Review of International Studies (2014), 40, 877–896 *© 2014 British International Studies Association*
doi:10.1017|S0260210514000333

Norm diffusion and health system strengthening: The persistent relevance of national leadership in global health governance

GARRETT WALLACE BROWN

Abstract. Academics and policymakers often argue that global health policy greatly affects and influences national health systems because these policies transfer and implant 'best practice' norms and accountability techniques into local health systems. On the whole these arguments about the 'diffusion of norms' have merit since there is considerable evidence to suggest the existence of a positive correlation between global norms and national behaviour. Nevertheless, this article argues that traditional analytical frameworks to explain norm diffusion underplay the fact that norms are significantly 'glocalised' by national actors and further discount the role that national leadership plays in strengthening health systems. In response, this article presents a ten-year comparative paired study of the participatory governance mechanisms of the South African health system and its health strengthening measures. In doing so, the role of the national government in their relations with the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) will be examined and how key 'partnership' norms were amalgamated into health governance mechanisms. It will be argued that although global policy plays an important guiding role, health norms are never transcribed straightforwardly and a central element to successful health governance remains vested in the nation and the leadership role it exerts.

Garrett Wallace Brown is Reader in Political Theory and Global Ethics in the Department of Politics at the University of Sheffield. His publications include work on cosmopolitanism, globalisation theory, global justice, and global health governance. He has published widely on issues in global health and has recently published *Grounding Cosmopolitanism: From Kant to the Idea of a Cosmopolitan Constitution* (Edinburgh) and *Global Health Policy* (Wiley-Blackwell). His latest IDRC / EQUINET Africa funded research is examining the practice of performance based funding in global health.

Introduction

The last fifteen years have witnessed a consistent effort by academics and policy-makers to draw connections between global health policy and its influencing affects on national health systems. It is usually posited that global health policy greatly affects and influences national health systems because these policies help to transfer and implant 'best practice' norms, standards, medical procedures, and accountability techniques into local health systems. On the whole these arguments about the 'diffusion of norms' have a great deal of merit since there is considerable evidence to suggest the existence of a positive correlation and that global norms have helped to radically alter national practice. Nevertheless, this article argues that a focus on top-down diffusion overlooks several important aspects of global health governance

and in particular sidelines the relevance of national leadership in producing successful health outcomes. First, assuming a unidirectional top-down diffusion misses the fact that these influences are significantly 'glocalised' by national actors and that policies are not adopted wholeheartedly without an infusion of local customs and practices. Because of this it is important to better understand the ways that national and local agents amalgamate policies into national systems and how these translate into unique approaches for effective or ineffective health policy. Second, although global policy influences are a factor, focusing too narrowly on top-down diffusion discounts the key role that national leadership plays in strengthening health systems and ignores the persistent fact that national leadership is a crucial component to successful health outcomes. In other words, although the influence of global policy can play an important guiding role, health norms are never transcribed straightforwardly into national systems and a central element to successful health governance remains vested in the nation and the leadership role it exerts.

As a response, the purpose of this article is to explore the continued relevance of national leadership in global health governance (and by association global governance generally) by presenting the findings of two paired comparative case studies that examine the governance mechanisms of the South African health system and its health system strengthening measures between 2002 and 2012. In particular, this article will examine the role of the national government *vis-à-vis* their relations with the external funder the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and how key multisectoral 'partnership' norms where amalgamated (or not) within the governance mechanisms of the South African health system. In doing so, this article will examine: (1) The role of the national government to organise its National AIDS Council (SANAC) and its corresponding GFATM Country Coordination Mechanism (CCM); (2) The way that the national government interacted with global partnership norms through its organisation of internal participatory governance procedures and; (3) the role of key national government leaders in transforming a fragmented health governance system into a more nationally strengthened process of participatory engagement. As an analytical device, the article will employ deliberative participation criteria to measure the role of leadership in effecting these changes through creating more productive and meaningful multisectoral health partnerships. From this it will be argued that despite the influence of international partnership norms, national health leadership remained the key driver in producing more successful health system partnerships in South Africa, and that the role of national leadership remains an important aspect that requires further study in global health governance. Through illustrating these points, this article will also locate important leadership measures used by South Africa to move it from what was once considered a 'chaotic development quagmire' to what has recently been described as 'on the road to a more genuine health partnership' as well as highlight some wider implications generated for the study of leadership in global governance and norm diffusion more broadly.

I. Background

The empirical material in this article comes from two separate research projects conducted between 2002–5 and 2012–13 in South Africa. The first, funded by the Ford Foundation, is connected to a project on 'Global Institutional Design' and consisted

of six weeks of South African fieldwork between 2002 and 2005 with over 100 interviews being conducted with government health officials, health professionals, the Global Fund Secretariat, members of civil society, and other key stakeholders, including patients.[1] The second, funded by the International Development Research Council (IDRC) and EQUINET Africa, related to a project on 'Performance Based Funding in Global Health' and consisted of five weeks of South African fieldwork between 2012 and 2013 with over 50 interviews taking place with key stakeholders.[2] The participatory framework applied in this article was originally used in an earlier *Review of International Studies* article, in which the 2005 findings were examined in relation to deliberative democracy criteria in order to determine the participatory quality of both the South African national CCM as well as the Global Fund's decision-making structures.[3] The aim of this article is to revisit this participatory framework in relation to the new 2012–13 data in order to locate and account for key changes that have occurred in South African health partnerships since 2002 and to isolate key factors that have facilitated noticeable improvements in participatory decision-making within the health sector. As will be argued, a key factor in the adoption of more deliberative procedures within the health system relates to a near wholesale change in health leadership within South Africa in 2008–9. Due to the dramatic changes that took place after this period, this helps to illustrate the important role leadership had in building more genuine health partnerships and participatory deliberative processes. As a result, this article will demonstrate that despite the fact that global norms around health partnerships and multisectoral governance were prevalent within the South African development lexicon in 2002–5 (particularly at the provincial and local level), it was changes in national leadership in 2009 that ultimately allowed a high degree of 'norm congruence' to be established within the national health system and thus affected the dramatic health policy changes that are currently underway in South Africa.

II. Norm diffusion and global health governance

The global health literature is ripe with discussions about the diffusion of norms that flow from international organisations into national systems. These norms span the spectrum of health policy initiatives to include ethical, technical, and institutional considerations. For example, ethical norms such as the enshrining of legal protections against HIV/AIDS stigmatisation and the acceptance of new language for a 'human right to health' are often argued to be the result of the global diffusion of health norms.[4] In addition, norm diffusion has been credited with improving global

[1] The 2002–5 empirical material in this article was part of a larger Ford Foundation grant project on 'Global Institutional Design' conducted with David Held, Anthony McGrew, and M. Koenig-Archibugi. Some of the names of the interviewees have been left anonymous by request, due to the political ramifications involved with their responses. The quotes used in this article were selected because they were most representative of a particular viewpoint or widely held belief.

[2] The 2012–13 empirical material in this article is part of an ongoing IDRC grant project on 'The Role of African Actors in Performance Based Funding in Global Health' conducted with Amy Barnes, Sophie Harman, and five African Partners from South Africa, Tanzania, and Zambia. As above, the names of interviewees have been left anonymous by request due to the political nature of health reforms currently taking place in South Africa.

[3] Garrett Wallace Brown, 'Safeguarding deliberative global governance: The case of the Global Fund to Fight AIDS, Tuberculosis and Malaria', *Review of International Studies*, 36:2 (2010), pp. 511–30.

