

Policy Shifts in Norwegian Development Assistance for Health

- *A contextual analysis*

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List of abbreviations and acronyms:

AIDS: Acquired immune deficiency syndrome

BMGF: Bill and Melinda Gates Foundation

CMH: Commission on Macroeconomics and Health

DFID: Department for International Development (UK)

GAVI: Global Alliance for Vaccines and Immunization

GFATM: Global Fund to fight AIDS, Tuberculosis and Malaria

GOBI: for Growth monitoring to fight malnutrition in children, Oral rehydration techniques to defeat diarrheal diseases, Breastfeeding to protect children, and Immunization

G8: The Group of Eight

G20: The Group of Twenty

HIV: Human immunodeficiency virus

EU: European Union

IDG: International Development Goal

IFI: International financial institution

IHP+: International Health Partnership

IMF: International Monetary Fund

LMIC: Low- and middle income countries

MDG: Millennium Development Goal

MFA: Ministry of Foreign Affairs

MHCS: The Ministry of Health and Care Services

MP: Member of Parliament

NCD: Non-Communicable Diseases

NDAFH: Norwegian development assistance for health

NGO: Non-governmental organization

NORAD: Norwegian Agency for Development Cooperation

NOK: Norwegian Kroner

NPM: New Public Management

NUH: Norsk Utviklingshjelp

ODA: Official Development Assistance

OECD: Organisation for Economic Co-operation and Development

SARS: Severe acute respiratory syndrome

SMI: Safe Motherhood Initiative

PEPFAR: The President's Emergency Plan for AIDS Relief

PHC: Primary Health Care

PPP: Public-Private Partnership

SARS: Severe Acute Respiratory Syndrome

SPHC: Selective Primary Health Care

TB: Tuberculosis

UK: United Kingdom

UN: United Nations

UNAIDS: the Joint United Nations Programme on HIV/AIDS

UNDP: United Nations Development Programme

UNFPA: United Nations Population Fund

UNICEF: the United Nations Children's Fund

US: United States

USD: United States dollar

WB: World Bank

WHO: World Health Organization

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1. Introduction

In 2000, Jens Stoltenberg, the Norwegian Prime Minister, announced that Norway would support the new vaccine initiative – the GAVI Alliance – with 125 million USD over five years. With this, he supported a vertical initiative¹ – an approach new within the Norwegian development field. When the Labour party returned to office in 2005, their efforts towards Millennium Development Goal (MDG) 4 on reducing child mortality by two thirds by 2015 were stepped up, with vaccination as the remedy (Sandberg and Andresen 2010). Again, in 2007, Jens Stoltenberg announced that MDG 5 should be a priority for the Norwegian development assistance for health (NDAFH). Shortly prior to this, in 2006, the Minister of Foreign Affairs, together with foreign ministers from 6 other countries², launched a new and unique initiative to link health and foreign policy (Amorim et al. 2007).

This focus on health within the Norwegian development assistance was not new; neither was the focus on vaccination and maternal health, or the focus on health as part of foreign policy. However, these announcements happened within the historical context of comprehensive health care, long-term investments in health systems and a tradition of bilateral funding for health³. A core tension in the history of international health is the balance between comprehensive primary health care and specific approaches to public health. “Norad’s annual report for 2006 emphasizes the importance of encouraging collaborating countries towards a united health policy, strengthening health systems and solving the health personnel crisis” (Sandberg and Andresen 2010: 314). Although health was not one of the three priority areas listed in the Norwegian Agency for Development

¹ Vertical initiatives are targeted initiatives. They have historically been used to address specific diseases such as TB, Malaria and smallpox (Skolnik 2012). The opposite of vertical initiatives are horizontal initiatives, defined as “those that strengthen the primary care system, improve health systems services and delivery, and address general non-disease specific problems such as health worker shortages and inadequate skilled birth attendances” (Sridhar 2010: 464).

² In addition to Norway, this initiative consists of Thailand, South Africa, Indonesia, Senegal, Brazil and France (Amorim et al. 2007)

³ Historically, Norway’s development assistance has been channelled multilaterally through the UN family or directly to the recipient country, bilaterally.

Cooperation's (NORAD) strategy towards 2012 (ibid), health continues to be a more and more prominent part of the policy. In terms of budget, Norway's engagement in global health is channelled through the aid budget, health being part of the development portfolio. Politically, however, health and development are separated and both are being used as means to different ends within foreign policy. In the 2012 state budget, aid makes up 27.8 billion NOK, or 1 % of GDP. Of this, 1.8 billion NOK is estimated for global health and vaccine initiatives (Zachrisen 2011).

Today Norway's development assistance for health does not make up more of the aid budget than in 2005, when Stoltenberg II took office. New initiatives within health, however, have gained more focus and resources, while others have diminished in priority and funds. This means that while politically speaking, nothing new has been agreed upon there has been a shift from right-based arguments towards technocratic and instrumental justifications within development assistance for health. This shift entails an 'evidence-based' approach and a pervasive 'trust in numbers'.

The Norwegian focus on and engagement in global health has in many ways changed; including a range of new initiatives and actors at the same time as the bilateral health related aid has changed. The engagement and focus have become more vertical, targeted, and many would say simplistic, but within a far more complex global health arena⁴. This emergence of institutional pluralism can be understood as a manifestation of globalization of health (Chen et al. 1999). Since the 1960s, Norway has had a tradition of "multilateral and bilateral aid funding to primary health care interventions in developing countries, building on an extensive history of missionary medicine" (Sandberg and Andresen 2010: 308). In the beginning of the 1990s, Norway's approach to global health was focused towards comprehensive health care (Ofstad 1992). At the same time, NORAD

⁴ As I will come back to in the analysis, the bilateral agreements have in many ways declined, however, five new bilateral initiatives have been initiated to focus on MDG 4 and 5. Nevertheless, it can be argued that they, despite being bilateral agreements, also are vertical and strategically chosen, hence, illustrates the change in focus.

was sceptical towards the disease-specific focus, or vertical approach, within health aid unless the recipient country specifically asked for support to fight Tuberculosis (TB), AIDS or leprosy. Back then, Norway was also pushing UNICEF to adopt a broad approach to health, focusing on more than just specific diseases and emphasizing a horizontal approach with a broader set of determinants (Ofstad 1992). The attempt to adopt a broad approach was due to the fact that the early vertical approaches – disease eradication campaigns being the most prominent, had led to a deterioration of health systems. Or rather as Buse and Waxman warned in 2001 that it created “islands of excellence in seas of under provision” (Buse and Waxman 2001: 750).

1.1 Research questions

My focus in this thesis is on changes and shifts in the development assistance for health and what I see as paradoxes within that policy. I will explore the power and processes in health policy, how some issues make their way onto policy agendas, how to frame these issues so that they are better received, how policy makers treat evidence, and why some policy initiatives are implemented while others languish (Buse et al. 2005). To do this I will use central concepts from the health policy analysis framework; *actor*, *context* and *process*.

The changes in focus and importance in NDAFH prompt some questions. What enforces these policy shifts and changes? Is it due to national actors and national politics, or due to changes in the international development and health agenda and discourse?

According to Walt et al. (2008: 309), the main question in health policy analysis is often “‘what happened’, to the neglect of ‘what explains what happened’”. In this thesis I will try to go beyond ‘telling the story’, I will try to explain what has happened which mechanisms have fuelled and influenced the process and how global health has risen to its current prominence within the Norwegian development assistance?

With this in mind, I have interviewed different actors from the Norwegian global health arena – the different agencies and actors participating and having interests in global health policy. In addition to these, I have interviewed people outside this arena, sitting on the outside looking in. These are people working with global health in different ways. My methodological approach has been a flexible one, using semi-structured, in-depth interviews, reading documents and observation, allowing the different parts of the analytic process to influence each other. My focus has been the established bureaucracy. Norwegian non-governmental organisations (NGOs) have until recently had little interest in health. Although, it needs to be mentioned that the focus on HIV/AIDS can be seen as a forerunner for these vertical approaches to health burdens, and that NGOs have been essential in putting HIV/AIDS on the political agenda, however, this lies outside of the scope of this theses.

1.2 Rationale

In February 2012, Norway issued its first white paper focusing solely on global health – Report no. 11 (2011-2012) to the Storting: *Global Health in Foreign and Development Policy*. Having a white paper solely on one topic has emphasized the importance of this topic, highlighting global health as important both for development and foreign policy. Health has traditionally been a satellite within development assistance, whereas now it is considered a core theme “approaching high politics” (Sandberg and Andresen 2010: 302). The concept of health and development as part of foreign policy is not new (cf. Fidler 2011a, Stokke 1987), however, the way health and development is framed, approached and implemented is. Is there more to it than just a shift in approach from horizontal to vertical?

I was looking forward to this white paper, hoping it would address these changes in prioritization, frame a debate, or explain the recent shifts, however, it did not. Global health is now one of the biggest posts in the ‘aid-budget’ and new alliances have been initiated in the frame of global health. According to the Soria

Moria II platform (Stoltenberg et al. 2009), the main principals of the Norwegian development aid are drawn in Report no. 13 (2009-2010) to the Storting, stating that it should be poverty- and gender oriented, and that national ownership and development strategies should be emphasized. In addition to this, a human rights-based approach is central (NORAD 2012a). Looking closer, there seems to be a mismatch between this image and reality and there is also a lack of public debate addressing these issues. It is important therefore to explore and analyse the changes within global health policies in Norway. Global health is today, an important and integrated part of the Norwegian development portfolio, and more importantly, the foreign policy portfolio.

Throughout the last decade, the focus on global health - nationally as well as internationally - has risen to prominence on the political agenda. Health has always been a political issue, but not always seen as one. For a long time health and health inequalities were understood as a technical issue dealt with by medical experts and therefore not a political issue or concern. Health is now on the political agenda framed as high status issues within foreign policy. Health is no longer only a technical issue to be dealt with by medical practitioners; yet the policy approach is still highly technical. How globalization manifests itself in health is an important context for these policy shifts. How international health has transferred into global health has also influenced the Norwegian development discourse. Globalization entered the development literature with full force during the 1990s. The term has multiple and contested definitions and meanings. In this thesis globalization is seen as

“a process of greater integration within the world economy through movements of goods and services, capital, technology, [microbes] and (to a lesser extent) labour, which lead increasingly to economic decisions being influenced by global conditions” (Jenkins 2004: 1).

Economy is here seen as one of the main drivers of health and development. In addition to this definition, I find it useful to also include some other aspects of globalization emphasized by Kelley Lee (2002). She considers globalization a product of the interaction of technology, culture and economics leading to

compression of time, space and cognition – time in the sense of everything being faster, space as geographic boundaries beginning to blur, and cognition as an increasing awareness of the world as a whole. Ill health or local or regional outbreaks of avian flu or other infectious diseases are not only something happening far away - with the compression of time and space they happen in our backyard. Ill health crosses borders. The fact that ill health in one place becomes a potential threat in another place has put health on the political agenda. It is not only a more interconnected world but also a world with greater interdependence. Health is therefore often framed as a security issue.

1.3 Structure of thesis

I have divided this thesis into seven chapters. I will start by presenting my methodological approach in Chapter Two, explain why a qualitative and flexible approach is of benefit when building an in-depth picture of the process, and illustrate why interviews can reveal valid data about the topic studied. In Chapter Three, I will look at the methods for studying health policy, and the challenges with applying these to a fragmented field with a proliferation of actors. I will also present the concepts used when seeking to understand what has happened and how it took place, and discuss why *power* is so important in order to understand these policy shifts.

A country's international or global health policies are not only a result of domestic processes and actors but also a result of the push and pull factors of international discourses and priorities. How has the changes on the global health arena influenced and manifested itself in the Norwegian agenda for health aid? In Chapter Four I identify four shifts in Norway's global health policy; a shift of power within the major actors in the global health arena; from being a topic dealt with by technocrats/medical practitioners in NORAD, to becoming a 'high politics' issue lead by the Minister of Foreign Affairs. With this shift health has become a soft-power tool creating political room for manoeuvre; a change in the overall focus within global health policy – from local to global. The bilateral

bonds between Norway and partner countries have historically been important, and the focus has been on local change – on better health or healthcare services at a local level. Now, the pendulum has swung and the focus is on global change, hoping for a ‘trickle down’ effect to the local; and lastly, this has led to a shift in implementation from its former broad horizontal focus to a vertical emphasis on the more specific diseases.

In Chapter Five I present a short historical overview of health-related development assistance in terms of global trends and then in terms of Norwegian development assistance. In this chapter I discuss how the focus on health has shifted and developed; different challenges, and different cures, have waxed and waned, for so to reappear throughout recent history. This overview is important for understanding the transition from international health to global health. There is no common definition of global health. According to Kickbusch (2006), global health can be understood as “those health issues that transcend national boundaries and governments and call for actions on the global forces that determine the health of people”. In international health, the nation-state played a more prominent role and the World Health Organization was seen as the major international health actor. According to Brown et al. (2006: 62), global health as a term “emerged as part of larger political and historical processes” along with the proliferation of actors on the global health field. Central to this is the challenging of World Health Organization’s dominant role and its effort to re-establish itself as the main actor at the global health scene.

In Chapter Six I focus on the turn of the millennium and the establishment of the MDGs. I highlight how the MDGs were embraced due to their alluring frames of measurability and simplicity, and their integrated and synergistic nature. I discuss also if the MDGs were in fact (mis)interpreted as a one-size-fits-all solution and hence, unintendedly strengthened the prevailing discourse and its emphasis on results and the mantra ‘what gets measured gets done’.

Lastly, in Chapter Seven, I will draw some concluding remarks highlighting the challenges brought by this shift in policy.

2. Methodology

This thesis is a study of a policy process in NDAFH. My aim was to build an in-depth picture of the process and try to understand how such shifts in focus can be promoted. The methods chosen for this thesis are therefore qualitative.

A qualitative approach enables the topic to be examined in depth and breadth, whilst also highlighting nuances (Thagaard 1998). According to Denzin and Lincoln (1994 in Thagaard 1998) qualitative study as a concept or idea implies emphasizing process and meaning that cannot be measured by quantity or frequency. A qualitative method is based on a broad and holistic understanding of reality, and on a subject-to-subject relationship between the researcher and the informant, implying that both the interviewer and the interviewee influence the process (Thagaard 1998: 16). Within a qualitative methodology, the focus is on the central tendencies in the material. This gives a broader and more accurate picture rather than a narrower selection which could represent a distorted picture of the process or reality being studied. To do this, the researcher must focus on the breadth of the stories told by the informants while also taking the researcher's own understanding and interpretation into consideration. The study must also include substantive sampling and efforts must be made to obtain data that might contradict or modify the analysis (Gilson and Raphaely 2008, Thagaard 1998). I found this important to bear in mind when talking to people both internal and external to the bureaucratic network surrounding this subject, since they had different approaches to and explanations of what had happened.

2.1 A flexible research design

I chose to apply a flexible⁵ research design which is the most common within qualitative method (Robson 2011: 70, 130). When using a flexible design there is also a need for a flexible researcher, this involves the “researcher-as-instrument”

⁵ Robson (2011) uses the term 'flexible' and not 'qualitative' since a so-called qualitative design can incorporate quantitative methods of data collection. These approaches show substantial flexibility in their research design, typically anticipating that the design will emerge and develop during data collection, therefore, he label them 'flexible'. However, Creswell and Thagaard use the label 'qualitative' and since the meaning is the same I will therefore use the terms interchangeably depending on which author I am referring to.

(Robson 2011: 132) meaning that the researcher, to a large extent, has to interact directly with the source subjects rather than relying on tools and instruments to collect data. According to Creswell (2007: 19) “the procedures of qualitative research, or its method, are characterized as inductive, emerging, and shaped by the researcher’s experience in collecting and analyzing the data”. Hence, the quality of the study depends to a great extent on the quality of the investigator (Robson 2011, Thagaard 1998). The researcher needs to gain knowledge about the topic, be prepared for the interviews, and be a good listener. In being able to listen to what the interviewee is saying and at the same time have a good level of knowledge about the topic, the interviewer is able to ask relevant follow-up questions.

The researcher’s flexibility is not only important within the interview setting. The flexibility that characterizes the qualitative research can be described as a cyclic model where theory, method and data are influencing each other (Wadel 1991 in Thagaard 1998: 25). Therefore, it is important to revisit the research questions and the interview guide and revise them if needed after exploring the background literature and relevant documents, and after conducting a couple of interviews. It is also important to listen to what the interviewees are actually saying, rather than only listening for what you want to hear. Including both reading of documents and literature and continual observation helps to expose the researcher to other approaches and thoughts, hence keeping the bias to a minimum. In this way, theory, data, and analysis mutually influence one another. The interviewer also needs to be open for new information that might influence the research in an unforeseen way. I experienced this process of work as demanding patience. It was an open process, and at times it feels like everything was floating. Nevertheless, I found this approach rewarding in the end.

A flexible design must be rigorous when it comes to data collection, analysis and writing (Robson 2011: 132). It is common to collect data by using a range of different techniques. I interviewed, read policy documents, and observation.

Hence I used a mix of interviews, reading of documents, and observation – interviews and reading of documents being the two main techniques.

2.2 Data collection

My aim in this research was to look at a policy process and try to understand a policy process – what had happened and how and why. To do this I chose semi-structured in-depth interviews as my main source for information. As recommended in a qualitative and flexible study I have interviewed and studied the theory, background literature and policy documents in parallel (Robson 2011, Bryman 2008, Creswell 2007). As mentioned earlier, this flexibility is characteristic for qualitative research. By doing all this in parallel it has been possible to calibrate the interview guide to both reflect what I found in the background material and documents, and also according to what I found during the first couple of interviews.

I conducted two rounds of interviews from October 2011 to June 2012, punctuated by a break where I worked on the background chapter, theory, and analysis. This break gave me the opportunity to get an overview of the data I had collected, and to highlight areas of analysis which required greater emphasis in the remaining interviews. I then held the second round with interviews, notably smaller in number than the first. Letting the different factors influencing each other resulted in a slightly change of focus and I realised that I had to move away from the theoretical framework to which I had originally subscribed in my research proposal. I found most of the theories dealing with health policy analysis to be too simplified, as they did not include the ‘messiness’ surrounding such a policy shift, cf. chapter 3.

To get good data I needed a purposeful sampling. A sample within qualitative research plays a very different kind of game than in quantitative research since it is not seeking to be representative of a whole population (Robson 2011). To decide who to interview I used a variety of different methods. While writing my research proposal, I talked to researchers within the field of global health and

development, and I also used LEVE's research network as a starting point when trying to get the overview over the Norwegian global health landscape. I also talked to a bureaucrat working with global health to get tips on who have been, and who are currently, central to the development of Norway's development assistance for health (bureaucrats, NGOs, and researcher, that had followed this process). The Norwegian global health sphere is not large, which made it easier for me to get the overview. I also used official documents to see how policy had changed and to understand who had been central at different stages in the development of the health related development assistance. After finding some informants, I used the snowball method; asking each interviewee if he or she could recommend other potential interviewees (Bryman 2008). I found this method very useful since it gave me contacts that my informants, who knew the process and the milieu better than I did, thought would be relevant for me – sometimes they confirmed people I had already selected or been recommended, and at other times they came up with new names.

2.2.1 Semi-structured in-depth interviews

I chose semi-structured in-depth interviews as the primary source of information. This type of interview is characterized as “a series of questions that are in the general form of an interview schedule but [the interviewer] is able to vary the sequence of questions” (Bryman 2008: 196). The interviewer also has some latitude to ask further questions in response to significant replies (ibid). It can be seen as a conversation between the researcher and the interviewee about the topics the researcher wants information about. The topics are decided by the researcher but the order is flexible and the interviewer follows the interviewee's story. It is of importance that the interviewer is also able to further probe topics or approaches that the interviewee may come up with that the interviewer has not identified in advance (Thagaard 1998). The interview is used to obtain information about specific situations or processes, not to generalize (Kvale 1997: 39).

I chose interviews because I wanted to get insight into the process; what had happened and how, and interviews can reveal the interviewee's ideas, reflections, and thoughts about the topic. I was interested in the different oral narratives; what they told me and how. A semi-structured in-depth interview gives the interviewer the possibility to be flexible, listening to the interviewee and what they tell, and elaborating on it. I wanted to hear their thoughts about their understanding of what had happened and why the policy process had developed in the way it did and perhaps how it is still evolving.

During my interviews I used an interview guide with key questions and topics. My interviewees held different knowledge about the process, some through direct participation in it, others from the outside. Before every interview I therefore had to gain as much knowledge as possible about the interviewee to be able to ask relevant questions. This preparation was also important for me to be able to be flexible and ask relevant follow up questions. With knowledge about the interviewee's background and experience it was easier for me to structure the interview. I opened every interview with an open question about what had happened and how, in order to allow the interviewee to give their overall opinion and to indicate which change(s) they found most important. By doing this, I got feedback on variables I had not thought of as important, and the interviewee's narrative/story was at the centre. This, however, did not mean that the interviewees got to decide the agenda for the interview, but only that their responses influenced the order of the questions and topics.

There are contrasting viewpoints regarding to which degree interviews can reveal the truth about the topic studied. The two opposite approaches are positivism and constructivism (Thagaard 1998). A positivistic approach presupposes that the informant's or interviewee's experience and hence description of the world is correct. In this approach, the researcher is seen as a neutral person, or mediator of the interviewee's truth. On the other hand, a constructivist approach claims that the relationship between the researcher and informant is of greater importance and that the information you get, or the story told, is a result of this specific

context (Bryman 2008, Thagaard 1998). Hence, an interview cannot give you valid data about the reality since the answers are context-bound and depend upon how the interviewee perceives his or her own experience. I choose a middle ground between these two approaches, where the information collected through interviews represents more or less true descriptions, but at the same time, is influenced by this subject-subject relationship between interviewer and interviewee and how they perceive each other in addition to the interviewee's reflections of his or her knowledge (Thagaard 1998). The knowledge is produced through this interaction between the interviewer and the interviewee (Kvale 1997: 75, Thagaard 1998), implying that both the interviewer and the interviewee influence the process. A qualitative interview is two-sided in nature. On the one hand, the interview must also be seen as a complex interpersonal process where the data or answers the interviewer receives depend on how the interviewer and the interviewee perceive each other (Thagaard 1998). I did experience some interviews going better than other, however, I do not believe that it influenced the validity of the answers. It may, however, have influenced the amount of information garnered and how the interviewees presented their stories. My research topic is not related to my informants' personal life; it is more or less exclusively related to their professional life, which makes these objections less relevant for the validity of my data.

Challenges related to using interviews

Even though I believe that using interviews as a tool for data collection did not influence the validity of the information gained, this does not mean that there are no challenges related to using this tool. My interviewees were mainly from the global health arena in Norway, representing bureaucrats, researchers and representatives from the civil society. The majority were bureaucrats. According to Terje Tvedt (2009: 234-5) there are several drawbacks with using interviews when focusing on the Norwegian development system, one of them being related to the bureaucratic language. The Norwegian development system's description

of itself is so dominating that it represents a challenge for its “members” to use different vocabulary.

The language used is a consensus-based language, obscuring possible internal conflicts, making them hard to uncover without any knowledge of the field. By using this collective vocabulary, the system is strengthening itself, and the ruling ideas as being valid (ibid). I experienced that some of my interviewees were speaking in general terms, and that it was difficult to move beyond this. Especially one interviewee was using a general policy language talking in terms of official policy. When trying to move beyond this by asking more specific questions, and questions to reflect upon, the interviewee ‘zoomed’ back to the policy language only answering parts of the questions. One factor influencing this might have been the time frame. Some of the interviews lasted for an hour, giving me time to build trust and to move beyond this language; however, other interviews were by necessity completed within 20 minutes, giving me limited time to focus on building a relationship with the interviewee. I also believe that by representing a directorate or ministry interviewees can feel obliged not to stray beyond this common language, hence presenting the policy and not their own thoughts about the policy. Nevertheless, I do not think that this influenced the validity of the data, even though some would argue that it may have. As an interviewer, I observed how interviewees presented their responses, to see if there were questions and topics they avoided or if their language changed during the interview – some questions being answered in general terms while others being answered using a more personal language. I also experienced that some interviewees had decided in advance what to tell me, and that even though they moved beyond using general terms, they avoided some questions and topics.

These nuances resulted in each interview taking on distinct structures, with some interviews being more formal while others being more like a conversation. In some of my interviews I also experienced that the interviewee started to ask me questions, being interested in my opinions and thoughts about the topic. In the beginning I was reluctant to answer, being afraid of influencing the interviewee’s

answers. However, I realised that by being open and sharing some of my thoughts, they opened up and reflected upon the topic more freely. These interviews were all with people that had made it clear that they talked on behalf of themselves and not on behalf of their workplace, which again made it easier for them to move beyond bureaucratic language. During the more formal interviews, I also experienced that by showing, through the questions I asked, that I held a certain level of knowledge about the topic, the interviewee also told me more and elaborated more on certain topics.

One challenge regarding interviewing bureaucrats is that they often have a tight schedule, and often I had to wait for months for them to make room for an interview in their schedule. That said, many replied quickly and found time for me within a couple of weeks. Having some difficulties or challenges regarding booking interviews and in encouraging interviewees to extend their responses beyond the official policy, it was natural to focus more on the reading of documents and text, conducting the interviews in parallel with this and the reading of background literature. Nevertheless, this parallel approach turned out to be something positive, giving me time to have a flexible design and approach.

Anonymity and confidentiality

An important issue within social science research ethics is the principle of informed consent, meaning that the informants are given enough information to be able to make a decision whether or not to be interviewed. When contacting the potential informants, I told them briefly what I was focusing on and asked them to get back to my supervisor or me if they had any questions. I also started most of the interviews by telling the interviewees about the project and my background. In some of the interviews, this was done a bit further into the interview. During the interview, I also asked them whether they wanted to remain anonymous, something most of them wanted. The global health sphere in Norway is quite small, and the different camps or branches within this milieu are well-defined, making it easy to trace the source of the information. Nevertheless,

I have done my best in trying to hide my informants' identity. Since the majority of my informants wanted to be anonymous I have chosen to anonymize everyone. Respecting this anonymity, I have also tried to use as few direct quotes as possible.

