The Politics of Health Diplomacy: Traditional & Emerging Middle Powers Compared (the Case of Norway & South Africa)

by
Anders Granmo

Thesis presented in partial fulfilment of the requirements for the degree of Master of Arts (International Studies) in the Faculty of Arts and Social Sciences at Stellenbosch University

Supervisor: Prof. Pieter Fourie

March 2015

Declaration

By submitting this thesis/dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: 30th October, 2014

Abstract

Globalization is changing the face of health concerns worldwide and states are reacting by modifying their foreign policies to keep up with the resultant challenges and opportunities. The purpose of this study is to investigate, using the case studies of South Africa and Norway, the similarities and differences in how emerging and traditional middle powers respectively approach the new foreign policy phenomenon of health diplomacy. The study is interested in the reasons for how and why these similarities and differences manifest themselves in practice. Health diplomacy is a multifaceted concept which envelops negotiation involving health in a number of different concerts and across a wide spectrum of actors. Despite its novelty within the fields of both Global Health Governance and International Relations, the literature offers limited but sufficient frameworks that have utility for its study. The study surveys the literature on middle powers, and its sub-categories of *emerging* and *traditional* middle powers. Whilst identification with the middle power category requires the fulfilment of a number of criteria, this further categorization is made on the background of both quantifiable and behavioural characteristics, making their respective members' inclinations and rationales for engaging in specific foreign policy types typically divergent on a number of issues. The two countries selected for case studies, South Africa and Norway, are generally regarded as exemplars of the two respective middle power categories. In these case studies the health diplomacy of these countries is assessed on the basis on the frameworks developed in the first half of this study, serving as the empirical foundation upon which the subsequent analysis is based. The findings speak volumes both for the two different middle power types and for the respective case study states. A common emphasis on multilateralism is one unsurprising similarity, as middle powers of both types tend to share this general preference in their foreign policy undertakings. However, as South Africa's health diplomacy is nascent and Norway's well-developed, divergences are obvious in terms of what strategies the respective countries use in order to gain the international influence that they covet. Furthermore, domestic and regional issues clog the agendas of emerging middle powers, whilst traditional ones enjoy stability in this regard and are able to seek opportunities elsewhere. These characteristics are exemplified in an extreme sense in South Africa, where a genuine health crisis is ravaging the country; conversely, in Norway, domestic issues are relatively minor, and niche diplomacy has bred massive success. At bottom, health diplomacy is a significant nascent area of interest within International Relations broadly, and in niche diplomacy and global health governance specifically, and demands further study.

Opsomming

Globalisering verander wêreldwyd die aard van gesondheidsoorwegings en state reageer hierop deur hul buitelandse beleide aan te pas om tred te hou met die gevolglike uitdagings en geleenthede. Die doel van hierdie studie is om die ooreenkomstige en verskille duidelik te stel van hoe ontluikende en tradisionele middelmoondhede (met Suid-Afrika en Noorweë as onderskeidelike voorbeelde) die nuwe buitelandse beleidsfenomeen van gesondheidsdiplomasie benader. Die studie stel belang in die redes waarom en hoe hierdie ooreenkomste en verskille in die praktyk manifesteer. Gesondheidsdiplomasie is ‘n veelkantige konsep wat onderhandelings aangaande gesondheid in verskillende kontekste en oor ‘n wye spektrum akteurs heen omvat. Ondanks die nuutheid van beide Globale Gesondheidsregering en Internasionale Betrekkinge as studievelde, bied die literatuur beperkte maar voldoende raamwerke aan vir die doel van hierdie studie. Die tesis bied ‘n oorsig van die literatuur aangaande middelmoondhede, sowel as die subkategorieë van *ontluikende* en *tradisionele* middelmoondhede. Alhoewel lidmaatskap van die middelmoondheid kategorie die bevrediging van ‘n paar kriteria vereis, word hierdie verdere kategorisering gemaak teen die agtergrond van beide kwantifiseerbare en gedragspatrone, en dit maak hul onderskeie lede se oorwegings en beweegredes i.t.v. buitelandse beleidstipes uniek oor ‘n hele paar kwessies heen. Die twee state waarop besluit is as gevallestudies, Suid-Afrika en Noorweë, word algemeen beskou as kernvoorbeelde van die twee onderskeie middelmoondheid kategorieë. In hierdie gevallestudies word die gesondheidsdiplomasie van die twee state oorweeg aan die hand van raamwerke wat in die eerste helfte van die studie ontwikkel word, en dit dien dan as die empiriese ondersteuning vir die analise wat daarop volg. Die bevindings spreek boekdele beide oor die twee verskillende middelmoondheid tipes en vir die onderskeie gevallestudie state. ‘n Gedeelde fokus op multilateralisme is een onverrassende ooreenkoms, aangesien alle middelmoondhede hierdie voorkeur in hul buitelandse beleidsondernemings openbaar. Maar tog, aangesien Suid-Afrika onluikend is en Noorweë goed-ontwikkeld is, is uiteenlopendheid bespeurbaar i.t.v. die strategieë wat die onderskeie state gebruik ten einde die internasionale invloed te kry waarna hulle op soek is. Voorts verlangsaam plaaslike en streekskwessies die agendas van ontluikende middelmoondhede, terwyl tradisionele middelmoondhede in hierdie verband stabiliteit geniet, en dit dan moontlik word vir lg. om elders geleenthede te ondersoek. Sodanige kenmerke is duidelik in Suid-Afrika, waar ‘n ernstige gesondheidskrisis die land verlam; in Noorweë, aan die ander kant, is plaaslike uitdagings nie ernstig nie, en nisdiplomasie word met groot sukses onderneem. Die kernboodskap van die studie is dat gesondheidsdiplomasie ‘n beduidende nuwe ondersoekveld is binne Internasionale Betrekkinge in die algemeen, en dan spesifiek in nisdiplomasie en globale gesondheidsregering, en dit vereis verdere studie.

Acknowledgements

First and foremost, I would like to express my genuine gratitude to my supervisor, Prof. Pieter Fourie, for his continuous support in the process of writing this thesis. His encouragement, advice, knowledge and generally pleasant nature have all helped me immeasurably in reaching this end product. I would also like to thank all of the unsung heroes who work at the Stellenbosch University Library for their readiness to assist in matters large and small. Finally, I would like to thank my friends and family for their continued encouragement.

List of Tables

Table **Page**

List of Acronyms & Abbreviations

ANC	African National Congress
AU	African Union
DIRCO	Department of International Relations and Cooperation
EU	European Union
FCTC	Framework Convention on Tobacco Control
FPGHI	Foreign Policy and Global Health Initiative
GAVI	Global Alliance for Vaccines and Immunization
GHD	Global Health Diplomacy
GHG	Global Health Governance
GNI	Gross National Income
GNP	Gross National Product
GPG	Global Public Good
HD	Health Diplomacy
HDI	Human Development Index
IBSA	India, Brazil, South Africa
IGO	Intergovernmental Organisation
IR	International Relations
ISC	International Sanitary Convention
MDG	Millennium Development Goal
MFA	Norwegian Ministry of Foreign Affairs
MOU	Memorandum of Understanding
NATO	North Atlantic Treaty Organization
NEPAD	New Economic Partnership for Africa's Development
NGO	Non-Governmental Organisation
NORAD	Norwegian Agency for Development Coordination
NTPI	Norway Tanzania Partnership Initiative
ODA	Official Development Assistance

PEPFAR	President's Emergency Plan for AIDS Relief
SADC	Southern African Development Community
SADPA	South African Development Partnership Agency
SAFPI	South African Foreign Policy Initiative
SAIIA	South African Institute of International Affairs
TOC	Theory of Change
UN	United Nations
UNDP	United Nations Development Programme
UNSC	United Nations Security Council
WHA	World Health Assembly
WHO	World Health Organization
WHO-CC	World Health Organization Collaborating Center

Table of contents

Chapter 1: Introduction

Background and rationale

The future is approaching. Having come well into the 21st century, it is clear that the world is in a state of continuous and seemingly exponential change, resulting in ever-increasing complexity. This fact has enormous implications and consequences, both consciously and unconsciously, on how the different agents of the international arena act in their various endeavours. For sovereign states, the original sole agent of this arena, the issue of health historically tended to tie up with traditional notions of national security and prosperity. Subsequently, health issues were viewed as internal to the state, which was thus responsible for its own citizens' general well-being and handling of potential health crises such as epidemics. However, in a world characterized by the flux presented by the unstoppable force that is globalization, the nature of how health issues are dealt with is inevitably changing along with the very system itself. Indeed, as an increasing amount of observers, scholars and politicians have realized and subsequently argued (see for example Fidler, 2013), health issues, now more than ever, have the ability to transcend national borders in a number of ways – the current Ebola outbreak being the most recent example. This necessitates a degree of cooperation and coordination between both states and other actors to in order to engage in collective action for the benefit of all. As Dodgson, Lee & Drager write,

> This is particularly so as a range of health determinants are increasingly affected by factors outside of the health sector – trade and investment flows, collective violence and conflict, illicit and criminal activity, environmental change and communication technologies (Dogdson et al., 2002:5)

This realization has led to the concept and practice of Global Health Governance (GHG), the roots of which first started appearing in the early 19th century, as cholera, highly contagious and exceptionally lethal, started appearing along trade routes in Eastern Europe and spreading quickly, eventually following these routes to cities such as London and Paris (Youde, 2012). States included in the trade started cooperating on containing and quarantining the sick, lest their trade routes be destroyed completely. However, the success of international health conferences held in that century was often thwarted by disagreements concerning causes and solutions to the problems. One exception to this is perhaps the International Sanitary Convention (ISC) of 1892, which concerned international coordination and organization of medical checks on Muslim pilgrims going to and from Mecca through the Suez Canal. The reason for states involving

themselves in these matters was arguably mostly due to protecting economic interests rather than human concerns, but the existence of a forum for international cooperation and interdependence on health issues was now a fact. Fast forward through both world wars, and at the end of a highly unstable better part of 50 years, where agreements were made and broken, and conventions characterized by disagreements over strategies, 1946 finally saw the creation of the World Health Organization (WHO). Despite massive initial optimism, Jeremy Youde explains to some detail in his book *Global Health Governance* (2012), the credibility and power of the WHO declined greatly over the last half of the 20th century, only to regain some of its reputation in the early 2000s. However, as he points out: "[….] its previous position as the unquestioned leader of international health efforts is no longer tenable. Thanks to the organization's weakening during the 1970s and 1980s and the emergence of a host of new organizations, the architecture of global health governance is significantly more crowded" (Youde, 2012:45). Indeed, with increased globalization came a much more complex system in which state actors, multilateral organizations, transnational business corporations and non-governmental organizations (NGOs) all have interests and influence, constantly interacting and negotiating with each other. Thus the notion of GHG was conceived. Dodgson et al., in their *Global Health Diplomacy: A Conceptual Review* (2002), dissect the concept and define health governance as something that "[….] concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population" (2002:6). Adding the *global* part to the equation, David Fidler defines GHG as a concept used by scholars "[….] when thinking about how globalization affects the national and international pursuit of public health" (Fidler, 2002:6). In practical terms, the same Fidler labels GHG as something which refers to:

> [….] the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively. *This definition's relative simplicity should not obscure the breadth and complexity of this concept*. (Fidler, 2010:3, author's emphasis)

Over the last decade in particular, the globalization which GHG stems from has led to new ways in which states engage in the pursuit of promoting and protecting health. Indeed, health issues are increasingly becoming part of systems of bi- and multilateral negotiations in which diplomats are engaged on behalf of their governments to promote their states' global health policies. As a group of leading scholars on the subject write, "[t]he broad political, social and economic implications of health issues have brought more diplomats into the health arena and more public health experts

into the world of diplomacy. Simple classifications of policy and politics – domestic and foreign, hard and soft, or high and low – no longer apply" (Kickbusch et al., 2007:230). This development was manifested in the 2007 *Oslo Ministerial Declaration*, signed by seven foreign ministers from across the globe, in which global health was characterized in its subtitle as a 'pressing foreign policy issue of our time' (Foreign Ministers, 2007).

As a tentative definition, we can say that "'[g]lobal health diplomacy' refers to both a system of organization and to communication and negotiation processes that shape the global policy environment in the sphere of health and its determinants" (Kickbusch & Kokeny 2013:159). The ministerial declaration is an example that shows clearly and explicitly that health diplomacy is becoming an increasingly integral part of global health governance. But what drives the individual state into engaging in health diplomacy? Is it solely attributable to a desire to protect its own interests and citizens, has their 'circle of empathy' expanded in the sense of philosopher Peter Singer (1981; 2011), or are states beginning to truly adopt and practice altruistic norms such as the belief in the universal right to health?

Enter the *middle powers.* This concept refers to a category in which states that are viewed as being "[….] neither great nor small" (Jordaan, 2003:165) in the context of the international arena are placed. As a whole, members of this category typically have limited and moderate capabilites in regards to influencing the international system in any way on their own, so they are more prone to engage in activities that involve other middle powers in a cooperative bilateral or multilateral manner. These states, in lieu of having an imposing image in the form of *hard power*, tend to rely on *soft power* in order to promote their interests and spread ideas. This happens in the form of negotiation and cooperation, in particular by using attractive ideas such as human rights, democracy, peace and indeed *health* in negotiations. However, middle powers are increasingly difficult to define as a purely homogenous group whose behaviour can be summarized in the sentences stated above. Eduard Jordaan, in his seminal work, *The concept of a middle power in international relations: distinguishing between emerging and traditional middle powers* (2003), delineates two distinct groups of middle powers, namely *emerging* and *traditional* ones. The orthodox behaviour of middle powers, typically earning their spot within this category during the Cold War, has tended to consist of initiatives that stabilize and uphold the current global order in which their allies are in control (see for example Gilley, 2010). This sort of behaviour characterizes what is referred to as traditional middle powers, a group that consists of what can be

considered as household names when it comes to global soft power and specialty negotiations, such as Canada, Australia, Switzerland and Norway.

The category of *emerging* middle powers, on the other hand, includes states such as Mexico, South Korea, Indonesia and South Africa. In broad strokes, Jordaan puts these states in a separate category because they have histories that are very different from the traditional middle powers, and their behaviour and context diverges from the characterization outlined above. They only came into their present position after the Cold War, and are often viewed as regional bigwigs. As they do not necessarily have historical alliances with the powers that dominate the hierarchy of the status quo, their interests are different from the traditional middle powers. Indeed, they would rather reform the global system in order to advance their own position and influence in it. Geographical and historical concerns are highly constitutive of their behaviour and self-image, as many of these emerging middle powers are characterized as being members of what is known as the Global South, a point that is often consequential and indeed tend to be emphasized in the foreign policies of many of these states.

Both emerging and traditional middle powers engage in an array of diplomatic soft power activities, increasingly including that of health diplomacy (see for example Hawksley, 2009; Lee & Gomez, 2011). However, there is little or no specific literature on the role of middle powers in the context of health diplomacy. Further, there is a complete lack of studies that explicitly compare their respective behaviour, approach and rationale in engaging in matters that concern this particular form of diplomacy. In regards to the post-2015 United Nations (UN) development agenda, which will follow the questionable success (see for example Vandermoortele, 2011) of the original Millennium Development Goals (MDGs), health issues both were, and will continue to be, directly and indirectly linked to many of the goals. Thus, health diplomacy has a role to play considering its growing role in the general dynamics of global health governance, something which was hardly the case during the work with the original MDGs of the year 2000, when the notion, let alone the practice, of health diplomacy was absent. Another factor that will be more salient for the contemporary agenda is the very emergence of the new middle powers. This realization is already leading to what is perceived to be a much-needed influx of Global South perspectives and modes of South-South multilateral and bilateral cooperation (see for example Agarwal, 2013) rather than the traditional North-South recipe. The latter, characterized by the trickle of resources financial and otherwise and the flow of ideas never accomplished what it set

out to do. However, viewing South-South cooperation as a kind of a *panacea* is potentially dangerous. As for instance Oliver Stuenkel (2013) suggests, "[…] while praising South-South cooperation unconditionally may work for now, it may also backfire at some point" (Stuenkel, 2013:22). Regardless of their respective future results, this split between North-South and South-South relations is an implicit dimension when comparing how emerging versus traditional middle powers engage in health diplomacy. This affects how the different actors think about themselves, their role in global governance and further, and what constitutes and informs their interests and consequent behaviour. If both these sets of voices are going to be increasingly heard and have greater potential consequences, it is imperative to understand what informs them and how they are practiced.

Any big trend or transformation in how the international system functions on any level is of relevance to the discipline of International Relations (IR). The development of health diplomacy as a variable in global governance and its effect on the foreign policies of many states is no exception. For example, significant global health governance projects such as the post 2015-agenda or the more vague notion of 'the new development paradigm' (see for example Kickbusch, 2013) will continue to simultaneously *inform and be informed by* the foreign health policies of most if not all states – middle powers of both types outlined above included. Furthermore, the rise of emerging middle powers is changing the system by creating new and influential actors whose decisions and agency will have consequences, and so understanding how these states deal with their new role in global governance is of importance. The diplomacy of soft power will also be an important part of the practical implementation of these and other global and health governance initiatives. Viewed together, middle powers and their role in global health diplomacy create a nexus that potentially can be of vast significance for GHG and IR, both scholarly and in practice.

The general aim of this study is thus to show how and why activities in health diplomacy are conceived, treated and acted upon the way that they are by traditional as well as emerging middle powers. To accomplish this, the study will examine two exemplars of the two respective groups outlined above, namely Norway and South Africa. These two states are illustrative of the two groups of middle powers because their respective characteristics fit well into the archetypes of their categories, which will be defined in greater detail below.

Problem statement and focus

The concept and practice of GHG was born as a result of a changing and globalizing world, and is continually changing along with the composition of the larger global system in general. New players are coming to the fore, including increasingly influential NGOs and middle power states emerging from the Global South. As Jordaan suggests, this latter group has specific characteristics: while they mirror other global governance actors like traditional middle powers in many typical metrics and criteria, their identities are shaped by a very different kind of history; their subsequent interests lean more towards reform than the status quo; their values are often the result of reactions to a tumultuous past. With this in mind, the problem that the study will concern itself with is *how these differences manifest themselves in the different kinds of states' behaviour towards the relatively new health agenda in foreign policy and diplomacy.*

Research questions and goals

Based on the problem statement addressed above, the main research question investigated in this study is the following:

Using the exemplars of Norway and South Africa, (1) what can be said to be the respective similarities and differences in emerging and traditional middle powers' respective approaches to health diplomacy, and (2) how do these similarities and differences manifest?

Sub-questions explored in order to complement the main question stated above and form a more holistic picture of the subject are:

- Considering the relative youth of the concept and practice of GHG in general, and the even more fledgling state of the 'subgenre' of health diplomacy, do conceptual, theoretical and typological frameworks exist in IR which can be utilized in this analysis?
- What are the future prospects for health diplomacy in the two countries respectively, and, by extension, for traditional and emerging middle powers in general?

It is a goal of this study to explore possible paths that Norway and South Africa, and by extension, their respective categories of middle powers, might take in the future. This particular endeavour is addressed in the final chapter of the study. It provides general observations and considerations based on findings outlined in earlier chapters, before it provides recommendations in regards to both policy-making and future research.

Theoretical and conceptual framework

As introduced above, this study explores the notion of health diplomacy and how and why states characterized as *middle powers* relate to concerns of global health in their foreign policies. As suggested in the first of the sub-questions asked in the previous section, however, GHG and particularly health diplomacy are young fields with no consensually set parameters as to how one should approach them. This section briefly outlines three selected articles that are believed to provide key insights and which together serve as the theoretical framework for the study as a whole; two of the studies deal directly with health diplomacy in discrete ways, and the third serves as the conceptual framework for how this study views middle powers.

First, as a basis for comparison of different governments' stance on health diplomacy, the study utilizes a framework based on Labonte & Gagnon's article *Framing health and foreign policy: lessons for global health diplomacy* (2010). The article presents and explains six distinct, though not mutually exclusive ways in which states frame their foreign policies specifically related to global health. With this framework as a basis, the study is able to analyse the behaviour of the two individual states in question through a number of lenses, which in the case of this study is done with the middle power lens.

The six discrete types of global health framings in foreign policy conceptualized by Labonte & Gagnon are:

1. *Health and Security*, in which states refer to securing their own national and economic security as the central rationale for engaging in matters of global health.
2. *Health and Development* holds a view of health as inextricably linked with economic growth and thus views spending and engaging in health concerns as an investment rather than a cost.
3. *Health and Global Public Goods* introduces the concept of Global Public Goods (GPGs), defined in the article as something that is universally available and also "does not diminish through use by others" (Labonte & Gagnon, 2010:7), such as basic human rights, protection against disease, free access to knowledge, stable climate and so on.
4. *Health and Trade* emphasizes the intersection between the interests of global health and global trade, and typically follows the circular narrative that economic growth,

specifically as a result of trade liberalization, improves health, which in turn improves economic growth.

5. *Health and Human Rights* frame global health as legally binding to all states as all humans have an inherent right to life as per the International Covenant on Civil and Political Rights, signed and ratified by 168 states.
6. *Health and Ethical/Moral Reasoning* refers to values and ethical norms in the foreign policies.

In the second key article, Katz et al. (2011) attempt to define the concept of health diplomacy and write of the differences between *distinct spheres of conduct* in which participating actors operate. The study utilizes this article's typology when exploring whether and potentially why there are divergences or convergences between how Norway and South Africa act within these different spheres of negotiation. The salience of this aspect of health diplomacy becomes apparent when one considers the growing importance of multilateral cooperation, as the WHO's main decision-making body the World Health Assembly (WHA) regularly passes highly significant, formal health agreements. Further, the increased power and influence of NGOs such as the Bill and Melinda Gates Foundation and others are forcing states, for good or bad, to engage in serious cooperation and diplomacy with non-state actors. According to the article, these spheres can potentially be fundamentally different from one another. This is because the interests and identities that inform the diplomatic activities of a powerful NGO or other non-state actors can be very different from the traditional egotistic interest of security state actors.

The authors divide health diplomacy into three different "categories of interaction" (Katz et al., 2011:506).

1. *Core Global Health Diplomacy* is the formal diplomacy strictly between states, both bilaterally and multilaterally, with distinct characteristics which are explored at length.
2. *Multistakeholder Global Health Diplomacy* refers to a mode of interaction which includes not only states, but also non-state actors such as multilateral institutions and intergovernmental organisations (IGOs) such as the WHO, as well as NGOs, smaller government agencies and others.
3. *Informal Global Health Diplomacy* relates to more unofficial interactions between a myriad of actors, including academic research institutions, NGOs, people working in the field, and private enterprise.

As this study is more concerned with the actions of specific state types, the third category is not salient for the purpose of it, and will therefore not be considered in further detail in the chapters that follow.

Lastly, as a basic framework for defining what is characterized as traditional and emerging middle powers, the study stands on the shoulders of Eduard Jordaan. In short, he aims to give "[….] give the concept of middle power greater analytical clarity" (Jordaan, 2003:165) and accordingly explores and explains its characteristics and origins. Subsequently, he divides this concept into two constituent parts, namely what he terms traditional and emerging middle powers and presents the basis for the distinction by listing a number of defining characteristics, which is what this study utilizes in its conceptualization.

Jordaan's conceptualization is highly acclaimed and has been heavily cited after its publication roughly a decade ago (see for example Spies, 2010). At the same time, others (see for example Ramos, 2013) call for more critical ways of thinking about middle powers, specifically in Coxian or neo-gramscian schools of thought. The latter category of perspectives is accounted for below, as well as others, but Jordaan's conceptualization stands as this study's framework because of its well-argued simplicity, as well as its continued relevance.

The studies of Labonte & Gagnon, Katz et al. and Jordaan thus serve as the theoretical and conceptual scaffolding for the study as a whole.

Research design and methodology

The research question along with its sub-questions makes this study fit several classifications. As for the main research question, the study has a *contextual* or *descriptive* design, in that it aims to explore what differences exist between the states in the variables outlined in the theoretical framework, and how these are manifested. The second sub-question, as it explains the origins of these potential differences, is *explanatory* in nature, as such "[...] research is concerned with *why* phenomena occur and the forces and influences that drive their occurrence" (Ritchie & Lewis, 2003:26). Furthermore, when considering the final sub-question and the study's final chapter this research will also be *evaluative* and *generative*, as it will simultaneously "appraise the effectiveness of what exists" and attempt to contribute in "aiding the development of theories, *strategies or actions*" (Ritchie & Lewis, 2003:27, author's emphasis).

Methodologically, this study is undertaken applying a qualitative approach and a deductive logic. That is to say, the vast majority of the data on which the study will rely is from secondary and tertiary sources, as defined by Burnham et al. (2008) found through online scholarly databases, in addition to various books available in the library of Stellenbosch University. This collection of relevant data is interpreted and analysed in relation to the theoretical framework outlined above.

To complement this, additional secondary sources such as official government policy documents and statements, in aggregate also known as *grey literature*, are utilized and analysed in the framework outlined above. Ritchie & Lewis define this as *documentary analysis*, and is something which they deem useful when "[….] studies where written communications may be central to the enquiry [….]" (Ritchie & Lewis, 2003:35). The study uses official documents as a starting point for subsequent dissection and analysis.

Finally, this study uses the *case studies* of Norway and South Africa as the bases for comparison, as they are thought to be exemplars of the categories of traditional and emerging middle powers, respectively. Gerring defines a case study as "[….] an intensive study of a single unit for the purpose of understanding a larger class of (similar) units" (2004:342). In this thesis, Norway acts as the single unit for the larger class that is traditional middle powers, whilst South Africa is the unit which represents the class of emerging middle powers. Together the units form the basis for a generalized comparison between the two groups.

Chapter 2: Health Diplomacy: The emergence and evolution of a concept

This chapter surveys the literature relating to the first of the two main concepts in this study, namely Health Diplomacy (henceforth HD). It is the ultimate aim of the chapter to provide a clear, thorough, multi-layered and holistic understanding of what the numerous aspects of the concept entail, so as to make clear what is represented when it is referred to throughout. This fundamental element benefits the study as a whole, as the common denominator of the research problem and the additional research questions is a type of assessment of the attributes, utilization and consequences of HD. The endeavour of presenting this, however, is a complex one. Being as it is a concept still in its infancy, and furthermore one that begs concatenation between fields not traditionally affiliated with each other – finding its objective meaning and by extension, significance, is an on-going challenge. It is therefore important to take several perspectives into consideration in order to gain a full sense of overview on the matter.

