance related to health. First, one research hypothesis generated by this thesis is that the power or influence of a state actor in global health governance depends on the intersectoral composition of its national arena. The World Health Assembly would be an ideal field case for testing this

hypothesis by comparing those countries with delegations (Chief, deputy, and main delegates) from only health ministries or from a mix of health and foreign affairs ministries, over the time of the MDG era (2000-2015) or in the transition period from the MDG to SDG era (2012-2017). I suspect there to be stratification of the mixed nature of delegations within a North and South divide according to a more traditional donor-recipient classification, but I would like to test this against economic indicators such as group membership in the G20 or OECD to explore the relationship of countries' intersectoral delegations (ambition to influence in GHG in WHO) to their levels of economic development, in particular related to the emerging economies. Second, related to this hypothesis, one could assess the policy designs of the sectoral policies on global health (produced by health or foreign affairs ministries). The methodological choice in this dissertation research was made to exclude formal policy statements on global health that were developed by a single sector. The findings reported in Chapter 5 on the targets of national policies on global health lead me to question whether other national strategies on global health that are not multisectoral also target GHG, or do they target global health programmes or populations in particular? This analysis of policy design would also elucidate which sectoral national policies on global health have intersectoral cooperation regarding instruments or implementation structures.

Regarding the second area of future research, there are a number of potential replication studies or applications of the theoretical framework to other research objects. For example, the replication of a retrospective case study on another high-income country with NPGH, like France, could produce knowledge on a different model of action arena rules and situations for intersectoral policy development in another type of welfare state. It would provide an opportunity to test the forms of transnational interactions against a different set of empirical examples given France's more diversified membership in the international system related to global health, and francophone networks. Other replication studies of interest might include one on a middle-income country in the instance that a formal policy is adopted, or a prospective study that would follow the process of developing the NPGH in Canada or another country where there has been evolving debate about such a formal document.

Second, there is a potential for adapting the framework used in this research for the

national arena to regional arenas as another collective choice level. The intersectoral policy-making on global health in regional governance could serve as another field to explore how state actors (without resources for their own NPGH) are working collectively to influence and interact with GHG. By regional governance, I am referring to bodies such as the European Union, the Union of South American Nations, the Association of South East Asian Nations, or the African Union.

Finally, I suggest that there is a potential to apply the theoretical contributions of this thesis to other intersectoral policy arenas for transnational governance, such as those related to the SDGs or those related to significant issues in global health governance like antimicrobial resistance (AMR) or non-communicable diseases (NCDs) for which intersectoral policy at the national level is critical. In one instance, within the global governance space of the High Level Political Forum for the SDGs, over 40 countries have shared their voluntary plans for achieving the SDGs. Norway and Switzerland were among the first group to do so in 2016. Many of the plans submitted by countries include intersectoral coordination and monitoring mechanisms, and the OECD countries are part of an effort to focus on intersectoral instruments for policy coherence for development within their SDG policy plans. In another instance, the voluntary reported data from WHO's 2016 survey on AMR national action and preparedness plans showed that out of the 151 countries asked about their multisectoral arrangements for AMR, only 9 had already implemented integrated approaches to monitor progress, 37 had no formal multisectoral governance or coordination mechanism, and the remaining countries had various forms of multisectoral working groups or committees at different levels of institutionalisation. Regarding the global governance of AMR as a policy issue, there are a number of venues, networks, and institutions related involved in the management of AMR in addition to WHO.

These two areas are examples where intersectoral policy arenas are forming at the national level to develop policies that I suggest have similar dimensions and characteristics of action arenas as conceptualised and analysed in this thesis in terms of interactions for actors - *working across different policy sectors* and *working at different policy levels* – for which this theoretical framework might be useful to study rules for intersectoral policy and governance.

10.4 Learning from this thesis for the public health and health promotion fields

In the introduction of this thesis, I positioned NPGH as a research object whose exploration could shed light on three broad areas of concern to public health and health promotion policy-related research and practice. First, the thesis offers an in-depth look inside a specific set of processes of intersectoral collaboration between the sectors of health and foreign affairs (among others). The results from the two in-depth cases NPGH arena provide a detailed account of how "intersectorality" operated in practice between actors from these different sectors, which contributes to filling a knowledge gap that has been noted by public health and health promotion researchers (55, 56). This study of the ways that actors from different sectors worked together, how decisions were made, and with what information produced findings about intersectoral policy practices at the intersection of agency (individual actors), discourses (strategies and frames), and structures (institutional arrangements and coordination mechanisms). From this thesis, we learn that rules for engaging with other sectors in intersectoral policy reinforce or renegotiate the territorial boundaries and roles of sectors in governance of health-related matters. Second, the thesis provided learning that may serve to disentangle the concept of global health governance for public health and health promotion. The introduction of this thesis highlighted the ambiguity of this concept in terms of its meaning, functions, and application. The discussion of the third finding of this thesis accentuates the multifaceted realm of global health governance as a convergence of administrative, technical, and political domains (see Chapter 9). From this thesis, we learn that global health governance is a complex of domains for which not single sector is fully equipped to engage and interact with on its own. Furthermore, the findings in this thesis about the interactions within transnational spaces of governing global health also raise further questions about our general understanding of governance as a "managerial" activity and about the roles of government structures versus non-governmental ones in global health.

Finally, in the application of policy theories to the content and processes of intersectoral policy on global health, the thesis illustrated the symbiotic relationship between social sciences, in this instance political science, and policy research in public health. As a

thesis anchored in an interdisciplinary research field of health political science, it offered an example of how public policy theories can be used to understand intersectoral policy related to health and global health governance, as well as an example of how the study of global health policy can be used to develop theories of public policy. Some challenges for interdisciplinary approaches in policy research related to public health researchers operationalising frameworks from policy theory are discussed elsewhere in this thesis (see Chapter 3). To put simply, interdisciplinary work of this kind is generally understood as political science being the producers of models, and public health researchers being the users of models. While some of the more traditionally known policy theories and models (such as Kingdon's Multiple Streams or Sabatier's Advocacy Coalition Framework) have been used by public health researchers to study questions about policy, there have been multiple "new" theoretical models and "synthetic" or "hybrid" frameworks published more recently in the public policy literature (339, 340, 342, 353, 354) which have not, or minimally, been operationalised in health-related policy research. This thesis has contributed to identifying synergies between public health and policy studies as fields of research. As scholars in the policy studies produce more refined and sophisticated theories of complex policy processes, researchers in public health furnish a vast and rich empirical terrain of complex policy processes (e.g. HiAP, NPGH) for operationalising, testing, and revising such theories.

One of the lessons I have learned from this thesis is that one needs to be committed to an interaction between these two fields of study (e.g. engaging with both) to contribute to building a more reciprocal relationship between them. The dual co-supervision I received from thesis advisors in public health and political science contributed significantly to opportunities for building capacity in this project to do that. Building a more two-sided relationship between these fields of study also identifies areas of common theoretical and empirical interest for which there are gaps in both literatures, such as in this thesis, for example, regarding how do we define and analyse context for policy.

10.5 My #tweesis

I conclude with a proposal of my *Twitter* thread of ten tweets about this thesis.

1/10 There are 3 broad #policy #research concerns for #publichealth #healthpromotion : #intersectorality #governance & role of #socialscience

2/10 Governing #globalhealth is #intersectoralpolicy problem for national govts wanting multiple sectors to collaborate for influence in #GHG

3/10 Rules structure decision-making interactions & power btwn #health #dev #foreignaffairs sectors w/in public policy targeting #GHG

4/10 Transnational governance of #globalhealth develops from circulation of ideas in interactions btwn mutlisectoral national arenas & #GHG

5/10 Multisectoral action arenas for national policy in Norway & Switzerland are emblematic of #transnationalgovernance of #globalhealth

6/10 Transnationalisation of governing #globalhealth manifests in networking+learning btwn GHG system & national health+foreign policy arenas

7/10 National governments are state actors IN, ON, and OF #GHG in #transnationalgovernance of #globalhealth

8/10 I hypothesize that health+foreign affairs ministries collaborating may be strategy to secure status+influence as state actors in #GHG

9/10 #healthpoliticalscience is using #publicpolicy theory in #publichealth #research + #publichealth results to build #publicpolicy theory

10/10 #NPGH is #transnational #multisectoral policy arena in which health sector may not have leading role to act in and on #GHG system

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Appendices

Appendix A. Commentary published in *Journal of Health Diplomacy*

JOURNAL OF HEALTH DIPLOMACY

What could research on national policies on global health reveal about global health governance? An illustration using three perspectives

Catherine M. Jones*

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What could research on national policies on global health reveal about global health governance? An illustration using three perspectives

CATHERINE M. JONES*

National policies on global health (NPGH) are strategies developed at the country level for coordinating a state's action on global health across government ministries. NPGH constitute an intersectoral approach for coherence (Lanzalaco, 2011) of a country's policies related to improving the health of populations worldwide. Formal adoption of NPGH in the United Kingdom in 2008 (HM Government, 2008), Switzerland in 2006 and 2012 (Federal Department of Foreign Affairs & Federal Department of Home Affairs, 2012; Federal Department of Home Affairs, Federal Department of Foreign Affairs, & Federal Office of Public Health, 2006) and Norway in 2012 (Norwegian Ministry of Foreign Affairs, 2012), represents one way that health as foreign policy is being pursued. The involvement of multiple ministries such as Foreign Affairs, Health and Development underline the intersectoral nature of this pursuit (Hoffman, 2010).

NPGH may also be conceptualised as components of a set of processes, involving state and non-state actors, which steer and coordinate collective action on health at the global scale. I recognise the organisation and realisation of these formal and informal processes, operating beyond state boundaries, as global health governance (GHG). Acknowledging the variety of ways by which countries integrate health and foreign policy concerns (Fidler, 2009; Huang, 2010; Llano et al., 2011; McInnes & Lee, 2012; Sandberg & Andresen, 2010; Sridhar, 2009; Watt, Gomez, & McKee, 2013), I propose that NPGH serve as interesting cases because investigating the policy processes leading to their formal adoption may create opportunities for the empirical appraisal of GHG. Using the example of *Health is Global: a UK Government strategy 2008-2013*, this commentary aims to show that various theoretical perspectives on the development of NPGH illuminate different aspects of the policy process, some of which may intersect with GHG processes.

An empirical example of NPGH

Health is Global (HM Government, 2008) is recognised amongst the first, and most detailed, of formally adopted NPGH (Banatvala, Gibbs, & Chand, 2013; Gagnon & Labonté, 2013; Sridhar, 2009; Sridhar & Smolina, 2012). While primary research on NPGH is sparse, two empirical case studies of *Health is Global* have investigated how and why health is integrated into foreign policy in the UK (Gagnon & Labonté, 2013) and the role of non-state actors in this strategy (Bargeman, 2011). These studies focused on policy processes within the UK, pertaining to the rationale for health as foreign policy and the influences on the

strategy's development from inside and outside government. Gagnon and Labonté note that policy communities impacted the framing of the UK strategy, and that individual policy entrepreneurs, especially in combination with political leadership at the highest levels of Government, were critical to its completion (Gagnon & Labonté, 2013). Bargeman's study proposed a typology for non-state actors and identified emerging themes associated with those categories, such as, the working relationship between government and non-state actors, stakeholder engagement and mechanisms of influence (Bargeman, 2011).

Both studies' analyses (Bargeman, 2011; Gagnon & Labonté, 2013) reflect a statist approach (Davies, 2010) to the development of the UK's NPGH, due to the focus on protecting national security and interests, the importance of state actors as key actors, and the central role of the state in managing potential threats. Gagnon's findings that national self-interest appeared to dominate the rationale for the UK policy (Gagnon & Labonté, 2013) support analyses from a secondary review of motivations that drive national approaches to health and foreign policy (Sridhar & Smolina, 2012).

I present three theoretical perspectives that offer possibilities for exploring alternative aspects of the policy process of *Health is Global*, including those external to the boundaries of the state. I briefly introduce institutional, network and policy regime perspectives, and I propose hypothetical case studies with the purpose of illustrating how each would create opportunities for capturing GHG.

Institutions

In the policy sciences, institutions are broadly understood as routines, rules, procedures, norms or symbols entrenched in organisational structures of the polity. Institutionalisation processes are generally concerned with embedding ideas into the policies and practices of organisations. New institutionalism frameworks take institutions as aggregate and autonomous analytical units (March & Olsen, 1984); they highlight the role of institutions in structuring political and social outcomes and explain behaviour in relation to institutions (Hall & Taylor, 1996; Schmidt, 2010).

In the case of the UK's NPGH, institutional analyses would vary according to schools of new institutionalism. For example, a rational choice institutionalism perspective underscores how institutions structure interactions strategically to reduce the uncertainty of how actors will behave, thereby allowing calculated choices between policy alternatives. In this example, institutions that structure interactions may be considered within the UK, either state (e.g. DFID) or non-state (e.g. Chatham House), or outside of the UK (e.g. WHO). Alternately, sociological institutionalism suggests that institutions establish moral, cognitive and ideational templates for decision-making to assist individual actors in interpreting problems and solutions; it emphasises how institutions create social legitimacy of their practices. Here, one might ask how a UK health institution (e.g. National Health Service) or non-health institutions outside of the UK (e.g. European Commission, World Bank, World Trade Organization) may influence problem definition and decision-making frameworks for *Health is Global* at the national level. Reciprocally, this perspective could be used to explore how the UK's NPGH may influence multilateral institutions that are concerned with health of populations worldwide. Institutionalist perspectives allow for the

identification of relevant institutions outside of the UK and for the investigation of their relationship to state institutions in the UK.

Networks

Network perspectives refer to concepts and theories that give prominence to connections between actors. Networks can be conceptualised in many ways, as: modes of organisation (hierarchies, markets, networks), interest negotiation and knowledge-exchange settings (policy networks, epistemic communities), types of governance (network governance), or spatial-social forms. Networks span geographic, cultural and socio-political boundaries. Networks are less focused on embedding ideas in places; rather, they emphasise the inter-connections between actors regarding knowledge and ideas within a particular policy domain. Policy networks are not bound or determined by formal institutions; they result from a process of mutual recognition between actors whereby the linkages between them form channels for communication and exchange of expertise, information and other policy resources (Kenis & Schneider, 1991). As such, policy networks can be of a transnational or global reach (Stone, 2004, 2008; Witte, Reinicke, & Benner, 2000) and are considered by some as part of the global governance apparatus (Benner, Reinicke, & Witte, 2004).

In the case of the UK's NPGH, a network perspective would ask who are the actors that constitute a policy network for contributing to the development of *Health is Global*, and how are they connected to the policy process. Studying the web of connections between various actors, a network perspective might question the role global public policy networks play in the circulation of information and policy ideas between national policy development process and other interested actors outside of the country. Connections between actors may be identified through their participation in conferences, policy dialogues, summits, commissions, and collaboration on strategic documents.

Policy regimes

Regime perspectives focus on system-wide governance arrangements that support work across the policy subsystems invested in a policy domain. Boundary-spanning policy regimes are understood as governing arrangements that facilitate the development and implementation of integrated policies in coordination across policy subsystems (Jochim & May, 2010). Regime perspectives challenge thinking about how governing arrangements shape policy, and the role of policies as governing instruments (May & Jochim, 2013). Changes in policy regimes are linked to shifts in dominant policy paradigms, power and organisational arrangements (Wison, 2000). Similarly to Health in All Policies as a policy practice (Kickbusch, 2010; Kickbusch, McCann, & Sherbon, 2008; Lin, Jones, Synnot, & Wismar, 2012; Puska & Stahl, 2010), regime perspectives hold a systemic view of policy-making and governance.