2.2.2 Reading documents

When I started to work on the idea for this thesis, Norway did not have a white paper on global health. Norway's first white paper on global health was supposed to come in February 2011; however it was delayed till February 2012. In addition to this white paper I have used official documents, such as policy documents from NORAD, white papers on development policy and issue reports, progress reports and evaluation reports on MDG 4 and 5 and other global health related topics within the development portfolio. These texts represent the ideal or formalized policy; what Norway has done, or what we are planning on doing; and it was interesting to compare these findings to the ones from the interviews – seeing how and if they fit together. These documents became important as they provided me with the official argumentation and justification for these changes within the global health policy, or the lack of it. They also serve as historical sources, telling a story about changing foci and priority areas within Norwegian health related development aid. In addition to these documents, I have also used political speeches and articles by Prime Minister Jens Stoltenberg and former⁶ Minister of Foreign Affairs Jonas G. Støre. In addition to official documents and white papers I also used intra- and intergovernmental correspondence on global health related issues from electronic public records, however, not all of them were easily accessible, and I was denied access to some. Decision-making processes are often opaque, and obtaining relevant documents and papers can be problematic (Walt et al. 2008: 310).

⁶ The 21st of September 2012, Jonas Gahr Støre was appointed the new Minister of Health, succeeded by Espen Barth Eide, the former Minister of Defence.

2.2.3 Observation

As mentioned earlier, I combined interviews and the reading of documents with observation. Throughout my research period I participated in meetings, seminars and conferences related to global health whenever possible. To see who participated in which meetings, who were talking, what kind of stories they told, and how they told their story, have been interesting and very useful for me in my research. These seminars and meetings were also important for me when deciding whom to interview; they helped me to gain an overview of central actors and to find out whether contrasting camps or approaches existed within the global health milieu.

In the beginning of the autumn, before I had started the interviews, I attended the conference ‘Contributing to Global Health Research, Capacity building and Governance’. The aim for this conference was to increase the attention on the global health challenges and to work for an increased Norwegian and Western contribution to medical research on the global health and disease burden. Which areas were seen as successes and which were emphasized as challenges? I also attended the seminar ‘Universal coverage: Women’s and children’s health’ arranged by LEVE and Save the Children. After starting with interviews, I attended a half day seminar at the Norwegian Directorate of Health focusing on health and human rights, where the report ‘The Health of the World’s Poor – a Human Rights Challenge’ was presented. In February 2012, the white paper on Global Health in Foreign and Development Policy was launched followed by a seminar on the role of women and women’s health in economic development at the Norwegian Knowledge Centre for the Health Services. In addition to these seminars I have attended student seminars and meetings related to global health whenever possible.

2.2.4 The researcher’s role

When doing qualitative research it is important to recognize that your background shapes your interpretation – to have a hermeneutic notion that I

myself as a researcher am inevitable a part of the material. I have an interdisciplinary background from development studies and environmental science, and I have also been engaged in several NGOs working within this field. When starting to develop the idea for this thesis I had very little knowledge or experience in global health, neither from former studies nor from civil society. I had only touched upon the topic of health when focusing on other development related topics. That said, I had a pre-existing interest in development policy, especially how Norway uses peace-, development-, and humanitarian aid and policy to build a self-image – branding Norway – and on how certain topics managed to make it to the top of the agenda, while other failed. What caught my attention when starting to look into the world of global health and Norway’s engagement within this field was how certain topics and approaches had waxed and waned in importance throughout history, and the paradoxes or contradictions that I found in the Norwegian global health policy.

I see both pros and cons writing about a field that to some extent is quite new to you. I invested some time in reading background literature to gather essential knowledge about Norway’s foci and international trends. I did not have a clear idea about what to look for in advance and I had no in-depth knowledge about internal processes and conflicting approaches, this was not necessarily a bad thing. I entered the field open minded and unbiased regarding internal conflicts and conflicting approaches, having to learn everything from scratch. Even though I may not have been biased regarding the global health policy, my background in development studies may have biased me regarding the Norwegian aid system. Research is, in the most cases, founded upon the researcher’s values, hence rarely being value-free or politically neutral (Robson 2011, Thagaard 1998), and it is important to bear in mind that “[w]e (re)present our data, partly based on participants’ perspectives and partly based on our own interpretation, newer clearly escaping our own personal stamp on a study” (Creswell 2007: 43). As a researcher you need to be aware of the fact that your own biases and expectations

influence the way you ask questions and follow up on replies (Bryman 2008: 444).

As a researcher you are also an ‘outsider’. Within this lies a disadvantage relating to access, on the other side, the outsider’s advantages lie in curiosity for the unfamiliar, the ability to ask taboo questions, and in being seen as impartial (Walt et al. 2008: 314).

Doing research the interdisciplinary way

As mentioned above, I have an interdisciplinary background; hence I do not have a background or training in one particular way of looking at, perceiving, and interpreting the world surrounding us. My topic is located somewhere in the intersection of political science, international health, history, and development studies. Manoeuvring within this landscape of known- and unknown approaches and traditions has been challenging, nevertheless also interesting and rewarding. I found it especially challenging when focusing on the theoretical part, having limited knowledge of theoretical tradition within political science and policy analysis. The process of deciding which theoretical framework to use as a tool to better understand this process that Norway has been through was not an easy one. Having an interdisciplinary background can be seen both as a strength and a weakness, the latter due to the lack of a given set of lenses to see the world through, no disciplinary *doxa*⁷. However, this has enabled me to see other things, (since I did not know what I was looking for in the first place), and to approach the field with an open mind. With an explorative research question, I am emphasizing a dialectic relationship between theory and findings, using the theory as a tool to better understand and interpret the empirical data (cf. chapter 3). The theory will help me to see some of the areas more clearly, however, not necessarily all of them.

Being a master student at the Centre for Development and the Environment, I am also interested in sustainability. The long-term goal of development aid should be

⁷ Cf. Bourdieu 1977.

to build resilience and robustness in the local context in order to create sustainability. How does the Norwegian approach to global health fit into this?

2.2.5 Storing data – recording and transcription

In addition to documents, my data was mainly collected through interviews. All the interviews were recorded and transcribed. I chose to audio-record the interviews to be able to focus more on the interviewee and what was being said and only take some key notes for follow-up questions instead of having to concentrate on getting notes. By being able to listen to the interviews later I was able to adjust or correct my own biases and also to hear what the interviewee emphasized, not only *what* was said, but also *how* it was said. However, using a tape recorder can also create a distance between the interviewer and the interviewee; the interviewee can be reluctant to share certain thoughts or meanings – not wanting them on tape.

Transcribing interviews is time-consuming, but nevertheless, I found it very useful in making it possible to get a thorough examination of what people said and it helped to correct the limitation of my memory. After every interview, I wrote down my thoughts and feelings about the interview, how it went, if the interviewee was talkative, where it took place and if it opened up new avenues of interest. After transcribing, the audio files were stored together with the transcribed version.

3. Processes, partners and power

In this chapter, I present the health policy analysis approach, and elaborate on the challenges involved in undertaking health policy analysis before I present the central concepts that I am using as tools to better understand the changes in policy. Globalization manifests itself quite clearly in the health realm through a proliferation of actors. Within this new landscape of global health, the state gets a new role. We see new concentrations of power where the state has less influence. One of the shortcomings in health policy analysis is that the concept of power remains under- used and hence under-researched (Buse et al. 2007: 3). I discuss therefore Foucault's concept of governmentality and its usefulness in analysing the changes seen in Norwegian global health policy, and suggest a use of the concept as integrated with the concepts of actor, context, and process.

Setting the scene

The global health field has experienced distinct changes the last 10 – 15 years. From being an arena characterized by consensus, it is now characterized by conflict (Walt and Gilson 1994). The World Health Organization (WHO) is no longer the only inter- or supranational organisation working on health. Globalization is manifesting itself within health, inter alia through the emergence of institutional pluralism (Chen et al 1999). Myriad actors have entered the field, embodying different solutions and approaches to the challenges, hence increasing the complexity of the field for diplomats and health bureaucrats.

These changes in the global arena have also influenced Norwegian engagement within the health field. Norway's current global health engagement is channelled through the 'aid budget'. Nevertheless, it has been lifted out of traditional aid frames and up to a level of 'high politics', also falling within the domain of Norway's foreign policy. As we will see, health has become an area of strategic importance for Norway; global health is more than 'just' aid (interview 12, 22.06.2012). Health is now being lifted up from the realm of national responsibility and is perceived as a global area of responsibility – to use the

words of the Minister of Foreign Affairs; “Health is everybody’s business” (Støre 2012). Due to changes in health – from international to global health – it has also become a prominent issue within global governance. To focus on Norway’s engagement in global health is to focus on an area of change. Norway’s global health policy cannot be isolated from the global field as it is to a certain extent influenced by the international and global trends. Similarly, Norway is a significant player on the global health arena, and thus influence (Interview 12, 22.06.2012).

3.1 A matter of theory

As I touch upon in the methodology chapter (cf. chapter 2), deciding which theory or theoretical framework to use was not easy. A theory should not limit the analysis. At first glance, the health policy analysis approach; “a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process” (Walt et al. 2008: 308) seemed like a natural choice when trying to better understand the mechanisms within these policy shifts. Health policy analysis can help explain why health policy or health-related policy changes, or why certain health issues receive political attention while others do not. It can be helpful in increasing “our understanding of complexities of health policy processes and provide insight as to how best to intervene in developing and implementing policy” (Buse et al. 2007: 3).

Nevertheless, I found these different theories and frameworks somewhat insufficient. The theories and frameworks within the health policy analysis approach focus on different aspects of the policy process, not the whole, and much of the literature is characterised by case studies on particular issues (ibid). These approaches did not really grasp the different aspects, complexity, and ‘messiness’ of the process that I found interesting – there was more involved in this process than these frameworks could encompass. As already mentioned, the concept of power is often under-researched within this approach, a concept I find

essential to include in my study. Within health policy analysis, “the need for ‘thick description’, rather than ‘parsimonious models’” (Walt and Gilson 1994: 354) has been argued for. According to Gilson and Raphaely (2008), the main question within health policy analysis is often ‘what happened’, which does not focusing on explaining the reasons behind change. Despite these shortcomings, I found the concepts of process, actor, and context helpful when seeking to better understand the recent policy shifts.

I will proceed more on the health policy approach; its strengths and the challenges; and present the concepts that I choose as a guide for my analysis.

3.2 Health policy analysis

Health policy analysis is argued to be a multidisciplinary approach to “policy that aims to explain the interaction between institutions, interests and ideas in the policy process” (Walt et al. 2008: 308). It can be used both retrospectively, to understand the failures and successes of past policy, and prospectively, to plan for future policy implementations (ibid). Here, I am using central concepts from this approach to better understand the processes that have taken place in Norway throughout the last decade. Health policy analysis is derived from policy analysis which “draws on concepts from a number of disciplines: economics, political science, sociology, public administration and history and emerged as a subdiscipline in the 1960s” (Walt and Gilson 1994: 358).

As with policy analysis, health policy analysis consists of many different theoretical frameworks with different approaches and different focus points. According to Gilson and Raphaely (2008: 294) “[l]iterature on health policy analysis in low and middle income countries (LMIC) clearly demonstrates that politics, process and power must be integrated into the study of health politics and the practice of health system development”. Even though their study is about health policy analysis in LMIC, it resonates when studying Norway’s engagement in global health, where aid policy and aid money influence the health status in the recipient country. Health priorities and policy options in

recipient countries are “frequently determined by international actors and agencies (...) [that] provide support for various initiatives” (Johnson 2009: 1). I will apply central concepts from health policy analysis literature to my study of NDAFH, as the purpose of both health policy and development assistance for health concerns the health status of a given group of people, whether or not this group is located within the ‘donor’ state’s own borders.

During the 1990s, new paradigms of health policy analysis began to emerge, focusing less on the technical content of the policy – the “what” of policy – “and more on the actors, power and processes involved in developing and implementing policy, and the contexts within which decisions are made” (Buse et al. 2007: 1). These aspects are important when trying to understand why and how certain policies succeed while others do not. There was a call for new ways of thinking regarding health policy analysis “to enable understanding of the factors influencing the experience and results of policy change” (Gilson and Raphaely 2008: 295). It is now widely acknowledged that ideas, knowledge, interests, power, and institutions influence the policy process. The study of these processes is often concerned with public policy, focusing primarily on how problems are defined, how agendas are set, and how the policy is (re)formulated and implemented (Parson 1995 in Gilson and Raphaely 2008: 295). This approach is based on an understanding of policy as a product of - and constructed through - political and social processes (ibid: 295). “Policy is not simply about prescription or description, and nor does it develop in a social vacuum; it is the outcome of complex social, political and economic interaction” (Walt and Gilson 1994: 359). Both global trends and domestic interests influence policy. “Seeing policy as a dynamic process is also key to this analysis: the policy environment is continuously shifting, transforming relations between groups and between institutions” (Walt and Gilson 1994: 366).

Since health policy analysis is a somewhat conglomerate of theoretical frameworks and approaches trying to explain different parts of health policy, I find these frameworks, when taken individually, tend to over-simplify the reality,

and I find none of them entirely satisfactory in its own right. In the next section I will elaborate on the shortcomings of health policy analysis as an approach before I present the conceptual ideas; actor, context, and process.

3.2.1 Challenges of ‘doing’ health policy analysis

According to Walt et al. (2008: 309) “It is important to contextualize the health policy environment in order to understand the challenges to methodology and theory”. One of the major challenges is, as already mentioned, the changes that have occurred on the global health scene. In addition to this, health is also influenced by many determinants outside the health system or policy sphere, and health policy should, therefore, also have an interest in external factors (Buse et al. 2005: 6). This in turn makes health policy a somewhat larger and more complex field for the different approaches to simplify in order to manage.

According to Lodgaard (2007), complex realities are being simplified to enable the decision maker, being a bureaucrat or a politician, to manage or deal with them. This has led to a “greater recognition of the need for more open-ended forms of analysis, ones that can take account of the characteristic complexity and messiness of (policy-making) processes” (Czarniawska-Joerges 1992: 16 in Storeng 2011). However, processes of making policy are, according to Walt et al. “not necessarily overt or clearly bounded” (2008: 310). Decisions are part of processes, and are therefore emergent rather than taking place at a single point in time. Hence, the process of policy making is hard to observe and therefore difficult for the researcher to unpack and explain (Walt et al. 2008: 310). “It can also be difficult to ‘tell the story’, without getting immersed in detail. Researches have to find ways of organizing their analysis so that it provides a lens that represents but also explains a highly complex environment” (Walt et al 2008: 310).

Health policy analysis is of course focused on health policy and health issues, whereas development assistance for health is focused on both health issues *and* health as a means for other ends – as part of a country’s foreign policy domain –

and lately also as part of ‘high politics’. These factors result in mainstream health policy analysis coming up short when trying to explain what has happened in a policy change and how health policy manages to serve medical technical need, altruism, idealism, and *realpolitik*. The “developments over the last decade have forced public health experts and diplomats to think of health *as* foreign policy, namely public health as important to states’ pursuit of their interests and values in international relations” (Fidler 2007a: 53), leaving health as a relatively new topic within International Relations.

To capture and measure the different levels of resources, values, beliefs, and power within the different actors in health policy development is a challenging activity. What Hunter (2003, in Walt et al. 2008: 310) calls “the curse of temporal challenges” is of importance here; the tension that can often be found between the long-term nature of policy development and implementation versus policy-makers’ demand for quick answers and remedies.

Despite the shortcomings described above, I have found the concepts of actor, context, and process useful when trying to understand the policy shifts. I will elaborate on these concepts in the next section.

3.3 My conceptual ideas and their role in policy shifts

I base my conceptual ideas on Walt and Gilson’s policy analysis triangle; “the most commonly used overarching framework” (Gilson and Raphaely 2008: 301). This framework “acknowledge[s] the importance of looking at the content of policy, the process of policy making and how power is used in health policy” (Buse et al. 2005: 8). Walt and Gilson’s framework can be applied to both low- and middle-income countries as well as to high-income countries and is often used to help “explore systematically the somewhat neglected place of politics in health policy” (ibid: 8-9). The approach borrows different elements from different disciplines and uses them eclectically (Walt 1994: 3). Nevertheless, this approach is a simplified approach to a complex policy field with different interrelationships, and these concepts or factors cannot be dealt with separately.

Actors are influenced by context and vice versa, and values, beliefs and culture affect both. The process, on the other hand, is influenced by actors and their position and power in different organizations and contexts. The policy triangle can be useful for helping to think systematically about the factors that can affect policy, however, it comes up short when looking at the details, or as Buse et al (2005: 9) explains it; “it is like a map that shows the main roads but that has yet to have contours, river, forests, paths and dwellings added to it”.

By focusing on the process, the actors and their behaviour in “formulating and implementing policy and the context in which policies are promulgated” it becomes clear that policy is not just about description, and that “it is the outcome of complex social, political and economic interactions” (Walt and Gilson 1994: 359).

3.3.1 Actor

According to Walt and Gilson (1994), actors are at the centre of the health policy framework, and when dealing with how policies or decisions are made, one has to recognize who is influencing policy (Walt 1994: 35). Actors can here be recognized as both state and non-state actors, individuals and groups, interest groups, NGOs, civil society organizations – groups that “do not seek formal political power for themselves, although they want to influence those with formal political power” (Buse et al 2005: 9), and political parties.

Actors, as both individuals and groups, can be national or international, and they will try to influence policy processes at local, national, regional, or international level. Even though the term ‘actor’ can be used to denote individuals, organizations and agencies, or states and governments, and their actions that affect policy, it is, according to Buse et al (2005) important to recognize that it can be hard to distinguish between them. Individuals are influenced by the organizations, within which they work, and organizations, groups or governments, are made up of the individuals, and it cannot be taken for granted

that all of these individuals will speak with one voice – their values, interests and beliefs may differ (ibid).

As we shall see, Norway as an international actor consists of different actors with different agenda, interests, and approaches. Actors do not operate in isolation. Their position power and values influence their ability to set the agenda, frame issues, identify problems and come up with solutions. (Buse et al. 2005). Actors often become part of networks, such as policy networks or epistemic communities which are loose networks of actors or professionals “with recognized expertise and competence in a particular domain and an authoritative claim to policy relevant knowledge within that domain or issue-area” (Haas 1992: 3). Central to these policy networks is that they encompass both formal and informal linkages and interactions, and these linkages that bind a network together can, in turn, create exclusivity (Lee and Goodman 2002: 103).

Different actors have different opportunities to influence the policy process, depending on their perceived or actual power which is characterized by “a mixture of individual wealth, personality, level of or access to knowledge, or authority, but it is strongly tied up with the organization and structures (including networks) within which the individual actor works and lives” (Buse et al 2005: 10). Here, power can be seen as interplay between agency and structure; actors’ ability to act, their agency, is intertwined with the structures, their organizations (ibid).

Actors make up and configure the changing institutional landscape (Standing 2004). In the global arena, focus has shifted from the state – the government and public sector – to a much larger array of actors, including the private sector, Public-Private Partnerships (PPP) and the global civil society (Walt et al. 2008: 309, Buse et al 2005). These changes in the institutional landscape must be seen in relation to changes in the contextual socio-political orthodoxy of what Giddens (1999) has called the Third Way – making it possible to open up the heart of social democracy for privatization and neoliberalism. In Norway, as we shall see,

this can be seen as a left-wing or centre-oriented government's ability to embrace and promote a right-wing development policy that emphasizes results and measurability. Actors can also have shifting roles, and possess different roles and power positions at the same time, like being a politician and member of the board of an international organization or PPP at the same time. The new constellation of power that has come with the proliferation of actors and partnerships has also brought with it the need for governments to more centrally involved. It has become politically important for states to be represented in these power concentrations. When WHO initiated new partnerships with the private sector, notably the Global Alliance for Vaccines and Immunization (GAVI) and The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), it became politically important for the Norway government to take part in it since it represented an embodiment of different authorities or power that had been spread on several actors earlier. WHO still holds a normative and technical authority, but no monetary authority.

Powerful actors also use their power to get other actors to do what they want; they exercise their power by framing issues in specific ways. Framing, according to Bøås and McNeill,

“serves to limit the power of potentially radical ideas to achieve change. A successful framing exercise will both cause an issue to be seen by those who matter, and ensure that they see it in a specific way. And this is achieved with the minimum of conflict or pressure. For the ideas appear to be ‘natural’ and ‘common sense’” (2004: 220 in Bull and McNeill 2007: 37).

The media is often seen as a powerful tool for agenda setting as it can draw attention to certain topics or happenings. However, there has been no public debate about the shifts in Norwegian global health policy. Due to this, little media attention has been given to global health, except in the case of the swine flu – but even then with a focus on national health and security.

3.3.2 Context

“Context refers to the systemic factors – political, economic and social, both national and international – which may have an effect on health policy” (Buse et al. 2005: 11). There are different types of contextual factors, and Leicher (1979 in Buse et al. 2005: 11) categorizes them into situational, structural, cultural, and international and exogenous factors.

Situational factors are often more or less “transient, impermanent or idiosyncratic conditions that have an impact on policy” (Walt 1994: 30). These factors can be referred to as ‘focusing events’; an earthquake, an outbreak of a pandemic influenza or the inauguration of a new government can be examples of situational factors. “Situational factors such as (...) change of prime minister, may provide opportunities for change not usually perceived possible” (Walt 1994: 34). As we shall see, a new Prime Minister with vaccination as a passion, or a Foreign Minister with a background in WHO and global health can be seen as examples.

Structural factors are the “relatively unchanging elements of the society and policy” (Walt 1994: 30) and include the political system and the level of democracy and civil society’s ability or opportunity to influence it and hence participate in policy discussions and decisions (Buse et al 2005: 11). National wealth is also a structural factor alongside with technological advancement, the type of economy and employment base.

Cultural factors can also influence health policy, and can be understood as the “value commitments of groups within communities or the society as a whole” (Walt 1994: 30). These factors have, for instance, influenced reproductive health policies in several countries. The political culture must here also be seen as a cultural factor, as it “affects people’s participation and belief in government and change” (ibid: 32). Language and the status of women are other cultural factors that may influence policy. A country’s tradition for development assistance or

self-image as a humanitarian superpower or aid giving nation can also be seen as a cultural factor.

International and *exogenous factors* can be seen as factors that lead to greater interdependence between states, influencing the sovereignty and international cooperation. Few countries or health policies are immune to international influence, whether through international conventions or transnational corporations. Some health challenges are dealt with at a national level, however, overcoming some challenges requires cooperation between national, regional, and multilateral organisations. Immunization serves here as a good example. The MDG are an example of an international factor that has influenced the policy agenda, and so too are the establishment of Bill and Melinda Gates Foundation (BMGF) and GAVI. Some countries, mostly high-income countries, “also voluntarily adopt policies so as to coordinate action to address global health threats”, e.g. SARS and pandemic influenza (Buse et al. 2005: 138). As we shall see later, actors frame health in different ways. Framing health as a security issue has been successful in putting infectious diseases on the political agenda in many high-income countries, helping to coordinate the action against- and concentrate the focus on some health issues. Policy conditionality in development assistance is another example of an international or exogenous factor. NDAFH is influenced by international factors like the MDGs and actors like GAVI. However, Norwegian development assistance is again an exogenous factor for recipient countries, focusing on vaccination and maternal mortality. “With the intensification of global integration, these global factors are playing an increasingly prominent role in national policy making” (Buse et al. 2005: 137).

All the factors presented above are complex and unique in both time and place (Buse et al. 2005: 12). To be able to understand “how health policies change, or do not, means being able to analyse the context in which they are made, and try to assess how far any, or some, of these sorts of factors may influence policy outcomes” (Buse et al. 2005: 12). The changes in Norwegian global health policy

must be seen as a result of several of these factors, both domestic and international.

3.3.3 Process

Within health policy analysis literature there exist several frameworks and approaches for understanding policy processes. The process(es) of policy making can be seen as “the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated” (Buse et al. 2005: 13). When studying processes within the health policy analysis approach, the ‘stages heuristic’, and Kingdon’s ‘three stream approach’ are the most common ones. The actual policy process is neither necessarily linear nor sequential, and is therefore difficult to identify and theorize about.

The ‘stages heuristic’ approach divides the process into four different stages; problem identification, issue recognition and agenda setting; policy formulation; implementation; and policy evaluation. Nonetheless, policy-making processes are seldom rational processes; they are rarely linear, clear or obvious. They are often iterative and affected by the values and interests of the different actors operating within the organizations. On the other hand, Kingdon’s three stream theory argues that policy process has a more random character with problems, policies and politics flowing along independent streams. For an issue to make it onto the agenda the problem has to be identified, there must be a solution to the problem, and there must be political will to change it. If all this happens at the same time, the issue will get onto the agenda (Buse et al. 2005: Walt 1994). As we shall see, the way immunization made it to the top of the global health agenda in Norway was through the problem being identified (the tragedy of the child), a solution existing (vaccines,) and the existence of political will (a new Prime Minister with a passion for vaccines and a PPP with focus on vaccines).

The study of a decision-making process, and how it has been influenced by ideas, knowledge, interests, power and institutions, should primarily be “concerned with public policy and pays particular attention to how problems are defined,

agendas are set, policy is formulated and re-formulated, implemented and evaluated” (Parson 1995 in Gilson and Raphaely 2008: 295).

3.4 How to study global health policy?

In this section I will focus on how health policy analysis is affected by the proliferation of actors. To study the shifts in Norwegian global health policy is to study an evolving field. The increase of actors, powerful in terms of resources, has influenced the concentration of power and thus the state’s ability to influence. There has been an “increased porosity of the borders between the public and private domains” (Kaul 2006: 88). This has made the field more complex, and is one of the reasons why I find health policy analysis approaches incomprehensive in helping me understand and explain the different levels and shifts that I have identified within Norwegian global health policy. During the 1990s global governance⁸ emerged as a new and powerful research agenda due to these “changing roles and significance of sovereign states in the governing of global or transnational affairs” (Sending and Neumann 2006: 651). Initially, policy analysis was centred around the state, the public or governmental sector, on politicians, bureaucrats, and interest groups. It is increasingly recognized, however, that policy processes are changing everywhere, heavily influenced by these new powerful actors (Walt et al. 2008: 309).

