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How states engage in and exercise power in global health: Indonesian and Japanese engagement in the conceptualization of Sustainable Development Goal 3

Robert Marten [a,*], Johanna Hanefeld [a], Richard D. Smith [b]

[a] London School of Hygiene and Tropical Medicine, University of London, London, WC1H 9SH, UK
[b] University of Exeter, Medical School Building, St Luke's Campus, Magdalen Road, Exeter, EX1 2LU, UK

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ABSTRACT

While long overlooked, power is central to understand how actors engage in global health policymaking. We reviewed how the Japanese and Indonesian governments exerted power and engaged in global health diplomacy during negotiations to conceptualize the post-2015 Sustainable Development Goal for health (SDG3). We conducted deliberative policy analysis including semi-structured, in-depth, interviews with more than 71 policymakers, which we analyzed adapting Barnett and Duvall's power framework. We find that both Japan and Indonesia exerted non-material power (institutional, productive and structural power) to advance largely domestic political interests. Japan's government mainly exerted institutional power, leveraging relationships within the World Bank and the World Health Organization, whereas Indonesia's government focused on structural power, with its president serving as co-chair of the UN Secretary-General's High-Level Post-2015 Panel. Our analysis suggests that the ways in which states engage in global health diplomacy is shaped by the relationship between different intra-state institutions, particularly the Ministry of Foreign Affairs and the Ministry of Health, and is further determined by broader foreign policy and diplomatic priorities. We find that the decline of states' influence is over-stated: states continue to exercise significant power in global health diplomacy, pursuing domestic political imperatives and strategies to improve population health. As states expand their global health engagement, researchers should seek to better understand how states participate in an increasingly crowded and contested global health field.

1. Introduction

The Millennium Development Goals (MDGs) transformed global health. They mobilized politicians and citizens, galvanized civil society, initiated robust monitoring frameworks, created research communities, and catalyzed new institutions (Vega, 2013). Global governance scholars argue that the MDGs represented a "super norm" for global development (Fukuda-Parr and Hulme, 2011). The MDGs were also a "super norm" for global health—they defined and codified a normative global health agenda in the 2000s shaping funding and programming (Marten, 2018). Given the MDGs' importance in defining the global development and global health agenda, there was tremendous interest in the process to create the successor framework to the MDGs, the Sustainable Development Goals (the SDGs). Compared to the creation of the MDGs (criticized as a top-down process driven by high-income countries), the process to conceptualize the post-2015 development framework between 2012 and 2015 was one of the most inclusive and participatory processes in the history of the United Nations. Whereas the MDGs heavily focused on health (three out of the eight goals were explicitly health goals), it was clear in 2012 that there would only be one health goal in the SDG framework. As the new health SDG would not only determine global health targets and agendas, but also ultimately shape priorities, funding allocations and resource commitments for years to come, the negotiation of the health goal was heavily contested. It was a high-stakes process involving all global health actors. Traditionally global goal setting processes reflect the will of more powerful actors with the participation of less powerful states being more symbolic. Moreover, in global health, concern has been raised for some time about the eclipsing of state power. This study therefore aimed to explore how states exercised power during the post-2015 process. We reviewed

* Corresponding author.
E-mail address: robert.marten@lshtm.ac.uk (R. Marten).

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how the Japanese and Indonesian governments exerted power and engaged in global health diplomacy during negotiations to conceptualize the post-2015 Sustainable Development Goal for health.

2. Background

Barnett and Duvall argue that studying "global governance without power looks very different from global governance with power […] much of the scholarship on global governance proceeds as if power either does not exist" (Barnett and Duvall, 2005a). This also applies to global health. While long ignored, power is central to understanding and analyzing how actors engage in global health policymaking. There has also been a growing sense that a proliferation of new global health actors is fragmenting global health governance to an extent that states hold little power over policymaking (McInnes and Lee, 2012). While recognizing new actors, analysis predicting the decline of states within global governance and global health may be premature (Marten and Smith, 2017). Instead, the rise of new actors and shifts in geopolitics, technology and policy processes as well as better connected epistemic communities (Shiffman, 2016) are challenging states to reconsider how they engage in global health. States are beginning to recognize that they may have more power than previously appreciated.

Power is traditionally associated with states deploying material resources like financing. Yet new shifts in how states engage are not necessarily tied to changes in material resources. Instead, states are increasingly strategically leveraging non-material resources. This helps explain how states which may not appear "powerful" are exerting outsized influence shaping global health. This shift has profound implications, including for how states use 'global health diplomacy'. However, understanding how states exert non-material power in global health is limited. The term 'global health diplomacy' (GHD) came into usage in the early 2000s. The emergent GHD literature often overlooks how health is incorporated into foreign policy efforts, and remains generally undertheorized (Ruckert et al., 2016). Similar to the concept of "global health", there is no dominant, widely-used definition of global health diplomacy (limiting both research and policy). GHD is considered as "policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilize health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve other political, economic or social objectives" (Lee and Smith, 2011). GHD is therefore an important lens to examine global health and the role of power.

Global health too remains a contested field, and one which Schrecker argues contains "little theorizing or critical reflection on the role of the state" (Schrecker, 2020). States' roles, both explicit and implicit, deserve further study to understand how they engage and exert power. While this is shaped by both intra-state institutional relationships and broader foreign policy priorities, there is limited research seeking to codify national global health engagement efforts. As Jones and colleagues argued, "little is known about policy processes for global health at the national scale" (Jones et al., 2017). Moreover, the literature on GHD remains largely normative (Lee and Smith, 2011) and is theoretically fragmented (Ruckert et al., 2016). Despite an emergent interest (Erasmus and Gilson, 2008; Shiffman, 2014; Moon, 2019), the role of power, particularly non-material power, in determining global health policy remains underappreciated and rarely studied empirically. This article addresses how power may contribute to a deeper theoretical understanding of both national global health policymaking and global health diplomacy.