[4] Jonathan Wolff, *The Human Right to Health* (London: Norton, 2012).

medical practice, through the adoption of modern medical innovations such as the universal application of DOTS and DOTS-Plus treatment programmes against tuberculosis (TB),[5] through the adoption of further International Health Regulations (IHR),[6] and via new 'virus sharing' institutions to control against emerging pandemics.[7] As is often suggested, these international norms have emerged through the policies of multinational organisations such as the World Health Organization (WHO),[8] the Global Fund to Prevent AIDS, Tuberculosis and Malaria (GFATM),[9] and the World Bank.[10] More recently, charitable foundations and public-private partnerships have also been seen as important international organisations with the ability to diffuse health norms, with actors such as the Bill and Melinda Gates Foundation (BMGF),[11] the Bill Clinton Foundation,[12] Anglo-American and pharmaceutical companies getting particular attention from scholars of global health governance.[13]

In illustrating a link between global policy and national practice those who study norm diffusion have traditionally employed two main approaches. The first is generally referred to as the 'norm life-cycle' model, which tracks norm diffusion over three stages: (1) The production of the norm; (2) the emerging acceptance by key actors and its corresponding 'norm cascade'; and (3) norm internalisation and its eventual stature as an 'established' norm.[14] A second approach is generally referred to as the 'spiral model', which instead of positing a largely unopposed process of norm diffusion, allows for a greater number of stages where international norms are resisted by states, reinforced through international pressure, strategically appropriated, and then finally accepted via corresponding state compliance.[15] In most cases the literature on

[5] John Porter, Kelley Lee, and Jessica Ogdens, 'The globalization of DOTS: Tuberculosis as a global emergency', in K. Lee, K. Buse, and S. Fustukian (eds), *Health Policy in a Globalising World* (Cambridge: Cambridge University Press, 2002), pp. 181–94; Michelle Forrest, 'Using the power of the World Health Organization: The international health regulations and the future of international health law', *Columbia Journal of Legal and Social Problems*, 30 (1999), pp. 153–79.

[6] David Fidler, *SARS, Governance and the Globalization of Disease* (Basingstoke: Palgrave, 2004).

[7] Jeremy Youde, *Global Health Governance* (Cambridge: Polity Press, 2012), pp. 117–31; Mark Zacher and Tania Keefe, *The Politics of Global Health Governance* (Basingstoke: Palgrave, 2008), pp. 43–76.

[8] Nitsan Chorev, *The World Health Organization Between North and South* (Ithaca: Cornell University Press, 2012).

[9] Amy Barnes and Garrett Wallace Brown, 'The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Expertise, accountability and the depoliticisation of global health governance', in S. Rushton and D. Williams (eds), *Partnerships and Foundations in Global Health Governance* (Basingstoke: Palgrave, 2011), pp. 53–75.

[10] Sophie Harman, 'The World Bank and health', in A. Kay and O. Williams (eds), *Global Health Governance: Crisis, Institutions and Political Economy* (Basingstoke: Palgrave, 2009), pp. 227–44.

[11] David McCoy and Linsey McGoey, 'Global health and the Gates Foundations – in perspective', in S. Rushton and D. Williams (eds), *Partnerships and Foundations in Global Health Governance* (Basingstoke: Palgrave, 2011), pp. 143–63.

[12] Jeremy Youde, 'The Clinton Foundation and global health governance', in S. Rushton and D. Williams (eds), *Partnerships and Foundations in Global Health Governance* (Basingstoke: Palgrave, 2011), pp. 164–83.

[13] Kent Buse and Gill Walt, 'The World Health Organization and global public private partnerships: In search of the ''good'' global governance', in M. Reich (ed.), *Public-Private Partnerships for Public Health* (Harvard full pub. details please), pp. 169–96. Also see the article by Anne Roemer-Mahler in this Special Issue, which explores the role of pharmaceutical companies in the growing number of private-public partnerships emerging at both the global level as a norm driver and at the local level as a norm supplier.

[14] Martha Finnemore and Kathryn Sikkink, 'International norm dynamics and political change', *International Organizations*, 52:4 (1998), pp. 887–917.

[15] Thomas Risse and Kathryn Sikkink, 'The socialization of international human rights norms into domestic practices: Introduction', in T. Risse, S. Ropp, and K. Sikkink (eds), *The Power of Human Rights: International Norms and Domestic Conditions* (Cambridge, Cambridge University Press, 1999).

global health governance has either implicitly or explicitly viewed norm diffusion in line with these models and has generally claimed that although there can be resistance to emerging norms, there is generally an acceptance of these norms over time and that these norms have directly changed national behaviour for better or for worse.[16] Furthermore, there is often an implicit acceptance of these models within global governance scholarship more widely and it is commonplace to see these models cited as foundational assumptions in discussions regarding the strength of norm diffusion on national behaviour.

However, most analytical treatments of norm diffusion within the global health literature (as well as in much global governance literature in general) remain underdeveloped and the causal relationship between norm production, cascade, and internalisation is either assumed or receives lite-touch investigation by scholars. This is potentially problematic, since under close inspection there arise a number of concerns with how these models conceptualise the process in which norms diffuse as well as their impact on health systems. First, as Hayley Stevenson has argued in relation to environmental norms, a key concern with the 'norm lifecycle model' is that it often assumes that the 'norms retain their meaning throughout the diffusion process'.[17] Put differently, this model often 'focuses on the successful or failed internalisation of a norm in its original form rather than allowing for the possibility that a modified version may be internalised after domestic actors have contested the original meaning of the norm'.[18] As norm diffusion relates to global health, a differentiated and more nuanced model is therefore important, since there are many cases where norms are amalgamated in uniquely idiosyncratic ways. A key example of modified norms in global health can be witnessed in the GFATM's CCM multisectoral compliance recommendation, which stipulates that at least 40 per cent of national CCM makeup should include sectors beyond departments of health. Although most GFATM recipients claim to have created multisectoral CCMs, a 2009 report suggested that less than 50 per cent of CCMs have actually complied with this GFATM norm.[19] This suggests that there are subjective modifications involved with translating the meaning of these norms as they move from the global level to the domestic level and that these variances can create vastly different outcomes depending on context. Consequently, as the example above suggests, norms can often be internalised (thus not presenting a complete failure of diffusion), while at the same time undergoing significant reinterpretation in a way that makes the norm significantly altered from its original form.

A second issue involved with many treatments of norm diffusion relates directly to the concern above. Namely, there is a concern that these diffusion models pay too little attention to processes of intersubjective 'glocalising' that takes place between the global and the local.[20] This trend is troubling, since the few studies that have

[16] Sonja Barthsch, Carmen Huckel-Schneider, and Lars Kohlmorgen, 'Governance norms in global health: Key concepts', in K. Buse, W. Hein, and N. Drager (eds), *Making Sense of Global Health Governance: A Policy Perspective* (Basingstoke: Palgrave, 2009), pp. 99–121.

[17] Hayley Stevenson, *Institutionalizing Unsustainability: The Paradox of Global Climate Change* (Berkeley: University of California Press, 2013), p. 53.

[18] Ibid.

[19] Garrett Wallace Brown, 'Multisectoralism, participation, and stakeholder effectiveness: Increasing the role of nonstate actors in the Global Fund to Fight AIDS, Tuberculosis, and Malaria', *Global Governance*, 15:1 (2009), pp. 169–77.