Over the past 10 -15 years, a larger array of actors have been involved in policy making processes. There has been a shift in the nature of policy and policy-making and players such as NGOs and private actors are now playing an important role as agenda setters (Buse et al 2005). Globalization has changed the global health arena, and, according to the former Norwegian Minister of Foreign Affairs, Jonas Gahr Støre (2012), global health can be seen as one of the main manifestations of globalisation. “This means that the policy environment is increasingly populated by complex cross-border, inter-organizational and

⁸ “Governance can be defined as ‘the process whereby an organization or society steers itself’ (Rosenau, 1995). Broadly speaking, governance comprises the systems of rules, processes, and institutions through which power and decision making are exercised” (Buse and Walt 2007: 188).

network relationships, with policies influenced by global decisions as well as by domestic actions” (Walt et al. 2008: 309). Nation-states are not static or isolated entities; they are, on the contrary, “subject to both internal dynamics and external forces” (Sandberg 2011: 251). These changes in the policy environment, or the context, are also influencing the policy analysis, and making it somehow more complex. Within NDAFH, the global arena and global health architecture have become more important. Due to this, global governance of health is also relevant to this thesis. A typical claim regarding global governance is that “the state has lost power to nonstate actors and that political authority is increasingly institutionalized in spheres not controlled by the state” (Sending and Neumann 2006: 651). GAVI is an example of this, being a powerful actor and agenda setter, having managed to unite actors with different authorities in the effort to immunize the world’s children.

Introducing power makes it possible to grasp, and theorize, about “the logic of the processes of governance” (Sending and Neumann 2006: 652). According to Foucault and his studies of governmentality, to analyse modern political power, one has to treat “the state as only one element, albeit a rather important one, in a multiple network of actors, organizations, and entities involved in exercising authority over the conduct of individuals and populations” (Inda 2005: 1-2). Political power has “assigned itself the duty of administering life” (ibid: 2). Global governance literature has traditionally had a zero-sum conception of power, meaning that a fragmentation of the field and increased power and influence to non-state actors also means a reduction in state power and authority (Sending and Neumann 2006: 652). It has been argued that to gain influence states and other actors have to pool authorities or power to exercise power in a global environment, now highly influenced by private actors (Buse and Walt 2007: 169). PPPs represented new concentrations of powers, where the state has less influence.

It is not only governmental states that find it strategically important to be part of PPPs – multilateral organisations like the UN and the different UN bodies, see

engagement with the private sector as a strategy to “regain authority and legitimacy in an increasingly market-oriented world” (Bull and McNeill 2007: 3). As we shall see, this was what the WHO tried to do in the 1990s when embracing “open and constructive relations with the private sector and industry” (Brundtland in Buse and Walt 2000: 554), hence initiating and supporting the establishment of GAVI.

Foucault’s understanding of modern political power - governmentality - can be useful when trying to understand why Norway has changed focus when dealing with global health. According to Inda (2005) there are three important elements to governmentality. The first is that it is assigned a rather broad meaning, essentially referring to “the conduct of conduct” (ibid: 6). “[T]o the more or less considered and calculated ways of thinking and acting that propose to shape, regulate, or manage the conduct of individuals or groups toward specific goals or ends”⁹ (Inda 2005: 6). Having the power to frame something as the right thing to do is of importance here in order to use the political tool to coordinate actors in approaching the same goal. As we shall see, GAVI and Stoltenberg have with great success managed using the tragedy of the child, to convince actors that immunization is the right thing to do – speaking directly to the common sense.

I already have touched upon the second element here, “a refusal of reducing the political power to the activities of the state” (Inda 2005: 6). Governing – that is, the regulation of conduct – is not just the preserve of *the* government, it includes a multitude of entities, from philanthropists to politicians, bureaucrats, and academia – all the actors and “agencies concerned with exercising authority over the conduct of human beings” (Inda 2005: 6). This is illustrated by BMGF and GAVI becoming important agenda setters and the World Bank (WB) becoming an important global health actor. As we will see, this element can help explain

⁹ “Government points our attention very broadly to any rational effort to influence or guide the comportment of others – whether these be workers, children, communities, families, or the sick – through acting upon their hopes, desires, or milieu” (Inda 2005: 6).

why Norway needs new alliances and why its portfolio has extended to include PPPs, which we also have been central in establishing.

Last, but not least, the third element is the concept of the population as the principal target of government. “All told, then, governmentality draws attention to all those strategies, tactics, and authorities – state and nonstate alike – that seek to mold conduct individually and collectively in order to safeguard the welfare of each and of all” (Inda 2005: 6). Some actors, focusing on vertical programs or specific diseases operate within a country, looking beyond the state, and sometimes taking on the role and responsibilities of that which in a horizontal approach would be seen as the state’s domain. The focus here is not on the state, but on individuals, either as a member of ‘the bottom billion’¹⁰, a carrier of HIV/AIDS, or an unvaccinated child.

Health policy analysis is often used when studying a health policy process and how health policy shifts take place. Actors, context, and process are central concepts within this approach - power, however, has been under-researched. In a field with increasing number of actors and new constellations of power, Foucault’s understanding of modern political power – governmentality – can be useful when focusing on why Norway has changed focus on global health.

When studying the shifts in Norwegian global health policy, the concepts of actor, context, process, and power are of importance. In the next chapter I identify four major shifts in policy and explore *who* has been the central actors, which *factors* that have influenced their actions and approaches, *how* they have managed to influence the agenda and why.

¹⁰ Cf. Paul Collier (2008)

4. Policy changes in Norwegian assistance for health

Norwegian development assistance for health has been known until recently for its strong focus on health systems, developed through bilateral relationships with developing countries. In addition, strong priority has been given to multilateral institutions, specifically the United Nations (UN) and the WHO. Today, the high priority of the multilateral system remains within Norwegian health assistance, yet the manner in which health aid is understood, approached and implemented has changed. Health assistance has increasingly become ‘global assistance’. This global emphasis changes both approach and implementation. How can this major policy shift be explained?

In the previous chapter, I argued that we need to adopt clear descriptions of actors, contexts, and processes in order to understand such profound shifts in policy. In this chapter, I will describe the Norwegian health arena, its actors and institutions, in order to explore the processes leading to such policy shifts. As we shall see, we can identify 4 major shifts, interconnected but on different levels.

Health, foreign affairs, and development aid are all demanding areas; nevertheless, global health requires cooperation across these different policy fields. Here, I will map out the different actors and present the most common frames used. Firstly, I will briefly describe the Norwegian health arena and the actors within global health in Norway. These have different mandates, organizational and social, which are reflected in how health is framed. Secondly, I will focus on the change in the distribution of responsibility between NORAD and Ministry of Foreign Affairs (MFA) and see how this has affected the focus on global health. Finally, I will focus on the consequences of this institutional shift, a shift that is more far-reaching than just a change in responsibilities.

4.1 The institutionalization of global health in Norway – a shift in actors

In this chapter, I will map out the central actors within the Norwegian global health arena, appraise how they frame health in different ways, and examine if and how power relations amongst them have changed.

4.1.1 The Norwegian health administration

In recent years, the Norwegian health administration has strengthened its global engagement, becoming active both politically and technically. The Ministry of Health and Care Services (MHCS) has a small international office as its work is mainly focused on national interests. Global health affairs are, to a large extent, delegated to the Norwegian Directorate of Health, which is a “specialist entity and administrative body under the Ministry” (Sandberg and Andresen 2010: 310). Since around 2005, the directorate has positioned itself as a new actor on global health within the domestic arena. It has its own agenda, and works mainly on addressing issues related to the WHO, the EU, and the Baltic region (ibid, Larsen 2011). One of my informants describes this devolution of influence from the Ministry to the Directorate as a depoliticization of the Norwegian global health agenda, withdrawing it from the centre of political power (Interview 12, 22.06.2012). It is no longer the Ministry of Health itself that deals with global health, but a directorate under the Ministry. Even though global health is a political issue, it can be argued that within the health administration it is being depoliticized. That the Directorate advocates health as a science, and epidemiology as its primary focus, indicates its place on the axis between science and politics. According one of my respondents from within the health administration, the Directorate is better qualified to act on behalf of epidemiology than many of the other actors (Interview 7, 15.12.2012). Within the health administration, health is often advocated as a human right - a frame closely linked to Article 1 of WHO’s constitution - broadly defined by both political and social determinants of health (SDH). In 2011, the Directorate launched the report *The health of the World’s Poor – a Human Rights Challenge*.

As the Ministry of Foreign Affairs is responsible to the UN and the Treasury is responsible to the WB, so is the Ministry of Health constitutionally responsible to the WHO. The Norwegian Government, therefore, has to maintain a clear overview of how health is perceived through its different policies to see how different actors can contribute to coherent health policy (Møgedal et al. 2011). That said, most of Norway's membership fee to the WHO is allocated through the aid budget via MFA. The WHO has always been important for Norway; Norway was central to the establishment of the organization in 1948. When Gro Harlem Brundtland was Director-General, she aimed to strengthen the organization's position in a fragmented and complex landscape undergoing transition from international health to global health. For Norway, it remains important that the WHO remains an independent normative and advisory organization for all countries (Sanne 2011: 202). The WHO has authority as a democratic organization where only countries can be members, and this authority is of importance from a development perspective. Nevertheless, the WHO has fallen in rankings of the most influential organizations within global health. The WHO is only one of many international organizations, institutions and partnerships in health that Norway now engages with, however, these are part of MFA's portfolio.

Norway is a current member of the WHO board from 2010 – 2013, represented by the director of the Directorate of Health, Bjørn-Inge Larsen. Due to this, Norway has developed an inter-departmental WHO strategy, which has been developed through cooperation between the MFA and MHCS and their directorates. The aim of such a strategy is two-fold: to define the overarching goals and objectives of Norway's engagement with the WHO, and for Norway to unite and harmonize its dealings with the WHO and other global health related issues in general (Sanne 2011: 202). Whether this aim is achieved is a different question. Even though there is cooperation between the different actors in the WHO process, one of my informants from within the health administration emphasizes the need for more inter-departmental processes like this since they

help to institutionalize the global health policy. With a high turnover of staff within governmental departments there is a chance of losing valuable knowledge and resources if processes do not exist or are not sufficiently institutionalized (Interview 2, 17.10.2011). These examples emphasize the importance of actors and process to understand the shifts in Norway's global health policy. My informants from within the health administration all emphasize an increase in communication between actors, but that the interests and focus these actors hold have not changed. One issue raised was the conflict between science and politics, the health administration and NORAD representing the former, and MFA the latter. They argue that there is a conflict of interest between these two positions and that in the end it is money that decides which wins (Interview 6, 15.12.2011, Interview 8.11.2012, Interview 10, 03 02 2012).

4.1.2 The Ministry of Foreign Affairs and NORAD

Norway's development assistance became institutionalized in 'Fondet for hjelp til underutviklede land'¹¹ in 1952 and later through Norsk Utviklingshjelp (NUH) in 1962 which became NORAD in 1968. From the beginning there was disagreement between MFA and NUH, the latter wanting more than just bilateral aid agreements and the former wanting to control NUH and the budget (Simensen 2003). This disagreement over how to organize and share responsibilities between the two institutions still exists, and influences the way in which Norway's global health engagement is framed.

In the beginning, NORAD functioned more or less as an independent agency and was given relatively extensive powers. During the 1970s, its influence increased, and as Norway's development aid increased both in scope and complexity, a Ministry of Aid was established in 1986. This ministry, however, merged into the MFA after just 6 years (Simensen 2003). During the 1980s, the interest in- and critique of the development assistance increased, which resulted in stronger political control over the field and increasing focus on evaluation (Engelsen

¹¹ 'The Foundation for Help to the Underdeveloped Countries' (Authors own translation).

Ruud and Alsaker Kierland 2003). From its inception and until 2004, the development assistance was divided between the two actors. However, after 2004, MFA took over the responsibility for the development assistance channelled through the embassies and later in the same year the bilateral aid as well. In the last decade there has been a shift from an extensive bilateral profile to a multilateral profile in aid. The political part of the global health arena argues that a multilateral approach enables smaller actors like Norway to wield more influence by pooling leverage with other countries and actors (Interview 4, 18.11.2011).

Much of Norway's global health assistance has been bilateral (except support to UN bodies such as the WHO, UNICEF, UNFPA and other multilateral organizations) rooted in NORAD, which to a certain extent also represents continuity in Norwegian engagement. Even though NORAD formally answers to the MFA, it has a tradition of having its own minister of international development (Sandberg and Andresen 2012: 309, NORAD 2012b). During the last decade, NORAD's role has moved towards closer collaboration with MFA, and since 2004 NORAD has been the primary specialized directorate assuring the quality of Norwegian development assistance by means of evaluation, quality assurance, communication of results and technical advisory services (NORAD 2012b). During this time, however, NORAD has to some extent lost its direct contact with policy, no longer being so influential. This can be seen as a result of the increased focus on numbers and results, which I will elaborate on in 4.4 when focusing on the shift from horizontal to vertical programs.

The division of labour between NORAD and MFA in relation to global health is of interest here. Today, NORAD's areas of responsibility are rooted in its mandate which was approved in the Council of State by the prince regent in 2004 (NORAD 2011b). Its main functions are laid down in the agency's terms of reference and annual letter of allocation issued by the MFA, and for 2012, one of the focus strategies is global health, especially maternal and child health (MFA 2012A). It is the MFA that houses the Department for UN, Peace and

Humanitarian Affairs which in turn houses the Section for UN Policy and Gender Equality, and the Section for Climate Change, Global Health and Sustainable Development. The management of the Norwegian support for GAVI, GFATM, and UNAIDS are located within this department. The MFA also houses the Department of regional affairs and Development which in turn houses the Section for International Development Policy (MFA 2012b). As we shall see in section 6.3, the multilateral health field has become fragmented, but successful participation within this fragmented field has become of increased importance to Norway's positioning on the global stage.

Over the past decade, the burden of activity has shifted from NORAD to MFA in parallel with a movement of funds. Nevertheless, "the links between health specialists in Norad and MFA on global health issues are extensive" (Sandberg and Andresen 2010: 309). According to Sandberg and Andersen (2010: 309), this shift in balance between the two institutions has happened at the same time as a "decline in direct bilateral project support, causing a loss in Norway's historical comparative advantage as contributor of development assistance to health". As argued by an informant (Interview 5, 25.11.2011), development policy can be seen as the main financial muscle within Norwegian foreign policy. This can help to explain why health is now a part of MFA's domain, where global health is lifted up in status to 'high politics' and framed as a security issue, not as a development issue. Even though NORAD is a directorate under the MFA, the two actors have different approaches to global health due to their institutional domain and organizational mandates. NORAD takes an advisory role, focusing on health as a science, while for the MFA health is about politics (Interview 6. 15.12.2012, Interview 7. 15.12.2012). The mandate of the Ministry of Foreign Affairs is to serve the country's interests and not necessarily to serve the interests of developing countries, hence infectious diseases and the threat of pandemics become relevant for foreign policy, whereas other health needs can be more pressing in a local context. The global health policy is not decided by the advisory directorate, but by the MFA, being in charge of both funding and

policy. Several of my informants made comments about this, arguing that NORAD and the health administration ought to have more influence on the flow of funding (Interview 6, 15.12.2012, Interview 10, 03.02.2012). Here it becomes clear that the different actors have different goals, agendas and discourse. They have different roles that they use to achieve different aims. Due to this, the issue of health is being framed in different ways in order to serve different purposes.

That health is rising in priority within Norwegian foreign policy is also evident in white paper no. 11 (2011-2012) on global health in foreign- and development policy, where no distinction is made between the development policy interests and mandate and the foreign policy interest and mandate.

As mentioned earlier, there are a handful of different national actors that execute their engagement in different ways according to their social mission or institutional mandate (Sanne 2011: 11). Even though communication between them has improved, these actors still take different approaches. The MFA's focus is more towards health as a security issue, hence its continuing focus on communicable diseases. The health administration, however, takes a more holistic approach, focusing on a broader range of determinants of health, and more on non-communicable diseases (NCD). One of my informants emphasizes this difference, saying that the health administration is more attentive and responsive when it comes to work on NCDs (Interview 3, 10.11.2011).

4.1.3 The Prime Minister's Office

One new actor on the health scene is the Prime Minister's Office, with its own international division. Until recently¹² its webpage told us that the Office's focus areas were climate change and the MDGs, of which 3 focus directly on health, and the rest are determinants of health (Sanne 2011). The establishment of GAVI, the vaccine alliance, in 1999 became a key milestone in Norwegian global health relations as it engaged both the political leadership and the

¹² 'Focus areas' are no longer shown on the web page, however, according to the Prime Minister's initiatives on MDG 4 and 5 it is likely to believe that it is still a focus area.

development establishment (Sandberg and Andresen 2010: 310). Jens Stoltenberg's interest in global health was first visible after the establishment of GAVI, when, as leader of the opposition, he argued for Norwegian support for this new alliance. He used similar framing as BMGF; advocating vaccines as a smart investment and the most cost-effective way to create and improve economic development. When he took office in 2000, the Labour Party's youth organization lobbied heavily to vaccines and GAVI onto the political agenda (Larsen 2012). Stoltenberg continued this focus on vaccines, passionately advocating a narrower approach to health, while out of office between 2001 and 2005. When he returned to office in October 2005 he increased Norway's focus on the health related MDGs, especially on MDGs 4 and 5 on reducing child- and maternal mortality, of which immunization and GAVI are constituent parts.

Under the leadership of Stoltenberg, the Prime Minister's Office has become a central actor in the Norwegian global health arena, advocating a narrower focus on vaccination and maternal health. In 2006, shortly after returning to office, Stoltenberg also hired Tore Godal, former head of tropical medicine in WHO and the first Executive Secretary¹³ of the GAVI Alliance, as a special advisor. This was highly criticized by the MFA, and after several years, Godal was transferred from the Prime Minister's Office to a position as special advisor to the MFA (Interview 5, 25.11.2012).

Prime Minister Stoltenberg's tenure has been important for Norway's engagement in global health. What was new with the Stoltenberg government was that the Prime Minister directly participated in the planning of development policy, and that he personally advocated certain initiatives over others. He has been central in allocating funding to GAVI, focusing on our moral obligation to prevent children from dying of preventable diseases. The Prime Minister has been central in advocating health as a catalyst for development, working on the

¹³ He was appointed Executive Secretary of the GAVI Alliance during the last phase of negotiations, and he is also "given credit for the final compromise around which all stakeholders finally united: saving children's lives" (Sandberg and Andresen 2010: 311).

premise that not only does development lead to better health, but that the causal relation also goes the other way, from health to development, meaning that investment in health is investment in development (Stoltenberg 2004, Sachs 2001, Bloom et al. 2005, Bloom and Canning 2000). Health is here seen as a means for economic development, and not an end in itself.

When Stoltenberg returned to office in 2005, the focus was broadened to include MDG 4 and 5, focusing on child- and maternal mortality. Under his leadership, Norway has initiated a new bilateral initiative focusing on MDG 4 and 5 in India, Pakistan, Tanzania, Nigeria and Malawi. These countries are strategically chosen and initiatives established due to Stoltenberg's contact with the Heads of State, a rather unorthodox method within Norwegian development assistance (Interview 9, 30.01.2012). In addition to this, Jens Stoltenberg has also initiated "the Network of Global Leaders to provide political backing and advocacy at the highest possible level for the Global Campaign for the Health MDGs" (NORAD 2011a), a campaign launched in 2007. Through his engagement with improving the health of women and children, he has also worked in close collaboration with the UN Secretary-General. UN is an actor with great historical as well as political importance for Norway, and through his focus on MDG 4 and 5, the Prime Minister is strengthening these bonds.

All of the recent Norwegian Prime Ministers, such as Gro Harlem Brundtland, Torbjørn Jagland and Kjell Magne Bondevik, have been engaged in international development, strengthening Norway as a humanitarian superpower. Jens Stoltenberg, however, is the first to personally participate, strengthening the Office's international division and sharing responsibility with the MFA (Amland 2009: 7). The government that Stoltenberg succeeded in 2005, Kjell Magne Bondevik's second government, had Hilde Frafjord Johnsen as Minister of International Development. She had been a central actor in the international

arena as part of the Utstein Group¹⁴, promoting targeted development goals with a clear time line. Even though this government supported a long term approach when dealing with global health, there was an increased focus on the MDGs as important tools in the fight against poverty and as a rich country, Norway had a moral obligation to contribute (MFA 2004). Nevertheless, poverty reduction was at the heart of that development discourse. It has been argued (Development Today 2011) that Stoltenberg has more directly left his fingerprint on the aid budget and that the initiatives that stand out on the aid budget, GAVI being one of them, are all anchored by the Prime Minister's Office (ibid).

What we see here is that Stoltenberg is using his power as Prime Minister to influence the agenda, and that he acts as a situational factor (Buse et al 2005), using the window of opportunity of a change in government to set the agenda. In an article in Development Today (2011), it is argued that the same initiatives, GAVI being one of them, are also “key elements that help to profile Norway abroad” (Development Today 2011). It continues, saying “[i]n no other Western country will you see aid policy being fronted at such a high political level” (ibid). This is a view that several of my respondents have corroborated. Nevertheless, some of my respondents also emphasized that while Stoltenberg had been an important actor in prioritizing global health and specific approaches within global health, he had not been so involved in defining how the policy was applied and implemented (Interview 11, 15.06.2012).

4.1.4 More than just an institutional shift

The different Norwegian global health actors are framing health and executing their engagement in different ways due to their mandate and social mission (Sanne 2011). The health administration has to work from a health policy perspective while the Ministry of Foreign Affairs and NORAD have to work

¹⁴ The Utstein Group was initiated by the British Minister of International Development, Clair Short, to advocate for the International Development Goals (IDGs). The IDGs were DAC's effort to put international development back on the agenda in a time where ODA was declining. The Utstein Group was a union of the female Ministers of International Development from the UK, Germany, the Netherlands and Norway

with the same topic from a foreign- and development policy perspective. These different groups have divergent goals and agendas due to their different social missions and institutional mandates, which again is visible through their different ways of framing health. Internationally, Norway is perceived as one actor, whether through foreign policy initiatives, PPPs or through WHO delegation. According to Czarniawska-Joerges (1992: 152-5) there can be many frames of meaning within one organization, hence within one actor. The different Norwegian actors have different goals, therefore, different action can be seen as rational if taken from the point of view of certain mandates.

Sanne (2011) argues that there are two main challenges to overcome if Norway wants to improve its role within the global health arena. The first is to strengthen the cooperation and dialog between the national actors and the second is to redress the balance of monetary influence – meaning that the current health administration does not have any (monetary) influence regarding who receives development assistance for health, pointing to the conflict between the different ways to frame health, and the science-politics axis. Several of my respondents also pointed to this need for better cooperation both within ministries and departments, and between them (Interview 6, 15.12.2012, Interview 12, 22.06.2012). Health, foreign policy and development aid are all demanding areas; nevertheless, global health requires cooperation across these different policy fields. A good example here is Norway's engagement in the WHO. The MFA is in charge of the financial support, whereas it is MHCS that is constitutionally responsible to WHO and the Directorate of Health that holds delegated responsibility for the day-to-day work. Here, the Norwegian delegation to WHO has limited influence, or no influence at all, over the flow of finances and the MFA does not have the same knowledge about epidemiology as the health administration to take decisions based on the burden of diseases. These different actors have different goals and agendas – political and technical – and part of the challenge has been to create common goals to ease the cooperation and to achieve the Norwegian global health goals (Sanne 2011).

What these shifts in the Norwegian health arena shows is that health has been embraced by new actors, such as the Prime Minister's Office and the Ministry of Foreign Affairs, actors that have traditionally been external to the debate about development assistance for health, but that have greater political power than the actors traditionally engaged. The actors emphasizing the 'politics' side of the science-politics axis are framing health in different ways than actors focusing on epidemiology. A new Prime Minister and a new Minister of Foreign Affairs have been situational factors (Buse et al. 2005), and they have used the windows of opportunity brought by changes in government and the devolvement of responsibility to influence the agenda and position themselves as actors. Several respondents talked about key individuals within the global health arena, highlighting the fact that the individual presenting an initiative is of importance due to their personal power (Interview 2, 17.10.2012, Interview 7. 15.12.2011). However, this range of different frames also illustrates a lack of consensus within the global health field, which also is present at a global level (Ng and Ruger 2011). There is more to it than just a shift in institutions, new actors entering the field and others losing their influence. A new actor can also change the focus, influencing the agenda, and framing health in new ways. The shift in power from NORAD to MFA is of importance here. I will elaborate on this more in the next chapter.

4.1.5 Shift 1: The institutionalization of global health in Norway – a shift in actors. Summing up

This change from international to global health – with a proliferation of actors and new concentrations of power – is manifest in the Norwegian setting. New actors have become prominent and old power relations and domains have been challenged. Development policy has been, and is still, an important part of Norway's foreign policy, but has traditionally been the domain of NORAD. The MFA has entered the health field together with the Prime Minister's Office, and both are now important actors. MHCS, Norwegian Directorate of Health and the Norwegian Knowledge Centre for the Health Services, the latter being located

under the Directorate of Health, are also important actors. With the shift in power and responsibility towards the MFA and Prime Minister's Office, MHCS, which originally held the responsibility towards the WHO as part of their mandate, has outsourced this responsibility to the Directorate of Health that since 2005 has positioned itself as a central actor within the global health field.

The different actors have different institutional mandates and social missions. NORAD's main mandate is to reduce poverty, whereas the MFA's mandate is to serve the interests of the nation, hence focusing on security. The different actors act on behalf of their institutional mandate and along an axis from science to politics, hence the way they frame health varies. The global health related work within the Norwegian bureaucracy and within the Norwegian context in general, requires cooperation between the different actors and along the science/politics axis. Internationally, Norway is perceived as one actor, whereas nationally, the engagement consists of several actors with different perceptions of, and interests in, health.