In the case of the UK's NPGH, a regime perspective would emphasise the ideas, institutional arrangements and interests (May & Jochim, 2013)[see Table 1, p.434] that constitute a boundary-spanning policy regime for health as foreign policy to develop *Health is Global*. It would explore how institutional design facilitates or hinders the achievement of the regime's policy goals. A regime perspective would allow for the identification of sources of support and opposition for the regime (from within and outside the UK) and could use them

to attempt to explain power differentials within the regime or a regime's durability. In particular, boundary spanning policy regime perspectives would support analyses of feedback processes of NPGH, which could include those of similar regimes producing NPGH in other countries, and processes of global governance.

Nonetheless, these perspectives also necessitate a critical stance. Institutional perspectives can reproduce hierarchal, top-down approaches and limit the consideration of individual agency. Network perspectives offer a lens for exploring interconnections, but they require critical thinking about the relationship between form and function (Davies, 2011). Although policy regimes provide a way to consider political factors that shape governing arrangements to address problems across multiple policy subsystems, they are a state-centric perspective.

Based on the example of *Health is Global*, I aim to show how three theoretical perspectives can be used to create avenues for discerning elements of GHG. By way of constituting an example of *Health is Global* as NPGH with two studies (Bargeman, 2011; Gagnon & Labonté, 2013), I illustrate by means of hypothetical cases inspired from them. I recognise this as a limitation of the exercise. Noting this, I propose that the study of NPGH using diverse perspectives may construct new research objects for scholars interested in GHG and health diplomacy. In particular, perspectives that have a horizontal character, such as networks and boundary-spanning policy regimes, furnish conceptual tools for exploring policy ideas, interests, and institutional arrangements that operate both within and outside state boundaries. Such perspectives provide theoretical support for arguments about relationships and interactions of national policy processes within GHG as a complex system (Hill, 2011). In this manner, the study of NPGH can be seen as means to decipher components of GHG and empirically assess them. As NPGH emerge in high-income countries as one model for coordinating health as foreign policy, they may serve as research objects providing opportunities to capture GHG and to understand the relationship between NPGH and GHG.

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Appendix B. Certificates of ethical approval by Health Research Ethics Committee (CERES)

Université de Montréal

N° de certificat
14-083-CERES-D(1)

Comité d'éthique de la recherche en santé

CERTIFICAT D'APPROBATION ÉTHIQUE
- 1er renouvellement -

Le Comité d'éthique de la recherche en santé (CERES), selon les procédures en vigueur et en vertu des documents relatifs au suivi qui lui a été fournis conclu qu'il respecte les règles d'éthique énoncées dans la Politique sur la recherche avec des êtres humains *de l'Université de Montréal*

Projet	
Titre du projet	**Exploring the interdependence between the development of national policy on global health and global health governance: A retrospective multiple case study**
Étudiante requérante	**Catherine Jones** [redacted], Candidate au Ph. D. option promotion de la santé, École de santé publique - Département de médecine sociale et préventive
Sous la direction de	Louise Potvin, professeure titulaire, École de santé publique - Département de médecine sociale et préventive, Université de Montréal & Carole Clavier, professeure adjointe, Département de sciences politiques, Université du Québec à Montréal.

Financement	
Organisme	Non financé
Programme	
Titre de l'octroi si différent	
Numéro d'octroi	
Chercheur principal	
No de compte	

MODALITÉS D'APPLICATION

Tout changement anticipé au protocole de recherche doit être communiqué au CERES qui en évaluera l'impact au chapitre de l'éthique. Toute interruption prématurée du projet ou tout incident grave doit être immédiatement signalé au CERES.

Selon les règles universitaires en vigueur, un suivi annuel est minimalement exigé pour maintenir la validité de la présente approbation éthique, et ce, jusqu'à la fin du projet. Le questionnaire de suivi est disponible sur la page web du CERES.

[redacted]

Guillaume Paré
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Comité d'éthique de la recherche en santé
Université de Montréal

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8 septembre 2014 — Date du certificat initial
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Comité d'éthique de la recherche en santé

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Le Comité d'éthique de la recherche en santé (CERES), selon les procédures en vigueur, en vertu des documents qui lui ont été fournis, a examiné le projet de recherche suivant et conclu qu'il respecte les règles d'éthique énoncées dans la Politique sur la recherche avec des êtres humains *de l'Université de Montréal.*

Projet	
Titre du projet	**Exploring the interdependence between the development of national policy on global health and global health governance: A retrospective multiple case study**
Étudiante requérante	**Catherine Jones** ([redacted]), Candidate au Ph. D. option promotion de la santé, École de santé publique - Département de médecine sociale et préventive
Sous la direction de	Louise Potvin, professeure titulaire, Faculté de médecine - Département de médecine sociale et préventive, Université de Montréal & Carole Clavier, professeure adjointe, Département de sciences politiques, Université du Québec à Montréal.

Financement	
Organisme	Non financé
Programme	
Titre de l'octroi si différent	
Numéro d'octroi	
Chercheur principal	
No de compte	

MODALITÉS D'APPLICATION

Tout changement anticipé au protocole de recherche doit être communiqué au CERES qui en évaluera l'impact au chapitre de l'éthique.

Toute interruption prématurée du projet ou tout incident grave doit être immédiatement signalé au CERES

Selon les règles universitaires en vigueur, un suivi annuel est minimalement exigé pour maintenir la validité de la présente approbation éthique, et ce, jusqu'à la fin du projet. Le questionnaire de suivi est disponible sur la page web du CERES

[redacted]

Dominique Langelier, présidente
Comité d'éthique de la recherche en santé
Université de Montréal

8 septembre 2014
Date de délivrance

1er octobre 2015
Date de fin de validité

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Appendix C. Terms of Reference for Context Advisory Groups

Exploring the development of public policy on global health in Norway and Switzerland

Terms of Reference for Context Advisory Groups

The project has an important **international expert collaboration** dimension built into its design. International expert collaborators provide specific expertise through their participation as members of a **Context Advisory Group** established for each of the case countries. The Context Advisory Groups are methodological tools to support the data collection and analyses for constructing the cases of Norway and Switzerland.

CAG Composition:

Two Context Advisory Groups (CAG) will be established, one for each case country.
Catherine Jones (PhD candidate) and Carole Clavier (Jones' co-supervisor) will be members of both CAG. In addition, each CAG for Norway and Switzerland will be comprised of two members from the respective case countries. One member will come from a health field (global health, public health, or health promotion), and one member will come from a political science or international relations field.
Members of the CAG will be researchers, with university and/or research institute affiliations. To the extent possible, the research team will seek gender parity in the composition of the CAG.
Members of the CAG are not eligible for selection as country key informants.
CAG members from the case countries have the right to withdraw from the CAG at any time, without any obligation to provide a reason for doing so.

CAG Selection Criteria:

CAG members are identified on the basis of their:

- *knowledge* about the policy-making process and relevant actors the federal/state levels in their respective cases;
- *experience* doing public policy research in their country; and
- *research interests* in public policy, global health, international relations, development/foreign policy, global governance/global health governance.

Roles of each CAG member from Norway and Switzerland:

1) To provide feedback on the modelling of the NPGH action arena for their respective case country.
2) To assist in the identification of relevant archives of the policy process from their respective case country.
3) To contribute to the process of identifying key country informants from their respective case country, and to provide strategic or practical advice/assistance to facilitate their recruitment.
4) To discuss the case report for their respective country and inform analyses.
5) To generate ideas towards the development of dissemination strategy for targeting researchers, policy and decision-makers and other relevant actors in their country.

Expected participation commitments from CAG members for Norway and Switzerland:

- 5 video conferences with an estimated maximum duration of 3.5 hours each (3 in the first year of the project, 2 in the second year)

Additional opportunities for CAG members for Norway and Switzerland to participate, potential to:

- be a co-author on case report disseminated to knowledge users in-country
- be a co-author on case monograph/paper to be submitted for publication in scientific journal
- be a co-author on CAG strategy evaluation/methods paper to be submitted for publication in scientific journal

Appendix D. Agendas for three Context Advisory Group Meetings

The following examples of agendas are from the three Norwegian CAG meetings.

The agendas for the Swiss CAG meetings were similar.

1st meeting of CAG Norway (CAG Norway M1)

Thursday, September 4, 2014
9h (Québec, Canada) / 15h (Norway/France)
Meeting to be held by video chat on ooVoo
Participants: Catherine Jones (PhD student, CAG convenor), Dr. Carole Clavier (C. Jones' Co-Supervisor, CAG member), Dr. Kristin Sandberg (Norway CAG member)

The general objective of the first meeting of the CAG Norway is two-fold:
1. to present key elements of the thesis research project to the Context Advisory Group members
2. for the Norwegian case and discuss the role of CAG members; andto initiate the consultation phase of the project with the CAG Norway members and seek feedback on preliminary analyses of the policy design and policy context as well as reactions and contributions to the identification of archives of the policy process, action situations and actors involved in developing national policy on global health in Norway.

Access to the list of documents provided to CAG in advance of the meeting:
Under each agenda point, a "→" indicates materials provided to CAG members in advance of the meeting for the preparation of the items for discussion and consultation. All documents have been placed in a Dropbox to facilitate your access to them and reduce the number of email attachments.

Agenda – M1

Opening of meeting and introductions (15 minutes)
Welcome
Technical and practical issues – any questions about the ooVoo interface
Presentation of CAG members – getting acquainted

Meeting objective 1 (30 minutes)

1.1 Research project overview: a short power point presentation of the research project (namely, the research objective and question, the conceptual model and the methods)

→ Exploring the development of National Policy on Global Health in Norway.ppt
- Questions and discussion

1.2 Role and involvement of the Context Advisory Group members
→ CAG Terms of Reference (revised)
→ CAG Timeline and workplan (revised)
- Questions and discussion

Expected outcomes: - PhD student will address questions from the CAG members on the project and CAG's role - Make any necessary clarifications to reach agreement on the CAG Terms of Reference and proposed work-plan

Meeting objective 2 (maximum of 90 minutes)

2.1 Presentation of a summary of the policy design and emerging questions
→ Preliminary analysis of the policy design ("White Paper") of National Policy on Global Health in Norway (*Meld. St. 11 2011-2012*)
- Comments, critiques and contributions from CAG to consultation on the policy design

2.2 Presentation of a first draft of a country vignette on the policy context and emerging questions
→ Draft vignette on the policy context related to the development of National Policy on Global Health in Norway (*Meld. St. 11 2011-2012*)
- Comments, critiques and contributions from CAG to consultation on the policy context

2.3 Presentation of archives of the policy process, action situations and actors identified to date
→ Preliminary list of archives of the policy process, action situations and actors
→ Draft timeline of development of National Policy on Global Health in Norway
- Comments, critiques and contributions from CAG to consultation on archives of the policy process, action situations and actors

The CAG members will help to identify: - Archives of the policy process (key products of the policy process) not currently catalogued by the PhD student that may be artefacts of action situations - Action situations not currently listed and names of actors known to be involved in them - List of potential country key informants for the first wave of interviews and indication of those with whom CAG members could assist for recruitment

Wrap-up and conclusion to meeting (15 minutes)
Questions emerging from meeting

Practical issues and next steps

- process and format of CAG meeting notes
- preferences of CAG members for means and frequency of communication
- evaluation of CAG process and individual meetings
- other
-

Closing remarks

Thank you!

- - - - -

2nd meeting of CAG Norway (CAG Norway M2)

Thursday, April 30, 2015

Starting at 9h30 (Québec) / 15h30 (Norway/France) for a maximum duration of 80 minutes

Meeting to be held on Skype or ooVoo

Participants: Catherine Jones (PhD student, CAG convenor), Dr. Carole Clavier (C. Jones' Co-Supervisor, CAG member), Dr. Kristin Sandberg (Norway CAG member)

The purpose of the second meeting of the CAG Norway is two fold:

1) To seek CAG members' expert feedback and comments on draft model of the action situations in Norway's National Policy on Global Health Action Arena.

2) To validate strategy for the 2nd wave of informant interviews and a list of priority actors for recruitment.

The following documents are available to support this CAG Norway consultation :

For information - an overview report on data collection and field work (1st wave of informant interviews)

For discussion - a draft model of Norwegian NPGH action arena (focusing on action situations)

For action – a proposal for the 2nd wave of informant interviews.

Access to the list of documents provided to CAG in advance of the meeting:

Under each agenda point, a "→" indicates materials provided to CAG members in advance of the meeting for the preparation of the items for discussion and consultation.

Agenda – M2

Opening of meeting (5 minutes)

Welcome

Meeting objective 1 (35 minutes)

1.1 Update on data collection and field work

→ Agenda item 1.1 Data collection for NPGH in Norway.pdf

1.2 Presentation of a draft model mapping the action situations for the Norwegian White Paper

→Draft model of Norwegian NPGH action situations_V1.pdf

Expected outcomes:
- CAG members will comment on the model and its representation of action situations
- PhD student will reflect on emergent ideas about integration of the model with its other elements (rules, context, mechanisms)

Meeting objective 2 (30 minutes)
2.1 Presentation of a proposal for the second wave of Norwegian key country informants
→ Agenda item 2.1 Actors analysis for wave 2.pdf

Expected outcomes:
- CAG members will make recommendations for prioritizing the list of names of actors for recruitment in 2nd wave

Wrap-up and conclusion to meeting (10 minutes)
Additional comments, questions, discussion
Practical issues and next steps
- Revised CAG workplan
- Evaluation of CAG meetings
- Next CAG meeting

Closing remarks
Thank you!

- - - - -

3rd meeting of CAG Norway (CAG Norway M3)
- May 4, 2017: 9h30 (Québec, Canada) / 15h30 (Norway/France)
- Meeting to be held via Google Hangouts video chat
- Participants:
Catherine Jones, PhD student, CAG convenor
Dr. Carole Clavier (C. Jones' Co-Supervisor, CAG member)
Dr. Kristin I. Sandberg (CAG member from Norway)

The general objective of the third meeting of the CAG Norway is:
1. to consult with the Norwegian CAG Members on the draft of a monograph presenting the results of analyses of the Norwegian case in C. Jones' thesis.

Agenda – M3

Introduction to meeting (5 minutes)
Welcome
Background

Meeting objective 1: Consultation on Swiss case monograph (60 minutes)

→ Five documents were sent by email on April 11, 2017[1]:
2017.04.10_Norwegian NPGH case monograph.docx
Table 1.docx – Rules for the six action situations
Table 2.docx – Rules for the NPGH arena
Figure 1 – Context map
Figure 2 – Norwegian NPGH action arena

Questions for Norwegian CAG members
1) What are your general impressions of the analysis of the case? Do you have any specific critiques?
2) Given your expert knowledge about the case, do the analytical categories of this model allow you to recognise the case? Can you identify the places where it does not?
3) Are there any significant omissions?

Expected outcomes: C. Jones will
- draw on CAG discussion to assess validity, credibility and limitations of analyses of the case
- reflect on CAG critique within strategy for monograph's revision as a results chapter in thesis

Wrap-up and conclusion to meeting (5 minutes)
Questions or ideas emerging from meeting
Practical issues and next steps
Closing remarks
Thank you!

[1] *Note regarding file sharing with CAG:* The documents prepared for the Norwegian CAG are the property of the PhD student and should neither be used for purposes other than the CAG members' participation in this research project nor circulated outside of this group without her consent.