[20] Garrett Wallace Brown and Ron Labronte, 'Globalization and its methodological discontents: Contextualizing globalization through the study of HIV/AIDS', *Globalization and Health*, 7:29 (2011), pp. 1–12.

attempted to examine how health norms are 'glocalised' into domestic settings have found that these norms are amalgamated in particularly localised ways and that the transcription of the norm often takes on a distinctively local flavour that can generate idiosyncratic results.[21] For example, a study examining the relationship between global HIV/AIDS funding mechanisms and the development of public health policy in Peru found that the policy norms associated with UNGASS and GFATM were cherry-picked by national agents and then selectively incorporated in multidimensional ways which generated unique outcomes in terms of political and economic disease mobilisation, the transfer of HIV/AIDS anti-stigmatisation laws to other diseases, and in terms of generating policy 'black-holes' relating to 'neglected diseases'.[22] In this case, as with others like it, a key to understanding health governance revolves around the way in which a norm is engaged with and how this norm becomes altered, coopted, or transposed onto the existing health system and policy directives. A reading of this kind also resonates with Amitav Acharya's critical understanding of traditional norm diffusion models in global governance more broadly, where he stresses local agency and existing processes of discursive 'grafting', where norm aspects are fused onto local foundations in particularly 'localised' ways (to be discussed further in Section Three).[23]

Third, and resulting from above, the global norm diffusion literature often assumes that there is what Michele Betsill calls a 'normative fit' between the global norm and the local contexts in which these norms are diffused.[24] Whereas point two above is concerned with how norms are 'glocalised' and reshaped within domestic settings, the concern here is more that global norms are often seen as static entities that simply 'fit' nicely into existing domestic peg holes without considerable alteration. Again, like points one and two above, the problem here is that the diffusion of norms in global health can often be seen by international health organisations as uncomplicatedly 'fit for purpose', where the domestic settings that will receive these norms are empty vessels ready for the norm to slot into place.[25] As Mark Laffey and Jutta Weldes suggest, this model is too simplistic, since 'the "fit" between various ideas and the plausibility, or not, of new ideas are actively constructed rather than simply "there" in the ideas themselves'.[26]

[21] Ibid.

[22] Ibid.

[23] Amitav Acharya, 'How ideas spread: Whose norms matter? Norm localization and institutional change in Asian regionalism', *International Organization*, 58:2 (2004), pp. 239–75.

[24] Michele Betsill, 'The United States and the evolution of international climate change norms', in P. Harris (ed.), *Climate Change and American Foreign Policy* (New York: St. Martin's Press, 2000), pp. 205–24.

[25] As was pointed out by one anonymous reviewer, there is also a related concern about how global actors embed power via their funding 'diffusions' and their ability to shape agendas that can enhance power imbalances between the national and global level. As the reviewer rightly suggested, although South Africa may have had some success in better 'glocalising' certain norms due to their economic standing this may not be the case more generally and a broader study which looked at a range of issues could reveal that norms are less likely to be significantly 'glocalised' where there is traditionally little negotiating space in terms of funding conditionalities. This is a key point and one that is beyond the scope of this article. That said, this issue has been better explored in Amy Barnes, Garrett Wallace Brown, and Sophie Harman, 'Performance based funding for African health systems: Who is setting the A agenda', *EQUINET Africa*, 10:2 (2012). Also see the full corresponding 65-page report due out in June 2014.

[26] Mark Laffey and Jutta Weldes, 'Beyond belief: Ideas and symbolic technologies in the study of International Relations', *European Journal of International Relations*, 3:2 (1997), pp. 225–6.

An interesting example of assumed symmetry between global norms and domestic settings relates to a study conducted in Russia in 2006,[27] where the assumed introduction of WHO DOTS and DOTS-Plus treatment programmes were 'surprisingly' resisted by tuberculosis doctors who saw the new treatment regime as either 'belittling' or as threatening their professional livelihood. As was expressed in several interviews with health professionals and policymakers in 2006, since DOTS is a nonsurgical procedure, many existing TB surgeons resisted the implementation of DOTS, which significantly slowed the corresponding World Bank loan to tackle TB and that also caused significant delays and additional negotiations with health professionals in order to 'get the loan back on track'.[28] As was suggested, 'there was some serious resistance to the way the WHO wanted Russia to accept its DOTS recommendations, with many Russian doctors arguing a 'need to strengthen Russian systems, not massively revise them'. In addition, as one senior Russian health official complained, 'the World Bank and WHO at every corner assumed that Russia didn't have the right technology or ability to tackle the problem, which was insulting and generated a great deal of frustration … they simply didn't understand the economic situation on the ground or want to hear that Russia had implemented similar technical programs many years prior, but only now lacked the cash to continue them'.[29] As this example helps to illustrate, the WHO and World Bank DOTS norm was not able to slot nicely into this particular domestic setting, but actually required a prolonged negotiation between global actors and local agents.

Lastly, another potential problem with traditional norm diffusion models is that the globalisation of norms is not necessarily unidirectional as it is often implied. In many cases the intersubjective communicative processes of norm diffusion are multidirectional, with norms being regurgitated and spat back up to the global level where further iterative processes take place before they are rediffused.[30] Moreover, these norms can also be hijacked as they move across various global actors, either directly through greater financial access in the case of the Gates Foundation or by various market forces that shape the behaviour of key private actors in health. As Anne Roemer-Mahler suggests in this Special Issue, pharmaceutical companies play an extremely important role in global health delivery systems as well as set the terms of health 'partnerships' in developing countries, which can result in tensions between global health partnership norms and global / national access to medicine policies.[31]

Following from this, global norms are also often the result of more localised or regional movements where local demands drive change at the global level, only to then 'cascade' across to other global institutions or domestic settings. An example of norm 'up flow' from the local to the global was involved in the WHO 'Global Code of Practice on the International Recruitment of Health Professionals' (the CODE), which was adopted by the World Health Assembly (WHA) in May 2010.[32]

[27] Interviews part of aforementioned Ford Foundation grant project on 'Global Institutional Design' conducted with David Held, Anthony McGrew, and M. Koenig-Archibugi.

[28] Three WHO TB Coordinators, Senior Officials, Centre for TB Research Institute - Russian Academy of Medical Sciences, 5 July 2006.

[29] Senior Official in the Government Health Department, Scientific and Clinical Anti-Tuberculosis Centre, Moscow. 3 July 2006.

[30] Acharya, 'How ideas spread'.

[31] Anne Roemer-Mahler, 'The rise of companies from emerging markets in global health governance: Opportunities and challeges', this Special Issue.

[32] A. L. Taylor and I. S. Dhillon, 'The WHO global code of practice on the international recruitment of health personnel: The evolution of global health diplomacy', *Global Health Governance*, 5:1 (2011).

Due to the persistent human resource crisis within many developing countries, several African countries initiated calls for the development of an ethical code of practice regarding the international recruitment of health professionals from developing countries.[33] As has been noted, African states were a key driver in the six-year process of negotiating the CODE at the WHA, where norm resistance was felt from Western countries that benefitted from overseas recruitment.[34] Although the CODE still remains a voluntary ethical mechanism, and its use has received minimal uptake from the countries that originally pushed for it,[35] this process of norm diffusion from the local to the global does illustrate that norm diffusion is multidirectional (or interactive)[36] with both upstream and downstream variables that can deliver divergent permutations in norm emergence and internalisation.