For this reason, much of the following chapter deals with the different meanings of the concept of HD and their subsequent connotations. It starts by briefly introducing the etymology of its constituent parts, before moving on to debates surrounding the meaning and significance of HD as well as the debates surrounding what can be characterized as its ancestral and deeply interrelated theme, the matter of health's place in foreign policy. Once this is presented and summarized, the chapter moves on to the other dimension of the concept that is salient for the purpose of this study, which is to explore the academic landscape for suggested analytical frameworks that can lend themselves to the study of HD's various aspects. In addition to being one of the core research questions in the study, this endeavour is important for creating a lens through which the exemplars in later chapters are viewed. Therefore, the latter part, constituting about a third of the chapter, aims to present frameworks and categorizations suggested to better understand the phenomenon, and to assess which ones the most useful are to answer the problem statement and research questions outlined in Chapter 1.

The subject of HD is highly multifaceted. Any study of it can therefore have several points of departure, such as assessing the increasing power of non-state actors, analysing the deep roots of the history of the term or exploring metrics for measuring it. While these factors inevitably come into play, this particular study is focused on two main aspects. Firstly, and most importantly, it is interested in the various aspects of how the middle power exemplars of Norway and South Africa

interpret, integrate, frame and conduct HD in their foreign policies. Therefore, the relevant literature is largely state-centric. Secondly, it is interested in whether or not adequate conceptual, theoretical and typological frameworks exist in the literature that can be utilized to study various aspects of HD, again specifically focusing on its state-specific aspects.

Initial conceptual and definitional issues

As has been reiterated in the introduction and indeed in one of the core sub-questions of the study, the concept of HD is a fairly young one. One immediate consequence seems to be that any one universal or consensual definition does not exist. A section that explores the linguistic etymology of the concept as well as the evolution GHG that made the formation such a concept possible introduces this section. Following this, the main segment of this part of the chapter explores the reasoning behind the conceptual and definitional approach of some of the leading scholars in the field of HD and the broader field of GHG in general.

Constituent parts of the concept

In the literature, there is a subtle divergence regarding the usage of the term as a whole. While some (see for example Feldbaum & Michaud, 2010; Fidler, 2013) refer to simply Health Diplomacy, a large host of other scholars and observers (see for example Kickbusch & Silberschmidt, 2007; Lee & Gomez, 2011) refer to it as *Global* Health Diplomacy (GHD); and sometimes individual authors use the two interchangeably (see for example Katz et al., 2010). However, the insertion of the word *global* might be interpreted as having certain implications, especially in cases related to the broader field of GHG. Indeed, the *global* in GHG was only consensually included once there was no longer doubt about the exponential interconnectedness of a globalized world, a process briefly referred to in in Chapter 1 of this study. However, this consensus has not yet been reached regarding HD, which can be said to at once be a sub-field of both GHG and of foreign policy. In fact, this somewhat mixed parenthood is the source of several points of disagreement, which will become clear over the course of this chapter. With this in mind, this study refrains from including the term *global* when referring to the concept of HD, although it quotes without discrimination authors who utilize both versions.

This leaves the observer with the common denominators of both of these variations, health and diplomacy. First, the definition of *health* is not as clear cut as one might assume at first glance. Unsurprisingly, the standard definition in the Merriam-Webster dictionary is simply "the condition of being well or free from disease". However, this definition has long been considered

to be much too simplistic by scholars and organizations alike. Indeed, the WHO's own definition, which has gone unchanged since its implementation in 1948, clearly shows this. The preamble to its constitution states that "[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1950:2). This definition is however, not without its critics. Saracci (1997) suggests that this idea of health is not only erroneous, but also highly impractical. He argues that what the WHO is referring to in the latter part of their definition is actually the idea of happiness, not health. Happiness, unlike health in its simplest form, is subjectively determined and potentially insatiable. By removing this ambiguity, he suggests, it would actually be possible to equitably distribute health on a global scale. This line of reasoning seems to make sense, but Saracci's focus on purely somatic health is nevertheless far from generally accepted. For example, for Huber and his colleagues of the British Medical Journal, there is a necessity to include physical, mental and social variables in a definition of health, and finally suggest a broad definition of health "as the ability to adapt and self-manage" (Huber et al., 2011:2).

As for *diplomacy*, the most common definitions given by analysts and scholars have tended to refer to varieties of description of peaceful means with which a state exercises its foreign policy (see for example Fendrick, 2004). Seen from this perspective, diplomacy is an instrument, characterized by negotiation and brokering, utilized by states in order to accomplish the primary goal of foreign policy, namely securing their own national interests.

However, as Cooper, Heine and Thakur suggests in the introduction to the most recent edition of the *Oxford Handbook of Modern Diplomacy* (2013), the nature of diplomacy may be changing along with a changing global landscape towards a more cosmopolitanist reality:

> In a globalizing and highly interdependent world, the traditional power-maximizing pursuit of competitive foreign policies may not just be anachronistic, but acutely counterproductive. Instead, what is needed is identification of problems that are common to many if not all actors and the adoption of solutions that require collaboration (Cooper et al., 2013:20-21).

Incidentally, this is not the first time that a perceived transforming world has led to the announcement of a paradigm shift regarding the relationship between states; declaring dead traditional ideas about foreign policy and by extension, diplomacy. In the late 1940s, after the birth and rise of liberal institutions such as the UN, debates were rife on whether the sovereign state would be gone such as we know it, and that perhaps diplomacy was a thing of the past. In an

article published in The Yale Law Journal in 1946, one of the 'founding fathers' of modern political realism, Hans Morgenthau, dismissively sums up the main points of such a view with a palpable scorn:

> Here, the disappearance of foreign policy and, with it, of diplomacy is expected as a by-product of the ascendancy of liberal principles over the feudal state, and this expectation is indeed in harmony with the laissez-faire philosophy of nineteenth-century liberalism. The twentieth-century opponents of any foreign policy and any kind of diplomacy have found in the conception of world government a positive instrumentality which will make foreign policy and diplomacy super-fluous (Morgenthau, 1946:1068).

Viewed in hindsight, Morgenthau can indeed be said to have been correct in his assessment regarding the continued importance of foreign policy and the tool of diplomacy. However, the 1940s independent variable of a liberal 'conception of a world government' is quite different from that of today's globalization. Whether or not Cooper, Heine and Thakur are right in their assessment quoted above is nevertheless yet to be consensually accepted. However, the very idea of a new kind of diplomacy, based on ideas of interdependence, interconnectedness and *common* identities and interests, has meaningful and interesting ramifications and indeed many supporters. This view, juxtaposed with the traditional sense of identities and interests limited to an ultimately *self-serving* and *self-helping* sovereign state is a recurring theme in discussions around the meaning of the concept of HD. Actually, this divergence tends to permeate everything about the concept, from its conceptualization to its meaning and implementation.

The evolution of GHG and foreign policy's connection with public and global health

As suggested, HD only came into its present form of discourse in the mid-to-late 2000s. However, the origins of the idea date back to the roots of its parent concept of GHG. In the late 1820s, as cholera mercilessly ravaged trade routes in Europe, shared economic interests among the states who largely depended on these routes incentivized coordinated efforts to contain it, sowing the seeds for this kind of cooperation in the future. The first documented large-scale encounter between foreign policy and public health was a historical fact (McKinnes & Lee, 2012). Following this, many early examples of international health conferences were held over the course of the century, most of which were not particularly successful. In fact, it would take as long as until 1892 before the first agreement, the ISC was adopted, four decades after the first conference in 1852. At this point, both formal and informal rationalization for adopting such conventions was based upon securing the sovereign state and protection of largely economic

interests. From 1900, the international system was characterized by a high degree of instability and lack of trust, culminating in the First World War in 1914. The wake of it saw the creation of the League of Nations, which ultimately failed to help create meaningful and long-lasting international cooperation regarding health. It was only after the Second World War and the creation of the UN, the WHO and with these, significantly, the introduction of health as a fundamental human right, that truly organized coordination concerning international health was a fact.

Over the course of the following decades, the WHO would dominate the climate and shape the climate of international health governance before having a significant drop in credibility and power in the 1970s and 1980s. The wheels of globalization had by this time already begun to slowly turn, and new actors were introduced to the scene, shifting the balance of power to a more diverse playing field characterized by negotiation and a plurality of interests and voices. As Jeremy Youde (2012) suggests, this process could introduce the truly global component of health governance, in the end creating a discourse and practice of GHG. As time has passed, it is clear that this was only a sign of things to come. Indeed, various aspects of globalization continue to transform GHG and the way its actors perceive global health and subsequently engage with it. Occasionally, as a reaction to this constant flux, new sub-genres and discourses have the potential to be created. HD is a good exemplar of such a process.

Nevertheless, new discourses will always have to compete with old ones and prove its validity over time. The debate characterizing the discourse around HD hinted at above is no exception, and is quite naturally related and corollary with another debate within GHG that has been around for slightly longer, namely concerning the implications of the increased inclusion of global health issues in foreign policy. In fact, the initiative that led to the *Oslo Ministerial Declaration* was named the *Global Health and Foreign Policy Initiative* (FPGHI). As diplomacy is defined as a tool for states to promote their foreign policies, it follows that these debates are interlocked and is therefore, as it is in the literature, treated as one.

The Oslo Ministerial Declaration

As suggested in the Chapter 1, the Oslo Ministerial Declaration, signed by in 2007, laid much of the groundwork for an explicit discourse of HD, both academically and amongst and between governments. The foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand constitute the signatories to the declaration and its Memorandum of Understanding

(MOU), boasting a broad spectrum of states both in a geographical and economic sense. In summary, the declaration repeatedly emphasizes that health is a matter of fundamental human rights and that it is the duty of every state to ensure them. In addition to addressing this sense of duty, the rhetoric is based around ideas of interdependence and common interests among states, and is quite reminiscent of the world envisaged by Cooper et al. quoted above. It argues that "[h]ealth is deeply interconnected with the environment, trade, economic growth, social development, national security, and human rights and dignity" (Pibulsonggram, 2007:1), thus hinting at health's cross-cutting relevance in foreign policy. Indeed, it posits, global health and foreign policy are mutually beneficial and its coordination full of potential, and that "[p]owerful synergies arise when national interest coincides with the need for concerted regional and global effort" (2007:1).

Most of all, the goal of the declaration is to argue that health should be prioritized over all other interests, and indeed that it should be "[….] a point of departure and defining lens [….]" (2007:1) in the foreign policies of its signatories. As such, it thus prioritizes health as the primary goal of foreign policy, which is framed as more of a tool to achieve health goals rather than vice-versa. For the ministers, it is the effects of globalization that has pushed health issues to a point where common interests and the primacy of upholding basic human rights trumps that of traditional, national security characterized by self-help.

Basic premise	Globalization has led to an increasing interdependence in the world, and there is thus a need to widen the scope of foreign policy and raise the priority of health within it.
Motivation/Rationale	States should prioritize health in their foreign policies, to fulfil both their duty and their interests.
Pledge made by signatories	Health is to be a "point of departure and defining lens" in examining the signatories' foreign policies, through steps defined in the 10-point *Agenda for Action*
Signatory states	*Norway*, France, Brazil, Indonesia, Senegal, *South Africa* and Thailand

Table 2.1: Main points of the Oslo Ministerial Declaration (2007)

Discursive challenges in the form of scholarly scarcity

A characteristic regarding this field that is worth making a note of is its shortage of diverse writers and proper scholarly debate. For example, as Eggen and Sending (2012) point out, the literature concerning these topics is dominated by a limited few scholars, even if this is slowly evolving into a more expanded circle. While this lack of quantity of authors does not in and of

itself negate neither its quality nor its diversity, it does limit the output somewhat. Additionally, proper discussion between divergent views seems to be lacking. As Eggen & Sending suggest, "[…] there is very little disagreement and scholarly focused debate, and it is hard to identify scholars engaging each other's substantive arguments with critical analytical tools" (2012:7). Indeed, such an engagement of argument among any of the writers mentioned in this chapter seems generally absent from the present literature.

Definitional approaches: The bi-directional nature of health diplomacy

As hinted to above and as we shall see at length below, there is little or no consensus on what truly defines HD, a point that is almost always repeated in the literature (see for example Lee & Smith, 2011). However, there are definitions that attempt to be as objective and non-controversial as possible, covering all aspects of the matter. In the aforementioned *Oxford Handbook of Modern Diplomacy* (2013), there is a chapter dedicated to HD, written by David P. Fidler. Fidler, professor of law at Indiana University, has written extensively on matters concerning GHG for the better part of two decades, and is one of the most cited scholars on the concept of HD. In his chapter, Fidler makes reference to the diversity of perspectives on the matter, but characterizes this myriad of meanings as "[….] refreshing despite a *paucity of analytical rigour or lack of consensus* about what the relationship between health and diplomacy means" (2013:691, author's emphasis). He goes on to utilize a definition that was collaboratively reached over a series of meetings among GHG scholars in 2009. This describes HD

> [….] as the policy-shaping processes through which States, intergovernmental organizations, and non-state actors negotiate responses to health challenges or utilize health concepts or mechanisms in policy-shaping and negotiation strategies to achieve other political, economic, or social objectives (Fidler, 2013:693)

By Fidler's own logic, this definition includes two kinds of dimensions regarding diplomatic activity that includes health, and hints at the bi-directional nature of the concept of HD suggested above. The first one is in relation to health challenges, immediate or otherwise, i.e. coordinated handling of epidemics as well as other, less urgent situations and agreements that can be said to be specifically health-oriented. Secondly, HD also encompasses a degree being a means to an end, or a tool in the foreign policy 'box of tricks'. In this way, diplomats use "[….] health concepts and mechanisms to achieve non-health objectives, such as incorporating health into an overall package for improving relations among countries" (Fidler, 2013:693). Other scholars have also used this would-be all-encompassing definition, perhaps most prominently in the

introduction to the first issue of the first volume of the *Journal of Health Diplomacy*, in which Irwin & Pearcey (2013) use the very same words.

An additional concise definition is a rather recent one from another prolific writer on the matter, Joshua Michaud. In this article along with colleague Jennifer Kates, they write about the main characteristics of HD:

> Generally, GHD refers to international diplomatic activities that (directly or indirectly) address issues of global health importance, and is concerned with how and why global health issues play out in a foreign policy context. GHD can encompass a broad set of activities and actors, such as formal country delegations holding bilateral and multilateral negotiations on health issues, a combination of governmental and nongovernmental actors negotiating on health-related issues, and, although not considered "diplomacy" in the traditional sense, official or semi-official representatives of one country acting in health capacity in another (Michaud & Kates, 2013:24-25).

What these definitions have in common is that they attempt to be merely *descriptive.* That is, they do not carry any normative weight, but simply pronounce the main, objective characteristics of the system of HD.

However, there are many who seem to promote HD as something of a silver bullet for dealing with global health issues. The writings of probably the biggest 'celebrity' in the academic field of HD, Ilona Kickbusch, begin to hint of this view. Currently holding a position as adjunct professor at the Graduate Institute of International and Development Studies Geneva in Geneva, where future health diplomats are trained, Kickbusch has a long and successful background of working within global health. She is also a very prolific writer on matters concerning GHG in general and specifically HD, and has numerous times written about the definition and conceptualization of the concept.

In a relatively speaking very early article in which the focus is explicitly on HD, Kickbusch, Silberschmidt & Buss (2007) requests new perspectives and increased research on the matter. Here, they refer to HD as a term that "aims to capture […] multi-level, multi-actor negotiation processes that shape and manage the global policy environment for health" (Kickbusch et al., 2007:230). More recently, in an editorial of the journal *Bulletin for the World Health Organization* from March of 2013, Kickbusch along with colleague Mihály Kökény describes HD as something which "[….] refers to both a system of organization and to communication and negotiation processes that shape the global policy environment in the sphere of health and its

determinants" (Kickhbusch & Kokeny, 2013:159). While Kickbusch tends to keep the term reasonably neutral and free from any kind hyperbole or normative suggestion, there is a slightly more positive angle to it, and there is no mention of potential non-health foreign policy goals. The focus is thus exclusively kept on the first dimension of HD as described above.

Some authors explicitly hold a more noble and hopeful view in their descriptions, as they see HD as something that will contribute very positively indeed in the endeavors of GHG. In fact, one main characteristic that is immediately noticeable when researching HD is that much of the literature tends to, implicitly or explicitly; present a normative argument to the reader. Indeed, as Eggen & Sending somewhat sternly comments, "[m]any of the texts aim to convince readers about the importance of the health in foreign policy rather than trying to offer explanations backed by empirical data" (2012:7). For example, in a much-cited comment published in the medical journal *The Lancet* in 2007, editor-in-chief Richard Horton suggested that "[h]ealth moves foreign policy away from a debate about national interests to one about global altruism" (Horton, 2007:807).

A similarly optimistic example is found in the journal *Medical Anthropology*, where Adams, Novotny & Leslie, in an article which they themselves characterize as "[….] critical but hopeful" (2008:315) define HD as "[….] an emerging field that addresses the dual goals of improving global health and bettering international relations, particularly in conflict areas and in resource-poor environments" (Adams et al., 2008:316). In this case, as with Horton's, the wording is angled slightly different from the ones noted above, in that it connotes altruism and assumes that all participants will benefit from unbiased and fair dealings. This perspective assumes that the introduction of health into foreign policy has the possibility of transforming traditional state interests, and thus believes in what Cooper et al. suggested above.

The limitations of this kind of literature however, are several. Its authors are criticized for their tendency of sugar-coating the issue to fit their biases, and end up losing credibility due to the absence of empirical evidence. As both Fidler (2009) and Eggen & Sending (2012) argue, this kind of bias can potentially undermine important critical views that look at the potential and realistic confines as well as the promises of HD. Indeed, as Michaud & Kates point out, there are several examples of objectives relating to traditional foreign policy interests in the end trumping global health objectives in situations where these have been in direct conflict. "Promoting the

production, sale, and trade of products detrimental to health (such as tobacco, alcohol, and junk foods)" (2013:24) is one such example.

There are also those who focus on this side of HD. That is, as something far less noble than what it appears to some, and that it is actually nothing but a tool for states used solely to ensure their own interests. The betterment of global health, in this view, is purely incidental and not at all the primary goal. These observers de-emphasize the aspects of HD concerning negotiation, altruism and global health concerns, and direct the focus more towards the strategic and instrumental facets. Anthony Fauci (2007) for example, a US government official with experience working for the President's Emergency Plan for AIDS Relief (PEPFAR), refers to 'medical diplomacy' as characterized by "[….] the winning of hearts and minds of people in poor countries by exporting medical care, expertise and personnel to help those who need it most" (Fauci, 2007: xxiii).

What Fauci refers to is an example of *soft power*. Rather than being an activity motivated by altruism and genuine concern for the well-being of all and their access to the universal human right of health, many observers believe that states' engagement in HD is, in fact, merely a form of exercising soft power. The term, as defined by its originator Joseph Nye (2004), refers to the ability of states to exert influence on other actors on the international arena not by the use of coercion or various forms of bribery, but by cooperation and persuasion, creating mutually beneficial situations in the long term, or as MacFarlane defines it, "the promotion of ideas and values that is attractive to others" (MacFarlane, 2006:42). A related term for this is *enlightened self-interest*, in which an action performed ostensibly to benefit others is ultimately performed to secure one's own interests in the long run. When speaking of HD as soft power, David Fidler argues that

> Importantly, health diplomacy often involves foreign policy 'double dipping': states provide assistance to other states in order (1) to address a particular health threat of mutual concern, and (2) to strengthen ties with those states in the face of political or economic competition from rivals (Fidler, 2013:704).

In this view, the ultimate goal of HD is to better the relations with the recipient states for strategic reasons, suggesting that there may be a stronger desire to provide such assistance in regions or countries where there are potential strategic benefits in gaining influence, alliances and trade partnerships.

Relatedly, Feldbaum & Michaud (2010) argue against the notion that health has become so global so as to transcend traditional foreign policy interests. Instead, they suggest, that states' involvement in HD is guided by self-interest in its core, just like all other foreign policy. They use the example of the *Framework Convention on Tobacco Control* (FCTC), in proving their point. The FCTC, adopted by the WHO in 2003, is an early example of a formal multilateral treaty directly prioritizing health concerns over economic interests, as the treaty implores its 168 signatories to explicitly inform about the lethality of smoking cigarettes to their citizens. While this treaty is often used by those who seek to prove health's transformational power in diplomatic relations (for example Kickbush et al., 2007), Feldbaum & Michaud point out that in fact, "[k]ey to the adoption of this new treaty was the evidence provided by the WHO and World Bank on the economic burden that tobacco and tobacco-related diseases place on governments" (Feldbaum & Michaud, 2010:4). From this perspective, rather that genuine concern for the health of individuals in and of itself, the adoption of this treaty was yet another way of protecting the self-interests of its signatory states, as a way for these governments to protect themselves from the poor health choices of their citizens.

David Fidler, while happy to utilize the non-controversial definition in his aforementioned chapter in the *Oxford Handbook of Diplomacy*, has in fact tended to be quite critical of the notion of health having a transformative influence on foreign policy and diplomacy. In a thorough article titled *Health in Foreign Policy: An Analytical Overview* (2009), he clears up what in his mind is 'misconceptions' held by the proponents of this view. Fidler is very sympathetic to the idea of the significant powers of globalization and its role in changing the way states conduct themselves in the international system, and that it significantly alters the way in which they construct and conduct foreign policy and diplomacy. Indeed, along with the end of the Cold War and the rise of non-state actors, he argues, globalization's ramifications should not be underestimated: "Globalization helped to create and illuminate new forms of interdependence and interconnectedness between states and peoples, which forced countries to reconsider the scope and substance of the national interest in making foreign policy and conducting diplomacy" (2009:16).

However, he does not see the integration of global health issues in foreign policy as a truly transformative process in which altruism is the motive rather than self-interest. He writes,

> The normative attractiveness of health as a transformative endeavor in foreign policy reflects confusion about what ramifications health has on international relations. Global health challenges often reveal interdependence and interconnectedness among countries and societies, and these realities persuade many people to believe that such interdependence and interconnectedness produce a harmony of interests among states in engaging in effective collective action. This line of reasoning contains some problematical features that deserve examination (2009: 18)

Following this, Fidler spends time arguing how global health issues, far from being having a transformative effect, are rather taken into account in foreign policies just as any other interest, and must thus compete with these other interests in specific situations. They are therefore are just as liable to be sacrificed in favour of another interest which seems more beneficial for the state at the particular time, for example those pertaining to trade. Additionally, he notes, a degree of interdependence does not denote a complete lack of opposing interests between actors, but is actually a more fleeting notion that waxes and wanes in significance depending on what is often temporary conditions, as for instance an epidemic outbreak.

Based on this, the fact seems to be for Fidler that health will always be ultimately deprioritized because its importance is elastic, whilst other dimensions of foreign policy like military power and security are constant. Therefore, for Fidler, and a number of other scholars (see Chan et al., 2008; Feldbaum & Michaud 2010), the reality is still such that: "Matched against other foreign policy crises and priorities, these global health problems stay part of the low politics of foreign policy, where health issues historically tend to reside" (Fidler 2009:22).

When referring to *low politics*, Fidler refers to a distinction between it and *high politics*, and thus touches upon a core point in this debate. High politics, within the field of IR, refers to what is viewed as ever-present concerns of a state's foreign policy. In essence, the matters that are imperative for the survival of the state belong to this classification. Military security is the only consensually defined aspect of a given state's concern that can truly be said to possess this quality. In diplomatic terms, it refers to "[….] a state's security relationship to other states in the international system" (Barnett, 1990: 531). Low politics, on the other hand, is associated with concerns that are secondary, "[….] economic and social affairs" (Keohane & Nye: 1989:24). In the end, low politics always play second fiddle to high politics. The question surrounding the HD debate, viewed in this scope, concerns which of these categories global health issues fits into. For Fidler, health issues are only occasionally included in high politics; its relevance to it seems fleeting and crisis-driven. Indeed, as Margaret Chan of the WHO along with then-foreign

ministers of Norway and France admit: "Health competes poorly with other priorities in absence of crisis" (Chan et al., 2008: 498).

Finally, in a somewhat unique article, Raphael Lenchucha (2013) admits that the national security frame is still dominant and is what motivates the vast majority of states when it comes to integrating issues of global health in their foreign policies, and it is merely used as a means to an end for ultimately selfish reasons. He wants to argue, however, that this need not be set in stone. Instead, he suggests what is equivalent to a veritable cosmopolitanist revolution in the ethics of states, in which the health of all individuals regardless of nationality and citizenship is the primary concern of all states.

The inherent divergences of a bi-directional concept

In June of 2011, Chatham House held a meeting where the topic was discussing the future of HD subtitled *'A Way Forward in International Affairs'*. In the summary published in the wake of it, they concluded that the inability for the constituent actors of the field to agree on a definition stems from a tendency for global health professionals to see HD only in the light of improving global health, whilst foreign policy analysts and diplomats view it as a tool of traditional foreign policy. Indeed, it is largely health practitioners and politicians who has suggested or announced a true paradigm shift in foreign policy, who seem to be described by some critics as equipped with a blue-eyed naiveté, and who in short "[….] often want global health to be more politically important, but without all the politics" (Fidler, 2009:21).

Lee & Smith sums this divergence up succinctly in their article *'What is Global Health Diplomacy'? A conceptual Review'* (2011), in which they assess that "[w]hile there is broad consensus that negotiation is at its heart, normatively-driven views about whether GHD is intended to serve foreign policy or health goals adds to this analytical challenge." (2011:9). Similarly, Benjamin Anaemene from the University of Lagos dissects the matter succinctly:

> First, there are those definitions focusing on the field being driven by globalization, diverse actors beyond nation states, health negotiations and health impact of non-health negotiations. [….] Second, are conceptions that deemphasize both negotiations and the primary role of global health. They dwell basically on efforts aimed at improving health of a receiving country within the larger context of supporting the providing country's national interest (Anaemene, 2013:66).

For Lee & Smith (2011), this divergence correlates with a split between what they name 'traditional' and 'new' diplomacy, respectively. While the former fits well into the definition of

diplomacy as an instrument for foreign policy, the latter is much more complex in nature. Its description involves changes in the hierarchy of the international system after the Cold War, but more importantly it emphasizes the entrance of new actors into the field of global diplomacy, specifically non-state actors in the form of NGOs, making the goals of global diplomacy significantly more heterogeneous.

In addition to being somewhat confusing for the casual observer, this diversity of interpretations makes for a challenge for the researcher. In a comprehensive annotated literature review of much of the existing writings on HD, Blouin, Molenaar & Pearcey (2012), suggest that

> A lack of theoretical underpinning of analysis means that the literature on global health diplomacy is still relatively fragmented and not clearly structured around key research problems or questions. Multiple disciplines, from international law, public health, political science and other social sciences, are active in the field and there is no agreement drawn from shared theory on what the main components of a research agenda on GHD should be (Blouin et al., 2012:5).