4.2 A matter of framing – from development to the securitization of health

The change in institutional organization, the relation between the organizations and the positioning of actors within global health engagement has also influenced global health policy, and represents a new focus and framing of health. With the shift from NORAD to MFA and a new Minister of Foreign Affairs with a background from the WHO, global health was lifted out of the aid-frame and into the domain of foreign policy. Development policy has been, and still is, an important part of Norway's foreign policy, but has traditionally been NORAD's domain. Now the MFA is housing the main initiatives on health, the main channel is multilateral, and global health has become 'high politics'. The role of the state has changed due to globalization and states have become more interdependent; this is also the case with health. There is a shared vulnerability, e.g. communicable diseases; hence the rights of individuals depend on the vulnerability of the state. Disease surveillance has traditionally been seen as

being carried out for the national public good, whereas now that states are challenged to globalize elements of their policy, there is a blending of external and domestic policy demands, influencing states' territorial sovereignty (Kaul 2006). This process is referred to as the securitization of health amongst global health scholars. Lakoff (2010) refers to this as the return of the microbe; the microbe that crosses national borders; SARS, avian influenza or H1N1. Global health management within this perspective focuses on infectious diseases that are seen as a threat to the health of the national population. Thus "seeks to implement systems of preparedness for events whose likelihood is incalculable but whose political, economic and health consequences could be catastrophic" (Lakoff 2010: 59).

4.2.1 In the realm of foreign policy

As we have seen, during the last decade NORAD moved towards the MFA, and the MFA is now housing the main initiatives through which Norway's development assistance for health is channelled. Even though NORAD is a directorate under the MFA, it has traditionally influenced the aid policy and budget. Now, however, its focus is mainly on evaluation and results. Jonas Gahr Støre, until recently incumbent as minister of foreign affairs, has a background of working with the WHO under the leadership of Gro Harlem Brundtland. As Brundtland's Executive Director, Gahr Støre observed that in many countries Ministers of Health had a limited influence on the health budget and that in some countries they were not even seen as part of the government (Støre 2008). By the time he took office as Minister of Foreign Affairs, he knew the importance of approaching health through channels other than just the Ministry of Health, he knew that the old approach did, in many cases, not work, and he had learned from Dr. Brundtland that you should approach the Head of State. He was "inspired by new conceptualizations of health as part of a whole and inextricably linked to international relations between countries in a globalizing world" (Sandberg 2011: 255). As Minister of Foreign Affairs, he used his influence, power, and experience to address health as a foreign policy issue, emphasizing

that health has to be seen through the lens of foreign policy. He therefore played an important role in lifting health up from development policy and into the realm of foreign policy. Prior to 2006, the focus within Norwegian global health engagement had been on development assistance for health and on new global initiatives such as GAVI and GFATM. With Gahr Støre back from Geneva and WHO¹⁵, the focus was moved towards the growing interconnectedness and shared vulnerability between nations – a broader focus than the health related development aid (Sandberg et al. 2010).

The conflicts along the axis of science and policy became more visible during this shift due to the different mandates of foreign policy and development policy. Foreign policy's mandate is to serve the interest of the country, to secure its freedom, safety and prosperity (Fidler 2011b: 4), whereas the primary mandate of Norwegian development aid is to reduce poverty, and health is here communicated by NORAD¹⁶ as a human right. Again, referring to Lakoff, I suggest that NORAD holds a perspective on health aid as “humanitarian biomedicine (...) targets diseases that currently afflict the poorer nations of the world such as malaria, tuberculosis and HIV/AIDS” (2010: 60). Not surprisingly, MFA's priorities could be said, following Lakoff, apparent to lean towards regime of global health security.

Linking developing aid and national interests, however, is not new. Aid is an integral part of a nation's foreign policy – as an objective in its own right, or as an instrument to achieve other objectives (Stokke 1987: 9). According to Lodgaard (2002) the Norwegian focus on development aid is not just altruistic, but also a matter of the nation's own interest. Norway has traditionally been reluctant to assert foreign policy in terms of its own national interests, but this has recently begun to change. Jonas Gahr Støre argues that Norway needs to

¹⁵ After he returned from Geneva, he first worked as an advisor at the Prime Minister's Office before he became the Secretary-General of the Norwegian Red Cross.

¹⁶ <http://www.norad.no/no/tema/helse>, <http://www.norad.no/no/tema/menneskerettigheter/retten-til-helse>, <http://www.norad.no/no/tema/menneskerettigheter/rettighetsbasert-utvikling/dette-gj%C3%B8r-norge-og-norad>

focus its foreign policy on what the nation is good at, moving the focus from assisting where the need is greatest to focusing on areas where the nation can make a difference in world affairs (Lunde et al. 2008, Sandberg and Andresen 2010). The traditional division between *idealpolitik* and *realpolitik* is over-emphasized, and the focus should be on what he calls *global realism* (Støre 2010), where aid policy, traditionally *idealpolitik*, can encompass both aid and security policy (*realpolitik*) (ibid). Gahr Støre, enters the field as a new actor, and with the benefit of being part of a situational factor – a change in government – is influencing the agenda, using international factors like SARS and the fear of pandemic influenza to put health on the agenda of ‘high politics’.

Global health and foreign policy

In 2006, Gahr Støre launched a new initiative on Global Health and Foreign Policy together with his colleagues from Brazil, France, Indonesia, Senegal, South Africa, and Thailand (Sandberg et al. 2011). Gahr Støre and his French colleague Blazy had developed the idea, and asked colleagues from five strategically chosen countries of importance to participate. Together they launched the subsequent Oslo Ministerial Declaration in 2007. The Declaration states, amongst other things, that

“We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make impact on health a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies, and to engage in a dialogue on how to deal with policy option from this perspective” (Amorim et al. 2007: 1373).

The document argues in favour of a broad agenda for global health, emphasizing that health should hold a strategic place on the international agenda and that an increased awareness of health has an impact on other areas and processes within foreign policy (Amorim et al. 2007: 1373, Sandberg et al. 2011). According to Møgedal and Alveberg (2010: 1), the idea can be summarized as “common vulnerability, shared risk and common responsibilities”. The group became a new forum for informal consultations between its members, and a network of its

Geneva-based diplomats was established in 2008. This network became a place where the actors could discuss different political topics, not only health (Sandberg et al. 2010: 1785).

The Foreign Policy and Global Health Initiative and the Oslo Ministerial Declaration have gained prominence by reflecting the growing emphasis upon health issues in foreign policy that had started in the mid-1990s. The initiative has established a process for making health a strategic foreign policy concern and frames it as a global health security issue to emphasize the link to security, grounding the initiative in topics and concepts meaningful to policy makers. Hence, it proposes health as a defining lens for foreign policy (Fidler 2011a). It frames and hence emphasizes health as a shared vulnerability, not as a shared human right. The goal of the initiative is not to realize the right to health, but rather to realize that everyone shares the same vulnerability (Interview 12, 22.06.2012), that we are living, not only in an interconnected world, but also an interdependent world.

For Norway, this network of Ministers of Foreign Affairs represents new actors compared to the likeminded nations that Norway has traditionally cooperated with (Interview 2, 17.10.2012). The group is heterogeneous and therefore a rather untraditional case within international politics in general. The group has representatives from four different continents, and G8 and G20 are represented in addition to the majority being strong developing countries (Sandberg et al. 2011). This diversity has given Norway the opportunity to expand its alliances and broaden the scope of its political influence. I will not go into further detail about this group but rather, I will focus on the international factors making it possible for health to rise to prominence, and how health has been securitized.

For Gahr Støre, being both part of a new government and the new Minister of Foreign Affairs – a rather more powerful position than the Minister of International Development – made this shift in framing possible. However, these

were not the only factors and actors enabling this. International factors and changes must also be elaborated upon.

4.2.2 Contextualising securitization

In a globalizing world, the perception of foreign policy and international relations is changing. New actors and partnerships are entering the field, gaining influence and power. New alliances and networks are occurring due to increased interdependence between states. These new interdependencies also come in the form of changing perceptions of threats and challenges. The idea of the topic of health being central to international relations (IR) is by no means a new one. International cooperation on health began with the convening of the international sanitary conference in 1851 (Birn et al. 2009). Since that meeting, states have concluded many treaties, created international health organizations and cooperated with a range of actors to regulate the treatment of different health issues, both communicable and non-communicable (Fidler 2005). That said, health as a diplomatic and foreign policy concern has been neglected in the study of IR, where it has been treated as a technical matter.

Infectious diseases and disease surveillance have been foreign policy topics throughout history. However, with improved domestic public health capabilities during the 20th Century, they fell on the agenda. Health, or health related issues, were no longer seen as a concern among the major international players (Fidler 2011b: 3), and were referred to as a ‘low politics’ issues within the realm of foreign policy. ‘High politics’ concerns war and peace, competition for power, national security and the fight for survival within the political structure of international relations (Fidler 2005, Fidler 2007b). On the other hand, ‘low politics’ “concerns international cooperation on economic, environmental, and social issues” (Fidler 2005: 180), development aid falling within this level. This distinction between ‘low’ and ‘high’ politics has been prominent within international relations theory. According to Fidler (2005: 180) health was not

only seen as a 'low politics' issue, but a 'really low politics' issue from the mid-1990s, due to being considered technical, humanitarian, and non-political.

During the last 10 to 15 years, health has moved from 'low politics' to 'high politics' due to the changing security landscape. In 2000, the UN Security Council considered the HIV/AIDS pandemic in the developing world as a threat to international peace and security, this being the first time that the Security Council had discussed a health threat (Fidler 2005). This focus on the HIV/AIDS pandemic in developing countries as a threat to 'our' security resulted in the US President's Emergency Plan for AIDS Relief (PEPFAR), a 15 billion USD five-year initiative in 2003. In 2004, the UN Secretary-General's High-level Panel on Threats, Challenges and Change included threats from biological weapons, bioterrorism, infectious diseases and social determinants of health, e.g. poverty, as important components of "comprehensive collective security" (UN 2004: 14). The report emphasized mutual vulnerability and interdependence between weak and strong states. In addition to these threats, the threat from pandemic influenza and SARS also helped to heighten health's status within foreign policy. These are only some examples of this new perception of risk that health issues have represented in the last 10 to 15 years. As we shall see in the next chapters, international development aid also reveals this growing focus on health problems through an increased focus on infectious diseases and the MDGs. In the UN Secretary-General's March 2005 report *In Larger Freedom*, emphasis is given to the achievement of the MDGs as important for the achievement of freedom of want and freedom from fear (Fidler 2007b: 54-5). Again, MDG 6 on HIV/AIDS and infectious diseases, and infectious disease surveillance is emphasized.

Framing health as a security issue presents different opportunities and challenges. Health has become a more politically prominent topic, a range of different initiatives and partnerships have been established, and development assistance

for health has increased tremendously on a global basis¹⁷. Nevertheless, this frame “emphasizes the defence of borders against infectious diseases and bioweapons with little consideration for non-communicable diseases and social determinants of health” (Ng and Ruger 2011: 8). Due to this, the securitization of health favours those diseases perceived as a threat by richer countries, “some infectious diseases receive little attention because they are geographically concentrated away from developed countries, and are not perceived as important threats” (Ng and Ruger 2011: 8). Even though the Oslo Ministerial Group emphasizes the risk as a shared vulnerability, with a focus on avian influenza, H1N1 and SARS, it can be argued that “[t]he shape of international health activities today reflects how the great powers want health issues addressed” (Fidler 2005: 189). According to Ollila (2005), the primary foci in global health today serve the interests of the wealthy. It is the diseases most likely to inconvenience global trade and finance that are likely to receive the most attention (Labonté 2008: 468).

“Use of the science-politics dynamic can be seen in the ways governments, international organizations, and non-state actors linked communicable disease problems to national and international security, international trade, economic development, national and regional stability, and the effectiveness of international aid” (Fidler 2005: 190).

As noted above, Lakoff (2010: 59) refers to this frame as “oriented towards outbreaks that *have not yet occurred*”. This again is “reversing ‘international health responses’ from their historic ‘people-centred’ values to a narrower understanding of health as a national security risk” (Labonté 2008: 468-9). However, for a country to ensure health security it is not enough to focus solely on national issues and patients; the approach must also encompass other nations’ challenges (Lakoff 2010). By translating health into the language of security and foreign policy, one might manage to gain attention from high profile ministers and governments, as with the Oslo Ministerial Group. Nevertheless, attention

¹⁷ From 1990 to 2010 development assistance for health increased from 5.66 billion USD to 22.87 billion USD (Murray et al. 2011).

will only be drawn to a few high-profiled problems, e.g. AIDS and pandemic influenza, and, most likely, this attention will “not move into less glamorous areas such as health systems, malnutrition, and water and sanitation” (Sridhar 2010: 466); areas that are crucial for long-term improvement of the local health situation. As one of my informants said, it is more effective to use the fear of disease pandemics - to state that your diabetes is my diabetes is not as effective (Interview 2, 17. 10.2012).

That this framing is common within Norwegian global health engagement is made clear in the white paper, report no. 11 (2011-2012) to the Storting, focusing on health precisely as both a development policy matter *and* a foreign policy matter. It is visible both through the extensive focus on communicable diseases and in health now being lifted into the realm of foreign policy, evidenced by the minister of foreign affairs saying that health is everybody’s business (Støre 2012). In the white paper, it is also stated that health is a global public good (MFA 2012c: 11). The framing of health as ‘common’ or as a ‘global public good’ understands health as something beyond the interests of two or more countries or their populations. Public goods can be described as non-rival and non-exclusive - “people cannot be excluded from consuming such goods, nor does one person’s consumption of such goods preclude consumption by another” (Ng and Ruger 2011: 10, MFA 2012c: 11). Public goods have a spatial dimension as well. The geographical reach of a public good flows from the local community into the global sphere. Within health, control and eradication of infectious diseases have traditionally been considered global public goods. The frame of health as a global public good also provides actors with a language by which they can convince other actors that this is the right focus to have, or the right thing to do (Labonté 2008). In the white paper, report no. 11 (2011-2012) to the Storting on global health in foreign and development policy, health is argued

to be a global public good¹⁸, however, it is not specified which part of health is seen as a global public good. “Simply adapting a global goods perspective does not by itself resolve the dilemma of which disease should receive priority in global surveillance or how limited global resources should be prioritized” (Chen et al. 1999: 292).

4.2.3 Health as a soft-power tool

It is not only an increased focus on security and hence infectious diseases, that is an indicator of the growing focus on health within foreign policy. The rise of health in foreign policy also involves the return of health as a soft-power tool (Fidler 2011b). During the Cold War, health was used by the US and its allies to win hearts and minds in the fight against Communism, “to boost their geopolitical position and ideological ambitions” (ibid: 3) in a polarized world. Today, the geopolitical landscape has changed compared to the Cold War era, and new coalitions and concentrations of power have emerged, renewing the interest in using health to secure non-health objectives (ibid). “What is unfolding now is a multi-polar system marked by the rise of emerging powers, especially China, and the decline of U.S. power and influence” (Fidler 2011b: 7). In addition to the rise of emerging state powers, I will also argue that health has focused more political attention on non-state actors in international relations, e.g. the emergence of PPPs in global health, which has become powerful actors within global health. This makes it necessary to build new alliances and expand the political horizon to include new actors. As mentioned above when presenting the Global Health and Foreign Policy Initiative, the initiative is a rather new constellation of actors, and for Norway it is argued to be quite strategic, consisting of some emerging economies and important and powerful actors within different regions. Brazil is also a new and important actor in Norway’s foreign policy- and aid portfolio. Within this group or forum, health can be used

¹⁸ The same framing of health as a global public good can also be found in report no. 13 (2008-2009) to the Storting Climate, conflict and capital. In this white paper, communicable disease surveillance is framed as a global public good.

as a soft-power tool to pursue non-health objectives in addition to health. Development policy and objectives can here be seen as the financial muscle within foreign policy (Interview 5, 25.11.2012). That health in foreign policy is politically important to achieve other goals, as alliances was emphasized by a respondent (Interview 2, 17.10.2011). “Increased soft-power use of health demonstrates greater instrumentalization of health for foreign policy purposes, challenging the ethos that health is an end in itself and not a tool for geopolitical machinations” (Fidler 2011b: 4). Using health in soft-power strategies indicates that foreign policy concerning health is not being transformed by this ethos. These initiatives might produce some positive health outcomes, but these are not the main purpose of the strategy or initiative (ibid).

Alliances

In the age of globalization, foreign policy faces the same challenges that it always has. Foreign policy is still about power and exerting influence over the other actors on the international scene. What is new is the increased number of players, which again has made it progressively more difficult, hence the state can only be seen as one element in this network of actors (Inda 2005). Historically it was enough for Norway to have a good relationship with its allies and to keep tension with its neighbours to a minimum. Today, according to Christoph Bertram (2011), this is not enough to serve the interests of a country. Countries now have to relate to each other in more complex ways and on issues new to foreign policy, or issues that have reappeared after being absent for a long time, health being an example of this. Becoming an influential international player depends on different variables, and a country’s status is important for its ability to influence the global agenda (Interview 11, 15.06.2012).

Alliances are important for increased status and building political strength and position, and therefore also important in creating global impact. During my interviews I asked the interviewees about the need for alliances, and if, and how, Norway’s alliance-building activity had changed. Those respondents who had an

opinion about this topic all said that Norway was using health to increase its alliance repertoire (Interview 2, 17.10.2011, Interview 3, 10.11.2011, Interview 6, 15.12.2011, Interview 11, 15.06.2012). Here, health is used strategically to build new alliances and it can also be argued that health as a soft-power tool (at least traditionally) can be used to unite new actors and hence create space for other topics to be discussed as well (interview 2, 17.10.2011). Norway, a European country outside of the European Union, needs to build reliable multilateral partnerships and alliances to be able to (re)position itself on the global scene (Bertram 2011).

Global health has become a means for Norway to both position itself and to build new alliances. What my informants have told me about health being important for Norway in establishing new global political networks and alliances is also being confirmed in the report no. 11 (2011-2012) to the Storting on global health in foreign and development policy. While dealing with the objectives of Norway's global health policy, it states that "[p]olitical networks that cut across traditional forums and alliances are also important" (MFA 2012c: 5). Under the heading 'Arenas for global health efforts and Norwegian health diplomacy', the importance of the new Norwegian-led initiatives – the Global Campaign for the Health MDGs, the Network of Global Leaders and the Oslo Ministerial Declaration – is explained. The paper also states that

“Norwegian effort is underpinned by seats on several boards, for instance in WHO 2010-2012. Taken together, this is the basis for a large part of the Norwegian global health effort, and has made it possible to establish important strategic alliances in foreign policy, development policy and health policy” (MFA 2012c: 11).

These networks and alliances within global health do not focus solely on health issues. One informant praises them as although their primary purpose is to discuss health issues, they also provide opportunities for discussing other pressing issues (Interview 2, 17.10.2011). Health is being used to increase the level of trust and political capital and the Oslo Ministerial Declaration is a good

example of this. Since the establishment of this initiative, the political bonds between Norway and Brazil, France, Indonesia, Senegal, South Africa and Thailand have tightened. Even though traditionally Norway had little in common with those countries involved, they are now of importance to Norway (Eggen and Sending 2012: 214), e.g. France as member of the UN's Security Council and Brazil as an emerging economy with an increasing market for offshore industries, to mention two.

Political room for manoeuvre

Health is not only an important access point into a world of political networks and alliances – creating political capital – it is also important for the Ministry of Foreign Affairs in creating political room for manoeuvre. Norway has to exploit the full political potential that lies within this (Interview 7. 15.12.2011).

By lifting health up to the realm of foreign policy it becomes a political issue, not only a technical issue. This also opens up political room for manoeuvre where health can be used. The map guiding us through the foreign policy landscape is changing due to the evolving international scene. The axis from science to politics, along which the different actors are positioned, becomes clear in this landscape. The different actors have different approaches to health due to their organizational mandates. For the MFA, the job is therefore complete when the money is transferred, whereas for the health administration, the job begins at this point (Interview 6, 15.12.2011; Interview 7, 15.12.2012). Seeing health as foreign policy will serve the interest of the MFA, while seeing health as a science will serve practitioners in the health administration or NORAD. Whether health is a means or an end in itself depends on whose policy it is part of.

What we see here is that Norway is trying to be both an aid-giving nation while at the same time using health to create political arenas where they also can build new networks and alliances, and address other issues of national interest

4.2.4 Not only a matter of security

In the white paper, no. 11 (2011-2012) to the Storting on global health in foreign and development policy, health is not only framed as a security issue. According to this white paper the “cornerstone of Norwegian policy is to promote and respect fundamental human rights” (MFA 2012c: 5). It continues, stating that “[t]he principle of equal access to health services based on comprehensive, robust health systems serves as a guideline” (ibid: 5). The policy is linking health and human rights with equal access to comprehensive and robust health systems. The Commission Report *Coherent for Development? How coherent Norwegian policies can assist development in poor countries* (Instefjord et al. 2008) devotes considerable attention to framing Norway’s foreign policy in terms of human rights. In his analysis, Fidler (2004) argues that infectious diseases can be seen as a threat not only to nations, as in the security frame, but also as a threat to individual rights and justice.

Human rights concern the relationship between the state and the individual; its population. They generate both individual rights and state obligations (Hogerzeil 2006). The new white paper also states that

“[i]t is the authorities in each individual country that have the main responsibility for ensuring that human rights are respected. International cooperation can strengthen the capacity and willingness of national authorities to meet these responsibilities, and should promote robust health systems and universal access to health services. Norway will speak out with a clear voice internationally, and will particularly advocate the human rights of oppressed and marginalized groups” (MFA 2012c: 7).

This represents a somehow strict interpretation of the rights-based approach, leaving the responsibility to each country. However, due to this, a human rights biased framing can therefore also be used as justification for changing policy (Interview 11, 15.06.2012). “The enjoyment of the highest attainable standard of health as a fundamental right of every human being was enshrined in WHO’s Constitution over fifty years ago” (Brundtland in Nygren-Krug 2002: 5). Through international human rights instruments, the right to health has been

established¹⁹. In 2002, a “Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health was appointed by the UN Commission on Human Rights” (MFA 2012c: 13). By framing health as a human right, or using a rights-based language, you are moving away from a focus on state security and health as a means for other goals, towards “a human entitlement or global citizenship right, adding moral force to actions and appear[ing] to help the poor” (Ng and Ruger 2011: 9). Within the security frame, diseases are seen as a threat to national security. Within a human rights frame, the same diseases are perceived as a threat to individual rights and justice (Fidler 2004). Within the international health debate there has also always been tension between the rights based approach and the economic approach due to the view that “equity and efficiency are frequently opposed objectives” (Standing 2004: 11).

“One striking thing about the last decade is the extent to which arguments for more foreign policy attention on health connected epidemiological evidence with adverse material consequences for states were relied upon rather than traditional concepts of health as a humanitarian or human rights issue” (Fidler 2005: 190).

According to Lakoff (2010: 59), the different projects and the different frames of global health imply “different understanding of the most salient threats facing global populations, of the relevant groups whose health should be protected, and of the appropriate justification for health interventions that transgress national sovereignty”. He identifies two different regimes of global health; global health security and humanitarian biomedicine. The securitization of health identified in the Norwegian foreign policy falls within the former regime, with a focus on emerging infectious diseases and an emphasis on the “protection of risk to the self” (ibid: 60). Humanitarian biomedicine, on the other hand, “targets diseases that currently afflict the poorer nations of the world, such as malaria,

¹⁹ e.g. article 12 in the International Covenant on Economic, Social, and Cultural Rights, article 12 in the Convention on the Elimination of All forms of Discrimination against Women and article 24 in the Convention on the Rights of the Child, to mention some

tuberculosis, and HIV/AIDS” (ibid: 60). It is oriented towards the alleviation of suffering for individuals, emphasizing the moral obligation to the other. The approach is often of an apolitical character, not going through local government, but cooperating with nongovernmental organizations or local activists or health workers. “Its target of intervention is not a collectivity conceived as a national population but rather individual human lives” (ibid: 60). Vertical initiatives like GAVI and GFATM falls within this regime. The Prime Minister’s focus on immunization, and the BMGF are other examples of initiatives and actors within this regime.

Even though health has become an important issue within Norway’s foreign policy, emphasizing security over human rights, Norway’s global health engagement expands this sole focus on securitization of health. Norway holds a long and strong tradition as a humanitarian actor, and much of the nation’s self-image can be argued to lie in the realm of international development (Tvedt 2007, Tvedt 2009). Norway’s global health actors possess both regimes; infectious diseases are perceived as both security and humanitarian issues, and the regime advocated depends on the actor. In a multipolar world, new concentrations of power will gain new and greater influence. States will continue to use health as a soft-power tool, but as other challenges dominate the international policy picture, the pay-off will decline. According to Fidler (2011b:7) “[t]his environment will prove conducive for non-state actors, especially the Bill and Melinda Gates Foundation, to become even more important in shaping the global health agenda”, advocating the regime of humanitarian biomedicine – vertical initiatives. Norway is, through MFA, the biggest donor to GFATM if measured in dollar per capita, and we were important both for the establishment of GAVI and in supporting it after established.

4.2.5 Shift 2: a matter of framing – from development to securitization of health. Summing up

In this chapter I have focused on the securitization of health as a process starting long before we became aware that it was emerging. A new Minister of Foreign

Affairs with a background from WHO and global health governance became a situational factor whereas the international focus on specific diseases as security issues became international factors lifting health to the realm of ‘high politics’. However, Norway’s global health engagement goes beyond the realm of security, remaining an important part of the development policy. The Millennium Development Goals and global initiatives for health have risen on the development agenda. A Prime Minister passionate about women’s and children’s health has been important for this increased focus, however, not the only reason for a more vertical approach.

In the next chapter I will focus on the overall change in policy, from the local to the global.

4.3 Think locally, act globally

Both the institutional shift in power balance and the shifts in policy towards a focus on security and specific diseases are part of a greater shift – a shift in the overall focus from the local to the global. Health is here becoming global and one of my informants calls this a “conspicuous change” (interview no. 11, 15.06.2012), due to the historical context of development assistance for health. With health becoming a global issue, lifted up on the foreign policy agenda, the number of actors engaged in health has increased, leaving the field more fragmented and in need of coordination. As we shall see, the focus on participating and influencing this multilateral field has increased in Norway

4.3.1 From the local...

Norway’s development assistance for health has historically taken a horizontal approach focusing on the local context. The approach has been broad, aiming at several health foci and goals simultaneously. The approach has often involved joint responsibility for strengthening health systems in the recipient countries (Interview 11, 15.06.2012). Norway has done this through bilateral agreements and through active engagement in multilateral organizations working with health, e.g. WHO, UNICEF and UNFPA. The success criterion for this health

engagement has been the change that has manifested in the poorer countries; the local context. Now, the focus has shifted towards the change occurring in the global arena. Even though the global arena has always been part of the picture, through the engagement in multilateral organizations, there was also a link from the global to the local – from Norway via the multilateral organization and to the local context. Change at the local level was the goal, not at the global level (Interview 11, 15.06.2012). Even though reforms of the UN and UN bodies have previously been on the agenda, this has only been as part of the whole picture, and always with a link to the local.

