Hybrid norms and the politics of integration: evolving linkages between global health security and universal health coverage

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A thesis submitted to the Department of Health Policy at the
London School of Economics and Political Science
for the degree of Doctor of Philosophy (PhD)

London, UK, June 2025

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Declaration

I certify that this thesis is solely my own work, other than where I have clearly indicated that the work was shared with others, in which case the extent of any work carried out jointly with co-authors is clearly identified (see "Statement of conjoint work").

The total word count for this thesis is 86,932 words (excluding works cited and annex).

London

June 2025

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Acknowledgements

This thesis was conceived in the early weeks of the COVID-19 pandemic – when the world stood still, borders were sealed, and the very systems I set out to study were thrown into disarray. It was written in the midst of a rapidly evolving landscape: institutions fractured, painful conflicts erupted, geopolitical tensions deepened, and the impacts of climate change exacerbated existing inequities. Our conventional ways of working suddenly appeared inadequate. This context reshaped what we mean by global health, and who is actually served by it. In many ways, this project is both a product of and a response to that moment – a way to make sense of fragmentation, diplomacy, and the enduring pursuit of solidarity. For me, it has also been, quite simply, a light in the dark.

To my supervisors: Dr. Justin Parkhurst and Dr. Clare Wenham, thank you for sharpening my mind and steadying my hand. Justin, your insistence on clarity – on anchoring every word, every claim, in narrative and precision – kept me from getting lost in the fog. Clare, your challenge to root this work in theory and to think beyond my disciplinary silos gave this thesis its conceptual backbone and relevance to contemporary challenges. I am deeply thankful to you both for your time, your wisdom, and your guidance throughout this project.

To my family: my parents, Rohit and Sangeeta Lal, thank you for raising me to be curious, to lead with empathy, and to always reach higher – your belief in me is the wind beneath my wings. And to my sister, Arshiya Lal, my confidante and twin flame, your strength and intuition never fail to bring me back to myself. I am forever grateful to each of you for your love, support, and encouragement.

To my partner: Noah Ponton, few words can fully capture your impact on this work. This thesis was made possible by your patience, nourished by your meals, and completed because of your unwavering faith that I could finish what I started. This is as much yours as it is mine. Every page carries with it the reassurance and care you poured into the quiet spaces between me writing them.

To the mentors who paved my path, from school through my professional life: you took a chance on me when I didn't yet know how to take one on myself. Thank you for seeing something in me when I couldn't. Your ideas have shaped this project in countless ways, and your insights are reflected in its chapters. This thesis is born out of the work you have inspired along the way.

To the friends who shaped me and kept me whole: those from university who molded me into the person I am today, and those in London who made sure I kept going when I didn't think I could. Thank you – all of you – for the sunsets, the sunrises, the laughter, the space to fall apart, and the reminders of who I am and what really matters. I couldn't have done this without you.

And finally, this thesis is dedicated to health workers around the world: from war zones to hospital rooms, in health systems stretched beyond recognition – you continue to show up for others with a courage and compassion that defies power and politics. You are the beating heart of global health, and the soul of this project. Thank you for what you do.

Abstract

This thesis examines the evolving relationship between global health security (GHS) and universal health coverage (UHC), two dominant – yet historically fragmented – normative agendas shaping global health. While GHS prioritizes preparedness and response to acute health threats, UHC emphasizes equitable access and affordability of health services. Despite growing recognition of their interdependence, meaningful integration between GHS and UHC remains limited in policy and practice – potentially weakening coordination and undermining public health outcomes, especially during crises. The COVID-19 pandemic created an inflection point, accelerating discussions on their alignment and potential synergies. However, existing scholarship lacks a robust theoretical framework to explain how two established and influential norms can co-evolve without one subsuming the other. This thesis addresses this gap by introducing two related concepts, rooted in constructivist international relations and political science literature: 'hybrid norms' (a framework for tracing the construction, convergence, and coherence of previously-distinct norms and their associated regimes) and the 'politics of integration' (a lens for unpacking the strategic processes of framing, negotiation, and institutionalization that shape normative integration).

The study unfolds through three empirical chapters, each interrogating GHS-UHC integration at successive stages of development, reflecting the hybrid norm framework. The first empirical chapter traces their historical (re)construction through major crises and international agreements, employing a discursive analysis of key policy texts to argue that both norms have been shaped through repeated interaction and contestation, rather than linear adoption. The second empirical chapter utilizes a multimethod qualitative analysis to examine recent diplomatic negotiations (WHO Pandemic Agreement and the 2023 UN Political Declaration on UHC), analyzing normative convergence between GHS and UHC through the co-promotion of complementary discourse and core functions – while also revealing how political contestations, institutional path dependencies, and operational trade-offs constrain deeper integration. The third empirical chapter uses thematic analysis of key informant interviews to explore how stakeholders across governments, global health organizations, donors, and civil society conceptualize and operationalize GHS-UHC coherence in practice. It finds that a hybrid norm linking GHS and UHC is emerging, which may help overcome geopolitical power asymmetries, foster strategic collaboration across diverging actor priorities, and enable more integrative forms of diplomacy to better address multiple overlapping crises.

This project offers novel contributions to global health policy and governance, constructivist norm theories, and international relations and political science scholarship. Empirically, it traces the emergence of a hybrid norm linking GHS and UHC through diplomacy and institutional design – revealing how normative integration unfolds incrementally across geopolitical and operational contexts in response to longstanding fragmentation. Conceptually, it introduces a new framework that reorients integration from a technical fix to a dynamic, contested, and co-evolving normative process to improve cross-sector collaboration and coordination. Methodologically, it advances a real-time discursive analysis approach for studying norm development across overlapping regimes

through global negotiations. Taken together, these contributions provide a new lens for understanding the politics of integration, and offer fresh insights and practical implications for building a more equitable, resilient, and sustainable global health architecture.

Preface & motivation

I am often asked why I chose to focus my doctoral research on the fragmentation between global health security (GHS) and universal health coverage (UHC) – a topic some have characterized as niche or overly theoretical amid the numerous existential threats facing global health. But to me, the difficulty of integrating GHS and UHC – despite mounting evidence and repeated calls for synergy – cuts to the heart of a deeper issue: a political and structural failure in how we conceptualize, fund, and implement health priorities. Confronting this disconnect, I believe, could be catalytic in building a more equitable and resilient global health architecture that better meets the needs of all communities.

Setting the scene[1]

In the months leading up to the adoption of the World Health Organization (WHO) Thirteenth General Programme of Work[2] in May 2018, Director-General Tedros Adhanom Ghebreyesus reflected on his five-year organizational plan by emphasizing a statement that would profoundly influence contemporary global health discourse:

"Universal health coverage and health security are two sides of the same coin."[3]

At that moment, WHO was at a crossroads, with Tedros steering the world's foremost public health agency[4] through a period of complex global health challenges. The Democratic Republic of the Congo (DRC) was grappling with a major Ebola outbreak, determined as a Public Health Emergency of International Concern (PHEIC)[5] – which, despite benefiting from a more coordinated response than the preceding West African Ebola epidemic of 2014-2016, still revealed

[1] Note that this thesis uses continuous footnote numbering throughout, except for Chapters 6-8 which retain the original formatting of published and under-review articles.

[2] 'Thirteenth General Programme of Work 2019-2023', *World Health Organization* <https://www.who.int/about/what-we-do/thirteenth-general-programme-of-work-2019---2023> [accessed 2 May 2021].

[3] Tedros Adhanom Ghebreyesus, 'All Roads Lead to Universal Health Coverage', *The Lancet Global Health*, 5.9 (2017), pp. e839–40, doi:10.1016/S2214-109X(17)30295-4; WHO, 'Exchange of Views on the Importance of Health in Development', 19 March 2018 <https://www.who.int/director-general/speeches/detail/exchange-of-views-on-the-importance-of-health-in-development-european-parliament-committee-on-development>.

[4] Benjamin Mason Meier and Alexandra Finch, 'Seventy-Five Years of Global Health Lawmaking under the World Health Organization: Evolving Foundations of Global Health Law through Global Health Governance', *Journal of Global Health Law*, 1.1 (2024), pp. 26–49, doi:10.4337/jghl.2024.01.02.

[5] WHO, 'Statement on the Meeting of the International Health Regulations (2005) Emergency Committee for Ebola Virus Disease in the Democratic Republic of the Congo on 17 July 2019', *Https://Www.Who.Int/Ihr/Procedures/Statement-Emergency-Committee-Ebola-Drc-July-2019.Pdf?Ua=1*, no. July (2019), pp. 1–6.

persistent weaknesses in health system resilience.[6] At the same time, WHO was preparing for the Global Conference on Primary Health Care in Astana, commemorating the fortieth anniversary of the Alma-Ata Declaration by reaffirming a global commitment to "health for all" and renewed emphasis on health equity.[7] Just over a year later, the first-ever United Nations High-Level Meeting (UN-HLM) on Universal Health Coverage was set to convene, where world leaders would pledge to enhance access to essential health services without imposing financial hardship on vulnerable populations.[8]

The broader context was equally significant. The UN Sustainable Development Goals (SDGs), adopted just three years earlier in 2015, had cemented health as a foundational, cross-cutting pillar of international development[9] – pushing global health stakeholders to navigate a dual imperative: expanding access to care while safeguarding populations from emerging health threats. Tedros' framing of GHS and UHC as interdependent – rather than competing – goals reflected a growing recognition[10] that integrated approaches were vital to simultaneously address both chronic and acute health challenges. This framing offered not just a rhetorical shift, but a potential reorientation of global health diplomacy itself – one that hinted at a new paradigm of alignment between previously-distinct public health priorities. Yet significant obstacles remained – not only in policy debates, but in the very ways that global health institutions, funding streams, and health systems were designed to function.

Contestation between the goals of GHS and UHC did not begin there. Underpinning these agendas, related tensions between security and human rights[11], between emergency response and long-term capacity-building[12], between biomedical interventions and social determinants of health[13] stretch back decades – centuries even. Health policymakers have long wrestled with how to effectively

[6] Joseph Kimuli Balikuddembe, 'Re-Emergency of Ebola in the Democratic Republic of Congo: Synergizing the Preparedness and Response Measures with the Sustainable Development Goals', *Disaster Prevention and Management: An International Journal*, 29.5 (2020), pp. 649–62, doi:10.1108/DPM-04-2020-0116.
[7] 'Declaration of Astana' <https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.61> [accessed 21 April 2025].
[8] WHO, 'Preparation for the High-Level Meeting of the United Nations General Assembly on Universal Health Coverage', 25 March 2019 <https://apps.who.int/gb/e/e_wha72.html>.
[9] Sakiko Fukuda-Parr, 'From the Millennium Development Goals to the Sustainable Development Goals: Shifts in Purpose, Concept, and Politics of Global Goal Setting for Development', *Gender & Development*, 24.1 (2016), pp. 43–52, doi:10.1080/13552074.2016.1145895.
[10] Ilona Kickbusch and Martina Marianna Cassar and Szabo, 'A New Governance Space for Health', *Global Health Action*, 7.1 (2014), p. 23507, doi:10.3402/gha.v7.23507.
[11] Sharifah Sekalala, Caitlin Williams, and Benjamin Meier, 'Global Health Governance through the UN Security Council: Health Security vs. Human Rights?', *Australian Journal of International Affairs*, 76 (2022), pp. 27–34, doi:10.1080/10357718.2021.2017843.
[12] Josefien van Olmen and others, 'Health Systems Frameworks in Their Political Context: Framing Divergent Agendas', *BMC Public Health*, 12.1 (2012), p. 774, doi:10.1186/1471-2458-12-774.
[13] Jens Holst, 'Global Health – Emergence, Hegemonic Trends and Biomedical Reductionism', *Globalization and Health*, 16.1 (2020), p. 42, doi:10.1186/s12992-020-00573-4.

balance protecting populations from epidemics alongside sustaining universal access to health.[14] These competing paradigms have shaped national and global health priorities across geographies and over time. Today, as new crises emerge and political landscapes shift, the conceptual and operational linkages between GHS and UHC remain deeply contested, continuously evolving in response to geopolitical realities, institutional pressures, and economic constraints.[15]

It is within this dynamic landscape that this thesis is situated. My research began at a moment when interest in explicitly promoting synergies[16] between major global agendas was just beginning to take root, including via revised strategies of major UN agencies and global health organizations.[17] Meanwhile, the academic community was responding in parallel. In 2018, *The Lancet* launched a "Commission on synergies between universal health coverage, health security, and health promotion" – seeking to examine where these agendas converged, where they conflicted, and how they might be harmonized. In the same year, a collaboration between the Georgetown University Center for Global Health Science & Security and the University of Edinburgh Global Health Governance Programme established a Working Group on Global Health Security & Universal Health Coverage, while several other research studies on health system integration and GHS-UHC synergies were cropping up.[18] Yet, despite these efforts, the institutional and political forces influencing the alignment of GHS and UHC remained largely undertheorized, necessitating deeper conceptual and empirical examination.

Personal encounters with fragmentation in global health

For me, these debates were not just academic; they were deeply personal. At the same time Tedros was urging stakeholders to view GHS and UHC as interconnected priorities, I had just completed a

[14] Gilles Raguin and Pierre-Marie Girard, 'Toward a Global Health Approach: Lessons from the HIV and Ebola Epidemics', *Globalization and Health*, 14.1 (2018), p. 114, doi:10.1186/s12992-018-0435-9.

[15] Gorik Ooms and others, 'Synergies and Tensions between Universal Health Coverage and Global Health Security: Why We Need a Second "Maximizing Positive Synergies" Initiative', *BMJ Global Health*, 2.1 (2017), p. 217, doi:10.1136/bmjgh-2016-000217.

[16] World Health Organization and PEPFAR, 'Report on the WHO/PEPFAR Consultation on Maximizing Positive Synergies between Health Systems and Global Health Initiatives through Work on Building and Sustaining Health Workforce Development, Washington DC, 17-18 March 2009' 2009, 2009 <https://iris.who.int/handle/10665/76443>.

[17] 'An Assessment of Interactions between Global Health Initiatives and Country Health Systems', *The Lancet*, 373.9681 (2009), pp. 2137–69, doi:10.1016/S0140-6736(09)60919-3; GPW-13 team, 'Draft Thirteenth General Programme of Work, 2019–2023', *WHO Press*, no. April 2018 (2018), p. 50; 'African Union, Gavi and Japan Unite to Bolster Health Security and Universal Health Coverage in Africa', *GAVI* <https://www.gavi.org/news/media-room/african-union-gavi-and-japan-unite-bolster-health-security-and-universal-health> [accessed 29 January 2025].

[18] 'Working Group on Global Health Security & Universal Health Coverage - Center for Global Health Science and Security' <https://ghss.georgetown.edu/ghs_uhc/> [accessed 21 April 2025]; Rifat Atun and others, 'Integration of Targeted Health Interventions into Health Systems: A Conceptual Framework for Analysis', *Health Policy and Planning*, 25.2 (2010), pp. 104–11, doi:10.1093/HEAPOL/CZP055; Joseph Kutzin and Susan P. Sparkes, 'Health Systems Strengthening, Universal Health Coverage, Health Security and Resilience', *Bulletin of the World Health Organization*, 94.1 (2016), p. 2, doi:10.2471/BLT.15.165050.

stint working in the United States (US) Office of Pandemics & Emerging Threats, supporting the rollout of the Global Health Security Agenda (GHSA). Here, links between security and global health were especially pronounced, and pandemic preparedness and biothreat mitigation were dominant priorities. I witnessed this firsthand during the response to the Zika virus (also declared a PHEIC by WHO)[19], where decision-making was driven primarily by concerns about cross-border transmission. Admittedly, I initially viewed GHS uncritically – even with optimism – seeing that the framing of health as a 'national security issue' could be an effective way to foster international cooperation on thorny public health challenges that had long evaded attention and success.

However, in early 2017, the political landscape shifted dramatically. The Trump administration's deprioritization of international assistance rendered GHS one of the few politically viable rationales for sustaining US engagement in global health. With it, support for UHC – already a contentious term within American foreign policy[20] – significantly declined; as the largest bilateral donor for global health, this had important implications. During this period, I had transitioned to a health workforce non-governmental organization (NGO), where it became increasingly evident that an exclusive focus on emergency response and disease containment was unsustainable without complementary investments in UHC-related interventions like affordable medicines, primary health care, and financial protection. The disconnect was glaring. Funding streams were siloed. Priorities were dictated by short-term security imperatives rather than long-term health system strengthening. Certain narratives carried more weight than others, shaping not only where resources were allocated, but whose health needs were deemed urgent – and whose were not.