It is however, possible to place the perspectives described above, or *academic gangs*, to use the terminology of Thomas Scheff (1995), on a spectrum; as is shown in Table 2.2.

	Statist / realist / traditional diplomacy	**Globalist/cosmopolitanist/new diplomacy**
Referent object of security	State	Individual
Core rationale for conducting health diplomacy	(Enlightened) self-interest, tool for exercise of soft power.	Altruism, mutually beneficial. Assuring the wellbeing of individuals and communities.
The role of global health issues in foreign policy	Importance has grown over past 20 years, but is only one interest which must constantly compete with potentially conflicting, 'traditional' interests.	Integral and permeating, health works in symbiosis with all other foreign policy interests and should be the basis upon which policy is made.
Relationship between states	Fleetingly interrelated, self-interest and self-help prevailing.	Constantly growing interdependence, blurring interests of self and others.

Table 2.2: The bi-directional perspectives on the relationship between foreign policy and global health issues

While these outlined perspectives are academic, they also reflect to a large extent the kinds of approaches can be taken by states when integrating global health in their foreign policies and subsequently practicing HD. Thus, this bipolar spectrum between altruism and self-interest is useful in assessing Norway's and South Africa' HD engagements in later chapters, both in

regards to how they present themselves and how conduct is actually practiced. This purpose of the spectrum is not however, to place actors on its extremes in a dogmatic manner. Indeed, a large degree of mobility along its continuum is both possible and probable, and the difference between pretence and conduct additionally has the potential to be highly discrepant. Rather, the purpose is one of reference, for the purpose relating the actual behaviour of states back to the detailed and somewhat entrenched scholarly debate described at some length above.

The statist-globalist divide and the need for holistic research

These split views correspond roughly to what Sara Davies (2010a; 2010b) refers to as the *statist* and *globalist* perspectives. Davies has written extensively about the ways in which the field of IR engages with global health issues. While underscoring that these perspectives are rather "[….] modes of thinking and prioritization than cogent theories" (2010a:1170), and that most scholars actually belong somewhere in the middle of the two. Nevertheless, Davies' typology is useful for making order of the divergent views on the dynamic between foreign policy and health.

For the statist viewpoint of the typology, the state is seen as the referent object of security. In essence, this means that health issues are only salient when it affects the security of a state, be it political, economic or military. In this view, health challenges, urgent or otherwise, become national security threats; the protection against which is the main goal of contributing to global health.

An assumption here is that the state is the only actor capable of leading the global health agenda. For the globalists, on the other hand, the referent object has shifted to the individual, and the state is only one of many actors responsible for ensuring its security. In fact, they argue, the state must adapt its own security needs to fit that of the global individual.

Following the Chatham House meeting mentioned above, it was concluded by its participants that "[f]or both definitions, there is a need for greater understanding of the landscape – who the actors are, what the processes, strategies and tactics are, and what motivations and interests are in play" (Chatham House, 2011:16).

As Watt, Gomez & McKee write, HD "[…] envisages a bi-directional set of relationships whereby foreign policy is used to achieve health goals, and health policy is used to achieve foreign policy goals" (2013:1). From such a contradictory starting point, it is only natural and perhaps inevitable that the emphasis on which of the two is more significant in practice is split

between both scholars of different disciplines, backgrounds and schools of thought, as well as among practitioners and politicians. The lack of evidence along with a tendency of referencing only concurring sources characterizes much of the more optimistic literature is however, not convincing. Therefore, this study attempts a more empirical stance and attempt to explore how Norway and South Africa actually engage in HD, but utilizes analytical frameworks that adopt a moderately statist viewpoint. In fact, this approach might be inevitable, as the main focus of the study, as explicitly laid out in the research problem and research questions, is on the motivation and behaviour of a certain type of state-actor. This does not mean, however, that it accepts the aforementioned statist archetypical view as defined by Davies (2010a). Rather, it means that its main focus is the state actor and its practices regarding matters of HD, and that it strives to attain what Gomez refers to as "[….] the processes of defining and refining theoretical concepts, causal mechanisms and case studies [which] is an on-going process that entails the *incessant interaction of theory and evidence* (2012:19, author's emphasis).

It is, however, important to consider the points made by both sides, as the final answers to these questions might never be reached consensually. This is true also of how actors relate to this new phenomenon. Indeed, as is the case in academia, the bi-directional nature of HD also opens up for many ways in which actors, specifically state actors, both practice and preach it. The need for frameworks through which an analysis of actual conduct can be possible is consequently imperative. In the section below, the study therefore explores the various aspects of HD and how these can be gauged and evaluated through specific lenses, categorizing types of behaviour for comparison and analysis.

Analytical frameworks for understanding HD practices

Keeping in mind the inherent bi-directionality of HD described above and in spite of David Fidler's above-mentioned remark on the 'lack of analytical rigour' on the subject, the problem remains how the study should assess the ways in which HD fits into the foreign policy of states. Not only is one of the research questions of the study explicitly interested in whether or not adequate theoretical frameworks exist for the study of HD; a successful solution to the problem statement also largely begs an at least partially affirmative answer to it. The purpose of conceptual and typological frameworks is to provide a basis for identifying and making connections and extrapolations between variables of a particular subject, phenomenon or concept. At first glance, perhaps because it is a new concept, HD seems to be largely in want of literature

in this regard, a point lamented by several observers (see for example Blouin et al., 2012; Mookherji et al., 2014). Indeed, as Blouin et al. remarks, only a minority of 17 out of the 51 articles they surveyed in their extensive literature review explicitly presented a theoretical framework. Following this, they conclude:

> The field tends to focus more on a descriptive account of policy processes and outcomes rather than explanatory inquiries. Several authors conclude their articles with comments on the potential explanations for the outcome they have described, but these are not structured into an explicit theoretical framework (2012:5).

Those that do include what can be characterised as a framework focus on a variety of specific areas of emphasis within the concept, each highlighting particular phases or dimensions of the process of conducting HD. To help gain oversight of these different phases, Blouin et al. refer to Walt et al. (2008), who suggest the *stages heuristic*, a general tool which can be used when attempting to understand or analyse a given policy process. In essence, the stages heuristic categorizes different stages any policy practice goes through in a step-by-step manner. These stages are categorised as (1) *agenda setting*, which refers to the part of the process where policy-makers are made aware of an issue and decide to include and act on it; (2) *formulation* is a stage which refers to the procedure of designing and enacting the policy; (3) *implementation* to how governments carry them out; and finally (4) *evaluation*, which focuses on assessing the effects and outcomes.

This study is interested in four separate dimensions of HD, roughly the corollary of the stages heuristic. First of all, the historical, geopolitical, social and economic context which can be said to lead up to the adoption a certain set of policy practices of a given state should be explored, corresponding with the *agenda setting* stage. This is not so much a framework for exploring HD specifically, as it is applicable as a starting point for any foreign policy analysis. Second, and moving on to actual HD-specific frameworks, it looks at models trying to explain how states rationalize and integrate the inclusion of global health issues in their foreign policies. This corresponds roughly to the category of *formulation* as posited by Walt et al.. Third, it reviews models that aim to look at the different types of HD practice, and the different manners of how states relate to these. While this falls somewhat outside the stages heuristic, it can be seen as an aspect of the *implementation* stage. Fourth, articles that discuss the metrics of HD in terms of

explicit implementation in the form of measurable actions and the subsequent stage of *evaluation* are presented.

Agenda-setting: The contextual roots of inclusion

As suggested, an examination of the stage of agenda-setting is important in exploring any given country's various types of foreign policy behaviours. Indeed, the inclusion or prioritization of any particular dimension in the foreign policies of states is a process that is always relative to the specific context of the state in question. As Eduardo Gomez (2012) writes in his analysis of Brazil's engagement in HD, this contextual focus is often overlooked in the relevant literature. Gomez argues that future studies concerning the matter of inclusion of global health issues into foreign policy should include such contextual factors if they are to accomplish the aim of gaining a truly nuanced view. First, assessing the historical, social and political factors both domestically and internationally of the state in question is crucial to gain a proper understanding of their motivations and the nature of how decisions are made within it. Second, an assessment of the international reputation and subsequent expectations of a state should also be taken into consideration, as these factors can, Gomez argues, play a role as a "[….] catalyzing force" (2012:21) in the decision-making process regardless of the size of the state.

As Katherine Bliss remarks, "Broadly speaking, each country's engagement is driven by its history and political outlook and the image it seeks to project regionally and internationally" (2011:2). Contextualization and accounting for these factors is a recurring theme over the course of this study, and an important forerunner in the country-specific analyses in relation to the difference between emerging and traditional middle powers**.**

The importance of these contextual and state-specific factors should not be underestimated. In the chapter dealing with case studies, this study thus makes a point of presenting the background contexts of Norway and South Africa explicitly. Additionally, the following chapter, in its description of middle powers and its subgroups of traditional and emerging, is in large part intended to create a contextual understanding of the *state-types* that these countries belong to, contributing to explaining some of the underlying rationales for their respective foreign policy behaviours.

Formulation: Integration of global health in foreign policies

As diverse approaches and rationales are adopted by different states in the matter of including global health issues in their foreign policies and subsequently conducting HD (Watt et al., 2013), some analytical frameworks that aim to classify these approaches within defined categories have been proposed. In fact, most explicit frameworks in the literature focus on this particular stage of the policy process. Usually, the frameworks are split into three to six distinct but overlapping categories. For Stuckler & McKee (2008), these are *security, charity, investment* and *public health*. Similarly, Lee (2009) posits *biomedicine, economism, human rights* and *security.* For Mookherji et al., these are defined as strategies and identified as *global health, diplomatic* and *security*, respectively. Ilona Kickbusch, in one article (2011), makes a framework out of a note by the UN Secretary General Ban Ki-Moon presented at the General Assembly in 2009. In the note, he identifies "[….] achieving security, creating economic wealth, supporting development in low-income countries and protecting human dignity" (UN Secretary General, 2009:5) as the potential possibilities of global health in foreign policies and urges member states to take steps to achieve these. Kickbusch uses this as a basis and proposes three categories defined as *security*, *economic* and *social justice* as good reasons and rationalizations for states to integrate global health issues in their foreign policies and conduct HD.

While worded differently, these examples clearly share common denominators in substance, something which reflects the relevant literature at large. However, while the different authors use many of the same classifications, they sometimes diverge in their bias towards one or the other. However, there is consensus on the recognition of diversity, complexity and unpredictability. As Watt et al. writes, "[w]hichever classification is used, they all agree that there are different rationales for engaging in global health activities, with health and foreign policy usually co-existing but to different extents" (2013:2).

This calls for more nuanced perspectives. Labonte & Gagnon's "Framing health and foreign policy: lessons for global health diplomacy" (2010) provides one such framework. As shown in the introductory chapter of this study, it suggests an expanded framework of six classifications in which different states frame the inclusion of global health activities into their foreign policies, thus widening the spectrum slightly for a more subtle distinction. These frames represent "[….] several of the rationales that have been, or could be, used to position health better within foreign policy" (2010:1). Their research is done by exploring foreign policy documents from a selection

of states. The usage of the word *frame* is understood to simultaneously both refer to what Druckmann (2001) refers to as *frames of communication* and *frames of thought*, respectively. The former refers to as "[....] the words, images, phrases and presentations styles that a speaker uses when relaying information to another [....]" (2001:227), often utilized by politicians or other rhetoricians in their efforts to present situations in a certain way to the public and, following this, in official documents – a source type which relied on by both Labonte and Gagnon's article and this study. The latter refers to the understanding of a concept or situation within the mind of an individual: "[….] the frame reveals what an individual sees as relevant to understanding a situation" (Druckmann, 2001:228). As such, frames can also be seen to refer to the frames of thought of the policy makers who worded these key documents, simply because they also need something which can be described as an internal shorthand for these meanings, especially regarding the relatively novel concept of health in foreign policy.

As the authors themselves emphasise, the frames presented below are, like most scholarly archetypes, not mutually exclusive and can easily intermingle within specific contexts.

Name of Frame	Core rationale	Actions proposed
Health and Security	Disease detrimental to the stability, security and/or growth of a state.	Limit spread of epidemics to own state. Limit conflict/terrorism as result of epidemics/disease.
Health and Development	Supporting good health means investing in growth and securing future trade partners and/or strategic allies.	Giving health aid to gain economic return in the long-term; and for strategic reasons, militarily or resource-related.
Health and Global Public Goods	Encouraging a greater supply of GPGs for the benefit of all.	Providing assistance in emergencies, regulating health-damaging products.
Health and Trade	Economic growth is beneficial for health, which is beneficial for economic growth, creating a virtuous circle.	Trade liberalization believed to increase growth and development. Intellectual property rights subject of debate. Health services as tradable commodities.
Health and Human Rights	Health is a fundamental right of all human beings, and thus guaranteed by law.	Providing assistance and cooperation to ensure these rights is a duty for affluent countries.
Health and Ethical/Moral Reasoning	Foreign policy decisions should be assessed against a set of ethical principles.	Using moral arguments related to justice to guide actions.

Table 2.3: Main points of Labonte & Gagnon's (2010) typology of the different frames of rationale states adopt for engaging in health diplomacy.

Implementation: Categories of interaction

As is pointed out by many (Fidler, 2013; Fourie, 2013; Michaud & Kates, 2013), HD emerged in a setting of globalization, characterized in a perhaps increasingly significant way by new types of actors beside the state; rife with novelties in the context of foreign policy such as untraditional identities with subsequent alternate interests aside from self-help. These actors include progressively powerful and influential NGOs in particular, but also cooperation between specific government agencies of which the Oslo Ministerial Declaration is an example. This process of heterogenization is still on-going and its implications are potentially highly significant. Therefore, while this study is focused on the behaviour of certain states, one important dimension of their reality in this continually globalized and multifaceted system is the need to interact with these new types of actors, large or small. Therefore, a framework that classifies "categories of interaction around international public health issues" (Katz et al., 2011:56), is necessary for a more nuanced and orderly view of the workings of HD. Indeed, such a framework, working in accord with the frameworks for rationalization of inclusion, is vital for the goal of gaining a deeper understanding of the many facets of a state's engagement in HD. Katz et al.'s categorization, originally meant to make order in the diversity of definitions of the concept, is thus a useful tool which the study utilizes to explore whether there are divergences both within and between Norway and South Africa regarding how they interact with other states versus non-state actors. In fact, it is the only academic article found in the literature that explicitly draws up the characteristics of the different categories or dimensions of interaction only mentioned in passing in most texts. While the article outlines three different categories of interaction, the last one does not include states at all and is therefore omitted in this study for lack of relevance to its purpose. The two included here is therefore *Core Global Health Diplomacy* and *Multistakeholder Global Health Diplomacy*, the characteristics of which are outlined in Table 2.4.

Category	Actors	Characteristics	Products/Actions
Core	Sovereign states engaging bilaterally or multilaterally in fora such as the WHO.	Policy implementation and advocacy, large scale negotiation, intelligence, issue-based diplomacy.	Formal agreements, as for example the FCTC in 2003.
Multistakeholder	Various actors including states, government agencies, non-state actors such as NGOs and multistate actors such as IGOs.	Medium to small scale negotiations, initiatives and long-term partnerships between the various actors.	Can take formal and informal forms. MOUs such as the Oslo Ministerial Declaration.

Table 2.4: Katz et al.'s (2011) categories of interaction states relate to within the sphere of health diplomacy.

As a supplement to this conceptual framework, Lencucha, Kothari & Labonte (2010) explore more thoroughly the implications of the emergence NGOs as key actors in a globalized world, using the process of the ratification of the FCTC as a reference point. As the FCTC is perhaps the prime example of large-scale cooperation and negotiation in the context of HD, the observations of this article is useful to understand the relationships between NGOs and states regarding global health policy issues. While the FCTC is viewed as belonging to the *Core Global Health Diplomacy* category, it was still influenced by the effort of many powerful NGOs. This indicates that the two categories are not mutually exclusive, and that they can affect each other in a variety of ways in keeping with the complex nature of HD. This is not to say that the categorization is unenforceable however, as its purpose is to describe the characteristics of strictly direct interaction between the various types of actors.

Further implementation and evaluation: The metrics and measurement of health diplomacy

One last dimension of assessing activities in HD is the question of how its activities can practically be measured and subsequently evaluated in terms of outcomes. Symptomatically, the fledgling state of this subfield of GHG makes the landscape of relevant suggestions regarding this somewhat barren. A few tentative suggestions have been made, however. For instance, Marten, Hanefeld & Smith (2014), in a two-page commentary published through the *Journal of Health Diplomacy*, suggest a focus on power relations between the participants of any given negotiation or cooperation in regards to activities that can be described as HD exist:

> Understanding how we can measure or assess global health diplomacy effectiveness necessarily depends on the intended goal of the efforts and type of power. Is global health diplomacy about getting A to do what B wants (by whatever means necessary) or is it about getting A to come to the realization that it wants the same as B (and change its respective values or norms)? (Marten et al., 2014:2).

By the logic of these particular authors, the concept of power is one that is adaptable from one context to another, as power can take various forms. For example, the degree to which soft power versus hard power is the main form characterizing the relation could be one aspect. This assessment of the power relations between actors speak both to domestic structure such as the power of institutions and individuals *and* to the relations between countries or any other of the actors engaged in HD. According to the authors, "[t]his could contribute to developing a conceptual framework to better understand why certain health diplomacy efforts succeed or fail" (2014:2), and perhaps help point out key components to failed or successful endeavours in HD,

which could be useful in constructing a proper framework for measuring it. Being as it is only two pages however, this commentary is more a suggestion for future work than an actual framework or developed theory.

Mookherji, Greb & Katz, in a very recent article, suggest a Theory of Change (TOC) "[….] approach as one way to conceptualize GHD practice and potential impacts that could also depict its complexity and identify relationships and pathways for measuring success" (2014:1). TOC, in short, is an interdisciplinary methodology most commonly used for measuring the process of philanthropic endeavours aiming to achieve positive social change (see for example Brest, 2010 for a full explanation of TOC). Endeavours for the betterment of health are perhaps the most typical in this regard and as such mirrors the major and most immediate outcome-aspect of HD. In essence, this sort of approach is meant to "[….] describe the relationships between activities, outputs, and short- and long-term *outcomes, which is one of the least systematically described and understood areas of GHD*" (2014:3, author's emphasis). Using the case study of Myanmar, they conclude that the TOC approach potentially can contribute to the theoretical foundation around HD, particularly in exploring how outcomes are reached and subsequently assessing and evaluating these outcomes in regards to the expectations of the various stakeholders. As the authors themselves concede, however, this is but one of many first steps required in achieving a full understanding of the process of evaluating and measuring the multifaceted effects of HD.

In general, explicitly structured analytical frameworks regarding this dimension, or phase, of HD seem largely to be lacking. Indeed, as both Eggen & Sending (2012) and Blouin et al. (2012) remark, measuring the practical utilization or appliance of HD is to a broad extent only implicitly found in the literature, and is often used descriptively to illustrate a point which is subject to a bias placed somewhere on the spectrum described above (see Table 2.2). As Eggen & Sending comment, "[i]ndividual countries, groups of countries and regions integrate health [in] their foreign policies in very different ways. The scope and need for empirical investigation is obviously huge" (2012:20). It would seem that there is simply no standardized way of measuring the conduct of HD. Once again, this might change as this sub-field of GHG gains maturity. For now however, it seems that individual case studies and comparative studies are the *modi operandi*, perhaps in an inductive manner contributing to a more generalizable framework or theory in the future.

Conclusion

Being multifaceted and very young, both academically and practically, HD is a concept and practice that is clearly not yet fully understood and developed. However, there are many opinions regarding both what it does and should constitute. This literature review, constructed in order to bring clarity the concept for the sake of integrating its meaning into the broader research statement and sub-questions of the study at large, began by dissecting the linguistic constituent parts of the concept. Next, the roots of the context from which HD evolved were briefly reiterated, culminating in the 2007 Oslo Ministerial Declaration, of which South Africa and Norway both are signatories. Following this, literature concerning various definitions of the concept was discussed at length. The keyword in this section was indeed *various*, as it became abundantly clear that a consensus regarding such a definition is absent. While standardized definitions do exist, the very meaning of the concept inevitably seems to create a tension between its two constituent dimensions, that characterized by altruism and mutual benefit; and that characterized by self-interest – enlightened or otherwise. This dichotomy is referred to in the case studies as well, and a spectrum reflecting this academic ambivalence was thus created. Its purpose is to relate later chapters and their description of the various HD-related conducts of South Africa and Norway back to this bi-directional debate.

In the final third of the chapter, following one of the research questions and laying an important foundation for the methodology used in subsequent chapters, a review of HD-related conceptual and typological frameworks was undertaken. This consisted of a selection of those frameworks that were perceived to be most adequate for the purpose of this study, ordered loosely in the categories of the four-part stages heuristic. While reasonably successful in this endeavour, one dimension that the study is interested did not have an adequate framework with which to work with, namely identifying the metrics of implementation or, in a word, the *measurement* of HD. Filling this gap seems to be dependent of a slow process of theory-building, where case studies and different suggestions of broadly applicable approaches must be added to the foundation and assessed.

Nevertheless, the search for applicable and relevant frameworks was not fruitless for the purpose of this study. First, it has become clear that the first foundational step in the analysis is to contextualise the specific contexts of Norway and South Africa which can be said to have led up to their current approach to HD. Second, in analysing the official documents as well as the

behaviour of these countries in relation to HD, the typological framework of Labonte & Gagnon facilitates a categorisation of rationales used for including global health in their foreign policies. Further, Katz et al.'s categories of interaction distinguishes the various channels through which HD is conducted, and assists in making more nuanced observations. In the attempt to answer the research problem and research questions, these form the basis for assessment in regards to HD activity. It is the purpose of the next chapter to introduce the concept of middle power in order to complete this analytical foundation.

Chapter 3: The history and evolution of the concept of middle powers and the work of Eduard Jordaan

While the previous chapter was focused with the definitional aspects as well as the existence of practical frameworks relevant to this study in relation to the concept of HD, this chapter attempts to accomplish the same goal with regards to the concept of *middle power*. Indeed, it is the aim of the chapter to present both the meaning and the relevance of the concept with utmost clarity in order to best answer the problem statement. This is for the purpose of solidifying an idea of what is referred to throughout when the concept is utilized in subsequent chapters. In essence, in addition to understanding the history and characteristics of the concept from various perspectives, the relative context in which this understanding is used in this study specifically is especially emphasized.

In an introductory section, the history of the concept's usage is outlined briefly, before shifting the focus to the origins and rationales that paved the way for its modern usages in academia and otherwise. Next, the chapter examines the different perspectives that have developed in the discourse, exploring and discussing their respective arguments and counter-arguments. The point of this is to introduce the ideas preceding the work of Eduard Jordaan and his delineation of the subtypes of *traditional* versus *emerging* middle powers. In addition to the frameworks on HD outlined in the previous chapter, Jordaan's conceptualisation will serve as a key dimension of the study's analytical framework, and is therefore explored in detail in the latter part of this chapter.

While ostensibly serving the same purpose, namely the exploration and explanation of key concepts, this chapter differs from the previous one in regards to two aspects. First, unlike the one regarding HD, the definitional debate surrounding the concept of middle powers is, for the purpose of this study, anecdotal. As is clear in the first part of the chapter, there is no denying that there are still 'definitional difficulties' and lack of consensus in regards to its meaning. However, this divergence, which has been debated for decades and might in fact be intractable, it is relatively insignificant in terms of practical utilization, and is far from displaying the bi-directional pull of the HD concept. In fact, as this chapter illustrates, views that accommodate a mixture of once discrete interpretations are quite common in the contemporary literature. Furthermore, while the search for analytical frameworks was indeed multi-dimensional, this study is mainly focused on one certain strain of middle power discourse.

Origins and early definitions

In contrast to that of HD, the concept of *middle power* has been part of the vocabulary of the field of IR for decades. One can at least trace it as being in common, if not consensually delineated, use since the late 1940s (Huelsz, 2009). However, types of categorization of defined, individual political entities can be traced back much further than this, even pre-dating the 1648 Peace of Westphalia and its newfound sense of clearly defined sovereignty. It is reasonable to assume that there have existed notions and ideas about which empires, albeit geographically limited, are great and small relative to each other for millennia, particularly among leaders, politicians and philosophers. Carsten Holbraad (1984) dates the use of the middle power term, or what can be seen as its synonyms, to 13th century Christian philosopher Thomas Aquinas. Fast forward about three hundred years, and Italian political philosopher Giovanni Botero, living in the 16th century, is the first source to have identified explicitly a category for the states that are neither great nor small, but somewhere in the middle. In his seminal work *The Reason of State*, he suggests the following classification system: "[…] some dominions are small, others are large, others of a middle size, not absolutely but comparatively, and with respect to their neighbours" (Botero, 1956[1589]:3). This final caveat of relative comparability, while prudent and valid in Botero's 16th century reality, perhaps loses some of its relevance in the globalized 21st century world: a world in which accessibility, in terms of information and mobility among states regardless of neighbourhoods, is more or less complete.

In political science and the field of IR, the middle power classification only gained significant prominence around the middle of the 20th century, as suggested above. Among many others, David & Rousell (1998) and Huelsz (2009) suggest that Canadian policymakers played a significant and pioneering part in introducing the concept both to the vocabulary of politicians and to the discourse of IR. David & Rousell point out that this was a process Canadian reflexivity, instigated in an attempt of placing themselves favourably in what they refer to as "[….] postwar world order" (1998:134) that was in the process of being set up by the victors of the Second World War. Canada, essentially attempting to convince the victors of the war – now the great powers of the UN – that states considered to be of 'medium stature' should have an inherent preference over small ones regarding the privileges of non-permanent membership of the United Nation Security Council (UNSC). Even before the war was over, in 1944, Canadian Prime Minister Mackenzie King already referred to his own country as a middle power (Chapnick,

1999; Fraser, 1966). As for how to actually distinguish the middle powers from the small, Canadian diplomat Lionel Gelber stated that "[w]hat the Middle Power idea does, in brief, is to adopt the conclusions of realism and extend them. Since major Powers are differentiated by their greater functions from the rest, the Middle Powers ask that they be distinguished from the lesser ones by the same criteria" (1946:280-281). In the end, Canada's efforts were to be thwarted by article XXIII in the UN Charter, which explicitly prioritizes the importance of geographical diversity rather than criteria revolving around capabilities when deciding the frequency of admittance to the UNSC's non-permanent seats. Indeed, some observers (see for example Chapnick, 1999; Holmes 1976) have later characterized this construction of the concept as no more than a Canadian foreign policy tool at the time, and constitute the remnants of what was essentially a failed attempt to maximize or inflate their own standing in the system. However, as Holbraad writes in his influential *Middle Powers in International Politics*, "[t]he virtual failure of the attempt to secure special status and lasting advantages for middle powers within the organisation of the United Nations did not put an end to writing about the character and role of such powers" (Holbraad, 1984:68).