4.3.2 ...to the global

Gro Harlem Brundtland, succeeding Hiroshi Nakajima as WHO's Secretary-General in 1998, was determined to reposition WHO as an important global health player; she moved beyond the ministries of health and directly addressed Heads of State, contributing to a more political approach to health. She also aimed to strengthen the financial situation, largely by opening up the arena to global partnerships and global funds and embracing cooperation with the private sector. This led to an increase in actors within global health, but also a lack of governance. An increased number of actors, a pressing financial situation, increased focus on results in development aid, and increased cross-sector cooperation and partnerships called for not only international but global regulation and governance (Møgedal et al. 2011)

New actors, especially the BMGF, became powerful, having financial authority. Within this landscape, the role of the state changed. Previously, nation-states held influence through WHO, or the World Health Assembly. With a proliferation of actors, the WHO was only one of many organizations on health, nation-states had to focus on a range of new actors and relate to them. To have influence, supporting WHO was not enough, and focus was therefore directed towards the global arena, and the governance thereof. Political authority became increasingly institutionalized in areas not directly controlled by states (Sending

and Neumann 2006: 651). In relation to this expanding global health architecture and new arrays of power, the Norwegian state had to include new actors in its portfolio while also expanding support to already existing actors. In the second Soria Moria Declaration, the government states that they want to prioritize development programs under the auspices of UN, hence step down the financial support to WB. However, Norway granted 200 million USD to the bank and the Health for Result (H4R) initiative, an actor Norway had decided to support less. This shows a lack of policy coherence (interview 10, 03.02.2012). However, these 200 million USD are not much compared to the money channelled through PPPs as GAVI and GFATM.

“One of the most substantive losses resulting from the shift towards the partnership paradigm is the loss of distinction between different actors in the global health arena. UN agencies, governments, transnational corporations, their business associations, and public interest NGOs are called ‘partner’. The realization that these actors have different and possibly conflicting mandates, goals, and roles has been lost” (Ollilla 2005: 3).

The focus now is more on securing global reform and governance, assuming that global reform and good global governance will ‘trickle down’ to a local level (interview 11, 15.06.2012). From this, one can assume that Norway tends to be satisfied with change at the global level, and that global change is a primary aim. This might not be a formal indicator; nevertheless, a respondent argues that it seems to be the mental point of reference (ibid).

In addition to being focused on reforming and strengthening global institutions, one can also argue that there is also an exchange at play, where Norway supports global institutions and receives results in exchange, or pays them to produce results in poorer countries. As long as the results are delivered, how they are produced seems to be of little interest (Interview 11, 15.06.2012). According to Sridhar (2010: 464), “the question of whom donors fund is extremely important”. Among newer institutions such as GFATM and the BMGF, there has been a move towards funding non-state actors, hence, circumventing the government. Within the regime of humanitarian biomedicine – actors focusing on alleviating

the suffering of individuals, on the moral obligation to help – “human suffering demands urgent and immediate response outside the framework of state sovereignty” (Lakoff 2010: 64). This is especially true within the context of a low-capacity state, or a failed state, where the public health infrastructure has collapsed, and the actors seek to govern through nongovernmental means (ibid: 66). The ‘target’ is not the state, and helping it rebuild the infrastructure, but rather the population, taking over the role of the state. In a human rights framing of health, the population’s health is the responsibility of the state.

Sridhar (ibid 2010) is sceptical towards this decreasing involvement of developing country governments due to the question of sustainability, and he argues that in terms of process, a bypassing of the government is unsustainable. “Although it might be more difficult in the short-term, strengthening health systems through government might be the most efficient in the long-term” (Sridhar 2010: 465). By supporting initiatives that bypass the government there is a risk of indirectly guiding national policy and influencing or dictating national health policy prioritization. This goes against the Paris and Accra Declarations. Global actors, like GAVI, are given access to a country’s territory and citizens, and the state has limited influence and control over strategies and prioritization, losing the ability to put the country’s health burden into focus. Global actors often have a vertical approach to health, focusing on specific issues, e.g. MDG 5, immunization, HIV/AIDS. Even though local ownership has been emphasized in the development literature and Norwegian policy documents this practice of bypassing government is common, challenging the principles of state sovereignty (Eggen and Sending 2012).

In addition to this, there has also been an increasing focus on involving Heads of State in supporting different initiatives. This was a practice Brundtland started during her tenure as Secretary- General of WHO, addressing heads of states in order to politicise health. We see the legacy of this in both health as development, and health as foreign policy in Norway. There is, however, no evidence that this contributes to change in a local context. It does not necessarily

mean that the Head of State turns around and asks his or her fellow citizens how they can realize an initiative (Interview 12, 22.06.2012). As this shows, there is a gap between the rhetoric and the action. Health is used in new ways, as a means to access other goals.

The dream of coordination

One informant, while talking about the same overall shift in focus, emphasizes the risk of losing focus when the aid flows upstream, indicating that there is a risk of creating distance from the local context, which makes it easier for a means to become an end in itself (Interview 8, 11.01.2012). Sridhar (2010: 460) talks about this “dream of coordination” as one of the seven challenges that development assistance for health is facing, especially when focusing on how to govern this global field. With the increased number of actors on the global health stage comes an increased focus on, and need for, coordination and governance. During the seminar ‘global health: a new star in the institutional sky’²⁰, the work ‘coordination’, or ‘the need for coordination’ was mentioned 13 times. For Norway, it has become important to participate in this coordination of the global health arena. The white paper on global health states that

“[t]hrough political leadership, diplomacy and economic support, Norway will be at the forefront of efforts to mobilize a strong and broad global consensus on cooperation to address national health needs. At the same time, we will encourage national authorities to take responsibility for establishing and securing universal access to health services” (MFA 2012c: 5).

The involvement in the International Health Partnership (IHP+) initiative is an example of Norway’s contribution to global health governance. The IHP+ was launched in 2007 with Norway as an important contributor, and aims to increase the cooperation between the different actors and partnerships working with the health related MDGs (MFA 2009: 22). However, according to Sridhar (2010: 461), “the lack of progress with the IHP+ is an indication that the rhetoric of coordination should be viewed sceptically”. He continues, saying that

²⁰ Author’s own translation: Global helse: en ny stjerne på den institusjonelle himmelen, NUPI, 07.05.2012

“[w]hile the rhetoric is in place, and the principles are outlined in the Paris Declaration and Accra Agenda, action lags far behind. Rather than put countries in the driver’s seat so that investment can be made in long-term priority-setting and planning, donors focus on “quick wins” and measurable returns through vertical programming. The focus on these quick results discourages investment in health systems and indicates the need for a country-led process of priority setting” (Sridhar 2010: 461).

This change in focus from the local to the global can be, to a certain extent, explained due to governance-related challenges at a global level (Interview 11, 15.06.2012). 10-15 years ago, health was seen as a rather simple field within international relations. WHO was the main actor and it was a consensus-based approach where WHO was a consensus-producing institution. This led to health being seen as a rather simple field, or at least not a complex field. Technical experts dominated, and there were not many diplomatic challenges associated with it. This does not mean that it was a conflict-free area, but more that conflicts were dealt with as a national matter and on a national level. Today, the global health field looks quite different, cf. chapter 5. From being one of the simplest or least complex fields in diplomacy, it is now one of the most complex and challenging fields.

According to one of my informants (interview 11, 15.06.2012), this increasing diplomatic complexity is also connected with conflicts between sectors, or areas of policy being lifted to an international level. As mentioned above, conflicts are not new within health development, but the setting in which they are dealt with is. Conflicts between health and trade and between commercial and health interests were previously dealt with at a national level. Now, however, conflicts are lifted to a global level and setting, e.g. TRIPS and patents, a level without norms and political traditions and forums for these disputes to be handled (ibid). Due to this, conflicts of interest have become more visible and hence more difficult for diplomats to deal with. As we have seen, health has become a strategically important topic for Norway, hence its elevation from NORAD to

MFA. However, it has also been lifted from an environment with a focus on health as science, as epidemiology, to become high politics and a soft-power tool; not an end in itself, but a means. Both the Prime Minister and the former Minister of foreign Affairs have been central actors in this shift of focus within the global health policy. This involvement has in turn influenced policy focus, moving it from the local to the global due to these dominant actors' mandates.

Focusing to such a great extent on coordination of global health is important in different ways; a fragmented and chaotic situation needs coordination and structure. However, Norway has a lot to gain by contributing to this coordination; the global health field is a field where it is possible to stand out, to gain status, and to influence the development of new institutions (Eggen and Sending 2012). WHO, GAVI, GFATM, and UNAIDS are all examples of this. Norway has, at different stages in the process of establishing and strengthening these, contributed with assistance reflecting our own experience and expertise or through diplomatic effort in important organizational processes (Eggen and Sending 2012: 213). Through this, Norway has not only built new networks and alliances, but also increased its own power and influence by engaging in the new global structure.

4.3.3 Framing as political tool

In this shift from the local to the global Norway spend annually 27,8 billion NOK on development aid. We may ask how the Norwegian development administration convinces the public that this is money well spent. To answer this, it is helpful to consider how framing is being used as a political tool to convince taxpayers and other actors that spending this money is the right thing to do (cf Labonté 2008).

Moral obligation to save lives

Neither vaccination nor maternal health are new areas within the Norwegian health portfolio. However, the way in which these topics are legitimized – the framing – is new. Previously, the moral argument was enough; we had a moral

obligation to help. With the increased focus on proving aid's effectiveness, the moral language was not enough, however, it is still being used. Both regarding vaccines and maternal mortality, Stoltenberg still uses a moral vocabulary, saying that we have a moral obligation to help, and that we are betraying the world's children by not doing what we know works – vaccinating. According to Stoltenberg, “[it is] a betrayal letting millions of children die from diseases they could have been vaccinated against” (Stoltenberg 2004), and “the fact that women are not given the care they need during child birth is the most brutal expression of discrimination against women” (Stoltenberg 2012). This speaks directly to common sense – who could argue against it? Here, he is addressing the problem in a way that everyone understands, and highlighting the fact that the remedies are already there – vaccines –, or in the case of maternal mortality, by providing medicines, or treatments for eclampsia and haemorrhage to mention but two.

In addition to this, both women's and children's health are seen as means for economic development. This idea was made quite clear at the launch of the white paper which was directly followed by a seminar on women's role in economic development. One of the key speakers was David Bloom, a scholar Stoltenberg has cited when arguing for an increased focus on vaccines due to their importance for economic development.

The humanitarian nation

This shift in overall focus, resulting in a more vertical approach, has gained little attention in neither the public nor the political sphere. During the hearing in the Parliament for the new white paper on health in foreign and development policy, only one of the Members of Parliament (MPs) (Trine Skei Grande) asked questions about the reason for the change in focus, or the scientific argument or justification for these priorities. She did not criticize the vertical initiatives per se, saying that they are cost efficient. However, she emphasized the need to take the

drawbacks with such initiatives into consideration. Such a discussion is, according to her, absent in the white paper (Stortinget 2012).

The white paper on global health (MFA 2012c: 5) “highlights the challenges and establishes clear priorities for a coherent Norwegian policy on global health”. Nevertheless, the budget, rather than the white paper, indicates what is being prioritized (Stortinget 2012, Interview 11, 15.06.2012). Looking at WHO, UNICEF, and UNFPA, none of them have seen increased funding, whereas projects focusing on specific diseases or targets have (ibid). The same can be found when focusing on health systems. This government’s initiatives on health system strengthening in general have been given less priority compared to the PPPs (Eggen and Sending 2012: 213, Interview 11, 15.06.2012, Interview 5, 25.11.2011). Nevertheless, here it can be argued that they are supporting HSS through the vertical initiatives.

Even though health has become a star in the institutional sky, Norway has not increased its overall funding. Norway has, however, changed what initiatives it funds and the channels used (Interview 11, 15.06.2012). This has happened quietly, as no active decision has been made; it is more of a passive change in that even though initiatives have been reprioritized, this has not been brought about by concrete action. Some existing funding projects reaching closure have been phased out, bringing a natural end to cooperation. This has meant that funding has been released and much of this funding has been redirected to support GAVI. According to Eggen (2012a), all in all, the portion of the aid budget focusing on global health has not increased, but the funds have been reallocated to new initiatives of interest²¹. Due to this, it can be argued that debate hasn’t been necessary since no new funding has been used and no negative decisions have been made.

²¹ According to NORAD’s statistical overview the Norwegian development assistance for health was 1,38 billion NOK in 2000, 1,8 billion NOK in 2007, 2,2 billion NOK in 2009, 1,7 billion NOK in 2010 and 1,8 billion NOK in 2011.

According to Tvedt (2007), such reallocations within aid in Norway can be done without debate due to the role that international development aid takes in Norwegian society; it can be seen as a cultural factor (cf. chapter 3.3.2). He argues that MPs' ability to argue is confined within national borders; they are capable of discussing budgets for roads and schools in a rational way, but when it comes to the aid budget, the debate turns in to a "competition over willingness to donate and thereby exercise moral supremacy" (ibid: 622). "This discursive practice has legitimized the systematic mixture of aims and means within this policy field, reinforced by the fact that the aims are to be implemented in places that lie far from the donor community" (ibid: 622). This distance can also be seen as a reason for technical interventions (Interview 10, 03.02.2012). Tvedt (2007) continues, arguing that due to this, debates on policy goals can be "interpreted as a ritual that has served to confirm the national self-image of doing the good things" (ibid: 622). He describes the policy as "the pride of the nation" (ibid: 622). By doing so, it has also helped position the "do-gooder" regime as a guardian of the country's morals, and as an interpreter of Norway's role in a globalizing world. The policy's role, as "the pride of the nation" helps explain this "broadly based national consensus over extremely complex political problems in other countries and over major questions such as that of what creates development" (ibid: 622). The aid policy being as integrated with and important to the nation's self-image also leads to rejection of criticism, as critique of the aid policy easily becomes criticism of the Norwegian self-image. Tvedt also uses this to argue why and how the content of this policy can change without any particular discussion (ibid: 622-3).

What we have seen here is that the shift in overall focus has been possible due to some strong actors entering the field, some of them also being situational factors. Norway's history and self-image as a 'do-gooder' provides them with an arena, making it easier to change the overall focus. However, this change is also a result of the interface between the national and the global, and political principles and

ideological differences might dilute its power in the transition from the national to the global (Eggen and Sending 2012: 214).

4.3.4 Shift 3: Think locally, act globally. Summing up

With health becoming a pressing foreign policy issue, the move from international health to global health also creates a possible area of conflict between the global arena and the nation state. The more power that is localized within the global arena the more necessary it becomes for small state actors to participate. Thus this shift from the local to the global blurs the boundaries between a state and global powers. The modern state has become an intermediary state, facilitating global policies (Kaul 2006). The health of the population becomes a global responsibility, and global health initiatives become a way of governing it. As we shall see, the target is the welfare of the individual, either as a member of the bottom billion²², a carrier of HIV, TB, or malaria, or as an unvaccinated child. Distance between policy actors and the field of implementation allows for pure technical interventions, interventions far removed from the Norwegian everyday. The necessity of using framing as a political tool to convince actors and the population of why health is being funded, something that two decades ago was seen as common sense, also bears evidence to this distancing. Health is no longer perceived as an end in itself. With health as a global interest, our shared vulnerabilities are emphasized. We are all in the same boat, living in a world of greater and greater interdependence. Norway, a small player with an identity as a humanitarian actor, wants to act and use framing as a political tool that lends legitimacy to the spending of tax payers' money and the new focus in foreign policy. While using a moral vocabulary - saying that it is a moral obligation to save women and children from dying - you also need to document that what you are presenting as the right thing to do is both effective and cost-effective, hence a focus on measurability and a vertical approach delivers the results.

²² Cf. Paul Collier (2008)

4.4 Big shots and quick fixes – from horizontal to vertical aid

With an increased focus on health central to foreign policy, health, or certain parts of health, becomes intrinsically global. Simultaneously in the international development discourse, there is a growing emphasis on the need for numbers, or results – a result based management. This focus on obtaining results to legitimize development aid has also influenced the Norwegian setting; the policy and how it is implemented. The aid debate has historically focused more on ideals than on effect, and the moral aspect has been emphasized. Both altruism and the moral obligation to help have been important arguments, making it easier to overcome aid opponents. With an increased focus on results, however, the old arguments are now not enough. However, as we have seen, they are still being used, but now they are used to legitimize the focus on results – we have to do what works – and what gets measured gets done. With this increasing focus on measurability and results reporting in combination with Norway’s identity as a humanitarian actor, the argument of ‘we have to do what works’ has flourished in the aid rhetoric. It has become possible to measure how much good is being done. According to the new white paper, no. 11 (1011-2012) on global health in foreign and development policy, the Government’s foremost priority is mobilising for women’s and children’s rights and health, and the Millennium Development Goals “form the cornerstone of the Government’s development efforts” (MFA 2012c: 10).

In this section, I will focus on how the shift in focus towards results and timeframes has influenced the Norwegian assistance for health and its implementation. As shown in 4.1, this shift is also visible in NORAD’s new role as an actor focusing on reporting the results of Norway’s development aid, while the delivery of health initiatives themselves is now part of MFA’s portfolio through multilateral partnerships and the embassies. This increased need for results is also visible in the policy initiatives and choice of partners.

4.4.1 Saving women and children

The globalization of health has meant greater involvement of actors from the private sector and philanthropists, actors with a business-like approach to development. Within health, the BMGF has become one of the biggest players and an important agenda setter²³. What both these new initiatives and partnerships and the foreign policy approach to health do is to “ruthlessly winnow complex problems into defined tasks with measurable targets” (Fidler 2011b: 8) – reducing complex challenges to easy quick fixes. This approach manifests itself in the debate between adopting a horizontal or vertical approach. The dominant global approach has waxed and waned, whereas until recently, Norway has preached the gospel of a horizontal approach. Now, however, new initiatives have emerged, focusing on specific diseases or health challenges. With these new actors, the focus becomes more targeted, and with a business model comes sharper focus on results and cost-effectiveness. Globally, HIV/AIDS initiatives and programmes targeting maternal, new-born, and child health receive the largest and second largest share of funding. Compared with other areas, non-communicable diseases receive the least (Murray et al. 2011: 9).

Since their emergence at the turn of the Millennium, both the MDGs and GAVI have influenced Norwegian policy setting. Even though they have different goals - MDGs wanting to save the Millennium Declaration from oblivion and to move the focus within the development discourse away from economic development (Vandemoortele 2011), and GAVI, on the other hand, focusing on the development of new vaccines - they are both targeted, which influences the agenda. With these two factors, health has become measurable and manageable. One of the things that has made the MDGs so alluring and powerful is their measurability, their integrated and synergic nature, and that they are communicated in a transparent way, convincing due to their simplicity

²³ “When the Gates Foundation supports an initiative, many other bilateral, multilateral, public, and private donors are often keen to join, or match its funding in order to be associated with a successful, high-profile activity. (...) [T]his gives enormous public policy-making power to a private actor which is not democratically accountable” (Birn et al. 2009: 101).

(Vandemoortele 2011: 7). GAVI's focus on immunization has made it possible to quickly report on results. This measurement influences and shapes the political debate (Vandemoortele 2011: 12). As we shall see, through the MDGs, reproductive health is perceived as less complex since MDG 5 is zooming in on maternal health, resulting in increased focus and funding.

Today, Norway's development assistance for health is centred on immunization and maternal health (cf. MFA 2012c), two topics that have been part of Norway's portfolio since the start. Nevertheless, the approach, and framing is new. In the next sections I will briefly present how vaccines and the initiatives on child- and maternal health have entered the agenda.

***The crusade to immunize the world's children*²⁴**

Vaccination as part of development assistance is not a new phenomenon. The world saw a renewed effort on child immunization with the creation of the GAVI Alliance in 1999. This became "a key junction in the Norwegian global health relations as it engaged both the political leaders and the development establishment in Norway" (Sandberg and Andresen 2010: 310). For Norway, this was the starting point for a broader global health portfolio, extending to include initiatives and partnerships with the private sector (ibid). As mentioned in 4.1, Prime Minister Stoltenberg became an important actor for placing GAVI on Norway's political agenda. However, this approach was not unanimously supported. Health bureaucrats in both Oslo and Geneva opposed this new vaccine initiative, and the Norwegian diplomat on health to the UN gave clear warnings regarding this matter. The Geneva-based delegation to the UN warned Stoltenberg about supporting this new initiative so heavily at the outset. Part of their critique pointed towards the potential significance the organization could gain in relation to already existing actors (Interview 5, 25.11.2011; NTB 2000).

The reason why GAVI was placed on the Norwegian agenda has to be seen in relation to factors other than just a passionate actor using his new position as

²⁴ Cf. Muraskin, William (2005): *Crusade to Immunize the World's Children*.

Prime Minister as a situational factor. Norway's new effort within the field of vaccination and its support for GAVI can be seen in relation to WHO's new focus on PPPs and its involvement in the creation of the GAVI Alliance. As Secretary-General in WHO, Gro Harlem Brundtland (as well as Jonas Gahr Støre as her Executive Director) was directly involved in the process of deciding GAVI's objectives, and pressed for a structure that was compatible and integrated with the UN system (Sandberg and Andresen 2010: 311). Tore Godal, a former WHO employee, and incumbent special advisor at the Norwegian MFA was appointed Executive Secretary of the GAVI Alliance and was a key influence in the process of agreeing the primary aim of the alliance: saving children's lives (Sandberg et al. 2010). By framing the aim as the solution to, and ending of, the tragedy of the child, he managed to highlight the problem and at the same time address GAVI as the solution. Brundtland, as "first chair to the GAVI board was instrumental in mobilizing Stoltenberg in eventually making Norway the first donor country to the Fund" (Sandberg and Andresen 2011: 311). GAVI, as a PPP, was important for Brundtland and WHO in re-establishing WHO as a main actor. Stoltenberg, and Norway, became important actors for Brundtland in making this a success, using her network to succeed. During the initial years of the fund, Stoltenberg succeeded in annually granting NOK 500 million, or US\$125million over five years, making GAVI "the biggest single programme in the Norwegian development budget" (Sandberg and Andresen 2010: 312). After leaving office in 2001, Stoltenberg advocated for the continuation of this support, winning "tough battles of budget increases to GAVI during this period when in opposition to the government at the time" (Sandberg and Andresen 2010: 311).

GAVI's objective was to focus on the development of new vaccines, as a supplement to existing basic vaccines. It can be argued that one reason why vaccines have risen to prominence in Norwegian development assistance, despite internal disagreements, is their simplicity, as the chain of causality is so short (Interview 12, 22.06.2012). The simplicity of the message is alluring to politicians as it makes aid policy easier, less complex, and more results-oriented.

And who could argue that saving children was not the right thing to do? This focus on vaccines ties in with MDG 4, and GAVI has become a flagship for Norway's engagement on MDG 4, on immunization and children's health (MFA 2012c).

Within foreign and development policy Norway holds a tradition of cooperating with 'like-minded' countries. Collaboration with Bill Gates in supporting GAVI represents something new. This also illustrates the importance of individuals in lobbying for this change, using their power and networks (both as Prime Minister and as Director-General of WHO) to set the agenda (Interview 5, 25.11.2012; Interview 7, 15.12.2012). "Following the establishment of GAVI, the Norwegian political leadership and policy practitioners were closely involved in the global agenda on the governance of what was now becoming the new generation of global health initiatives" (Sandberg and Andresen 2010: 312). Norway has also been important at different stages in the establishment of GFATM, and UNAIDS, and we continue to influence many of these.

Broadening the agenda, narrowing the focus - women's and children's health

When Stoltenberg returned to office in 2005, Tore Godal, an important global health actor with extensive experience and networks, was appointed special advisor to the Prime Minister's Office. The focus on vaccination continued, but was broadened to include maternal health as well. These being the goals furthest away from achievement, Norway decided to focus particularly on MDG 4 and 5. Goal 5 in particular was lagging behind – one of the reasons being that its results were difficult to quantify. Norway decided to help improve the system of measurement (interview 4, 18.11.2011). Having a Prime Minister engaged in the cause, Norway saw that they could contribute on the political front, politicizing the issue by using the Prime Minister as a figurehead. Norway and Stoltenberg initiated close cooperation with the UN Secretary-General Ban Ki-moon on the cause and were central to establishing the initiative '*Every woman every child*', launched by UN Secretary-General in 2010. This initiative puts into action the

'Global Strategy for Women's and Children's Health', which Norway was central in developing (ibid). The prioritization of children's and women's health in this way illustrates how health is seen as essential for development and poverty reduction, and this UN initiative forms the basis of the effort (MFA 2012c: 5). Here, Stoltenberg has again been a central actor in setting the agenda, this time partnering not with PPPs, but rather the UN. What he did, together with the Secretary-General of the UN, was to define the problem (pregnancy related deaths, hence mothers dying from their babies) and galvanize political will (bringing the UN on board together with a range of international initiatives). The only thing left to do was to address the solutions and that meant not only effective, but measurable targets, hence narrowing the focus by zooming in on maternal mortality. This way, this narrower focus was also anchored in a UN initiative, a historically important actor for Norway. In addition to this, as mentioned earlier, Stoltenberg initiated five bilateral initiatives on MDG 4 and 5. In addition to the UN Secretary-General, WB became an important actor for Norway's focus on MDG 4 and 5. Through the initiative on results-based financing Norway has increased its financial support to WB, defying the first Soria Moria Declaration which states that the support given via the WB should be reduced and support through the UN increased (Interview 10, 03.02.2012).

Reducing maternal mortality – a quick fix?