Three years later in 2020, the first cases of COVID-19 were reported during my first few weeks at the Pan American Health Organization (PAHO). Our team suddenly faced the daunting task of balancing access to chronic treatments alongside surging demand for pandemic countermeasures, such as masks and diagnostic tests. Furthermore, countries around the world reported major disruptions to routine and essential health services, many of which continued for years into the pandemic.[21] These disproportionately impacted marginalized communities and exacerbated existing inequalities.[22] I watched as governments were forced to make impossible choices on which health facilities to shutter, which services to cut, and which health workers could operate without adequate personal protective equipment (PPE) – choices which, one way or another, would undermine public health for everyone.

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[19] Clare Wenham and others, 'Zika, Abortion and Health Emergencies: A Review of Contemporary Debates', *Globalization and Health*, 15.1 (2019), p. 49, doi:10.1186/s12992-019-0489-3.

[20] Scott L. Greer and Claudio A. Méndez, 'Universal Health Coverage: A Political Struggle and Governance Challenge', *American Journal of Public Health*, 105.Suppl 5 (2015), pp. S637–39, doi:10.2105/AJPH.2015.302733.

[21] 'COVID-19 Continues to Disrupt Essential Health Services in 90% of Countries', *WHO*, 23 April 2021 <https://www.who.int/news/item/23-04-2021-covid-19-continues-to-disrupt-essential-health-services-in-90-of-countries>.

[22] Sulzhan Bali and others, 'Off the Back Burner: Diverse and Gender-Inclusive Decision-Making for COVID-19 Response and Recovery.', *BMJ Global Health*, 5.5 (2020), p. e002595, doi:10.1136/bmjgh-2020-002595.

I repeatedly encountered what Frenk and Gómez-Dantés have referred to as "false dichotomies"[23] plaguing all parts of the global health architecture – from government ministries to philanthropic initiatives to advocacy coalitions. It felt like everywhere I looked, precious time and effort was wasted trying to coordinate between seemingly irreconcilable health priorities. Even emerging paradigms, ostensibly developed with the explicit aim "to foster synthesis" between different sectors – such as 'Planetary Health' and 'One Health' – were likewise plagued by fragmentation "across instruments, fields, and institutions."[24] As a result, collaboration between sectors like climate change and public health has struggled to seed progress, with detrimental impacts on addressing urgent and collective threats to our rapidly-warming planet.

Zooming out

As I tried to make sense of this dizzying array of challenges, they gradually began to converge. What I had previously assumed were many distinct problems started to feel like different expressions of the same underlying issue: persistent and chronic fragmentation between GHS and UHC across health systems.

Security framings have become increasingly promoted as a mainstay in a world confronted with multiple existential crises, and are evidently effective at attracting resources and attention to key issues.[25] Yet, what consistently undermines this approach is its neglect of principles like equity, access, and human rights – which are core to UHC. Conversely, UHC – often dismissed as overly complex, ambiguous, or idealistic – has been profoundly effective at addressing local health gaps.[26] However, its proponents struggle to sustain prioritization when pitted against pressing emergencies or neoliberal policy constraints. Here, GHS frameworks might offer a pragmatic path forward, leveraging established political resonance to reinforce UHC objectives in a period of overlapping emergencies, while UHC advocates may be able to provide greater legitimacy and social support for GHS capacities – in a manner Ooms et. al characterize as "the 'triangle that moves the mountain'."[27]

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[23] Julio Frenk and Octavio Gómez-Dantés, 'False Dichotomies in Global Health: The Need for Integrative Thinking', *The Lancet*, 389.10069 (2017), pp. 667–70, doi:10.1016/S0140-6736(16)30181-7.

[24] Alexandra L. Phelan, Stefania Negri, and Marlies Hesselman, 'Environmental Health: Towards Synthesis in Global Law and Governance', *Journal of Law, Medicine & Ethics*, 2025, pp. 1–5, doi:10.1017/jme.2025.10; Nicholas Frank, Sharon Friel, and Megan Arthur, 'Exploring the Planetary Health Equity Governance Supercluster Complex', *Earth System Governance*, 20 (2024), p. 100207, doi:10.1016/j.esg.2024.100207; Azza Elnaiem and others, 'Global and Regional Governance of One Health and Implications for Global Health Security', *The Lancet*, 401.10377 (2023), pp. 688–704, doi:10.1016/S0140-6736(22)01597-5.

[25] Jeremy Shiffman and Yusra Ribhi Shawar, 'Framing and the Formation of Global Health Priorities', *The Lancet*, 399.10339 (2022), pp. 1977–90, doi:10.1016/S0140-6736(22)00584-0.

[26] Katri Bertram and others, 'Confronting the Elephants in the Room: Reigniting Momentum for Universal Health Coverage', *The Lancet*, 0.0 (2024), doi:10.1016/S0140-6736(24)00365-9.

[27] Ooms and others, 'Synergies and Tensions between Universal Health Coverage and Global Health Security: Why We Need a Second "Maximizing Positive Synergies" Initiative'.

GHS and UHC have both proven to be deeply compelling normative agendas in global health – though each appeal to different timelines, ministries, operational levels, and power structures. The imperative, then, may not be to prioritize one over the other, but to reckon seriously with both. Tomorrow's crises may benefit from security framings and universal access commitments which reinforce, rather than undermine, each other. The COVID-19 pandemic was a harsh wake-up call to all parts of our political, economic, and social systems; in my area of global health, it exposed major gaps in the way health systems have been designed and the norms which underpin them – pointing to a fundamentally political challenge, not a technological or scientific one.

From questions to thesis formation

I began my doctoral journey against this backdrop, trying to ascertain whether Tedros' joint framing of GHS and UHC might truly offer a 'better' path forward. Could linking both agendas help overcome the chronic fragmentation, funding gaps, and policy misalignments that had long undermined global health initiatives? The question of how to reconceptualize our global health architecture to simultaneously strengthen both GHS and UHC became the cornerstone of my academic inquiry into fostering equitable and resilient health systems – and ultimately the central focus of this work.

My thesis therefore sets out to answer critical questions about how GHS and UHC evolved into interconnected domains, and the implications of synergizing these agendas through global health diplomacy and governance mechanisms. By unpacking the political and structural – and ultimately *normative* – dimensions of GHS-UHC integration, it seeks both to illuminate historical complexities and to articulate a more adaptable, inclusive future for global health.

Closing reflection

At the time of submission, just over four years after I began researching this topic, the second Trump administration has thrown the entire global health and development sector into disarray, pulling the plug on billions of dollars of lifesaving aid.[28] Multilateralism is fast eroding, protracted crises and conflicts are weakening public health institutions, and countries appear to be lurching toward isolationism and transactional diplomacy.[29] The need for health policy research that bridges security and human rights for all communities, that offers a more coherent and productive vision of global health, that reduces donor dependencies on siloed priorities, that provides a clear pathway to long-term health development may be more urgent than ever.

We must imagine a future where GHS and UHC build each other up instead of tearing each other down through needless competition and fragmentation, and – at least partially as a result of this

[28] Talha Burki, 'WHO, USAID, PEPFAR: First Targets of Trump's Presidency', *The Lancet Microbe*, 6.3 (2025), doi:10.1016/j.lanmic.2025.101101.
[29] Ilona Kickbusch and founder, 'Trump, the Rise of the Global South, and a New World Order for Health', *BMJ*, 387 (2024), p. q2708, doi:10.1136/bmj.q2708.

endeavor – countries and global health organizations may be better equipped to collaborate and coordinate their approaches to complex health challenges in a way that more effectively supports our people and our planet.

This thesis therefore investigates how GHS and UHC are negotiated, linked, and ultimately integrated through the lens of global health diplomacy – and how these efforts are structured by political forces, normative struggles, and institutional power. It argues that this is not a linear or technocratic process. Instead, it is one shaped by interaction, contestation, strategic adaptation, and moments of opportunity. This means that change is possible – and likely already underway.

I hope that this research contributes to a deeper understanding of how and why global health agendas evolve as they do, where sticking points of fragmentation persist, and how hybrid norms may offer a viable path forward. Most importantly, I hope it supports those working toward equity-driven, resilient, and sustainable global health systems that neither sacrifice preparedness nor abandon people's right to health and wellbeing.

Statement of conjoint work

The first empirical article in this thesis (**Chapter 6**) was co-authored with Dr. Justin Parkhurst and Dr. Clare Wenham, and published in *International Affairs*.

Summary of Author Contributions: *AL conceived of the study and conducted all research and drafting, while JP and CW provided oversight, support on the conceptual approach and writing process, and review of the manuscripts.*

The second empirical article in this thesis (**Chapter 7**) was co-authored with Dr. Clare Wenham and Dr. Justin Parkhurst, and published in *Globalization and Health*.

Summary of Author Contributions: *AL conceived of the study and conducted all research and drafting, while CW and JP provided oversight, support on the methodological approach and writing process, and review of the manuscripts.*

The third empirical article in this thesis (**Chapter 8**) was single authored by the Ph.D. candidate, and is under peer review in *Health Policy and Planning*.

Acknowledged Contributions: *AL conceived of the study and conducted all research and drafting, and CW and JP provided helpful feedback on the manuscript.*

This statement is to confirm that I (the PhD candidate) contributed a minimum of 70% effort to all empirical Chapters 6, 7, and 8; as agreed to by the undersigned:

Justin Parkhurst Clare Wenham

Other relevant work

During my PhD studies, I co-authored peer-reviewed articles, reports, book chapters, and commentaries on global health security, universal health coverage, health systems strengthening, and global health governance. These outputs (listed below in reverse order), while not contributing directly to this thesis, are relevant to the work presented throughout.

Mhazo A, **Lal A**, Mossialos E. (2024). The COVID-19 pandemic: a focusing event to promote domestic investment for health systems strengthening in the WHO African Region. *Social Science & Medicine – Health Systems*. https://doi.org/10.1016/j.ssmhs.2024.100034.

Bertram K, Aylward B, Bosio L, Clark H...**Lal A**, et al. (2024). Confronting the elephants in the room: reigniting momentum for universal health coverage. *The Lancet*. https://doi.org/10.1016/S0140-6736(24)00365-9.

Lal A, Schwalbe N. (2023). Primary health care: a cornerstone of pandemic prevention, preparedness, response, and recovery. *The Lancet*. https://doi.org/10.1016/S0140-6736(23)00963-7.

Bertram K, **Lal A**. (2023). Opinion: Global health security and universal health coverage: from fragmented aspirations to ambitious commitments. *BMJ Global Health*. https://www.bmj.com/content/381/bmj.p1029.long.

Lal A, Phelan A, Abdalla S, et al. (2022). Pandemic preparedness and response: exploring the role of universal health coverage within the global health security architecture. *The Lancet Global Health*. https://bit.ly/3DxQBZf.

Lal A, Haldane V, Saha S, Kandel N. Making Health Systems Work in L&MICs: A Textbook for Public Health Practitioners. (2022). Chapter title: Health system response to the COVID-19 pandemic: Fault lines exposed, and lessons learnt. *Cambridge University Press*. https://bit.ly/3R4ihdx.

Shroff Z, Marten R,…,**Lal A** et al. (2022). "Systems for health: everyone has a role." *WHO (Alliance for Health Policy and Systems Research)*. https://ahpsr.who.int/publications/i/item/systems-for-health-everyone-has-a-role.

Rackimuthu, S., Narain, K., **Lal, A**. et al. (2022). Redressing COVID-19 vaccine inequity amidst booster doses: charting a bold path for global health solidarity, together. *Globalization and Health*. 18, 23. https://doi.org/10.1186/s12992-022-00817-5.

Deussom R, **Lal, A**. et al. (2022). Putting health workers at the centre of health system investments in COVID-19 and beyond. *Family Medicine and Community Health / BMJ*. http://fmch.bmj.com/content/10/2/e001449.

Lal A, Lim C, Almeida G, Fitzgerald J. (2021). Minimizing COVID-19 disruption: ensuring the supply of essential health products for health emergencies and routine health services. *The Lancet Regional Health – Americas*. https://doi.org/10.1016/j.lana.2021.100129.

Lal A, Gregory R. (2021). "Action on health systems, for universal health coverage and health security." *WHO (UHC2030)*. https://www.uhc2030.org/what-we-do/working-better-together/hss-paper/.

Lal A, Erondu N, Heymann D, Gitahi G, Yates R. (2020). Fragmented health system resiliency to COVID-19: rectifying the misalignment between global health security and universal health coverage. *The Lancet*. https://doi.org/10.1016/S0140-6736(20)32228-5.

Lal A, Ashworth HC, Dada S, Hoemeke L, Tambo E. (2020). Optimizing Pandemic Preparedness and Response through Health Information Systems: Lessons Learned from Ebola to COVID-19. *Disaster Medicine & Public Health Preparedness*. https://doi.org/10.1017/dmp.2020.361.

Extended abstracts

GHS and UHC are two dominant, yet historically siloed, agendas that shape how the global health architecture is governed, financed, and delivered. Despite intensified calls to more effectively mitigate fragmentation between them, the processes through which GHS and UHC have been increasingly normatively aligned remain underexplored. Comprised of three related empirical studies (two published, one under peer review), this thesis examines how GHS-UHC integration has developed through diplomacy – and, in turn, how hybrid norms linking both are being operationalized across health systems.

Chapter 6: (Re)constructing global health security and universal health coverage: norm contestation and interaction, *International Affairs* (2024)

To effectively tackle public health challenges, policy-makers increasingly advocate for aligning global health security (GHS) and universal health coverage (UHC), two influential norms driving international health cooperation. However, despite operating within overlapping spheres of governance, the normative histories linking GHS and UHC remain relatively unexplored in the literature. This article examines how GHS and UHC have been (re)constructed—from distinct policy sectors to synergistic norm regimes—through repeated contestation and interaction. Utilizing the 'norm life-cycle' framework to trace development across three stages (emergence, tipping-point/cascade and internalization), this study discursively analyses key texts from major crises and international agreements spanning several decades to unpack how norms and their underlying discourses and core functions have influenced each other as they evolved. The findings illustrate that GHS and UHC norms would be better understood as dynamic 'processes' rather than static concepts. The article concludes that GHS and UHC norms have shaped each other more significantly than previous scholarship suggests, characterizing them as continuously evolving, closely interlinked and increasingly integrated. This work contributes not only to the broader scholarship on international norms theory, but also offers pragmatic implications for navigating normative development where multiple norms compete for influence amid ever-shifting priorities.

Chapter 7: Normative convergence between global health security and universal health coverage: a qualitative analysis of international health negotiations in the wake of COVID-19, *Globalization and Health* (2025)

Background: The UN Sustainable Development Goals (SDGs) and WHO Thirteenth General Programme of Work underscored the importance of mitigating health emergencies while ensuring accessible and affordable health services. Central to these efforts are global health security (GHS) and universal health coverage (UHC), which act both as standalone goals and as cross-cutting approaches to health policy and practice. While GHS and UHC each operate as distinct norms, global health stakeholders increasingly advocate for advancing them synergistically to address interconnected health challenges amid limited resources. However, the current extent of alignment

between GHS and UHC remains unclear, especially post-COVID-19. This qualitative study assesses normative convergence between GHS and UHC by tracing their development through iterative draft texts across two major international health negotiations – specifically examining how UHC norms are expressed in the WHO Pandemic Agreement, and how GHS norms are expressed in the 2023 UNGA Political Declaration on Universal Health Coverage.

Results: UHC was promoted in the WHO Pandemic Agreement through three closely-associated discourse themes (rights-based narratives, equity frames, focus on social determinants of health) and three closely-associated core functions (accessible and affordable health commodities, prioritizing vulnerable populations, primary health care approach). Meanwhile, GHS was reciprocally promoted in the 2023 UHC Political Declaration through three related discourse themes (existential threat narratives, resilience frames, focus on infectious diseases) and three related core functions (outbreak preparedness, health emergency response, One Health approach).

Conclusions: The findings indicate that the COVID-19 pandemic created a policy window uniquely-positioned to accelerate normative convergence between GHS and UHC. Both international agreements advanced convergence by demonstrating increased complementarity and interdependency between the two norms through the co-promotion of their underlying features. However, negotiators agreed to political and operational trade-offs which made it difficult to sustain progress. This study provides a nuanced account of how global health norms evolve through integration in complex policy environments – finding that normative convergence may not always be explicit, but rather implicit through incremental linkages in their underlying discourse and core functions. This research contributes to pragmatic efforts by global health actors seeking consensus amidst an era of polycrisis, and highlights the importance of navigating geopolitics and overcoming path dependencies. It also deepens scholarly understanding on how 'hybrid norms' develop through the dynamic process of normative convergence via diplomacy.