Appendix E. Data collection and coding grids

Grid 1: Policy design of NPGH

Policy design elements	Sub-categories
1. Goals	1.1 Objectives 1.2 Problems
2. Targets	2.1 Proximate 2.2 Intermediate 2.3 Remote
3. Implementation structures	
4. Instruments	4.1 Legislative – regulatory 4.2 Economic – fiscal 4.3 Agreement – incentive-based 4.4 Information – communication-based 4.5 Standards – best practices
5. Implementation rules	5.1 Eligibility rules 5.2 Timing rules 5.3 Boundary/participation rules 5.4 Decision rules
6. Arguments	6.1 Rationales 6.2 Assumptions 6.3 Knowledge and evidence 6.4 Ideas

Grid 2: Action arena

Three constitutive elements of a NPGH action arena:

2.1) Action situations (boxes in the NPGH action arena model)

Action area element: 2.1 Action situations	**Sub-categories**
1. Actors	2. Positions for actors
3. Action	
4. Results	
5. Processes	
6. Materials	Ideas (policy-programmatic) Values Beliefs Knowledge & information Normative frameworks
7. Power	7.1 Relational power 7.2 Dispositional power

2.2) Actors (circles inside the boxes in the NPGH action arena model)

Action area element: 2.2 Actors	**Sub-categories**
1. Spheres	1.1 State 1.2 Private 1.3 Market 1.4 Civil society 1.5 Knowledge - technical
2. Resources	2.1 Positional 2.2 Material 2.3 Knowledge 2.4 Political 2.5 Social 2.6 Temporal

2.3) Rules-in-use structuring action situations (the procedures that structure the operations and limits of action situations)

Action area element: 2.3 Rules	**Sub-categories**	**Action situation elements**
1. Boundary rules	1.1 Access rules 1.2 Flow rules	1. Actors 6. Materials
2. Position rules		2. Positions
3. Interaction rules	3.1 Decision-making rules 3.2 Power rules	5. Processes 7. Power

Grid 3: National policy context

Policy context elements	Sub-categories
1. Contexts	1.1 Socio-demographic 1.2 Scientific & technical 1.3 State 1.4 Economic 1.5 Political 1.6 International / global

Grid 4: Mechanisms of policy change

Mechanisms of policy change between Global governance to the NPGH action arena

Mechanisms of policy change		**Internal** (NPGH)	**External** (GHG)
Policy learning - *knowledge creation*: actors' production of usable knowledge for public policy - *knowledge circulation*: actors managing the flow of knowledge in & out of action situations and how it is shared with actors within the situations - *learning process*: how information is processed and how learning takes place (individually / collectively) - *knowledge institutionalisation*: actors' translation of knowledge for public policy	Sources of knowledge ?	Internal policy learning	External policy learning
Conflict expansion - *policy image(s):* actors' representations of the policy issue - *policy principles*: assumptions, values, beliefs, ideas actors associate with images - *policy venues:* institutions for policy decision making at the collective choice level	Sources of conflict ?	Internal conflict expansion	External conflict expansion

Appendix F. Sources for documentary data collection on contexts

1. Governmental and international organisation websites

Source	Data on	Related context variables
Websites of the Norwegian and Swiss governments	Government procedures and processes, organisation of the public administration, Ministerial structures and subordinate agencies, past Governments, reviews of multilateral partners, documentation on policy, budget allocation	State, political, international
Websites of the Norwegian and Swiss Parliaments	Parliamentary procedures, elections, standing committees, organisation, links to political parties, documentation on policy and oversight	State, political
Statistics Norway Statistics Switzerland	Population data and other statistics by category and year	Socio-demographic, scientific & technical, political, economic, international
Organisation for Economic Cooperation and Development	- Statistical profiles of case counties - Development policy peer review reports - Health policy reports	Economic, international
World Health Organization	- Global Health Observatory - Foreign Policy and Global Health Initiative - Country profiles - WHO Board - World Health Assembly & resolutions	Scientific & technical, international

2. Political science research databases

Source	Data on	Related context variables
PARLINE	Parliament, election archives, special bodies	Political
Facts on International Relations and Security Trends	Country's membership in international organisations related to peace, security, human rights	International
EUROPA World Plus	Country profiles, contemporary political history, analysis of domestic and political affairs	State, political, international
Worldwide Governance Indicators	Good governance profiles Country data reports	State, political
European Election Database	Election and party data	Political
EUROSTAT	European statistics	Socio-demographic, economic, international

3. Scientific and grey literature

Selection criteria: The article is available in English or French. The article provides an analysis of at least one of the six context elements relevant to NPGH.

Source	Search strategy	Results
Web of Science	Topic: ((global or international) and health) AND Topic: (policy) AND Topic: (Norway or Norwegian) Refined by: Document types: (article or review) Timespan: All years.	Selected 6 articles from 72 results.
	TOPIC: ('global health') AND TOPIC: (policy) AND TOPIC: (Switzerland or Swiss) Refined by: DOCUMENT TYPES: (ARTICLE OR REVIEW) Timespan: All years.	Selected 5 articles from 28 results - as relevant for the policy context, in particular the international and scientific/technical context
	TOPIC: ('global health') AND TOPIC: (strategy) AND TOPIC: (Switzerland or Swiss) Refined by: DOCUMENT TYPES: (ARTICLE OR REVIEW) Timespan: All years.	24 results - no additional relevant references found.
Pubmed	((Norway[Title/Abstract]) OR Norwegian[Title/Abstract]) AND "global health"	Selected 2 articles from 40 results.

	((Switzerland[Title/Abstract]) OR Swiss[Title/Abstract]) AND "global health"	Selected 1 article from 26 results - as relevant for the policy context, in terms of decisions about health care.
Medline (Ovid)	((Norway or Norwegian) and (global health or international development) and policy) No articles selected from 21 results.	No articles selected from 21 results.
	((Switzerland or Swiss) and (global or international) and (health or development) and policy) 1990-2014	Selected 7 articles from 128 results – including articles in French.
	((Switzerland or Swiss) and (health or development) and (global or international) and (strategy or policy)) 1990-2014	Selected 1 article from 160 results - as relevant for the policy context, regarding research partnerships in a global context
IPSA (EBSCO)	Full text ((Norway or Norwegian) and (global or international) and (health or development) and policy)	Selected 4 articles from 42 results.
	((Switzerland or Swiss) and (global or international) and (health or development) and (strategy or policy))	Selected 4 articles from 10 results.
PAIS international (ProQuest)	(Norway OR Norwegian) AND (global OR international) AND health AND policy LIMITED to peer review.	Selected 6 articles from 164 results.
	ab((Norway OR Norwegian)) AND ab((global OR international)) AND ab((health OR development)) AND policy.	Selected 1 article from 32 results.
	(switzerland OR swiss) AND (global health OR international health) AND (policy OR strategy) LIMITED to: peer reviewed, 1990 to 2015, in English or French. Document type: Article, Book, Editorial, Government & Official Document, Review in books or Scholarly Journals	Selected 8 articles from 495 results.

Source	Search strategy	Results
FRANCIS (base de données en français)	AB Suisse AND AB santé AND AB politique	Selected 1 article from 21 results.
Worldwide Political Science Abstracts	(switzerland OR swiss) AND (global health OR international health) AND (policy OR strategy) LIMITED to: peer reviewed, 1990 to 2015 from Books, Reports, Scholarly Journals in English or French	Selected 6 articles from 35 results.
Journal of Scandinavian Political Studies	Searched : Norway or Norwegian in Abstract. (1999-Present).	Selected 7 articles from 505 results.
Scandinavian Journal of Public Health	Searched : Norway or Norwegian in Abstract and policy in Full Text (Mar 1999-Feb 2015).	Selected 5 articles from 77 results.
Swiss Political Science Review	Global health	Selected 7 articles from 43 results.
Swiss Political Science Review	policy process federal	Selected 8 articles from 172 results.

Appendix G. Recruitment template cover messages

Wave 1 standard template recruitment cover message for Norwegian sample

Dear (name),

Hello. My name is Catherine Jones, and I am a PhD student at the School of Public Health at the University of Montreal working under the supervision of Dr. Louise Potvin (School of Public Health, University of Montreal) and Dr. Carole Clavier (Department of Political Science, University of Québec in Montreal). The general objective of my doctoral research project is to explore mechanisms through which national policy processes for developing national policy on global health are interconnected with global processes.

I am contacting you today to invite you to participate in a research project as a key country informant for the Norwegian case of my study. You are invited to participate in this capacity because during the first two phases of the project, you were identified as being an actor involved in the policy process of developing the Norwegian White Paper on Global Health and Foreign Policy during the timeframe between 2006 and 2012.

In the first phase, I collected data on the policy context for developing global health policy in Norway and the policy design of the White Paper project for the purpose of modelling the policy process for developing national policy on global health in Norway. In the second phase, I convened a meeting of the Context Advisory Group [1] for the Norwegian case to seek feedback on preliminary analyses and to discuss the events and actors involved in the process.

I will be in Oslo for 10 days to conduct interviews with key informants in November. Please let me know, if you are willing to participate, your preference for dates between Wednesday, November 5th and Friday, November 14th. Also please indicate whether you have a preference for the morning, afternoon or evening so that I can schedule a time and date that is most convenient for you. The interview is estimated to last between 60-90 minutes.

I would appreciate hearing back from you soon, and if possible before (*date*).

An information and consent form is attached in which you will find further details about the project and ethical issues related to your participation. I am available to answer any questions you may have regarding this invitation. Please feel free to contact me by email, telephone or Skype.

With regards,
Catherine M. Jones
Email: [redacted]
Cell : [redacted]
Skype: [redacted]

[1] Members of the Context Advisory Group for Norway:
Dr. Kristin Ingstad Sandberg Associate Researcher, Fridtjof Nansen Institute (Oslo)
Dr. Carole Clavier Assistant Professor, Department of Political Science, l'Université du Québec à Montréal
Catherine M. Jones PhD candidate, School of Public Health, l'Université de Montréal

Wave 2 standard template recruitment cover message for Norwegian sample

Dear (name),

Hello. My name is Catherine Jones, and I am a PhD student at the School of Public Health at the University of Montreal working under the supervision of Dr. Louise Potvin (School of Public Health, University of Montreal) and Dr. Carole Clavier (Department of Political Science, University of Québec in Montreal). The general objective of my doctoral research project is to explore mechanisms through which national processes for developing global health policy are interconnected with global processes.

I am contacting you today to invite you to participate in a research project as a key country informant for the Norwegian case of my study. During the first round of interviews in November 2014 in Oslo, multiple informants mentioned you as being an critical actor with whom I should speak about your involvement in consolidating the work of the writing group for the White Paper as the person who was responsible for producing the final policy paper. I know that your involvement was between September 2011 and the spring of 2012, and I am very interested to discuss your role and experience as an actor in this process at this important stage.

I am based in Paris. I will be conducting interviews in Switzerland later this month. If you will be in **Geneva** for the World Health Assembly, and this would be a convenient moment to set up a meeting, please let me know, if you are willing to participate, your preference for dates ***between Monday, May 18 and Thursday, May 28.*** Alternatively, if you prefer a meeting in **Oslo**, kindly inform me of your availability ***between Monday June 1st and Monday June 15th.*** In all cases, please indicate whether you have a time preference. The interview will take no more than one hour.

An information and consent form is attached in which you will find further details about the project and ethical issues related to your participation. In the first phase, I collected data on the policy context for developing global health policy in Norway and the policy design of the White Paper project for the purpose of modelling the policy process for developing national policy on global health in Norway. In the second phase, I convened a meeting of the Context Advisory Group[1] for the Norwegian case to seek feedback on preliminary analyses and to discuss the events and actors involved in the process. In the third phase, I conducted a first round of key informant interviews, which resulted in a snowball sample for a second round of key informant interviews.

I am available to answer any questions you may have regarding this invitation. Please feel free to contact me by email, telephone or Skype.

With regards,
Catherine M. Jones
Email: [redacted]
Cell phone: [redacted]
Skype: [redacted]

[1] Members of the Context Advisory Group for Norway:
Dr. Kristin Ingstad Sandberg Associate Researcher, Fridtjof Nansen Institute (Oslo)
Dr. Carole Clavier Assistant Professor, Department of Political Science, l'Université du Québec à Montréal
Catherine M. Jones PhD candidate, School of Public Health, l'Université de Montréal

Standard template recruitment cover message for Swiss sample
(This was adapted on continued basis due to rolling recruitment for this case.)

Dear (name),

Hello. My name is Catherine Jones, and I am a PhD student at the School of Public Health at the University of Montreal working under the supervision of Dr. Louise Potvin (School of Public Health, University of Montreal) and Dr. Carole Clavier (Department of Political Science, University of Québec in Montreal). The general objective of my doctoral research project is to explore mechanisms through which national policy processes for developing national policy on global health are interconnected with global processes.

I am contacting you today to invite you to participate in a research project as a key country informant for the Swiss case of my study. You are invited to participate in this capacity because during the first two phases of the project, you were identified as being an actor involved in the policy process of developing the Swiss Health Foreign Policy. I am particularly interested in the time period between 2006 and 2012, and I am very keen to discuss your involvement as an actor in this process with you.

In the first phase, I collected data on the policy context for developing global health policy in Switzerland and the policy design of the Swiss Health Foreign Policy for the purpose of modelling the policy process for developing national policy on global health in Switzerland. In the second phase, I convened a meeting of the Context Advisory Group [1] for the Swiss case to seek feedback on preliminary analyses and to discuss the events and actors involved in the process.

I will be available to conduct interviews with key informants in Switzerland throughout the month of (*month*) 2015. Please let me know, if you are willing to participate, your preference for dates between (*date*) and (*date*). Also please indicate whether you have a preference for the morning, afternoon or evening so that I can schedule a time and date that is most convenient for you. The interview is estimated to last a maximum of 90 minutes.

An information and consent form is attached in which you will find further details about the project and ethical issues related to your participation. I am available to answer any questions you may have regarding this invitation. Please feel free to contact me by email, telephone or Skype.

With regards,
Catherine M. Jones
Email: [redacted]
Cell phone: [redacted]
Skype: [redacted]

[1] Members of the Context Advisory Group for Switzerland:
Dr. Ilona Kickbusch Director of the Global Health Programme, Graduate Institute of International and Development Studies (Geneva)
Dr. Carole Clavier Assistant Professor, Department of Political Science, l'Université du Québec à Montréal
Catherine M. Jones PhD candidate, School of Public Health, l'Université de Montréal

Appendix H. Information and consent form for recruiting informants in Norway and Switzerland

Information and Consent Form
(for Norwegian participants)

General information

Title of the study
Exploring the interdependence between the development of national policy on global health and global health governance: a retrospective multiple case study
Name of the doctoral student
Catherine M. Jones, PhD candidate in public health, School of Public Health, Université de Montréal
Names of the student's supervisors
1) Louise Potvin, Canada Research Chair Community Approaches and Health Inequalities and Professor, School of Public Health, Université de Montréal
2) Carole Clavier, Assistant Professor, Department of Political Science, Université du Québec à Montréal
Sources of funding
This research project is not funded. Funding from the Canadian Institutes of Health Research (CIHR) through a Vanier Canada Graduate Scholarship supports the doctoral student (grant number: CGV 127503).

Description of the research project

Public policy making at the national level can be a process that involves actors from a variety of institutions in multiple sectors of government working together. National policies on global health (NPGH) are strategies developed at the country level for coordinating a state's action on global health across government ministries. It seems that public policy processes within countries are not independent of global governance processes when it comes to steering policy on issues of global scope. The general objective of this study is to explore mechanisms through which national policy processes for developing NPGH are interconnected with global processes.

Data collection methods include literature review, analysis of official policy documents and interviews with key informants. The formal adoption of NPGH in Norway and Switzerland in 2012 serves as the end point for the retrospective analyses of the two cases. A Context Advisory Group (CAG), composed of researchers from the case country, participates in the identification of country key informants involved in the policy development process and informing analyses for the case reports in their respective countries. Within each case, I will focus on the policy process for developing of NPGH. Classification of situations in which actors from various sectors

participated in the policy development process is the starting point to model action arenas according to perspectives of country key informants obtained from semi-structured interviews.

You are invited to participate in this research project as a country key informant for Norway. We plan to interview about 15 country key informants for each case who participated in activities related to the development of NPGH in their country. We expect that having two cases will provide the opportunity to illuminate a more diverse set of observations on the different aspects related to the flow of ideas, information and learning within the national levels of policy-making. We suggest that this is important because it is one example of exploring how governance processes at the global level and policy-making processes at the national level may be reshaping each other in matters related to collective action on health.