Reproductive health is a complex field, and has to be integrated in the health system to work; hence you need a good health system to support it. Therefore, it has often been seen as part of a horizontal approach, compared to vaccination that has a tradition for vertical initiatives (Austveg 2009). It can be seen as a package of a set of interrelated activities; each unachievable without the other (Austveg 2011: 28). Due to being a complex field it is also difficult to measure and to find good indicators for progress. It is not as clear as with the vaccine initiative, where X NOK equals Y vaccinated children – it does not focus on one single disease. In itself, good reproductive health is an indicator of a good health

system. Within a field and an era where measurability and results drive to increase the effectiveness of aid, reproductive health becomes a challenge because it is based on a broad set of determinants and it takes time to improve the numbers.

To be able to measure improvements in reproductive health, you need good indicators. Globally, the maternal mortality ratio²⁵ was chosen as an indicator, as visible in MDG 5. Nevertheless, it has been argued that an extensive focus on maternal mortality as an indicator for reproductive health has led to a new type of verticality (Austveg 2011: 28). To measure something complex, you need good measuring tools. An indicator has to be valid, reliable and robust, implying that it can act as a buffer against biases (ibid). You have to avoid the indicator becoming a planning tool; it needs to remain a goal. If you use immunization cover as an indicator for health system performance, there is an overhanging threat of focusing solely on immunization, reducing the priority of other equally important health issues (ibid). This is the possible outcome of any indicator, and the maternal mortality ratio is not immune to this bias. What was apparent with maternal mortality as an indicator was that “there was a zooming in on maternal health care, often with the justification that mothers should remain alive for their children” (Austveg 2011: 28). Maternal health becomes extensively linked with child health. This reduces maternal health to be about the mother and her child after delivery, the child she should not die from, whereas what the term maternal health is, is in fact much broader. It is “about pregnancy and the outcome of the pregnancy – be it the delivery of a living child, stillbirth, induced abortion, or miscarriage” (Austveg 2011: 28).

Reducing the focus, from reproductive health to maternal health, is what the initiatives that Norway supports do, and these initiatives’ efforts are not always in coherence with the Norwegian policy which frames reproductive rights,

²⁵ Maternal Mortality Ratio (MMR) is the number of women who die as a result of pregnancy and childbirth complication per 100 000 live births in a given year (Skolnik 2012: 20)

women's rights and human rights in general as fundamental principles for the development aid (cf. MFA 2012c) (Interview 10, 03.02.2012). By narrowing it down from reproductive health to maternal mortality, there is also a depoliticization, where the parts of reproductive health that lie outside of this political consensus on prevention of maternal deaths are not addressed. Conflicts such as abortion are neglected at the level where decisions are made and hence political will is not transformed into necessary changes (Austveg 2011: 27). Here, maternal health is made political but at the same time depoliticized to be made politically palatable, and this is not necessarily what is scientifically or epidemiologically the best thing to do. Again, the conflict between science and politics is visible. One of my respondents was puzzled over why Norway was supporting, and exporting, this model, since it took a completely different model to solve the same challenges at home. In Norway, maternal or reproductive health has been integrated in primary health care since the 19th Century; a model that other countries are looking to Norway to learn from (Interview 10, 03.02.2012). One explanation might be the distance; it is not in our backyard. A technical intervention is also alluring for its simplicity (ibid). The latest contribution to improving maternal- and child health is the UN Commission on Life-saving Commodities for Women and Children, co-chaired by Prime Minister Stoltenberg and President of Nigeria Jonathan Goodluck, which was established in March 2012 (MFA 26.09.2012). They launched their report at the UN General Assembly in September 2012, presenting a list of essential, but under used, life-saving medicines for improving women's and children's health. As with vaccination, these medicines are important, but they are technical remedies for a complex issue.

4.4.2 An Increased belief in numbers

What we see here is not only an inclination against, or shift towards initiatives that have a history of verticality, like GAVI and vaccination, but also a change of approach when dealing with issues that have historically been horizontal –

making maternal health vertical. In a field with increasing focus on results-based financing, measurability, and results; what get measured gets done.

This new belief in numbers is not only to produce results *per se*, but rather to produce results that can justify the money spent and the effort expended within a short time frame, and it should be possible to document that it is your money creating the results. Whereas a horizontal approach also creates results, they are more difficult to trace in terms of money and effort, and it may take a longer time frame. Every day there may be change, or results, due to efforts to strengthen a country's health system, but it is difficult to trace these changes and results back to one single 'donor' (Interview 11, 15.06.2012). A vertical approach makes documenting the results and tracing them back to the original funding much easier. In the development aid sector where there is an increasing demand for results, it is easy to understand why this shift from horizontal to vertical happens (ibid).

Nevertheless, what we have seen during the last decade is that greater emphasis has been placed on quantifiable targets, which again has led to a proliferation of indicators and other means to measure whether or not targets are met/reached (Shibuya 2007: 1). During my interviews, not all of the respondents praised this change towards a more results-oriented approach. Measurability and results can be seen as politically important; you can increase your profile as an actor that achieves something (Interview 7, 15.12.2012). However, a vertical approach is not necessarily the right thing to do if the time frame is expanded – it is not necessarily what creates good health in 20 years.

4.4.3 Shift 4: Big shots and quick fixes – from horizontal to vertical health aid. Summing up

With health becoming global and within a context of increased belief in numbers, the need for results and hence measurability within aid increases. Due to this, the way aid is being implemented changes. To be able to show results to both home and global audiences, the need for indicators and the desire to show value for the

money increase. What we have seen in this chapter is that the quest for results has led to a narrower focus on specific diseases or health burdens and the way Norway's development assistance for health is implemented change. The UN family and UN led initiatives like the MDGs have been important in this process. In the effort to transform complex realities into measurable indicators something gets lost along the way if only what gets measured gets done. What happens with the health burden that is not easily measured? Is this increasing focus on measurability what creates the best health in 20 years? Even though health is seen as a political issue, it is at the same time depoliticized to create an apparent consensus, in an effort to making it politically viable.

Focusing on actor, context, and processes this chapter explores recent profound changes in NDAFH. To better understand these changes the manner in which health aid is understood, approached, and implemented must be explored. I show how the focus on implementation has shifted from a horizontal to a vertical approach, focusing on targeted diseases and health burdens; how the overall focus has shifted from the local to the global – using framing as a political tool to legitimize this shift; how the securitization of health – framing the risk of infectious diseases as a shared vulnerability, hence a security issue and 'high politics' – has enabled the shift from NORAD to MFA; and how the national global health arena now embodies new actors, with new areas of interest, due to the new prominent place health has both nationally and internationally.

When focusing on policy shifts like these, what is going on internationally is of great importance – a national policy shift does not happen isolated from the global arena, and therefore, cannot be fully understood outside of the global and historical context. In the next two chapters I will focus on the global and

historical contexts that place Norway in the heart of WHO and the UN system. Norway, as a small country and actor, becomes a player on the international scene through the multilateral system – the system we are extending our support to today. Through the multilateral system health and development are moved into the domain of foreign policy and international relations, creating new prominent actors and frames. As we shall see, the approaches as well as the implementation within global health have waxed and waned throughout history, from vertical to horizontal and back. With the multilateral system as its main channel, Norway has followed this global pendulum.

5. From national to global, health assistance in transition

To understand the development of the four shifts identified in last chapter, it is of importance to place them in a historical context. Norway, and Norwegian actors, operate within a tradition of a close collaboration with the UN family, especially WHO. This backdrop creates the context within which the actors operate and processes happen. At the same time it shows the importance of the multilateral system as an actor influencing Norway's focus. The process leading up to the recent policy shifts started long before the change in the Norwegian health arena. To better understand these shifts, we need to look closer at the relationship between Norway and the UN family. In this chapter I will first focus on the WHO, and how the focus on health has waxed and waned, or evolved, due to the changing world within which it operates, then I will illustrate how Norway's development assistance for health has developed.

5.1 The World Health Organization

In the aftermath of World War II, with people's suffering from the war still fresh, "some health authorities and political leaders believed conditions for future global peace and security could be enhanced by creating a multilateral organization to coordinate all aspects of international public health" (Irwin and Scali 2007: 236). Health was here seen as an important factor for peace and security, a focus that is still prominent within the UN, e.g. in the MDGs. The World Health Organization was proposed at the UN Conference on International Organization in San Francisco in 1945. A draft constitution was made by Rene Sand and Karl Evang²⁶, among others, and revised by representatives of UN member states in 1946 before being ratified in 1948 by the first World Health

²⁶ Karl Evang was a Norwegian physician and a reformist within the field of social medicine. He was appointed Norway's Chief Medical Officer in 1938. As part of the Norwegian government, he had to flee the country in 1940, and he spent considerable time in the US. "During that time he contributed greatly to defining the missions of two of the U.N.'s most successful organizations: First, the Food and Agricultural Organization, and later, the World Health Organization" (Ringen 1990: 361). He was one of three men providing the philosophical direction for WHO, and their social medicine tradition can be seen both in WHO's broad definition of health and its constitution.

Assembly, “whose endorsement formally brought WHO into being” (ibid: 236). Norway was an important actor from the beginning through Karl Evang.

“With the establishment of the WHO, international health’s broadest mandate resided in a single agency for the first time, including standard-settings, data collection, epidemiological surveillance, training and research, emergency relief, and cooperative activities” (Birn 2009a: 56).

WHO’s overall goal, Article 1 of its Constitution, is “the attainment by all peoples of the highest possible level of health” (WHO 1946, Lee 2009: 16), and the organization has a broad definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1946, Lee 2009: 16). Based on this, WHO had a social approach to health, and saw health as pre-eminently shaped by social conditions. “The WHO Constitution provided space for a social model of health linked to broad human rights commitments” (Irwin and Scali 2007: 237). The WHO saw the urge for peace and rebuilding in Europe in the aftermath of the World War II, and increasing human wellbeing was seen as a peace-building effort.

The Cold War had an unmistakable impact on the organisation, and when the Soviet Union left the UN system and therefore also WHO in 1949, the ‘Western’ allies had a dominating influence (Brown et al. 2006: 64-5). The Soviet Union did not return to the UN until 1956. This post-World War II context of Cold War politics and decolonization hampered the implementation of a social model of health and instead it favoured an approach based more on technologies delivered through targeted campaigns (Irwin and Scali 2007: 237). This trend was promoted by major breakthroughs in drug research that produced an array of medicines, vaccines and antibiotics during this period, thus promoting the view that technology held the answers to the world’s health problems (ibid).

The WHO was created in a post-World War II context where many national health systems had been destroyed; hence, a top-down approach focusing on vertical disease-specific initiatives was seen as a necessity in the beginning. In 1955, the WHO started its campaign to eradicate malaria. It was believed that a “global malaria eradication [would] usher in economic growth and create

overseas markets” (Brown et al. 2006: 65), and “build support for local governments and their US supporters and help win ‘hearts and minds’ in the battle against communism” (ibid). This initiative mirrored the prevailing development thinking of the time. “Such initiatives were international – rather than “global” – in that they required cooperation between WHO and national public health services” (Lakoff 2010: 65). This approach was quite the contrary of the vertical disease-specific initiatives that dominate now. By the time the Soviet Union returned to the WHO in 1956, the WHO was closely allied with US interests.

This belief in technology also influenced healthcare models in the developing world. “The health systems established in areas of Africa and Asia colonized by European powers catered almost exclusively to colonizing elites and focused on high-technology curative care in a handful of urban hospitals” (Irwin and Scali 2007:237). The concern for broader public health was low, with little focus on services for slum dwellers and the rural population. While many colonies gained independence during the 1950s and 1960s, a large proportion of them modelled their national health systems on the model provided by the former colonial power (ibid).

During this post-war decade an approach to health based on health technologies delivered through targeted campaigns was favoured, and international health was characterized by the proliferation of vertical programs; disease specific and technology-driven campaigns targeting diseases like malaria, smallpox and tuberculosis (Irwin and Scali 2007, Brown et al. 2006). This approach was supported by “an array of new antibiotics, vaccines and other medicines [being discovered] in this period” (Irwin and Scali 2007: 237). These disease-specific programs were seen as highly efficient, and in some cases easily measurable, targets, and important in the process of rebuilding countries and delivering health fast. “Yet by their nature they tend[ed] to ignore the social context and its role in providing well-being or disease”. (Irwin and Scali 2007:237). These early technology-driven disease-specific campaigns can be seen as leading towards the

securitization of health (cf. 4.2), where global peace and security is closely linked with disease surveillance.

5.1.1 Health for All

During the 1960s and 1970s, the political context changed with the emergence of decolonized African states. The spread of nationalist and socialist movements and new development theories emphasized long-term socio-economic growth rather than short-term technological interventions, changes that also influenced the WHO. During the 1960s and early 1970s it became evident in many parts of the world that the dominant health models promoting vertical disease initiatives and the emphasis on urban-based curative care did not meet the most urgent needs of the poor and disadvantaged. The effectiveness of a programme was now believed to be influenced by “values and culture, accountability, morale, and communication, among other things, but that such factors had been neglected in the belief that better techniques or technologies could by themselves tackle the causes of ill-health” (Walt and Gilson 1994: 357). Communities and healthcare workers started to look for alternatives, and “a renewed concern with the social, economic, and political dimensions of health emerged” (Newell 1975 in Irwin and Scali 2007: 238). Here, the pendulum swings from a vertical disease-specific and technical approach towards a broader bottom-up approach to health. This community-based approach to health rose in importance on the agenda, downplaying the importance of high-end medical technology and the reliance on highly trained medical professionals – ‘barefoot doctors’. Health education and disease prevention were at the heart of these strategies (Cueto 2004). “What had begun as independent, local, or national community-based experiments acquired a growing international profile and a cumulative authority in the early 1970s” (Irwin and Scali 2007: 239). This bottom-up approach to health focused on prevention and on managing health problems in their social context. Social equity and human rights were central in this approach. The changes in the political environment also influenced the WHO, which was now *the* most influential international health institution.

During the 1960s, the WHO acknowledged that a good health infrastructure was prerequisite to the success of the malaria control campaign initiated in the mid-1950s, and this emerging new model of health work was spearheaded by WHO's Director-General from 1973- 1988, Halfdan Mahler. Together with UNICEF, the WHO launched the report *Alternative Approaches to Meeting Basic Health Needs in Developing Countries* in 1975 – a report that challenged the traditional vertical disease-specific programs and focused on the principal causes of morbidity in developing countries as a result of poverty (Cueto 2004). This report shaped WHO's ideas on primary health care, and at the World Health Assembly in 1976, Mahler proposed the goal of 'Health for All by the Year 2000' (HFA) – a target that according to Mahler, required radical change and also implied the removal of the obstacles to health (ibid, Irwin and Scali 2007: 239). HFA placed the nation state at the centre and established health as a national policy responsibility, not a global. It also placed health within the triangle of human rights, economics and politics (Kickbusch 2000).

In 1978, WHO held a conference on health services in Alma-Ata, USSR, now Kazakhstan, a conference that became a landmark event for primary healthcare (Brown et al 2006, Irwin and Scali 2007, Cueto 2004). "The conference declaration embraced Mahler's goal of 'Health for All by the Year 2000', with primary care as the means" (Irwin and Scali 2007: 239), thus marking a re-emergence of social determinants as a major public health concern (ibid). The conference's main document, the Declaration of Alma-Ata, was permeated by three key concepts. The first being 'appropriate technology', the second being opposition to medical elitism and the third being the concept of health as a tool for socioeconomic development. They focused on 'appropriate' technology that was relevant to the needs of the people - not only the rich urban minority - scientifically sound, and financially feasible, and the support of health posts in rural areas and shantytowns was emphasized (Cueto 2004: 1867). The second concept was the rejection of elitism, overspecialization of health personell and top-down health campaigns, instead focusing on lay health workers and

community participation. The final concept linked health and development, emphasizing that health work was not an isolated and short-lived intervention but part of the process of improving living conditions, the social determinants of health, and that inter-sector action was needed to support this approach (ibid).

5.1.2 In the wake of Alma-Ata

In the late 1970s, the WHO was focusing on both HFA and primary health care (PHC), and on vertical initiatives such as the campaign to eradicate smallpox that lasted from 1967 and until 1977. Both the smallpox campaign and the HFA/PHC approaches were painted as success stories, respectively as successes for science and global health cooperation, and for international health at a community level (Birn 2009a: 58). Within the WHO, and between international health actors, there have always been tensions between the social and the technical approach. “These approaches are not necessarily incompatible, although they have often been at odds” (Brown et al. 2006: 66). As we have seen, this tension is still in force in Norwegian policy today. In a way, this illustrates contradictions in the meaning and strategies of international health success; “vertical vs. horizontal, technical vs. social, centrally driven vs. locally defined, disease-based vs. health based, individually vs. collectively-oriented (...) and so on” (Birn 2009a: 58). Over time, the dominance of these factors waxes and wanes, depending on factors such as the balance of power, the changing interests of international players, the intellectual and ideological commitments of key individuals and actors, and the way these different factors interact with the health policymaking process (Brown et al. 2006: 66).

“With these dichotomies deeply politicised and ultimately irreconcilable, the broadly defined primary health care success was selectively dismantled into a technical shadow of its former comprehensive approach” (Birn 2009a: 58). Nevertheless, Alma-Ata’s link between health and development had political implications, and the HFA/PHC approaches were seen as too broad, too idealistic, and with an unrealistic timetable. The condemnation of global

economic inequalities and the call for social justice sparked “resistance from global actors committed to market-based approaches in development and health”, among them the WB (Irwin and Scali 2007: 242). As we shall see, another reason for the fall of HFA and the Alma Ata Declaration can be found in international relations of the time. The WHO-led push for HFA converged with the ideological battles of the Cold War – raising the initiative’s foreign policy stakes. At the end of the 1970s, things started to change. The Iranian revolution in 1979, the Soviet invasion of Afghanistan, and the oil crisis and its impact on the economy, marginalized HFA as a foreign policy concern for the major players. *Realpolitik* affected the responses to health problems, and here it was seated in the shadow of bigger and ‘harder’ issues, preoccupying policy makers within the realm of foreign policy (Fidler 2011b: 5).

Selective primary health care (SPHC) was proposed in the wake of the Alma-Ata conference as being more pragmatic, and building on “low-cost interventions that were limited in scope and easy to monitor and evaluate” (Brown et al. 2006: 67). The SPHC was also a politically unthreatening alternative to the PHC. This approach, aiming to reduce “Alma-Ata’s idealism to a practical set of technical interventions that could be implemented and measured more easily” (Brown et al. 2006: 67) was first introduced at the Bellagio conference sponsored by the WB and the Rockefeller Foundation in 1979. Here, the WB and the Rockefeller Foundation were important actors in reintroducing a more technical and specific approach which at the same time reduced health’s political implications. SPHC was swiftly adopted by influential global actors, notably UNICEF. Instead of focusing on how to strengthen all aspects of the health system simultaneously, or how to transform both social and political power relations, SPHC advocated concentrating on a small number of cost-effective interventions. Hence, SPHC focused primarily on maternal health and child health, seen as areas where a few simple interventions could reduce mortality and morbidity (ibid, Irwin and Scali 2007), and the most famous example of SPHC was UNICEF’s strategy for

reducing child mortality: GOBI²⁷. This initiative became the centrepiece of the targeted campaign to reduce child mortality in the 1980s. However, this narrow focus on women and children under 5 years old “was designed to improve health statistics, but it abandoned Alma Ata’s focus on social equality and health systems development” (Magnussen et al 2004: 169). PHC was formed as an approach at a time with broad agreement that the causes of poverty were non-natural and that social justice was a necessity for health. What UNICEF did with GOBI was to locate “health action wholly outside the realm of socio-economic rights and responsibility” (Wisner 1988: 965), hence, depoliticizing poverty, not taking into consideration the health effects of the economic crisis in the 1980s. It has also been argued that this focus on targeting, and therefore on appropriate technologies, had become a substitute for social transformation (ibid). Once again we see that the pendulum had moved from a technical- to a horizontal approach and back, due to the political surroundings.

This change in focus, from equity to a more narrow focus on selected interventions that could improve the statistics in the early 1980s was not a coincidence. It was a reflection of an area in which political power relations were changing and global economic doctrines were shifting, hence global health thinking was changing as well, and actors as UNICEF and the WB were important in putting it on the agenda (Hardon and Blume 2005, Irwin and Scali 2007). As we shall see, Norway lobbied UNICEF to adopt a broad focus, emphasizing WHO’s broad approach to health.

5.1.3 The ascendance of economism

Before the 1980s the state played a strong and central role in health and development. Health policy was controlled by a medical elite and was fuelled by tremendous confidence in medical science, resulting in health policy being

²⁷ The abbreviation stands for Growth monitoring to fight malnutrition in children, Oral rehydration techniques to defeat diarrheal diseases, Breastfeeding to protect children, and Immunization. Later some agencies added ‘FFF’ for Food supplementation, Female literacy and Family planning (Brown et al 2006; 67, Irwin and Scali 2007; 243-4, Cueto 2004; 1869).

decided largely consensually. At that time, health policy was largely uncontroversial and was visible as “low policy” issues on the political agenda (Walt and Gilson 1994: 356). International and bilateral agencies became more involved in health from the 1950s, and they established their credibility through technical expertise. In the late 1960s this technical-medical paradigm was challenged. Much illness became seen as poverty related. The Alma-Ata declaration in 1978 and the PHC approach reflected this critique and the health policy arena expanded to include many groups other than medical professionals (Walt and Gilson 1994). This resulted in a shift from consensus to conflict in health policy. Health was no longer just a technical topic, but highly political. This politicization of health started in the 1980s as neoliberal²⁸ ideas began to dominate and previously accepted values were challenged (ibid).

During the Cold War, the arms race was preferred to the health race, a trend that donor countries followed which again influenced and restricted developing countries’ health sovereignty. “The preference of donors and agencies lay in vertical programs and medical/technical solutions rather than in infrastructure and human capital investments such as sanitation and community development” (Kickbusch 2000: 982). In the aftermath of the Cold War, donor countries experienced increased pressure from back home to prove that foreign aid was efficient, that it made a difference and that it “fulfilled a national interest ‘back home’”(Kickbusch 2000: 982). This resulted in funding being approved according to donors’ preferences, not recipients’ agendas. This neoliberal doctrine “shaped international development policy via donor governments’ bilateral programmes, but most importantly through the activities of the World Bank²⁹ and IMF” (Irwin and Scali 2007: 245). During the 1980s, the WHO

²⁸ The historical origin of the neoliberal model does not fall within the scope of this thesis, however, the core of the neoliberal vision was, and still is, “the conviction that markets freed from government interference ‘are the best and most efficient allocators of resources in productions and distribution’ and thus the most effective mechanisms for promoting the common good, including health” (Cuborn in Irwin and Scali 2007; 245).

²⁹ The World Bank had initially been formed to help in the reconstruction of Europe; however, its mandate was expanded to include providing loans, grants, and technical assistance to developing countries. In the 1970s it started to give loans to family planning and got more and more involved in health policy. During the 1980s, the WB became a more and more important player in the field of international public health. It believed that improving health and

steadily lost its share of resources and influence, and was eclipsed by WB as the most influential international health organization in the early 1990s. The Bank's World Development Report³⁰ of 1993 labeled 'Investing in health' pointed out poverty and lack of education as important determinants of health, nevertheless, its focus was on "misallocation and wastefulness as the key health sector problem in developing countries" (Birn 2009a: 60), problems that could be addressed "through an increased private sector role in health service delivery" (ibid: 60). The international financial institutions (IFIs), such as the WB and International Monetary Fund (IMF), introduced significant conditions on loans in the form of structural adjustment programmes which demanded political- and economic reforms. These reforms affected the health sector through "cuts in budgets, promotion of the private sector, and introduction of user charges for health services" (Walt and Gilson 1994: 355).

During the 1990s, the WHO tried to reposition itself as the main hub of international health by increasing its collaboration with business (Ollila 2005). It had to choose whether to be *the* main international organisation on health within a narrow health definition, or to be one of many organisations inwith a broader definition of health and its determinants. In 1998, Gro Harlem Brundtland, the former Prime Minister of Norway, succeeded Hiroshi Nakajima as Director-General of the WHO and she managed to restore much of WHO's credibility. One of her most significant legacies was that she reframed health "strategically in terms of other policy goals, such as development, economic growth, poverty reduction and national security" (Lee 2009: 107). Hence, health became a means and not only an end in itself, being made available and relevant for a broader set

nutrition could accelerate economic growth, and it favored free markets and a diminished role for national governments (Brown et al. 2006; 67, Birn 2009a).

³⁰In addition to the focus on the private sector's role in health, the report also introduced a new "composite measure called the disability adjusted life year DALY (...) as a generic indication to help set policy priorities, facilitate comparison between countries, and standardize health sector decision making" (Birn et al. 2009: 230). It included both mortality and morbidity in the statistics, whereas prior to this, the health burden had been measured only by mortality. Reproductive health was given priority, even though the way the report reflected reproductive health has since been criticized (Austveg 2006: 53).

of actors. She also initiated the ‘Commission on Macroeconomics and Health: Investing in Health for Economic Development’ (CMH), launched in 2001, which echoed the WB’s argument of investing in health for development (Birn 2009a, Waitzkin 2003). Both of these documents have been seen as “neoliberal health manifestos” (Birn 2009b). CMH encourages medico-technical solutions to health problems and it asserts that disease is a major determinant of poverty, and that hence, investing in health is a key strategy towards economic development. By doing this, it distances itself from previous interpretations of poverty as a cause of disease – technical solutions are ones more prominent in the WHO portfolio (Katz 2004, Waitzkin 2003). Nevertheless, the term ‘investing in health’ has a double meaning. First, investing through cost-effective, narrow, technical interventions to improve health, economic productivity and poverty, and second, investing capital, especially private capital, as a route to private profit in the health sector (Birn 2009b, Waitzkin 2003). It places health economics at the heart of health sector development, emphasizing the measurement of the performance of the sector and issues of cost-effectiveness and efficiency within the health sector. This can be done either by direct service delivery or through public-private collaboration.