Chapter 8: Pathways to coherence: perspectives on integrating global health security and universal health coverage (Under review with *Health Policy and Planning* as of May 2025)

Within the global health landscape exists a complex interplay between global health security (GHS) and universal health coverage (UHC) – two influential norms with profound influence on health system strengthening initiatives. There is a need to understand why and how coherence between GHS and UHC is being pursued in health policy and planning, particularly in the wake of the COVID-19 pandemic, which profoundly reshaped the field of global health. This paper presents one of the first detailed analyses of contemporary efforts to conceptualize and operationalize GHS-UHC coherence – through the perspectives of key actors responsible for its implementation. The study employed thirty-one interviews with senior officials across four major types of global health actors: multilateral and global health organizations, country governments, donors and international finance institutions, and civil society organizations. It reveals important insights in the way specific actor and geopolitical groups varied in terms of shifting perceptions of GHS and UHC, as well as

major factors influencing GHS-UHC coherence (e.g., strategic considerations including motivations and concerns, and structural considerations including enablers and barriers). The analysis suggests that an emerging 'hybrid norm' linking GHS and UHC appears well-underway. It further contends that strengthening coherence between GHS and UHC not only depends on, but also enhances, three key strategies: 1) overcoming geopolitical power asymmetries, 2) leveraging strategic collaboration across actor types, and 3) pursuing integrative health diplomacy amid polycrisis. While this study centers on GHS-UHC alignment, its broader objective is to foster a more equitable and resilient global health architecture by tackling the interconnected causes of fragmentation through hybrid normative frameworks. By focusing on the politics of norms underpinning GHS and UHC integration, this work contributes to rethinking how global health institutions collaborate, ultimately helping to build more sustainable global health governance fit to withstand future political, economic, and social challenges.

Abbreviations

AU – African Union

AIDS – acquired immunodeficiency syndrome

AMR – antimicrobial resistance

ASEAN - Association of Southeast Asian Nations

BRICS – Brazil, Russia, India, China, South Africa

CDC – Centers for Disease Control and Prevention

CEPI – Center for Epidemic Preparedness and Innovation

COVID-19 – Coronavirus Disease 2019

CSOs – civil society organizations

G7 – Group of Seven

G20 – Group of Twenty

GAVI – Global Alliance for Vaccines and Immunisation

GFATM – Global Fund for AIDs, Tuberculosis, and Malaria

GHD – global health diplomacy

GHS – global health security

GHSA – Global Health Security Agenda

GN – Global North

GPW – General Programme of Work

GS – Global South

HLM – High-Level Meeting

HSS – health system strengthening

IHR – International Health Regulations

INB – Intergovernmental Negotiating Body

IR – international relations

LMICs – low- and middle-income countries

MDGs – Millennium Development Goals

NCDs – non-communicable diseases

ODA – Official Development Assistance

PA – Pandemic Agreement

PD – Political Declaration

PHC – primary health care

PPPs – public-private partnerships

SDGs – Sustainable Development Goals

UHC – universal health coverage

UN – United Nations

UNGA – United Nations General Assembly

UNICEF – United Nations Children's Fund

UNSC – United Nations Security Council

USAID – United States Agency for International Development

WHO – World Health Organization

Chapter 1: Introduction

1.1 Summary

This chapter introduces the scope, significance, and structure of the thesis. It sets out the central research aim – how global health security (GHS) and universal health coverage (UHC) are integrated through global health diplomacy (GHD) – and outlines the analytical and empirical approaches used to examine this. It begins by presenting the persistent fragmentation between GHS and UHC as a core challenge in global health. This fragmentation continues despite mounting calls for alignment, and has been brought to the fore in the wake of recent health emergencies. It further introduces the premise that integration between GHS and UHC is not merely a policy imperative, but a deeply political and normative challenge – one that reflects wider contestation over global health priorities, governance models, and the future of multilateral cooperation.

Section 1.2 offers an opening narrative and clear articulation of the research problem, providing an overview of how tensions between GHS and UHC reflect broader struggles across the global health architecture. Section 1.3 sets out the rationale for this research and explains why a deeper investigation of normative integration – particularly through the lens of diplomacy – is a timely and necessary approach to better investigate this issue. Section 1.4 presents the central research question and sub-questions that guide the thesis, while Section 1.5 introduces the core argument and briefly summarizes the conceptual and methodological approaches used in subsequent chapters. Finally, Section 1.6 outlines the structure of the thesis, providing a roadmap for the chapters that follow.

Taken together, Chapter 1 aims to provide a concise but comprehensive overview for the thesis. It identifies the core problem, clarifies the purpose of the study, and previews how the thesis seeks to advance both theoretical and policy-relevant insights. By laying the groundwork for the 'hybrid norm' framework (introduced in Chapter 4) – which is used to trace how GHS and UHC evolve together through normative construction, convergence, and coherence – this introduction sets the stage for the three empirical papers (Chapters 6-8), each of which corresponds to a successive stage in the hybrid norm framework. It also situates GHD as the key site through which these dynamics unfold, offering a clear lens to investigate where and how the 'politics of integration' between GHS and UHC are framed, negotiated, and institutionalized. In doing so, this chapter introduces the thesis's contributions – both conceptual and practical – offering lessons for scholars and policymakers interested in building more equitable, resilient, and sustainable health systems.

1.2 Opening narrative and statement of the problem

As public health has become key issue for international cooperation, two goals have emerged as influential concepts and agendas shaping global health: GHS (e.g., focused on addressing public

health threats) and UHC (e.g., focused on access to affordable care).[30] As will be covered in greater detail in Chapter 2, efforts to integrate GHS and UHC are not new, but they remain difficult, uneven, and often superficial. Promoting both goals in principle has nonetheless led to health systems and investments that are fragmented in practice.[31] This can be most apparent during health emergencies. The COVID-19 pandemic exposed deep fissures in the global health architecture. It laid bare diverging public health investments, and revealed how public health institutions and legal norms often operate in parallel rather than in synergy.[32] Recent diplomatic negotiations have further struggled to balance commitments to pandemic response with human rights and chronic care, exposing the consequences of siloed priorities and disconnected governance structures.[33] These gaps have real-world implications: greater training of epidemiologists is ineffective if patients still cannot afford care and treatment; surveillance and laboratory systems may be strengthened, but have limited impact without accessible diagnostic tests.[34] As calls mount for health systems that are both resilient to threats and equitable in service delivery,[35] the integration of GHS and UHC has emerged as both a policy imperative and a political challenge.

This challenge is rooted in a deeper, more pervasive problem: fragmentation. Global health today is increasingly marked by competing mandates, overlapping initiatives, and vertical silos that hinder effective coordination and cross-sector cooperation.[36] Multiple actors operate between conflicting goals, incentives, and timelines, thus leading to duplication, inefficiency, and missed opportunities for alignment.[37] While some scholars argue that integration may not always be beneficial, and that distinct programs can indeed yield creative problem-solving or opportunities to focus on priority

[30] Ayal Debie, Resham B. Khatri, and Yibeltal Assefa, 'Successes and Challenges of Health Systems Governance towards Universal Health Coverage and Global Health Security: A Narrative Review and Synthesis of the Literature', *Health Research Policy and Systems*, 20.1 (2022), p. 50, doi:10.1186/s12961-022-00858-7.
[31] Arush Lal and others, 'Fragmented Health Systems in COVID-19: Rectifying the Misalignment between Global Health Security and Universal Health Coverage', *The Lancet*, 397.10268 (2021), pp. 61–67, doi:10.1016/S0140-6736(20)32228-5; Yibeltal Assefa and others, 'Global Health Security and Universal Health Coverage: Understanding Convergences and Divergences for a Synergistic Response', *PLoS ONE*, 15.12 (2020), p. e0244555, doi:10.1371/journal.pone.0244555.
[32] Lawrence O. Gostin, Suerie Moon, and Benjamin Mason Meier, 'Reimagining Global Health Governance in the Age of COVID-19', *American Journal of Public Health*, 110.11 (2020), pp. 1615–19, doi:10.2105/AJPH.2020.305933.
[33] Lawrence O. Gostin and others, '70 Years of Human Rights in Global Health: Drawing on a Contentious Past to Secure a Hopeful Future', *The Lancet*, 392.10165 (2018), pp. 2731–35, doi:10.1016/S0140-6736(18)32997-0.
[34] Arush Lal and others, 'Health System Response to the COVID-19 Pandemic: Fault Lines Exposed and Lessons Learned', in *Making Health Systems Work in Low and Middle Income Countries: Textbook for Public Health Practitioners*, ed. by Awad Mataria and others (Cambridge University Press, 2022), pp. 529–44, doi:10.1017/9781009211086.035.
[35] Flaminia Ortenzi and others, 'Whole of Government and Whole of Society Approaches: Call for Further Research to Improve Population Health and Health Equity', *BMJ Global Health*, 7.7 (2022), p. e009972, doi:10.1136/bmjgh-2022-009972.
[36] Neil Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health', *Globalization and Health*, 16.1 (2020), pp. 1–13, doi:10.1186/S12992-020-00592-1/FIGURES/1.
[37] Devi Sridhar, Sanjeev Khagram, and Tikki Pang, 'Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges -Towards Systematic Coherence in Scaling Up', *Global Health Governance*, 2 (2009).

issues [38], routine fragmentation nonetheless tends to obstruct efforts to build cohesive and inclusive health systems that sustainably meet everyone's needs.[39] This systemic challenge sets the backdrop for understanding why GHS and UHC, despite their acknowledged synergies, continue to operate in isolation.

While a variety of global health stakeholders thus increasingly recognize the interdependence of GHS and UHC agendas, both frameworks remain governed by different institutional structures, policy logics, and funding mechanisms.[40] Their separation extends beyond a coordination failure to reflect competing visions of what health governance should prioritize, for whom, and how. For example, in emergency settings, security-driven approaches tend to eclipse complex, longer-term health system investments.[41] In more stable periods, rights-based narratives often lack the urgency needed to sustain high-level political commitment.[42] This disconnect has real consequences, particularly during crises: investments are fragmented, accountability structures misaligned, and key capacities underdeveloped. Banerjee et al. lay out the blindspots of research that overlooks these connections, especially in the wake of crises:

> *"Health shocks are "high consequence events that have a major disruptive effect on society," with health, social, economic, and psychological effects, and are not limited to pandemics. Whether responding to shocks related to antimicrobial resistance, climate change, or conflict, siloed research cannot deliver the science needed quickly enough at the required scale."*[43]

If global health can be considered as a continuum spanning prevention, preparedness, service delivery, emergency response, and recovery, then both GHS and UHC should – in principle – reinforce each other, given their intended goals. Yet chronic fragmentation between both policy paradigms persists, limiting the ability of global actors to respond holistically to emerging and routine health needs. This thesis contends that addressing this misalignment requires more than technical solutions, necessitating a deeper engagement with the normative politics shaping how global health agendas are conceptualized, integrated, and operationalized.

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[38] Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health'.
[39] 'Systems for Health: Everyone Has a Role' <https://ahpsr.who.int/publications/i/item/systems-for-health-everyone-has-a-role> [accessed 25 September 2023].
[40] Irene Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion', *The Lancet*, 401.10392 (2023), pp. 1964–2012, doi:10.1016/S0140-6736(22)01930-4.
[41] William Aldis, 'Health Security as a Public Health Concept: A Critical Analysis', *Health Policy and Planning*, 23.6 (2008), pp. 369–75, doi:10.1093/heapol/czn030.
[42] Gilbert Abotisem Abiiro and Manuela De Allegri, 'Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates', *BMC International Health and Human Rights*, 15.1 (2015), pp. 1–7, doi:10.1186/s12914-015-0056-9.
[43] Amitava Banerjee and others, 'Research across Multiple Disciplines to Respond to Health Shocks', *BMJ*, 387 (2024), p. e078445, doi:10.1136/bmj-2023-078445.

Understanding the roots of this fragmentation, as well as why efforts to sustain integration remain incomplete, is essential to diagnosing the failures of past reform attempts and identifying new paths forward. Indeed, as McCoy et al. have urged, "positive benefits will only happen if we explicitly set out to achieve them."[44] The rest of this chapter expands on this argument by outlining the rationale, research questions, conceptual lens, and structure of the thesis.

1.3 Research aims and rationale

The overall aim of this thesis is to unpack how GHS and UHC interact and align through processes of global health diplomacy (GHD) – and what this reveals about the evolving architecture of global health. Rather than focusing solely on technical coordination or institutional reform, it examines the deeper normative, political, and structural dynamics shaping integration in practice.

This inquiry is motivated by a clear gap in both empirical research and conceptual theory. While there is growing literature on health systems strengthening, policy fragmentation, and norm development, recent studies have struggled to pull these concepts together to explore how two already-deeply institutionalized global health norms (each underpinned by diverging agendas and backed by powerful actors and embedded logics) can evolve together in a way that productively advances both. Instead, most prior scholarship either treats GHS and UHC separately, frames their alignment as "a marriage of convenience", or suggests that one will inevitably be prioritized over the other.[45]

Instead, I argue in this thesis that mitigating fragmentation between GHS and UHC is a worthwhile endeavor (one that is already well-underway), and that academic inquiry into its legitimacy and approaches would benefit from reconceptualizing GHS-UHC integration as a *normative* process characterized by a "strategic ambiguity"[46] that may often be implicit and incremental – yet ultimately beneficial for both agendas. I further argue that without meaningful attention as to how their related norms are (re)constructed, negotiated towards convergence, and institutionalize coherence over time, efforts to integrate GHS and UHC will remain shallow and inconsistent.

To focus exclusively on institutional and policy reforms in the process of integrating GHS and UHC risks overlooking broader shifts that fundamentally reshape global health governance. As Gómez reminds us, "political power dynamics [are] crucial in helping to identify why certain public health

[44] David McCoy and others, 'Expanding Access to Antiretroviral Therapy in Sub-Saharan Africa: Avoiding the Pitfalls and Dangers, Capitalizing on the Opportunities', *American Journal of Public Health*, 95.1 (2005), pp. 18–22, doi:10.2105/AJPH.2004.040121.
[45] Ooms and others, 'Synergies and Tensions between Universal Health Coverage and Global Health Security: Why We Need a Second "Maximizing Positive Synergies" Initiative'.
[46] Thomas Linsenmaier, Dennis R. Schmidt, and Kilian Spandler, 'On the Meaning(s) of Norms: Ambiguity and Global Governance in a Post-Hegemonic World', *Review of International Studies*, 47.4 (2021), pp. 508–27, doi:10.1017/S0260210521000371.

policies might be more likely to succeed in adoption and implementation."[47] Additionally, integration initiatives that do not yield immediate financial or operational results may nonetheless recalibrate expectations, reshape discourses[48], and alter patterns of legitimacy among state and non-state actors. By tracing the evolution of normative alignment between GHS and UHC through hybrid norms, both discursively and institutionally, this thesis will highlight how integration can occur even in deeply divided contexts, and how small shifts may open up political space for more ambitious reform. Thus, I aim to shine a light on the importance of integration as a process in and of itself, and the moments where integration becomes not just feasible, but strategically valuable – when actors choose to pursue alignment not because it is easy or inevitable, but because it offers leverage, legitimacy, or improved cooperation for key stakeholders involved.

This matters to future global health research because we are entering a new paradigm in the politics of global health – one that demands fresh ways of making decisions, influencing policy, and navigating an evolving landscape of actors amid increasing resource constraints and overlapping crises.[49] GHS and UHC, though often critiqued for their limitations, are unlikely to disappear; both have well-established interests and institutions promoting their advancement – often for good reason given their ability to address major health challenges. Therefore, as emerging players gain prominence, traditional institutions will need to adapt and better collaborate between both agendas to maintain relevance and advance more effective and sustainable health outcomes.

1.4 Central research questions and objectives

As a recap, the main provocation of this thesis (explored in greater detail in Chapter 2) is that fragmentation between GHS and UHC remains a chronic challenge because efforts to improve integration across competing health agendas fail to adequately consider the normative dynamics underpinning them, or the politics of effectively integrating them – thus struggling to realize and sustain synergistic approaches in the long term.