Barnett and Duvall define power "as the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate." Their framework (see Fig. 1 below) distinguishes between specific and diffuse relations as well as direct and indirect forms of power—namely: 1) compulsory (direct power, such as use of military force); 2) institutional (indirect power, such as how international institutions are designed to favor one actor over another); 3) structural (the direct constitution or framework of actors and their roles); or 4) productive (the indirect control over the possession and distribution of resources) power. While this framework acknowledges material power or compulsory power, it is most helpful in terms of helping identify non-material forms of power, i.e., institutional, structural and productive forms of power. Their framework presents an integrated approach seeking to move beyond the idea that multiple concepts of power are competing, and identifying intersections across approaches. This approach codifies different ways actors engage and exert power, illustrating exertions of power possibly overlooked by other frameworks.

	Direct Power	**Indirect Power**
Specific Actor Interaction	Compulsory Power	Institutional Power
Social Relations of Actors	Structural Power	Productive Power

Fig. 1. Barnett and Duvall's power framework (Barnett and Duvall, 2005b).

Based on empirical research in Japan and Indonesia, this article adapts Barnett and Duvall's power framework to analyze how these states engaged in the process to conceptualize the post-2015 Sustainable Development Goal (SDG) for health (SDG3, to ensure healthy lives and promote well-being for all at all ages) between 2012 and 2015. Given the existing attention to compulsory or material power within the literature, we modified this framework to focus on non-material forms of power. We consider how both Japan and Indonesia exerted institutional, productive and structural power in negotiations to conceptualize SDG3.

The SDGs are the successor to the Millennium Development Goals (MDGs). The MDGs themselves exerted tremendous power within global health; they strongly influenced early conceptualizations of global health (Marten, 2018), and continue to shape global health governance (Marten et al., 2018). Given this importance, many actors expected the SDGs, and particularly SDG3, to have similar importance in defining a future normative global health agenda. While the SDGs' influence and impact remains to be seen, the process to conceptualize the SDGs, particularly SDG3 was extremely consultative and contested. The process to conceptualize SDG3 was primarily driven by national ministries of foreign affairs representing their governments in coordination with national ministries of health amongst others. A deeper understanding of this process within governments is critical to improving global health diplomacy.

How did different states engage in and exert power in the process to conceptualize SDG3? This article examines how two different states, Japan and Indonesia, engaged within the same process, identifying different outcomes in the way each government exerted non-material power to influence SDG3. This is important as it provides insights for policymakers and researchers seeking to understand how to exert power to advance health policy interests. This matters, as argued above, the MDGs shaped and determined many countries' health priorities. This analysis illustrates the pivotal role of states in global health, and presents evidence on two understudied states and their exertions of power in global health.

After this introduction, this article proceeds by first describing the methodology of this study. Next we contextualize Japan and Indonesia's engagement in the SDG process and explain these countries' interests in global health and utility as case studies. We then present the analysis and results of how both Japan and Indonesia engaged and exerted power to conceptualize SDG3. We conclude by summarizing and considering the implications of this analysis for global health diplomacy.

3. Methods

To examine how power operates in GHD, we conducted analysis of

two countries, Japan and Indonesia. In a global health space largely dominated by Anglophone policymaking, research institutions and publications, Japanese and Indonesian global health actors have not received sufficient rigorous, analytical attention. Moreover, considering counties that are largely neglected and understanding better how they engage can challenge existing assumptions about global health.

Japan, a member of the OECD and sometimes called a "soft power, super power" (Watanabe and McConnell, 2008), represents an established, but understudied state seeking to maintain and continue projecting its power. Japan was involved in establishing the MDGs, and sought to continue to play this role in the conceptualization of the SDGs. Indonesia represents an emerging economy and little-studied state seeking to exert greater influence and power regionally and globally. Indonesia was, in a sense, a "recipient" of the MDGs, and its government was keen to engage more actively in the SDGs' conceptualization to showcase its development progress. Both the Japanese and Indonesian governments committed to engaging in the SDG process, and experienced elections and changes in governments within the post-2015 process (2012–2015). Both these states are largely ignored in the global health diplomacy literature, yet both governments are committed to engaging in global health. Assessing these experiences together highlights how these governments understood the evolving SDG process differently and developed contrasting strategies according to their national context.

We conducted an interpretive, deliberative policy analysis (Hajer and Wagenaar, 2003; Li and Wagenaar, 2019) to understand how Japan and Indonesia engaged in the process and exerted power to develop and conceptualize SDG3. Deliberative policy analysis conceptualizes policymaking to identify and distinguish across different and often competing understandings which shape policymaking; this approach provides a focus on policy arguments and framing of vocabularies, story lines and generative metaphors (Hajer and Wagenaar, 2003). We used this as a methodological approach focused on interpretation, deliberation and practice using data drawn from literature and policy document review as well as semi-structured, in-depth, qualitative policymaker interviews adapting Barnett and Duvall's conceptual framework for power analysis.

Using interviews and policy document analysis, we applied this modified framework to the process to conceptualize SDG3. We conducted interviews with 71 policymakers, in English in interviewees' offices, including 13 high-level global policymakers in New York, London and Geneva, 31 policymakers in Tokyo and 27 policymakers in Jakarta between 2015 and 2018. Interviews were recorded and transcribed verbatim, and were selected based on their policy engagement in the SDG3 process, starting with the Ministries of Foreign Affairs and Health, and then snowballing to identify further interviewees. Additional interviewees were a mix of policymakers within the President and Prime Minister's offices, finance and planning ministries plus other policymakers, academics and members of civil society and/or the private sector consulted by government officials developing national negotiating positions.