Although the author of the report “refers to health as “an end in itself”, the focus on economic productivity diminishes the importance of health as a fundamental human right” (Waitzkin 2003: 523). However, “by putting numbers on the idea that ill health among the poor costs the global economy vast sums of money, the CMH captured the attention of policymakers” (Irwin and Scali 2007: 250), and it contributed to securing prominence for health through quantifying the “potential economic payoff of health improvements” in low- and middle income countries in terms of dollars (ibid: 250). It has also been argued that the CMH was perceived as more “realistic, pragmatic, and in touch with the real world than earlier WHO initiatives” (ibid: 250) since embracing the language of cost-effectiveness and focusing on health “in terms of returns on investment” (ibid: 250).

5.1.4 Partnerships as ‘modum operandi’

“While the post-war multilateral system made it possible for the new globalization to emerge and flourish, globalization in turn has progressively rendered its designs antiquated. Simply put, our post-war institutions were built for an international world, but we now live in a global world” (Kofi Annan 2000: 11).

During Brundtland’s period as Director-General, the WHO’s collaboration with business increased and partnerships became a *modus operandi*. This was as a result of the rise of ‘third way’ politics – seeking to find the middle ground between traditional left- and right wing politics, or in other words between interventionism and *laissez faire* market liberalism (Lee 2009: 115). Brundtland called for “open and constructive relations with the private sector and business” (Lee 2009: 115), resulting in the private sector becoming more involved in a range of WHO initiatives³¹ (Lee 2009: 115). This also led to an increase in private-sector financial contribution to the organisation. Its close collaboration with the pharmaceutical business has, however, been criticized (Lee 2009).

Philanthropic and business interests were not new within the international health arena (e.g. the Rockefeller Foundation was established in 1913), however, “it was not until the mid-1990s that public-private-partnerships (PPP) were formalized as a central modality of international health” (Birn et al. 2009: 105-6). The ulterior motive of the PPPs was to expand the funding and visibility of international health efforts, thus, giving the private sector a major role in policy making. From the mid 1990s and onwards there has been an increase in PPPs in the multilateral system and the flow of private capital has increased whereas there has been a relative decline in the ‘official’ flow of capital (Bull and McNeill 2007: 43). It is also in the health sector that PPPs have been most prominent, or used to the greatest extent (ibid: 65).

Today, there are many large-scale global PPPs and the WHO is involved in nearly 100 of them, for example Roll Back Malaria and GAVI (Birn et al. 2009:

³¹ Brundtland appointed Jonas Gahr Støre as head of the Director-General’s Office to professionalize its operations (Lee 2009).

106). PPPs are often disease-specific or narrowly targeted, entrenching the concept of vertical programs, hence, “jeopardizing health system development and impending integrated approaches” (Birn et al. 2009:106). For instance, there is no PPP for primary health care. Even though the WHO is a partner in some of these PPPs, its “mandated responsibility for world health is superseded in some PPPs, which relegate [the WHO] to the margins” (Birn et al. 2009: 106). This is due to the “contradictions between the profit-making mandates of corporations and the WHO’s commitment to health as a human right” (Birn et al. 2009: 106). However, there has also been a tendency towards reluctance among many of the PPPs to channel funds through the WHO. The BMGF, founded in 1994, is the most influential player in this respect. Instead of being seen as a coordinating- or lead agency, the WHO is seen as a potential partner alongside other potential partners from private sector or governments, resulting in the bypassing of the WHO’s role as the leading UN health agency (Lee 2009: 116-7).

Two of the largest and most influential PPPs had been established by the turn of the millennium, GFATM in 2002 and the GAVI Alliance in 2000. GAVI was initiated by BMGF to increase the immunization of the world’s children. Initiatives like these have helped to place health on the global political agenda, however, they also “share an approach to health based on ‘North-to-South’ aid derived from donor agendas and cost-effective technical control of the issues they deem priorities” (Birn et al. 2009: 62). With the GAVI Alliance, vaccination became global best practice and was framed as an important and cost-efficient tool for economic development.

Between 1990 and 2012 there was a massive expansion of development assistance for health, and new institutions and actors channeled these resources. Between 2007 and 2010 the funding of global health expanded from USD 20.4 billion to USD 26.9 billion (Murray et al. 2011). The shift in the balance of contributors between the different channels continued to be an underlying trend, with UN agencies playing a smaller role and GFATM, GAVI, and BMGF

growing in importance as channels of assistance, in addition to US and UK bilateral aid (ibid: 9).

In the late 1990s, new statistical analysis was published showing that major aid-receiving countries did not experience greater growth than other countries (cf. Burnside and Dollar 1997, Boone 1996, World Bank 1998). Within research, this was a well-known statement and was met with studies showing the opposite. Nevertheless, within politics these new statistical studies gained a lot of attention and fuelled the discussion about the size of the aid budget (Eggen 2012b). Why should funding be spent on initiatives that did not necessarily work? For the aid industry this was an argument that could not be met with a speech about moral obligations and the focus turned towards documenting results. This happened at the same time as New Public Management³² (NPM) and a focus on results spread within other parts of the public sector (Eggen 2012b), leaving the development discourse and policy, under a double pressure to focus on numbers and results (interview 11, 15.06.2012). This happened at the same time as the MDGs were presented, again focusing on reaching highly uncontroversial goals that gained broad political support, and leaving little room for political discussion – everyone could agree on them, and they were apparently measurable.

5.1.5 The return of a broader focus?

In parallel to the increasing focus on cost-effectiveness and PPPs, the contrasting approach of a broader definition of health with a focus on the social determinants of health made itself once again present in Western countries. By the turn of the millennium, momentum had gathered for policy action to tackle health inequalities and address social determinants of health in Europe. “Some commentators foresaw that aggressive action on health determinants in wealthy countries, without corresponding initiatives in the developing world, might lead to a widening of global health gaps” (Marmot 2004 in Irwin and Scali 2007:

³² NPM denotes the prevailing regime within government policies since the 1980s. It aimed at an effective and liberalized public sector, emphasizing measurability and result-based management.

251). Within this context of growing awareness of the SDH and an uncertainty about how to best implement SDH policies in LMIC, lacking evidence on effective interventions, the need for a global commission on social determinants of health arose. In 2003, the new Director-General of the WHO, Dr. Lee Jong-wook was appointed. Jong-wook saw action on SDH as key to strengthening global health equity, and a global commission was announced in 2004.

Most recently, the principles of the Declaration of Alma-Ata were reaffirmed in the Ouagadougou Declaration, issued by the member states of the WHO African Region. In particular, they focused on health as a fundamental human right and on governmental responsibility for the health of citizens. These foci indicate the return of a broader focus.

5.2 The Norwegian development assistance for health

Norway's motives for engaging in development aid are closely related to the country's foreign policy. The political and strategic motives of stability and peace, international co-operation, collective security and defence, as well as economic growth have all been seen as necessities for creating a safer world. The UN in general and WHO in particular have always been, and continues to be, important for Norway – in the post-war period we have generally played an active role through engagement in UN's different bodies - and the wish to strengthen the organisation has been one of the reasons why so much of Norwegian aid has been multilateral and channelled through the UN. UN and the rules developed by the international community “are essential for safeguarding Norway's economic development, security and values” (MFA 21.09.2012) and to Norway's effort to promote these. A new white paper on Norway and UN, report no. 33 (2011-2012) to the Storting, also emphasize Norway's interest in creating and promote a global order, and that this should be done through, and by, the UN (ibid). Even though political and strategic motives have determined development policy, ideal or altruistic motives such as humanitarian ideas, human equality, and a notion of the universal value of human life, have been the most distinct in the governments' arguments and justifications. The legacy of the Marshall plan

also implied that we, as previous recipients of aid, had a moral obligation to help to ease the suffering in every corner of the world. As a rich country, we should take our share of the burden to create an equal distribution. These motives are still dominant in the formulation of Norwegian engagement in aid policy (Stokke 1987, Stokke 1992).

5.1.6 The early beginning

Since the dawn of Norway's engagement in development aid, health has been an important component, however the approach has changed. The 'Indo-Norwegian Fisheries Project' also had a health component, initiated by Karl Evang. It was believed that the focus on health would increase the level of trust, which would affect the project in a positive way, a reasoning applied in later development projects as well. According to the agreement between the governments, the focus should be on preventive care such as vaccination, however, there was an increasing focus on curative care, and a health station focusing on maternal health was built. In addition to this, there was also an increasing focus on water and sanitation (Simensen 2003). At this time, family planning became an area of priority for the Indian government; consequently, the Norwegian health centre took part in the country's family planning effort. This involvement in family planning became a rather sensitive issue in the domestic political debate in Norway, and the issue of abortion caused a debate that to a certain extent is still going on. In 1968, the Onarheim committee stated that family planning should be an area of priority, and despite being heavily debated, the support for family planning passed parliament with opposing votes (ibid).

Population growth was seen as connected to food shortage and economic development, and a reduction of population growth was seen as a necessity in bringing developing countries up to a western level. Contrary to this was the argument that individuals had a right to decide in matters of fertility and family planning without interference from outside (Strøm 1998). After the bill passed parliament, NORAD focused heavily on family planning, and in 1970 launched

‘the expanded family planning concept’, intending to integrate family planning into primary health care, e.g. vaccination and nutrition, and to integrate services related to pregnancy and birth. Thus, maternal- and child health were part of a horizontal approach. Additionally, NORAD decided that 10 % of the bilateral aid budget should be spent on family planning projects (ibid, Jensen 1995). The country-focus was now broader, e.g. a family planning project was initiated in Kenya in 1967 (Simensen 2003).

5.1.7 From family planning to reproductive health

Norway is one of the countries that have contributed most to population policy in developing countries, and this focus has been maintained from the outset (Jensen 1995, MFA 1993). Norway was the 3rd biggest donor to UNFPA – the United Nations Population Fund – from 1982 till 1988, and the 4th biggest in 1991 (Jensen 1995).

From the mid-1980s and onward, several international conferences were held by the UN, as we shall see, preparing the ground for the MDGs. In contrast to the Cold-War era, where the tensions between the West and East dominated development policy, these conferences had human rights, women’s rights, environmental problems, and development problems at the centrepiece (Strøm 1998). Norway’s population policy in developing countries changed from family planning to reproductive health after the ‘International Conference on Population and Development’ in Cairo, 1994, the third international conference held on population issues (Austveg 2006). Earlier, the Safe Motherhood Initiative (SMI) had put maternal mortality on the international agenda in 1987. Several UN bodies were involved, including UNICEF, UNDP and the WHO. What the SMI did was to quantify a measure on reducing maternal mortality by 50% by 2000, however, progress was slow (Austveg 2006). This goal was integrated into the Cairo Declaration, stating that maternal mortality should be reduced by 50% by 2000 and additionally reduced by 25% by 2015, using 1990 as a baseline. The declaration also emphasized the human right aspects of safe motherhood, a focus

that made an entry into the Norwegian development policy through report no. 36 (1984-85) to the Storting, making human rights a policy goal. Compared to family planning, reproductive health as a concept is more holistic, focusing on reproductive health as a “state of complex physical, mental, and social well-being” (Austveg 2006). It has an increased focus on the individual, not just the family, and primary healthcare is an important component. The declaration also emphasizes reproductive health services for everyone of appropriate age as soon as possible, with 2015 as a definite deadline (Austveg 2006: 59).

Women’s health and women’s rights have a strong tradition within Norwegian development assistance, and they are areas that Norway thinks of as areas of expertise, especially focusing on maternal- and child mortality and the feminization of the AIDS epidemic, and emphasizing a rights-based approach. This is also seen in the white paper on global health - report no. 11 (2011-2012) to the Storting.

5.1.8 From primary health care to quick fixes

Family planning, and later reproductive health, were not the only focus in Norway’s approach to health in developing countries. The main objective for development assistance for health had been the same as for the development policy in general; to increase the social, economic, and political welfare of people in developing countries, primarily focusing on the poor. Humans were seen as an important resource, good health as a precondition for high quality of life, ill health as a result of poverty, war, and discrimination of women. A well-functioning health service was seen as a necessity, however not necessarily a means to improve the situation (Ofstad 1992: 262). With this as a point of departure, Norway wanted to improve the level of public health through improved economic development and fair distribution, and through supporting the health sector. In supporting the health sector, primary healthcare was for a long time a priority, reflecting WHO’s focus. This was in addition to the focus on women and children, however, the two goals were intertwined. Since the 1960s,

Norway has had a tradition of “multilateral and bilateral aid funding to primary health care interventions in developing countries, building on an extensive history of missionary medicine” (Sandberg and Andresen 2010: 308).

During the 1990s, the trend was to concentrate bilateral aid on fewer countries and priority areas. In countries where the health sector was a priority, the support was planned as long-term and comprehensive. Another trend that occurred during the 1990s was a focus on national ownership: that recipient governments should be responsible for their own development, hence being in control of the design, implementation, and monitoring of their own development strategy (Ofstad 1992: 262). At that time, all of Norway’s bilateral partner-countries had primary health services as a priority, mainly driven by the WHO’s primary strategy of the time. NORAD focused on improving the equity aspects of primary healthcare services, emphasizing poverty reduction and health for all.

Throughout the 1980s and 1990s, Norway as a state and international development assistance in general became more and more influenced by neo-liberalism, focusing on a smaller state and the importance of a free market (Stokke 1992). However, in report no. 51 (1991-1992) to the Storting, *Om utviklingstrekk i Nord-Sør-forholdet og Norges samarbeid med utviklingslandene*³³, the underlying development philosophy leads in different directions, showing the lack of an integrated development philosophy. Some of the policy within the report is in the neo-liberal tradition while other initiatives focus on the important role of the state and emphasize equal sharing and human development (Stokke 1992: 67). While more and more international organisations focused their funds through vertical, disease-specific initiatives during the 1990’s, the Norwegian policy was centred towards horizontal initiatives, unless the recipient especially asked for support to fight one specific poverty related disease like TB or HIV/AIDS. At this time, development assistance for health was geographically limited or country-specific, but not

³³ *Development trends and Norway’s cooperation with the developing countries* (Authors own translation)

disease-specific. The focus was on rural primary health services. NORAD was also endeavouring to better coordinate the donors with the aim of creating a 'health basket'. By channeling health related funds to a health basket, the national government would then be able to decide its own priorities (Ofstad 1992).

In the early 1990s, UNICEF was the biggest recipient of Norwegian aid towards health, and Norway lobbied UNICEF to adopt a broad approach to health, not just acting through vertical initiatives. This was due to the fact that the early vertical approach had led to a deterioration of the health services that did not receive money through vertical initiatives (ibid), or as Buse and Waxman warned in 2001 that it created "islands of excellence in seas of under provision" (Buse and Waxman 2001: 750). This illustrates how important a broad focus on health has been for Norway.

This chapter emphasizes the Norwegian loyalty to the WHO, how Norwegian focus on health has followed the global focus – how the global to a certain extent has influenced the Norwegian focus within health aid – and that what we see today as policy shifts are the result of a process starting long before we were aware of it. To understand Norway's focus on and approach to global health we need to put it into a historical context, to understand the UN system and its stipulation of conditions and focuses that we follow. The next chapter focuses on the MDGs – a global UN initiative to increase focus on human development. As we shall see, the MDGs have been used to increase the focus on results and measurability, advocating a vertical approach.

6. Globalizing health – the MDGs as a breaking point

With the globalization of health, the Norwegian policy and way of implementing health aid has changed, and it fall within the domain of foreign policy. The last chapter showed that the global policy promoted by the UN system, especially the WHO, is of great importance to how Norway approaches health, and development aid in general. With an increased focus on the global, the focus on results and measurability becomes profound – the actors have to prove value for money in order to prove how much improvement is being made. In this chapter, I will start by focusing on Norway. The global project has become a Norwegian concern, taking us from a tradition of a horizontal approach to a vertical approach. The increased focus on results and measurability is has also been adopted, making it possible for a small actor such as Norway to take strategic choices. In the second part of the chapter, I will focus on the MDGs as a source in the shift towards a more global focus, and hence a more vertical approach. I will also look at how these goals make development, and health everybody's business. The full story of how the MDGs came into being can be found elsewhere (cf. Vandemoortele 2011, Hulme 2007, Hulme 2009), and falls outside of the scope of this thesis.

6.1 Branding Norway – a 'do-good' nation

Norway's reputation as a small country, and its need for branding, is also "of importance when considering the driving forces behind Norwegian global relations" (Sandberg and Andresen 2010: 307). Norway's self-image and identity has traditionally been one of an idealistic regime of 'goodness' or as a humanitarian superpower (ibid). This self-image is perpetuated primarily for the benefit of the Norwegian population, however, it is also aimed at countries already interacting with Norway and those who observe Norwegian action (Leira et al. 2007: 9). Being among the top donors of the world and punching above its weight, aid is seen as an expression of Norwegian goodwill, and perceived as a

good thing. Norway's wealth can here be seen as a structural factor, making it possible for Norway to be one of the top donors. According to Lodgaard (2007), the Norwegian aid policy is also of importance to Norway to 'soften' other countries' impressions of Norway. Norway needs coherence between its self-image and how other players perceive them. Without a generous aid policy, the impression of Norway internationally would be quite different; a country with a protectionist trade policy and a huge oil-fortune (Lodgaard 2007: 282). In other words: without a generous aid policy, the external image of Norway would not be consistent with its self-image. Now, supporting vertical disease and target specific initiatives makes it possible for the Norwegian government and its global health actors to measure how much good that is being done as a result of the funding give.

Traditionally, aid policies in Norway have generally been seen to be dominated by altruistic motives, even though this contradicts the general assumptions about what motivates states (Bull and McNeill 2007). Global health as part of development and foreign policy has become important for Norway as a tool for positioning and branding itself. During the hearing of the white paper on global health, report no. 11 (2011-2012) to the Storting, at the Parliament, the Minister of Foreign Affairs was asked why the Ministry had chosen to change policy. In his reply, he emphasized that "we, from time to time, have to evaluate 'our' initiatives, and engagement, where we choose to put our money" (Stortinget 2012). According to Støre,

*"we can ask the question: 'What is the most important or urgent challenge in the world right now, and in the countries that we want to help'? However, we also have to ask the question: 'Where can we make a difference?' 'What is our specialism'? We might end up having the qualifications needed to support a part of a country's health burden that is not among the top three in the local context, like access to clean water. We might not have the qualifications to do anything about that, but we have what it takes to support immunization. This is a strategic choice we have to make"*³⁴(Stortinget 2012).

³⁴ Authors own translation

This perspective, that Norway has to make strategic choices, is also emphasized in interviews with those engaged in the political part of the Norwegian policy environment (e.g. Interview 4, 18.11.2011). This strategic choice is presented as a politically smart thing to do. However, according to other informants, this strategic approach is not consistent with the overarching development policy. If you really want to make a difference, if you really want to save the world's children, you have to focus on the long term initiatives; on access to clean water, malnutrition, the structural causes of poor health – the day to day struggle, which is not as 'sexy' and full of action as vaccination, however equally as important (Interview 8, 11.01.2012, Interview 10, 03.02.2012). Again, this reflects the global focus and illustrates the differences between the Norwegian actors along the axis from science to politics. The campaign to vaccinate the world's children has shown impressive results during the last decade, and is an important factor in good health. It also meets the politicians' demand for quick answers and remedies. It is easy to measure, and details of what has been carried out and how many lives have been saved can be easily communicated. It is a rather simple field, with clear causalities (Interview 7, 15.12.2011). However, what happens with the diseases or challenges that cannot be framed as quick fixes or as challenges to our security, but that represent great burdens within the local context?

By having a Prime Minister so heavily engaged in the global health field, focusing especially on the MDGs and allowing his name to be used to draw attention to several initiatives on women's and children's health, he himself is also being branded. According to *Women Deliver* (2011), he, and his former special advisor Tore Godal are among the world's top 100 most influential people in improving women's health. Internationally, Stoltenberg and 'his' advisor are perceived as proactive and powerful actors. That health has been lifted out of the development frame, and into a foreign policy frame, and that it is the Prime Minister and not the Minister of International Development or the Minister of Foreign Affairs that are in the forefront of these initiatives is not

because the Prime Minister, as an actor, holds a higher level of knowledge about the field, but because of the strategic importance that global health holds for Norway and for Stoltenberg (Eggen and Sending 2012).

Forming alliances and successful branding are important for a small country when participating on the international field. Health being of political importance in this regard, it is important to utilize the full political potential, to be able to gain some kind of political profit from every NOK spent on global health (Interview 7, 15.12.2011). For the Ministry of Foreign Affairs, being part of alliances and having a successful brand is a part of that profit. The change that we have seen in the last decade must be seen in parallel to the reasons that Norway is engaged in global forums in the first place. Due to being a small country, we have to try to be part of the different global policy processes as we do not have any real power and we are not one of the big players (ibid). Nevertheless, we punch above our weight when it comes to development aid.

The importance of branding also became clear in my interviews with those engaged in the political side of Norway's global health arena. Not only were the stories told about how much we had done, and how much we had contributed, but also the way the stories were told was framed from the perspective of Norway as a brand. What we have seen here is that Norway is adapting its global health policy to the focus on the global scene, thus being able to use this scene to brand itself through global initiatives. Both the Prime Minister and the Minister of Foreign Affairs are here central actors. One of the most prominent initiatives, and turning points for the Norwegian shift in focus, are the MDGs, making it possible for Norway to brand itself through a UN initiative.

6.2 The Millennium Development Goals – the making of a global consensus

In 2000, at the Millennium Summit, the largest gathering of world leaders in history adopted the UN Millennium Declaration³⁵, committing to a new global partnership to reduce extreme poverty and setting out a series of goals on how to reach it. They pledged to “spare no effort to free our fellow men, women and children from abject and dehumanizing conditions of extreme poverty” (UN 2000). Nevertheless, the MDGs, *per se*, were not part of the Declaration, but were fleshed out by a group of elite technocrats from the multilateral system, and informally agreed upon in 2001, presented in the Summit follow-up report, the *Roadmap* (Saith 2006, Hulme 2007). The MDGs constituted a normative consensus in the development community of the beginning of the 21st century (Saith 2006: 1169-70). Many UN members started to use them as part of their policy and planning process, as we have seen, Norway being one of them.

6.2.1 Preparing the ground

The process of creating the MDGs did not have a clear start, or end, and it was not consciously planned, “it followed an iterative course across a number of agencies” (Hulme and Scott 2010: 297). Their origin can be traced to the consolidation of different waves of earlier unachieved goals and promises made in different international summits and conferences³⁶ during the 1990s.

The 1990s was a decade full of summits and grand new promises – promises that were not in accordance with the long-term decline of the total level of Official Development Assistance (ODA) (Hulme 2009: 12). Due to this proliferation of promises, the environment of aid was not propitious. Throughout the 1990s a

³⁵ The United Nations Millennium Declaration was signed by leaders of 189 countries assembled in New York on 8th of September 2000.

³⁶ The summits and conferences with most direct relevance being the International World Summit for Children in 1990, the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 (Saith 2006: 1169-70). These conferences set up different goals and established critical areas of concern and action for children and women. In addition to these, the World Summit for Social Development held in Copenhagen in 1995 is worth mentioning. This summit was “crucial for the MDGs as a global consensus was reached that poverty eradication was *the* priority for development. (...) It drew on the idea of human development and viewed poverty as being multidimensional” (Hulme 2010: 16-7).

‘summit fatigue’, caused by too many recommendations and too many subjects, spread. “Many aid agency actors had come to accept an earlier assertion that structural adjustment had not only failed to drive long-term economic growth, but had resulted in social injustices and social harm” (Barnes and Brown 2011: 168). The awareness of a failing aid system spread, and “by the mid-1990s there were generalised feelings of disappointment, anxiety and uncertainty among many aid agency actors as to the overall effectiveness of aid” (ibid). The UNDP searched for an alternative to the ‘Washington Consensus’³⁷ and created a decade with Human Development Reports, starting in 1990, and human development³⁸ thinking started to influence the discourse.

At this time, when the aid agencies were losing not only their constituency of support but also their budgets, the OECD’s Development Assistance Committee (DAC) launched the report *Shaping the 21st century: The Contribution of Development Co-operation*³⁹ in 1996, a report that has since been named by Riddell (2007: 41) the “manifesto for the reinvention of aid”. Within this report, they published their own list of international development goals (IDG), “clustered under three heads – economic well-being, social development and environmental sustainability and regeneration – leading to the specification of seven time-bound targets, most of which are numerically explicit” (Saith 2006: 1170). This was their effort to pull the promises from the UN during the 1990s together into a more coherent format. The goals were “headed by a target for reducing income poverty, on the assumption that economic growth was

³⁷ The Washington Consensus is used to describe the policies of the major international financial institutions based in the US capital in the 1980s. “Essentially, the view was that the a combination of liberal market capitalism in an international context and liberal democracy and ‘good governance’ domestically were mutually reinforcing (a ‘virtuous cycle’) and provided core elements of a comprehensive strategy for development success equally valid for all types of society” (Potter 2000:375).

³⁸ Human Development posits humans as the ends as well as the means in development, challenging the focus on per capita economic growth. The focus is on the poor and poorest and the prioritization of capability enhancing services (such as food security, primary education and primary health) (Hulme 2010).

³⁹ This report was a result of the *Groupe the Reflexion* that had been established at the DAC high level meeting the prior year to review the future of development aid. “Early on the *Groupe* asked the DAC staff to compile a list of UN summit declarations and unexpectedly, this listing became a focus for the *Groupe*. Assembling list of targets had become a common device in the public services of OECD members, as their governments had adopted RBM” (Hulme 2010: 17).

indispensable for poverty reduction” (Hulme 2010: 17). With this report, DAC also “reformulated and reframed the idea [of partnership] into a more coherent and generalised narrative about the need for development co-operation in a post-cold war era” (Barnes and Brown 2011: 171). “The late 1990s thus marked the start of what Maia Green calls the ‘acceptance of the idea of partnership in the ‘cognitive architecture of intelligibility’ of a wide range of different agents involved in development” (Barnes and Brown 2011: 173). DAC also argued that development cooperation should be seen as an investment, not as an expenditure.