[47] Eduardo J. Gómez and others, 'Political Science and Global Health Policy', *The Lancet*, 399.10341 (2022), pp. 2080–82, doi:10.1016/S0140-6736(22)00923-0.

[48] Rachel George, 'From Contestation to Convergence? A Constructivist Critique of the Impact of UN Human Rights Treaty Ratification on Interpretations of Islam in the Gulf Cooperation Council (GCC) Countries' (LSE, 2018) <http://etheses.lse.ac.uk/3722/>.

[49] Paul Rosenbaum and others, 'Navigating Global Health Diplomacy: Challenges and Opportunities in Building a Community of Practice', *Globalization and Health*, 21.1 (2025), p. 9, doi:10.1186/s12992-025-01100-z; Kumanan Rasanathan and others, 'Navigating Health Financing Cliffs: A New Era in Global Health', *The Lancet*, 0.0 (2025), doi:10.1016/S0140-6736(25)00720-2; Jani Siirilä and Arto O. Salonen, 'Towards a Sustainable Future in the Age of Polycrisis', *Frontiers in Sustainability*, 5 (2024), doi:10.3389/frsus.2024.1436740; Kamran Abbasi, 'Climate, Pandemic, and War: An Uncontrolled Multicrisis of Existential Proportions', *BMJ*, 376 (2022), p. o689, doi:10.1136/bmj.o689.

One way to explore the integration of GHS and UHC is through their construction (i.e., reframing normative and technical aspects), convergence (i.e., negotiating areas of synergy and alignment), and coherence (i.e., institutionalizing mutually-reinforcing features) – further defined in Chapter 4.

Therefore, the central research question guiding this thesis is:

How have global health security and universal health coverage been integrated through global health diplomacy – and what are the implications on the broader global health architecture?

To address this question, the thesis investigates three interrelated sub-questions, each aligned to a corresponding empirical chapter, based on the hybrid norm framework conceptualized in Chapter 4:

- **Construction (Chapter 6)**: How have GHS and UHC emerged as distinct but increasingly overlapping normative agendas in global health? What discursive, political, and institutional milestones have (re)constructed their development over time, and how has their contestation and interaction contributed to evolving, mutually-reinforcing framings?

- **Convergence (Chapter 7)**: How are GHS and UHC being aligned through contemporary diplomatic negotiations? What strategies and political dynamics have enabled or constrained normative convergence via global agreements?

- **Coherence (Chapter 8)**: How do actors across governments, multilateral institutions, donors, and civil society understand and enact GHS-UHC integration in practice? What tensions, power asymmetries, and opportunities shape the institutionalization of coherence at various levels of global health diplomacy and governance?

Together, these sub-questions enable a multi-layered exploration of normative evolution for GHS and UHC – from their historical origins, to contemporary alignment, to practical implementation across the global health architecture.

While often treated as distinct policy agendas, this thesis reconceptualizes GHS and UHC as evolving norms – each with established regimes underpinning them (elaborated further in subsequent sections). While the central research question serves as the anchor for the empirical studies – particularly in analyzing the evolving relationship between GHS and UHC – the wider aim of the thesis is therefore to situate these findings within a broader conceptual framework of normative integration. This distinction reflects the dual ambition of the thesis: to investigate how GHS-UHC alignment occurs in practice, and to theorize the political processes through which overlapping normative agendas like GHS and UHC evolve and integrate into hybrid norms.

Building on this, the overall objective of this thesis is:

To develop and apply a conceptual framework of 'hybrid norms' to explain how global health security and universal health coverage are constructed, converged, and made coherent through global health diplomacy – and to advance a greater understanding of the 'politics of integration' and how its iterative processes of framing, negotiation, and institutionalization influence the broader global health architecture.

This objective establishes the thesis' broader contributions to global health, international relations, and political sciences: providing an empirically grounded and theoretically innovative lens through which to understand how complex normative agendas evolve together, and exploring how integration (when pursued strategically) can be a tool for building more legitimate, coordinated, and sustainable approaches in global health and foreign policy.

1.5 Overview of core argument and conceptual approach

After previous sections have laid out the research aims and key questions, this section briefly outlines the core argument and analytical lens that ground this thesis. It introduces the conceptual framework of 'hybrid norms' and explains how this helps unpack the 'politics of integration' linking GHS and UHC.

As subsequent chapters detail, the costs of fragmentation in global health are not abstract. They manifest concretely in inefficiencies, duplication, and ultimately, weaker health systems.[50] This thesis therefore argues that in an era of "financing cliffs"[51] and "polycrisis"[52], it appears increasingly ineffective and even unsustainable to frame GHS and UHC as competing or disconnected priorities – particularly given that both are likely to be operationalized through the same health system. And yet, despite rising calls for integration, efforts to align these two paradigms remain limited and patchy.

Most existing scholarship on health system integration emphasizes narrowly linked interventions or technocratic solutions to improve coordination.[53] While important, this focus risks overlooking deeper questions about how efforts to synergize different global health agendas are conceptualized and legitimized – thereby neglecting the normative and political dynamics required to sustain

[50] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'; Lal and others, 'Fragmented Health Systems in COVID-19: Rectifying the Misalignment between Global Health Security and Universal Health Coverage'.
[51] Rasanathan and others, 'Navigating Health Financing Cliffs'.
[52] Siirilä and Salonen, 'Towards a Sustainable Future in the Age of Polycrisis'.
[53] Atun and others, 'Integration of Targeted Health Interventions into Health Systems: A Conceptual Framework for Analysis'; Diane Cooper and others, 'The HIV Epidemic and Sexual and Reproductive Health Policy Integration: Views of South African Policymakers', *BMC Public Health*, 15.1 (2015), p. 217, doi:10.1186/s12889-015-1577-9; Vergil de Claro and others, 'The Role of Local Health Officers in Advancing Public Health and Primary Care Integration: Lessons from the Ongoing Universal Health Coverage Reforms in the Philippines', *BMJ Global Health*, 9.1 (2024), p. e014118, doi:10.1136/bmjgh-2023-014118.

integration over time. Parkhurst and colleagues unpack the value of going beyond empirical indicators to better understand global health problems:

> *"Regardless of any epidemiological data or biomedical effects, the technical components (or artefacts) embedded in health policies can often have other context-specific social meanings of importance to populations and, therefore, to policy decision makers. It is these social meanings that must be explored to understand the uptake of any body of global health evidence or global policy recommendations."*[54]

Even where fragmentation/integration research has considered issues of politics (e.g., structure, power), they have struggled to provide a holistic account of how to reconcile divergent ideas and structures. Given this, the thesis draws heavily from theoretical concepts in international relations and political science literature. In particular, it positions norms as the primary unit of analysis for better examining GHS-UHC integration, arguing that norms illuminate not only how things are, but also how they 'ought' to be[55] – and reveal the principles and values that guide decision-making as well as the necessary obligations and actions required for their operationalization.

As Finnemore and Sikkink assert, norms (defined as ideas that encompass a spectrum of shared values and standardized procedures that ultimately shape interactions among state and non-state actors[56]) possess a unique power because they articulate "shared moral assessments"[57] that guide collective action, making them uniquely powerful for shaping the long-term trajectory of global health governance. Ooms summarizes why inadequately engaging with normative features undermines global health research:

> *"The actors with the power to set policies may use a different normative premise than the scholars that propose policies – which may explain the 'implementation gap' in global health. If global health scholars shy away from the normative debate – because it requires normative premises that cannot be derived from empirical evidence alone – they not only mislead each other, they also prevent and stymie debate on the role of the powerhouses of global health, their normative premises, and the rights and wrongs of these premises."*[58]

Studying the intersection of GHS and UHC therefore goes beyond explaining the operational challenges of health system integration to reckon with the underlying political dynamics that profoundly shape how global health initiatives evolve.

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[54] Justin O. Parkhurst, David Chilongozi, and Eleanor Hutchinson, 'Doubt, Defiance, and Identity: Understanding Resistance to Male Circumcision for HIV Prevention in Malawi', *Social Science & Medicine*, 135 (2015), pp. 15–22, doi:10.1016/j.socscimed.2015.04.020.

[55] Finnemore and Sikkink, 'International Norm Dynamics and Political Change', *International Organization*, 1998 <https://www.jstor.org/stable/2601361?seq=1#metadata_info_tab_contents>.

[56] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.

[57] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.

[58] Gorik Ooms, 'Navigating Between Stealth Advocacy and Unconscious Dogmatism: The Challenge of Researching the Norms, Politics and Power of Global Health', *International Journal of Health Policy and Management*, 4.10 (2015), pp. 641–44, doi:10.15171/ijhpm.2015.116.

Thus, this thesis departs from related scholarship that views integration (including in health systems) as a largely technical exercise[59] or as an explicit endpoint of alignment efforts[60], instead demonstrating that integration between both agendas is an iterative, strategic, and continuously-contested *normative* process – one shaped by diplomacy, varying approaches, and evolving frames. It is about reconciling competing visions of health (e.g, security-driven for GHS versus rights-driven for UHC), and asking how global institutions can effectively advance both as a way to better manage geopolitical asymmetries and diverse stakeholder interests. Indeed, as Shiffman argues, "when policy communities develop convincing ideas and strong institutions, attention and resources may follow."[61] In this way, the examination of GHS and UHC as norms can help concretize the principles and expectations for integration efforts, as well as make legitimate the normative processes of contestation and interaction required to actualize and sustain integration over time.

In the case of GHS and UHC norms, this thesis focuses the analysis on the integration of key discourse (principles and ideals) and core functions (interventions and capacities) of each across a global health architecture, as a way that protects populations from acute threats while ensuring universal and equitable access to essential care. This thesis further argues that GHS and UHC norms also represent their respective broader, well-established normative 'regimes,'[62] each shaped by different histories, actors, and power structures. The ways these regimes are contested, aligned, or kept apart fundamentally affects which issues get funded, which actors are empowered, and whose health needs are recognized in global decision-making.[63] Given that the drivers of fragmentation – ranging from contrasting policies to institutional silos to divergent financing mechanisms – are deeply interconnected, new scholarship is required to design strategies that similarly adopt integrative approaches.

Therefore, to better understand how GHS and UHC – two historically fragmented yet increasingly overlapping global health agendas – can be brought into sustained alignment, this thesis traces the normative process through which both regimes evolve together. It goes beyond empirically describing how they interact operationally to also unpack how they are normatively conceptualized, negotiated, and embedded through diplomacy.

In order to offer a structured way of analyzing this process, the 'hybrid norm' framework introduced in Chapter 4 of this thesis draws on global health diplomacy, constructivist international relations, and political science literature. As elaborated in Chapters 2 through 4, this approach advances scholarship on the 'politics of integration' that centers on how actors align framing practices,

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[59] Cooper and others, 'The HIV Epidemic and Sexual and Reproductive Health Policy Integration'.
[60] Luke N. Allen and others, 'Integrating Public Health and Primary Care: A Framework for Seamless Collaboration', *BJGP Open* 2024, 2024, doi:10.3399/BJGPO.2024.0096.
[61] Jeremy Shiffman, 'A Social Explanation for the Rise and Fall of Global Health Issues', *Bulletin of the World Health Organization*, 87.8 (2009), pp. 608–13.
[62] Steven J Hoffman, 'The Evolution, Etiology and Eventualities of the Global Health Security Regime', *Health Policy and Planning*, 25.6 (2010), pp. 510–22, doi:10.1093/heapol/czq037.
[63] Wenham, Clare, 'Forum Shifting in Global Health Security'.

negotiate shared meanings, and gradually institutionalize new integrated norms into governance systems.

The hybrid norm framework rests on three pillars, using GHS and UHC as the key case study. These stages can be summarized as:

- **Norm construction**: The framing of GHS and UHC as distinct norms and evolution into increasingly overlapping normative regimes.

- **Norm convergence**: The negotiation of shared discourse and functions through a shared normative framework marked by increasing complementarity and interdependency.

- **Norm coherence**: The institutionalization of a hybrid norm linking both normative regimes that is subsequently embedded across the global health architecture.

In contrast to prior research that emphasizes the diffusion of a singular norm across a regime or sphere of governance[64], this framework enables the thesis to more effectively examine how two entrenched and partially-conflicting norms – each with their own associated normative regimes – are actively brought into alignment through processes of diplomacy. This conceptual model provides the basis for the three related empirical studies, which each employ specific qualitative research methods outlined in Chapter 5 to iteratively examine GHS and UHC integration: discursive analysis of policy texts to assess norm construction in Chapter 6, multimethod content and discourse analysis of negotiation drafts to assess norm convergence in Chapter 7, and thematic analysis of key informant interviews to assess norm coherence in Chapter 8. In doing so, this methodological approach has thus been designed to offer new insights into how discourse and institutional design can shape integration of complex agendas like GHS and UHC to address pervasive fragmentation between both. It contributes to ongoing efforts that aim to prevent GHS or UHC from being pitted against each other, or either from being significantly undermined in resource-constrained environments. Additionally, by tracing the evolution of interactive norms, this research reveals strategic policy windows for normative alignment that may have been previously overlooked.

It is important to acknowledge upfront, as Spicer and colleagues have, that fragmentation may not always negative "and can even be positive" in some contexts (e.g., competition might catalyze innovation, vertical investments may yield more tangible and rapid results).[65] Others have noted

[64] Jennifer L. Bailey, 'Arrested Development: The Fight to End Commercial Whaling as a Case of Failed Norm Change', *European Journal of International Relations*, 14.2 (2008), pp. 289–318, doi:10.1177/1354066108089244; Mona Lena Krook and Jacqui True, 'Rethinking the Life Cycles of International Norms: The United Nations and the Global Promotion of Gender Equality', *European Journal of International Relations*, 18.1 (2012), pp. 103–27, doi:10.1177/1354066110380963; Wayne Sandholtz, 'Dynamics of International Norm Change: Rules against Wartime Plunder', *European Journal of International Relations*, 14.1 (2008), pp. 101–31, doi:10.1177/1354066107087766.

[65] Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health'.

how integration is a contested issue in its own right, carrying with it risks such as issue creep, diluted messaging and financial support, and lack of accountability.[66] Reflecting this, Agyepong et al. noted how US funding for GFATM was largely sustained *because* of health security framings, and that an expanded mandate through integration with other approaches risked reduced investments.[67] However, for the purposes of this thesis, where fragmentation reinforces inequities or prevents collective action, I argue that integration becomes not only desirable, but a crucial process for effective global health policy (as subsequent empirical chapters detail).

Secondly, as Florini reminds us, normative change typically happens when powerful stakeholders shift their principles and behaviors.[68] The decision to focus this study on global governance rather than country-level implementation reflects this logic, contending that pursing integration between GHS and UHC cannot fall solely on low- and middle-income countries (LMICs), who often shoulder the operational burdens of fragmentation while receiving limited decision-making power.[69] Without structural and normative change at the international level, local reforms will remain constrained. Therefore, the methods (explained in greater detail in Chapter 5) enable a proactive examination of GHS and UHC alignment through state and non-state actors largely engaged on international norm-setting related to both agendas, given the important role they play in shaping and operationalizing hybrid norms through diplomacy.

Finally, this study does not set out to dictate when integration should be pursued and when it should not. Rather – in recognizing that if fragmentation is political, integration must also be political – the thesis offers a clear conceptual model to unpack the mechanisms that enable normative alignment. Furthermore, this thesis does not seek to revisit well-established critiques of securitization in health, nor to comprehensively center legal definitions of the right to health, which have been explored extensively elsewhere.[70] Rather, it is rooted in a more pragmatic concern: if GHS has already been

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[66] Deanna Tollefson and others, 'Lessons Learned from the COVID-19 Pandemic: Opportunities and Challenges to Leverage Investments in HIV, Tuberculosis and Malaria for Pandemic Preparedness and Response', *BMJ Global Health*, 10.4 (2025), doi:10.1136/bmjgh-2024-015868; Toni Delany and others, 'Health in All Policies in South Australia: What Has Supported Early Implementation?', *Health Promotion International*, 31.4 (2016), pp. 888–98, doi:10.1093/heapro/dav084.

[67] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'.

[68] Ann Florini, 'The Evolution of International Norms', *International Studies Quarterly*, 40.3 (1996), p. 363, doi:10.2307/2600716.

[69] Madhukar Pai, Shashika Bandara, and Catherine Kyobutungi, 'Shifting Power in Global Health Will Require Leadership by the Global South and Allyship by the Global North', *The Lancet*, 404.10464 (2024), pp. 1711–13, doi:10.1016/S0140-6736(24)02323-7.