III. Rethinking norm diffusion in global health governance

As a result of these deficiencies, it is clear that a more nuanced framework is required to better capture the dynamic diffusion processes involved with health norms as they move between the global, the domestic, and back to the global. In an attempt to offer an alternative approach, Stevenson has suggested the adoption of what she calls the *normative congruence building model*. In contrast to traditional diffusion models, congruence building sees norm generation as akin to ideational constructivism where the final content of norms is produced intersubjectivity, from which they become 'collectively meaningful' and thus more prone to general compliance or altered compliance.[37] As part of understanding congruence building, stress is placed on the domestic 'social foundations' that underpin the ideational process, since these foundations collectively enable or constrain a state's structural capacity to meaningfully respond, accept, reject, and/or transfuse global norms into domestic policy. In examining these foundations, Stevenson highlights three key domestic areas where investigation can occur. The first area of investigation relates to understanding the basic material foundations associated with each domestic setting, which in this context can include such factors as the general state of national health, the level of disease burden, key health risks, national wealth, and other national health statistics. The

[33] A. L. Taylor, L. Hwenda, B. I. Larsen, and N. Daulaire, 'Stemming the brain drain – a WHO global code of practice on international recruitment of health personnel', *New England Journal of Medicine*, 365:25 (2011), pp. 2348–51; Dussault and Franceschini, 'Not enough there, too many here: Understanding geographical imbalances in the distribution of the health workforce', *Human Resources for Health*, 4:12 (2006), pp. 1–16; M. Sheikh, 'Commitment and action to boost health workforce', *The Lancet*, 379:e2-e3; DOI:10.1016/50140-6736 (11), pp. 60023–8.

[34] Taylor and Dhillon, 'The WHO global code'; O. B. Ahmed, 'Brain drain: The flight of human capital', *Bulletin of the World Health Organization*, 82 (2004), pp. 7978; M. Robinson and P. Clark, 'Forging solutions to health worker migration', *The Lancet*, 371 (2008), pp. 691–3; L. C. Chen and J. L. Boufford, 'Fatel flows – doctors on the move', *New England Journal of Medicine*, 353 (2005), pp. 1850–2.

[35] Yoswa Dambisya, Patrick Kadama, Sheillah Matinhure, Nancy Malema, and Charles Dulo, 'Literature review on codes of practice on international recruitment of health professionals in global health diplomacy', *EQUINET Africa* (2013), available at: {http://www.equinetafrica.org/bibl/docs/Diss%2097%20GHD%20Lit%20review%20Codes%20May%202013.pdf}.

[36] Gill Walt, Louisiana Lush, and Jessica Ogden, 'International organizations in the transfer of infectious diseases: Iterative loops of adoption, adaptation and marketing', *Governance*, 17:2 (2004), pp. 189–210.

[37] Stevenson, *Institutionalizing Unsustainability*, pp. 52–60. Although Stevenson's framework is focused primarily on explaining the diffusion of global environmental norms, the framework utilised here is influenced by this framework. What is presented here represents an augmented form of this framework that is merely refocused on examining the diffusion of global health norms.

second area of investigation borrows from Peter Hall, in which the congruence model attempts to understand the 'policy paradigm' underpinning domestic politics, which acts as the 'interpretive framework of ideas and standards that specifies not only the goals of policy and the kinds of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing'.[38] Finally, another area of investigation involves understanding key social factors that help orient governance within the state and which expand or limit the discursive capacity for norm congruence.

It is important to point out that a key methodological difference between the congruence model and the norm diffusion models outlined above is that the congruence model is less concerned with either confirming or denying the diffusion of a norm. As an alternative, the congruence model rather focuses on the 'underlying domestic conditions that have provided actors with the ''conceptions of possibility'' in responding' to global norms and the processes of intersubjective negotiation associated with any transmutation. This will be key in the analysis of South African health leadership below, since an underwriting assumption of the congruence model is that norms are never adopted straightforwardly and are amalgamated with uniquely contextual features. As a result, this model posits that norm diffusion 'does not manifest as either a direct transfer of norms from the global to the domestic sphere, or as a linear process where the norms are gradually embedded in domestic conditions over time. Instead … norm diffusion manifests as a dynamic and unpredictable process of congruence building … where actors … (oscillate) between perceptions of congruence and incongruence between the global norms and domestic conditions.'[39]

Stemming from these constructivist presuppositions are two additional concepts that can be useful in attempting to understand how congruence is constructed between global norms and the social foundations within the domestic sphere. These concepts are also useful for understanding the diffusion of health partnership norms in South Africa, since the two concepts allow for a more nuanced analysis of how multisectoral partnership was infused into health policy (or not) and what factors altered those policies over time. The first concept is what Acharya has called *grafting*, namely, 'institutionaliz(ing) a new norm by associating it with a pre-existing norm in the same issue area, which makes a similar prohibition or injunction'.[40] The second concept relates to Robert Entman's notion of *framing*, which is defined as the process of 'selecting some aspects of a perceived reality and making them more salient in a communicating text, in such a way as to promote a particular problem definition, casual interpretation, moral evaluation, and/or treatment recommendation'.[41]

In line with the above, the following three sections will use the congruence model as an analytical tool to examine the diffusion of health partnership norms in South Africa between 2002 and 2013, with particular attention being paid to the adoption of multisectoral participatory mechanisms behind the formation and operation of the South African National AIDS Council (SANAC) and its corresponding Country Coordination Mechanism (CCM). As will be shown in more detail below, the way

[38] Peter Hall, 'Policy paradigms, social learning, and the state: The case of economic policymaking in Britain', *Comparative Politics*, 25:3 (1993), p. 279.
[39] Stevenson *Institutionalizing Unsustainability*, p. 11.
[40] Acharya, 'How ideas spread', p. 244.
[41] Robert Entman, 'Framing: Toward clarification of a fractured paradigm', *Journal of Communication*, 43:4 (1993), pp. 51–2.

the global norm of health partnership was framed and grafted onto South African health policy was largely influenced by key material, political, and social factors which at first allowed for a rejection of multisectoralism as weakening the central authority of the state; but which has been embraced after 2009 as a potential mechanism to strengthen national health governance. As will also be shown, a major factor in reforming South African health toward multisectoral governance was a dynamic change in national leadership in 2008–9, which helped to create a willingness for new communicative spaces to exist, where deliberative processes could operate and allow greater intersubjectivity, reinterpretation, participation, and normative linkages with health partnership norms.

IV. The diffusion of health partnership norms in South Africa 2002–8: Foundations for incongruence and the quagmire of Thabo Mbeki and Manto Tshabalala-Msimang

There has been considerable literature dedicated to trying to unpack the phenomenon of official AIDS denialism witnessed in South Africa during the presidency of Thabo Mbeki. As is often cited, Mbeki claimed 'to know no one who has been affected by, let alone died of AIDS, despite South Africa having the highest rates of people living with HIV in the world'.[42] In addition, his administration publically announced a position that Western science was biased in favour of commercial and medical interests and that there was not a credible link between HIV and AIDS. Because of this official position, and due to the political structure of the African National Congress (ANC), this meant that dissenting voices within the party were often not tolerated and that the administration was able to present a fairly united front in the face of growing domestic and international criticism.

A key leadership consideration associated with this AIDS denialism revolved around the appointment of Manto Tshabalala-Msimang as the South African Health Minister. The extremity of denial politics on the ability to construct effective HIV/AIDS policy came to a head in 2005, when at a press conference Tshabalala-Msimang argued that 'raw garlic and a skin of the lemon … give you protection from the disease'.[43] This led to mass ridicule from the media leading to Tshabalala-Msimang being anointed 'Dr Beetroot'.[44] Despite the outrage from both the international community and South African citizens, Tshabalala-Msimang retained her post, whilst President Mbeki continued to defend the actions of his health minister, hailing her as 'one of the pioneer architects of a South African public health system constructed to ensure that we achieve the objective of health for all our people, and especially the poor'.[45] However, according to Treatment Action Campaign and others, her stewardship was in fact dysfunctional and Tshabalala-Msimang's actions had led 'to the slow provision of drugs to prevent HIV-positive mothers passing

[42] Murphey,V. Septmeber, 'Mbeki Stirs up Aids Controversy', available at: {http://news.bbc.co.uk/1/hi/world/africa/3143850.stm} accessed 16 October 2013.