Type, duration and conditions of participation

As a country key informant, you will be asked to participate in one semi-structured interview with the doctoral student researcher between October 2014 and July 2015. The interview is estimated to last between 60-90 minutes. The interview will be conducted either in person on your professional premises or via a web-based video-conferencing service, and it will be recorded with an audio recording device with your consent. During the interview, we will also use a large notepad to map out the key activities in which you were involved, list other actors with whom you collaborated, and to visualise the relationships between relevant events, institutions and documents. The interview will be scheduled at the most convenient time possible for you and the doctoral student researcher, and you will receive the information and consent form in advance of the meeting. After the interview takes place, you may be contacted by email with a request to clarify a response to a question. You will receive a summary of the interview (maximum of 2 pages) with the opportunity to identify any elements that you do not wish to appear in the full transcript. You will be invited to make modifications for clarification should you wish to rephrase any responses, but you are not obliged to do so.

Risks and disadvantages

The time you will spend participating in this study is the principal drawback.

Advantages and benefits

Your participation in this study may allow you to the opportunity to reflect on the policy process of developing NPGH in your country and to consider how actors from various institutions in your country interacted in that process. Your participation will contribute to developing knowledge about these processes for policy and decision-makers in other countries who are interested in global health by highlighting ways in which links between national and global levels are negotiated through intersectoral policy processes.

Compensation

You will not be compensated for your participation in this study as a country key informant.

Dissemination of results

You will receive a case report on the development of NPGH in your country before the end of 2015 by email. A series of articles for submission to scientific journals are planned for publishing the results of this study.

Protection of confidentiality

The information you share will be used only for the purposes of this study. A neutral code will be assigned to you to protect your confidentiality, and this identifier will be assigned to all data gathered under your country key informant information. It will be used in any reference to data collected, in analyses and in the dissemination of results when direct quotes are used. No personal identification information will be used to protect your anonymity (neither your name nor your job titles will be cited). You are requested to note that even with these provisions, it is possible that your identity may be inferred by some readers who are intimately familiar with your country's case.

All electronic files (recordings and transcripts) will be kept in a password-protected computer and backed up on password-protected external hard drive. Printed transcripts, paper copies of drawings mapping out activities and actors with informants, notes from interviews and consent forms will be kept in a locked cabinet accessible only to the researcher and her supervisors. Data collected will be conserved for up to seven years after the end of the project, after which time it will be destroyed.

Right to withdrawal

If you choose to participate you have the right to withdrawal from the study at any time, without any obligation to provide a reason for doing so. If you choose to withdraw from the study or you would like to refuse to answer any questions, please notify the doctoral student. You may indicate your choice to withdraw or refusal to answer any questions either verbally or in writing.
If you choose to withdraw, all data collected through your participation up until such time will be stored, used for analyses and destroyed in the same manner as all other data for the study, unless you specifically request for it to be destroyed. It is impossible to take out the analyses conducted on your data once these have been submitted for publication or disseminated.

Responsibility of the research team

By accepting to participate in this study, you do not waive any of your rights nor do you release the researchers, the universities, the partners or the funders of their civil and professional responsibilities.

Key contacts

If you have any questions regarding the scientific aspects of the research project, you may contact Professor Louise Potvin, School of Public Health, Université de Montréal by email at [redacted] or by phone at [redacted].
If you would like to withdraw from the study, you may contact Catherine M. Jones, PhD candidate, School of Public Health, Université de Montréal by email at

[redacted] or Professor Louise Potvin, School of Public Health, Université de Montréal by email at [redacted] or by phone at [redacted].

For any information related to ethics concerning the conditions under which your participation in the project is taking place, you may contact the coordinator of the Health Research Ethics Committee (CERES) by email at ceres@umontreal.ca or by telephone [redacted].

For further information on your rights as a participant, you are invited to consult the section for research participants on the Université de Montréal's website at: http://recherche.umontreal.ca/participants.

All complaints related to your participation in this research project may be addressed to the ombudsman of the Université de Montréal, either by email ombudsman@umontreal.ca or by telephone at [redacted] between the hours of 9h00 and 17h00 (Eastern Standard Time). The complaints investigator accepts collect calls. He speaks English and French.

Consent

Your participation in this study is voluntary. You are free to accept or to refuse to participate without any negative consequences. Should the interview take place via telephone or web-based conferencing, your confirmation of consent via email is acceptable.

First and last name of participant (in print)	Signature of participant
	Date :

Information and Consent Form
(for Swiss participants)

General information

Title of the study
Exploring the interdependence between the development of national policy on global health and global health governance: a retrospective multiple case study
Name of the doctoral student
Catherine M. Jones, PhD candidate in public health, School of Public Health, Université de Montréal
Names of the student's supervisors
1) Louise Potvin, Canada Research Chair Community Approaches and Health Inequalities and Professor, School of Public Health, Université de Montréal
2) Carole Clavier, Assistant Professor, Department of Political Science, Université du Québec à Montréal
Sources of funding
This research project is not funded. Funding from the Canadian Institutes of Health Research (CIHR) through a Vanier Canada Graduate Scholarship supports the doctoral student (grant number: CGV 127503).

Description of the research project

Public policy making at the national level can be a process that involves actors from a variety of institutions in multiple sectors of government working together. National policies on global health (NPGH) are strategies developed at the country level for coordinating a state's action on global health across government ministries. It seems that public policy processes within countries are not independent of global governance processes when it comes to steering policy on issues of global scope. The general objective of this study is to explore mechanisms through which national policy processes for developing NPGH are interconnected with global processes.

Data collection methods include literature review, analysis of official policy documents and interviews with key informants. The formal adoption of NPGH in Norway and Switzerland in 2012 serves as the end point for the retrospective analyses of the two cases. A Context Advisory Group (CAG), composed of researchers from the case country, participates in the identification of country key informants involved in the policy development process and informing analyses for the case reports in their respective countries. Within each case, I will focus on the policy process for developing of NPGH. Classification of situations in which actors from various sectors participated in the policy development process is the starting point to model action arenas according to perspectives of country key informants obtained from semi-structured interviews.

You are invited to participate in this research project as a country key informant for Switzerland. We plan to interview about 15 country key informants for each case who participated in activities related to the development of NPGH in their country. We expect that having two cases will provide the opportunity to illuminate a more diverse set of observations on

the different aspects related to the flow of ideas, information and learning within the national levels of policy-making. We suggest that this is important because it is one example of exploring how governance processes at the global level and policy-making processes at the national level may be reshaping each other in matters related to collective action on health.

Type, duration and conditions of participation

As a country key informant, you will be asked to participate in one semi-structured interview with the doctoral student researcher between March and October 2015. The interview is estimated to last between 60-90 minutes. The interview will be conducted either in person on your professional premises or via a web-based video-conferencing service, and it will be recorded with an audio recording device with your consent. During the interview, we will also use a large notepad to map out the key activities in which you were involved, list other actors with whom you collaborated, and to visualise the relationships between relevant events, institutions and documents. The interview will be scheduled at the most convenient time possible for you and the doctoral student researcher, and you will receive the information and consent form in advance of the meeting. After the interview takes place, you may be contacted by email with a request to clarify a response to a question. You will receive a full transcript of the interview, and you will be invited to make modifications for clarification should you wish to rephrase any responses, but you are not obliged to do so.

Risks and disadvantages

The time you will spend participating in this study is the principal drawback.

Advantages and benefits

Your participation in this study may allow you to the opportunity to reflect on the policy process of developing NPGH in your country and to consider how actors from various institutions in your country interacted in that process. Your participation will contribute to developing knowledge about these processes for policy and decision-makers in other countries who are interested in global health by highlighting ways in which links between national and global levels are negotiated through intersectoral policy processes.

Compensation

You will not be compensated for your participation in this study as a country key informant.

Dissemination of results

You will receive a case report on the development of NPGH in your country before the end of 2015 by email. A series of articles for submission to scientific journals are planned for publishing the results of this study.

Protection of confidentiality

The information you share will be used only for the purposes of this study. A neutral code will be assigned to you to protect your confidentiality, and this identifier will be assigned to all data gathered under your country key informant information. It will be used in any reference to data collected, in analyses and in the dissemination of results when direct quotes are used. No personal

identification information will be used to protect your anonymity (neither your name nor your job titles will be cited). You are requested to note that even with these provisions, it is possible that your identity may be inferred by some readers who are intimately familiar with your country's case.

All electronic files (recordings and transcripts) will be kept in a password-protected computer and backed up on password-protected external hard drive. Printed transcripts, paper copies of drawings mapping out activities and actors with informants, notes from interviews and consent forms will be kept in a locked cabinet accessible only to the researcher and her supervisors. Data collected will be conserved for up to seven years after the end of the project, after which time it will be destroyed.

Right to withdrawal

If you choose to participate you have the right to withdrawal from the study at any time, without any obligation to provide a reason for doing so. If you choose to withdraw from the study or you would like to refuse to answer any questions, please notify the doctoral student. You may indicate your choice to withdraw or refusal to answer any questions either verbally or in writing.
If you choose to withdraw, all data collected through your participation up until such time will be stored, used for analyses and destroyed in the same manner as all other data for the study, unless you specifically request for it to be destroyed. It is impossible to take out the analyses conducted on your data once these have been submitted for publication or disseminated.

Responsibility of the research team

By accepting to participate in this study, you do not waive any of your rights nor do you release the researchers, the universities, the partners or the funders of their civil and professional responsibilities.

Key contacts

If you have any questions regarding the scientific aspects of the research project, you may contact Professor Louise Potvin, School of Public Health, Université de Montréal by email at [redacted] or by phone at [redacted].
If you would like to withdraw from the study, you may contact Catherine M. Jones, PhD candidate, School of Public Health, Université de Montréal by email at [redacted] or Professor Louise Potvin, School of Public Health, Université de ontréal by email at [redacted] or by phone at [redacted].

For any information related to ethics concerning the conditions under which your participation in the project is taking place, you may contact the coordinator of the Health Research Ethics Committee (CERES) by email at ceres@umontreal.ca or by telephone at [redacted].

For further information on your rights as a participant, you are invited to consult the section for research participants on the Université de Montréal's website at:
http://recherche.umontreal.ca/participants.

All complaints related to your participation in this research project may be addressed to the ombudsman of the Université de Montréal, either by email ombudsman@umontreal.ca or by telephone at [redacted] between the hours of 9h00 and 17h00 (Eastern Standard Time). The complaints investigator accepts collect calls. He speaks English and French.

Consent

Your participation in this study is voluntary. You are free to accept or to refuse to participate without any negative consequences. Should the interview take place via telephone or web-based conferencing, your confirmation of consent via email is acceptable.

First and last name of participant (in print)	Signature of participant
	Date :

Appendix I. Template reminder letters in informant follow-up packages

Reminder kit message for Norwegian informants

Hello (*informant's name*),
I am pleased to send this reminder of our meeting tomorrow (date) for (time) at (address). I would like to thank you in advance for taking time to meet with me to discuss your participation in the development of the Norwegian White Paper on Global Health and Foreign Policy. Please feel free to call or text me if there are any changes or scheduling conflicts that arise. Here is my mobile telephone number: [redacted]

Please find attached the information and consent form (which was also attached to the original invitation you received). We will have an opportunity to go over this tomorrow; I can respond to any questions you might have. Before we begin the interview, I will kindly ask that you read and sign the consent form. I will bring two copies of the form, so that we can each keep a signed copy.

As mentioned in the attached project description, in the coming months, I will interview actors from the countries of Norway and Switzerland who participated in the development of a formally adopted national policy on global health in their respective countries. Tomorrow, I will ask you about your involvement in that process in Norway between 2006 and the adoption of the Norwegian White Paper on Global Health by the *Stortinget* on May 29, 2012.

Our discussion should last approximately 60-90 minutes maximum. I will be recording our interview with an audio recording device, and I will also be taking some hand written notes. As we discuss your participation in activities and your collaborations with others in these processes (see section 2 below), I will ask you to map this out with me on a large sketch pad, to better get a sense of the various events and connections between them.

Please find below the main headings for topics under which I will be asking you questions:
1) Your professional situation between 2006-2012 - What was your job during this period? How did you become involved in the development of the White Paper? What were the most important activities that you participated in for the development of the policy?
2) **Policy and decision-making processes for developing the White Paper -** I would like to hear about each one of the activities you consider to be most significant in more detail. We can go through them more in-depth one by one – mapping them in terms of what was their purpose, who was involved, how the activity was organised, and what material and information were used.
3) Mechanisms of policy change - Furthering our discussion of activities, I would like to hear about what you think influenced the policy process in the development of the White Paper from within Norway and from outside of Norway. I am also interested in your own appraisal of the White Paper, by this I mean your assessment of what the policy is about, what it does, and where it sits in the landscape of the national policy environment in Norway.

With regard to all of the activities we will discuss, if you have any written documentation about them or products that emerged from them (e.g. records, minutes, notes, interim reports, draft products), I would be very interested to collect any that you are willing and able to share with me.

With kind regards,
Catherine Jones

Reminder kit message for Swiss informants

Hello (*informant's name*),

I am pleased to send this reminder of our meeting tomorrow (date) for (time) at (address). I would like to thank you in advance for taking time to meet with me to discuss your participation in the development of the Swiss Health Foreign Policy. Please feel free to call or text me if there are any changes or scheduling conflicts that arise. Here is my mobile telephone number: [redacted]

Please find attached the information and consent form (which was also attached to the original invitation you received). We will have an opportunity to go over this tomorrow if need be, and I can respond to any questions you might have. Before we begin the interview, I will kindly ask that you read and sign the consent form. I will bring two copies of the form, so that we can each keep a signed copy.
As mentioned in the attached project description, I am interviewing actors from the countries of Norway and Switzerland who participated in the development of a formally adopted national policy on global health in their respective countries. Tomorrow, I will ask you about your involvement in that process in Switzerland between 2006 and the adoption of the Swiss Health Foreign Policy by the Federal Council on March 9, 2012.

Our discussion should last approximately 60-90 minutes maximum. I will be recording our interview with an audio recording device, and I will also be taking some hand written notes. As we discuss your participation in activities and your collaborations with others in these processes (see section 2 below), I will ask you to map this out with me on a large sketch pad, to better get a sense of the various events and connections between them.

Please find below the main headings for topics under which I will be asking you questions:
1) Your professional situation between 2006-2012 - What was your job during this period? How did you become involved in the development of the SHFP? What were the most important activities that you participated in for the development of the policy?
2) **Policy and decision-making processes for developing the SHFP -** I would like to hear about each one of the activities you consider to be most significant in more detail. We can go through them more in-depth one by one – mapping them in terms of what was their purpose, who was involved, how the activity was organised, and what material and information were used.
3) Mechanisms of policy change - Furthering our discussion of activities, I would like to hear about what you think influenced the policy process in the development of the SHFP from within Switzerland and from outside of Switzerland. I am also interested in your own appraisal of the SHFP, by this I mean your assessment of what the policy is about, what it does, and where it sits in the landscape of the national policy environment in Switzerland.

With regard to all of the activities we will discuss, if you have any written documentation about them or products that emerged from them (e.g. records, agendas, minutes, notes, interim reports, draft products), I would be very interested to collect any that you are willing and able to share with me as archives of the policy process.

With kind regards,
Catherine Jones

Appendix J. Interview guide

This version of the interview guide is the most recent version used for the project, which included the question about visual method tool. It is non-specific to cases.

Interview information (filled out by doctoral researcher for audit trail with pictures of the exteriors of interview locations recorded in *DayOne* journal) Date: Start Time: Finish Time: Location: Setting/environment: Informant information (to be filled out by me, based on information available from business card and confirmed by informant) Informant code assigned: Position: Office/Department: Institution: Sector:

The interview has four main themes noted below in **bold**. The first is the presentation of the informant, the institution with which they were affiliated during the period 2006-2012, and the way through which they were involved in the policy process. The second is related to the three core elements (activities, actors and rules) of action arenas according to my theoretical framework, this theme will be the central theme for integrating the informant in the modelling exercise. The third relates to mechanisms of policy change. The fourth relates to the identification of boundary relationships (interactions with actors from other action situations) and the snowball sampling of other potential informants. Lastly, I close with a question about the visual method.