[70] Clare Wenham, 'The Oversecuritization of Global Health: Changing the Terms of Debate', *International Affairs*, 95.5 (2019), pp. 1093–110, doi:10.1093/ia/iiz170; Delaram Akhavein, Meru Sheel, and Seye Abimbola, 'Health Security—Why Is "Public Health" Not Enough?', *Global Health Research and Policy*, 10.1 (2025), p. 1, doi:10.1186/s41256-024-00394-7; Simon Rushton, 'Global Health Security: Security for Whom? Security from What?', *Political Studies*, 59.4 (2011), pp. 779–96, doi:10.1111/j.1467-9248.2011.00919.x; Benjamin Mason Meier, 'Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for

deeply institutionalized as a dominant global health norm that continues to shape health diplomacy and policy, where and how is being strategically aligned with UHC (another deeply institutionalized norm in global health) to support a more equitable and resilient global health architecture?

Ultimately, this thesis contends that integration between GHS and UHC is already happening – but in uneven, sometimes invisible ways. The challenge is to understand how, where, and under what conditions such integration becomes politically feasible and normatively coherent. By tracing the "justifications for action" and "extensive trails of communication among actors"[71] that shape norm development and institutionalization of a GHS-UHC hybrid norm, the subsequent chapters offer a conceptual and empirical roadmap for integration between both agendas. In doing so, this research envisions a global health system that is not only better prepared for emergencies, but more committed to equity and long-term resilience in an increasingly fractured world.

1.6 Thesis structure and roadmap

The remainder of this thesis is structured as follows:

- **Chapter 2** defines key dimensions related to the global health architecture and provides important background on global health diplomacy. This followed by a review of GHS and UHC as the primary focus of this thesis. It concludes with a discussion of fragmentation and the need for a new analytical lens to unpack GHS and UHC integration.
- **Chapter 3** outlines the theoretical foundations of the study, drawing on constructivist international relations scholarship and complementary political science approaches to examine integration.
- **Chapter 4** presents the 'hybrid norms' conceptual framework, including its key stages of norm construction, norm convergence, and norm coherence and its role in better unpacking the 'politics of integration' compared to existing norms theory and policy integration models.
- **Chapter 5** details the methodology and research design, explaining the rationale for the multimethod qualitative approaches used and how each empirical chapter contributes to the conceptual framework.
- **Chapter 6** presents the first empirical paper, focused on the initial 'construction' stage of the hybrid norm framework by discursively examining how GHS and UHC norms evolved together in the wake of major agreements and crises.

Public Health Advancement', *Stanford Journal of International Law*, 46 (2010), p. 1; BENJAMIN MASON MEIER, 'The World Health Organization, the Evolution of Human Rights, and the Failure to Achieve Health for All', in *Global Health and Human Rights* (Routledge, 2010); Claire E. Brolan, Peter S. Hill, and Gorik Ooms, '"Everywhere but Not Specifically Somewhere": A Qualitative Study on Why the Right to Health Is Not Explicit in the Post-2015 Negotiations', *BMC International Health and Human Rights*, 15.1 (2015), p. 22, doi:10.1186/s12914-015-0061-z.

[71] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'; Anders Granmo, 'Health Norms in the Global Governance of Development : A Constructivist Analysis', no. April (2019).

- **Chapter 7** presents the second empirical paper, focused on the middle 'convergence' stage of the hybrid norm framework by qualitatively unpacking how GHS and UHC norms were promoted across iterative negotiation drafts of two major health diplomacy processes.
- **Chapter 8** presents the third empirical paper, focused on the final 'coherence' stage of the hybrid norm framework by conducting a thematic analysis of key informant interviews across four major actor types engaged on GHS and UHC initiatives.
- **Chapter 9** restates the main objectives of the thesis and provides a synthesis of findings across the three empirical studies.
- **Chapter 10** discusses the substantive contributions (empirical and interpretive) and foundational contributions (theoretical, conceptual, and methodological), as well as key implications for policy and practice. It concludes with the study's limitations, future research directions, and final reflections.

Chapter 2: Background and context

To understand the political context in which GHS and UHC have emerged and become normatively intertwined, this chapter begins by introducing the global health architecture and its core dimensions. Section 2.1 provides the foundation by situating the thesis within the broader field of global health, clarifying key concepts and outlining how major agendas like GHS and UHC are developed and operationalized. This framing sets the stage for analyzing how globalization and interdependence have reshaped the field – elevating diplomacy as a central force in agenda-setting for GHS and UHC (Section 2.2). The chapter then turns to a more focused review of GHS and UHC (Section 2.3), and concludes by mapping current debates on fragmentation and the political challenges of integration between both agendas (Section 2.4).

2.1 Understanding the global health architecture

2.1.1 Defining global health

Global health has evolved significantly in response to shifting health challenges, shaped by processes of globalization, transnational governance, and deepening interdependencies between health systems. As a result, while definitions of global health can be contested, scholars largely agree that the field extends beyond a technical domain to include one deeply embedded in political, economic, and social structures.[72] As Horton argues, global health is "biomedicine, epidemiology, demography, public health, anthropology, economics, political science, law, engineering, geography, informatics, even philosophy [...and...] involves the chaotic tumbling, rumbling and knocking together of ideas and aspirations."[73] This reflects the broader context for this thesis, where health is viewed as a central pillar of international cooperation and foreign policy – not only among traditional health institutions but also across development, security, climate, labor, finance, and trade sectors.

While the conceptual roots of global health stretch back centuries, its formalization as a distinct field (previously termed 'international health) emerged in the post-World War II era with the establishment of the World Health Organization (WHO) in 1948.[74] Early global health efforts

[72] Sara E. Davies and others, 'Global Health in International Relations: Editors' Introduction', *Review of International Studies*, 40.5 (2014), pp. 825–34, doi:10.1017/S0260210514000308; Anders Granmo and Pieter Fourie, *Health Norms and the Governance of Global Development: The Invention of Global Health* (Routledge, 2021), doi:10.4324/9781003109716; Robert Marten, 'Global Health Warning: Definitions Wield Power Comment on "Navigating Between Stealth Advocacy and Unconscious Dogmatism: The Challenge of Researching the Norms, Politics and Power of Global Health"', *International Journal of Health Policy and Management*, 5.3 (2015), pp. 207–09, doi:10.15171/ijhpm.2015.213.

[73] Richard Horton, 'Global Science and Social Movements: Towards a Rational Politics of Global Health', *International Health*, 1.1 (2009), pp. 26–30, doi:10.1016/j.inhe.2009.06.003.

[74] Horton, 'Global Science and Social Movements'; David Fidler, 'Navigating the Global Health Terrain: Mapping Global Health Diplomacy', *Asian Journal of WTO & International Health Law and Policy*, 2011 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1822908>; Benjamin Meier, 'Global Health Takes a

focused primarily on disease eradication, exemplified by campaigns against smallpox, cholera, and yellow fever.[75] However, the 1978 Alma-Ata Declaration marked a major shift, advocating for primary health care (PHC) as a vehicle for achieving "health for all."[76] Although this expansive vision was undercut by the rise of structural adjustment policies in the 1980s[77], it resurfaced following critiques of the Millennium Development Goals (MDGs) and subsequently more prominently through the Sustainable Development Goals (SDGs)[78] – with SDG 3 institutionalizing a comprehensive set of indicators and targets for health system strengthening, universal access to care, and emergency preparedness and response.[79]

As Shawar et al. reflect, "the lack of clarity and consistency in understanding common terms in the field of global health may at least in part be driven by ideological differences among its actors."[80] Thus, Ooms asserts that "whatever definition of global health one uses, it always contains a normative element."[81] A central challenge of this thesis, therefore, is exploring how global health actors navigate these competing forces in ways that enable coherent outcomes, and sustain progress across multiple diverging global health goals.

2.1.2 Key dimensions of the global health architecture

Building on the conceptual foundations of global health outlined above, this section expands the analytical lens to examine the broader institutional landscape through which global health agendas (such as GHS and UHC) are debated, conceptualized, and operationalized. It focuses on four interconnected pillars: policy, governance, financing, and health systems strengthening. Together, these dimensions form the operational architecture of global health, shaping the environments in which norms in health emerge and evolve.

Normative Turn: The Expanding Purview of International Health Law and Global Health Policy to Meet the Public Health Challenges of the 21st Century', *Yearbook of International Law & Jurisprudence*, 2012, pp. 69–108.

[75] David P. Fidler, 'From International Sanitary Conventions to Global Health Security: The New International Health Regulations', *Chinese Journal of International Law*, 4.2 (2005), pp. 325–92, doi:10.1093/chinesejil/jmi029; Sara Davies, *Disease Diplomacy* (Johns Hopkins University Press, 2015), doi:10.1353/book.38785.

[76] WHO, 'Declaration of Alma-Ata' <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata>; Gorik Ooms and others, 'Anchoring Universal Health Coverage in the Right to Health', 2017 <https://www.who.int/publications/i/item/9789241509770>.

[77] Sandy Cairncross, Hervé Periès, and Felicity Cutts, 'Vertical Health Programmes', *The Lancet*, 349 (1997), pp. S20–21, doi:10.1016/S0140-6736(97)90079-9.

[78] Fukuda-Parr, 'From the Millennium Development Goals to the Sustainable Development Goals'; Anders Granmo and Pieter Fourie, *Health Norms and the Governance of Global Development: The Invention of Global Health* (Routledge, 2021), doi:10.4324/9781003109716.

[79] Harald Schmidt, Lawrence O. Gostin, and Ezekiel J. Emanuel, 'Public Health, Universal Health Coverage, and Sustainable Development Goals: Can They Coexist?', *The Lancet*, 386.9996 (2015), pp. 928–30, doi:10.1016/S0140-6736(15)60244-6; WHO, 'Sustainable Development Goals' <https://www.who.int/health-topics/sustainable-development-goals#tab=tab_2>.

[80] Yusra Ribhi Shawar and others, 'Understanding Resilience, Self-Reliance and Increasing Country Voice: A Clash of Ideologies in Global Health', *BMJ Global Health*, 8.1 (2023), p. e010895, doi:10.1136/bmjgh-2022-010895.

[81] Ooms, 'Navigating Between Stealth Advocacy and Unconscious Dogmatism'.

While not intended to provide a comprehensive analysis of all parts of global health, by clarifying these key concepts and their contemporary associations, this section lays the groundwork for better understanding how global health diplomacy is embedded within broader systemic and political structures (Section 2.2). Efforts to align GHS and UHC – whether through policy changes, governance reforms, funding shifts, or capacity-strengthening – must contend with a fragmented institutional landscape that shapes whose priorities are legitimized and which actors hold influence. This understanding equips the empirical chapters to more effectively grapple with the nuanced dynamics inherent in normative integration and the possible solutions to addressing persistent fragmentation across various parts of global health.

Global health policy and key issues

Rushton and Williams reflect that global health policy "is seldom, if ever, defined," despite being "regularly invoked in the literature, although in a variety of ways, often with little precision, and often in a manner synonymous with other concepts such as global health governance."[82] However, they suggest that the term best refers to "policies, both formal and informal, adopted on either an international or domestic level that respond to or affect health."[83] Lee, Fustukian and Buse add another important insight, emphasizing "the ways in which globalization may be impacting on health policy, and alternatively what health policies are needed to respond to the challenges raised by globalising processes"[84] – situating global health policy as fundamentally embroiled with issues of power, international norms, and diplomatic processes.

At the heart of global health policymaking lies a complex web of actors (e.g., WHO, ministries of health, donors, advocacy coalitions) who engage in constant negotiation over agenda-setting and priority allocation.[85] Shiffman further explains that "the core activity of a global health policy community is ideational: it aims to secure attention for its issue by advancing truth claims about the issue."[86] These ideas are then formalized through institutional instruments such as WHO resolutions, national health strategies, and multilateral declarations like the 2019 UN Political Declaration on UHC or the IHR (2005).[87] Thus, policy frameworks play a key role in conceptualizing global health ideas and shaping them into distinct agendas, which Shiffman and colleagues define as "the list of health issues that a set of elite organizations involved in global health

[82] Simon Rushton and Owain David Williams, 'Frames, Paradigms and Power: Global Health Policy-Making under Neoliberalism', *Global Society*, 26.2 (2012), pp. 147–67, doi:10.1080/13600826.2012.656266.
[83] Rushton and Williams, 'Frames, Paradigms and Power'.
[84] Kelley Lee, Suzanne Fustukian, and Kent Buse, 'An Introduction to Global Health Policy', in *Health Policy in a Globalising World*, ed. by Kelley Lee, Kent Buse, and Suzanne Fustukian (Cambridge University Press, 2002), pp. 3–17, doi:10.1017/CBO9780511489037.003.
[85] Andrew Harmer, 'Understanding Change in Global Health Policy: Ideas, Discourse and Networks', *Global Public Health*, 6.7 (2011), pp. 703–18, doi:10.1080/17441692.2010.515236.
[86] Shiffman, 'A Social Explanation for the Rise and Fall of Global Health Issues'.
[87] David Berlan and others, 'The Bit in the Middle: A Synthesis of Global Health Literature on Policy Formulation and Adoption', *Health Policy and Planning*, 29.suppl_3 (2014), pp. iii23–34, doi:10.1093/heapol/czu060.

are paying attention to at any given point in time."[88] Policies are also central to operationalizing these agendas through legislation and allocation of resources – central issues explored throughout this thesis.[89] These key features are important for understanding the content of GHS and UHC, and further described in detail in Section 2.3.

Notably, global health policies covering the same issue can vary widely based on the context, despite shared rhetorical commitments. Political pressures, divergent mandates, and financing incentives can manifest in differing manifestations (e.g., UHC for some might mean policy reform on service coverage, while for others it may signify financial protection).[90] Various scholars have particularly underscored how divergences in policy definitions may be more pronounced when translating between domestic policy and foreign policy positions in health, requiring careful management and support through health diplomacy.[91] Furthermore, political challenges may entrench conflict between different policy priorities (e.g., when emergency preparedness investments outpace commitments to primary care, or when equity agendas are deprioritized during crisis-driven reforms). This tension is explored in the empirical chapters, where global health policies serve as the manifestations of GHS and UHC norms in key contexts, and can be traced through the discursive and institutional responses of global actors.

Global health governance and key actors

While scholars similarly describe varying definitions of global health governance[92], Fidler defines it as "the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively."[93] Kickbusch and Szabo help to parse this out further, stating:

[88] Jeremy Shiffman and others, 'Defining and Measuring the "Global Health Agenda"' (Social Science Research Network, 26 August 2010) <https://papers.ssrn.com/abstract=1644585>.
[89] Lee, Fustukian, and Buse, 'An Introduction to Global Health Policy'; Zsuzsanna Jakab and others, 'Building the Evidence Base for Global Health Policy: The Need to Strengthen Institutional Networks, Geographical Representation and Global Collaboration', *BMJ Global Health*, 6.8 (2021), p. e006852, doi:10.1136/bmjgh-2021-006852.
[90] Carlos Bruen and Ruairí Brugha, 'A Ghost in the Machine? Politics in Global Health Policy', *International Journal of Health Policy and Management*, 3.1 (2014), pp. 1–4, doi:10.15171/ijhpm.2014.59.
[91] Ronald Labonté and Michelle L. Gagnon, 'Framing Health and Foreign Policy: Lessons for Global Health Diplomacy', *Globalization and Health*, 6.1 (2010), p. 14, doi:10.1186/1744-8603-6-14; Harley Feldbaum, Kelley Lee, and Joshua Michaud, 'Global Health and Foreign Policy', *Epidemiologic Reviews*, 32.1 (2010), pp. 82–92, doi:10.1093/epirev/mxq006.
[92] Sridhar, Khagram, and Pang, 'Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges -Towards Systematic Coherence in Scaling Up'; Rushton and Williams, 'Frames, Paradigms and Power'; Robert Marten, 'How States Exerted Power to Create the Millennium Development Goals and How This Shaped the Global Health Agenda: Lessons for the Sustainable Development Goals and the Future of Global Health', *Global Public Health*, 14.4 (2019), pp. 584–99, doi:10.1080/17441692.2018.1468474.
[93] David Fidler, 'The Challenges of Global Health Governance', *Council on Foreign Relations Working Paper*, 2010.