Informants identified as particularly critical, ie those closely involved in the policy negotiations or those developing the strategy for national engagement, were interviewed two or three times to validate findings. Interview transcripts were analyzed with Nvivo 11 with themes according to exertions of institutional, structural and productive power and by policy process; for example, to identify different forms of power, the researchers coded interview transcripts based on institutional, structural and productive power to identify examples where actors exerted these different forms of power. This research was approved for ethical review by the London School of Hygiene and Tropical Medicine as well as Nagasaki University in Japan and the Ministry of Research, Technology and Higher Education in Indonesia. We strove to maintain objectivity and deliberately did not include co-authors from the countries studied; however, we engaged in periodic "member checking" to ensure analysis was contextually grounded (Maxwell, 2005).

4. Results

4.1. Setting the context: Japan and Indonesia's engagement in the post-2015 process

The process to develop SDG3 overlapped with ongoing political transformations in Japan and Indonesia, which had implications for how both governments engaged. While both countries ultimately participated in the post-2015 process, their motivations for participation and subsequent form of engagement with the process varied based on their domestic foreign policy agendas. Japan was eager to use the process as means of advancing its stature globally and within global health; whereas Indonesia was also interested in advancing its stature globally, but was less interested in engaging on health.

Following years of economic malaise in Japan in the 1990s (known as the "lost decade") and unstable governments in the 2000s (with seven different Prime Ministers between 2000 and 2010), Prime Minister Abe was re-elected in December 2012 (having previously served briefly in 2006–2007). Abe's administration was committed to asserting Japanese leadership and interests globally. Building on cross-government discussions starting from hosting the 2007 G8 Summit, Japan's Ministry of Foreign Affairs launched a new Global Health Diplomacy Strategy in June 2013 (Ministry of Foreign Affairs, Japan, 2013) centered on universal health coverage (UHC). It declared Japan's commitment to promote UHC as an integral part of the SDGs, to advance its own development efforts and national economic interests (increasing global market access for Japanese healthcare industries).

This GHD strategy grounded Japan's focus on UHC in its own experience (showcasing what informants considered the need for some level of "Japanese-ness") arguing that UHC was "indispensable to achieve human security", a key pillar of Japan's foreign policy. The GHD strategy was carefully constructed to appeal to foreign global health policymakers, and was also deeply anchored in Japan's domestic politics. Since 1961, Japan had pursued achieving UHC by providing social health insurance to its entire population (Ikegami et al., 2011). Building on this and invoking Japan's world-leading life expectancy, UHC was an issue on which Abe himself (supported by Japanese policymakers) would argue, Japan could exert "responsible and mature" global leadership (Abe, 2013). This was also aligned with Abe's agenda of stabilizing the domestic political situation and creating a stronger Japanese state by expanding external economic opportunities. Japan's GHD Strategy contended that UHC could be an "effective post-2015 development agenda" to achieve the remaining MDG health goals, advance efforts to strengthen health systems and address non-communicable diseases (NCDs) as well as ageing challenges (Ministry of Foreign Affairs, Japan, 2013).

For Indonesia, a recipient of the Millennium Development Goals (MDGs) agenda, the chance to develop the post-2015, SDG agenda, with President Yudhoyono co-chairing the UN Secretary-General's High-Level Panel (HLP) was a major opportunity to showcase the country's development success and emergence on the global stage. Elected in 2004 and re-elected in 2009, President Yudhoyono was nearing the end of his second term during the conceptualization of SDG3 and focused on his legacy. Following the tumultuous 1997 end of Suharto's reign, he was a stabilizing force in Indonesian politics and oversaw rapid economic expansion. He aimed to modernize and reform state bureaucracy and exert regional and global leadership (Nabbs-Keller, 2013; Parameswaran, 2014).

Watching these developments from outside Indonesia, particularly in the US (Hiebert, 2013) and the UK (Seiff, 2013), analysts expected Yudhoyono's government would increase global health engagement, including within the post-2015 agenda; however, in Jakarta, the reality was different. Indonesian policymakers were less interested in global health policymaking, and more interested in advancing domestic health reforms. Yet once Yudhoyono was named as an HLP Co-Chair, Indonesian policymakers saw an opportunity to advance domestic interests by

contesting how and where the government engaged on health. The President's Office as well as the Ministries of Foreign Affairs and Health engaged in the post-2015 process, which served Indonesia's foreign policy aims, but these were not part of a broader global health strategy. Unlike in Japan, there was not an ongoing cross-government global health policy dialogue. Instead, policymakers viewed the post-2015 process opportunistically. This was not part of an overall effort to mobilize, and then leverage, deeper Indonesian commitment to global health. There was no Indonesian global health strategy aligned with national foreign policy. Indeed, the need for (and/or potential benefits from) coordinating efforts did not appear necessary or worthwhile to informants.

4.2. Analysis and results: how Japan and Indonesia engaged in the SDG3 policy process

As the MDG era was coming to a close, a consultative process to begin the design of the SDGs led by the UN Secretary General and UN member states was initiated in 2012. Japan and Indonesia were active participants. The consultative process was unclear, it occurred in several stages and was continually evolving. Based on document analysis of the process outputs, including the final contents of SDG3, and on interviews with those engaged, there were three pivotal parts of the official UN process to conceptualize SDG3 held between 2012 and 2015: 1) First, the Secretary-General's High-Level Panel (HLP) convened in July 2012; 2) the thematic consultation on health hosted by UNICEF and WHO along with Sweden and Botswana (the "thematic consultation") convened in October 2012; and 3) the Open Working Group (OWG). Table 1 provides an overview and timeline of these policy processes. The result section below analyses how both Japan and Indonesia engaged across these three policy processes. Reviewing the results in the timeline of these three pivotal processes as they happened and built upon each other illustrates the different approaches taken by Japan and Indonesia, the different forms of power they applied, and the different impacts each had as within the dynamic process to conceptualize SDG3.