1. Presentation and situation of the informant (2006-2012)
2. Policy and decision-making processes for developing NPGH
    2.1 Activities (action situations), Resources (actors) and Rules
    2.2 Informant's appraisal of NPGH
3. Mechanisms of policy change
    3.1 Internal (within the country)
    3.2 External (outside of the country)
4. Boundary relationships, snowball sampling, and question about visual method

The table below presents a grid to orient the interview. The **main themes are in bold**. The first column from the left presents questions to open the discussion. The middle column contains more specific questions as probes. The last column on the right presents probes and examples to be used. I will navigate the interview using this grid as a guide.

1. Presentation and professional situation of the informant (2006-2012)		
1.1 What was your job during the period from 2006 – 2012, up to [*insert the date of the adoption of NPGH in your country*])?	Are you working in the same institution as you did during the period between 2006 and 2012? If not, what other positions did you hold (and in which institutions) over the course of those six years?	
1.2 How did you become involved in the development of NPGH in your country?	What did you do? What kinds of activities were you involved in during that time related to NPGH development in your country? What were your responsibilities in this process?	By *activities*, I am referring to events such as seminars, conferences, commissions, meetings, committees, policy dialogues or any other situations or venues wherein activities took place in your country related to development of NPGH. These may be public or private gatherings.
1.3 What were the most important activities that you participated in for the development of the policy?	Could you please list them specifically?	By *most important activities*, I am referring to those gatherings that you might qualify as ***critical moments in the process*** of the NPGH's development. I am interested in those activities that had agendas specifically related to contributing to the policy and/or which generated products that you consider to have been particularly significant for the outcome of the policy development process. These contributions to the outcome of the policy process may be in terms of the final design of the policy, or the materials needed to make decisions about policy objectives or instruments, or the understanding of the way to approach developing the policy.

2. Policy and decision-making processes for developing NPGH		
I would like to hear about each one of the activities you consider to be most significant in more detail. Could we go through them more in-depth one by one?	May I suggest that we take them one at a time and map them out together in terms of what was their purpose, who was involved, how the activity was organised, and what materials were used.	*As a tool for doing this, a large artist's sketch pad and coloured pens are proposed to conduct this exercise with the informant.* REPEAT the following for mapping <u>each activity</u> listed by informant.
2.1 For each of the most significant activities in detail (min 1, max 3) (SITUATIONS + ACTORS) (RULES)	What was your role in that activity? Who else participated/was involved in this activity? What institutions did they come from? [Relaunch if needed: Were there participants from different sectors of public action?] What were the criteria for being invited to participate? Who provided leadership for this activity (ie Chairing meetings)? Who organised, managed, or coordinated this activity (ie secretariat)? Who was responsible for communication and follow-up (ie rapporteurs, special portfolios)?	By *roles and responsibilities* I am referring to things such as Chair, committee members, secretariat, coordinator, convenors, rapporteurs, leadership positions, special portfolio mandates. What were the formal and/or informal rules or guidelines orienting the activity?
(PURPOSIVE NATURE of activity)	How did people work together in this activity? Did you work more closely with any particular actors? What was the output of this activity? Were the results of this activity used in the development of the policy? Were there any particular struggles or challenges that stand out in your recollection of the activity? How was conflict dealt with?	How did the collective process of working together happen? How did it go? What were the methods, technologies, strategies used by participants to realise and accomplish their actions? How did those involved deal with conflicts or in matters of differences regarding the policy objectives, content, or instruments?

2. Policy and decision-making processes for developing NPGH (contd.)		
(RESOURCES)	What kind of information, knowledge, ideas or other resources were mobilised and used for making decisions? How were these knowledge and information needs identified? What do you consider are the main resources that you contributed to this activity?	Where did they come from? Who were the main proponents? How was they used? What were the channels of communication? How was content communicated and shared amongst participants? By *resources*, I am referring to a broad spectrum of resources in terms of material (financial & human), social (networks & connections), political (coalitions, interest groups, bureaucrats) scientific/knowledge (information & strategic analyses), time.
(BOUNDARY, INTERACTON)	Was this activity linked to any others related to the development of NPGH? If yes, which ones? And how were they linked? How important/significant was this activity in relation to other activities you are aware of related to the development of NPGH?	Do you know of other significant activities for the development of NPGH which took place in which you did not participate? (I mean any key events that you were not involved in, but that to your knowledge were important to the process.)
3. Mechanisms of policy change		
Furthering our discussion of the activities of which you were aware and those in which you participated, I would like to hear about what you think influenced the policy process in the development of NPGH.	What do you consider "critical moments" in the process of developing NPGH?	What was most influential?
3.1 Internal mechanisms (within the country)	In particular, what do you think influenced the policy process for the development of NPGH from within your country? What were the major influences? Why? What did they contribute? How did this influence any changes in the policy?	What were the sources of influence from within your country? What kind of learning arose from this that you consider was important for the NPGH in your country? How was it translated for others (for example for the other activities mentioned above?)

3.2 External mechanisms (outside the country)	In particular, was anything introduced from outside of your country that influenced the policy process for developing NPGH in your country? If so, what was it? Where did it come from ? Who brought it to the attention of those involved? How was it used?	What were the sources of influence from outside your country? In your opinion, were actors from outside of your country involved with or linked to any activities related to developing NPGH in your country?
4. Appraisal & Snowballing		
Informant's appraisal of NPGH (CAN ALSO BEGIN interview with this question)	Finally, I would like to know what you think of your country's NPGH. - How do you define (or describe) your country's NPGH? - In your opinion, what should it do? What does it do well or not? - Do you consider it health policy, foreign policy or something else?	By appraisal, I am referring to your assessment of what the policy is about, what it does, and where it sits in the institutional landscape of the national policy environment.
	With regard to all of the activities we have discussed, do you have any written documentation about them or products that emerged from them that you can share with me?	Are there any records, minutes, notes or reports that you could share with me?
	Do you know of other significant activities for the development of NPGH which took place in which you did not participate?	(I mean any key events that you were not involved in, but that to your knowledge were important to the process.) Do you know with whom I could speak for more information about this? If so, can you provide me with their contact details?
Question about visual method: ***What did you think about this tool for our discussion on the activities and processes for developing national policy on global health in your country?***		

Conclusion to the interview: Thank you for taking this time to have a discussion with me about your experience in participating in these activities and your perspectives on the critical moments and major influences in the policy process of developing NPGH in your country.

Appendix K. Interview methods audit trail

These summary tables are submitted as an audit trail for data collected from interviews with key informants. They cover the list of audio, transcripts, sketch maps, and archives of the policy process from the data collection for each case study.

NORWAY

I collected data from two waves (W) of informant interviews between November 2014 and June 2015. The face-to-face (F) interviews were conducted in Oslo, and the rest by telephone (T). At their request, two of the informants NI4 and NI5 were interviewed together, and the interview with NI8 was conducted in two parts.

Norwegian key informant classification (actor sphere / policy sector)

Actors' societal spheres (policy sectors)	**Number of Norwegian key informants**
State actor (development)	3
State actor (health)	7
State actor (foreign affairs)	4
Civil society actor (health)	1
Knowledge actor (global health research)	4
	19

Overview of data collected during key informant interviews in Norwegian fieldwork

Wave	Informant ID	F /T	Audio (minutes)	Transcripts (.docx)	Sketch-pad map / drawing (.pdf)
1	NI 1	F	104 min	26 pgs	NI 1 map
1	NI 2	F	98 min	22 pgs	NI 2 map
1	NI 3	F	84 min	25 pgs	NI 3 map
1	NI 4	F	81 min	29 pgs	NI4&5 map
1	NI 5	F			
1	NI 6	F	98 min	22 pgs	NI 6 map
1	NI 7	F	93 min	24 pgs	NI 7 map
1	NI 8 - part1	F	32 min	26 pgs	NI 8 map
1	NI 8 - part2	F	61 min		
1	NI 9	F	53 min	14 pgs	no map
1	NI 10	F	97 min	19 pgs	NI 10 maps #1-4
2	NI 11	F	54 min	20 pgs	NI 11 map
2	NI 12	F	39 min	10 pgs	no map
2	NI 13	F	43 min	13 pgs	NI 13 map
2	NI 14	F	63 min	15 pgs	NI 14 map
2	NI 15	F	51 min	11 pgs	NI 15 map
2	NI 16	F	59 min	18 pgs	NI 16 map
2	NI17	F	71 min	19 pgs	NI 17 map
2	NI 18	T	45 min	10 pgs	no map
2	NI 19	T	52 min	11 pgs	no map
	TOTALS		**1278 min**	**334 pages**	**14 sketches**

Archives of the policy process (APP) for modelling action arena for Norwegian case

Code	Name of archive	APP date	APP author	Language	NAS links	Context links
APP 1	Chapter 12 from the 2012 budget proposal from the Ministry of Foreign Affairs (Report to the *Storting* on Policy coherence for Development 2011)	March 2012	Ministry of Foreign Affairs	English		State, Political & International
APP 2	Norwegian actors' engagement in global health	May 2013	Co-published by the Ministry of Health and Care Services and the Ministry of Foreign Affairs, Norwegian Agency for Development Cooperation	English	Follow-up process	Scientific & Technical, International
APP 3	Summary report and recommendations to the Storting (300 S (2011-2012)– the "opinon" from the Standing Committee on Foreign Affairs and Defense regarding the white paper on global health (Meld. St. 11 2011-2012)	May 16, 2012	FAC, Norwegian Parliament	Norwegian*	Foreign Affairs and Defense Committee Public Hearing	State, Political, Scientific & Technical
APP 4	Minutes from the parliamentary debate and discussion of the recommendation of the Foreign Affairs and and Defense committee on global health in foreign and development policy	May 29,2014	Norwegian Parliament	Norwegian*	Foreign Affairs and Defense Committee Public Hearing	State, Political, Scientific & Technical, International
APP 5	Mr Jonas Gahr Støre, Foreign Minister of Norway's address to the 65th Session of the WHA	May 23, 2012	Minister of Foreign Affairs	English		International
APP 6	Presentation of the Norewegian Government's White Paper	Feb 15, 2012	University of Oslo events	English	High-level Ministerial Steering Group	State, Political, Scientific & Technical
APP 7	Opening address at the launch of the White Paper on global health in foreign policy: Oslo	Feb 15, 2012	Minister of Foreign Affairs	English	High-level Ministerial Steering Group	State, Political, Scientific & Technical,

Code	Name of archive	APP date	APP author	Language	NAS links	Context links
APP 8	Statement at the Launch of the white paper Global Health in Foreign and Development Policy by former healthcare Minister Anne-Grete Strøm-Erichsen	Feb 16, 2012	Ministry of Health	English	High-level Ministerial Steering Group	State, Political, Scientific & Technical
APP 9	Input from Changemaker (NGO) - CSO/NGO comments submitted for open consultation on White Paper	2010	Changemaker	Norwegian*	CSO consultation	Scientific & Technical
APP 10	Input from FAFO Institute for Applied international studies - CSO/NGO comments submitted submitted for open consultation on White Paper	Nov 5, 2010	FAFO	Norwegian*	CSO consultation	Scientific & Technical
APP 11	Input from the Norwegian Medical Association- CSO/NGO comments submitted submitted for open consultation on White Paper	Nov 5, 2010	NMA	Norwegian*	CSO consultation	Scientific & Technical
APP 12	Summary of input from Ministry of Health on priorities in the draft White Paper on global health	Nov 11, 2010	MHCS	Norwegian* (original doc contains track changes which have not been translated)	High-level Ministerial Steering Group / Writing Group	State, Political, Scientific & Technical
APP 13	Draft White paper for open consultation	Oct 27, 2010		Norwegian*	CSO consultation / Writing Group	State, Scientific & Technical
APP 14	Email regarding working schedule, processes and monitoring of Writing Group	Oct 17, 2010	Ministry of Foreign Affairs	Norwegian*	Writing Group	
APP 15	Email from MFA regarding follow up to CSO consultation process	Oct 19, 2010	Ministry of Foreign Affairs	Norwegian*	CSO consultation	

Code	Name of archive	APP date	APP author	Language	NAS links	Context links
APP 16	Text from power point presentation from kick-off meeting of the writing group	October 2010		Norwegian*	Writing Group	
APP 17	Summary Matrix - Monitoring of Meld.St.11-12 White Paper on global health in foreign and development policy	2013	NIPH	Norwegian*	Follow-up process	Political, Scientific & Technical
APP 18	Excel spreadsheet on institutions, activities, timeline, resources, and international partners for each priority, sub-priority and recommendation of the White Paper	2014	NIPH	Norwegian*	Follow-up process	Political, Scientific & Technical
APP19	Confidential evaluation report	March 2014		English		Scientific & Technical
APP 20	Input from Save the Children Norway for hearing statement	May 2012	Save the Children	Norwegian*	Foreign Affairs and Defense Committee Public Hearing	Political, Scientific & Technical
APP 21	Email with revised outline of White Paper	May 2, 2012	MFA	Norwegian*	Writing Group	
APP 22	Web page from Norad on the follow up to the White Paper and Norwegian actors' commitment to global health (Title: “Wide commitment and many success stories in global health")	August 4, 2013	Norad	Norwegian*	Follow-up process	
APP 23	Norway’s WHO Strategy 2010-2013	Sept. 2010	MHCS	English	WHO Strategy Group	International, Scientific & Technical

***Archives of the policy process in Norwegian were translated into English with Google Translate.**

SWITZERLAND

I collected data from two waves (W) of informant interview between March and October 2015. The face-to-face (F) interviews were conducted in Geneva, Bern, and Basel, and the rest by telephone (T) At their request, two of the informants SI8 and SI9 were interviewed together, and a follow-up interview with SI9 was conducted by telephone (T).