> *"Global health governance refers mainly to those institutions and processes of governance with an explicit health mandate, such as the World Health Organization (WHO); global governance for health refers mainly to those institutions and processes of global governance which do not necessarily have explicit health mandates, but have a direct and indirect health impact, such as the United Nations, the World Trade Organization or the Human Rights Council; Governance for global health refers to the institutions and mechanisms established at the national and regional level to contribute to global health governance and/or to governance for global health – such as national global health strategies or regional strategies for global health."*[94]

While this thesis largely uses 'global health governance' in its broadest sense (more closely reflecting Fidler's maximalist definition) for simplicity, Kickbusch and Szabo's characterization makes it clear that global health governance, while traditionally anchored by actors like WHO, has evolved into a much more complex ecosystem involving a wide range of state and non-state actors – all with varying mandates and authorities. Indeed, Kentikelenis and Rochford argue that as the number of initiatives, funds, and agencies focused on health ballooned from 175 in 2010 to 203 in 2019 (many more exist today), "it has become commonplace to note that the governance arrangements impacting health encompass an increasing number of actors that are bound together through complex linkages."[95]

Contemporary global health is thus shaped by a proliferating and pluralistic constellation of stakeholders, including country governments, multilateral institutions, bilateral donors, non-governmental organizations (NGOs), private sector entities, philanthropic foundations, and civil society groups.[96] While each actor brings distinct interests and mechanisms of engagement, this multiplicity leads to both collaborative synergies as well as tensions in health policymaking. WHO remains the central coordinating body at the global level, but public-private partnerships (PPPs) such as The Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), Gavi, the Vaccine Alliance (GAVI), and Coalition for Epidemic Preparedness Innovations (CEPI) increasingly influence agenda-setting.[97] As described in further detail in Section 2.4, these actors may often favor disease-specific interventions over systemic health investments, with Sridhar et al. contending that "instead of representing prioritized contributions to sustainable change, funds are simply fueling an

[94] Kickbusch and and Szabo, 'A New Governance Space for Health'.
[95] Alexander Kentikelenis and Connor Rochford, 'Power Asymmetries in Global Governance for Health: A Conceptual Framework for Analyzing the Political-Economic Determinants of Health Inequities', *Globalization and Health*, 15.1 (2019), p. 70, doi:10.1186/s12992-019-0516-4.
[96] Fidler, 'Navigating the Global Health Terrain: Mapping Global Health Diplomacy'; Marten, 'How States Exerted Power to Create the Millennium Development Goals and How This Shaped the Global Health Agenda'; Sridhar, Khagram, and Pang, 'Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges - Towards Systematic Coherence in Scaling Up'.
[97] Meier and Finch, 'Seventy-Five Years of Global Health Lawmaking under the World Health Organization'; Antoine de Bengy Puyvallée, 'The Rising Authority and Agency of Public–Private Partnerships in Global Health Governance', *Policy and Society*, 2024, p. puad032, doi:10.1093/polsoc/puad032; Antoine de Bengy Puyvallée and others, 'Global Health Partnerships for a Post-2030 Agenda', *The Lancet*, 405.10477 (2025), pp. 514–16, doi:10.1016/S0140-6736(24)02816-2.

'aid industry' of fragmented assistance."[98] Furthermore, the role of influential philanthropies – most notably the Gates Foundation, Wellcome Trust, and Rockefeller Foundation – further complicates global health governance, with challenges related to accountability, equity, and potential conflicts of interest; critics have raised particularly concerns given the significant amount of funding these organizations provide to actors like WHO without adequate oversight.[99]

Frenk and Moon have therefore argued that the challenge of global health governance is not the absence of actors but the lack of coordination among them.[100] Gostin, Moon, and Meier further reflect that this proliferating constellation of actors has "led to political conflict and institutional disorder, undermining international cooperation"[101] – particularly in the wake of the COVID-19 pandemic. These dynamics are starkly visible in the governance of GHS and UHC, which are sometimes led by the same actors, and other times by separate actors and separate forums. For example, PPPs like GAVI and CEPI are more active in GHS contexts, while country governments and civil society have been more active in promoting UHC.

Wenham has described how a critical tension in global health governance lies in effectively balancing national sovereignty with international cooperation.[102] The "legally-binding" revised IHR (2005) offer a salient example, mandating countries to voluntarily report and build core capacities for disease detection and response, which is often in conflict with domestic priorities; there are also limited governance mechanisms for enforcement or accountability, which Davies argues can undermine compliance.[103] Recent debates on a new pandemic agreement (a key empirical case study in Chapter 7) reflects this ongoing challenge between collective action and the reluctance to cede autonomy, with states remaining divided on the governance reforms they are willing to institutionalize.[104]

These governance dilemmas are directly relevant to the thesis' focus on improving coordination and cooperation across the global health architecture. Indeed, scholars have emphasized ensuring

[98] Sridhar, Khagram, and Pang, 'Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges -Towards Systematic Coherence in Scaling Up'; 'An Assessment of Interactions between Global Health Initiatives and Country Health Systems'.
[99] Katerini T. Storeng, 'The GAVI Alliance and the "Gates Approach" to Health System Strengthening', *Global Public Health*, 9.8 (2014), pp. 865–79, doi:10.1080/17441692.2014.940362; Sophie Harman, 'The Bill and Melinda Gates Foundation and Legitimacy in Global Health Governance', *Global Governance*, 22.3 (2016), pp. 349–68, doi:10.1163/19426720-02203004.
[100] Julio Frenk and Suerie Moon, 'Governance Challenges in Global Health', *New England Journal of Medicine*, 368.10 (2013), pp. 936–42, doi:10.1056/NEJMra1109339.
[101] Gostin, Moon, and Meier, 'Reimagining Global Health Governance in the Age of COVID-19'.
[102] Wenham, Clare, 'Examining Sovereignty in Global Disease Governance: Surveillance Practices in United Kingdom, Thailand and Lao People's Democratic Republic', 2015.
[103] Davies, *Disease Diplomacy*.
[104] Clare Wenham, Mark Eccleston-Turner, and Maike Voss, 'The Futility of the Pandemic Treaty: Caught between Globalism and Statism', *International Affairs*, 98.3 (2022), pp. 837–52, doi:10.1093/ia/iiac023.

coherence is considered an "essential function" of global health governance.[105] As the thesis's empirical chapters illustrate, GHS and UHC norms (and their subsequent integration) are both enabled and constrained by different aspects of global health governance, and processes of health diplomacy are crucial to negotiating and institutionalizing normative alignment between the two policy paradigms – though sometimes through different mechanisms and with varying levels of coherence.

Global health financing and funding constraints

As with other dimensions of the global health architecture, global health financing remains a structurally fragmented and politically charged domain – often compartmentalized, donor-driven, and subject to rapid shifts based on geopolitical events or emerging health threats.[106] The financing landscape for global health has grown significantly in over the past few decades, and includes bilateral aid (often through official development assistance, or ODA), vertical programs (often supported by PPPs), philanthropic contributions, and pooled mechanisms coordinated by multilateral organizations.[107] However, Sridhar and colleagues reflect that the increase in investments has not been effectively coordinated:

> *"Despite this financial windfall, and in spite of the articulation of a set of principles for more effective and equitable aid delivery, in the form of the Paris and Accra Declarations on Aid Effectiveness, it is disconcerting to note that the current landscape is characterized by fragmentation, lack of coordination and even confusion as a diverse array of well-funded and well-meaning initiatives descend with good intentions on countries in the developing world."*[108]

Global health financing has continued to prioritize vertical, disease-specific programs such as HIV/AIDS, malaria, and tuberculosis – often at the expense of comprehensive health system strengthening.[109] This emphasis reflects the logic of demonstrating "measurable returns," as performance-based financing and results-oriented models have dominated the donor landscape.[110]

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[105] Sridhar, Khagram, and Pang, 'Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges -Towards Systematic Coherence in Scaling Up'.
[106] J. Røttingen and others, 'Shared Responsibilities for Health: A Coherent Global Framework for Health Financing. Final Report of the Centre on Global Health Security Working Group on Health Financing', 2014 <https://www.semanticscholar.org/paper/Shared-Responsibilities-for-Health%3A-A-Coherent-for-R%C3%B8ttingen-Ottersen/899a4dd896d3596ba1c2bd05d8db24138b8cf6c2>.
[107] Karin Stenberg and others, 'Financing Transformative Health Systems towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-Income and Middle-Income Countries', *The Lancet Global Health*, 5.9 (2017), pp. e875–87, doi:10.1016/S2214-109X(17)30263-2.
[108] Sridhar, Khagram, and Pang, 'Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges -Towards Systematic Coherence in Scaling Up'.
[109] Stenberg and others, 'Financing Transformative Health Systems towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-Income and Middle-Income Countries'.
[110] Lara Gautier and Valéry Ridde, 'Health Financing Policies in Sub-Saharan Africa: Government Ownership or Donors' Influence? A Scoping Review of Policymaking Processes', *Global Health Research and Policy*, 2.1 (2017), p. 23, doi:10.1186/s41256-017-0043-x.

These trends mirror broader tensions in global health described in earlier sections, such as between short-term outputs and long-term systems investments or between donor priorities and country ownership. In response, a variety of institutions have advanced pooled financing models with the aim of improving sustainability and coordination of financial resources, such as the Global Financing Facility (GFF) housed at the World Bank, Revolving Funds for Vaccines and Essential Medicines housed at PAHO, and the International Finance Facility for Immunisation (IFFIm) housed at GAVI.[111] However, concerns persist about equity, transparency, and the ability of such models to support integrated agendas. For example, while some mechanisms claim to support both GHS and UHC, their operationalization often defaults to siloed or donor-preferred interventions, with many non-state actors calling for greater transparency and accountability in global health financing.[112] Meanwhile, former WHO Director-General Gro Harlem Brundtland has argued that "public financing for primary health care is the key to universal health coverage and strengthening health security," thus placing the focus on domestic resource mobilization for core health system capacities – an approach most global health stakeholders promote.[113] Rasanathan and colleagues summarize this issue:

> *"Domestic spending is of paramount importance for health coverage, as development assistance for health makes up less than 0·5% of total health spending globally. However, external support has played a crucial role for specific programmes, populations, and services, particularly in LICs and in humanitarian crises. Development assistance for health has already been sharply declining, following the large increases during the COVID-19 pandemic, and even earlier, from US$84 billion in 2021 to $65 billion in 2023. The prognosis is now grim: the USA alone accounted for almost a third of external health funding in 2023."*[114]

As discussed in Chapters 8 through 10, the financing architecture plays a critical role in enabling or hindering coherence across GHS and UHC. Normative alignment alone is insufficient if it is not backed by aligned financial flows, incentive structures, and shared outcome frameworks. Siloed funding structures, including between GHS and UHC initiatives, are likely to have an even greater impact in a rapidly shifting global health landscape marked by overlapping crises, pushes for self-

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[111] Arush Lal and others, 'Minimizing COVID-19 Disruption: Ensuring the Supply of Essential Health Products for Health Emergencies and Routine Health Services', *The Lancet Regional Health – Americas*, 6 (2022), p. 100129, doi:10.1016/J.LANA.2021.100129; Rob Yates, 'Pooled Public Financing Is the Route to Universal Health Coverage', *The Lancet*, 397.10273 (2021), p. 472, doi:10.1016/S0140-6736(21)00225-7; 'Homepage | International Finance Facility for Immunisation (IFFIm)' <https://iffim.org/> [accessed 22 April 2025]; 'Global Financing Facility' <https://www.globalfinancingfacility.org/> [accessed 22 April 2025].

[112] 'Five Ideas for the Future of Global Health Financing: The Road Not Yet Taken', *Center For Global Development* <https://www.cgdev.org/blog/five-ideas-future-global-health-financing-road-not-yet-taken> [accessed 27 August 2024]; 'Calling for a New Multilateral Financing Mechanism for Global Health Security and Pandemic Preparedness - Pandemic Action Network', *Pandemic Action Network*, 13 August 2021 <https://pandemicactionnetwork.org/calling-for-a-new-multilateral-financing-mechanism-for-global-health-security-and-pandemic-preparedness/>.

[113] Gro Harlem Brundtland, 'Public Financing for Primary Health Care Is the Key to Universal Health Coverage and Strengthening Health Security', *The Lancet Global Health*, 10.5 (2022), pp. e602–03, doi:10.1016/S2214-109X(22)00166-8.

[114] Rasanathan and others, 'Navigating Health Financing Cliffs'.

reliance in the face of dwindling foreign assistance budgets, and evolving political priorities that may favor defense over development.[115]

Health systems and programs

Health systems are another key concept within this thesis, serving as the operational and capacity-building dimension of the global health architecture. Indeed, Agyepong et al. emphasize that "global-health agendas are implemented within health systems."[116] However, given that health system strengthening (HSS) efforts are inherently achieved through implementation at the domestic and local levels, they are often plagued by fragmentation and political constraints that reflect the priorities of a range of stakeholders – from ministries of health to public health institutions to advocates to donors and global health organizations (described in Section 2.4).[117] WHO's six building blocks of health systems (service delivery, health workforce, information systems, access to essential medicines, financing, and leadership/governance) offers a comprehensive vision of key features to include, but few countries fully integrated them in practice.[118] Key to this is well-functioning primary health care (PHC), which "can be characterised as a whole-of-society approach to organising national health systems to bring services closer to communities," and which cover "a broad range of essential and cost-effective interventions."[119]

A key challenge is the persistence of vertical approaches and program-driven financing.[120] In practice, the same issues that plague policy, governance, and financing dimensions of global health (e.g., siloed planning, multisectoral collaboration, short funding cycles, earmarked aid) have undermined integrated and sustainable HSS efforts.[121] For example, Gatome-Munyua et al. note that "critical health interventions such as prevention and treatment of HIV/AIDS, tuberculosis, malaria

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[115] Susan P Sparkes, Zubin Cyrus Shroff, and Kara Hanson, 'Still Rethinking External Assistance for Health', *Health Policy and Planning*, 39.Supplement_1 (2024), pp. i1–3, doi:10.1093/heapol/czad103.
[116] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'.
[117] van Olmen and others, 'Health Systems Frameworks in Their Political Context'.
[118] Marie Paule Kieny and others, 'Strengthening Health Systems for Universal Health Coverage and Sustainable Development', *Bulletin of the World Health Organization*, 95.7 (2017), p. 537, doi:10.2471/BLT.16.187476; George Shakarishvili and others, 'Health Systems Strengthening: A Common Classification and Framework for Investment Analysis', *Health Policy and Planning*, 26.4 (2011), p. 316, doi:10.1093/HEAPOL/CZQ053.
[119] Agnes Gatome-Munyua and others, 'Reducing Fragmentation of Primary Healthcare Financing for More Equitable, People-Centred Primary Healthcare', *BMJ Global Health*, 10.1 (2025), doi:10.1136/bmjgh-2024-015088.
[120] Jens Byskov and others, 'A Systems Perspective on the Importance of Global Health Strategy Developments for Accomplishing Today's Sustainable Development Goals', *Health Policy and Planning*, 34.9 (2019), pp. 635–45, doi:10.1093/heapol/czz042.
[121] Vivian Lin and others, 'Strengthening Health Systems Globally: A Lingering Challenge of Funding', *Public Health Research & Practice*, 31.4 (2021), doi:10.17061/PHRP3142115; Phyllida Travis and others, 'Overcoming Health-Systems Constraints to Achieve the Millennium Development Goals', *Lancet*, 364.9437 (2004), pp. 900–06, doi:10.1016/S0140-6736(04)16987-0; Joseph F. Naimoli, 'Global Health Partnerships in Practice: Taking Stock of the GAVI Alliance's New Investment in Health Systems Strengthening', *The International Journal of Health Planning and Management*, 24.1 (2009), pp. 3–25, doi:10.1002/hpm.969.

and immunisation are often reliant on external sources of funding, frequently allocated vertically to specific programmes. This can cause misalignments, duplication and overlaps in components of the health system."[122] Given this, Swanson and colleagues call for a move away from "reductionist approaches that suggest a limited set of targeted interventions to improve health around the world" and instead urge a comprehensive 'systems thinking' perspective spanning "collaboration across disciplines, sectors and organizations; ongoing, iterative learning; and transformational leadership."[123]

Nonetheless, health systems remain a critical site for bridging GHS and UHC.[124] Debie et al. have argued for countries to "transform their health systems through an integrated and multi-sectoral approach to serve as a road map to realise UHC and health security," emphasizing cross-cutting capacities like "advanced healthcare infrastructures and adequate number of health care workers" – but also more normative and political reorientations including "the health system's ideology, traditions in policymaking and management, orientation of service delivery, capacities, motivation, and morale of healthcare workers."[125] These examples dovetail with the thesis's analytical focus on hybrid norms that are equipped to translate into policy and institutional design that fosters synergies across health systems. As later chapters further highlight, GHS-UHC integration is increasingly being pursued through these system-oriented reforms, such as national health insurance schemes that incorporate emergency preparedness functions, or pandemic response frameworks that embed equity and access safeguards.