4.3. Part one: the Secretary-General's High-Level Panel (HLP)

In July 2012, the UN Secretary General announced a High-Level Panel with twenty-seven members co-chaired by President Susilo Bambang Yudhoyono of Indonesia, President Ellen Johnson Sirleaf of Liberia, and Prime Minister David Cameron of the United Kingdom. As one of three HLP Co-Chairs, Indonesian President Yudhoyono represented emerging economies and bridged the gap between low-income countries and developed economies. As one Jakarta-based diplomat recognized: "Indonesia was in the middle, the President was in the middle; we understood our position." In contrast, Japan's former Prime Minister Naoto Kan joined the HLP as one of the HLP's twenty-seven members. Japan's engagement was a representation of Japan's structural power in global affairs given that most countries were not represented. Yet the Japanese government was not able to promote its global health interests within this panel (the panel's final report did not include a strong focus on UHC, Japan's priority). In contrast, Indonesia's President exerted structural power as Co-Chair over the scope and focus of the Commission and exerted productive power with the eventual Commission report shaping the broader post-2015 process, particularly the thematic consultation for health and the OWG.

President Yudhoyono established a high-level national committee defining Indonesia's engagement in the post-2015, SDG process. But this committee did not focus on health; informants argued that neither the President's office nor the Ministry of Foreign Affairs prioritized health. After a final meeting in Bali (the result of a deliberate Indonesian strategy to host the last meeting to shape the discussion and exert structural power), the HLP launched its final report in May 2013. In its final report, the Panel proposed expanding the MDGs to twelve goals and consolidating the three MDGs for health into one SDG for health. This one health goal to "ensure healthy lives" proposed a focus on continuing the MDGs, but also including an unspecific reference to "neglected tropical diseases and priority non-communicable diseases" as well as an explicit sexual and reproductive rights target. Global health commentators characterized the report as "weak" (Horton, 2013). Senior Indonesian Ministry of Health officials considered it disappointing as it

Table 1
The most influential processes for SDG3 on health.

Post-2015 Sustainable Development Goals Process	UN Secretary-General's High-Level Panel (HLP)	Thematic Consultation on Health	Open Working Group (OWG) Session on Health
Timeline	The UN Secretary-General announced the HLP in July 2012. The HLP finalized its report in May 2013.	This consultation started in October 2012 and culminated with a three-day meeting in Botswana in March 2013, which included inputs from over 1500 individuals participating in thirteen global in-person consultations and an online consultation with 150,000 visitors (*High Level Dialogue on Health in the Post-2015 Development Agenda Gaborone, 4-6 March 2013*, 2013).	The Open Working Group (OWG) of the UN General Assembly met between March 2013 and April 2014. The OWG had thirteen official two-week long sessions, with health considered during the fourth meeting in June 2013.
Leadership and Structure	The Secretary-General's HLP was co-chaired by Indonesia's President, Susilo Bambang Yudhoyono, along with Liberian President Ellen Johnson Sirleaf, and British Prime Minister David Cameron, and included 24 high-level individual members (including former Japanese Prime Minister Naoto Kan).	The thematic consultation on health (co-convened and managed by Botswana and Sweden, in collaboration with WHO and UNICEF) was part of nine thematic consultations coordinated by the United Nations Development Programme (UNDP).	The OWG was co-chaired by Kenya and Hungary's Permanent Representatives to the UN in New York, and had 30 members (members were made up of three countries in so-called "troikas.")
Output and recommendations for SDG3	In its final report, the Panel proposed expanding the original 8 MDGs to 12 SDGs, but consolidating the three MDGs for health into one SDG for health. This one health goal to "ensure healthy lives" with five targets proposed a focus on continuing the MDGs, but also included an unspecific reference to "neglected tropical diseases and priority non-communicable diseases" as well as an explicit sexual and reproductive rights target. Neither health systems nor UHC received attention within this report.	The Botswana meeting report recommended "maximizing healthy lives" as the SDG3 goal, which would include "acceleration of progress on the health Millennium Development Goal (MDG) agenda; reduction of the burden of non-communicable diseases (NCDs); and ensuring universal health coverage (UHC) and access" (Boerma et al., 2013).	The OWG formulation to "ensure healthy lives and promote well-being for all at all ages" with nine targets and four mechanisms for implementation became SDG3 which includes targets on UHC, reproductive health, NCDs as well as pollution and road traffic injuries.

overlooked UHC and paid only passing attention to NCDs—two issues it considered priorities from Indonesia's domestic health experience. For the Japanese, it was also disappointing as it included only one mention of human security and UHC.

4.4. Part two: the Botswana thematic consultation on health

As described in Table 1, this consultation started in October 2012 and culminated with a three-day meeting in Botswana in March 2013, which built upon inputs from over 1500 individuals participating in thirteen global in-person consultations and an online consultation with 150,000 visitors (WHO, UNICEF, Governments of Sweden and Botswana, 2013). None of the consultations occurred in Japan, and there was only one submission, out of the more than 100 papers submitted, from Japan. No Indonesian institution contributed. One Japanese representative participated in the Botswana meeting, but did not play a strong role according to key informants in attendance.

In contrast (and because of Indonesia's structural power as HLP Co-Chair), Indonesia's Minister of Health, along with three advisors and the Indonesian Ambassador to South Africa, participated and addressed the consultation. According to informants, the Minister focused on moving beyond the HLP vision, and expanding the MDG approach to include a focus on NCDs and on UHC. But as one Indonesian government official shared about the Ministry's engagement, "[The Minister] was pretty calm [about the post-2015 process]." Yet, others still sought the Ministry and Indonesia's collaboration. For example, Thailand, advocating for a stronger focus on UHC and attempting to leverage Indonesia's structural power, actively engaged the Indonesian Ministry of Health to support UHC as a goal for SDG3 (instead of the HLP-suggested focus on "healthy lives").