I will not go into further detail about DAC’s goals due to the scope of this theses, however, it is significant to note that the objective of halving extreme poverty in developing countries by 2015, using the WB’s 1 dollar a day criterion, was made explicit for the first time in this list⁴⁰, a list that had a different character to the earlier declarations since this formulation emerged from a small club of rich nations, and not from the global community. With this list there was also a “clear shift in the perspective in favour of a narrower frame focusing essentially on absolute aspects of some key measurable facets of poverty and deprivation, and away from a broader, more essential rights-based approach” (Saith 2006: 1170). The idea of setting targets had become a common device for reform in public services, based on ideas from result-based management (Hulme 2009). This overall context is of importance in describing the scene that UN was operating within, and trying to strengthen its position as a powerful global actor.

The UK Minister of International Development, Clare Short, heavily promoted the approach laid out in the IDGs, establishing the Utstein Group – a network of four female Ministers of International Development, Hilde Frafjord Johnsen from Norway being one of them – to publicise the approach. They became an important actor in preparing the ground for a global set of measurable goals with

⁴⁰ The World Bank’s \$1/day criterion sets the target at half the level demanded in the Copenhagen conference (Saith 2006: 1170).

a given timeline, and Frafjord Johnsen became an important actor in advocating these goals, and later the MDGs in Norwegian policy.

6.2.2 The making of the world's biggest promise

During the planning for the Millennium Assembly to be held in New York in September 2000, the UN re-entered the game of global target setting. At that time it was important for the UN's new Secretary-General, Kofi Annan, to make poverty reduction central to the organization's agenda. In May 1999, he identified 'development, including poverty eradication' as one of four main themes for the Millennium Assembly (Hulme 2009).

In the run up to the Millennium Assembly, different actors – from countries and international agencies to NGOs, networks, and activists – began to try to shape the content of the Assembly and thus the Millennium Declaration. "Getting into the Declaration would create an unprecedented opportunity – if 'your goal' was in the declaration then it would automatically be on the agenda at national and international meetings for years to come" (Hulme 2007: 8-9). For the UN, the Assembly was important as they needed to generate a vision of how the world could be better and different in the new millennium, and to publicise the fact that they could act on global problems beyond security, positioning the UN as an important development actor. However, as we have seen, development was also framed as important for peace and security. Prior to the summit, Kofi Annan launched the report *We the Peoples: the Role of the United Nations in the 21st Century*⁴¹ in April 2000, a report functioning as a basis for a final round of negotiation to determine what went into the declaration (Hulme 2007, Hulme 2009). The report also presented a set of development goals that were quite different from the IDGs. "The DAC approach is based much more in the audit culture of the 'new public management' that was so powerful in many OECD

⁴¹ The report was written under the leadership of John Ruggie, Kofi Annan's very effective chief advisor for strategic planning from 1997 to 2001 (Crossette 2005: 72). It has been argued that Ruggie, when he first produced the draft, wanted goals that were quantifiable, and that his view was that reproductive health could not be quantified in any way. However, he and others in the UN agreed that this topic should be factored into the 'indicators' device to measure progress on the goals (Crossette 2005: 76).

countries in the 1990s” (Hulme 2009: 21). “The values behind DAC’s list are a Third Way-type ‘politics of what works’, not a normative or ideological belief in human rights” (ibid: 21). This resulted in a dual process, both UN and DAC working with their own set of goals (ibid).

The onerous negotiation process to finalize the text for the Millennium Declaration continued, and there was a particular focus on what would go into the goals⁴² “as these seemed likely to attract publicity, policy changes and resources” (Hulme 2009: 33). On the 8th of September 2000, the UN Millennium Declaration was unanimously approved, calling for “collective responsibility to uphold the principles of human dignity, equality and equity at the global level” (UN 2000). However, what the Declaration did not manage to address were the “inequalities of power within and between countries as both the prime cause of and solution to underdevelopment” and it did not predicate structural change in the global political economy (Birn et al. 2009: 174). The Assembly had been a success, and with the Declaration the UN had the material to draw up an “authorative set of goals for global poverty reduction” (Hulme 2009: 36).

As with the other conferences or world summits during the 1990s, the Millennium Summit also produced a declaration presenting the norms derived from the conference, capturing the public’s attention for a while. What had happened with the other conferences was that their declarations had receded into oblivion after a while. After the Millennium Summit, the Millennium Declaration was quoted in speeches, reports, and articles, but after a while, the attention started to fade. To rescue the Declaration from oblivion, from the ‘dustbin of global promises’, the idea of placing selected targets from the declaration into a free-standing document arose (Vandemoortele 2011: 4). To do this, a task force of experts from DAC, the WB, the IMF, and the UNDP was established to finalize the goals (Vandemoortele 2011: 4, Hulme 2012: 18). Many of these

⁴² The focus here is only on the ‘development and poverty eradication’ section and not the entire document, due to the scope of this thesis. It is only this section that is of interest regarding the MDGs and the focus on health.

experts had worked together to create the IDGs in the mid-1990s, which made it easier to resolve the challenge of the dual process of two sets of international goals (Hulme and Fukuda-Parr 2009). For the UN Secretary-General, Kofi Annan, it would have been difficult to modify an agreement that 189 countries had reached.

Even though this group also consisted of experts from outside the UN, the aim was still to rescue the Millennium Declaration from oblivion, hence the targets were taken verbatim from the Declaration, which was agreed language among UN member states (ibid). “Their selection was based upon the availability of established indicators and reasonably good data to measure and monitor progress at the global level” (Vandemoortele 2009: 355). According to Jan Vandemoortele (2011: 1), one of the members of the expert group behind the MDGs, the aims of the MDGs were two-fold; in addition to rescuing the Millennium Declaration from oblivion, the MDGs should also “expand the development narrative beyond economic growth”. Even though they did not have the ambition of formulating an agenda for international development, the MDGs have become the overarching goal of the international development agenda and global poverty eradication/reduction is now a moral or ethical imperative for all states and international development organizations (Hulme and Fukuda-Parr 2009).

This historical context illustrates the importance the MDGs were for the UN to create a global optimism about the new millennium, at the same time as the organisation positioned itself as a major actor, placing the UN at the centre of international development and global affairs.

6.2.3 The story of a super-norm: how the MDGs became a breaking point

As mentioned, the goals were formulated by a group of elite technocrats from the multilateral system. They did not focus on the ideological or scientific content of the goals, rather they “applied diplomatic skills to the selection of a reasonably coherent and concise set of norms” (Hulme and Fukuda-Parr 2009: 8). Hence,

being more technical and focused on how the goals could best be communicated and understood, and thus not forgotten. By doing this, they managed to create a significant shift in the international development discourse, placing poverty reduction as the top priority. In addition to this, the goals also focused on poverty as being multi-dimensional, hence, moving away from a single focus on economic poverty increasing the focus on human wellbeing, hence creating a means for how to achieve freedom from wants and freedom from fear. This focus on poverty reduction was not new, but what the technocrats and hence the MDGs did was to bring “specificity and concreteness to the idea of ending poverty” (ibid: 3). Doing this enabled poverty reduction to become the primary focus due to the clarity of the goals, due to them holding unprecedented political legitimacy, and due to them being quantifiable with time-bound targets, or what Hulme and Fukuda-Parr (2009: 4) call a ‘super-norm’⁴³. By doing so, they managed to capture “the imagination and empathy of leaders and publics around the world” (ibid: 4), creating consensus around the goals.

According to Vandemoortele (2011: 7), this success, or power, stems from three factors: “(i) the charm of simplicity; (ii) their integrated and synergic nature; and (iii) their measurability”. All these factors are reasons why the MDGs, according to Hulme and Fukuda-Parr (2009) became a super-norm, focusing on poverty reduction. Throughout the 1990s, the different conferences and summits had promoted different norms, but what the MDGs did was to promote “global poverty eradication by encompassing a number of specific norms that relate to particular dimensions of poverty, such as education, women’s empowerment and improved health” (Hulme and Fukuda-Parr 2009: 4). Hulme and Fukuda-Parr (2009) especially emphasized goal number one as important⁴⁴. This goal re-defines human deprivation in money-metric terms (Vandemoortele 2011: 9). What we have seen here is that elite technocrats appointed by the UN were

⁴³ A super-norm can be defined as “a cluster of inter-related prescriptive norms grouped into a united and coherent framework” (Hulme and Fukuda-Parr 2009: 4).

⁴⁴ Goals one is “Eradicating extreme poverty and hunger” and target 1 says “Halve, between 1990 and 2015 the proportion of people whose income is less than \$1 a day” (UN 2001).

central actors, in shaping the goals. What they did was to address the problem; the need to move away from a focus on economic development and towards focusing on human development to be able to eradicate poverty. They created a set of 8 time-bound targets that represented the solution to this, and as the targets were taken verbatim from the Millennium Declaration, already agreed upon by the UN member states, there existed a global agreement, or consensus around the goals, and therefore the political will to carry them out.

6.2.4 Meaning versus measurement – the role of the MDGs in international development

“The poverty has been dollarized, and the MDG discourse has been donorized”

Vandemoortele 2011: 18

The UN Conference of Finance for Development in Monterrey 2002, was an important landmark in the MDGs’ rise to prominence, in addition to the MDG World summit in 2005 (Ziai 2011: 28). The Monterrey Consensus embedded the implementation of the MDGs within the “mainstream neoliberal strategy and policy framework, significantly emphasizing the responsibility of the poor countries themselves in addressing their development agenda” (Saith 2006: 1170). What this did was to make “external assistance contingent on such efforts, and at the same time heavily underscore the role of the private sector in the development process” (ibid). This also led to a change or expansion of PPPs. From focusing on a type of partnership where the government mainly created an environment favourable for the private sector to involve itself and invest in development, it broadened PPPs into types of partnership “which were based on joint activities of private and public players” (Saith 2006: 1171).

Despite succeeding in the first part of the aim - saving the Millennium Declaration from oblivion - the goals failed in the second part - expanding the development discourse. In this section, I will elaborate on how they were (mis)interpreted, and hence, how they played an important part in increasing the focus on results and measurability. By doing this, they also changed the

implementation of development assistance for health by focusing on specific diseases and health burdens.

During the 1980s and 1990s there was a major shift in global health policy making from the UN towards the IFIs, resulting in increased attention being given to private actors in health policy. Due to this increased reliance on private actors, there was a fear that the UN would be marginalised, and the need for reform increased. Towards the end of the 20th century, the UN increased its collaboration with private actors and business, resulting in the UN wielding an increased influence on private interests in the UN system. Nevertheless, this change of approach was not only due to the fear of becoming marginalized, it was also due to the overall decline in development assistance from the OECD countries to the UN (Ollila 2005: 1). Despite this fall in ODA, development aid to health kept growing. New funding sources entered the arena, such as the BMGF, and they have “become not only important in size, but also in setting health policy” (ibid: 2). In recent years, global health priorities have been decided through different forums, actors and processes, the MDGs being one of them (Ollila 2005: 2).

The MDGs created a global platform with goals and targets that nations could agree upon and create a common understanding of their importance. This resulted in new partnerships and initiatives, and these have played a major role in focusing development assistance policy. Some countries and bilateral agencies “have gone so far as to judge the value of *all* their activities on the contribution to achieving the MDGs” (Sumner and Tiwari 2009: 68), UK, or DFID, being one of them. Norway has also adopted the focus on the MDGs, and they “are the main framework for Norway’s priorities in its health efforts” (MFA 2012c: 15).

Since the MDGs were adopted in 2001, the UN family and system have been requested to do their share in achieving the goals, and countries are supposed to report to the Secretary-General on their achievement in this area. This strong

focus on the MDGs has resulted in the WHO being pressured by some of its member states to refocus its work on the MDGs, most notably MDG 6 on HIV/AIDS, TB and Malaria, meaning that “its wider mandate as the normative health organisation that sets norms and standards and promotes the building up a wider health systems would not be so emphasised” (Ollila 2005: 2). For the UN system, the MDGs have become an important tool to show that they take global responsibility, however, the goals have also steered the UN system “towards a narrower agenda with more emphasis on selected interventions and country presences” (ibid: 2), nevertheless, in recent years more attention has been drawn to the need for addressing development more comprehensively (ibid).

Slow economic growth is often used as the main reason for why many countries have not seen greater progress towards achieving the goals. Within international development literature, slow economic growth, insufficient foreign aid or inadequate governance are often used as the main reasons for poverty and hence the reason for not reaching the targets. “[H]uman development is [here] considered either as growth-mediated, aid-mediated or as governance-mediated” (Vandemoortele 2011: 2). Hence, the development narrative is reduced to be about one of these three; economic growth, aid or governance. What these three approaches have in common is an interpretation of the MDG agenda “in a manner that fits the donor-centric perspective of development” (Vandemoortele 2011: 2). This implies that the solutions to development problems are considered to lie in the hands of development experts with a technocratic slant. With this also comes a strong belief in ‘silver bullets’ and ‘global blueprints’. “They firmly believe in best practices that can be replicated and scaled up” (ibid: 2), and they all “reduce the MDG agenda to the application of a standard set of macroeconomic, sectoral or institutional reforms of a technical nature” (ibid: 2), hence, missing the point of broadening the agenda. As we have seen, the Monterrey Conference was an important factor in embedding the implementation of the MDGs in neoliberalism emphasizing private actors, the IFIs like the WB were important actors in advocating this view, emphasizing a money-metric

approach to poverty reduction and the technocratic development experts from multilateral and bilateral aid agencies were important actors advocating global ‘best practices’ that could be replicated. However, policy-makers have also been important in this process of narrowing down the focus due to their preference for objective measures and indicators that can be the same for all people (Sumner 2007), a preference that is visible in Stoltenberg’s approach towards the work on women’s and children’s health. Here, Norway is both influenced by the UN initiative but at the same time participating in it and strengthening a vertical interpretation of the goals.

Vandemoortele (2009) stresses that the MDGs were thought of as global goals to foster human well-being set on the basis of global trends, not on trends for a particular country or region. The world leaders “signed the Millennium Declaration on the premise that the targets would be met collectively, not necessarily by each and every country” (ibid: 358). They were not intended to be a ‘one-size-fits-all’ yardstick for judging national performance. However, within a fragmented global field with new actors from the private sector and PPPs, increased focus is given to measurability, results and quick fixes, and countries using the achievement of global goals to show power and willingness to act, the MDGs became sanitized and usurped by the conventional perspectives of development (Vandemoortele 2011). According to Vandemoortele (2011: 2), achieving the MDGs requires a “fundamental transformation of society, which transcends macroeconomic, sectoral and institutional models”. As examples he uses gender equality and maternal health; improving these two will take more than some improved technical solutions and replications of lessons learned elsewhere (ibid: 2). However, as shown in Chapter 4.4 it is through technical solutions that willingness and progress on goal 5 is being promoted and measured.

One of the factors that gave the MDGs power was their simplicity, a list of eight goals everyone could remember and agree upon. However, this simplicity has been criticised by many interest groups – they cannot see that their objectives are

represented. Reproductive health serves as an example. Many have argued that the legacy of the Cairo Declaration is not integrated well enough into the goals. Vandemoortele (2011) meets this critique by saying that the goals have been misappropriated – that they are not to be understood literally. He stresses that the MDGs are not “an exhaustive list of all things necessary for achieving human development” (Vandemoortele 2011: 8). If all aspects of development and well-being were to be included in the list, their brevity and measurability would be lost. He also stresses that to achieve the eight goals, you need to focus on a broader set of determinants, e.g. infrastructure, and therefore, they can be used to make the case of topics not mentioned specifically. Even though a narrower agenda was not a part of the intention, the goals have been used as a tool to promote this approach. The focus on measurability and results has increased in international development discourse during the last two decades and the goals must be contextualised within this environment. Here, there is also a risk of using indicators as planning tools, and not only as goals, resulting in focus and effort being drawn towards what is possible to measure easily. Both the Millennium Declaration and the MDGs have been lauded for focusing efforts towards a shared global commitment to reducing poverty and creating development. Nevertheless, they have also been criticized for a narrow definition of poverty due to the 1 USD a day measure, for focusing on market-based approaches and debt servicing, and for setting priorities which potentially conflict with domestic needs (Birn et al. 2009: 174).

Despite the goals’ intentions being misinterpreted, they have become important tools in the international development discourse, regardless of their intention. They have been adopted and sanitized by the current development paradigm and used to dollarize poverty and ‘donorize’ the development discourse. They have been used to fuel the current development discourse. Due to this, the question can be asked as to whether they have acted as a watershed. Would development have gone in the same direction due to globalization, neo-liberalism, NPM and an

increased need for measuring development and showing results (Interview 11, 15.06.2012)?

6.2.5 Health and the MDGs

The MDGs place a great deal of focus on health. 3 out of 8 goals are focused directly towards health and the other goals are strong determinants of health (Møgedal 2012). Due to lack of progress on the health-related millennium development goals, the Global Campaign for the Health Millennium Development Goals, with a special emphasis on women and children, was launched in 2007. Prime Minister Stoltenberg has been a central actor in this initiative, and is also its Chairman (UN 2008). The campaign was launched by the Network of Global Leaders, a network formed at the invitation of Stoltenberg in 2007 (MFA 2012c). The campaign consists of several interrelated initiatives – all with the aim to accelerate progress on the health related MDGs. One of the commitments to the campaign is to find better ways for achieving value for money (UN 2008). In 2010, UN Secretary-General Ban Ki-moon initiated the global strategy ‘Every Women, every child’ to reach these goals. It is argued that investing in women’s and children’s health makes good sense since it reduces poverty, stimulates economic productivity and growth, is cost-effective, and helps women and children to realize their fundamental human rights (UN 2010: 6). These initiatives have resulted in greater focus on child health and maternal mortality globally and also illustrate how much of the international focus on health circles around the MDGs. As shown in Chapter 4, to create consensus around this goal the focus was zoomed in on maternal mortality making a vertical and depoliticized approach to a highly complex and political issue.

By focusing on health directly, the MDGs have lifted certain health challenges from state level up to a global level, as a global or international affair (Eggen and Sending 2012: 210-11). Within this lies an area of possibly conflicting interests between the global health field and the sovereign states, in spite of agreement on

the goals⁴⁵. The MDGs focus on specific diseases and hence people with specific diseases, e.g. HIV/AIDS, Malaria, TB, or towards specific health challenges, e.g. maternal mortality, and addresses them as global responsibilities. In poorer countries, these diseases and challenges are only some among other diseases, challenges, and health burdens in general. Since the global community are only focusing on certain challenges and diseases, the countries are, more or less, expected to deal with the other health burdens on their own (Eggen and Sending 2012). What can be seen as a result of this focus on the MDGs is that policy is narrowed down to these eight topics, and several bilateral agencies use the MDGs as a framework for their policy, and new initiatives have been born, focusing on 'their' goal or target. Where international agencies are given access to countries' territory, the state runs the risk of being left out of decision making, and being left without the option to channel resources towards other domestic health challenges that are not being addressed by the MDGs. The MDGs in general have been attractive due to their concrete targets and their measurability, whereas the health-related goals have proven difficult or impossible to measure due to a lack of reliable statistics in many underdeveloped countries (Birn et al. 2009: 175).

According to Fan and Rosinski (2012), the focus on indicators and measurement has changed the focus in health related development aid. Through focusing on the World Health Statistics 2012 Report, they argue that the use of indicators creates global health priorities and hence prioritizes the money given by donors. AIDS, TB, and Malaria were all leading single-disease categories for development assistance. It can also be argued that the use of indicators has developed into having a double effect or meaning; not only are they indicators of whether a goal is reached or not, they also tend to be steering tools for policy priorities. Due to the call for measurable goals, indicators are being used as a basis for planning, instead of valid and reliable measures for monitoring complex

⁴⁵ Trade and the dialog between WHO and WTO on this matter serve as an example, however, falling outside of the scope of this thesis.

processes (Austveg 2011). Where there is interest and money, there is an indicator. As Margaret Chan, Director-General of the WHO, has said on many occasions; what gets measured gets done (Fan & Rosinski 2012). But what happens with the things that cannot be measured that easily? Will cost-efficiency then influence our understanding of what is important? And is it only the things of interest that are measured?

The MDGs have been important in this process of moving towards an increased focus on results and indicators and they have also been important for the use of PPPs, even though neither of these are new elements in the global health debate. The MDGs have increased the UNs focus and use of these mechanisms. UN bodies, like the WHO, also used these mechanisms prior to the MDGs, at a time when they were initiated by the other big multilateral agencies As mentioned earlier in this chapter when telling the brief history of the MDGs, the international development arena was in need of change, the forerunners for the MDGs were initiated by OECD and much of the preparation was done by other big multilaterals. Whereas the MDGs were important in creating a globally shared project, and apparent consensus or unity on which topics were the most urgent or important to deal with, it can be argued that this shift towards a narrower approach and focus on results would have developed due to the IDGs, the participation of the other big multilaterals in the process leading up to the MDGs and the prevailing development discourse (Interview 11, 15.06.2012). Nevertheless, the MDGs have been important as a super-norm derived from the UN system, and they are important for Norwegian development policy.

This chapter shows that the global system, here through UN, influence and shape the Norwegian global health focus. With the MDGs, health becomes a global issue and a global responsibility, enabling the governing of the global population.

Norway, as a small actor with a history of loyalty to the UN, adopts the goals as fundamental guidelines for their development assistance for health, and uses them to be a player at the global arena as well. Operating within an era where development aid is in crisis with decreasing funding, the need to legitimize the money spent, to be able to show results prevails, resulting in the goals being usurped by the contemporary focus on economic development and quick fixes within the development discourse due to their simplicity and measurability. Through the MDGs health is lifted up to a political sphere, but at the same time depoliticized to create political consensus, or an apparent consensus. The reality is here simplified to make graspable and possible to intervene in. As we have seen, the global defines Norway's global health focus, however, there is also a feedback from Norway into the global through extensive focus on some of the goals. Hence, making it possible for a small actor to increase its focus on results and measurability, anchored in the UN system, and use it to promote itself as a global do-gooder or humanitarian superpower.

7. Concluding remarks

The aim of this thesis has been to explore and understand the changes in Norwegian development assistance for health. The global shift or transition from international health to global health has influenced the Norwegian focus and arena.

As discussed in chapter 6, the MDG development agenda strengthened health as a global issue, and a global responsibility. Three out of eight goals focus directly on health, the remaining 5 is important determinants of health. The emphasis however has been and still is on maternal and child health, HIV/AIDS and other major infectious diseases. At the same time as the goals lift health to a political sphere, health is also depoliticized in the effort of creating global consensus, or an apparent consensus. Being a UN initiative it became important for Norway to support the MDGs, and the MDGs became a global factor heavily influencing Norwegian development assistance for health, defining approaches as well as implementation of health. The MDGs also made it possible for Norway, and Norwegian actors, to participate on the global arena through an extensive focus on the MDG 4 and 5. They influenced a focus on aid's effectiveness.

Historically, the UN family, especially the WHO, has always been of importance for Norway, being a small player clearly benefiting politically by acting through the multilateral system. As stated in chapter 5, the shifts in Norway's global health policy must therefore be seen in a historical context where the different focuses in health has waxed and waned throughout history, oscillating from a vertical approach to a horizontal and back depending on political situation and who the dominant global actors were. Hence, today's policy shifts are part of a process starting long before they became visible in Norway. Women's and children's health have been part of the Norwegian development portfolio since the very beginning. Presently we see significant changes in implementation, however, following the priorities of WHO and the WHO initiated PPPs. Again,

the global context is of importance for Norway's focus within development assistance for health.

These changes on the global health field also influence the implementation of NDAFH, resulting in a shift in implementation from a horizontal approach emphasizing health system strengthening to a vertical approach focusing on specific diseases or health issues – MDG 4 and 5 on women's and children's health being the most prominent. As shown in chapter 4.4, the prevailing quest for results has led to a narrower focus on specific diseases or health burdens and the way Norway's development assistance for health is implemented changes. GAVI as well as the UN led initiatives like the MDGs have been important in this process.

With globalization came a proliferation of actors on the global health scene, representing new concentrations of power. PPPs, having a vertical approach to health, became influential both globally and in the NDAFH. This new fragmented global field created new networks and initiatives. Participation in these new initiatives became important in order to remain a significant global player. The more power that is localized within the global arena, the more important it becomes for small state actors to participate within it. For Norway, to partake in and contribute to the coordination or governing of this fragmented field became important. As shown in chapter 4.3, there is a change in overall focus, from the local to the global, a shift that blurs the boundaries between a state and the global powers. This shift also represents a distance between policy actors and the field of implementation, a distance that allows for pure technical interventions. The necessity of using framing as a political tool to convince actors and the population of why health should be funded, something that two decades ago was seen as common sense, also bears evidence to this distancing.

This shift in overall focus is not only prompting the implementation of Norwegian development assistance. As we saw in chapter 4.2, a new Minister of Foreign Affairs with a background from WHO and global health governance

became a situational factor whereas the international focus on specific diseases as security issues became international factors lifting health from NORAD and into the realm of 'high politics'. Through securitization of health, the global health management focuses on infectious diseases that are seen as a threat to the health of the national population. Health were seen as relevant for MFA, both directly as a security issue, but also as a soft-power tool important for building new alliances and political room for manoeuvring. Norway, being a small nation-state used the global health field and the re-emerging focus on specific diseases and health challenges in UN initiatives to brand Norway and create new networks and alliances. However, Norway's global health engagement goes beyond the realm of security, remaining an important part of the development policy, focusing on the MDGs.

With the transition from international health to global health, there is also a shift from a bilateral system to a multilateral aid system, which traditionally has been MFA's domain, resulting in health as part of the development portfolio was lifted from NORAD to MFA. This, together with the securitization of health and health becoming a global responsibility, there is a shift in power between the Norwegian actors engaged in what now is labeled global health. As shown in chapter 4.1, the MFA has entered the health field together with the Prime Minister's Office, and both are now important actors. With the shift in power and responsibility towards the MFA and Prime Minister's Office, the Ministry of Health and Care Services, which originally held the responsibility towards the WHO as part of their mandate, has outsourced this responsibility to the Directorate of Health that since 2005 has positioned itself as a central actor within the global health field.

Global health and global health policy is an evolving field with new actors and power constellations, hence changing the role of the nation-state. Foucault's understanding of modern political power, governmentality, has been useful when seeking understanding of why Norway, as a small actor, has changed focus on global health. Throughout this thesis we have seen the importance of the

concepts actor, context and process for exploring how and why these changes in Norwegian development assistance for health evolved.

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