As Chapnick suggests, this view developed by the Canadian diplomats based around the notions of function and capability reigned supreme in middle power discourse the better part of two decades. Yet, while these first publications represented a self-asserting view that these Canadian scholars and politicians had of their country's capabilities and role in the international system, this view has since been challenged, and a clear consensus on the definition of what characterizes a middle power is indeed still in want.

Contemporary theoretical disputes

In spite of stark criticism owing to the nature of the origins of this initial approach, it remains one model among several for characterizing and categorizing middle powers. In the literature, there are various names for these perspectives, and an almost countless amount of articles utilizing either one or, more commonly, a mix of two or several, depending on how they are delineated. For the sake of this chapter, one need only look to Eduard Jordaan (2003). In the article which provides the main middle power framework for this study, he describes the discursive situation as one split into three perspectives: the *liberal*, the *realist* and *neo-Gramscian*, all focusing on different explanatory rationales for how and why states qualify for the characterisation of middle power. Jordaan's naming of the different branches corresponds with some of the main branches

in IR theory. However, in the isolated context of middle power, these are given different names by different authors. In the section that follows, the main points of these views will briefly be presented.

The realist/functionalist approach

Chapnick (1999) traces the modern origins of the realist models, or what he calls the *functional* model championed by the Canadian policymakers, back to political theorist and philosopher David Mitrany. According to Chapnick, Mitrany and the ideas posited in his book *The Progress of International Government*, published in 1933, "undoubtedly influenced" (2000:189) the construction of this early conception.

In essence, there is an assumption among the adherents of this approach that only the states that have permanent seats in the UNSC can be considered as great states because they are not only materially powerful but also heavily empowered by international law. Further, it suggests that all other states should have contextual or conditional influence on international matters. That is to say, if a situation arose that was of special relevance or interest to a state; one that a state had the capacity to contribute to; or perhaps one that a state could boast special competence of, then that state should be more involved than others in the decision-making process. As Chapnick puts it, "[…] some of the smaller states deserved greater relative status predetermined by three criteria: relevance, contribution and capacity" (2000:189). In this view, the middle power status of any given state is temporal, based on their functional capabilities to various set of situations and scenarios. By this logic, some states would almost always fulfil these criteria in terms of international matters, as was certainly the case for Canada in the period immediately after the war. However, the question of how one should measure capacity and to what extent they are temporal is a heavily contested issue.

In the book mentioned above, Carsten Holbraad attempts at length to justify types of proposed criteria which contribute to the characterization of what constitutes a middle power. While going through many one-sided suggestions that he deems unrepresentative or arbitrary, including regional status, geographical size and military power such as the capacity to produce nuclear weapons, he concludes that none of these are sufficient. In the end, while conceding that it has significant weaknesses and limitations, Holbraad suggests that economic factors and specifically a state's gross national product (GNP) could work as an adequate primary starting point for

placing members of this intermediary group of states. Secondary indicators, for Holbraad, include military strength in terms of size, expenditure and firing power.

There are several criticisms against made against this approach. First of all is the already mentioned overarching notion that it was initially developed as a foreign policy tool: the meaning of the concept was meant to give legitimacy to an increase in Canadian influence, particularly within the UN. Further, the criteria suggested for assessing who qualifies for a characterization as a middle power has never, even three decades after the publication of Holbraad's book, been consensually agreed upon. Therefore, these criteria cannot said to be truly objective and are consequently ultimately arbitrary. Indeed, as Andew Hurrell writes,

> Many people have tried to construct a theory of middle powers but without conspicuous success. On the one hand, it has proved very hard to decide what the shared attributes of middle powers should be and which states are to be included in the category. On the other, it has proved harder still to associate a set of plausible shared attributes (GNP, military resources etc.) with common patterns of foreign policy behaviour (2000:1).

In terms of corresponding classical IR theories, the focus on material power as the be-all and end-all of measuring the hierarchy of the international system resonates quite clearly with that of the realist tradition. It is therefore little surprise that the major alternative perspective argues for the importance of accounting for agency and the changing power of institutions.

The liberal/behavioural approach

The arbitrariness of the criteria suggested by functionalists became apparent to its critics because as it turned out; having identical criteria rarely correlated with what state actors actually did on the international arena. This problem of seemingly inevitable and inexplicable divergence between the capabilities of states categorized as having similar functional capacities when juxtaposed with the way they actually conducted foreign policy, soon led to another perspective regarding the characterisation of middle powers. The result was the *behavioural* approach to the identification of middle powers, which also has vague roots dating back to at least the 1940s (see for example Claxton, 1944; Glazebrook, 1947). However, it only came into distinction as a serious alternative model in the 1980s, and has since been the preferred one for most scholars on the matter (Chapnick, 1999). An early explicit example is Robert Keohane's 1969 article *Lilleputians' Dilemmas: Small States in International Politics*, a review essay in which he assesses and builds upon the ideas of four works discussing the implications and characteristics of different-sized states. Keohane introduces the core idea of the behavioural approach by stating

"[….] that state behaviour determines the nature of international systems as well as vice versa" (Keohane, 1969:295). Viewed in this way, rather than measuring the stature of states by means of apparently objective criteria, one must also assess their actual behaviour, or agency, as it significantly influences and determines their position in the system. The negation of the validity these objective criteria is, according to Keohane, due to their arbitrariness noted above. With this as a background, Keohane's characterisation is summed up in this way:

> A Great Power is a state whose leaders consider that it can, alone, exercise a large, perhaps decisive, impact on the international system: a secondary power is a state whose leaders consider that alone it can exercise some impact, although never in itself decisive, on that system; a middle power is a state whose leaders consider that it cannot act alone effectively but may be able to have systemic impact in a small group or through an international institution; a small power is a state whose leaders consider that it can never, acting alone or in a small group, make a significant impact on the system (1969:296).

In particular, the tendency of middle power states to engage in multilateral cooperation with others of the same stature in order to achieve common goals that they otherwise would be unable to due to lack of independent influence, is a common denominator in the writings of those who utilize this approach (see also Pratt, 1990; Cooper, Higgott & Nosal, 1993; Belanger & Mace, 1997). Further, Wood (1988) outlines some of the main ways in which this kind of behaviour is done in practice. Namely, that they tend to assume positions as third party mediators, engaging in peacekeeping and other activities which Joseph Nye would later refer to as exercises of *soft power*, a term discussed in the previous chapter as an angle from which to view the conduct of HD. This manner of behaviour is seen as a practical way to seek status and influence in and via multilateral institutions, as these states are in want of any significant independent influence and power. This sentiment is echoed by David & Rousell, as they suggest that middle powers tend to utilize a policy style which "[….] includes the pursuit of policies which seek to promote stability in the international system, a tendency towards specialization, a role centered on meditation, conciliation and coalition-building, and a sustained commitment to multilateral institutions" (1998:135), a policy style referred to in the literature as *internationalism*. The sum of these characteristics has now become what most scholars associate with typical middle power behaviour. As Carl Ungerer argues, this practical majority of use should have put the debate to the side long ago:

> Clearly, when foreign policy practitioners make declaratory statements about exercising a country's "middle power" role in the international system, they are employing a type of shorthand for a pre-defined and

> generally agreed set of foreign policy behaviours. That set of behaviours includes a preference for working through multilateral institutions and processes, a commitment to promoting international legal norms and a pro-active use of diplomatic military and economic measures to achieve selected political outcomes. Despite obvious definitional difficulties with the concept, middle power diplomacy continues to resonate with politicians, practitioners and scholars alike as a simple way of characterising the foreign policy activities of certain countries which are neither great nor small (2007:539-540).

Despite Ungerer's pleas however, this approach is not without its critics. Adam Chapnick in particular, is harsh in his characterisation of its core principles. Referring directly to the work done by one of the main proponents of the behavioural model, Andrew Cooper, he suggests:

> Cooper is only able to be so specific because he defines this statecraft through actions of states that he already considers to be middle powers. He works backwards, examining the international activities of a state such as Canada and then defining middle power behaviour by these same actions. [….] That middle powers are those that practice middle power internationalism, and that middle powers internationalism describes the behaviour of middle powers is a tautology (Chapnick, 1999:76).

This tautological component of the behavioural model is also mentioned by David Black (1997), suggesting that instead of pretending, as behaviouralists tend to do, that there are no measurable criteria which serve as precursors to the category of middle powers, one should rather seek to reach a compromise, allowing for both agency and what Jordaan (2003) refers to as 'constitutive features'.

With an emphasis on the importance and relevance of multilateral institutions, international law and the agency of actors, the behavioural model is clearly linked up with liberalism in terms of IR theory. Additionally, a degree of dynamism and allowance of change in the international system which was primarily caused by its constituent actors is also approaching a constructivist angle.

The neo-Gramscian approach

Following this, David Black is one of the proponents of a third perspective. In 1989, critical theorist Robert Cox published *Middlepowermanship, Japan and the future world order*, in which, building upon the work of the aforementioned Canadian diplomat and academic John Holmes, he takes a politically historical view and identifies the middle power role as present in any point in time throughout human history. According to Cox, based on some historical examples from previous world orders, posits that the middle power both has and will continue to be reproduced indefinitely. The middle power is, as he put it in an oft-cited phrase, "[….] a role in search of an

actor" (Cox 1989, 827). The existence of this category is thus constant, but the question of what specific states are present within it is continuously up for change.

Cox emphasizes that international organization, i.e. the structure and roles of the international system's constituent actors, both in the modern world and historically, is a continuous process rather than an absolute and static situation, and therefore that the middle power is something that constantly has to be rethought and reconfigured as the international system changes. He sums up the main traits of a historical middle power as the following:

> An ability to stand a certain distance from direct involvement in major conflicts, a sufficient degree of autonomy in relation to major powers, a commitment to orderliness and security in interstate relations and to the facilitation of orderly change in the world system are the critical elements for the fulfilment of the middle power role (Cox, 1989:827).

In this view, and moving on to modern and globalized times, the preference of middle powers to conduct an internationalist policy has internal roots as well as system-based, external influences such as hegemonic 'positive inducement' of values (see Ikenberry & Kupchan, 1990). In essence, material capabilities in the form of economic or military strength and the structural factors such as political economy which David Black and Heather Smith refers to as "[…] system-level interests and positioning […] (1993:775-776) are precursors to what Cox refers to as 'middlepowermanship' – that is, having the traits of a middle power. However, true and holistic picture of this status is only found when also examining the individual characteristics of the state in question. As Janis Van der Westhuizen writes, commenting on the work of David Black which in turn builds on of that of Cox**,** "[….] internationalism does not rest only on the values embedded in the political cultures of middle powers, nor exclusively on the stimuli from the state's external environment, but on the interpenetration of these elements" (1998:438). Viewed in this way, the quintessential middle power can be described by its internationalist behaviour, which is set in motion by a concoction of its objectively measurable capabilities, system-level conditions and unique internal matters. The latter variable makes for a somewhat confusing picture.

This sort of approach, like much critical theory, is somewhat protected from criticism, because it is in its very nature to deconstruct scholarly axioms as arbitrary, while not truly taking a clear cut position itself. However, as some recent authors have pointed out (see for example Beeson, 2011; Cooper, 2011), the middle power category is now used so freely and has become so diluted so as

to potentially lose some of its meaning. As Mark Beeson comments on the concept, "[l]ike 'globalisation' it can obscure at much as it reveals" (2011:564). Indeed, different scholars include different states in their lists of middle powers and as household names as Canada, Australia and the Netherlands are common denominators, countries as diverse as Romania, New Zealand, the Philippines and Venezuela have also been given the same characterisation. As no one is truly able to refute these claims of middle power category adherence because contextual conditions are hard to invalidate, the category has become increasingly diffuse.

Eduard Jordaan's emerging and traditional middle powers

Eduard Jordaan is explicitly sympathetic to the neo-Gramscian perspective, and believes in an approach which attempts at balancing agency with constitutive criteria, internal context and system-level variables such as hegemonic influence:

> The position of middle powers in the global political economy, the 'complex of dominant values, social forces and institutions embedded in their own … state-society complexes', as well as state-societal abilities in terms of diplomatic capacity and skills inform the internationalism of middle powers. However, these necessary features do not determine middle power internationalism. One has to allow for a degree of agency, in terms of leadership by specific individuals and the exercise of a choice as to whether to become more involved in a certain foreign policy issue (i.e. niche diplomacy) (2003:173).

At the same time, he concedes that the concept is indeed experiencing a process of dilution. In fact, this concern is the premise behind his article, '*The concept of a middle power in international relations: distinguishing between emerging and traditional middle powers'*. In this work, the delineation of emerging versus traditional middle powers is suggested, primarily, as Jordaan himself argues, "[….] in order to rescue the middle-power concept from increasing vagueness [….] (2003:167).

Common denominators for all middle powers

Jordaan begins this process of delineation with a section which explores the similarities in behaviour between the two, which is the rationale behind their initial characterisation as middle powers. First, middle powers tend to take on the role as international activists, in that they involve themselves in situations such as conflicts which do not, at first glance, immediately concern their own interests. For example, middle powers often serve as conflict managers, using multilateral channels in which they cooperate with other middle powers to reach compromises. This general tendency, or indeed necessity of, conducting multilateral activities is symptomatic of

middle power foreign policy behaviour at large. This is because, as both Jordaan and most behaviouralist scholars argue, middle powers do not have the ability to independently affect, shape or change the world system. So far, this view is on par with orthodox, mainstream behaviouralist thinking on the matter. The neo-Gramscian scope has much to add to this, however. For Jordaan, even if they are striving for increased influence, the very inability of middle powers to "[….] bring about deep global change [….]" (2003:169) makes them uninterested in changing the current world order *too* significantly, lest they risk losing their positions in the global and regional political economies, respectively. On the background of this, the predictability and continuity brought on by international law is conducive to middle power interests.

Relatedly, there is a conception of middle powers as less self-interested than other states. According to Jordaan, however, this is but an illusion; a sentiment he shares with several other scholars (see for example Ungerer, 2007). Jordaan clarifies:

> […] middle-power self-interest can be located at a deeper and more dispersed level; that is, an interest in global stability, controllability and predictability, a conservative strategy that has the effect of perpetuating the *status quo*, entrenching (and exacerbating) existing inequalities in power and wealth to their relative benefit. (2003:167).

The last part of this quote hints to the overarching normative weight in Jordaan's text and neo-Gramscian thinking in general. This is not of any major relevance to this study, as it is simply interested in the framework for analysing the foreign policy behaviour of middle powers in relation to HD. By the *status quo*, Jordaan is referring to the current balance of power in economic and military terms. Because he recognises this inclination to upholding this status quo, "[s]tates that deviate from hegemonic orthodoxy cannot be conceived of as middle powers in the sense that the term is used in this [that is, Jordaan's] article" (2003:167). Therefore, he excludes countries like Mexico and most Middle Eastern countries, as they are unlikely to ever engage in any sort of middle power trademark activity such as internationalism and spreading liberal values.

Introducing the emerging middle power: divergences within a concept

In the passages which delineate the characterisations between emerging and traditional middle powers, respectively, Jordaan divides the explanation into *constitutive* and *behavioural* differences. The former are summed up in table 3.1.

	Traditional middle powers	Emerging middle powers
Geographical position	Largely *Global North*	Largely *Global South*
Consolidation of democratic institutions	Stable, long-standing social democracies. Relatively homogenous populations.	Unconsolidated, young, superimposed and rife with undemocratic elements. Social cleavages, often heterogeneous populations.
Attainment of middle power status	Came to its present prominence *during* the Cold War.	Came to prominence only *after* the Cold War as economic priorities overtook military ones in foreign policy.
Internal wealth distribution	Highly egalitarian, equal distribution of wealth. Some welfare states. Generally very low Gini coefficients.	Severe to extreme unequal distribution of wealth. Generally very high Gini coefficients.
Position in world economy	At the core. Generally high standards of living. High scores in UN's Human Development Index (HDI).	Semi-peripheral. Generally low and unequal standard of living. Medium score in HDI rankings.
Position in geographical region	Relatively more or less equally as powerful as their neighbouring states, often including other middle powers.	Regionally dominant capacity in terms of economic and military power.

Table 3.1: The constitutive differences between traditional and emerging middle powers as defined by Jordaan.

The behavioural differences which separate emerging and traditional middle powers are somewhat more complicated and nuanced, and cannot as easily be summarized in a table. Jordaan emphasizes the hegemonic source of much of the behaviour on par with the above-mentioned 'positive inducement' theory posited by Ikenberry & Kupchan (1990). One telling example of divergence mentioned by Jordaan is the relationship of the respective state types with official development assistance (ODA). While both traditional and emerging middle powers are typically large-scale donors of ODA, the former has a historical and, as of yet, a far more significant role in this sort of activity. Importantly, while the donation of aid can be seen as a result of humanist values characterising the governments and broader domestic culture of many traditional middle powers, particularly by the Scandinavian welfare states; the rationale behind emerging middle powers' ODA contribution is more of, according to Jordaan, an attempt "[….] at raising the international profile of their countries along with seeking domestic legitimisation by gaining international approval for foreign policy initiatives (2003:175)". Prioritising funds for ODA is only one example of this kind of comportment, which seemingly goes outside the immediate interest of the middle power state. Other examples include promotion of the spread of democracy, notwithstanding their own democratic incapabilities and challenges mentioned in the constitutive outline. Further, emerging middle powers tend to have strong symbolic leaders who personify

such foreign policy behaviour, albeit with varied success; Nelson Mandela being a clear exemplar. Naturally, HD-related activity fits into this kind of behavioural category, and the differences in intention found by Jordaan in the context of ODA might hint at a similar difference in regards to HD. An additional aspect of interest in this regard is the potential divergence between official rationale and intentions versus actual ones, perhaps particularly in regards to the emerging middle powers.

Further, the constitutive difference of belonging to the semi-peripheral outskirts of the global economy inevitably shapes the behaviour of the typical emerging middle power. They actively aim to change their position, intending in the long-term to reform the global economic structure to an extent, moving themselves closer to the economic core in the process – or indeed creating a new such core in which they themselves are at the helm. Not surprisingly, this is done by way of multilateral institutions, in which emerging middle powers often take initiative and assume leadership roles. South Korea in ASEAN; South Africa in NEPAD and Brazil in MERCOSUR are clear examples of this. Additionally, they are often interested in promoting the importance of South-South cooperation and trade, subsequently taking leading positions in organizations which promote this, such as the Non-Aligned Movement. Traditional middle powers, on the other hand, are far more ambivalent in regards to regional cooperation, as becomes clear when considering the mixed relationship some of the mentioned members of this group have with the European Union (EU), among politicians and citizens alike. The traditional middle powers' long-standing position at the core of the global economy make them far less interested in any sort of reform, as this would threaten their current position. Indeed, they are more concerned with perpetuating the world order to which they owe their place.

One last focus area of Jordaan is the perception of middle powers as being neutral conflict negotiators and peace brokers, which in turn enables them to assume the position of mediator in certain situations, fuelling their soft power capabilities. First, addressing the question of the origin of this perception regarding traditional middle powers, he points to their aforementioned regional ambivalence as well as regional insignificance. The niche diplomacy-approach adopted by many of these countries is what gives them their international identity in lieu of boasting general power, making them appear benevolent instead of imposing and threatening. As Yolanda Kemp Spies suggests: "For these states, diplomacy offers the most viable foreign policy instrument: in the absence of economic might and other capabilities that could be used as carrots

and sticks, they have to rely disproportionately on diplomacy to impact international politics" (Spies, 2010:75). As for emerging middle powers, it is their regional strength and leadership and subsequent independence from any hegemon; coupled with an interest in regional stability which lends to this perception among its neighbours. Externally, this perception is fuelled by the regional powers' representation of these very same neighbours, formalized in regional leadership roles.

Criticisms of Jordaan's view

While the 2003 article by Eduard Jordaan has been received generally positively as well as widely used since its publication, it is nevertheless not without its critics. Malamud (2011) disagrees with Jordaan's exclusion of states such as Iran and Mexico in his categorization simply because they are not hegemonically conformist, and for omitting further explanation as to what category they actually do adhere to. Cornelia Huelsz (2009) is categorically opposed to the placing of emerging powers in with the middle power concept at large, emphasizing that the genesis of this latter concept was in a very specific, Western context. According to Huelsz, part and parcel with this context are problematic assumptions in terms of "[….] the structural positions these states have in the international political economy and the type of behaviour they exhibit, assumptions which [….] are not transferable and therefore become problematic once applied to emerging powers (2009:15). However, the neo-Gramscian scope that Jordaan is a proponent of is explicitly critical towards the assumptions of traditional approaches. Regardless, and as argued in the introduction, this study is not interested in a framework that is necessarily flawless. In fact, such a framework might not even exist for any IR subject, let alone for the somewhat contested concept of middle powers. What Jordaan contributes is an interesting and reasonably clear way to separate two different types of states who have many common denominators but also very divergent histories and contextual characteristics, which is helpful in exploring how these factors play into decision-making and foreign policy development and implementation.

Conclusion

Middle powers are states which are neither great nor small; they are at a point which is in more or less equal distance between two extremes. But this is not a reference to geographical size. Nor simply to material capabilities such as a middle-sized military force or a middle-sized economy, but it also refers to a set of behaviours. These include a preference and subsequent expertise in

diplomacy and multilateral cooperation and the exercise of soft power, put into practice in order to make up for insufficiencies in terms of hard power. Traditionally, these activities have included mediation in conflict situations and substantial ODA contribution, and more recently an interested in the in-vogue field of HD.

While the middle power concept is still strictly speaking contested, debated amongst proponents of different schools of thought who, much like participants in a political debate, are not as much open for new input as they are interested in invalidating opposing views, this discursive debate is practically insignificant for the purpose of this study. In this way, the debate stands in contrast with that of HD, and a neutral definition allowing for a combination of several views is not only possible, but perhaps even optimal in the case of the concept of middle powers. As Jordaan explicitly utilizes an approach which uses tools from various perspectives, allowing for both material and behavioural factors; his middle power framework is well-rounded and well argued for; though not impervious to criticism, as has been briefly illustrated above. While the explicit neo-Gramscian normative sentiments go beyond the scope of this study, the inclusion of factors such as hegemonic influence and interests in world order perpetuation or reform is highly valuable in order to approach a complete and holistic understanding of the middle power concept and its more nuanced subdivision of traditional and emerging species.

The details of this division are outlined above in table 3.1 as well as in the section following it, and can be summarized in a few brief sentences. First, traditional middle powers are situated in the Global North, gained their current systemic position during the Cold War, and can boast of long-standing, stable democracies; are highly egalitarian and high in wealth equality. They stand at the core of the global economy, and forerunners in human development, while remaining relatively anonymous in their regional climate. On the other hand, emerging middle powers have only recently gained their position, allowed, among other things, by the changing global dynamics following the end of the Cold War. From their position in the Global South and semi-periphery of the world economy, they are largely fledgling or pseudo-democracies which tend to be highly unequal. Regionally, they tend to be significantly more powerful than their neighbours in terms of capabilities.

All of these constitutive factors are followed by several divergences in behaviour between the two. Most importantly is the overarching notion that while the traditional middle powers are quite happy with the current world order to which they owe their position and are thus primarily

interested in perpetuating it, the emerging middle powers are far more interested in bringing themselves closer to the core of the global economy and gaining influence in international matters.

In essence, this is what informs the understanding of the specific state type of middle power and its ensuing subtypes that is used for the remainder of the study and in the endeavour of answering the problem statement. The characteristics listed for the respective types constitute the framework for middle powers which, in harmony with the frameworks posited in the previous chapter for HD, is the foundation for the analysis of the official statements, grey literature and other country-specific documents which will be presented in the next chapter.

Chapter 4: Assessing South Africa's health diplomacy as an exemplar of an *emerging* middle power

The purpose of this chapter is to present the empirical basis for one on of the case studies used in the analysis concerned with the main research question, namely assessing the similarities and differences in HD conduct between emerging and traditional middle powers, respectively. The chapter is the first of the case studies of countries representing these middle power categories, and focuses on South African HD conduct as it serves as an exemplar country within the group of emerging middle powers.

The presentation of South Africa's HD policies is based upon texts ranging from official documents, also known as grey literature; academic articles, as well as reports published by various research organisations – all viewed through the lenses of the different conceptual and typological frameworks presented in Chapter 2. The order in which these are assessed is loosely based on the *stages heuristic* which was also introduced in Chapter 2. Thus, the chapter begins by focusing on the *agenda-setting* stage. This involves the historical political trajectories which prelude the contemporary HD policies of the country, including past involvement in such activities. The contemporary policies are subsequently presented in the next section. This is done first by focusing on the aspect of formulation, which is to say the official rationale for HD conduct given by the state in question. Secondly, there is a focus on the different dimensions of the practical sides of HD, by focusing on what was defined in Chapter 2 as the *implementation* stage. Finally, a summary and short analysis of all of these dimensions is given, before viewing this in the emerging middle power framework based on Eduard Jordaan's (2003) work as described in the previous chapter.

Agenda-setting: The evolution of post-apartheid South African foreign policy and the place of global health

"Human rights will be the light that guides our foreign affairs" (Mandela, 1993:88)

Ambitious beginnings

In the 1993 November/December edition of *Foreign Affairs*, Nelson Mandela famously published an article in which he outlined how the foreign policy of the new, post-apartheid South Africa would take shape under the rule of his party, the African National Congress (ANC). The contents

of Mandela‘s article aimed to reintegrate the country into the international arena with a proverbial clean slate. In the preceding decades, South Africa had been somewhat in the periphery, and the last years of apartheid had seen the country all but frozen out of the international community in all but complete isolation, having earned the dubious status of an archetypal *pariah state*. In terms of policy-making this re-integration entailed, quite explicitly, simultaneously to meet external expectations in order to “[….] take South Africa into the new world order as a responsible global citizen” (Mandela, 1993:87) and to accommodate its highly diverse domestic citizenship. After a series of multiparty negotiations, six pillars were defined upon which the new foreign policy of South Africa would stand. These pillars would quite explicitly stand in stark contrast to apartheid-ruled South African foreign policy, and aimed to meet the demands of a rapidly changing world.