Swiss key informant classification (actor sphere / policy sector)

Actors' societal spheres (policy sectors)	Number of Swiss key informants
State actor (development)	1
State actor (health)	4
State actor (foreign affairs)	4
State actor (intellectual property/justice)	2
Civil society actor (health)	1
Knowledge actor (global health research)	1
Public actor (health)	1
	14

Overview of data collected during key informant interviews in Swiss fieldwork

Wave	Informant ID	F / T	Audio (minutes)	Transcripts (.docx)	Sketch-pad map / drawing (.pdf)
1	SI 1	F	84 min	25 pgs	SI 1 map
1	SI 2	F	69 min	23 pgs	SI 2 map
1	SI 3	T	61 min	12 pgs	no map
1	SI 4	T	78 min	16 pgs	no map
1	SI 5	F	83 min	19 pgs	SI 5 map
1	SI 6	F	65 min	16 pgs	SI 6 map
1	SI 7	F	61 min	12 pgs	SI 7 map
1	SI 8-9	F	126 min	29 pgs	SI 8-9 map
1	SI 9 follow-up	T	42 min	10 pgs	no map
2	SI 10	F	no audio	no transcript	SI 10 map
2	SI 11	F	58 min	16 pgs	SI 11 map
2	SI 12	F	66 min	13 pgs	SI 12 map
2	SI 13	T	56 min	11 pgs	no map
2	SI 14	T	35 min	7 pgs	no map
	TOTALS		**884 min**	**209 pages**	**9 sketches**

Archives of the policy process for modelling action arena for Swiss case

Code	Name of archive	APP date	APP author	Language	SAS links	Context links
APP 1	La Suisse adopte une nouvelle politique extérieure en matière de santé (press release)	March 2012	Swiss confederation	French	IK GAP / Idag GAP	
APP 2	Rapport sur la politique extérieure 2013	January 2014	Federal Council	French		State
APP 3	Rapport sur la politique extérieure 2012	January 2013	Federal Council	French		State
APP 4	Rapport sur la politique extérieure 2011	January 2012	Federal Council	French		State
APP 5	Rapport sur la politique extérieure 2010	December 2010	Federal Council	French		State
APP 25	Rapport sur la politique extérieure 2009	September 2009	Federal Council	French		State
APP 6	Rapport sur la politique extérieure 2007	June 2007	Federal Council	French		State
APP 7a	Message concernant la coopération internationale 2013–2016	February 2012	Federal Council	French		Political, State, International
APP 7b	Message on International Cooperation 2013 – 2016 Key points in brief	2012	Federal Council	English		Political, State, International
APP 8	Message concernant la continuation de la coopération technique et de l'aide financière en faveur des pays en développement	March 2008	Federal Council	French		Political, State, International
APP 9a	WHO-Switzerland Country Cooperation Strategy	May 2013	WHO	English	IK GAP / Idag GAP	
APP 9b	WHO and Switzerland sign country cooperation strategy	May 2013	WHO EURO	English		Scientific & Technical, International

Code	Name of archive	APP date	APP author	Language	SAS links	Context links
APP 10	Note d'information aux membres du Conseil Fédéral sur la politique extérieure de la Suisse en matière de santé (PES) adoptée en 2012: bilan à mi-parcours	April 2015	FDHA and FDFA	French	IK GAP, Idag GAP, Idag GIGE	
APP 11	Agenda for the 24th meeting of the Interdepartmental Working Group on Health Foreign Policy (Idag GAP) September 2014 (in German, but Google translated to English)	July 2014	FDFA	German*	Idag GAP	
APP 12	Evaluation de la collaboration interdépartementale dans le domaine de la politique extérieure : Rapport du Contrôle parlementaire de l'administration à l'intention de la Commission de gestion du Conseil national	June 2013	Contrôle parlementaire de l'administration	French		Political, State
APP 13	Collaboration interdépartementale dans le domaine de la politique extérieure: Rapport de la Commission de gestion du Conseil national	February 2014	Commission de gestion du Conseil national	French		Political, State
APP 14	Swiss Initiative Seeks To Dispel "Black-And-White" View Of Patents	December 2006	Intellectual Property Watch	English	Idag GIGE	Political, Scientific & Technical, International

Code	Name of archive	APP date	APP author	Language	SAS links	Context links
APP 15	WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property: the Contribution of Switzerland	May 2011	Swiss confederation	English	Idag GIGE	Scientific & Technical, International
APP 16	Text of email invitation to external partners and stakeholders for launch event on "pharmaceutical companies' efforts to improve global access to medicine"	March 2015	IPI	English	Idag GIGE	
APP 17	Bulletin 103 of the Medicus Mundi Schweiz (Special issue on the Global Health and Foreign Policy symposium held in Nov. 2006)	February 2007	Medicus Mundi Swiss	German*	Stakeholder	Scientific & Technical, International
APP 18	Swiss Contributions to Human Resources for Health Development in LMIC	September 2010	Swiss TPH	English	Idag GAP	
APP 19	Obsan rapport 39 - L'immigration du personnel de santé vers la Suiss	November 2010	Swiss Health Observatory	French	Idag GAP	
APP 20	Recherche qualitative sur le personnel de santé étranger en Suisse et sur son recrutement	November 2010	Conférence suisse des directrices et directeurs cantonaux de la santé	French	Idag GAP	
APP 21	Qualitative research on foreign health personnel in Switzerland	November 2010	Conférence suisse des directrices et directeurs cantonaux de la santé	English	Idag GAP	

Code	Name of archive	APP date	APP author	Language	SAS links	Context links
APP 22	Les migration internationale du personnel de santé en Suisse: Etat des lieux et pistes de réflexion	October 2010	FDHA (FOPH), FDFA	French	Idag GAP	
APP 23	Révision de la convention d'objectifs de la politique extérieure en matière de santé : position de la CDS	October 26, 2011	Conference suisse des directeurs cantonaux de la santé	French	IK GAP / Idag GAP	
APP 24	Rapport du Conseil fédéral sur sa gestion et sur les points essentiels de la gestion de l'administration fédérale en 2005	February 2006	Federal Council	French		State / international
APP 26a	Message sur la coopération internationale 2017–2020	February 2016	Federal Council	French		Political, State, International
APP 26b	Message sur la coopération internationale de la Suisse 2017–2020: L'essentiel en bref	February 2016	Federal Council	French		Political, State, International

***Archives of the policy process in German were translated into English with Google Translate.**

Appendix L. Coding system used in MAXQDA

- Codes
  - Visual method
  - NASothers
  - NAS-FPGH initiative
  - NAS-WHO strategy group
  - NAS-Follow-up process
    - Actors
    - Materials
    - Positions
    - Processes
    - Resources
    - Results
    - Rules
  - NAS-Minsterial Forum
  - NAS-FA interal
  - NAS-Dev internal
  - NAS-Health internal
  - NAS-FADC hearing
    - Actors
    - Materials
    - Positions
    - Processes
    - Resources
    - Results
    - Rules
  - NAS-CSO consultation
    - Actors
    - Materials
    - Positions
    - Processes
    - Resources
    - Results
    - Rules
  - NAS-Writing group
    - Actors
    - Materials
    - Positions
    - Processes
    - Resources
    - Results
    - Rules
  - N_Power
  - N_Influences on policy change
    - Internal

- External
- N_Rules
  - Institutional arrangements
- N_Policy design
  - Targets
  - Arguments
  - Implementation rules
  - Implementation structures
  - Instruments
  - Goals
- N_Context
  - Actor
  - International-global
  - Scientific-technical
  - Political
  - State
  - Socio-demographic
  - Economic
  - Intersectoral collaboration / sectoral identity
  - global health
- WHO
  - N_WHO/WHA
  - S_WHO/WHA
- Coherence
  - N_Policy coherence
  - S_policy coherence
- EBP
  - N_reserach-policy links
  - S_research-policy links
- trust-building / understanding other sectors
- S_Power
- S_Influences on policy change
  - Internal
  - External
- S_Rules
  - Institutional arrangements
- S_Policy design
  - Targets
  - Arguments
  - Implementation rules
  - Implementation structures
  - Instruments
  - Goals
- S_Context
  - Actor
  - International-global

- Scientific-technical
- Political
- State
- Socio-demographic
- Economic

SAS-Idag GAP
- Actors
- Materials
- Positions
- Processes
- Resources
- Results
- Rules

SAS-Idag GIGE
- Actors
- Materials
- Positions
- Processes
- Resources
- Results
- Rules

SAS-Executive Support Group
- Actors
- Materials
- Positions
- Processes
- Resources
- Results
- Rules

SAS-IK GAP
- Actors
- Materials
- Positions
- Processes
- Resources
- Results
- Rules

SAS-Stakeholder platform
- Actors
- Materials
- Positions
- Processes
- Resources
- Results
- Rules

SAS-Other

Appendix M. Methodological templates for analysis of action situations

Methodological sheets for Norwegian case
7 Norwegian action situations (NAS)

NAS 1: Writing Group

Characteristics	Writing Group
Time	Writing Group Meetings varied in their frequency and size of the group, for the duration of about one year between the fall of 2010 and the fall of 2011. Initiated in the summer (July/August) of 2010 by MFA. Following the official green light from the Government in September 2010, regular meetings were held in the Fall of 2010 with MFA, MHCS, Norad (meeting approximately 1x/week). Intense writing period to draft final White paper in January-August 2011, with the diplomat "policy writer" recruited in April 2011.
Space	Meetings were held in the MFA, the MFA was the line ministry for this White Paper, the leader / owner / manager of this policy process.
Purpose	The purpose of the Writing group was to develop the text of the White Paper on Global Health and Foreign Policy. The group was composed of different experts from the three main policy sectors (development, health, foreign affairs) to discuss what the content of the document should include, how it should be structured, and to ensure the quality of the evidence and information used.
Interaction of actors	The main interactions of focus for this group was to ensure a dialogue between the Ministry of Foreign Affairs and the Ministry of Health for the purpose of putting together and finalising the White Paper. At its largest the group was about 8 people, but it was reduced to essentially one key person at the end of the process tasked with drafting the policy. The process for the writing group was structured interaction because the manager of the process was in the MFA and the writing group acted as a hub for the MFA to collect information and ideas from the key actors from each policy sector, who were expected to share the work and contributions of those behind the scenes working in the action situations internal to each policy sector (compiling input on drafts of sections, contributing new text to fill in missing parts of the outline, doing quality assurance, backing up with examples and research).

Products (e.g. policy papers, projects) resulting from this action situation:

- Norwegian White Paper on Global health in foreign and development policy (Meld. St. 11 2011-2012 Report to the Storting)
- APP 6 Presentation of the Norwegian Government's White Paper (February 15, 2012 at the University of Oslo)
- APP 7 Opening address (MFA) at the Presentation of the Norwegian Government's White Paper (February 15, 2012 at the University of Oslo)
- APP 8 Statement (MH) at the Presentation of the Norwegian Government's White Paper (February 15, 2012 at the University of Oslo)
- APP 12 Summary of input from Ministry of Health on priorities in the draft White Paper on global health
- APP 13 Draft White Paper for open consultation
- APP 14 Email regarding working schedule, processes and monitoring of Writing Group
- APP 15 Email from MFA regarding follow up to CSO consultation process
- APP 16 Text from power point presentation from kick-off meeting of the writing group
- APP 17 Summary Matrix - Monitoring of Meld.St.11-12 White Paper on global health in foreign and development policy
- APP 18 Excel spread-sheet on institutions, activities, timeline, resources, and international partners for each priority, sub-priority and recommendation of the White Paper
- APP 21 Email with revised outline of White Paper

Related policies (e.g. materials from and for boundary action arenas)

Internal:

- APP 1 - Chapter 12 from the 2012 budget proposal from the Ministry of Foreign Affairs (Report to the Storting on Policy coherence for Development 2011)
- Norwegian MFA Action Plan for Women's Rights and Gender Equality in Development Cooperation 2007-2009
- Norwegian Government's action plan: Improving quality of life among lesbians, gays, bisexuals and trans persons 2009-2012
- National AIDS strategy 2009-2014 – Acceptance and coping
- Norway HIV/AIDS strategy November 2006
- Strategic Plan for Responsibility and Consideration – a strategy for the prevention of HIV and STDs
- The Norwegian Government's Action Plan for the Implementation of UN Security Council Resolution 1325 (2000) on Women, Peace and Security (March 2006)
- Norwegian WHO Strategy 2010-2013
- Norwegian Budget 2013-2014
- Norad presentation and Norad strategy towards 2015
- Norad results report on health and education 2013
- Special issue of the Journal of the Norwegian Medical Association on Global health
- Public Health Report - Good health – a common responsibility Meld. St. 34 (2012–2013) Report to the Storting (White paper)
- Meld. St. 25 (2012-2013) Report to the Storting (White Paper) Sharing for prosperity: Promoting democracy, fair distribution and growth in development policy
- Global health strategy of the Health Directorate 2011-2014

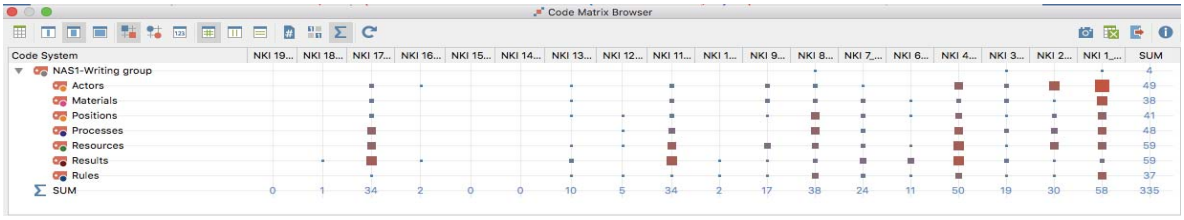
- EU strategy of the Health Directorate 2015-2017
- The Norwegian Institute of Public Health's global health strategy development (power point presentation)
- HelseOmsorg21 national strategy
- Supporting the development of a new health R&D strategy - A rapid review of international theory and practice for Norway's HelseOmsorg21

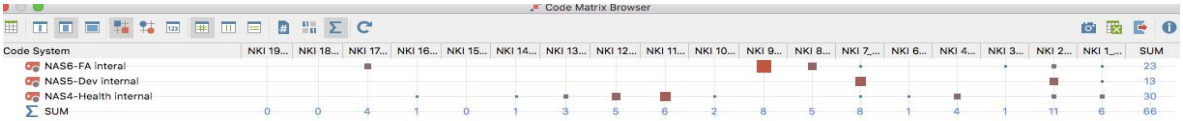
External:

- APP 5 Mr Jonas Gahr Støre, Foreign Minister of Norway's address to the 65th Session of the WHA (May 23, 2012)
- Global Campaign for the Health Millennium Development Goals (reports 2007-2013)
- Global health 2035: a world converging within a generation (Commission on Investing in Health)
- Global strategy for Women and children's health, Every Woman Every Child

Methods / sources triangulation	Writing Group
Documentary methods	No.
CAG - 1st MM	Yes. This is how I first learned about the existence of a writing group.
Interview methods	Most data collected on NAS 1 Writing Group from NI 1, 2, 4-5, 8, 11, 17 and some from NI 3, 6, 7, 9.
Archives of the policy process (APP)	APP 12 – 18, APP 21

Data coded per informant on Writing Group situation





NAS 2: Civil Society Organisation Consultation

Characteristics	CSO Consultation
Time	Two face-to-face meetings in mid-October 2010 and late May 2011, with the possibility also to contribute written proposal of input electronically.
Space	MFA hosted the meeting.
Purpose	The purpose of the CSO consultation was to collect feedback, not to brainstorm or develop new ideas.
Interaction of actors	This action situation was not "participatory" but rather a consultation seeking feedback. Over 70 organisations and groups were invited, but only 30-40 organisations took part since there were no funds to support participation of CSO and academic. Those who participated were either based in Oslo or had funding to facilitate their travel to attend the meeting. Rules did not favour interaction but rather a one-sided process for MFA to collect input from the resources of a broad range of CSOs.

Products (e.g. policy papers, projects) resulting from this action situation:

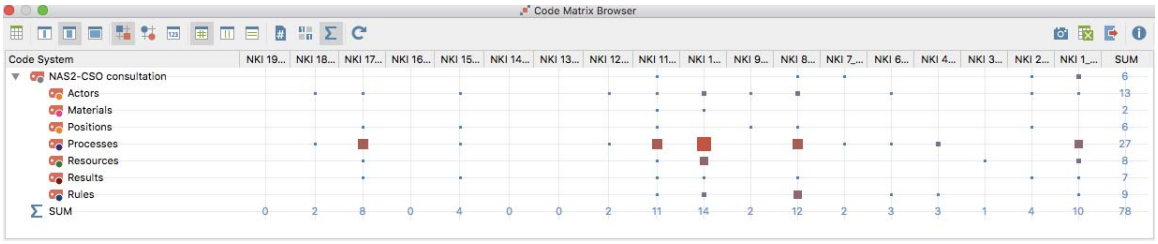
- APP 9 Input from Changemaker (NGO) - CSO/NGO comments submitted for open consultation on White Paper
- APP 10 Input from FAFO Institute for Applied international studies - CSO/NGO comments submitted for open consultation on White Paper
- APP 11 Input from the Norwegian Medical Association- CSO/NGO comments submitted for open consultation on White Paper
- APP 15 Email from MFA regarding follow up to CSO consultation process

Related policies (e.g. materials from and for boundary action arenas)
Internal:

- APP 13 Draft White Paper for open consultation

Methods / sources triangulation	CSO Consultation
Documentary methods	No.
CAG (1st MM)	Yes. This is how I first learned about the civil society and research consultation.
Interview methods	Data collected on NAS 2 Civil society consultation mainly from NI 1, 8, 10, 11, 17 but also NI 2, 7, 4, 5, 12.
Archives of the policy process (APP)	APP 15

Data coded per informant on CSO Consultation situation



NAS 3: Foreign Affairs and Defense Standing Committee Public Hearing

Characteristics	FADC public hearing
Time	The standing committee on Foreign Affairs met in the Spring of 2012 (when the White Paper was sent to Parliament in February 2012 from the Government). The FAC officially released and submitted its opinion (recommendation of the Foreign and Defense Committee) to the Storting on May 16, 2012.
Space	The public hearing of the committee and the invited speakers and experts was held in the Norwegian Parliament building.
Purpose	The purpose of the FAC public hearing is to give an opportunity for experts from outside of government to be heard about the contents of the White Paper and to respond to questions from the FAC as well as submit statements for its consideration. The FAC public hearing produces a recommendation for the final debate on the White Paper in Parliament.
Interaction of actors	The formal public hearings are not necessarily interactive as a format, but they are recognised by large CSO as key opportunities to address important issues in policy that they consider may not have been given adequate attention. There is a legislative political dimension to the FAC hearing because it relates to policy advocacy towards members of parliament, which is an avenue for policy influence that is preferable and more practiced by large organisations than via the executive branch or ministerial level. There is some obligation to be heard, but it is not formally interactive process. Nevertheless, there may be some potential for more informal interaction behind the scenes as part of the political machine.