At the end of the Botswana consultation, the meeting report recommended "maximizing healthy lives" as the SDG3 goal (Boerma et al., 2013). Ultimately, this formulation strongly shaped the OWG which would define SDG3. Despite the opportunity, Indonesia's Ministry of Health's engagement was not a strident exertion of structural or productive power. Nevertheless, Indonesian policymakers were pleased with the outcome as they felt their viewpoints were included. As an Indonesian informant from the Ministry of Health argued, "there was a lot of support for our ideas." This is correct, yet, few participants involved in the process associated or attributed them to Jakarta.

4.5. Part three: the Open Working Group (OWG)

Originally designed for thirty countries, there was so much interest in the UN General Assembly's Open Working Group (OWG) that countries needed to share their seats in so-called "troikas". Japan exerted structural power to be able to participate in this ad hoc mechanism (grouped together with Iran and Nepal). Indonesia also participated, and negotiated to be grouped with China and Kazakhstan. This gave Indonesia an opportunity to exert structural power leveraging China's voice in the G-77 plus China Group, which complemented Indonesia's own institutional power within the G-77. Working with China was aligned with broader foreign policy efforts to project Indonesia's leadership and role as an emergent middle power.

Between March 2013 and April 2014, the OWG held thirteen official sessions, with health considered during the fourth meeting in June 2013. Botswana and Sweden (along with UNICEF and WHO) hosted a side-event during this consultation to profile the thematic consultation work; however, neither Japan nor Indonesia hosted any events during this consultation, which is common practice for governments wishing to see a specific issue highlighted. In the session, Japan emphasized the importance of realizing UHC coordinating with other countries and attempting to rally support for UHC (International Institute for Sustainable Development (IISD), 2013); however, it did not invest in this process. Japanese diplomats incorrectly believed, like many others, that the OWG would not be important. Japanese diplomats perceived the OWG as a practice round before what they thought would be the decisive 2014–2015 intergovernmental negotiations.

On behalf of Indonesia's troika, China argued that "priority areas for health include decreasing the spread of communicable diseases and NCDs, UHC, accessibility to medicine, and reducing maternal and child mortality" (International Institute for Sustainable Development (IISD), 2013). Indonesian diplomats considered the health goal uncontroversial assuming it went beyond the MDGs (the so-called "MDGs+" approach) and included both UHC and NCDs (which informants indicated were important for Indonesia domestically). In other words, because the SDG3 on health seemed "moving in the right direction", Indonesian diplomats did not prioritize it. Indonesian negotiators agreed with the summary statement posted by the OWG Co-Chairs including references to UHC and NCDs (Co-Chairs' Summary bullet points from OWG-4, n. d.).

During the OWG negotiations, Japanese and Indonesia policymakers shared an understanding that the post-2015 process was ongoing, and a perception that the OWG was not necessarily final. This was a misunderstanding. In fact, the OWG became the definitive process for articulating the SDG agenda. OWG deliberations emphasized strengthening health systems and moving towards UHC, which was incorporated into the eventual goal (International Institute for Sustainable Development (IISD), 2013). The OWG formulation was adopted in the intergovernmental negotiations that followed in 2014 and 2015, and became SDG3.

Fig. 2 below summarizes how Indonesia engaged in the post-2015 process and exerted structural, institutional and productive power. In contrast (Fig. 3), the Japanese government did not robustly engage in the HLP process, the Botswana thematic consultation, or the OWG. Instead, Japan engaged in parallel processes where it could exert power more directly.

4.6. Beyond and outside the HLP, Botswana and the OWG

Following its June 2013 GHD Strategy, Japan's Ministry of Foreign Affairs exerted structural power leveraging Japan's development assistance. Japan's GHD Strategy sought both to re-purpose development assistance as support for UHC to signal Japan's backing for UHC in the post-2015 process. As part of renewed diplomatic efforts to revitalize trade and economic relationships, Prime Minister Abe vowed to raise the topic of UHC in every foreign visit and bilateral discussions for the duration of his administration (Garrett, 2013). Given the size of Japan's economy (the world's third largest), this high-level attention was a strong exertion of structural power. This direct exertion of power also led to indirect forms of power, ie productive and institutional power.

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

Japan's government also exerted structural power and built diplomatic alliances. In both Geneva and New York, Japan's Ministry of Foreign Affairs collaborated with "like-minded" countries, like France and Thailand, committed to promoting UHC as the health SDG. Japan allied with these states as they were not only supporters of UHC, but were also members of the Foreign Policy and Global Health Group (the so-called Oslo Group including Indonesia, France, South Africa, Norway, Senegal, Thailand and Brazil), which Japan sought to leverage to exert structural power.

Even before the GHD Strategy, and early in the post-2015 discussions in 2011 and 2012, Japan convened an informal "Post-MDGs Contact Group" as "a forum for informal policy dialogue on the development

Structural Power	• The President and his office shape the process for the HLP as well as the Ministry of Foreign Affairs and others leveraged the President's role as a Co-Chair to amplify its influence throughout the post-2015 process • The Ministry of Health and Foreign Affairs presented during the Botswana Thematic Consultation on Health
Institutional Power	• The Ministry of Foreign Affairs worked through the G77 to shape and influence the OWG discussions on health
Productive Power	• The President and his office engaged in writing and outlining the High-Level Panel report

Fig. 2. Indonesian Government's exertion of power in the Post-2015 process.