[43] S. Boseley, 'Aids group condemns South Africa's ''Dr Garlic''' (May 2005), available at: {http://www.theguardian.com/world/2005/may/06/internationalaidanddevelopment.southafrica} accessed 17 October 2013.

[44] *BBC*, 'South Africa HIV-row minister Tshabalala-Msimang dies' (December 2009), available at: {http://news.bbc.co.uk/1/hi/8416659.stm} accessed 20 October 2013.

[45] C. Kapp, 'South African Aids policy lurches into new crisis', *The Lancet* (September 2007), available at: {http://www.sciencedirect.com/science/article/pii/S0140673607613580}.

on the virus to their child, delays in treatment to people with AIDS, and failure to provide proper levels of expertise'.[46] As a *New York Times* article in 2008 further related, the official stance of Mbeki's rejection of scientific consensus on HIV/AIDS could be attributed to 365,000 deaths in South Africa,[47] of which 343,000 could have been avoided if the national government adopted policies that were already being implemented in South Africa's province of Western Cape.[48]

As mentioned before, there exists considerable material examining the failures of Mbeki's health policy (particularly as it relates to HIV/AIDS). The purpose of relating the details briefly above is not to reexamine this travelled ground and the controversies involved, but to convey general aspects of the political context that underwrote the normative stance of South African leadership in relation to global health partnership norms (which since the mid-1990s had become a dominate feature of the international health development lexicon).[49] In other words, what is important here is to understand how the narratives associated with Mbeki's position on HIV/AIDS impacted the general operation of SANAC and its continued failure to develop a credible multi-sectoral and participative CCM (the main body charged with developing funding proposals for the Global Fund). In particular, and as will be evidenced below from the 2002–5 fieldwork, the partnership norm was largely rejected by SANAC's leadership because it was viewed as undermining the ANC's ability to consolidate health efforts and therefore was seen as a Western instrument to weaken South Africa. This stance not only destabilised the establishment of the partnership norm within SANAC and its CCM, but also reinforced a lack of national consolidation, which actually increased fragmentation in three interconnected ways.[50]

First, despite the fact that Tshabalala-Msimang held a voting seat on the first GFATM board, her unwillingness to properly address HIV/AIDS destabilised SANAC's efforts to organise a credible CCM in line with GFATM requirements as well as its ability to make grant applications to the GFATM. This resulted in an inability to use GFATM bridge funding as a way to help mitigate the effects of the HIV/AIDS pandemic (as well as tuberculosis). During an interview in 2005, both Tshabalala-Msimang and one of her chief health advisors suggested that, 'there are processes outside of South Africa that seek to weaken our state and reduce the effectiveness of the ANC. In many ways [GFATM] mechanisms of external funding represent part of this process and we are making an effort to resist them.'[51] Although

[46] C. Nullis, 'Mbeki defends beleaguered health minister against critics', *The Guardian* (September 2007), available at: {http://www.theguardian.com/world/2007/sep/03/southafrica.aids} accessed 23 October 2013.

[47] Cella Dugger, 'Study cites toll of AIDS policy in South Africa', *New York Times* (25 November 2008).

[48] Nicoli Nattrass, 'AIDS and the scientific governance of medicine in post-apartheid South Africa', *African Affairs*, 107:427 (2008), pp. 157–76.

[49] Amy Barnes and Garrett W. Brown, 'The idea of partnership within the Millennium Development goals: Context, instrumentality and the normative demands of partnership', *Third World Quarterly*, 32:1 (2011), pp. 165–80.

[50] This is not to suggest that SANAC played no positive role in health. This is because SANAC did provide certain mechanisms to deal with the AIDS epidemic, such as implementing the cross-departmental National Integrated Plan (for children infected and affected by the disease) and the HIV/STD National Strategic Plan for South Africa 2000–8. However there was still the noticeable absence of mass-scale provision of antiretroviral drugs and large-scale underperformance in terms of delivery and coordination. See J. McNeil, 'A history of official government HIV/Aids policy in South Africa', available at: {http://www.sahistory.org.za/topic/history-official-government-hivaids-policy-south-africa#content-top} accessed 23 October 2013.

[51] Interview with Minister of Health Tshabalala-Msimang and a senior health advisor, 20 August 2005. Advisor wished to remain anonymous for political reasons.

there are legitimate concerns about having a health system reliant on external funding and there are certainly issues of power associated with the 'conditionalities' imposed by external funders, the long-term policy result of this position was that the CCM rarely met (for example, the chair was on maternity leave for eight months without replacement) and it did not submit a unified national grant proposal to the GFATM. Instead, the provinces of Western Cape and KwaZulu-Natal organised their own CCMs, submitting proposals that sidestepped SANAC and the national Department of Health (DoH) by dealing directly with GFATM. The rationale behind provincial countermeasures were summarised by the Director of the Health Department in Cape Town, who argued

> The National AIDS Council (SANAC) is chosen by the Minister of Health and does not reflect local provincial members. It is not representative and there are no mechanisms for communication between us and the CCM. Our requests have gone unacknowledged and this needs to be addressed … Since national is unable to take the lead, we've done so ourselves.[52]

In addition, it fell upon two NGOs, LoveLife and SoulCity, to submit a nationwide grant proposal on behalf of South African NGOs. As a senior leader of SoulCity claimed, 'the South African CCM is ineffective and since the GFATM rules allow non-state actors to submit grants, we organized one ourselves. I mean, this was a necessary step … [for example] the national CCM will meet a week before the next grant-call is due without having anything prepared and it is clear that nothing is going to happen this time either.'[53] As a consequence, there were multiple uncoordinated internal GFATM grants operating in isolation, which helped to perpetuate an inequitable and fragmented national health system. As was admitted by a member of the national government in an interview in 2005, 'the multiple GFATM grants have caused a level of inequity in how national health is rolled out and distributed … this will prove to be unsustainable in terms of designing a unified national strategy'.[54] Furthermore, as it relates to the partnership norm, at the national level, under the leadership of Tshabalala-Msimang there were very limited credible mechanisms from which meaningful participation in a nation-wide partnership on strategy with SANAC could be delivered. As a consequence, even if every actor wanted more participation, there were simply limited procedural mechanisms available to coordinate a form of participatory consensus.

Second, due to SANACs unwillingness to engage with the idea of a multisectoral national partnership within its CCMs, many NGO service providers disengaged from the national government, either finding their own external money through global funders, or by attaching themselves to provincial structures. As one NGO director suggested in 2005, 'there is essentially no communication channels at the national level … if we're to continue operations and service provision, we'll need to organize this ourselves'.[55] This sentiment was furthered by more local NGOs, who in a group interview agreed that

[52] Dr Ivan Toms, Director of the Department of Health Cape Town, interview, 22 August 2005.
[53] A senior leader at SoulCity, interview, 31 August 2005. This person wished to remain anonymous for political reasons.
[54] Lead official charged with designing the national health strategy, interview, 30 August 2005. This person wished to remain anonymous for political reasons.
[55] Senior member of Treatment Action Campaign, interview, 29 August 2005. This person wished to remain anonymous for political reasons.