Ultimately, HSS offers a pragmatic domain where the politics of integration can be negotiated. If health systems are the interface between people and health goals, then aligning the functions and values of GHS and UHC within these systems through shared principles and capacities is essential for building resilience and equity across the global health architecture – a core concern of this thesis.

2.2 Mapping global health diplomacy

Having introduced the historical and operational dimensions of the global health architecture, this section defines global health diplomacy and explains why it forms the conceptual foundation for this thesis.

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[122] Gatome-Munyua and others, 'Reducing Fragmentation of Primary Healthcare Financing for More Equitable, People-Centred Primary Healthcare'.
[123] R. Chad Swanson and others, 'Rethinking Health Systems Strengthening: Key Systems Thinking Tools and Strategies for Transformational Change', *Health Policy and Planning*, 27.SUPPL. 4 (2012), pp. 54–61, doi:10.1093/heapol/czs090.
[124] Kutzin and Sparkes, 'Health Systems Strengthening, Universal Health Coverage, Health Security and Resilience'; Lal and others, 'Fragmented Health Systems in COVID-19: Rectifying the Misalignment between Global Health Security and Universal Health Coverage'.
[125] Debie, Khatri, and Assefa, 'Successes and Challenges of Health Systems Governance towards Universal Health Coverage and Global Health Security'.

2.2.1 Defining global health diplomacy: concepts, traditions, and contestations

The need to examine the intersections of health and diplomacy has become increasingly salient as states and non-state actors navigate the complex terrain of global health governance, economic interdependence, and geopolitical competition.[126] Broadly defined, global health diplomacy (GHD) encompasses the practices through which global health policies and processes are coordinated and negotiated to address transnational challenges.[127] This involves a diverse set of stakeholders beyond traditional ministries of health and foreign affairs[128] – though states remain the primary actors through which intergovernmental health diplomacy is officially negotiated.[129] Lee and Smith emphasize that GHD involves both responses to direct health challenges as well as the strategic utilization of "health concepts or mechanisms in policy-shaping and negotiation strategies to achieve other political, economic, or social objectives."[130] Thus, GHD serves both as a policy instrument and as a lens for understanding the interplay of health, diplomacy, and international relations – with important implications for how and why norms like GHS and UHC may be pursued.

At its core, GHD can be better understood by its three interconnected dimensions: 'global', 'health', and 'diplomacy'. The global dimension captures the increasing interdependence of national health systems in a globalized world and the historical trajectory of international cooperation on health and non-health issues, highlighting the emerging linkages between domestic health policies and foreign policy priorities.[131] The health dimension encompasses the broad spectrum of efforts to protect and promote human well-being, from acute threats such as pandemics to indirect issues such as socioeconomic determinants and structural inequities in healthcare technologies.[132] The diplomacy dimension refers explicitly to the mechanisms through which actors orchestrate responses to competing interests, mobilize resources, shape collective action, and broker agreement – often through bilateral, multilateral, and informal negotiation venues.[133] Taken together, these dimensions underscore how GHD can function as a conduit for translating health concerns into political

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[126] Fidler, 'Navigating the Global Health Terrain: Mapping Global Health Diplomacy'.
[127] Ilona Kickbusch, 'Global Health Diplomacy', *Oxford Bibliographies* <https://www.oxfordbibliographies.com/display/document/obo-9780199756797/obo-9780199756797-0101.xml?d=%2Fdocument%2Fobo-9780199756797%2Fobo-9780199756797-0101.xml&p=emailAOTr7SQlIrOAk> [accessed 29 January 2025].
[128] Matthew D. Brown and others, 'Applied Global Health Diplomacy: Profile of Health Diplomats Accredited to the UNITED STATES and Foreign Governments', *Globalization and Health*, 14.1 (2018), p. 2, doi:10.1186/s12992-017-0316-7.
[129] Mohammed AlKhaldi and others, 'Rethinking and Strengthening the Global Health Diplomacy through Triangulated Nexus between Policy Makers, Scientists and the Community in Light of COVID-19 Global Crisis', *Global Health Research and Policy*, 6.1 (2021), p. 12, doi:10.1186/s41256-021-00195-2.
[130] Kelley Lee and Richard Smith, 'What Is 'Global Health Diplomacy'? A Conceptual Review', *Global Health Governance*, 5 (2011).
[131] Labonté and Gagnon, 'Framing Health and Foreign Policy'.
[132] Ilona Kickbusch and others, 'A Guide to Global Health Diplomacy' (Graduate Institute of International and Development Studies, Global Health Centre, 2021) <https://repository.graduateinstitute.ch/record/298891>.
[133] Arne Ruckert and others, 'Global Health Diplomacy: A Critical Review of the Literature', *Social Science & Medicine*, 155 (2016), pp. 61–72, doi:10.1016/j.socscimed.2016.03.004.

priorities that are both shaped by – and subsequently (re)shape – broader geopolitical dynamics. Indeed, Gagnon and Labonté describe GHD as "the process of negotiated collective action for global health."[134]

Of particular relevance to this thesis, GHD provides a useful conceptual field to explain global health processes through an international relations perspective (defined in greater detail in Chapter 3) – both to understand normative health priorities through political cooperation and the use of health to achieve foreign policy goals. Notably, empirical scholarship from other areas of global governance reinforces this approach, thus demonstrating feasibility of the conceptual frameworks and methodologies used in subsequent chapters. For example, Drope and Lencucha examined normative divergences between tobacco control and trade liberalization through GHD. In doing so, their study on "states' broader conceptualizations of how to integrate different policy-specific international obligations that run into tension"[135] offers clear parallels to this thesis – both in terms of examining how global discourse was used to negotiate more coherent policy integration across conflicting norms (in their case, health and trade; in my case, GHS and UHC), and in leveraging international relations frameworks to analyze norm contestation across governance levels through case studies based on GHD processes. Additional studies further demonstrate how GHD analysis can illuminate how integration can be strengthened through diplomatic tools in global health and foreign policy arenas, such as Harmer's research on the evolving interactions between global health partnerships, Ramírez's review of Chile's integration of health into foreign policy, and Nikogosian's examination of regional integration and cross-sectoral coherence on public health policy, among others.[136]

The value of GHD has intensified in recent years, bolstered by the rising political significance global health in foreign policy.[137] The growing threat of infectious disease outbreaks, antimicrobial resistance (AMR), and non-communicable diseases (NCDs) as drawn global health further into geopolitical spaces – including through various UN-HLMs, international agreements, and summit resolutions.[138] The COVID-19 pandemic sharply underscored both the necessity and limitations of

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[134] Michelle L. Gagnon and Ronald Labonté, 'Understanding How and Why Health Is Integrated into Foreign Policy - a Case Study of Health Is Global, a UK Government Strategy 2008-2013', *Globalization and Health*, 9.1 (2013), p. 24, doi:10.1186/1744-8603-9-24.

[135] Jeffrey Drope and Raphael Lencucha, 'Evolving Norms at the Intersection of Health and Trade', *Journal of Health Politics, Policy and Law*, 39.3 (2014), p. 591, doi:10.1215/03616878-2682621.

[136] Andrew Harmer, 'Understanding Change in Global Health Policy: Ideas, Discourse and Networks', *Global Public Health*, 6.7 (2011), pp. 703–18, doi:10.1080/17441692.2010.515236; Jorge Ramírez and others, 'Chile's Role in Global Health Diplomacy: A Narrative Literature Review', *Globalization and Health*, 14.1 (2018), p. 108, doi:10.1186/s12992-018-0428-8; Haik Nikogosian, 'Regional Integration, Health Policy and Global Health', *Global Policy*, 11.4 (2020), pp. 508–14, doi:10.1111/1758-5899.12835.

[137] Rebecca Katz and others, 'Defining Health Diplomacy: Changing Demands in the Era of Globalization', *Milbank Quarterly*, 89.3 (2011), pp. 503–23, doi:10.1111/j.1468-0009.2011.00637.x; Davies, *Disease Diplomacy*.

[138] Sara Davies, 'What Contribution Can International Relations Make to the Evolving Global Health Agenda?', *International Affairs*, 2010 <https://www.jstor.org/stable/40865133?seq=7#metadata_info_tab_contents>; Ronald Labonté, Greg Martin, and Katerini T. Storeng, 'Editorial: Whither Globalization and Health in an Era of Geopolitical Uncertainty?', *Globalization and Health*, 18.1 (2022), p. 87, doi:10.1186/s12992-022-00881-x.

GHD, as vaccine nationalism, supply chain disruptions, and inequitable access to medical countermeasures exposed profound blindspots in international cooperation.[139] With added pressures from increasingly overlapping crises, significant cuts to global health assistance around the world (largely in favor of greater defense spending), and the retraction of major countries from multilateral spaces (e.g., Trump Administration's withdrawal from WHO[140]), new scholarship is urgently needed to identify how GHD can be adapted to account for these evolving geopolitical dynamics[141] – and to prevent an increasingly transactional approach to health and foreign aid[142].

This section demonstrates why GHD provides an essential conceptual anchor for this thesis. GHD operates not just as a policy coordination mechanism, but as a site where ideas and power are constantly being framed and negotiated. It is therefore through GHD that GHS and UHC norms are co-constructed, and where the politics of integration can be expected to unfold most visibly. However, as indicated in the preceding Section 2.1, diplomacy processes cannot be disentangled from their structural settings. Not only do the various dimensions of the global health architecture (i.e., governance, financing, health systems) influence GHD processes, they also serve as the primary sites through which outcomes of GHD – such as GHS and UHC norms – are ultimately institutionalized. This cycle is described more clearly in the hybrid norm framework introduced in Chapter 4. Understanding GHD in this way enables a sharper examination on how integration efforts between GHS and UHC may be developing through discursive alignment, strategic adaptation, and shifting coalitions – followed by operationalization through other dimensions of the global health architecture.

2.2.2 Understanding the process of global health diplomacy

This section explores the processes involved in GHD – particularly the venues, actors, and cycles through which global health priorities are framed, negotiated, and institutionalized. It introduces Fidler's GHD cycle as one interpretive model, and highlights the relevance of these processes for understanding how GHS and UHC are shaped, and at times aligned, through diplomacy.

A critical aspect of GHD lies in the formal diplomatic spaces and multilateral negotiations that shape global health governance. Forums such as the World Health Assembly (WHA), UN General Assembly (UNGA), G7/G20 summits, and regional convenings like those hosted by the Association of Southeast Asian Nations (ASEAN) or the African Union (AU) serve as key platforms for debate

[139] Sara E Davies and Clare Wenham, 'Why the COVID-19 Response Needs International Relations', *International Affairs*, 96.5 (2020), pp. 1227–51, doi:10.1093/ia/iiaa135.
[140] Burki, 'WHO, USAID, PEPFAR'.
[141] David Fidler, 'Foreign Policy and Global Health in a Multipolar, Multi-Crisis World', *Think Global Health*, 1 August 2023 <https://www.thinkglobalhealth.org/article/foreign-policy-and-global-health-multipolar-multi-crisis-world>.
[142] Nelson Aghogho Evaborhene and Jessica Oga, 'Global Health Diplomacy in a Transactional Era', *The Lancet*, 405.10484 (2025), p. 1049, doi:10.1016/S0140-6736(25)00324-1.

and consensus-building.[143] However, as Marten challenges, these venues can also reflect entrenched geopolitical asymmetries in power and influence, with high-income countries (HICs) often driving agendas, leaving LMICs with limited leverage to shape outcomes or ensure meaningful and equitable representation.[144] Furthermore, the growing role of non-state actors and multilateral organizations in GHD (particularly PPPs, multinational corporations, philanthropic foundations, international financing institutions, and civil society groups) – while bringing needed innovation and crucial financing – introduce new governance challenges, particularly around legitimacy, transparency, and accountability.[145] As highlighted by the empirical chapters, such dynamics significantly affect integration efforts. When GHS and UHC are promoted within fragmented or asymmetric diplomatic arenas, alignment becomes more difficult to sustain; competing mandates, donor interests, and uneven distribution of resources all play a role in reinforcing certain norms and priorities over others.

From an analytical perspective, GHD is particularly valuable for explaining how and why global health governance is structured as it is, who influences agenda-setting, and what mechanisms determine policy alignment or fragmentation. This is especially relevant to the thesis' focus on GHS and UHC, which have historically been treated in GHD as distinct norms with corresponding legal frameworks, but which increasingly interact via international obligations – a phenomenon Phelan and Katz have documented.[146] They explain how GHS is underpinned by binding legal instruments such as the International Health Regulations (IHR 2005), emphasizing surveillance, outbreak preparedness, and emergency response. UHC, by contrast, has advanced primarily through political declarations and normative consensus, such as SDG3 and the 2019 UN Political Declaration on UHC, focused on financial protection and access to essential health services. Though the processes by which GHS and UHC are operationalized are covered more extensively in Section 2.3, it is crucial to recognize that these distinctions matter to subsequent efforts to integrate them – reflecting not only different policy logics, but also distinct venues, framings, agendas, and coalitions of support.

GHD thus provides researchers a useful lens to trace how parallel policy paradigms like GHS and UHC have begun to intersect, and how alignment is being pursued (or resisted) via multilateral negotiations – with newer concepts like integrative diplomacy (e.g., emphasizing interconnected challenges and collaborative interactions)[147] and system diplomacy (e.g., emphasizing the need for

[143] Kickbusch and others, 'A Guide to Global Health Diplomacy'; Lee and Smith, 'What Is 'Global Health Diplomacy'?'; Nippun Gupta and others, 'COVID-19 Pandemic and Reimagination of Multilateralism through Global Health Diplomacy', *Sustainability 2021, Vol. 13, Page 11551*, 13.20 (2021), p. 11551, doi:10.3390/SU132011551.
[144] Marten, 'How States Exerted Power to Create the Millennium Development Goals and How This Shaped the Global Health Agenda'.
[145] Katerini Tagmatarchi Storeng, Antoine de Bengy Puyvallée, and Felix Stein, 'COVAX and the Rise of the "Super Public Private Partnership" for Global Health', *Global Public Health*, 2021, p. undefined-undefined.
[146] Alexandra L. Phelan and Rebecca Katz, 'Legal Epidemiology for Global Health Security and Universal Health Coverage', *The Journal of Law, Medicine & Ethics*, 47.3 (2019), pp. 427–29, doi:10.1177/1073110519876175.
[147] Julius Adinoyi, 'Futures for Diplomacy: Integrative Diplomacy in the 21st Century', 2018.

collective change and coordination across complex systems)[148] providing helpful views for leveraging diplomacy to bridge political and institutional divides.

GHD not only helps explain how health priorities are negotiated, but also illuminates how global health agendas are advanced through cyclical diplomatic processes. Fidler's seminal paper on mapping GHD (Figure 1) offers a particularly useful template to interpret these patterns.[149] Through his conceptual framework, Fidler helps trace how problems are: 1) formed, articulated, and amplified as interests, 2) refined, contested, and debated by diverse players (states, intergovernmental organizations, non-state actors), and 3) and translated from common interests into collective action through negotiation processes. Drawing on theories of social constructivism, he argues that his framework for GHD helps "identify patterns of interdependence, interconnectedness, and other characteristics that influence prospects for diplomatic success or failure with respect to different global health problems."[150] This heuristic is particularly relevant for the focus of thesis on interpreting how distinct interests (like GHS and UHC) can be transformed by key actors through processes of GHD into shared health objectives.

Figure 1. Template for Mapping Global Health Diplomacy. Reproduced from Fidler (2011), *Asian Journal of WTO & International Health Law and Policy,* Vol. 6, No. 1, pp. 32.