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

Fig. 3. Japanese Government's exertion of power to influence the Post-2015 process.

agenda beyond 2015" (Ministry of Foreign Affairs, Japan, 2012). This was an effort to exert both structural and productive power, and included "participants from about 20 countries, as well as major international organizations, foundations, research institutions and NGOs to exchange views and ideas informally, free from their official positions." Japan chaired the group to exert structural power. Demonstrating its intended productive power, the summary note concluded that for the post-2015 process "four concepts are important: human security (i.e. a people-centered approach), equity, sustainable development, and resilience." Participants in these consultations considered them as an early, but ultimately unsuccessful, attempt to exert structural and productive power to advance the "human security" approach in the post-2015 process. This was intended to shape the previously described UN Secretary General's HLP.

Japan's government exerted structural, institutional and productive power through its position within global health institutions like the World Bank and WHO. Officials from the Ministry of Foreign Affairs in an interview stated, "we have the intention to use the World Bank [in collaboration with colleagues in the Ministry of Finance] and the WHO to promote UHC." In interviews Japanese nationals working at both these institutions confirmed this approach. The Japanese government exerted institutional and productive power through these two

institutions, which provided technical advice to countries engaged in the post-2015 process. Japan sought to leverage both institutions' abilities to produce knowledge and provide normative guidance. Combining financial support with hands-on engagement from policymakers and academics, Japan was able to strongly influence both institutions' agendas exerting institutional power to shape institutional research products ultimately exerting productive power.

In cooperation with these institutions between 2013 and 2015, Japan organized and hosted a number of informal technical briefings and seminars on UHC during the OWG and intergovernmental negotiations as well as the UN General Assembly in New York, the World Bank Spring Meetings in Washington and the World Health Assembly in Geneva. In these events, WHO and the World Bank disseminated research products supported by Japan. These research outputs exerted productive power as countries looked to the WHO and the World Bank for technical support.

For example, Japan established a Japan-World Bank Partnership Program on UHC starting in 2012, which "supported systematic analyses of health policies and programs in eleven countries with the aim of drawing lessons from Japan and other country experiences with UHC" (World Bank, 2013). These materials created through Japan's institutional power at the Bank were then leveraged into productive power to provide policy guidance to other countries.

These outputs were amplified using structural power during a high-level, 2013 UHC Forum which Japan co-hosted with the World Bank in Tokyo. Controlling which actors were invited and the agenda, Japan's government ensured global health institutions and national ministers attended, and exerted structural, institutional and productive power ensuring that all discussions were focused on countries' progress towards UHC and showcasing Japanese-supported products.

Japanese policymakers leveraged the government's diplomatic influence, ultimately exerting complementary productive, institutional and structural power to advance the government's GHD Strategy. The government exerted structural power through the Prime Minister's office, using development aid and alliances taking advantage of Japan's position as the world's third largest economy. The Ministry of Foreign Affairs exerted structural power directly leveraging Japan's diplomatic abilities and resources by convening an informal SDG-specific contact group comprised of national representatives and key policymakers in the early days of the post-2015 process. Parliamentarians and the Ministries of Finance, Foreign Affairs and Health together coordinated efforts to exert institutional and productive power indirectly leveraging key global health institutions like the World Bank and WHO. Exerting institutional power, Japan strategically used these institutions to ensure and support a focus on UHC. Japan then exerted productive power through the World Bank and WHO; both the Bank and WHO convened meetings and released reports and other knowledge products focused on UHC shaping the priorities of other countries. Japan's Ministry of Foreign Affairs also deployed structural and productive power hosting several high-level events as well as lower-level briefings and seminars on UHC again signaling the government's focus and wielding its role as a leading global economy to steer and direct other countries towards a focus on UHC. The government leveraged G7 diplomacy as well as its TICAD meetings with African states as well as development cooperation to exert additional power to advance a focus on and prioritization of UHC.

Indonesia's government exerted structural and institutional as well as productive power in the process to develop SDG3. The President's office exerted structural power throughout the HLP process by co-chairing the report. The HLP was an informal group established by the UN Secretary-General's office for the post-2015 process, and for Indonesia to be one of the three leaders of this Panel and subsequent report was an opportunity to exert structural power controlling how the panel was operationalized. For example, hosting the final meeting in Bali, combined with dispatching one of the few authors for writing the final report, enabled the Indonesian government to exert considerable productive power over the report's content.

While the Indonesian government exerted power, it did not exert this power within the HLP process on health; however, Indonesia's government did respond to both the thematic health consultation and the OWG process. The Ministry of Health and Foreign Affairs exerted structural power within the Botswana consultation by presenting in one of the limited sessions. The President's office along with the Ministry of Foreign Affairs, Health and Planning exerted structural and institutional power engaging throughout the OWG negotiations both unilaterally and multilaterally through the G77. More broadly, Indonesia exerted structural power via its role in the HLP throughout the SDG process as many sought to leverage Indonesia's role as a Co-Chair. In contrast to Japan, Indonesia's government largely engaged within the official process and did not seek to engage on health outside the official process. Indonesia's engagement on health was not part of a broader global health strategy.

Whereas some Indonesian policymakers advocated to incorporate UHC and NCDs along with the MDGs into the new SDG3, this was not a concerted government effort with consistent and deliberate exertions of power to this effect; moreover, Indonesian policymakers' voices were one amongst many in the global discourse on SDG3. In contrast, Japanese policymakers had an aligned, strategic government policy of how and where it would exert power to advance a focus on UHC. While Japanese policymakers were some of the most strident actors globally positioning UHC for SDG3 and engaging heavily in efforts to advance UHC in the global discourse, Japanese efforts largely overlooked the official post-2015 process. Japanese policymakers engaged outside the official process knowing that they could and would have more control over these policy processes.