The first two pillars highlight (1) the significance and primacy of human rights and (2) an unwavering belief in worldwide democracy and that the new South Africa‘s foreign policy decisions should always strive for the fulfilment and protraction of these values. Further, interactions with other nations should (3) be guided by a respect for international law and what is referred to as ‘justice‘. (4) Non-violent solutions such as for example arms-control regimes should be the primary method by which nations seek peace, which is considered to be a universal goal. The following pillar focuses on (5) a sort of partiality towards other African states and that their interests should be considered before others. Finally, Mandela submits that (6) the realization that economic development is best cultivated by regional and international cooperation in an increasingly interdependent reality will be essential – hinting, in a word, of an *internationalist* ideology. This last point especially illustrates the turn that many ANC members had taken towards the left on the political spectrum after many years of exile in which they were influenced by their Soviet supporters, even if they already were leisurely beginning to creep towards the right (see for example Peet, 2002).

Throughout the article, special weight is given to the first pillar and the importance of the notion of human rights as an overarching theme is stated repeatedly. For example, Mandela writes that that “South Africa’s future foreign relations will be based on our belief that human rights should be the core concern of international relations, and we are ready to play a role in fostering peace and prosperity in the world we share with the community of nations” (1993:97).

What was meant by human rights in this context can be inferred from South Africa's definition of the concept as it is stated in in the Bill of Rights of the 1996 Constitution of the Republic of South Africa, in which the rights protected by the Constitution and the South African Human Rights Commission are listed. While health, as shown in Chapter 2, is not so easily defined and can include several indirect factors such as for example dignity or other socially contextual indicators, an *explicit* mention of health is found under paragraph 27 in the bill of rights in Chapter 2 of the constitution, specifically 27 (1a), which states that "[e]veryone has the right to have access to health care services, including reproductive health care" (Bill of Rights of the Constitution of South Africa, 1996). Another one is found in paragraph 24 (a), stating that "[e]veryone has the right to an environment that is not harmful to health or well-being. Additionally, paragraph 11 states that "everyone has the right to life". The latter of these is also included in the 'table of non-derogable rights'.

The first few years of the post-apartheid era saw a massive escalation in the involvement of South Africa in the international arena (Barber, 2005). The country joined and re-joined from previous exclusion around 45 international organizations, and hosted several conventions and meetings as a part of this process of re-initiation. It immediately became apparent that South Africa was aiming towards a prominent role in the international community, and towards a role of a regional and continental leader that was to be a spokesperson for Southern Africa and Africa in general. However, the 90s were not without challenges in terms of South African foreign policy. In what can be described as an early example of how prioritizing moral considerations collided with what perhaps would be prudent in terms of *realpolitik*, a 1995 diplomatic clash with Nigeria showed signs of the utopian nature of the human rights-based policies. In short, Mandela spoke out against the behaviour of Nigeria's then-military regime for ordering the execution of nine civil rights activists (Evans, 1996). South Africa's official position was one of condemnation and of appeal to the West for sanctions by among other things boycotting Nigerian oil. This stance ended up backfiring, as Nigeria and particularly its neighbouring states condemned South Africa for not supporting its fellow African nations, even going as far as calling it "[….] a white state with a black head"(quoted in Barber, 2005:1084). Furthermore, no one answered the call for sanctions.

This incident, along with a few others made first few years of the new South Africa into one that can be characterized as underwhelming in terms of its international relations. This ultimately led

to adjustments of prioritization regarding some of the main tenets of South African foreign policy. As one observer suggests, this was simply because realistically, they could not continue with their idealistic visions of championing human rights while simultaneously having an ambition of regional leadership:

> […] it soon became clear that South Africa‘s ability to punch above its weight in international arenas could not rely solely on the ethical credentials of its democratic transition. As the post-Apartheid exuberance settled, South Africa‘s international stature became increasingly dependent on its ability to claim the status as a dominant power in sub-Saharan Africa and speak on behalf of its African peers. But Mandela‘s bilateral and outspoken human rights approach had little traction in African politics (Hammerstad, 2012:8).

Particularly interesting is an amendment to the idea of human rights, published by the ANC in a paper from 1997. As Barber writes, “The ANC authors noted that there was no single definition of ‘human rights‘: the meaning of the phrase depended on culture, creed and conviction” (Barber, 2005: 1087). For Eduard Jordaan, in his scathing article *Fall from Grace: South Africa and the Changing International Order* (2010), this was an early sign of the beginning of a downward spiral: “Following the Nigeria episode, human rights began to occupy a lesser importance in South African foreign policy. However, what was unexpected was that South Africa would quickly move from being a defender of human rights to a defender of human rights abusers” (Jordaan, 2010:86).

After Mandela: A further shift in priorities

From mid-1999 and for over nine consecutive years, Thabo Mbeki served as the 2nd President of the new South Africa. Significantly, the change of president brought a shift from the focus on one founding principle to another, which mainly entailed moving the main emphasis of South African foreign policy from that of human rights to that of ensuring the interests of Africa as a continent with an aim to gain legitimacy as a regional leader. In short, Mbeki was active both bilaterally, for example in repairing the country‘s relationship with Nigeria; and multilaterally, being very active in helping to facilitate the African Union (AU) as well as being a leading figure in establishing the New Economic Partnership for Africa‘s Development (NEPAD). This led to a South African foreign policy that Anne Hammerstad has characterized as “a ‘discourse in African solidarity‘” (2012:7).

During the first years of his tenure, there are two notable instances in which Mbeki‘s official stances was viewed as controversial both domestically and by the international community. First,

his perennial support of Zimbabwe's controversial *de facto* dictator Robert Mugabe shows clearly the pre-eminence of the pillar of supporting African peers over that of human rights. Second, he has been somewhat comically remembered for uttering distrust against accepting Western notions of medicine, particularly concerning the issue of HIV/AIDS, suggesting that traditional medicine such as beetroot and garlic should also be taken into consideration – a statement for which he was heavily criticised, particularly considering the major HIV/AIDS epidemic in South Africa.

As for example Bischoff (2009) suggests, the process of re-framing South African foreign policy in the Mbeki period came partly as a result of the increasing power of the executive branch of the ANC, and the intention to gain local support through a pan-African rhetoric in order to gain recognition as a regional leader. Inevitably, this meant giving up some of its idealistic principles. Indeed, Bischoff writes:

> This [strategy] implied finding the greatest followership around very broad issues – such as the restructuring of international financial institutions to allow for more representativeness – regardless of the political coleour of the governments in question. In what was now a self-chosen paradigm, ethical foreign policy principles to do with justice, human rights, solidarity or democratic legitimacy in guiding foreign policy conduct, were used more selectively (Bischoff, 2009: 97).

From 2007 through 2008, South Africa served its first tenure as a non-permanent member of the UNSC. In short, by displaying a certain voting pattern and questionable rationales regarding a few major controversial topics, specifically including Myanmar, Zimbabwe and Sudan, South Africa was heavily criticised globally for having departed from its rights-based foreign policy principles. Instead, they had chosen a counter-hegemonic angle, prioritizing decisions more in line with Mbeki's insistence on the pan-African agenda, as well as following suit with newfound partners China and Russia, even if these were clearly not conducive to upholding human rights. It is notable that in this same year, South Africa signed the Oslo Ministerial Declaration, pledging to prioritize global health in their foreign policies.

In May of 2009, following a 6-month brief intermediary tenure under Kgalema Motlanthe, the presidency was handed over to Jacob Zuma, the new leader of the ANC. In many ways, Zuma is seen as a controversial figure, and one who is routinely accused of various kinds of mismanagement and often ridiculed for his bizarre statements and behaviour. Yet he is the apparently unquestioned leader of the dominant party in South Africa.

Regardless, Zuma did have a clear cut basis for his planned foreign policy following his election. From his first state of the nation address, it was plain to see that the main tenets of this were to ensure growth and development of the country. This was thought to be conducive to the state's national interest, and effectively made the link between foreign policy issues and domestic policies explicit (Landsberg, 2010). In general, however, it was quite clear that no significant shifts would be made: "[…] foreign policy will not change. There will be continuity" (Zuma quoted in Olivier, 2012:180).

In 2009, the Department of International Relations and Cooperation (DIRCO), formerly known as the Department of Foreign Affairs, published its first strategic plan under this new name and the first under Zuma. The five key points outlined in this publication are (1) Consolidation of the African Agenda, (2) Strengthening South-South Cooperation, (3) Strengthening North-South Cooperation, (4) Participation in the Global System of Governance and (5) Strengthening Political and Economic Relations (DIRCO, 2009). The lack of mention of ensuring human rights and facilitating the spread of democracy is immediately noticeable, and follows Mbeki's departure from prioritizing these particular pillars.

Zuma would get to prove his intentions in a major context very soon, as South Africa once again was given a non-permanent seat in the UNSC in the period from 2011 through 2012. Even if South Africa made important progress regarding strengthening cooperative relationship between the UN and the AU, this tenure is best remembered by the country's position regarding the 2011 intervention in Libya, in which they voted in the affirmative, only to later change their opinion. South Africa's reputation was further marred by this incident, and earned their foreign policy a label of inconsistency and lacking in integrity.

Past examples of South African activity in health diplomacy

Thabo Mbeki's above-mentioned controversial stance on the HIV/AIDS matter arguably weakened his country's standing as a leading global health actor at the time. However, South Africa also has some history of commendable behaviour in terms of using diplomatic channels to influence decisions that have been able to salvage some of that reputation. Perhaps most significantly, South Africa, along with its trilateral partners of IBSA (India and Brazil), was heavily involved in the negotiations which concluded in 2003, implementing Paragraph 6 of the Doha Declaration in to the TRIPS Agreement (Yu, 2008). In short, this implementation secured

easier access to medicines for less developed and developing countries in an example of health-concerns trumping immediate economic interests.

In another example of promoting global health concerns, South Africa, along with its compatriots in the FPGHI, were the proponents of drafting a UN resolution which would make the place of health in foreign policy explicitly supported and recommended by the UN to its member states. In December of 2009, Ambassador Baso Sangqu, the permanent representative of South Africa to the UN, gave a speech to the General Assembly in which he introduced a draft resolution on the matter. In it, he stated that "[h]ealth has found its place on the foreign policy agenda, not as an occasional, sector specific item, but as one of the pressing foreign policy issues of our time, calling for ongoing attention and action", thus repeating much of the rhetoric found in the Oslo Ministerial Declaration. He also expressed the importance and advantages of the explicit inclusion of global health in the foreign policies of UN members:

> Foreign policy should support approaches to enhance access to medicines and production capacity for essential products and technologies, including better distribution of manufacturing capacity across regions and in developing countries. Furthermore foreign policy should also support the efforts to strengthen risk assessment and risk response of member states, especially developing countries, in the global pandemic influenza preparedness.

This long process, which included many intermediary draft resolutions, culminated in the December 2012 resolution A/67/L.36. A congratulatory statement from the WHO in the aftermath of this stated that "[i]t [the resolution] recognizes the role of health in achieving international development goals and calls for countries, civil society and international organizations to include universal health coverage in the international development agenda" (WHO, 2012).

Formulation: Current rationales for the inclusion of global health in South African foreign policy

Regardless of mixed opinions on performance and reputation on the international arena as well as domestically, Zuma and the ANC were unsurprisingly once again victorious in the 2014 election. Under the current ANC government, there are two official documents that lay the basis for all foreign policy conduct. Primarily, DIRCO's newest strategic plan, covering the period 2013-2018 outlines the major 'visions', 'missions' and 'values' on which this conduct is to be based. Secondly, a 2011 White Paper published by DIRCO named *Building a Better World: The*

Diplomacy of Ubuntu explains the key rationales behind South Africa's contemporary foreign policy and diplomacy. Perhaps somewhat surprisingly, the word *health* does not appear at all in the 40-page strategic plan. Likewise, in neither of them are terms such as *global health*, the Oslo Ministerial Declaration and the FPGHI to be found – nor is any explicit mention of HD.

The few independent reports and academic articles discussing South Africa's foreign policy in relation to global health credit the absence of such explicit reference to the fact that the country is dealing with major health issues within its own borders, not to mention other socio-economic issues. As Jennifer Cooke writes:

> To date, there has primarily been an inward focus in the leadership's health strategy as the government seeks to grapple with an overburdened health system and at the same time with a massively deficient educational system and growing social unease driven by high levels of unemployment and income disparities. This may change over time, but Zuma appears to lack Mbeki's ambition to position himself as a pan-African leader and interlocutor on big continental issues of development, security, governance – or health (Cooke, 2011:41).

In fact, South Africa is the only BRICS country, and the only member of the emerging middle power category, in which communicable diseases accounts for more deaths per year than non-communicable diseases (Tytel et al., 2012), perhaps surprisingly far surpassing for example Nigeria this respect. With up to a quarter of the adult population suffering from HIV/AIDS, and with subsequent opportunistic respiratory diseases such as Tuberculosis creating the bulk of the problem which siphons both lives and funds from the country, South Africa continues to be more a receiver of foreign aid and particularly in relation to health – a point DIRCO is less than eager to discuss in their official documents. Indeed, the Zuma administration's international concerns have been much more focused on trade and business and securing partners in these areas both within and outside of the continent (Cooke, 2011).

Accordingly, there is no straightforward way in which an official, explicit rationale behind engaging in global health matters can be drawn from these key documents, making South Africa's stance challenging to view in terms of the framework based on the work of Labonte & Gagnon (2010). This is a point which is somewhat surprising considering South Africa's status as a signatory to the Oslo Ministerial Declaration and even more so considering its vigorous efforts in passing the above-mentioned resolution A/67/L.36. Conversely, it may not be that surprising when bearing in mind that 'inconsistent' is an adjective that has been used to describe South

African foreign policy in the recent past. A closer look at these documents can provide some rationale, albeit indirectly.

In lieu of any explicit mentions of global health, what remain are indirect inferences that can be made from references to human rights and development, of which there are several. In both the abovementioned documents published by DIRCO, South Africa's commitment to human rights in repeatedly stated. Specifically, in the strategic plan, the mention of human rights is consistently followed by the mention of 'global mechanisms', bilateral cooperation as well as multilateral institutions and engagements. Under the subheading of *International Cooperation*, one section of the strategic plan expresses the desire to "[p]articipate in international organisations and institutions in line with South Africa's national values and foreign policy objectives" (DIRCO, 2013:20). By keeping this statement rather vague, DIRCO is able to give a nod of allegiance both towards UN-based organizations such as the WHO, but also to the BRICS and IBSA associations.

Additionally, the explicit main goal of the 2013-2018 strategic plan is "[t]o create a better South Africa and contribute to a better and safer Africa in a better world" (2013:13). In more detail, a three-part 'goal statement' closely describing the main ways in which this will be done is added. These are stated as follows:

> (1) Protect, promote and consolidate South Africa's national interests and constitutionally entrenched values through targeted bilateral and multilateral engagements (2) Contribute to continental and global development, security and human rights for all through identified processes, mediation, peace support, post-conflict reconstruction efforts of multilateral institutions, structured bilateral mechanisms and multilateral engagements (3) Promote multilateralism to secure an equitable rules-based global system of governance responsive to the needs of Africa and developing countries (2013:13).

The content of this statement runs the gamut of motivations for conducting a foreign policy. While the first sentence explicitly declares a sense of self-interest, the mention of 'constitutionally entrenched values' is up for interpretation, as the ANC's original six pillars have seen a range of different orders of prioritization. Additionally, some of them seem to be mutually exclusive in some contexts, as for example the above-mentioned Nigeria and Zimbabwe cases are testament to. The third part is yet again a broad statement that lends support both to the UN and its sub-organizations as well as the BRICS association.

Rhetoric of development and the vision of SADPA

Another indirect insight into South Africa's stance on HD is through its development policies. Both DIRCO's strategic plan and the White Paper are heavily laden with references to development both domestically and internationally, particularly within the context of Africa. As South Africa is an explicit supporter of the MDGs, several of which are directly health-related, development policy and global health policy in many ways go hand in hand. In the White Paper, while attempting to explain the overarching philosophy of *Ubuntu*, it is stated that "[….] it is in *our national interest* to promote and support the positive development of others. Similarly, national security would therefore depend on the centrality of human security as a universal goal, based on the principle of Batho Pele (putting people first)" (DIRCO, 2011:4, author's emphasis).

DIRCO submitted the Business Case for the establishment of the South African Development Partnership Agency (SADPA) to the Department of Public Service and Administration in April 2012, a move which Helen Yanacopolus has called "[….] a key marker of a middle power" (2014, 203). In short, the rationale behind the establishment of SADPA is to coordinate the many development programs South Africa is involved with. Additionally it can be seen, according to an extensive report written by the South African Institute of International Affairs (SAIIA), as a response to the growing trend in trilateral cooperation. Mainly, SADPA is envisioned" [….] to promote synergy, harmonisation and coherence among the different spheres, components and arms of the South African government undertaking development co-operation" (SAIIA, 2013:42).

What is meant by development cooperation can be interpreted in several ways, but in terms of foreign policy it serves a double function, to an extent matching the previously discussed two sides of HD, ultimately serving the purpose of enlightened self-interest. As the author of the SAIIA report puts it:

> A number of recent statements by DIRCO high-level officials have confirmed that development co-operation will be primarily used as a vehicle to promote South Africa's foreign policy and its strategic international diplomacy, while also addressing poverty and marginalisation in Africa and in the global South (2013:46).

The type of statements the report is referring to includes a speech by the Deputy Minister of DIRCO, Marius Fransman, in the context of a budget vote in May of 2013, in which he suggested that diplomatic tools of all kind should be used to further their position of global influence. For

the authors of the SAIIA report, the White Paper is, though permeated with the rhetoric of *Ubuntu*, revealing of two underlying self-interested priorities. First is the sense that the ultimate goal seems to be to ensure relationships with partners both on the continent and internationally in order to grow in influence and power. Second, and specifically for the region of Southern Africa, is a concern of a potential mass-influx of refugees from neighbouring countries in the case of potential health emergencies, as the country is already struggling with immigration in a number of ways.

Reviewing the rhetoric within the official key documents, the conclusion is that the South African foreign policy in relation to global health can be said to be implicitly embedded in its stance regarding human rights and development, both of which they claim to be arbiters and distributors. As for the former, there are explicit mentions of the entitlement of human rights for all, several of which are directly or indirectly connected with health as made explicit both in the South African constitution and in the Universal Declaration of Human Rights, earning the South African rationale a tentative place in the *human rights* frame of the formulation-framework based on Labonte & Gagnon 2010. Secondly, the heavy emphasis on development particularly concerning the immediate region of Southern Africa, involves, among other things, significant focus on building health systems and reducing the spread of both communicable and non-communicable diseases, a rationale placed more towards the *security* frame. However, the glaring lack of the language and rhetoric of the Oslo Ministerial Declaration is notable and gives the impression of a lack of following through on the MOU on the part of South Africa.

Implementation: Contemporary South African conduct in health diplomacy

As noted above, a large part of what characterises HD is the plurality of different actors engaged in it. This study considers two of Katz et al.'s (20111), 'spheres of communication' which include state actors: *core health diplomacy,* in which only state actors are involved in various ways; and *multistakeholder health diplomacy*, in which NGOs and other non-state actors interact and cooperate with state actors.

South Africa's core health diplomacy - bilateral

In spite of limited focus on global health in foreign policy at large, South Africa is involved in some bilateral relationships of cooperation that include the exchange of health services. According to the WHO's *South Africa Country Cooperation Strategy 2008-2013* as well as *2013-2014* publications, the country was involved in several such partnerships. Mainly, this is limited

to being on the receiving end of funds/aid amounting to almost ZAR8 billion per year, the bulk of which is funnelled straight into the department of health. The United States is the largest donor by far, from which the vast majority of funds is used specifically towards AIDS-related efforts through PEPFAR – making South Africa one of Washington's biggest strategic partners, or targets, in conducting their own HD and developing their soft power reputation through former president George W. Bush's pet organization.

One other notable bilateral relationship is the one with Cuba. The Caribbean island state is well known for providing health staff to other states in exchange for various goods and services. Perhaps most famous in this regard is its relationship with Venezuela, in which much needed oil is shipped to Cuba in exchange for not only health care workers, but also training of Venezuelan medical personnel. While South Africa's relationship with Cuba exists on a much smaller scale and is much less controversial, Cuba provides both Cuban medical staff as well as training for South African medical students. As one aspect of the domestic health problems in South Africa is the lack of competent medical personnel, this is a beneficial deal for the South African health sector, and one that the ANC seems interested in maintaining. South Africa is additionally an importer of Cuban-produced pharmaceuticals, an area of import which is extremely important to uphold the country's domestic health care system because of its current inability to sufficiently self-produce medicines.

While it is difficult to trace and locate exactly what South Africa is offering in direct return specifically for the medical services provided by Cuba, the bilateral relationship between the two states, while amiable since the beginning of the end of apartheid is one that has evolved into a mutually beneficial partnership over the past few years. According to a report published by the South African Foreign Policy Initiative (SAFPI), the South African government recently cancelled ZAR1 billion worth of Cuban debt, something which can be said to have "[….] paved the way for enhanced trade and commercial relations" (SAFPI, 2013). Additionally, South Africa's official position on the United States' 50 year embargo on Cuba has is doubtlessly one that sympathises with the views of the island state. Recently, this manifested in an open letter from the ANC's Secretary-General Gwede Mantashe to the Cuban government, in which he strongly expressed solidarity with Cuba and suggested that it is high time that the American blockade should be lifted.

South Africa's core health diplomacy – the WHO

South Africa is a member of numerous multilateral cooperative associations and organizations which both affect and are affected by the country's foreign policy. In fact, official documents published by DIRCO repeatedly state its allegiance to multilateral institutions, particularly in terms of global governance issues. These range from regional organizations such as NEPAD and the Southern African Development Community (SADC), to international associations such as the G-20, IBSA and BRICS and global institutions such as the UN and its sub-organizations, in this context particularly the WHO.

South Africa is both unilaterally and through statements issued by the BRICS association, highly supportive of the legitimacy and efforts of the WHO. In turn, the WHO's publications tend to be favourable towards South Africa's position as a global health actor. According to reports by the organization, South Africa is represented in many important sub-committees and panels of the organization:

> Participation from South Africa spans all categories of WHO work, including HIV/AIDs, vaccines, TB, malaria, vector control, environmental health, urban health, universal coverage, poison centers, financing, essential medicines, public health and intellectual property rights, noncommunicable disease conditions and risk factors, research, public health emergencies, international health regulations, and maternal and child health, among others (WHO, 2014:26).

Additionally, South Africa currently has a position in the WHO Executive Board, represented by the Director-General of Health, Precious Matsoso. South Africa is also a major hub for the WHOs various projects in Africa and particularly Southern Africa. In fact, South Africa houses 13 of the 26 WHO Collaborating Centers (WHO-CCs) on the continent, and contributes with research in a plethora of areas related to the betterment of health. Some national research centres such as the National Health Laboratory Service and the National Institute of Communicable Disease provide what the WHO refers to as 'crucial' assistance in several areas of research and response to regional disease burdens.

South Africa's multistakeholder health diplomacy – BRICS

Also in tune with South Africa's consistent preference for acting multilaterally in true middle power fashion is its relationship with the BRICS association, which heavily influences most if not all aspects of South African foreign policy, and which has recently developed a global health agenda.

The health ministers of the BRICS constituent states met both in Beijing in 2011 and in Cape Town in 2013, respectively, in order to discuss the association's official stance on global health. The former meeting concluded with the publication of what was called the Beijing Declaration, in which they outline the importance of states actively emphasising health issues in their agendas: " Public health is an essential element for social and economic development and should be reflected accordingly in national and international policies" (BRICS, 2011, point 2). Further, they recognize the increasing complexity following the surge of new actors in the arena of global health, but maintains that the WHO is, and should be, playing the lead role in global health efforts, even if it should be reformed to better accommodate Global South actors. Furthermore, they acknowledge the common health threats faced in all of the countries in the association, and that they will aim to cooperate and coordinate in the effort to contain and prevent diseases, both communicable and non-communicable.

In both these publications, they also emphasise "[….] the importance and need of technology transfer as a means to empower developing countries" (BRICS, 2011, point 16). In this context, they underlined the importance of ensuring access to affordable, quality, efficacious and safe medical products, including generic medicines, biological products, and diagnostics for the realization of the right to health". They furthermore refer repeatedly to the MDGs and the post-2015 development agenda, and specifically the importance of the health-related challenges.

Statements from these meetings also reiterated support to another set of WHA resolutions, such as one concerning non-communicable diseases, the aforementioned FCTC, the Comprehensive Mental Health Action Plan, the International Health Regulations, the WHO Consultative Working Group on Research and Development, the resolution on universal health coverage, and the health MDGs.

However, as Ilona Kickbusch writes, in spite of common goals, "[….] each BRICS country has its own foreign policy goals and astutely uses health as a 'soft power' strategy" (Kickbusch, 2014:463). Brazil in particular has built up a strong reputation based on soft power. For Kickbusch, an important factor in BRICS' engagement in global health is that they would rather be seen as partners than donors. This is because all of the BRICS countries aim to generate close relationships with the developing world at large in cooperative efforts that is explicitly mutually beneficial.

South Africa's multistakeholder health diplomacy – NGOs

As described, South Africa is a recipient of substantial amounts of aid from both bilaterally from states and from multilateral institutions because of its massive health problems. It is therefore unsurprising that NGOs large and small are also welcomed as donors with open arms, particularly as they grow in significance and influence. For example, the Global Fund to Fight Aids, Tuberculosis Malaria (The Global Fund) is currently the 7th largest donor of funds to South Africa annually. Other large donors include Roll Back Malaria, the Stop TB Partnership and the Bill and Melinda Gates Foundation. In order to keep receiving these funds on a regular basis, the government is generally required to follow recommendations and guidelines provided by the organizations themselves, thus affecting domestic health policies.

For example, The Global Fund has up until the time of writing donated $743 million to South Africa since the start of its relationship to the country in 2004. As a rule, it employs a rating system in which it assesses the performance of its recipient countries, measuring perceived success against pre-determined expectations made up of specific indicators. According to the statistics provided by the organization's online South Africa 'portfolio', this amounts to 14 different grants with adjoining projects in which performances generally meet the set expectations. The Global Fund's methods of work include what they have termed Country Coordinating Mechanisms, which entail recruiting local representatives, of both public and private sectors and of various backgrounds who nominate and subsequently oversee the prime recipients of grants.

Implementation summary

Largely, South Africa's conduct in HD is informed by its somewhat dire domestic health situation. Bilaterally, this means accepting the offers of funds, medicines and personnel as well as going into trade agreements in which various health-related goods or services are imported. This may or may not have an impact on various relations, as South Africa shows no reservation in sympathising with the Cubans despite the crucial funds donated by the United States each year.

Within the context of the WHO, South Africa has been appointed several to prominent positions in various boards and sub-committees. Its geographical position along with its domestic health situation has also led to the country accommodating many of the WHO-CCs, something which among other things has led to praise by the WHO towards South Africa's global health efforts, a praise which is habitually reciprocated. This good rapport is not too surprising, however, as

South Africa constantly appraises the legitimacy and authority of the WHO as the rightful leading actor in global health governance.