Products (e.g. policy papers, projects) resulting from this action situation:

- APP 3 Summary report and recommendations to the Storting (Insti.300 S (2011-2012), the opinion from the Standing Committee on Foreign Affairs and Defense regarding the white paper on global health (Meld. St. 11 2011-2012)
- APP 20 Save the Children's written input and presentation to the FAC public hearing at the Storting

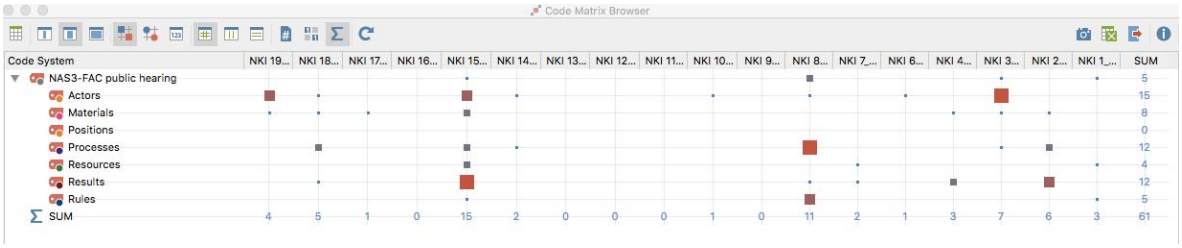
Related policies and policy statements (e.g. materials from and for boundary action arenas)

Internal :

- APP 4 Minutes from the parliamentary debate and discussion of the recommendation of the Foreign Affairs and Defense committee on global health in foreign and development policy

Methods / sources triangulation	FADC public hearing
Documentary methods	Yes, I found APP 3-4 in my literature search for documents on the Norwegian government and parliament websites.
CAG (1st MM)	Yes, the CAG M1 confirmed that there was a FAC public hearing.
Interview methods	Data collected on NAS 3 FADC public hearing from NI 2, 3, 8, 15, 18, 19.
Archives of the policy process (APP)	APP 3, APP 4

Data coded per informant on FADC public hearing situation



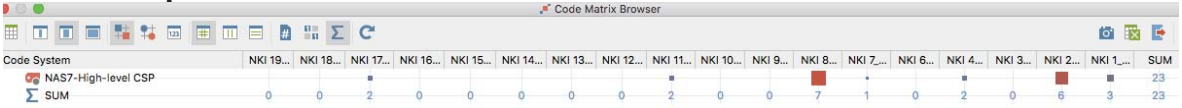
NAS 4: Ministerial Forum

Characteristics	Ministerial Forum
Time	High-level checks were consistent throughout the process (from fall 2010 to fall 2011). There are some milestones in this process such as in the summer of 2010 to have Government support before launching the team in MFA and in the fall of 2011 before getting Government support to send the White Paper to Parliament.
Space	The SGI in the MFA was the lead of the team for this cross-sectoral collaboration at deputy minister and minister level.
Purpose	Agreement and final approval for partnering ministries, before getting cross-ministerial support in Government for 1) the process to develop a White Paper, and 2) for the final product before it goes to Parliament.
Interaction of actors	This Ministerial Forum (Steering Group) of the Ministers of Foreign Affairs, Development and Health met about every month. Sometimes when the MFA did not convene the entire group, IM met with each team individually. There were a select few occasions when the members of the Writing Group also met with State Secretaries. The interaction was intended to keep a consistent flow of information at the senior level so that the political level was always in the loop with the development of the White Paper so issues could be dealt with accordingly when there was conflict at the lower level.

Products resulting from this action situation:
The *Government will* bullet points came from this level of agreement and corresponded to the areas of responsibility of the three state secretaries.
Final version of the White Paper on Global health in foreign and development policy submitted to the Government Conference and the Council of States

Methods / sources triangulation	Ministerial Forum
Documentary methods	No.
CAG (1st MM)	Yes.
Interview methods	Data collected on NAS 4 high-level cross sector ministerial forum from NI 1, 2, 5, 8, 11, 17.
Archives of the policy process (APP)	No.

Data coded per informant on Ministerial Forum situation



NAS 5: Follow-up processes

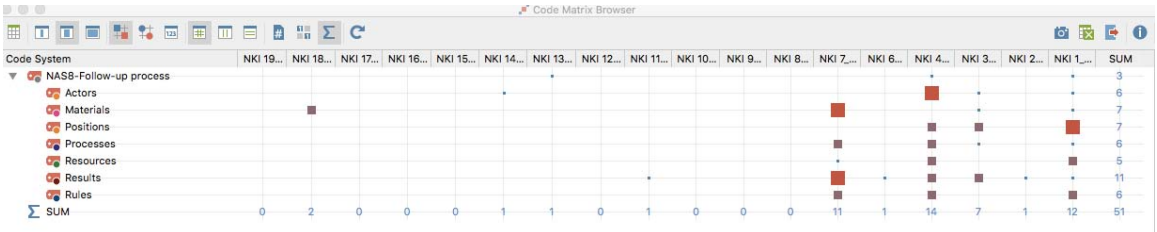
Characteristics	Follow-up processes
Time	In the year after the adoption of the White paper on Global health (2012-2013).
Space	Co-supported by the same two ministries who supported the White Paper.
Purpose	The three state secretaries (but in particular those 2 of the MFA) requested a follow up report and an evaluation of the action points (Government will recommendations).
Interaction of actors	The process was coordinated in Norad who worked in close partnership with the Public Health Institute. There was more exchange with the NGOs and other civil society actors to share what they were doing in global health to provide a snapshot, but it was not an interactive process in terms of communication and development of follow up on the policy.

Products (e.g. policy papers, projects) resulting from this action situation:

- APP 2 Norwegian actors' engagement in global health (Co- published by the Ministry of Health and Care Services and the Ministry of Foreign Affairs, Norwegian Agency for Development Cooperation)
- APP 22 Web page from Norad on the follow up to the White Paper and Norwegian actors' commitment to global health (Title: Wide commitment and many success stories in global health")

Methods / sources triangulation	Follow-up processes
Documentary methods	No.
CAG (1st MM)	Yes.
Interview methods	Data collected on NAS 5 follow-up processes mainly from NI 1, 3, 4, 5, 7.
Archives of the policy process (APP)	APP 2, APP 22

Data coded per informant on Follow-up processes situation



NAS 6: Norway's strategy group for WHO Executive Board seat 2010-2013

Characteristics	WHO Strategy Group
Time	Preparations began in 2007/2008, approximately 1.5 years before taking up the EB seat in May 2010 (EB 127). But the strategy was officially signed on September 1, 2010, released after the Board seat was active.
Space	Held about 4-6 meetings. The health sector was responsible for coordinating this action situation with the leadership coming from the Ministry of Health and Care Services.
Purpose	The purpose of this action situation was to have in-depth discussions about what should be the policy position of Norway in relation to the WHO portfolio and how it could have an impact using the WHO EB Board seat for 2010-2013. The strategy itself had the stated purpose of : The purpose of the strategy is twofold: *firstly, to define the overall objectives and priorities of Norwegian WHO efforts, and secondly, to provide the basis for a clear, coherent Norwegian WHO policy, thus enhancing the consistency of Nor way's approach in WHO forums as well as in the UN.*
Interaction of actors	There was a lot of interaction between the participants, in the official meetings and lots of correspondence between the meetings. Participants reported on this being an open process that maintained a good balance between the foreign affairs and the health policy sectors. This process of intense interaction helped to build understanding between the two sectors about the issues and priorities of their sectors and their ways of working. The strategy also laid out explicitly in section 7 the working methods for maintaining the interactions between these two policy sectors and coherency and identifying the responsible sectors and actors for decision-making.

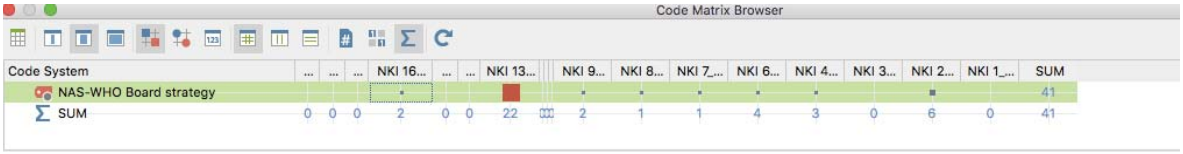
Products resulting from this action situation:

- APP 23 Norwegian WHO Strategy: Norway as a member of WHO's Executive Board 2010-2013

Related policies and policy statements (e.g. materials from and for boundary action arenas)
Note: The WHO EB is composed of 34 members technically qualified in the field of health. Members are elected for three-year terms. The main Board meeting, at which the agenda for the forthcoming Health Assembly is agreed upon and resolutions for forwarding to the Health Assembly are adopted, is held in January, with a second shorter meeting in May, immediately after the Health Assembly, for more administrative matters. The main functions of the Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work.
Refer to documentation EB 127-132 for the Norwegian delegation http://apps.who.int/gb/

Methods / sources triangulation	WHO Strategy Group
Documentary review	No.
CAG (1st MM)	Yes.
Interview methods	Data collected on NAS 6 WHO EB strategy from NI 2, 4, 5, 6, 7, 8, 9, 13, 16.
Archives of the policy process (APP)	No.

Data coded per informant on WHO strategy group situation



NAS (boundary situation): Foreign Policy and Global Health Initiative

Characteristics	FPGH initiative
Time	The FPGH initiative became known once its first main product was published in the Lancet in 2007, the Oslo Ministerial Declaration. However, the development of this initiative began in 2005 when Jonas Gahr Støre asked Sigrun Møgedal to begin developing a concept paper for an idea about a group that would unite Ministers of Foreign Affairs in an alliance to apply a FP lens to health and explore the connections and policy implications (benefits and challenges) of the links between health and foreign policy. He was developing this with Philippe Douste-Blazy, and then worked on recruiting the other 5 partnering countries with a strategic interest in capitalising on strong FP relationships and opportunities.
Space	The initiative was initially coordinated quite strongly by the Norwegians, but it quickly incorporated a more shared basis of power with a rotating chair and secretariat, which moved annually. The seven capitals had shared power for this within their MFA. Later, Geneva became more of the home of this initiative, coordinating across the seven missions of those countries in Geneva and with WHO.
Purpose	The purpose of this action situation was to use foreign policy and foreign policy partners and networks in a strategic way to advance the issue of making connections between health and foreign policy (at home in Norway, abroad in the seven countries, and in key global governance hubs like Geneva and New York through ambassadorial and ministerial collaborations, and also to have collective impact at venues like the UNGA or the WHA).
Interaction of actors	The initiative's structure facilitated interaction and exchange among the partnership countries (between the Ministers of FP and senior diplomats in charge of advancing the technical aspects of the work, and between the Ministers of Health and other ambassadors). It also facilitated exchange intra and intersectorally within Norway (between the MFA and the MOH – mostly at the senior bureaucrat level, with regularly meetings between the relevant teams, but also between different sections of the MFA concerned with the aspects of the policy issue of focus selected for each year). Within Norway there were regular meetings and for the initiative there were at least 2x/year – one in Geneva and one in New York. In the early stages of the initiative there were lots of meetings in the capitals to deliberate on text of the Oslo Declaration. Interactions were strongly encouraged in this initiative based on trust between the partners – part of the strategic design of the group. With hubs of activities in the capitals, in New York and in Geneva. It was a high-level collaboration between ministries of foreign affairs that spread out to the ministries of health.

Products resulting from this action situation:
Oslo Ministerial Declaration 2007 (published in the Lancet)

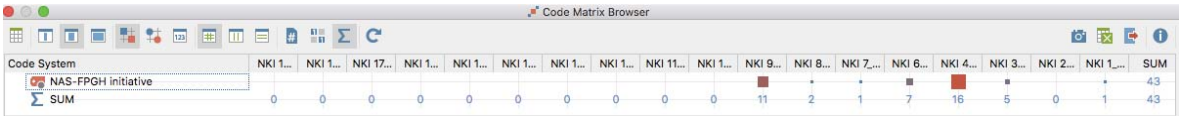
Related policies and policy statements (e.g. materials from and for boundary action arenas)

External:

- See all UNGA resolutions and UN General Assembly reports submitted between 2008 and 2013 : http://www.who.int/un-collaboration/health/unga-foreign-policy/en/

Methods / sources triangulation	FPGH initiative
Documentary methods	Yes.
CAG (1st MM)	Yes.
Interview methods	Data collected on NAS boundary situation FPGH from NI 3, 4, 5, 6, 7, 8, 9.
Archives of the policy process (APP)	No.

Data coded per informant on FPGH initiative situation



Methodological sheets for Swiss case
5 Swiss action situations (SAS)

SAS 1: IK GAP (interdepartmental conference on health and foreign policy)

Characteristics	IK GAP
Time	About half day 1x/year
Space	Rotating co-chair between health and foreign affairs
Purpose	Overview and monitoring of progress on SHFP. If there are unresolved issues, this body does have the power to make decisions, but this is in exceptional cases where consensus was not reached within the interdepartmental working groups or the Executive Breakfast support group. The agendas of these meetings (as those of the Idag groups) are strongly influenced by upcoming events and international meetings).
Interaction of actors	This is a high-level group with representation either at the Executive level in the case of offices and agencies (like the SDC or the FOPH) or the State Secretary level (for example in the case of foreign affairs). The three main senior officers are from the FDFA, SDC and FOPH. There are representatives from every federal department (foreign affairs, home affairs, justice, defense, economics, environment) except for finance. The group is about 10-15 people total (2 chairs, 5 directors, + some collaborators). The interaction is organised around a set of short background papers prepared and circulated in advance.