5. Discussion and implications

Driven by domestic interests, Japan and Indonesia constructed global health strategies (Indonesia implicitly; Japan explicitly) aligned with their national foreign policies. Given their position, authority and legitimacy, as well as their networks and technical expertise, governments dominated policy processes in these countries' engagement in the conceptualization of SDG3. These findings on how Japan and Indonesia exerted power suggest three implications and possible lessons for other states developing strategies to engage in global health.

First, states are not unitary actors when they engage in GHD meaning national global health policies and strategies are contested. Indeed, states negotiate their positions amongst and across domestic actors, and in regard to a head of government. In Japan, the government led by Prime Minister Abe was determined to exert leadership globally; there were also policymakers able to make the case on how Japan could lead on global health thus strengthening the Japanese state. In Indonesia, there was a President committed to and interested in exerting leadership globally; however, there was not a domestic leader or group of leaders able or attempting to make the case for global health.

In Japan, the Prime Minister's leadership created political policy space and a window of opportunity for politicians, policymakers and academics, and thereby also gain domestic political capital. Whereas in Indonesia, President Yudhoyono was committed to lead globally, but his commitment on health issues was limited. This meant policymakers had less political space and fewer incentives for global health policymaking, which offered little political capital, especially when there were more pressing domestic priorities for policymakers.

Whereas Japanese policymakers identified the post-2015 process to advance their global health and domestic interests, in Indonesia's case, the post-2015 process "identified" Indonesia. The UN Secretary-General and secretariat selected Indonesia's experience as important for the post-2015 process. Given Indonesia's rising global profile, the UN Secretary-General requested Indonesian President Yudhoyono to serve as one of the HLP Co-Chairs. In this role, Yudhoyono sought to draw upon policymakers to embed Indonesia's national development experience into the Panel's report. In turn, Indonesian policymakers leveraged the President's role as a Co-Chair within and beyond the HLP process. Yet

health was not a high priority for Yudhoyono's HLP involvement.

Indonesia's government largely engaged within the post-2015 process. It was keen to serve, and be seen serving domestically for political reasons and regionally for diplomatic reasons, in a leading position (eg: President Yudhoyono's role as Co-Chair in the HLP); this was consistent with its interest in projecting Indonesian leadership. Yet, it did not have a specific approach or focus for its efforts on health. Instead, the Indonesian government focused on other issues. Like Prime Minister Abe in Japan, President Yudhoyono was looking for issues where Indonesia could lead globally as this was important to his domestic audience. Health did not appear to be one of these issues. At the same time, there was not an active effort to construct or frame a rationale for health to be an issue on which Indonesia could exert power and lead globally.

How different state institutions, particularly the Ministries of Foreign Affairs and Health, collaborate is critical. The more understood or embedded a global health strategy is across actors within a government policy process, the stronger broad engagement might be, and the more power a state could exert. This also raises a broader point about power within global health. It is not finite. It is not necessarily dependent on material or financial resources. On the contrary, state power to shape global health can be amplified through international partnerships and technical knowledge. States can strategically cultivate an ability to influence global health policymaking. Japan did this; Indonesia did not.

Second, as more states begin to expand their engagement in global health and the field becomes more contested, states will need to exert multiple forms of power. The importance of collaboration across actors within a state as well as with non-state actors will likely become increasingly necessary, not only to exert power, but also to exert power more impactfully, strategically and successfully. This also affects the policy fora in which states engage. As states' understanding of, and experience in, engaging in GHD evolve, states actors can expand their ability to exert nonmaterial forms of power. States able to leverage the knowledge and experience of non-state actors can augment their impact and influence.

In Japan's case, in the beginning of its engagement in GHD in the early 2000s, the government largely exerted power through providing financial support. As Japan's engagement deepened, its exertion of nonmaterial power expanded. Japan exerted structural and institutional as well as productive power in the post-2015 process. In Indonesia's case, the government is still navigating how it engages in GHD. Accordingly, the Indonesian government exerted structural and institutional power, but only exerted limited expressions of productive power; thus, while Indonesia was in a position to exert influence over the content of SDG3, it did not shape the goal as much as might have been expected.

Aside from exerting power, the implementation of national strategies matter. For example, a state could exert tremendous amount of power and still not get the outcome it desired (like Japan focused on making UHC the overarching focus of SDG3); another actor could exert little power and get the outcome it desired (like Indonesia expressing an interest that both UHC and NCDs be incorporated along with the MDGs into the new SDG3).

While financial or material resources play an important role in determining global health priorities and policies, states no longer need to make large financial investments to engage. States can leverage small investments, and amplify this with strategic engagement. States can develop global health policymaking expertise to exert greater power, and thus expand their ability to influence global health. There is a spectrum of power with more experienced (and powerful) actors exerting multiple forms of power, and less powerful states focusing on one power form, or some combination of structural or institutional power.

The transition from structural and institutional power to productive power is also likely to be indicative of better coordination between Ministries of Foreign Affairs and Health as well as other government bodies and non-state actors. As Barnett and Duvall argued, different forms of power are not exclusive and often work together. Indeed, it is likely that different forms of power are most powerful when combined. For example, a Ministry of Foreign Affairs might be able to create opportunities to exert structural and institutional power; however, this is could be substantiated with technical inputs (possible forms of productive power) from the Ministry of Health. Given its likely deeper knowledge, a Ministry of Health would be in a better position to exert productive power; however, this would be best leveraged with opportunities to exert structural and institutional power.

In Japan's case, coordination between the Ministry of Foreign Affairs and Health notably improved around the time of the 2013 GHD Strategy; there were also mechanisms to solicit input from non-state actors. This enabled Japan to combine structural and institutional power with productive power and exert considerable influence. In Indonesia, coordination between the Ministry of Foreign Affairs, the Ministry of Health and the President's office in this same period was challenging. While the President's Office and the Ministry of Foreign Affairs were able to create opportunities for the government to exert structural and institutional power, a lack of coordination limited the exertion of productive power, and thus Indonesia's exertion of power in the conceptualization of SDG3.