As for HD relations which fall outside of the *core* category, the health ministers of the respective BRICS countries have created a common global health agenda for the association. While this might be more out of necessity for the sake of image rather than something which will be actively pursued is hitherto unclear – currently, however, the global health policies of each individual member state seems to have more significance for the actions of its individual member countries (Kickbusch, 2014).

Finally, South Africa's cooperation with large NGOs is once again informed by its massive health issues. This means that while not being completely passive recipients of funds, as there are various degrees of cooperation with a number of different kinds of local actors in terms of distribution and implementation, South Africa is generally required to follow the broad guidelines of the organisations they are in partnerships. Additionally, meeting certain expectations is a key to the willingness of these organizations to keep giving, or even increasing their donations.

General observations

South Africa's foreign policy is less than explicit of its stance on global health issues. However, its repeated support of realising the MDGs and a unquestionable support of the post-2015 development agenda, as well as its support of multilateral organisations such as the WHO and, more vaguely, other 'global mechanisms'; and finally its involvement in the FPGHI together give circumstantial hints to this stance.

Furthermore, while there is no clear official position to be easily placed within the framework of rationales based on the work of Labonte & Gagnon (2010), it is quite clear that the umbrella term of human rights, repeatedly mentioned in the key documents discussed above embodies the official stance of including health in foreign policy and in conducting HD. However, a closer look at the history of South African foreign relations in the past 20 years shows a gradual shift in prioritization away from importance of practicing diplomacy conducive to human rights, towards others such as African solidarity and indiscriminately securing and courting like-minded (in terms of anti-hegemony) partners in trade and politics internationally, has gained relative importance, and South Africa's emerging middle power image consolidates further.

In practical terms, South African HD is more focused on three separate but interconnected purposes. The first is a domestic one. As South Africa is heavily struggling with major health issues within its own borders, most notably because of the HIV/AIDS epidemic that is ravaging the country, it is highly dependent on foreign support in the form of aid and in the form of trade relationships in which health related products or personnel is the key commodity, the relationship with Cuba being one example. In this view, there is a sense that South Africa wishes to promote the global health in foreign policy agenda because of its own needs in terms of assistance from the international community. While it is certainly possible that the an ANC-led government would potentially like to pursue capabilities as a major health actor for altruistic purposes in the future, there is a glaring situation within its own borders that must be prioritized before endeavouring to use any significant health resources, or any other resource for that matter, elsewhere.

The second purpose is regional. One large dimension of the oft-mentioned 'African Agenda' in the documents published by DIRCO consists of multilateral coordination specifically in regards to development through organizations such as SADC and the AU through NEPAD – both of which view public health as an integral part of development, if not a prerequisite. In the potential case of an epidemic outbreak and lack of health services in the adjacent countries of South Africa, border-crossing of both disease and refugees in search for treatment, food and work is something which the ANC will want to avoid at all costs. It is already clear that the large influx of people, particularly of Zimbabweans, seen in recent years have led to many seemingly intractable issues such as widespread, explicit and often violent xenophobia and an exacerbation of the unemployment problem of the country. In this sense, there is a heavy emphasis on the security aspect of HD. While South Africa's entire foreign policy is ostensibly informed by the concept and philosophy of *Ubuntu*, this tends to be particularly emphasised in relation to regional matters and the African Agenda. As the above-mentioned report suggests, the impression of interconnectedness, partnership, cooperation and kindness provided by the Ubuntu frame, is driven rather by pragmatic security reasons in the form of enlightened self-interest than ideas of selflessly helping one's neighbours.

A third rationale for the South African government that can be interpreted from their stance on global health issues is in relation to its interests on a more global context. Throughout the rhetoric in speeches and documents concerning foreign policy and particularly in terms of health and

development is the constant reaffirmation of the importance, potential and competence of multilateral institutions. Being an explicitly internationalist state from the outset, this is one, if not the only one, of Mandela's original foreign policy pillars that has consistently been considered conducive and prudent to South African foreign relations interests. From being a leader regionally and continentally in organizations such as SADC and the AU to finding partners with a shared agenda in 'Southern interests' associations such as IBSA and BRICS, to having aspirations of playing a more influential role the UN and its sub-organizations: South Africa is aware of the fact that it cannot stand on its own feet in order to grow or even maintain, and promoting relationships with willing partners is perhaps the most central aspect to contemporary South African foreign policy. Answers to global health- and governance-related questions are therefore often simply answered with a reference to the frameworks or positions of one or more of the multilateral organizations and associations of which South Africa is a part, be it as a leader regionally and continentally or as an ambitious middle power globally. However, Southern solidarity is also a key aspect of South Africa's foreign policy in order to maintain regional legitimacy, and this entails supporting and working within existing global health governance institutions in order to secure their own as well as other friendly states' interests, perhaps best exemplified by being a spearhead in the campaign for the Doha Declaration and subsequent TRIPS amendment mentioned above.

South Africa's health diplomacy in the emerging middle power lens

As noted in earlier chapters, South Africa is one of the most commonly mentioned states when listing examples of emerging middle powers, and a large part of the emerging middle power discourse in academia stems from South African research. As for the constitutive features that make an emerging middle power according to Jordaan (2003), South Africa fulfils the criteria flawlessly. It is geographically located in the Global South; its democracy recently celebrated its 20th anniversary and is far from properly consolidated. There are enormous social cleavages both politically, economically and racially – all of which are connected in a muddy wake left by a less than proud heritage, and a high Gini coefficient is but a symptom of this concoction of issues. Its path to middle power status happened to coincide roughly with the end of the Cold War and it remains in the semi-periphery of the global economy. Furthermore, South Africa is unquestionably the regional powerhouse in Southern Africa by all indicators, soft and hard.

As for behavioural characteristics, the image is, not surprisingly, slightly more complex. As mentioned, a state's position and capacity towards ODA and its core rationale for practicing it can be a revealing indicator for the different kinds of middle powers. As for now, South Africa's reception of ODA far surpasses its donation (Global Humanitarian Assistance, 2013). However, with the creation of SADPA and the rhetoric surrounding Ubuntu-inspired development, particularly regionally, South Africa is increasingly attempting to create an image of itself as a generous regional father-figure ostensibly attempting to spread affluence and good values to its neighbours out of some sense of duty. This is, however, quite clearly a strategy with far less noble motives, as it is more realistically a way of protecting its own borders from large-scale influxes of foreigners. As such, the (mis)use of the term Ubuntu becomes more of an attempt of a quasi-version of the welfare- and egalitarianist-inspired ODA conduct typically displayed by the clearest traditional middle power exemplars.

South Africa had ambitions early on of being a role model for democracy and for spreading democratic values, particularly in Africa. Some bumps in the road since then has significantly slowed this idealistic foreign policy trajectory, as matters that fall within the realm of *realpolitik*, exemplified early on by the Nigeria affair, made Pretoria change their stride in order to secure good relations, regardless of the ideological values of the counterparts of these relations. The advantage of having a symbolic, almost universally respected leader like Mandela might have helped slightly in the beginning, but this all but disappeared when Thabo Mbeki took over; and is completely void in regards to Jacob Zuma. This trend has not been beneficial for South Africa as a global health actor, in spite of the work on the Doha Declaration its position in the FPGHI and signatory-status in the Oslo Ministerial Declaration. The change of outlook and ambitions becomes clear when reading DIRCOs strategic plans, in which the most important goal is to "[t]o promote policies, strategies and programmes to advance South Africa's national priorities through strengthened political, economic and social relations with targeted countries" (DIRCO, 2013:18), and in which any position on issues of global health is not mentioned.

South Africa's behaviour regarding multilateralism and internationalism in general is highly consistent with Jordaan's typology on emerging middle powers, and shines through in their HD activity. Further, it takes positions of leadership in the more local organizations such as SADC and NEPAD, while supporting larger ones such as the UN with an eye for improving its own position, being quite explicitly in favour of an expanded Security Council in which South Africa

is included. With the above-mentioned indiscriminate choices of partners, followed by recognition of the importance of having partners willing and able to potentially change the world order's status quo; welcoming the membership in the BRICS association is no surprise, even if South Africa's influence within it remains limited. The repeated reference to the authority and legitimacy of multilateral institutions has seemingly left South Africa with little autonomy and identity. However, the country does stick its own head out on occasion, such as was the case regarding the UN resolution regarding global health in foreign policy. But such initiatives tend to be ultimately little more than superficial gestures in the hope og gaining or retaining dwindling soft power credibility. Indeed, South Africa is yet to follow through on the subject matter of resolution themselves.

Alas, it would seem that South Africa is more concerned with assuring its own security and position than it is with keeping with steadfastly spearheading liberal values such as human rights and democracy, as was the original ambition of Mandela's ANC in the immediate post-apartheid euphoria. Indeed, this would come as no surprise to subscribers of the hierarchical divide between high versus low politics, in which prudency and a sense of self-preservation trumps idealism and altruism every time, leaving only various degrees of a masked self-interest – enlightened or otherwise. In the case of South Africa, the shift in focus from low to high politics is becoming more and more apparent, culminating in a recent nuclear power partnership deal with Russia. Contradictions in relation to an ostensibly environmentally friendly foreign policy rhetoric aside, the deal is struck with country whose domestic human rights situation and contemporary foreign relations are controversial to say the least.

In terms of HD's bi-directional nature, Pretoria's contemporary stance on global health, characterised by fleeting interest and sporadic initiatives seemingly designed to uphold an image within organisations and partnerships in which they wish to gain influence, is far from altruistic. Presently, South Africa seems to be more of a target for other, more stable and affluent states' HD as well as being the open-eared recipient of funds from various NGOs than meaningfully conducting their own HD. Indeed, South Africa might be somewhat of an extreme example, with more social cleavages and severer health issues than most emerging middle powers, and there is a sense that a degree of affluence and domestic stability is a prerequisite for meaningfully engaging in global health.

Future prospects

In spite of finding itself in a bleak situation, despairing and giving up on account of this need not be the only possible reaction for the future HD of the country. Henning Melber (2014) argues that South Africa should return to its roots in promoting human rights in order to regain some traction in the form of soft power and its status as a good international citizen. In an article in which he criticises the country's involvement in the UN and particularly its two tenures as a non-permanent member of the UNSC, he concludes that:

> A rights-based foreign policy in recognition of the fundamental values enshrined in the UN Charter and subsequent normative frameworks would require the courage to dissociate from otherwise preferred bedfellows if these are not up to standard measured against these criteria. What better way to enhance the international image of a country, and therefore to increase social capital, than to build a government that walks in the footsteps of Dag Hammarskjöld and Nelson Mandela? (Melber, 2014: 141-142).

In the same vein and in direct relation to HD, Pieter Fourie (2013) has argued that "South Africa can and should explore AIDS diplomacy within the broader perspective of HD to reclaim the sense of purpose in its foreign policy, to salvage the human rights focus as well as the moral stature that it seems to have lost" (2013:7). Fourie envisions AIDS diplomacy as a possibility for a South African niche diplomacy in which the country takes a leading role in helping to fight the epidemic globally in a number of ways. From continuing its good record of negotiating for more affordable medicines, particularly antiretroviral drugs; cooperating and aligning with its partners in for example IBSA to gain more traction multilaterally; to the training of health personnel and of health diplomats, South Africa can take advantage of the new foreign policy possibility that is HD and take what is a burden and turn it into something beneficial not only for itself, but for global health in general.

In addition to the direct health benefits for those afflicted by the epidemic, this kind of behaviour could help South Africa on the way to redeeming itself in terms of its international standing and to regain its reputation as a good international citizen.

Indeed, such efforts could potentially bridge the gap between the perennial conflict between high and low politics in South African foreign policy, a conflict in which the perceived importance of prioritizing the former has led to a complete loss of Mandela's and the ANC's original main goal – being a force for good in the world.

While South Africa is in a unique position because of its complicated history which led up to its perhaps even more complicated present, the possibility of building a reputation as a good international citizen is open for many emerging middle powers. Brazil, for example, has perhaps recognised and seized upon this more than anyone, and is considered to be a leading figure in terms of influence gained by its soft power, most notably by its significant contribution in the formulation of the FCTC.

While many emerging middle powers are struggling with domestic issues of various sorts, and that, for many of them, trade, business and retaining allies which share their position in the global economy is the top priority, re-allocating resources and perhaps choosing cooperation partners more carefully could improve their position in the global hierarchy by way of soft power and being role models for global health. Furthermore, in addition to catering to national interest in the way of preventing epidemics and mass immigration and in cementing their regional hegemony, this could also be extremely beneficial for the often limited health services for the smaller states in the regions in which these emerging middle powers hold a leading position.

Conclusion

From what has been discussed in this chapter, South Africa's involvement in global health and its dealings in HD can be said to be quite symptomatic of much of its post-apartheid foreign policy behaviour. In short, this involves adjectives such as inconsistent, short-sighted and somewhat superficial. South Africa's own health problems have left the country with little space in which to engage properly in in health concerns stretching outside their own borders, expect perhaps regarding their own immediate region. Indeed, being a country dependent on massive external funds every year to uphold its own unsatisfactory health system, South Africa only really speaks of global health sporadically – when it is time to uphold parts of a weakening soft power image.

This chapter started by explaining the evolution of South African foreign policy in the two decades that have passed since the end of apartheid. This initial section showed how the original ideas of being a global human rights role model was slowly but surely pushed aside for reasons of perceived prudency, as priorities changed into emphasising solidarity with African states as well as with other partners in the Global South, regardless of any moral compromises that had to be made or pillars which had to be put on the side-line.

While South Africa has taken strong positions in global health matters in the past and was, among other examples, instrumental in the implementation of the Doha Declaration which eventually ensured better access to medicines for struggling countries, its contemporary official stance on global health is unclear. Indeed, conclusions on this stance must be drawn from inferences in rhetoric regarding development and human rights, as the rhetoric found in the Oslo Ministerial Declaration, to which South Africa is a signatory; and that of the UN resolution which it was so eager to endorse, are both completely absent.

In terms of the different spheres of HD communication, Katz et al.'s division into *core* and *multistakeholder* is not the most salient divide in the case of South Africa. In fact, it seems rather that while the country praises multilateral institutions in which they have a relatively good standing because of their regional stature, its relationships with individual countries and NGOs are characterised by being on the receiving end of funds in relationships where the agency of South Africa is largely limited.

As a middle power exemplar, South Africa's global health activities are unsurprising in the sense that it is highly supportive of multilateral institutions in which it aims for top positions. Furthermore, it has taken up a position of leadership in regional health, at least on paper. Its initial middle power-like position as a propagator of humanist values has slowly waned into virtual on-existence. Indeed, South Africa is put in a very difficult position which is quite unique in terms of middle powers, emerging or traditional. This is because of its domestic health crisis, among many other issues faced within the country's borders. As suggested, this leaves the country with little autonomy and freedom with which to really engage with health on a global scale in a meaningful way, except for when seemingly benefits its own interest or in attempting to rebuild its image, aiming to regain some of its soft power capabilities.

Chapter 5: Assessing Norway's health diplomacy as an exemplar of a *traditional* middle power

The purpose of this chapter is to assess Norway's conduct in relation to HD and subsequently view it through the lens based on Jordaan's description of traditional middle powers. As such, it shares this purpose with the previous chapter on South Africa and emerging middle powers, and is thus the second case study contributing in the endeavour to illuminate and answer the research statement and research questions of the study.

It also shares the structural formula upon which the previous chapter is constructed, and will therefore start with the historical contextual leading up to Norway's contemporary HD activities in the sub-section focus on the *agenda-setting* stage of the *stages heuristic*. Next, it describes the country's official stance on the matter of global health, and how this can be placed within the archetypal frames of rationale defined by Labonte & Gagnon (2010) in the *formulation* stage, before exploring the multiple dimensions of the *implementation* stage in light of Katz et al.'s (2010) categorization of spheres of communication. Finally, these findings are summarized and reflected upon, before further discussed in light of the theoretical lens of traditional middle powers.

Agenda-setting: The evolution of global health concerns in Norwegian foreign policy

"The cornerstone of Norwegian policy is to promote and respect fundamental human rights" (Norwegian Ministry of Foreign Affairs, 2011:3).

The policy of involvement

This is the opening sentence of a White Paper published by the Norwegian Ministry of Foreign Affairs (MFA) in 2011. The title given to this White Paper is *Global health in foreign and development policy*, and is essentially a report with recommendations submitted to the Norwegian parliament. For most observers, the publication of such a report is unsurprising, as Norway is often viewed as an archetype of what embodies so-called 'good international citizenship', an attribute by which traditional middle powers are characterised. Indeed, Norway has for some time advertised and referred to itself as a 'peace nation' (see for example Skånland, 2010). The promotion of peace, allocating a relatively significant portion of its gross national

income (GNI) to ODA and, more recently, taking the initiative in promoting the importance of global health in foreign policy – Norway's foreign policy traits seem driven by a recognition that, in true middle power fashion, niche diplomacy is the *modus operandi*.

Norway, as it exists today, achieved its independence from Sweden in June of 1905, making it a relatively young sovereign state in European terms. However, in comparison to post-apartheid South Africa, its foreign policy history is generations older. Some authors (particularly Leira, 2002; 2005; 2014) suggest that the origins of Norwegian preference for conducting a foreign policy model based upon the principle of what some authors refer to as the policy of *involvement* or *engagement* (see Sandberg & Andresen, 2010; de Carvalho & Lie, 2014; henceforth *involvement policy*) can be traced back to key thinkers dating back to even before independence. However, the modern beginnings of the image of Norway as a peace-nation came with opposition to the Vietnam War and large contributions of personnel to UN peacekeeping missions in the 1970s and 80s, particularly in Lebanon. Nonetheless, there is little doubt that this sort of comportment only truly flourished after the end of the Cold War, as the prevalence of other types of status seeking aside from material, hard power became more feasible.

The notion of the *policy of involvement* in the context of Norwegian foreign relations attempts to describe some of the traits that have earned the country a standing as a 'good international citizen'. As suggested, these include the promotion of peace and leadership roles taken in peacekeeping and mediation, being a large and engaged donor of ODA and, most recently, as a promoter and fore-runner for global health governance at large and specifically global health's further inclusion in foreign policy. While the focus of this study is on the latter of these areas, it cannot be seen in isolation from the two preceding it. Indeed, the rationales behind all of these versions of *involvement* niche diplomacy share a common denominator – and HD is only the most recent numerator. Unlike South Africa, the factors leading up to of this focus on *involvement* did not arise as the result of a counter-discourse to a foreign policy conducted under an oppressive pariah regime, but rather as a mix of several, less obvious and far less dramatic circumstances and rationales.

According to Benjamin de Carvalho & Jon Harald Sande Lie (2014), Norway's foreign policy conduct of peacekeeping and engaging in humanitarian aid stems from three decisive factors. First, they credit what they refer to as "[….] the country's long-standing self-understanding as a peaceful nation" (2014:60). This idea, elaborated upon in more detail by Halvard Leira on several

occasions (2002; 2005; 2014), lays the groundwork for the other two factors and in short traces the evolution of humanist ideas in Norwegian politics as well as in civil society and the broader Norwegian culture.

The benefits of being a good international citizen

With this as a starting point, De Carvalho & Lie emphasise a sense of awareness, beginning from towards the end of the 1980s, that this self-understanding brought with it an image which had possibilities that could potentially positively affect Norwegian foreign policy and Norway's standing in the international community. This coincided with the end of the Cold War, an event which was especially liberating for Norwegian foreign policy, an area that had been almost completely static for decades due to the country's unique position of close geographical proximity with Russia and ideological proximity and subsequent allegiance with the United States via the North Atlantic Treaty Organization (NATO). As De Carvalho & Lie suggest, "[t]he end of the Cold War offered possibilities for recalibrating the foreign policy agenda – and led to a revitalized policy of involvement" (2014:61). Though the new type of agenda was broadly supported all across the relatively homogenous Norwegian political spectrum, this particular mind-set was perhaps initially most prevalent among Labour Party politicians. However, as the party held power throughout virtually all of the 1990s, the involvement agenda became an integral part of Norwegian foreign policy and had come to stay (Neumann, 2011). In addition to becoming part of the political culture, this is partly because it was visibly effective. Indeed, as De Carvalho & Lie explains, "[…] there was already a clear understanding that the policy of involvement gave Norway something more than just a good conscience: a better reputation internationally, and the acknowledgement of peers and great powers" (2014: 61).

Norway had found a niche and was receiving good feedback from large states such as the UK and the United States. This even went to the extent that foreign ministers who were against the involvement policy in principle could not help but see the benefits of it, as was the case with the Conservative Party's Jan Petersen who took over after a change of government in the early 2000s. The benefits included a closer friendship with particularly the U.S. State Department; with Colin Powell and Madeleine Albright both expressing admiration of the Norwegian style of foreign policy, something which led to a closer relationship between the two countries.

Another important benefit experienced by conducting this kind of foreign policy was, and still is, a spill-over effect in the form of broad domestic support. Turid Lægreid (1996) was early to

suggest that being viewed as a 'good international citizen' can be effective for ensuring domestic popularity of the sitting party as well as building influence and soft power internationally, something which fuelled the perpetuation and expansion of such a policy style even further.

Within the discourse of Norwegian politics, however, there was some initial aversion in terms of admitting or recognising that this type of comportment had dimensions of self-interest to it. In a report written in 2002 by Janne Haaland Matlary, who had served as the State Secretary of Foreign Affairs from 1997 to 2000, and who is currently a professor of international politics at the University of Oslo, the benefits in terms of gaining soft power with this kind of diplomatic activity, which she calls 'value diplomacy', is assessed. In its conclusion, she emphasises the balance between the dimension of contributing to the betterment of the world while and that of simultaneously reaping the benefits of the by-product of such behaviour, namely the attainment of soft power capabilities:

> Many have pointed out that a weakness in the debate surrounding Norwegian foreign policy is that we are so afraid about thinking strategically and in a goal-oriented manner, especially regarding value-based policies. There is almost something 'unethical' about considering the utility and bigger picture of it. This hinders any logical and clear assessment of how one should utilize resources. There are thousands of good causes and possible areas of exploration within value diplomacy, and a small country has to think about not spreading out too much and about how one can *use* the good efforts which benefit good purposes in order to promote own interests. This is both the right thing to do and necessary in terms of foreign policy, and in practice it will be very possible to 'do well' while simultaneously building influence in terms of *realpolitik* (Matlary, 2002, author's emphasis. Translated by author).

One term Matlary uses to describe the sum of this argument is that Norway is a 'strategic activist' in the international community, embodying the notion of enlightened self-interest. This is quite an accurate description of a role that has worked well for the country as a way of making a name for itself other than that of simply being a wealthy, oil-producing welfare state. As de Carvalho & Lie conclude, "[…] the policy of involvement has increased Norway's status internationally. To a large extent, this is due to one specific factor: Norway is perceived as a *good power*" (2014:68, original emphasis). Sandberg & Andresen sum the same point up in this manner: "Thus, global ethical responsibilities feature alongside Norway's interests and the resolution to 'make a difference'" (2010:307).

Past examples of Norwegian activity in health diplomacy

As suggested above, an effort in HD is the latest project in terms of Norwegian involvement policy, but the country started taking a special interest in global health matters at least as early as the time of the UN Millennium Declaration. In fact, Sandberg & Andresen traces the beginnings of Norwegian global health concerns to the 1960s, but that the engagement only started properly around the turn of the millennium, particularly arguing that the "[….] creation of the GAVI Alliance in 1999 [was] a key junction in the Norwegian global health relations as it engaged both the political leadership and the development establishment in Norway" (2010:310).

Under Former Prime Minister Jens Stoltenberg in particular, whom Katherine Bliss has called "[….] an ardent global health champion" (2011:13), Norway contributed large funds both bi- and multilaterally to global health. This was particularly focused within the area of maternal and child health and the related initiatives for vaccinations, for example being an initiator and long-time large scale supporter of the abovementioned GAVI alliance, for which it is one of the six original donor countries (Conley & Melino, 2013).

Indeed, the specific strategy of health and foreign policy agenda did not come to the interest of the Norwegian government completely by chance or through external channels. As Gagnon (2012) indicates, the fact that important political figures were preoccupied and heavily concerned with global health issues helped in introducing and keeping this focus on the foreign policy agenda. These individuals include long-time Prime Minister Jens Stoltenberg; long-time Minister of Foreign Affairs Jonas Gahr Støre; and perhaps most formatively of all, the Norwegian Prime Minister-cum-WHO Director-General Gro Harlem Brundtland (Gagnon, 2012).

The most glaring example of Norwegian HD activity is the leading role it took in creating the FPGHI an indication being that its subsequent declaration was named after its capital city in the form of the Oslo Ministerial Declaration. Since then, Norway has kept itself active in numerous global health initiatives and institutions, taking positions of leadership in several of these. Conley & Melino are helpful in their listing of a few of these global health exploits:

> Also in 2007 Prime Minister Jens Stoltenberg launched the Global Campaign for the Health MDGs aimed at accelerating progress toward achieving the health MDGs. At the UN in 2009 Prime Minister Stoltenberg renewed Norway's commitment to global health by announcing that Norway would provide NOK 3 billion for global cooperation on women's and children's health in the period up to 2020 (2013:9).

Among other examples, Norway, often represented by Prime Minister Stoltenberg, was a leading figure in both initiating and playing a leading role in the Taskforce on Innovative International Financing for Health Systems, launched in 2009. Besides Stoltenberg, other members in this high-level taskforce include Director-General of the WHO, Margaret Chan; then-President of the World Bank, Robert Zoellick; Graça Machel, international rights activist and widow of Nelson Mandela, as well prominent representatives from the governments of the UK, France and Germany, among others. In short, what this task force set out to do was to both increase and optimize the spending of funds within the sphere of *Development Assistance for Health*, with the catchphrases 'more money for health' and 'better health for the money'. This was to be accomplished in a variety of ways, outlined in their publications, all based upon the basic premise that "[e]very human being is entitled to good health" (MFA, 2012:6).

Formulation: Current rationales for the inclusion of global health in Norwegian foreign policy

Even though the result of the 2013 parliamentary election concluded with a change of government from the Labour-led one to a one led by a coalition slightly more inclined to the right-hand side of the political spectrum, foreign policy is not expected to change in any discernible way. Indeed, in relation to the topic at hand, a document published by the MFA in March of 2014 (MFA, 2014) repeatedly states the intention and rationale behind a continued promotion of both global health and human rights, among other major global governance themes.