Products resulting from this action situation:

- APP 10 - Note d'information aux membres du Conseil Fédéral sur la politique extérieure de la Suisse en matière de santé (PES) adoptée en 2012: bilan à mi-parcours
- Various studies for policy guidance carried out via the members of the Idag GAP (see SAS1) but under the mandate of the IK GAP

Related policies (e.g. materials from and for boundary action arenas):

Internal:

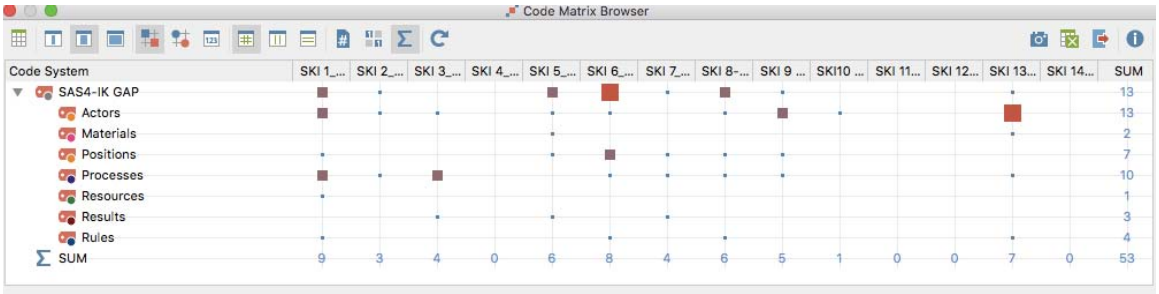
- APP 2 Rapport sur la politique extérieure 2013
- APP 3 Rapport sur la politique extérieure 2012
- APP 4 Rapport sur la politique extérieure 2011
- APP 5 Rapport sur la politique extérieure 2010
- APP 6 Rapport sur la politique extérieure 2007
- APP 7a Message concernant la coopération internationale 2013–2016
- APP 8 Message concernant la continuation de la coopération technique et de l'aide financière en faveur des pays en développement (2008)

External:

- APP 9a Country Cooperation Strategy with WHO

Methods / sources triangulation	IK GAP
Documentary methods **CAG (1st MM)** **Interview methods** **Archives of the policy process (APP)**	Yes, mentioned in the policy design. No. Data collected on SAS1 – IK GAP from SI 1-3, S5-9, and 13. APP 1, APP 10

Data coded by informant on IK GAP situation



SAS 2: Idag GAP (interdepartmental working-group on health and foreign policy)

Characteristics	Idag GAP
Time	Meetings held 2-3x/year for about a half-day (3 hrs)
Space	3 co-leads (shared responsibilities between the FOPH, SDC and FDFA)
Purpose	Information sharing between the key agencies, reports/reviews and responds to questions about existing projects and initiatives, explores new orientations.
Interaction of actors	In the formal Idag GAP meetings, there are generally 10-15 people participating, but it could potentially go up to 25 if everyone who was invited attended. High levels of interaction between the co-lead agencies, but more passive participation from the other members of the group attending the meetings. In particular, the desk officers who prepare these meetings, coordinate, and follow up have more frequent meetings and regular communication in between the meetings to prepare (i.e. set agenda, collect reports) and follow up. The Mission in Geneva is also an important actor in these meetings. For specific projects or studies sub-groups will be established that also include direct participation or project leadership from stakeholders like the Swiss Centre for International Health, such as the one on health personnel and human resources for health). [Before this was formalized in the after the shared SHFP objectives, there were more frequent meetings up to 6x/year. Also in the first agreement, the input and involvement of the SDC was marginal. They were much more integrated into the SHFP in 2012 version and play a more participatory role since.]

Products (e.g. policy papers, projects) resulting from this action situation:

- APP 22 La migration internationale du personnel de santé en Suisse: État des lieux et pistes de réflexion (Policy paper leading to Swiss implementation of WHO Code of Practice on International recruitment of health personnel)
    - Migration study (health personnel) (with WHO +OECD) – and multiple reports of the Swiss health observatory, Swiss TPH, Swiss Conference of Cantonal Health Ministers
        - APP 19 Jaccard Ruedin, H. & Widmer, M. (2010) L'immigration du personnel de santé vers la Suisse (Obsan Rapport 39). Neuchâtel: Observatoire suisse de la santé.
        - APP 20 (APP 21 in English) Huber, Kathrin & Mariéthoz, Ewa (2010) Recherche qualitative sur le personnel de santé étranger en Suisse et sur son recrutement. Berne, Conférence suisse des directrices et directeurs cantonaux de la santé.
        - APP 18 Wyss, Kaspar & Weiss, Svenja (2010) Swiss Contributions to Human Resources for Health Development in Low- and Middle-Income

Countries. Basel, Schweizerisches Tropen- and Public Health Institut.

- Global health security agenda participation (USA led initiative)
- Training programmes for new diplomats on SHFP
- Memorandum of Understanding between Bill & Melinda Gates Foundation, FDFA, FDHA (project implemented by Swissmedic)

Related policies (e.g. materials from and for boundary action arenas)

Internal:

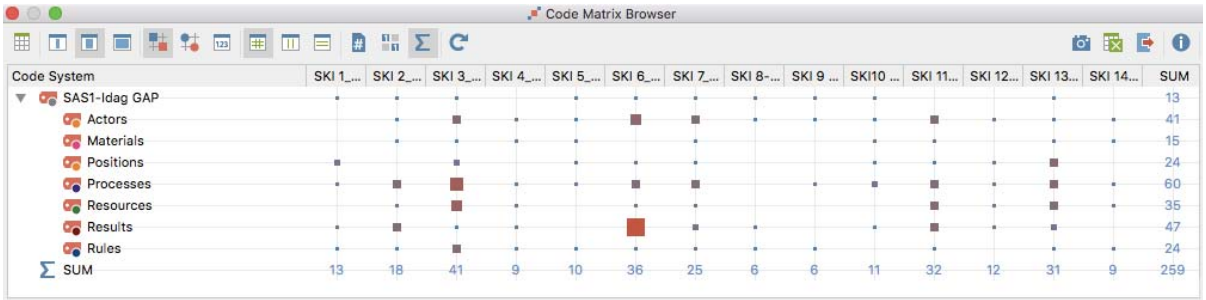
- Swiss drug policy
- SDC Health Brief on Human resources for health in LMICs
- Health in Switzerland: National Health Report 2008
- SDC Health Policy (2003-2010)
- SDC Health Policy (2013-2020)
- SDC evaluation policy
- The Federal Council's health-policy priorities (Health 2020)
- International Cooperation Strategy (Swiss National Science Foundation Roadmap 2013-2016)

External:

- International addiction policy (multilateral relationships)
- APP 9a WHO-Switzerland Country Cooperation Strategy

Methods / sources triangulation	Idag GAP
Documentary methods **CAG (1st MM)** **Interview methods** **Archives of the policy process (APP)**	Yes, mentioned in the policy design. All key informants spoke to me about SAS2 – Idag GAP, but most of the data came from SI 1-3, 5-7, 10-13. APP 10, APP 11, APP 23

Data coded by informant on Idag GAP situation



SAS 3: Idag GIGE (interdepartmental working-group on intellectual property, innovation, and public health)

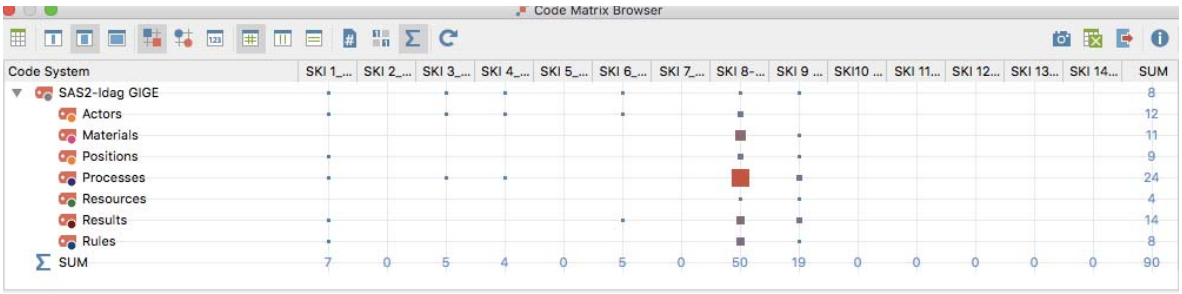
Characteristics	Idag GIGE
Time	Approximately 2x/year
Space	2 co-leads (rotating locations between the FOPH and the IPI)
Purpose	The purpose of this developed over time and it is very focused on issues of intellectual property, and how they relate to innovation and public health. It is less concerned with the broader or cross-cutting issues of global health and development that are addressed in the Idag GAP.
Interaction of actors	The main members of this group are the same as the Idag GAP + the IPI and Economic affairs. The most intense interaction in this action situation is between the two co-lead agencies, at the Director level and at the desk agent manager level. In particular, the desk officers who prepare these meetings, coordinate, and follow up have more frequent meetings and regular communication in between the meetings to prepare (ie set agenda, collect reports) and follow up. The IPI and FOPH directors also have regular lunches. There are also outreach activities (lunches, discussion panels, special events) related to special projects that feed into the Idag GIGE, including contributions from international guest presenters to stimulate dialogue. Sometimes participants for these activities also include Swiss NGOs and the pharma industry.

Products (e.g. policy papers, projects) resulting from this action situation :

- APP 15 - WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property: the Contribution of Switzerland (and implementation of the strategy on access to medicines in Switzerland)
- Training exercises, case studies

Methods / sources triangulation	Idag GIGE
Documentary methods CAG (1st MM)	Yes, mentioned in the policy design.
Interview methods	Data was collected on SAS2 – Idag GIGE from SI 1, 3, 4, 6, but most of the data on this action situation came from SI 8 and 9.
Archives of the policy process (APP)	APP 14, APP 16

Data coded by informant on Idag GIGE situation

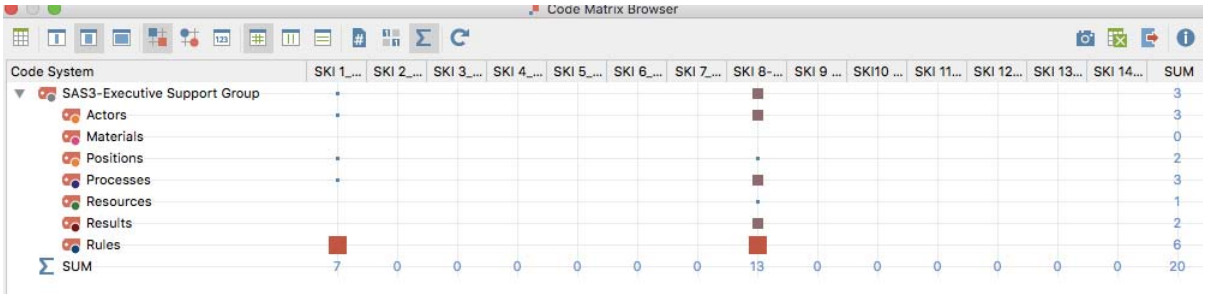


SAS 4: Executive support group

Characteristics	Executive support group
Time	About 5x/year
Space	Rotating host
Purpose	This group deals with the very strategic decisions that are not resolved in the Idag meetings, which can be addressed herein before going to the IK GAP or higher. This body has decision-making authority. It is used to strengthen relationships between the agencies through informal exchange and transparency. It is an informal setting where « pressure » can be applied in a non-threatening way regarding various interests and points of view.
Interaction of actors	Trust-building, but very informal, senior-director level (Ambassador level) interaction and open discussion. Actors include IPI, FOPH, SDC, FDFA, SECO (trade), State Secretary Innovation.

Methods / sources triangulation	Executive support group
Documentary methods	No.
CAG (1st MM)	Yes.
Interview methods	Coded segments of the interview transcripts indicate that I collected data on SAS4 executive support group from SI 1 and 8, but my notes indicate that SI 2 also spoke to me about it.
Archives of the policy process (APP)	No.

Data coded by informant on Executive support group situation

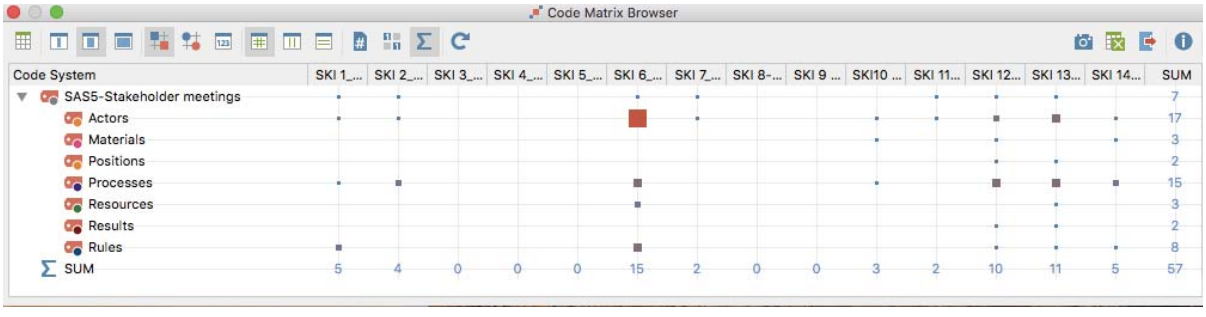


SAS 5: Stakeholder platform

Characteristics	Stakeholder platform
Time	Approximately annually (1x every year-18months) as of 2013 (also April 2014, September 2015) These meetings were also held more informally before policy adoption in 2012, since about 2010)
Space	
Purpose	Information exchange, government administration answering questions from stakeholders, establishing links, networking, connecting activities of partners to SHFP work, outlining future orientations of work. There is some stakeholder debate and feedback, but it is essentially information exchange – not intended to be influential or agenda-setting activities here for SHFP (one-way).
Interaction of actors	About 70-100 potential participants from government and civil society. It is a very heterogeneous group. There are representatives from the Idag GAP and Idag GIGE, but the stakeholders include organisations from private sector and industry, universities and research institutes, NGOs and professional associations, and other kinds of civil society and membership groups. The discussions are often organised following panel presentations on SHFP priority topics (ie drugs, post-2015 goals, neglected diseases).

Methods / sources triangulation	Stakeholder platform
Documentary methods CAG (1st MM)	Yes, mentioned in policy design.
Interview methods	Data collected on SAS5 stakeholder platform from SI 1, 2, 6, 7, 10-14.
Archives of the policy process (APP)	None (although one informant SI 10 showed me a programme and talked to me about an agenda for one of the meetings).

Data coded by informant on Stakeholder platform situation



Appendix N. Questions for analysing action situations

CONTEXT			
		RULES	***POWER***
Actors	Who participated? (politicians, senior/junior civil servants, academics, other) What are their institutional affiliations? Spheres? What sectors are represented?	What were the criteria for being a participant in this situation (*boundary / access rules*)?	Dispositional power
Positions	What positions existed in this action situation? Who held them? - Who provided the leadership? - Who organised, managed, or coordinated? - Who was responsible for communication and follow-up?	How are positions or roles assigned for actors in this situation *(position rules)*?	Dispositional power
Action			
Results	What were outputs produced by this action situation (reports, projects, collaborations, other)? How were the results used? What were the consequences?		
Processes	How are decisions negotiated between actors? How did people work together? How did it go? Did some actors work more closely with any particular actors? Any particular struggles or challenges that stand out? How did actors deal with conflict or tensions? What were the methods, technologies, strategies used by participants to realise / accomplish their actions?	What were the formal and/or informal rules or guidelines for the situation *(interaction rules)*? What are the rules and institutional arrangements that influenced how actors related to each other and work together *(interaction rules)*?	Relational power

<table>
<tr><td>Ideational materials (+ actors' resources)</td><td>What resources did actors contribute to the action situation?
What kind of information, knowledge, ideas, values, beliefs, normative frameworks or programmatic ideas or other resources were mobilised and used for decision-making?
How were knowledge, information or other resource needs identified?
Where did they come from?
Who were the main proponents?
How were these materials used?</td><td>What were the criteria for materials being considered and shared as important for the situation (boundary rules)?

Institutional arrangements</td><td>Dispositional power

Relational power</td></tr>
<tr><td></td><td></td><td colspan="2">MECHANISMS</td></tr>
<tr><td>INFLUENCES
+
CONTEXT</td><td>What were critical moments in the situation (or in the process of NPGH development at large)? What were the major influences? Why?</td><td colspan="2" rowspan="3">What did the influences contribute?
How did this influence policy changes?
What did the actors learn from these?</td></tr>
<tr><td>Internal</td><td>What were the sources of influence from within the country?</td></tr>
<tr><td>External</td><td>What were the sources of influence from outside the country?
What was introduced from outside?</td></tr>
<tr><td colspan="4">Boundary connections
Was this situation linked to others regarding the development of NPGH?
If so, which ones? How were they linked?
How significant was any particular activity in relation to the others? Why?
What was the appraisal of the adopted NPGH by situation's participants?</td></tr>
</table>