It is impossible to work with the Department of Health and they are resistant to the use of external funding . . . they won't listen to us . . . there is an epidemic going on here, hundreds of thousands of people are dying, and we need some help to get ourselves out of this. Being proud will not save lives now.[56]

As a result, the national leadership of Tshabalala-Msimang failed to embrace the partnership norm as it related to key service providers, thus weakening the potential for unified health system strengthening through coordinating expertise, resources, evidence, and provision systems. What resulted instead, according to the Head of the Department of Health for the province of KwaZulu-Natal, was 'various parallel health provision streams and a failure to coordinate these efforts at the national level'.[57]

Finally, despite Mbeki's claim that Tshabalala-Msimang was a champion of equitable health and the needs of the poor, there is a considerable lack of evidence to suggest that the DoH reached out to local advocacy groups or attempted to include unheard voices within national health policy debates. As one advocacy group proclaimed, 'there is a lack of honest communication and connection at the national level. This is due to political forces inside the national government and a lack of a consistent program within the Country Coordination Mechanism of South Africa.'[58] In addition, another interviewee who represented 'those living with the diseases' argued that, 'the Ministry doesn't listen and I am unable to effectively represent the needs of those living with the diseases as it is promoted by GFATM bi-laws'.[59] Moreover, several interviewees from the private sector echoed a lack of available communication with the national level on public-private partnership, suggesting that 'we largely provide our own HIV/AIDS health systems for our miners since coordinating with the Minister has proven to be near impossible'.[60] As result, in terms of the global health partnership norms that were at the time promoting multisectoral inclusion and the development of more public-private partnerships, the health leadership of the South African government failed to seriously engage with these norms, leaving them partially diffused at subnational levels and diffused in a way that did not mirror the normative agenda of global health partnerships as a means to strengthen cooperative national health systems.

What the 2002–5 data suggests is that despite the dominance of health partnership norms within the global lexicon at the time, and despite local pressure on the national government to embrace more substantial health partnerships in order to combat the scale of the epidemic, South African political leadership largely rejected this norm by *framing* it as a form of weakening South African progress. This meant that the norm was only limitedly *grafted* onto existing policies in the provinces (particularly Western Cape), where there were signs of effective multisectoral CCM partnerships with successful health results. As a consequence, and as widely reported in the literature, participatory decision-making within the health sector was stymied

[56] Group interview with four advocacy NGOs in Johannesburg, 28 August 2005. Anonymity protected by request.
[57] Professor Ronnie Green, Head of Health Department KwaZulu-Natal, interview, 5 September 2005.
[58] CEO of Networking AIDS Community of Western Cape, interview, 23 August 2005.
[59] Senior person in charge of governmental relations at an advocacy NGO in Pretoria, interview, 5 September 2005. This person wished for their identity and organisation to remain anonymous for political reasons.
[60] Senior officer for health, Anglo-American, interview, 16 August 2005. Interviewee wished to remain anonymous for political reasons.

at the national level and was in fact counterproductive to efforts to consolidate and strengthen the national health system. What this also illustrates is that the role of national leadership is a key element in understanding how global health norms are amalgamated into health systems and how the *normative congruence building model* can help to understand the affects of diffusion on that system. As will be illustrated below in terms of post-2009 South Africa, national leaders are highly influential in how norms are framed, grafted, and diffused within a national system and therefore leadership represents an area of study that requires greater attention in the study of global health norms as well as within the study of global health strengthening and global developmental governance more broadly.

V. The diffusion of health partnership norms in South Africa 2008–12: The importance of leadership for congruence building and health system partnerships

As was outlined above, Mbeki's reluctance to acknowledge the impact and importance of the HIV/AIDS epidemic, alongside the dismissive, controversial policies pursued by his Minister of Health, were seen as a key factor not only in the spread of the epidemic, but also in creating a fragmented health system that lacked genuine participatory space for strengthened health partnerships (domestically or internationally).[61] As was widely reported at the time, the election of Jacob Zuma in 2009 brought with it hope for significant improvement to the dysfunctional healthcare system.[62]

In attempt to set a new agenda, Zuma first appointed Barbara Hogan as Minister of Health, who paved the way for a more scientific, inclusive, and overall more effective treatment of the HIV epidemic. In doing so, Hogan openly announced that 'we know that HIV causes AIDS' in an attempt to distance the Zuma administration from earlier statements made by Mbeki.[63] Shortly thereafter, Pakishe Aaron Motsoaledi was appointed as Minister of Health (2009–present) and set about distancing the DoH from the AIDS denialism further. As a first step, Motsoaledi signed a contract alongside President Zuma, which ratified a national commitment to four key health targets: Increasing life expectancy; decreasing maternal and child mortality;

[61] One reviewer suggested that my presentation of a fragmented health system is too 'ahistorical' because between 1994 until 2002 the South African government did make great strides to bring together various fractions (post-apartheid) into a more unified system. Furthermore, the reviewer stressed that although Mbeki's regime caused fragmentation (particularly in relation to HIV/AIDS) it did not fragment the whole health system and there were areas of meaningful cooperation and multisectoralism between sectors. The points made by the reviewer are of course accurate and my contention is not that the entire national health system became ineffectively fragmented. My point is simply that between 2002 and 2008 many of the partnership norms that were dominating the global health lexicon were explicitly rejected at the national level and that it was largely NGOs, CSOs, and the provinces who engaged with these norms and built them into their governance structures despite national rejections. As the interviews presented in this article evidence, fragmentation was a widely held perception and knock-on effect of AIDS denialism and there were clear participatory problems with SANAC. Furthermore, this occurred at a crucial time, since South Africa faced a huge disease burden and the lack of national coordination resulted in a high level of unnecessary deaths.

[62] C. Kapp, 'New hope for South Africa', *The Lancet* (October 2008), available at: {http://www.sciencedirect.com/science/article/pii/S0140673608615019} accessed 23 October 2013.

[63] TAC, 'Health Minister Barbara Hogan delivers landmark speech at HIV Vaccine Conference' (October 2008), available at: {http://www.tac.org.za/community/node/2421} accessed 22 October 2013.

decreasing the burden of disease related to HIV/AIDS and tuberculosis; and strengthening the effectiveness of the health system.[64] As part of his effort to strengthen the effectiveness of the health system Motsoaledi stressed the importance of SANAC in ensuring coordination and cooperation between the government, external funders, civil society, and researchers in order to provide a holistic approach to tackling poor health.[65]

It is in relation to Motsoaledi's fourth target of 'strengthening the effectiveness of the health system' where it is possible to see the most visible engagement with the notion of global and domestic partnership and where again it is possible to witness the crucial role leadership plays in the diffusion of global health norms. As with the section above, it is possible to see four key areas where directed health leadership increased greater participatory partnerships within the South African national health system.

First, there has been a concerted effort by Motsoaledi to revamp SANAC and to construct a more multisectoral participatory health governance system. In particular, Motsoaledi has re-engaged with global donors and NGOs so as to coordinate service provision within South Africa and to initiate external bridge funding as a means to achieve his new National Strategic Plan (NSP). The aim of this plan includes the development of a new National Health Insurance (NHI) programme as well as enhanced policy coherency so as to mend the fragmented national health system. As part of the NSP, Motsoaledi set in motion a national Global Fund grant application via SANAC as well as furthered cooperation with other funders and NGOs. As a senior person at the Clinton Foundation in South Africa stated

> Things are changing under the new leadership. Since 2009 there is a better sense of cooperation between the local and the global – within SANAC, the DoH and from the new Minister of Health. Prior to that many global funders were shut out from working with the South African government because the Minister disliked the West, particularly the US.[66]

The general view of those interviewed between 2012 and 2013 was that this process of greater engagement and inclusion is producing positive affects in terms of renewed global partnerships. As was suggested by the CEO of one development NGO:

> SANAC has traditionally been very difficult to deal with. It was nepotistic and ineffective. In the past it had favorite NGOs that have not always been the most efficient or successful. Some NGOs were pushed out because they were not in-line with the government's political views. This is changing now and there is a general sense that the government means to reset the button on global health relations. Given the chaotic development quagmire created up until 2008, things look on the road to a more genuine health partnership.[67]

[64] A. Motsoaledi, 'Progress and changes in the South African health sector' (2012), available at: {http://ac.els-cdn.com/S0140673612619977/1-s2.0-S0140673612619977-main.pdf?_tid=08aad088-37eb-11e3-9bcb-00000aab0f26&acdnat=1382097018_397295eba72ad6b08dfdd1981f9ce972} accessed 18 October 2013; Chatham House, 'Meeting summary: South Africa's health policy and HIV' (September 2011), available at: {http://www.chathamhouse.org/sites/default/files/public/Research/Africa/160911motsoaledi.pdf} accessed 23 October 2013

[65] Ibid., p. 8.