In Japan, the Ministry of Foreign Affairs engaged in GHD policy as they considered it a policy space where they could exert leadership and advance foreign policy priorities. In Japan's case, the rationale was understood across state institutions. Japanese policymakers constructed a compelling case framing how the Japanese government should engage on health. To ensure coordination, the Ministry of Foreign Affairs and Health exchanged personnel working on global health to align their policies and build trust. Moreover, there were regular, formal coordination meetings between ministries, including the Ministry of Finance, as well as informal meetings across government institutions. As the focus on UHC was aligned with Japan's foreign policy, Japan's GHD Strategy was not just about engaging within the post-2015 process, but this strategy motivated wider engagement beyond the process.

Third, how and where a government engages in GHD and exerts power needs to be understood within a state's broader foreign policy and diplomatic priorities. This resonates with previous findings stressing the importance of how GHD is integrated into foreign policy (Ramírez et al., 2018) (Ruckert et al., 2021). This also means considering framing (Koon et al., 2016) and how global health is presented or "framed" domestically. McInnes and colleagues define this as how an "issue is presented in such a way as to tie it into a broader set of ideas about the world, or 'socially constructed reality', and through this gain influence and policy purchase" (McInnes et al., 2012). As they argue, "actors often deliberately (and in many cases strategically) use frames as a tool of persuasion, deploying them to call attention to an issue and influence actors' perceptions of their own interests." Understanding how national policymakers frame engaging in GHD is critical to understanding states' abilities to exert power.

The construction of a narrative to frame global health engagement was an explicit process in Japan, but occurred implicitly, if at all, in Indonesia. In Japan, government policymakers developed a compelling framing as part of the G7 process in 2007; this worked to inspire engagement and align actors across the government. In Indonesia, this sort of policy dialogue did not exist. This lack of a framing limited Indonesian actors' ability to participate.

6. Limitations

While applying Barnett and Duvall's power framework showcases how and where states engage and exert power, it does not alone explain global health policymaking outcomes. This is the primary limitation of power analysis. The mere exertion of power is not always sufficient to determine policy outcomes. Analyzing how Japan exerted power only tells part of the story. The results of Japan's efforts were broadly successful, but Japan could have engaged more in the official post-2015

process. There were also other exertions of power countering Japan's. The Japanese government positioned UHC as the overall goal for SDG3, and exerted considerable power to achieve this; however, this did not happen. Instead, UHC was included as a target (3.8) within SDG3 and the overall SDG3 goal focused on ensuring healthy lives. While Japanese policymakers were able to exert considerable power to advance a focus on UHC across Japanese institutions, they were not able to persuade global health actors of this same approach. It is likely that policymakers need different resources to exert power domestically versus globally; for example, while certain national policymakers might be able to dominate domestic discussions due to their position or their domestic network, this is likely considerably more difficult or challenging at a global level.

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

Appreciating the exercise of power illuminates the diverse, sometimes less visible, ways actors engage to advance their interests. Yet to understand how actors position their efforts, one must also identify countervailing exertions of power. It is important to compare and contrast exertions of power as well as consider the context and how narratives can be more or less persuasive. For example, in the post-2015 process, there were other states, like Sweden, actively championing a goal focused on healthy lives, implicitly aiming to block Japan's efforts for a SDG3 focused on UHC. This focus on healthy lives was adopted in the HLP as well as in the report of the Botswana consultation (which Sweden co-chaired). This alternative approach eventually prevailed and incorporated UHC into the SDG3 framework as one of the targets. Yet, Japan's efforts were not without effect. Japan's government continues to prioritize UHC at the G7 and G20, supports efforts at WHO and the World Bank to help advance progress on UHC and promotes UHC as a global health priority.

7. Conclusion

In the past, power in international health and later in global health was associated with states and material resources like financing. When power was considered, it was taken for granted that wealthy states like the United States or the United Kingdom used monetary resources to dominate policy agendas. As one study concluded, "money is […] a very important source of power" (McNeill et al., 2013). The prevailing understanding of power in global health was thus that rich states exert power using their material resources to determine priorities. This understanding is now evolving.

Reviewing how and where both the Japanese and Indonesian governments engaged and exerted power illustrates how differently states engage in global health. While Prime Minister Abe was supportive of Japanese efforts in global health, Indonesia's President was not interested. The support of a high-level leader can be transformational; if not always immediately available, it can also be strategically cultivated. The absence of this support, however, can be a significant barrier. With it, however, states can exert institutional, structural and productive power. Comparing the two countries, the Indonesian government's engagement was not closely integrated into national foreign policy efforts and was not coordinated across ministries. In contrast, support across the Japanese government enabled the government to exert comparatively considerable power. While money or material resources are important, researchers and policymakers are now rightfully recognizing that financial or material resources are not always necessary to advance their interests and exert power.

Given shifts in geopolitics and emerging economies' growing influence, it seems reasonable to expect that more states will exert power and contest global health policymaking, particularly in light of the ongoing COVID-19 pandemic (Taghizade et al., 2021). Indeed, as more traditional powers and emerging economies expand their foreign policy efforts to include GHD, states might also seek to shift policymaking venues to fora, structures and institutions more favorable to their own ability to exert power. This seems likely to both fragment and widen the global health agenda. It could also create opportunities for existing institutions to affirm or expand their roles; however, it could also expose new risks as emerging economies consider the creation of alternative policymaking spaces for global health and challenge existing policy processes.

Credit author statement

Robert Marten: Conceptualization, Writing - Original Draft Preparation. Johanna Hanefeld: Conceptualization, Writing - Review and Editing. Richard Smith: Conceptualization, Writing - Review and Editing.

Data availability

Data will be made available on request.

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