It is therefore safe to assume that the current government will heed core recommendations presented in the MFA's White Paper mentioned in the beginning of this chapter, entitled *Global health in foreign and development policy*. In general, this publication quite explicitly embodies the Norwegian government's stance on the place of global health in foreign policy as well as its more concrete plans within the conduct of HD. This White Paper will therefore be the main source upon which the analysis of the formulation-stage of Norwegian HD will base itself. Additionally, the Norwegian WHO Strategic Plan for their WHO executive board tenure of 2010-2013 will serve as a secondary document of reference.

The former of these publications is clear in its purpose from the very outset, as its opening paragraph explicitly states: "This White Paper highlights the challenges and establishes clear priorities for a coherent Norwegian policy on global health towards 2020 with particular focus on

three priority areas" (MFA, 2012:5). These areas consist of (1) mobilising for women's and children's rights and health, (2) reducing the burden of disease with emphasis on prevention, and (3) promoting human security through health.

Unlike the documents used in examining South Africa's stance towards global health, the White Paper on Norwegian position on this matter is made immediately clear, fitting well into the rationale-framework of Labonte & Gagnon almost serendipitously. In fact, it explicitly identifies itself with two of the frames set out above in Chapter 2.

First, the commitment to improving and promoting global health in terms of upholding universal human rights is stated in the White Paper:

> The Government's approach to global health is *rights based*. The point of departure is international human rights, as set out in for example the International Covenant on Economic, Social and Cultural Rights, and the conventions on the rights of children, women and persons with disabilities" (2012:7, original emphasis).

It goes on to emphasise that all governments have a duty to fulfil the basic human rights of its citizens, and that international cooperation is key in order to "[…] strengthen the capacity and willingness of national authorities to meet these responsibilities [….]" (2012:7). While defining the role of all governments to take care of the human rights of their own people, this position also implicitly defines Norway's and its multilateral partners' important role in ensuring human rights globally through enabling and encouraging local governments to take these duties seriously.

Secondly, *GPGs* are also mentioned explicitly: "Health is a global public good. There is potential in both rich and poor countries to increase growth through improvements to health" (2012:8). For Norway, the nature of GPGs as *nonrival* and *nonexcludable* is part of the *leitmotif* of equal and universal access to health for all, which serves as the "[….] guiding principle for Norway's health engagement in all forums" (2012:10). Nonrival and nonexludable is another way of describing the main traits of GPGs, which is that they do not diminish through use, and that "[….] once the good is provided for one person, it is available for all to benefit from it" (MFA, 2012: 11).

From 2010-2013, Norway served as a member of the WHO's Executive Board. The official strategic plan published by the MFA devoted to this tenure serves as an example of a more

practical dimension of Norwegian HD within a specific channel, arguably the most significant them all in terms of global health. In the introduction to this strategic plan, it is stated that:

> Norway's WHO strategy is based on an interest and value-oriented approach. WHO is an important arena for Norway's involvement in international health matters and thereby for safeguarding national interests. The links between health and an interest-oriented Norwegian foreign policy concern both Norwegian national interests and the interests we share with other countries (MFA, 2010:9).

Considering this, there is little doubt that there is a dimension to Norway's global health concerns that is also self-interested. This does not come as a surprise, seeing as the recognition of the benefits of niche diplomacy has long since been an accepted veracity for those involved in, or even familiar with, Norwegian foreign policy. Furthermore, there is explicit mention of strengthening the global standing and authority of the WHO present in this document, along with repeated statements of the legitimacy of the organization concerning the promotion of global health.

In sum, Norway's contemporary official rationale for including global health in foreign policy and engaging in matters that can be described as HD fit most explicitly into the *human rights* frame of the framework of rationales based on Labonte & Gagnon's (2010) work. However, the characterisation of health as a GPG in the documents explored above also places the rationale partly within the frame named after this concept.

Implementation: Contemporary Norwegian conduct in health diplomacy

According to the Norwegian Agency for Development Coordination (NORAD), the country engages with different actors in different ways for a variety of purposes in relation to its global health and development endeavours. In short, bilateral state-to-state cooperation is thought to empower sitting governments in order to enable them to perform their duty, namely taking good care of their own citizens. Multilateral channels both in the form of IGOs and large NGOs are used in order to reach several places at once. Cooperation with smaller NGOs is used primarily to target specific areas of interest.

Norway's core health diplomacy – bilateral

Norway is one of the few countries in the world consistently approaching a 1% share of its GNI going towards ODA. In general, about 75% of this gets channelled bilaterally (DONOR Tracker, 2014). As a report from the development strategy analyst website *DONOR Tracker* suggests, "[t]hese contributions are earmarked for sectors or countries of special interest to the Norwegian

government" (2014:2), indicating that recipients are not chosen by chance but with an eye for a potential future return in various areas of interest. The largest recipients of ODA grants from Norway as of March 2013 were, in falling order, Brazil, Afghanistan, Tanzania and Palestine; while countries located in Sub-Saharan Africa take up the next spots. Much of this aid is channelled through organizations such as the Norwegian Red Cross and Medicines Sans Frontiers, for example.

In a strategy plan regarding its relationship with Brazil published in 2011, Norway's MFA pointed out that, in addition to the cooperation on mainly environment, energy and rainforest preservation already in place between the two states and the cooperation consolidated by the common membership of the FPGHI,

> There is potential for strategic cooperation on health and global governance, not only in the efforts to achieve the Millennium Development Goals, but also in the fields of trade in pharmaceuticals, international agreements negotiated through WHO, security and peacebuilding, and humanitarian efforts (MFA, 2011:19).

Another example is Norway's long-standing relationship with Tanzania. The two countries have, through the Norway Tanzania Partnership Initiative (NTPI), a project started in 2007 aimed at reducing child and maternal mortality in the country – a project which has been successful. In a report published by the Royal Norwegian embassy in Dar es Salaam, the NTPI is characterised as "[….] an integrated part of Norway's global commitment to reduce maternal and child mortality" (Royal Norwegian Embassy of Tanzania, 2010:17). In neighbouring Malawi, about a third of the funds donated are funnelled directly into health services, including treatment of those afflicted with HIV/AIDS as well as training of local medical personnel, the latter most recently manifested in cooperation with the Clinton Health Access Initiative.

Generally speaking, Norway is in the opposite position of South Africa in terms of bilateral ODA and relations pertaining to health. The former's domestic health systems are among the best in the world, and it tends to act as a detail-oriented and consistent donor, while, needless to say, never receiving any ODA. What Norway stands to gain directly from countries such as for example Tanzania and Malawi, aside for generally excellent bilateral relations, is unclear as compared to the slightly more straightforward relationship between Cuba and South Africa, for example. In general, however, Sandberg & Andresen suggest that Norway views the link between health and economic development as inextricable. Additionally, with a successful portfolio bilateral

development and governance projects comes increased credibility and soft power, which can in turn potentially breed success and increased influence multilaterally and in the international arena, broadly speaking.

Norway's core health diplomacy – the WHO

As already indicated, Norway shares South Africa's official stance of clear allegiance and support to the WHO in terms of its legitimacy and competence in regards to global health governance, particularly in a normative and coordinating sense. At the same time, it recognises the importance of other emerging actors as well as institutions that indirectly have consequences for health such as the World Bank (see MFA, 2010:23). The aforementioned strategic plan developed for Norway's Executive Board tenure ending in 2013 is explicitly indicative on how Norway views and relates to the organisation.

Among other things, a position on the executive board gives member states a limited period of increased influence in the organisation, and more room for bringing up subjects and themes that they are particularly interested in. For Norway, these were stated explicitly as being 5 objectives that should be prioritized. In short, these were related to poverty, fulfilling the MDGs, reducing inequalities, supporting the universal right to health services, helping to reduce the burden of disease; and promoting women's rights and gender equality (2010:14).

While the WHO has a *country cooperation strategy* with South Africa, described in some detail above, in which the country was given praise for its important regional work, something like it does not exist for its relationship with Norway. This is symptomatic of other large-scale European donor countries, an therefore not an exceptional case. However, as Norway is the 4th largest donor to the organisation itself, it is fair to believe that the WHO finds Norway to be an important and generally like-minded partner.

Norway's multistakeholder health diplomacy

For NORAD, the main purpose of engaging in cooperation with, and donating to, large NGOs such as the GAVI Alliance and the Global Fund is the same as with even larger bodies such as the World Bank and the WHO – to reach as many people as possible with the funds donated.

For example, Norway is one of the six original and one of the largest donors of the GAVI Alliance, having donated close to $800 million in total to the organization, which accounts for about 10% of its total funding. Norway's relationship with GAVI seems to be one of mutual

respect and admiration. Indeed, while the organization are explicitly grateful in their description of the country's contribution on their website, Norway's official documents on GAVI expresses that "[f]or Norway, GAVI is the biggest, most important and most effective channel for the achievement of MDG number 4 on reduced child mortality" (MFA, 2013:4). In their global health White Paper, Norway explicitly mentions that it will continue to support GAVI in every way possible.

Smaller NGOs, often based in Norway, are required to apply for grants from NORAD, typically lasting for one year with the chance of renewal depending on the level of success or the perceived necessity of continuation. These projects often target specific focus areas in specific places in which the organizations have special competence, and grants are given partly by their chance of success or general importance, and partly by what NORAD has decided to focus on that particular year, as was the case with education for 2014.

Again, this position of power vis-à-vis small NGOs and, to a lesser extent, large organisations such as GAVI stands in stark contrast to that of South Africa. While Norway can pick and choose from grant applicants and support whoever they please, South Africa must itself abide by the rules and fulfil the expectations of its major donor organisations, lest the support be increasingly taken out of their control if not removed entirely.

Implementation summary

Norway has, in spite of its limited capabilities in terms of hard power, population and size, gained a prominent position as one of the global health leaders of the world. This has led to a powerful position in various arenas of global health and development, and with a wide variety of actors both bilaterally and multilaterally in the *core* dimension of HD (Katz et al., 2011). In its dealings with individual countries, Norway is adamant on their mixture of good governance and best practices on the one hand, and ownership on the other; all the while trying to strengthen ties with increasingly amicable and more like-minded partners. This process can be viewed as a combination of altruism and an eye for future benefits in terms of trade and minimised risk of the evolution of pandemic diseases as well as helping to increase soft power capabilities and credibility – in short, enlightened self-interest.

Multilaterally, Norway is highly supportive of the primacy of major institutions, and particularly the WHO, an organisation with which it shares many of its core values based on universal human

rights. This commitment shines through in the fact that it is one of the institution's major donors. As for *multistakeholder* negotiations, Norway is one of the bigwigs within the area of global health and HD. Indeed, in relation to organisations that fall outside of the core-characterisation of HD, Norway is an attractive partner for NGOs large and small, from which it can select, to various extents, whom and what to prioritize.

General observations

Unlike South Africa, Norway is quite explicit and clear about its engagements in global health, but only to some extent. In terms of the official documents reviewed, the main rationale given for Norway's involvement in these matters is a sense of duty to uphold human universal human rights. While this is expressed as being the duty of *everyone*, Norway has seamlessly taken a position of leadership in this matter, as its name is nearly synonymous with good governance when it comes to both managing its own domestic health and various other development practices globally. As far as core rationales are concerned, characterisations of health as being a *GPG* are also mentioned. Thus, pursuing universal access to health is not only considered to be a duty, but it is also practically feasible and furthermore a win-win situation for everyone – health's inherent qualities of nonrivalry and nonexcludabilty ensure this.

Eschewing all forms of naiveté, these noble sentiments while perhaps truthful and sincere, only represent a portion of the motivation regarding the inclusion of global health in Norwegian foreign policy. As was the case with the original *involvement* politics discussed above, the benefits in terms of influence and credibility gained from this line of behaviour on the international arena are seemingly too good to resist. Whether these benefits are side effects of the duty of ensuring human rights or vice versa are up for debate, but dimensions of both are doubtlessly present – perhaps best illustrated by the continuation of these policies after the election of politicians principally against them. Again, there is a sense of seeking for power and influence in alternative ways in lieu of traditional power capabilities, in many ways made possible by the end of the Cold War.

Engaging heavily in global health issues is, by all indicators, the newest version and indeed the logical next step of Norwegian niche diplomacy, an area in which they have excelled since at least the end of the Cold War. In fact, it seems self-evident that Norway's previous exploits in the niche diplomacies of conflict mediation and development, in aggregate known as *involvement* policies, were important prerequisites for this. While global health can be seen as a continuation

or branch of the work on development, the creation of the Oslo Ministerial Declaration and the explicit inclusion of its rhetoric and HD strategies in publications made by the MFA mark a transition into a new and more specific niche. This transition is not surprising considering the expressed awareness of a changing world which includes the increased interconnectedness in relation to the coordinated handling of diseases as well as the influx of new actors into an ever-growing field. Indeed, Norway recognises the necessity of functioning global mechanisms for preventing and handling potential health crises, both for the country itself and for the international community, and aims to be an integral part of this process. Furthermore and concurrently, there is also a wish to capitalise on these efforts, gaining even more credibility and influence by going forward as an example – perhaps best exemplified in initiating the Oslo Ministerial Declaration and simply by being among the largest donors within some of the largest health organizations in the world, state and non-state alike.

Norway's health diplomacy in the traditional middle power lens

Constitutively, Norway is one of the most accurate examples of a traditional middle power. Located in the northernmost reaches of the *Global North*, Norway boasts a healthy and long-running democracy, any serious criticism or characterisations of non-consolidation of which would be hard to find. Its position as a middle power can be said to have evolved during the Cold War, particularly with the discovery of vast oil reserves off its coast, from which it still benefits greatly and owes much of its possibility to be as generous as it is. As suggested, however, its position as a niche diplomat *par excellence* only truly consolidated over the course of the 1990s with a number of variables coinciding, including *the end* of the Cold War and a sustained Labour Party government headed by strong-minded individuals such as Brundtland.

Norway is a highly egalitarian country, and exhibits one of the lowest Gini coefficients in the world as the distribution of wealth is extremely equal when viewed on a global scale. In fact, Norway is one of the quintessential welfare states, and the number of people experiencing a lack of economic well-being is subsequently extraordinarily low. Furthermore, Norway, while a smaller economy than South Africa in terms of GNI, is at the core of the global economy and is a highly developed society which can display generally very high standards of living. Indeed, the country ranks 1st in the most recent UN Development Programme (UNDP) rating for HDI, while South Africa rests at 118th (UNDP, 2014: 160-161)

In terms of relative power with their neighbours, Norway is often rightly mentioned in the same sentence as Sweden and Denmark for sharing many of the traits mentioned in the previous paragraph, although Norway's economy is superior. It is also situated close to more powerful states such as the UK and Germany, and of course the organisation both these states are part of, the EU. Consequently, Norway is by no means a regional powerhouse or leader.

Being as it is something approaching a quintessential traditional middle power, Norway's conduct also generally fits the behavioural characteristics outlined by Jordaan (2003). Keeping with the example of the state in question's capacity and rationale for practicing ODA, it is clear that Norway is one of the very largest donors in the world, as it is one of few countries even close to donating 1% of its GNI annually. Indeed, Norway is an ODA juggernaut by most indicators, both contemporarily and in recent history. While much of the origins for this generosity owes to the same humanist values which are prevalent in welfare states, there is also a practical side to Norway's ODA policies, as it has doubtlessly raised the international profile of the country; a benefit long since recognised by the Norwegian MFA and various heads of state. In fact, this realisation, which rightly can be characterised as enlightened self-interest, quite conceivably both extended and enlarged this behaviour.

In terms of its position in the region, Norway is ambivalent towards regional institutions and organisations. Its relationship with the EU is the most obvious example. While the majority of Norwegian politicians and citizens are against joining the union, there are factions with the opposite opinion, even if this has not been a serious topic of discussion for quite a long time. In fact, Norway seems to be in a somewhat unique position as compared to other traditional middle powers in this respect, comparable only with perhaps Switzerland, as their independent sources of wealth enable them to have a solely external relationship with the EU. Furthermore, the country's current relatively privileged position in various institutions such as the UN and NATO and its general position at the core of the global economy lead Norway to be less than interested in reforming the world order and quite content with the *status quo*.

Also mentioned in the characteristics of a middle power is the perception of middle powers are neutral conflict mediators and other types of niche diplomacy. A state which embodies these qualities more than Norway is difficult to name. Again, to repeat Yolanda Kemp Spies: "For these states, diplomacy offers the most viable foreign policy instrument: in the absence of economic might and other capabilities that could be used as carrots and sticks, they have to rely

disproportionately on diplomacy to impact international politics" (Spies, 2010:75). While Norway does have an excellent economy and one of the world's highest GDPs per capita, they are no economic superpower, or even great power. Instead, they have smartly used some of their extra funds on becoming accomplished experts in the very niche diplomacy which Spies prescribes – and to great success. Add to this its excellent relationship with the largest multilateral health organisations such as the WHO and with newer large actors such as the GAVI alliance, and Norway largely fulfils the criteria expected from a traditional middle power in terms of HD to an extreme extent.

Future prospects

As already suggested, there is little or no sign of Norway slowing down or doing any significant modification on their dealings with global health in terms of foreign policy. Indeed, the White Paper repeatedly referred to above explicitly states that its purpose is to outline the priorities of this dimension of the MFAs work up until 2020.

For the category of traditional middle powers at large, the example of Norway in many ways stands out as a model to follow in this type of niche diplomacy. However, as Norway's current position in the global health arena is largely dependent on the foundation created by two decades of consistently conducting its *involvement* policy to great success, each traditional middle power must rely on their individual contextual strengths and reputations in order to gain such a position. Certainly, states like Switzerland and Sweden are already strong in soft power capabilities and the former a juggernaut in terms of global health. Even if Fidler (2013) is less than optimistic about the continued importance of HD, people like Ilona Kickbusch would disagree and suggest that there are ample possibilities for states to invest resources into global health in order to reap a number of benefits – both in case of potential crises and in terms of gaining influence in matters of global governance.

Conclusion

The HD of Norway, as suggested above, is the latest variety of its successful activities in niche diplomacy, and is thus a natural extension of the country's way of conducting themselves internationally, which in sum is a type of conduct nearly approaching the behaviour of the most archetypal traditional middle power. Through positive encouragement of its *involvement* policy both from within and without, coupled with the initiative and personal persuasions of strong and

well-connected personalities such as Brundtland and Stoltenberg, a strong and clear stance on global health has seamlessly become an important part of Norwegian foreign policy.

This chapter began by tracing the origins of the country's contemporary stance on HD, and attributed this to several coinciding factors which included a long-standing culture of the support of human rights and peace; new opportunities following the end of the Cold War and the presence of certain individuals in a semi-hegemonic Labour Party in the 1990s. Over the years, as a continuation of successful feats in development and peacekeeping engagements, Norway was involved in several initiatives and projects advocating the betterment and global health and the prioritization of its explicit presence in foreign policy – most notably in initiating the Oslo Ministerial Declaration.

Contemporarily, the official stance of Norway in relation to global health is one emphasising the right to health as a human right and the possibility of providing it as a GPG. More implicitly, Norway also recognises the link between health and increased development, as they choose their bilateral partners with some care, keeping future relations and potential gains in mind.

As the country has gained this position of a global health leader, coupled with the fact that it consistently allocates a significant amount of money to the cause annually, Norway holds a position of significant influence in all actor-spheres within HD, and perhaps especially in bilateral relationships and in cooperation with both large and small NGOs. Further, it is highly supportive of the WHO as well as with large NGOs, thus supporting both old and new actors in the global health landscape.

In sum, Norway's approach and rationale in regards to HD, both in rhetoric and in practical terms, in many ways embody the *bi-directionality* of the concept thoroughly discussed in Chapter 2. Inspired by the humanist culture of the welfare state and perpetuated and enlarged because of its success in terms of *realpolitik*, Norwegian involvement in global health is at once altruistic and self-interested – something which thus far seems to be to the benefit of all involved parties. Its global health conduct also embodies what can be expected by a traditional middle power, as its strategy for gaining soft power influence heavily relies on conducting niche diplomacy as well as supporting large multilateral institutions, in this case the WHO specifically. In fact, Norway can be said to have taken the traditional middle power role to an extreme regarding global health. This is because of its healthy economy, humanist domestic welfare-culture, the important steps

made by certain individuals and, not least, its successful reliance of niche diplomacy which has been utilized in lieu of hard power capabilities.

Chapter 6: Conclusion

This final chapter is designed to conclude the study and reflect on its findings. It starts by re-introducing the study's research problem and research questions. Next, it briefly summarizes what has been done in the previous chapters, before eventually answering the research problem and research questions. Finally, it suggests possibilities for further studies and future research on the topic.

This study was set out to assess, using the case studies of South Africa and Norway, the similarities and differences in how *emerging* and *traditional* middle powers, respectively, approach the new foreign policy phenomenon of HD, and subsequently the reasons for how and why these similarities and differences manifest themselves in practice. Literature conducting case studies in relation to HD is lacking in the field, and assessing this new foreign policy phenomenon with the multifaceted and topical middle power category is uncharted territory in the study of IR.

The study was also interested in assessing whether conceptual, theoretical and typological frameworks existed in the literature concerning HD, considering its relative infancy in the field of IR. Furthermore, it set out to explore the future prospects are for HD in the two countries used as case studies and, by extension, for traditional and emerging middle powers in general.

The first two chapters were designed to introduce and illuminate the two central concepts in the research statement, namely *health diplomacy* and *middle power* by way of a literature survey. With this goal in mind, the primary purpose of the second chapter was go give a thorough overview of all the facets surrounding the concept of HD in order to make the meaning of the term clear in subsequent chapters. The second purpose of the chapter was to evaluate and delineate which frameworks in the literature could be used in the analysis of specific state's HD conduct. While this latter purpose cannot be said to have been completely successful, this is attributed to the relative novelty of the sub-field. Furthermore, the endeavour was in fact sufficiently fruitful to carry out the study at hand in a satisfactory manner. The purpose of the third chapter was to provide the same kind of understanding for the concept of middle power, and to introduce the middle power framework upon which this study relies, namely the division of emerging and traditional middle powers proposed by Eduard Jordaan (2003).

With the key concepts defined, the following two chapters aimed to provide the empirical basis for addressing the research problem by presenting the case studies of South Africa and Norway, exemplar states of the categories of emerging and traditional middle powers, respectively. In both cases, this was done by presenting the historical context from which their contemporary HD evolve, specifically over the last two decades, before describing their current HD practices through the use of the selected frameworks presented in chapters 1 and 2. These findings were then assessed in relation to the two middle powers categories at large, and a short discussion on future prospects was included.

The research problem

While there were some similarities, the countries assessed in the case studies of this study diverged significantly in their approach to HD and in terms of the place of global health in their foreign policies. Many of these divergences can be attributed to the constitutive and behavioural features which divide traditional and emerging middle powers as they were delineated in Chapter 3.

Perhaps the most striking similarity between the two is the reliance on multilateralism. Both exemplars show an explicit allegiance to the legitimacy of the WHO in terms of global health governance and both strive to strengthen their positions within it. This is hardly surprising, however, as it was suggested that the dependence on acting within multilateral institutions is a common denominator for both middle power types: "This general tendency, or indeed necessity of, conducting multilateral activities is symptomatic of middle power foreign policy behaviour at large" (This study, page 47).

One more feature of commonality found is the *images* that both South Africa and Norway portray of themselves as international good citizens and as distributors of good values and particularly human rights. Indeed, in terms of the framework which categorises different *official* rationales for engaging in HD, based on the work by Labonte & Gagnon as described in the end of Chapter 2, these countries both fall within the category of *health and human rights* in the assessment of their approaches.

However, with rhetoric aside and in viewing the actual conduct of the two countries, the divergences start becoming apparent. For South Africa, the veracity of this self-imposed frame of a human rights activist has gradually decreased when scrutinised in relation with its actual

behaviour. In typical emerging middle power style, this image, which currently has become more of a poorly masked pretence, is mostly used superficially in order to gain or retain some international approval to combat their weakening international profile and to gain regional and domestic legitimacy, exemplified by the rhetoric of *Ubuntu* and in the signing of the Oslo Ministerial Declaration with little or no follow-up. Norway, on the other hand, as a country which has shown to be an exceedingly archetypal traditional middle power, has humanist values very much entrenched in its broader political culture, and has continuously committed large amounts of resources and thus act more in accordance with their statements.

However, both these countries have unique histories that have affected their comportment in significant ways, which cannot be said to be purely attributable to their traditional and emerging middle power positions. First, while Norway has enjoyed a flow of positive feedback for its humanist *involvement* policies, South Africa had to face difficult decisions early on, and in a perceived dilemma between showing solidarity with certain states in Africa and continuing a strictly human rights-based foreign policy, the choice fell on the former. While signs of this were clear even under Mandela, his successors have had little or no personal interest in prioritizing the humanist pillars defined by the ANC in 1993. Norway, on the other hand, has enjoyed the personal drive and initiative of several high-level individuals.

This is not to say that the HD of traditional middle powers is based solely upon a sense of altruism and an embrace of cosmopolitanist ideas of interconnectedness, as this is clearly not the case. If anything, the South African constitution is far more heavily laden with rhetoric inspired by such ideas than the Norwegian one. However, Norway has all but perfected their niche diplomacy in a display of enlightened self-interest in a way which South Africa has not been able to. There are two reasons why this is arguably an easier path for traditional middle powers than for emerging ones. First, and most significantly, the main partners of cooperation for traditional middle powers are states that share its culture of Western, humanist ideas – ideas that are also hegemonic. For emerging middle powers, the most eligible partners of cooperation are explicitly counter-hegemonic, and hardly concerned with the promotion of humanist ideas. The two traditionally most powerful states in the BRICS association, Russia and China, are perhaps the clearest examples of this. Second, there is also domestic support to lose in the case of Norway if one were to divert from incorporating *involvement* in foreign policy, a factor which might not be

present in South Africa and in the world of emerging middle powers at large, as domestic issues dominate, particularly in terms of inequality and various social cleavages.

In terms of the different spheres of communication and cooperation amongst the myriad types of actors involved in HD on a global scale, there are also a certain amount of similarities and differences between the two case studies. Again, some of these can be attributed to the respective middle power categories' characteristics, whilst some relate more to the specific context of the countries specific to this study.

Both countries are heavily involved in and supportive of the WHO, and share a mutual respect and admiration with the organization, albeit in separate ways. While South Africa in many ways holds a favourable position because of their regional superiority in an area which requires significant attention in terms of health issues including those within its own borders, Norway's high standing has come as a result of its consistent and vocal support, perhaps particularly of the MDGs. It can also be seen as one of the fruits of its increasingly successful *involvement* policies. However, South Africa is also multilaterally tied to the BRICS association, which recently has presented its own global health agenda. Bilaterally, partners are unsurprisingly chosen strategically, but Norway is, simply put, a donor whilst South Africa is largely a recipient of funds.