[66] Senior Officer, Clinton Foundation South Africa, interview, 20 February 2013.

[67] CEO of global development NGO, interview, 19 February 2013. Interviewee wanted their identity protected due to the sensitive nature of current service provision discussions between SANAC and NGOs in South Africa at the time.

Second, as a move to build trust and bolster the coordinating role of the DoH, Motsoaledi appointed Fareed Abdullah as the new CEO of SANAC. In terms of creating political goodwill, Abdullah brought three key leadership elements to the position. One, Abdullah was the successful chair of the Western Cape CCM, which maintained an A1* GFATM rating and which was able to coordinate various funding streams and service providers into a coherent and strengthened provincial health system. Two, under Abdullah's leadership, the Western Cape CCM was widely held to be a meaningful multisectoral body with high levels of deliberation, information sharing, and participation. Three, Abdullah brought to SANAC key links and trusted relationships from the Western Cape, where provincial distrust of SANAC and the national DoH were pervasive and where elements of trust building needed to be fostered. As Abdullah himself suggested during interview, 'real multisectoralism has not been the case in the past and there is a great deal of repair work that needs to be done. Part of this is to bring all stakeholders into the decision-making process.'[68]

The perceived success of Abdullah's effort so far has paid dividends, with consensus between internal and external partners that 'Fareed has been particularly good at setting up multisectoral forums and meetings where various interests can be heard'[69] and that 'since the change of minister [as well as moves in SANAC] a more positive outlook has been taken by all and as long as buy-in can be maintained through effective management at the top, the actors involved will be willing to co-operate'.[70] To achieve this level of 'cautious' cooperation, Abdullah expanded the number of SANAC meetings and forums for participatory deliberation. For example, a *Development Partners Forum* now meets quarterly between all external funders. This is done to avoid programme overlap and to make sure there is coherence between externally funded projects. In conjunction with this forum, SANAC has invited key NGOs, service providers and civil society organisations to be involved with all grant design. As a head director for Right to Care stated

> SANAC is stronger under new leadership and more multisectoral with 5 NGOs [all former Global Fund principle recipients] on the panel who are involved in the joint grant. Partners can bring their own grant ideas and deliberation between partners is very good and open. I think the relationship between NGOs and SANAC has improved, although we remain cautious about NGO's moving from service providers to technical assistants, since no one knows what this means yet.[71]

Furthermore, in designing the NSP, a large integration programme called the *Programme of U-committee* was created. The aim of this body was to make links between sectors; academics, the top nine NGOs, provinces, and the private sector. Although political tensions between the provincial governments and SANAC still remain (and this should be stressed), according to several interviewees:

> the situation is a work in progress … it has improved considerably and there is a greater effort to listen to experts, NGOs, international organizations and provinces. National [DoH] now invites many sectors to the NSP meetings and there were lot's of discussion and feedback loops in setting the NSP.[72]

[68] Fareed Abdullah, CEO SANAC, interview, 20 February 2013.
[69] Nonhlanhla Zindela (UNFPA) (18 February 2013).
[70] Senior Advisor at the Ministry of Health, interview, 20 February 2013. This person wished to remain anonymous.
[71] A key programme director – Right to Care, interview, 19 February 2013. This person wished to remain anonymous due to ongoing negotiations with SANAC and the DoH.
[72] Ameena Goga, South African Medical Research Specialist Scientist and co-author of Plan of Mother-to-Treatment programme within the NSP, interview, 22 February 2013.

That said, there does remain considerable scepticism between key provinces such as the Western Cape and SANAC. This can to some degree be attributed to the legacy of Mbeki and past political tensions between the national government and the provinces,[73] but current tensions no doubt remain as SANAC attempts to bring provincial programmes in line with the NSP. For example, two senior health officials at the Department of Health Western Cape argued that historically 'there was no political will or ability to meet any health targets at the national level … [and] this is why we created are own mechanisms and why they were able to have success'. When asked about the effects of the new leadership, the interviewees suggested 'that there is still not enough dialogue and mutual partnership between the provincial and national government'. As one interviewee said, 'the national government has never had success whereas we have, you would think they would want to draw upon our know how'.[74] In addition, these tensions are heightened by the fact that the provinces (notably Western Cape, Gauteng, and KwaZulu-Natal) have historically operated outside of national policy, creating their own systems that often ignored national norms as well as generated better results. This suggests that participatory mechanism still need strengthening and that SANAC has considerable work to do if it wishes to generate the large-scale buy-in required of the provinces. As an officer from the Clinton Foundation agreed, 'the structure needs to be significantly strengthened and current engagement is haphazard at times … but SANAC should take on a stronger role to bring various groups together if the national health system is to improve'.[75]

Third, in terms of overall multisectoral participation within the national CCM, the case evidence suggests a heightened sense of inclusion, deliberation, and collective decision-making. As another senior health official from Western Cape suggested in terms of coordination, 'the level of partnership at the national level has increased since Fareed assumed office. The CCM meetings now allow for knowledge transfer (although with political sensitivity), the knowledge of who is working on what and there is a generally positive attitude between participants'.[76] As another national CCM member suggested:

> Since 2009 there is good dialogue between the actors. Even the private sector, which was originally opposed to NHI is now coming onboard. The WHO, World Bank, USAID, Clinton [Foundation] and others are all providing technical assistance with good deliberation between the organizations. In this sense leadership has made a critical difference.[77]

Lastly, in terms of including unheard voices as represented by civil society organisations (CSOs) and advocacy groups there has been a marked, yet still inadequate, level of improvement. As the CEO of AIDS Laws and Section 27 claimed:

[73] It should be mentioned that there are political tensions between Western Cape (which is run by the Democratic Alliance) and the DoH (which is seen, rightly or wrongly, as a ANC led institution). This tension was played out within many interviews and opinions could be seen to fall along political lines as well as on historical battlegrounds concerning provincial autonomy.

[74] Joint interview with senior health officials at the Department of Health Western Cape, interview 26 February 2013.

[75] Senior Officer, Clinton Foundation South Africa, interview 19 February 2013.

[76] Senior health officer, Department of Health Western Cape, interview 28 February 2013.

[77] Senior Advisor Ministry of Health, interview, 1 March 2013.