As for relationships with different type of non-state actors, the two case studies represent two extremes in that Norway is empowered in these dealings whilst South Africa is disempowered. The negotiations are all heavily affected by South Africa's domestic health crisis and of Norway's semi-exceptionally large-scale and very detail-oriented ODA funding, respectivey. In conclusion, while the strong efforts in multilateralism is common for all middle powers, the divergences are more related to country-specific circumstances rather than adherence to any middle power group, directly.

Additional research questions

The first additional research question inquired about the availability of useable frameworks for the study of HD. As has been suggested several times and as indeed set decided the design of this study, workable frameworks *do* exist for assessing significant parts of this multifaceted concept. However, regarding the measurement and evaluation of HD policies, the literature is still too limited and tentative to provide a satisfactory framework.

The second additional research question was interested in the future implications of HD in South Africa and Norway and subsequently for the two middle power groups. Once again, there is a divide with what can be said for the individual countries and their unique contexts, and what can be said for the two state type categories. As South Africa gets increasingly involved with and dependent on its relationship with the BRICS association, and its domestic health crisis stays the same, its engagements within global health is unlikely to change. Indeed, this dimension of South African foreign policy seems to be stuck in the lower regions of its *low politics*, particularly if Jacob Zuma's successors show equal disinterest in the matter – even if the alternative ideas are there in the form of for example Pieter Fourie's AIDS diplomacy. For Norway, efforts in global health is an important part of its foreign policy, and is likely to be even further expanded in the future as it continues is success.

Realistically, emerging middle powers are more likely to engage in HD regionally for immediate security concerns in the case of an epidemic rather than engaging significantly in global health. While Brazil is an exception to this, most emerging middle powers view trade, business and counter-hegemonic initiatives as more conducive to their immediate interest than pursuing niche diplomacy in the form of global health matters. Traditional middle powers, on the other hand, can follow the example of Norway and seize opportunities in HD with both state- and non-state actors as a way to build influence in the form of soft power capabilities, and have far fewer challenges in the form of continuously having to confirm their regional legitimacy and are not in the same way inclined to rely on cooperation with questionable 'bedfellows', to use the terminology of Henning Melber.

Potential future studies

One suggestion for future studies that is immediately quite noticeable is the need for more case studies in the study of the topic which was explored in this study. Indeed, unique circumstances which cannot be directly attributed to middle power status affect Norway's and perhaps particularly South Africa's foreign policies significantly. Therefore, a larger sample size would help make the common denominators for several traditional and emerging middle powers' approach to HD clearer.

Relatedly, another subject could entail an investigation of the significance of external versus internal influences on a country's relation to HD, seen in relation to the exponential consequences

of globalization to which the concept owes its existence. This would be based on historical as well as current contexts in an array of case studies and with a view to the future.

Many emerging middle powers are explicit in their Global South solidarity and their subsequent preference for promoting South-South cooperation. One area within HD which could be explored is potential differences in how Global South actors cooperate and negotiate with other actors from the Global South versus those of the Global North. This comparative analysis would envelop bilateral as well as tri- and multilateral relations and all negotiations within and between these which include health.

Bibliography

Adams, V., Novotny, T. E., & Leslie, H. (2008). Global health diplomacy. *Medical Anthropology*, *27*(4), 315-323.

Agarwal, M. (2013) South-South Economic Cooperation, Emerging Trends and Future Challenges. Background Research paper Submitted to the High Level panel on Post-2015 Development Agenda, UN, New York.

Anaemene, B. U. (2013). Health Diplomacy under Structural Adjustment Programme: A View from Nigeria. *International Affairs and Global Strategy*, *15*, 65-75.

Barber, J. (2005). The new South Africa's foreign policy: principles and practice. *International Affairs*, *81*(5), 1079-1096.

Barnett, M. (1990). High Politics is Low Politics: The domestic and systemic sources of Israeli security policy, 1967–1977. *World Politics*, *42*(44), 529-562.

Beeson, M. (2011). Can Australia save the world? The limits and possibilities of middle power diplomacy. *Australian Journal of International Affairs*, *65*(5), 563-577.

Bélanger, L. and Mace, G. (1997) 'Middle Powers and Regionalism in the Americas'. In Cooper, A.F. (Ed.) *Niche Diplomacy: Middle Powers after the Cold War.* Macmillan, Basingstoke.

Bill of Rights of the Constitution of the Republic of South Africa. (1996). Available: http://www.justice.gov.za/legislation/constitution/bill-of-rights.html [Accessed 15th September, 2014]

Bischoff, P. H. (2009). Reform in defence of sovereignty: South Africa in the UN Security Council, 2007-2008. *Africa Spectrum*, *44*(2), 95-110.

Black, D. (1997). Addressing apartheid: lessons from Australian, Canadian and Swedish policies in Southern Africa. In Cooper, A.F. (Ed.) *Niche Diplomacy: Middle Powers after the Cold War.* Macmillan, Basingstoke.

Black, D. R., & Smith, H. A. (1993). Notable exceptions? New and arrested directions in Canadian foreign policy literature. *Canadian Journal of Political Science*, *26*(4), 745-774.

Bliss, K. E. (2011). *Health diplomacy of foreign governments*. Center for Strategic & International Studies. Washington, D.C.

Blouin, C., Molenaar, B., & Pearcey, M. (2012). Annotated literature review: Conceptual frameworks and strategies for research on global health diplomacy. Available: http://equinetafrica.org/bibl/docs/Diss92%20GHD%20Litrev%20July2012.pdf [Accessed 6th July, 2014)

Brest, P. (2010). The power of theories of change. *Stanford Social Innovation Review*, *8*(2), 47-51.

BRICS Information Centre (2011). *BRICS Health Ministers' Meeting: Beijing Declaration*. Available: http://www.brics.utoronto.ca/docs/110711-health.html [Accessed 21st September, 2014].

Botero, Giovanni (1956[1589]). *The Reason of State*. Routledge and Kegan Paul. Routledge, London.

Burnham, P., Grant, W., Lutz, K. G., & Layton-Henry, Z. (2008). *Research methods in politics*. Palgrave Macmillan. Basingstoke.

Chan, M., Støre, J. G., & Kouchner, B. (2008). Foreign policy and global public health: working together towards common goals. *Bulletin of the World Health Organization*, *86* (7), 498.

Claxton, B. (1944). The Place of Canada in Post-War Organization. *Canadian Journal of Economics and Political Science*, *10*(4), 409-421.

Chatham House (2011). Global Health Diplomacy: A Way Forward in International Affairs. London. Available: http://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/280611summary.pdf [Accessed 4th May, 2014)

Chapnick, A. (1999). The middle power. *Canadian Foreign Policy Journal*, *7*(2), 73-82.

Chapnick, A. (2000). The Canadian middle power myth. *International Journal: Canada's Journal of Global Policy Analysis*, *55*(2), 188-206.

Cooke, J. (2011). South Africa and global health: Minding the home front first. *International Organisations Research Journal*, *6*(4), 125-134.

Conley, H. and Melino, M. (2014). In: B. Katherine, (Ed.), *The Changing Landscape of Global Health Diplomacy*. Centre for Strategic and International Studies, Washington, D.C.

Cooper, A. F., Heine, J., & Thakur, R. (Eds.). (2013). *The Oxford handbook of modern diplomacy*. Oxford University Press, Oxford.

Cooper, A. F., Higgott, R. A., & Nossal, K. R. (Eds.). (1993). *Relocating middle powers: Australia and Canada in a changing world order* (Vol. 6). University of British Columbia Press, Vancouver.

Cooper, D. A. (2011), Challenging Contemporary Notions of Middle Power Influence: Implications of the Proliferation Security Initiative for "Middle Power Theory". *Foreign Policy Analysis 7*(3), 317–336.

Cox, R. W. (1989). Middlepowermanship, Japan, and future world order. *International Journal*, *44*(4), 823-862.

David, C. P., & Roussel, S. (1998). "Middle Power Blues": Canadian Policy and International Security after the Cold War. *American Review of Canadian Studies*, *28*(1-2), 131-156.

Davies, S. E. (2010a). What contribution can International Relations make to the evolving global health agenda?. *International Affairs*, *86*(5), 1167-1190.

Davies, S. (2010b). *Global politics of health*. Polity, Cambridge.

de Carvalho, B., & Neumann, I. B. (Eds.). (2014). *Small State Status Seeking: Norway's Quest for International Standing*. Routledge, Abingdon.

Department of International Relations and Cooperation (2009). *Strategic Plan, 2009-2012*. Pretoria. http://www.dfa.gov.za/department/stratpla2009-2012/index.htm [Accessed 3rd September, 2014]

Department of International Relations and Cooperation (2011). *Building a Better World: The Diplomacy of Ubuntu – White Paper on South Africa's Foreign Policy*. Pretoria. Available:

http://www.safpi.org/sites/default/files/publications/white_paper_on_sa_foreign_policy-building_a_better_world_20110513.pdf [Accessed 5th September, 2014).

Department of International Relations and Cooperation (2013). *Strategic Plan, 2013-2018*. Pretoria. Available: http://www.dfa.gov.za/department/strategic_plan_2013-2018/index.htm [Accessed 4th September, 2014).

Dodgson, R., Lee, K. and Drager, N. (2002) *Global Health Governance: A Conceptual Review*. Discussion Paper no. 1. World Health Organization & London School of Hygiene and Tropical Medicine, Geneva.

DONOR Tracker (2014). *Country Profile Norway*. Available: http://donortracker.org/sites/default/files/SEEK%20Donor%20Profile%20Norway%20February%202014.pdf [Accessed 1st October, 2014)

Druckman, J. N. (2001). The implications of framing effects for citizen competence. *Political Behavior*, *23*(3), 225-256.

Eggen, Ø., & Sending, O. J. (2012). Recent contributions to research on health and foreign policy. First Report of the International Research Initiative on Global Health and Foreign Policy. Norwegian Institute of International Affairs, Oslo.

Evans, G. (1996). South Africa in remission: the foreign policy of an altered state. *The Journal of Modern African Studies*, *34*(2), 249-269.

Fauci, A. S. (2007). The expanding global health agenda: a welcome development. *Nature Medicine*, *13*(10), xxi-xxiii.

Feldbaum, H., Lee, K., & Michaud, J. (2010). Global health and foreign policy. *Epidemiologic Reviews*, *32*(1), 82-92.

Fendrick, R. J. (2004). Diplomacy as an instrument of national power. In: J.B. Bartholomee (Ed.), *U.S. Army War College Guide to National Security Issues Vol. 1: Theory of War and Strategy*, (3rd. ed.). Security Studies Institute, Carlisle, PA.

Fidler, D. (2002). Global health governance: overview of the role of international law in protecting and promoting global public health. Discussion Paper No. 3. World Health Organisation, Geneva.

Fidler, D. P. (2009). Health in foreign policy: An analytical overview. *Canadian Foreign Policy Journal*, *15*(3), 11-29.

Fidler, D. (2010). *The challenges of global health governance*. Council on Foreign Relations, Incorporated, New York.

Fidler, D. (2013). Health Diplomacy. In: A. Cooper, J. Heine and R. Takur, (Eds.). *The Oxford Handbook of Modern Diplomacy*. Oxford University Press, Oxford.

Fraser, B. (1966). Canada: mediator or busybody. In: J. King Gordon (Ed.), *Canada's role as a middle power.* Canadian Institute for International Affairs, Toronto.

Foreign Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa & Thailand (2007), Oslo Ministerial Declaration – global health: A pressing foreign policy issue of our time. *The Lancet*, *369*(9570), 1373-1378

Fourie, P. (2013). Turning dread into capital: South Africa's AIDS diplomacy. *Globalization and Health*, *9*(1), 1-12.

Gagnon, M. L. (2012). *Global Health Diplomacy: Understanding How and Why Health is Integrated into Foreign Policy*. Doctoral dissertation, University of Ottawa, Ottawa.

Glazebrook, G. (1947). The middle powers in the United Nations system. *International Organization*, *1*(2), 307-318.

Global Humanitarian Assistance (2013) *South Africa – Key Figures, 2013*. Available: http://www.globalhumanitarianassistance.org/countryprofile/south-africa [Accessed 10 February 2015].

Gelber, L. (1946). Canada's New Stature. *Foreign Affairs*, *24*(2), 277-289.

Gerring, J. (2004). What is a case study and what is it good for?. *American political science review*, *98*(2), 341-354.

Gilley, B. (2010). Middle powers during great power transitions. *International Journal*, *66*(2), 245-264.

Gomez, E. (2012). Understanding Brazilian global health diplomacy: Social health movements, institutional infiltration, and the geopolitics of accessing HIV/AIDS medication. *Global Health Govern*, *6*(1), 1-29.

Hammerstad, A. (2012). Securitisation from below: the relationship between immigration and foreign policy in South Africa's approach to the Zimbabwe crisis. *Conflict, Security & Development*, *12*(1), 1-30.

Hawksley, C. (2009). Australia's aid diplomacy and the Pacific Islands: change and continuity in middle power foreign policy. *Global Change, Peace & Security*, *21*(1), 115-130.

Holbraad, C. (1984). *Middle powers in international politics*. Macmillan, London.

Holmes, John (1976). *Canada: A Middle-Aged Power*. McClelland and Stewart, Ottawa.

Horton, R. (2007). Health as an instrument of foreign policy. *The Lancet,369*(9564), 806-807.

Huber, M., Knottnerus, J. A., Green, L., Horst, H. V. D., Jadad, A. R., Kromhout, D. & Smid, H. (2011). How should we define health?. *British Medical Journal*, *343*(6), d4163

Huelsz, C. (2009). *Middle power theories and emerging powers in international political economy: A case study of Brazil*. PhD Dissertation, University of Manchester.

Hurrell, A. (2000). Some reflections on the role of intermediate powers in international institutions. In: Hurrel. A., et al., (Eds.), *Paths to power: Foreign policy strategies of intermediate states*, Latin American Program. Working Paper No. 244, Woodrow Wilson International Center, Washington D.C.

Ikenberry, G. J., & Kupchan, C. A. (1990). Socialization and hegemonic power. *International organization*, *44*(3), 283-315.

Irwin, R., Pearcey, M., Editor's Introduction. *Journal of Health Diplomacy Online 1*(1). 1-3.

Jordaan, E. (2003). The concept of a middle power in international relations: distinguishing between emerging and traditional middle powers. *Politikon*, *30*(1), 165-181.

Jordaan, E. (2010). Fall from Grace: South Africa and the Changing International Order. *Politics*, *30*(1), 82-90.

Katz, R., Kornblet, S., Arnold, G., Lief, E., & Fischer, J. E. (2011). Defining health diplomacy: changing demands in the era of globalization. *Milbank Quarterly*, *89*(3), 503-523.

Keohane, R. O. (1969). Lilliputians' Dilemmas: Small States in International Politics. *International Organization*, *23*(2), 291-310.

Keohane Robert, O., & Nye, J. S. (1989). *Power and interdependence*. (2nd ed.). Scott, Foresman, Glenview, IL.

Kickbusch, I. (2011). Global health diplomacy: how foreign policy can influence health. *British Medical Journal 342*, d3154.

Kickbusch, I. (2013). A game change in global health: the best is yet to come. *Public Health Reviews*, *35*(1).

Kickbusch, I., & Kökény, M. (2013). Global health diplomacy: five years on. *Bulletin of the World Health Organization*, *91*(3), 159-159.

Kickbusch, I., Silberschmidt, G., & Buss, P. (2007). Global health diplomacy: the need for new perspectives, strategic approaches and skills in global health.*Bulletin of the World Health Organization*, *85*(3), 230-232.

Labonté, R., & Gagnon, M. L. (2010). Framing health and foreign policy: lessons for global health diplomacy. *Globalization and Health*, *6*(14), 1-19.

Landsberg, C. (2010). *The diplomacy of transformation: South African foreign policy and statecraft*. Macmillan, Johannesburg.

Lee, K., 2009. Understandings of global health governance: the contested landscape. In: Williams, O., Kay, A. (Eds.), *The Crisis of Global Health Governance: Challenges, Institutions and Political Economy*. Palgrave Macmillan, London

Lee, K., & Smith, R. (2011). Global health diplomacy: A conceptual review. *Global Health Governance*, *5*(1), 1–12.

Lee, K., & Gomez, E. (2012). Brazil's ascendance: The soft power role of global health diplomacy. *The World Financial Review*.
Available: http://www.worldfinancialreview.com/?p=414 [Accessed 5th May, 2014)

Leira, H. (2002). Internasjonal idealisme og Norge. Utenrikspolitisk tenkning fra Justus Lipsius til Halvdan Koht. *Hovedoppgave i statsvitenskap (Master's thesis in political science)*. University of Oslo, Department of Political Science, Oslo.

Leira, H. (2005). Folket og freden. Utviklingstrekk i norsk fredsdiskurs 1890–2005. *Internasjonal politikk*, *63*(2), 135-60.

Leira, H. (2014). The formative years. In: de Carvalho, B., & Neumann, I. B. (Eds.). (2014). *Small State Status Seeking: Norway's Quest for International Standing*. Routledge, Abingdon.

Lencucha, R. (2013). Cosmopolitanism and foreign policy for health: ethics for and beyond the state. *BMC international health and human rights*, *13*(1), 29.

Lencucha, R., Kothari, A., & Labonté, R. (2011). The role of non-governmental organizations in global health diplomacy: negotiating the Framework Convention on Tobacco Control. *Health policy and planning*, *26*(5), 405-412.

Lægreid, Turid (1996). "Den "nye" utanrikspolitikken: humanitær assistanse som realpolitikk?" In: Iver B. Neumann & Ståle Ulriksen (Eds.) *Sikkerhetspoltikk. Norge i makttriangelet mellom EU, Russland og USA*. Tano Ascheoug, Oslo.

Macfarlane, S. (2006). The 'R'in BRICs: is Russia an emerging power?. *International Affairs*, *82*(1), 41-57.

Malamud, A. (2011). A leader without followers? The growing divergence between the regional and global performance of Brazilian foreign policy. *Latin American Politics and Society*, *53*(3), 1-24.

Mandela, N. (1993). South Africa's future foreign policy. *Foreign Affairs 72*(5), 86-97.

Marten, R., Hanefeld, J., & Smith, R. Power: The nexus of global health diplomacy. *Journal of Health Diplomacy online 1*(1) 1-3.

Matlary, J. (2014). *Verdidiplomati - kilde til makt? - Det samfunnsvitenskapelige fakultet*. Oslo. Available: http://www.sv.uio.no/mutr/publikasjoner/rapporter/rapp2002/Rapport46.html [Accessed 23 Sep. 2014].

McKinnes, C., & Lee, K. (2012). *Global health and international relations*. Polity, Cambridge.

Melber, H. (2014). Engagement matters: South Africa, the United Nations and a rights-based foreign policy. *South African Journal of International Affairs*, *21*(1), 131-145.

Michaud, J., & Kates, J. (2013). Global health diplomacy: advancing foreign policy and global health interests. *Global Health: Science and Practice*, *1*(1), 24-28.

Morgenthau, H. J. (1946). Diplomacy. *Yale Law Journal 55*(5), 1067-1080.

Mookherji, S., Greb, H., Katz, R. (2014) Using a theory of change approach to analyze global health diplomacy practice in Myanmar. *Journal of Health Diplomacy Online* 1 (2). 1-17.

Neumann, I. B. (2011). Peace and Reconciliation Efforts as Systems-Maintaining Diplomacy The Case of Norway. *International Journal: Canada's Journal of Global Policy Analysis*, *66*(3), 563-579.

Norwegian Ministry of Foreign Affairs (2010). *Norwegian WHO Strategy 2010-2013 – Norway as a member of WHO's Executive Board.* Oslo. Available: http://www.regjeringen.no/upload/HOD/Dokumenter%20ADA/Norwegian_WHO_Strategy_2010-2013_engelsk.pdf [Accessed 4th September, 2014)

Norwegian Ministry of Foreign Affairs (2011). *The Norwegian Government's strategy for cooperation between Brazil and Norway – New perspectives on a long-standing relationship*. Available: http://www.regjeringen.no/en/dep/ud/documents/Reports-programmes-of-action-and-plans/Action-plans-and-programmes/2011/brazil_strategy.html?id=636321 [Accessed 20th September, 2014)

Norwegian Ministry of Foreign Affairs (2012). *Global health in foreign policy and development policy.* Oslo. Available: http://www.regjeringen.no/en/dep/ud/documents/propositions-and-reports/reports-to-the-storting/2011-2012/meld-st-11-2011-2012.html?id=672110 [Accessed 4th September, 2014)

Norwegian Ministry of Foreign Affairs (2013) *Profile 2013 – GAVI*. Oslo. Available: http://www.regjeringen.no/upload/UD/Vedlegg/FN/profilark2013/Profilark2013-eng/GAVI.pdf [Accessed 1st October, 2014]

Norwegian Ministry of Foreign Affairs (2014). *Utenrikspolitisk redegjørelse for Stortinget – mars 2014*. Oslo. Available: http://www.regjeringen.no/nb/dep/ud/aktuelt/taler_artikler/bb_taler/2014/redgjoerelse_stortinget.html?id=753809 [Accessed 15th September, 2014)

Nye, J. S. (2004). *Soft power: The means to success in world politics*. PublicAffairs, New York.

Olivier, G. (2012). South Africa's foreign policy towards the Global North. In: Landsberg, C., & Van Wyk, J. A. (Eds.). *South African foreign policy review (Vol. 1).* Africa Institute of South Africa, Pretoria.

Peet, R. (2002). Ideology, discourse, and the geography of hegemony: From socialist to neoliberal development in postapartheid South Africa. *Antipode*, *34*(1), 54-84.

Pibulsonggram, N. (2007). Oslo Ministerial Declaration—global health: a pressing foreign policy issue of our time. *The Lancet*, *369*(9570), 1373-78.

Pratt, C. (Ed.). (1990). *Middle power internationalism: The north-south dimension*. McGill-Queen's Press, Quebec.

Ramos, L. (2013). Critically Thinking the Global Political Economy: Assessment for the study of Middle Powers. *Austral: Brazilian Journal of Strategy & International Relations*, *2*(3), 233-256.

Ritchie, J., & Lewis, J. (Eds.). (2003). *Qualitative research practice: A guide for social science students and researchers*. (1st ed.). Sage, London.

Royal Norwegian Embassy of Tanzania (2012) *Norway and Tanzania – Partners in Development*. Available: http://www.norway.go.tz/PageFiles/232663/Result_report_2012_rgb.pdf [Accessed 17th September, 2014]

Saracci, R. (1997). The World Health Organisation needs to reconsider its definition of health. *British Medical Journal*, *314*(7091), 1409-1410.

Sandberg, K. I., & Andresen, S. (2010). From development aid to foreign policy: Global immunization efforts as a turning point for Norwegian engagement in global health. *Forum for development studies*, 37(3), 301-325.

Scheff, T. J. (1995). Academic gangs. *Crime, Law and Social Change*, *23*(2), 157-162.

Singer, P. (1981). *The expanding circle*. Clarendon Press, Oxford.

Singer, P. (2011). *The expanding circle: Ethics, evolution, and moral progress*. Princeton University Press, Princeton.

Skånland, Ø. H. (2010). 'Norway is a peace nation': A discourse analytic reading of the Norwegian peace engagement. *Cooperation and conflict*, *45*(1), 34-54.

Spies, Y. K. (2010). South Africa's Multilateral Challenges in a 'Polypolar'World. *The International Spectator*, *45*(4), 73-91.

South African Foreign Policy Initiative (2013). *Dialogue on South Africa-Cuba Relations*. Available: http://www.safpi.org/news/article/2013/dialogue-south-africa-cuba-relations [Accessed 6th September, 2014)

South African Institute of International Affairs (2013). *South African Development Partnership Agency (SADPA): Strategic Aid or Development Packages for Africa?* Available: http://www.saiia.org.za/research-reports/south-african-development-partnership-agency-sadpa-strategic-aid-or-development-packages-for-africa [Accessed, 19th September, 2014)

Stuckler, D., & McKee, M. (2008). Five metaphors about global-health policy. *The Lancet*, *372*(9633), 95-97.

Stuenkel, O. (2013). Institutionalizing South-South Cooperation: Towards a New Paradigm?, Background Research Paper submitted to the High Level Panel on the Post-2015 Development Agenda. UN, New York.

Therien, J. P. (1999). Beyond the North-South divide: the two tales of world poverty. *Third World Quarterly*, *20*(4), 723-742.

Tytel, B., & Callahan, K. (2012). Shifting paradigm: how the BRICS are reshaping global health and development. *Global Health Strategies Initiative*. New York.

Ungerer, C. (2007). The "middle power" concept in Australian foreign policy. *Australian Journal of Politics & History*, *53*(4), 538-551.

United Nations Development Programme (2014) *Human Development Report 2014 – Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience.* Available: http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf [Accessed 25th September, 2014)

United Nations Secretary General (2009). Note by the Secretary-General A/64/365. Global health and foreign policy: strategic opportunities and challenges. Available: www.who.int/trade/foreignpolicy/en/ [Accessed 28th May, 2014]

Van Der Westhuizen, J. (1998). South Africa's emergence as a middle power. *Third World Quarterly*, *19*(3), 435-456.

Vandemoortele, J. (2011). The MDG story: intention denied. *Development and Change*, *42*(1), 1-21.

Watt, N. F., Gomez, E. J., & McKee, M. (2013). Global health in foreign policy—and foreign policy in health? Evidence from the BRICS. *Health policy and planning*, *29*(1), 1-11.

Walt, G., Shiffman, J., Schneider, H., Murray, S. F., Brugha, R., & Gilson, L. (2008). 'Doing'health policy analysis: methodological and conceptual reflections and challenges. *Health policy and planning*, *23*(5), 308-317.

World Health Organization. (1950). *The Preamble of the Constitution of the World Health Organization*. New York.

World Health Organization (2012). *Health: essential for sustainable development*. Available: http://www.who.int/universal_health_coverage/un_resolution/en/ [Accessed 1st October, 2014).

World Health Organization (2014). *South Africa Country Cooperation Strategy*. WHO, Regional Office for Africa. Available: http://www.afro.who.int/en/south-africa/country-cooperation-strategy.html [Accessed 11th September, 2014].

Wood, B. (1988). *The middle powers and the general interest*. North-South Institute, Ottawa.

Yanacopulos, H. (2014). The Janus Faces of a Middle Power: South Africa's Emergence in International Development. *Journal of Southern African Studies*, *40*(1), 203-216.

Youde, J. (2012). *Global health governance*. Polity, Cambridge.

Yu, P. K. (2008). Access to medicines, BRICS alliances, and collective action. *American Journal of Medicine*, *34*(2-3), 345-394.