The new minister of health has accepted the need for greater partnership and discussion with CSOs. There is a new spirit of cooperation in the DoH and SANAC. The 2011 NSP was fairly deliberative and built on consensus. In fact, we pushed for Fareed's hire as the new CEO of SANAC and our recommendation was obviously taken seriously. This shows some level of a CSO's ability to alter decision-making processes.[78]

However, Abdullah himself admitted that CSO inclusion is still not good enough, proclaiming that 'civil society groups are not as integrated as they should be … and finding legitimate CSOs is not always easy and there is a great deal of "political wrangling" between various CSOs looking for access'. He went on to say that the process of rebuilding partnerships 'will not happen overnight and that future efforts to bring CSOs into SANAC will be made … at the moment there are more pressing concerns to get the CCM working again and focus needs to remain on this immediate concern'.[79]

What the 2009–13 fieldwork suggests is that a change of leadership in 2009 allowed political discussions regarding health partnerships to be re*framed* away from Mbeki's notion of ANC weakening and toward a narrative that allowed for new participatory spaces to be created. As a result, the expansion of partnership norms has slowly been *grafted* onto existing national policies from both provincial sources as well as global institutions. Moreover, participatory decision-making within the health sector has been increased (although still finding its way) at the national level and has produced impressive results in terms of consolidating resources and strengthening the participatory spaces within the national health system. What the evidence also illustrates is the important role national leadership plays in understanding how global health norms can be amalgamated into health systems and how *normative congruence building* is heightened under certain leadership conditions. In other words, national leaders are highly influential in how norms are framed, grafted, and diffused within a national system. What this suggests, and what remains to a significant degree understudied, is that leadership represents an area of study that requires greater attention if we're going to properly understand the diffusion of global health norms and how these processes can strengthen global health more broadly.

VI. Conclusion: The importance of national leadership in promoting the norms of health partnership, participatory multisectoralism, and its implications for global governance more broadly

Academics and policymakers often claim that global policy norms diffuse into national systems and help to influence 'best practices'. As was suggested at the beginning of this article, these arguments about the 'diffusion of norms' have a great deal of merit, since there is considerable evidence to suggest the existence of a positive correlation and that global norms can alter national practice (for better or for worse). Nevertheless, this article has argued that norm diffusion is more complicated and nuanced than it is often discussed within the existing literature on global health governance (and in many cases global governance and International Relations more

[78] Mark Haywood, CEO AIDS Law and Section 27 and Founder of TAC (largest responder to HIV/AIDS). Also former Deputy Chair of SANAC as elected leader for CSOs representatives, interview, 5 March 2013.

[79] Fareed Abdullah, CEO SANAC, interview, 1 March 2013.

broadly). In particular, it has been argued that many traditional norm diffusion models overlook the fact that global norms are significantly 'glocalised' by national actors and that policies are not adopted wholeheartedly without the influence of domestic social foundations and practices. In addition, traditional norm diffusion models have seemingly underplayed the relevance of national leadership in producing successful outcomes.[80] As a result, and in relation to public health, although global policy certainly influences how national health systems are organised, particularly in the developing world, a focus on top-down diffusion discounts the key role that national leadership plays in strengthening health systems while ignoring the persistent fact that national leadership is a crucial component to successful health outcomes.

Consequently, the findings in this article correspond to recent, yet also understudied, research on the role of leadership in fostering more enhanced deliberative forums and democratic procedures. As has recently been argued by Jonathan Kuyper, leaders play a key role in establishing 'a coordinating focal point' in deliberative models as well as in 'facilitating meaningful deliberations'.[81] As he convincingly demonstrates, leaders have four important roles in deliberative participatory governance. Namely, leaders often help 'initiate' the formation of minipublics or multisectoral deliberative bodies; leaders play a central role in the procedural 'operation' of these bodies; leaders often have the ability to 'uptake' (or reject) the decisions reached by deliberative bodies; and, leaders are usually the people responsible for overseeing (or guaranteeing) the long-term 'execution' of any policy decision generated from a deliberative forum. As a result, and as this article has further supported, understanding the role of national leaders in coordinating and facilitating meaningful deliberative and participative governance structures is necessary in understanding the initiation, operation, uptake, and execution of partnership norms in global governance and how these norms are diffused, both from the top down as well as from the bottom up.

In support, this article explored the role that national leadership played in strengthening the participatory governance mechanisms of the South African health system between 2002 and 2012. In particular, it has been argued that leadership played the key role in the adoption of partnership norms within SANAC and its corresponding CCM. Leadership strengthened these systems by increasing the role of participatory politics within its governance procedures and did so by reframing the existing narratives associated with global partnership. In other words, despite the influence of international partnership norms from which normative material was drawn, national leadership remained the key driver in producing more successful health system partnerships in line with these global norms and that these norms are being amalgamated in a context that is uniquely South African.

[80] The importance of national leadership (or the ability to lead as a national body) has also been recently stressed by Ted Schrecker, who has suggested that recent focus on global health governance has seemingly overlooked and underplayed the key role national governments have in setting favourable national health and economic policies, resisting unfavourable market pressures, financial conditionalities, and external governance mechanisms that can have significant impact on the social determinants of health. See Ted Schrecker, 'The extraterritorial reach of money: Global finance and the social determinants of health', in G. W. Brown, G. Yamey, and S. Wamala (eds), *Global Health Policy* (Willey-Blackwell, 2014), pp. 393–408.

[81] Jonathan Kuyper, 'Deliberative democracy and the neglected dimension of leadership', *Journal of Public Deliberation*, 8:1 (2012), pp. 4–16.

In addition, it is also important to note that understanding the role of national leadership in the diffusion of global health governance norms is not limited to the South African case and there are generalisable implications for future global health research. In particular, there is considerable scope to understand how global health norms have been framed and grafted onto other health systems by national leaders as well as the unique role these leaders play in the way these norms were/are adopted, augmented, or rejected. For example, there is an increasing amount of literature focusing on the 'developmental success' of Rwanda as well as the unique political context in which this developmental process has taken place. As is often suggested, one significant factor in Rwanda's 'success' has been the leadership position of President Paul Kagame and his initiative to make Rwanda a middle-income country by 2020 as well as the way he played a crucial role in Rwanda's development programme, particularly in rebuilding its health system. In this case, as with other cases, leadership plays an important role in the way certain health norms have been framed and grafted onto existing systems. This case can be contrasted with other ways leadership plays a positive or negative role in health system strengthening, for example, by contrasting it with the less effective health programmes that have received weak support by the King of Swaziland Mswati III. In each of these cases, the framework and focus on leadership presented in this article provides valuable insights for understanding how norms are diffused (or not) and how a central element to successful health governance remains vested in the nation and the type of leadership role it exerts.

Furthermore, the analytical framework and focus on national leadership presented in this article has wider implications for the broader study of norm diffusion in International Relations. This is not only the case in regards to providing a better framework for understanding norm diffusion more generally, but also in regards to understanding the key role national leadership plays in norm diffusion across various subjects involved with global governance, international legal compliance, and international ethical commitments. In relation to understanding norm diffusion beyond traditional 'life cycle' and 'spiral' models, this article adopted an analytical framework based on a constructivist account that was originally applied for understanding norm diffusion within environmental global governance. As a result of this crossover, there is no reason why the framework used in this article would not have direct application to other areas of global governance in order to help understand how norms are grafted and framed within various political and social contexts. In addition, this article maintained a specific focus on the role of leaders in how global norms are introduced, adapted, augmented, or rejected. As above, there is no theoretical reason to limit the examination of leadership within processes of norm diffusion to global health. *Prima facie*, there is good reason to suggest that leadership plays an important role in a great number of governance sectors. Moreover, although there have been studies examining the role of leadership in the formation of international organisations and with the creation of elite driven global norms,[82] there is far less research looking at the role of leadership in how norms are diffused in national/local contexts. In other words, national leadership has a persistent relevance in the way norms are diffused and amalgamated into domestic policy (or not) and for this reason leadership represents an important research area in International Relations that needs to be better examined and understood.

[82] Oran Young, 'Political leadership and regime formation on the development of institutions in international society', *International Organizations*, 45:3 (1991), pp. 281–308.