Formation and Articulation of Interests			Translating Common Interests into Collective Action	
Problem	**Interest Amplification**	**Players**	**Negotiating Processes**	**Collective Action**
		States		
		Intergovernmental organizations		
		Non-State actors		

However, while helpful for capturing the procedural aspects of GHD (particularly how health challenges are translated into policy, negotiated through multilateral venues, and institutionalized through agreements), Fidler's framework pays less attention to the underlying normative shifts that accompany these diplomatic interactions, particularly how norms comprising divergent principles and functions might converge and be reconciled through sustained contestation and dialogue, or what happens after they have already passed through the cycle. More broadly, GHD's capacity to facilitate normative (not policy or interest-specific) integration remains underexplored in the

[148] Catherine Needham, Gale ,Nicola, and Justin and Waring, 'New Development: System Diplomacy—an Alternative to System Leadership', *Public Money & Management*, 0.0, pp. 1–5, doi:10.1080/09540962.2025.2462230.
[149] Fidler, 'Navigating the Global Health Terrain: Mapping Global Health Diplomacy'.
[150] Fidler, 'Navigating the Global Health Terrain: Mapping Global Health Diplomacy'.

literature – especially regarding how distinct agendas with already established normative regimes (like GHS and UHC) might evolve into new hybrid norms. My thesis addresses that gap by complementing Fidler's GHD model with a more explicit focus on normative construction, convergence, and coherence (introduced in Chapter 4).

As the next chapters argue, it is within GHD that health ideas become visible, where alignment is tested, and where integration either stalls or accelerates. Thus, GHD represents a political arena through which health shapes diplomacy, and diplomacy shapes health. As health threats grow more transnational and politically charged, understanding the processes of GHD is essential for developing more coherent, equitable, and resilient approaches to global health. This is the foundation upon which the thesis builds its subsequent analysis for examining the integration of GHS and UHC norms.

2.3 Conceptualizing global health security and universal health coverage

The preceding sections have laid the conceptual foundations for understanding the broader global health architecture, foregrounding the role of diplomacy in influencing the evolution of major global health agendas. This section introduces the two dominant agendas examined in this thesis – GHS and UHC – which both shape, and are shaped by, processes of GHD. Understanding their development is crucial to unpacking the extent of normative integration examined in later chapters.

To unpack these dynamics further, this section draws on three broad factors – ideas, interests, and institutions – to broadly capture the factors shaping policy making and policy change. Often referred together as the '3Is', this framework has been widely applied by various scholars to a variety of topics, including in the field of health policy.[151] I have drawn on this framework here to help structure the introduction of GHS and UHC in ways that reveal the unique dynamics of each agenda – including what they value, who they are associated with, and how they manifest in different political and institutional contexts. In doing so, I aim to provide an entry point for understanding key regime features and discursive patterns that underpin their normative dimensions, establishing the major differences between the two agendas as well as what they look like today in practice.

[151] Jessica C Shearer and others, 'Why Do Policies Change? Institutions, Interests, Ideas and Networks in Three Cases of Policy Reform', *Health Policy and Planning*, 31.9 (2016), pp. 1200–11, doi:10.1093/heapol/czw052; Carmen Jacqueline Ho and others, 'The Politics of Universal Health Coverage', *The Lancet*, 399.10340 (2022), pp. 2066–74, doi:10.1016/S0140-6736(22)00585-2; GILL WALT and LUCY GILSON, 'Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis', *Health Policy and Planning*, 9.4 (1994), pp. 353–70, doi:10.1093/heapol/9.4.353.

Ideas

Ideas refer to the values and forms of knowledge that shape how policy problems and solutions are defined, as well as how actors perceive the acceptability and feasibility of available policy options.[152] Béland notes that ideas "are often depicted as ideologies or overarching paradigms involving 'organised principles and causal beliefs.'"[153] Smith adds that ideas represent "organising frameworks for understanding the world"[154] (similar to Hall's concept of 'policy paradigms'[155]), and provide policymakers with a "relatively coherent set of assumptions about the functioning of economic, political and social institutions," further explaining that:

> *"...literature focusing on agenda-setting (Cobb and Elder 1972; Edelman 1988; Schattschneider 1960) highlights how ideas can operate as 'policy frames'. From this perspective, ideas are positioned as tools that can be constructed and deployed by interested policy actors [...] serving to define how policy problems are understood and who is involved (or not) in the policy process. Finally, ideas are often defined as simple policy proposals for responding to identifiable policy problems (Be´land 2005; Kingdon 1995, 1984)."*[156]

Building on this view, Yazdi-Feyzabadi and colleagues assert that "ideas can affect the way different societal actors define a problem," influencing how stakeholders judge the feasibility and legitimacy of diverse policy options, and thus helping explain why stakeholders may "favour certain policy options over others."[157] In this way, ideas are seen to "shape agenda-setting, policy formulation and implementation by determining which representations of the problem and potential solutions will be heard and understood by policy-makers," with the "clustering of actors around certain ideas" influencing the shape of policy networks.[158] In practice, this can elevate certain agendas, with ideas serving as "coalition magnets" that draw together actors who share common normative commitments.[159]

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[152] François-Pierre Gauvin, 'The 3-i Framework: Interests, Ideas, and Institutions in Policy Analysis' 2014, 2014 <https://policycommons.net/artifacts/1933501/understanding-policy-developments-and-choices-through-the-3-i-framework/2685271/>.

[153] 'Ideas and Social Policy: An Institutionalist Perspective - Béland - 2005 - Social Policy & Administration - Wiley Online Library' <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1467-9515.2005.00421.x> [accessed 30 May 2025].

[154] Katherine Smith, 'The Politics of Ideas: The Complex Interplay of Health Inequalities Research and Policy', *Science and Public Policy*, 41 (2013), pp. 561–74, doi:10.1093/scipol/sct085.

[155] Peter A. Hall, 'Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain', *Comparative Politics*, 25.3 (1993), pp. 275–96, doi:10.2307/422246.

[156] Smith, 'The Politics of Ideas'.

[157] Vahid Yazdi-Feyzabadi, Mohammad Bazyar, and Sara Ghasemi, 'District Health Network Policy in Iran: The Role of Ideas, Interests, and Institutions (3i Framework) in a Nutshell', *Archives of Public Health*, 79.1 (2021), p. 212, doi:10.1186/s13690-021-00737-7.

[158] Shearer and others, 'Why Do Policies Change?'

[159] Ho and others, 'The Politics of Universal Health Coverage'.

Of relevance to this thesis, Smith provides another important reflection to emphasize the value of examining ideas:

> *"Employing 'ideas', rather than 'evidence', as the primary unit of analysis is in some ways a simple distinction but it can be important in drawing attention to the potential malleability of evidence-informed messages as they move between actors and across contexts (Smith 2007; Weiss 1982; Stevens 2007). In turn, this highlights the importance of analysing how ideas are constructed and promoted and how politics, values and ethics can interact to shape the way in which ideas are subsequently translated and transformed (Sanderson 2006; Smith and Joyce 2012)."*[160]

By influencing what is seen as possible, desirable, or legitimate, ideas therefore play a foundational role in structuring the politics and conceptualizations of both GHS and UHC.

Interests

Interests refer to the preferences, agendas, and power embedded in policy actors – whether states, international organizations, or non-state actors like civil society – which drives their desire to influence the policy process for a beneficial result.[161] Yazdi-Feyzabadi et al. therefore emphasize that interests shape and change policy outcomes, helping determine "who will be losers or winners by adopting different policies."[162]

Shearer and colleagues provide additional insights on important dynamics between interests and actors:

> *"The ability of actors to attain and exercise their interests depends on the distribution of resources and power in a policy domain, as well as individual capacity and skills. Further, most interest-based theories acknowledge the structural constraints on individual agency. Pertinent, but not exclusive to LMIC settings, scholars describe a growing authority of private and non-state actors in government policymaking processes (Mathews 1997; Litvack et al. 1998; Buse and Walt 2002) adding to the power of international organizations (Kahler and Lake 2004; Dobbin et al. 2007). The distribution of power is largely driven by access to resources in these settings but has an equally important normative element (Shiffman 2014)."*[163]

Additionally, Ho et al. highlight significant contextual events as key to shaping interests:

> *"Political actors, acting individually or collectively, can use windows of opportunity—crucial junctures in the political process—to accelerate a preferred policy agenda. These windows of opportunity are created in various*

[160] Smith, 'The Politics of Ideas'.
[161] Gauvin, 'The 3-i Framework'.
[162] Yazdi-Feyzabadi, Bazyar, and Ghasemi, 'District Health Network Policy in Iran'; Shearer and others, 'Why Do Policies Change?'; Peter A. Hall and Rosemary C. R. Taylor, 'Political Science and the Three New Institutionalisms', *Political Studies*, 44.5 (1996), pp. 936–57, doi:10.1111/j.1467-9248.1996.tb00343.x.
[163] Shearer and others, 'Why Do Policies Change?'

> *ways. For example, sudden, attention-grabbing events can draw attention to the need for government action and create an exogenous opportunity for actors to mobilise and push through health reform."*[164]

The capacity of GHS and UHC actors to pursue their interests therefore depends on both material resources and strategic positioning, and the distribution of power reflects both access to resources and underlying normative dynamics.

Institutions

Institutions refer to the "collections of structures, rules and standard operating procedures" that shape policy actors' views and behaviors.[165] Referred to by some scholars as the "rules of the game," institutions may be formal or informal organizational factors, and are seen to "influence which actors have political power, how political power is organised, and how actors mobilise power and participate in the policy process."[166]

Shearer et al. posit that "institutions [...] shape policy change primarily through the ways in which they create and distribute incentives and learning."[167] They further link the concept of institutions to networks, noting that:

> *"Networks, like institutions, impose structural constraints on policymaking by mediating the pattern of relations among actors [...] Networks are likely to change in response to institutional pressures: 'a change in institutional rules directly affects network structure by creating new opportunities and incentives for policy interactions' (2012, p. 355). Conversely, networks can create, reinforce or challenge institutions by facilitating interactions among actors in ways that might lead to shifts in norms, preferences and power, a possibility which is most likely in contexts of highly informal or weak institutions (Hall and Taylor 1996; Helmke and Levitsky 2004)."*[168]

As this thesis aims to examine GHS and UHC over time, it is important to explore the historical aspect of institutions as well as the structural aspects of them. Reflecting this nuance, Ho and colleagues emphasize that "political contestation does not occur in a vacuum, but rather within specific institutional contexts,"[169] provide important grounding for the ways in which GHS and UHC have been structured through *evolving* institutions.

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[164] Ho and others, 'The Politics of Universal Health Coverage'.
[165] Yazdi-Feyzabadi, Bazyar, and Ghasemi, 'District Health Network Policy in Iran'; Gauvin, 'The 3-i Framework'.
[166] Shearer and others, 'Why Do Policies Change?'; Ho and others, 'The Politics of Universal Health Coverage'; Gauvin, 'The 3-i Framework'.
[167] Shearer and others, 'Why Do Policies Change?'; Paul Pierson, 'Increasing Returns, Path Dependence, and the Study of Politics', *American Political Science Review*, 94.2 (2000), pp. 251–67, doi:10.2307/2586011; Hall and Taylor, 'Political Science and the Three New Institutionalisms'.
[168] Shearer and others, 'Why Do Policies Change?'
[169] Ho and others, 'The Politics of Universal Health Coverage'.

2.3.1 Global health security

This section outlines the conceptual and normative foundations of GHS, providing critical analytical context for the subsequent exploration of normative alignment with UHC. Drawing on the 3Is framework, it examines the framing of GHS across three categories – ideas, interests, and institutions – to clarify how securitization has shaped global health priorities and governance arrangements, with an emphasis on infectious diseases and health emergencies. This review directly informs later chapters, which interrogate how GHS norms interact with – and at times contest – those of UHC through diplomacy, highlighting tensions and opportunities in achieving a more integrated global health architecture.

Ideas

According to WHO, global health security (GHS) aims to "minimize vulnerability to acute public health events that endanger the collective health of populations living across geographic and international boundaries."[170] Over the past two decades, GHS has increasingly shaped global health agendas, driven by the rising frequency of epidemics, climate-driven risks, and heightened awareness of the cross-border implications of disease outbreaks.[171]

Conceptually, the framing of health as a security issue has been significantly influenced by securitization theory, particularly from the Copenhagen School.[172] Scholars like Buzan and Wæver argue that securitization involves a "speech act" through which issues are discursively constructed as existential threats, legitimizing rapid, emergency-based action measures.[173] In global health, this framing gained prominence in response to events like the SARS outbreak (2003) and the H1N1 pandemic (2009), reinforcing a narrative of urgency and crisis where health threats were increasingly articulated as risks to national and international security.[174] As McInnes and Rushton observe, this framing has "cemented [the] seemingly unshakeable grasp [of GHS] in global health diplomacy discourse," solidifying the idea that pandemics, bioterrorism, and other cross-border health threats

[170] WHO, *The World Health Report 2007: A Safer Future: Global Public Health Security in the 21st Century*, 2007 <https://www.who.int/publications-detail-redirect/9789241563444>.
[171] Adam Kamradt-Scott and Colin McInnes, 'The Securitisation of Pandemic Influenza: Framing, Security and Public Policy', *Global Public Health*, 7.sup2 (2012), pp. S95–110, doi:10.1080/17441692.2012.725752; Adam Kamradt-Scott and Simon Rushton, 'The Revised International Health Regulations: Socialization, Compliance and Changing Norms of Global Health Security', *Global Change, Peace & Security*, 24.1 (2012), pp. 57–70, doi:10.1080/14781158.2012.641284; Sadia Mariam Malik, Amy Barlow, and Benjamin Johnson, 'Reconceptualising Health Security in Post-COVID-19 World', *BMJ Global Health*, 6.7 (2021), p. e006520, doi:10.1136/BMJGH-2021-006520.
[172] Stefan Elbe, 'Haggling over Viruses: The Downside Risks of Securitizing Infectious Disease', *Health Policy and Planning*, 25.6 (2010), pp. 476–85, doi:10.1093/heapol/czq050.
[173] Buzan, Wæver, and de Wilde, *Security: A New Framework for Analysis* (Lynne Rienner Publishers, 1998) <https://www.rienner.com/title/Security_A_New_Framework_for_Analysis>.
[174] Kamradt-Scott and McInnes, 'The Securitisation of Pandemic Influenza'.

demand security-oriented responses.[175] Youde adds that the notion of a security threat "relies on a crisis mentality" that "necessitates some sort of extraordinary response that goes outside the realm of normal politics."[176] While this approach has often elevated the political priority of health threats into what some scholars refer to as "high politics," critics also caution that securitized framings are not always effective and may marginalize health equity and vulnerable populations, privileging state- and emergency-centric responses at the expense of long-term, sustainable health system investments.[177]

Contemporary GHS frames draw from established global governance frameworks and national security policies – most recently manifesting in ideas around pandemic preparedness and response.[178] Key principles include international cooperation and coordination (given the cross-border nature of mitigating health threats) and political urgency (to ensure rapid response to health emergencies).[179] Furthermore, the resiliency of health systems to absorb shocks from crises has emerged as an important frame for GHS, particularly following the 2014 West Africa Ebola outbreak and the 2020 COVID-19 pandemic.[180]

However, as Shiffman points out, "health concerns become security issues for political reasons. It is a reflection of the exercise of power."[181] Complementary critiques therefore seek to interrogate whose security is prioritized – and how this translates to the frames used to position GHS.[182] Youde captures this divergence in how GHS is conceptualized, summarizing the views of key scholars in this space:

> *"Weir (2015) describes the securitization of health as an effort on behalf of Northern states for their benefit, which in turn further marginalizes the Southern states because it portrays those states as the source of the disease threat. Aldis (2008) criticizes the notion of health security as largely undefined and too dismissive of the concerns of developing states. Rushton (2011) argues that a securitization framework for health tends to emphasize the containment of threatening diseases over preventing disease outbreaks, raising questions about whose security counts. McInnes sees a disconnect between health and security because "the causal relationship between an adverse health effect and international stability is questionable, and/or the empirical evidence to*

[175] Colin McInnes and Simon Rushton, 'HIV/AIDS and Securitization Theory1', *European Journal of International Relations*, 19.1 (2013), pp. 115–38, doi:10.1177/1354066111425258.
[176] Jeremy Youde, 'High Politics, Low Politics, and Global Health', *Journal of Global Security Studies*, 1.2 (2016), pp. 157–70 (p. 20), doi:10.1093/jogss/ogw001.
[177] Youde, 'High Politics, Low Politics, and Global Health'; Wenham, 'The Oversecuritization of Global Health'; Akhavein, Sheel, and Abimbola, 'Health Security—Why Is "Public Health" Not Enough?'; Rushton, 'Global Health Security: Security for Whom? Security from What?'
[178] Malik, Barlow, and Johnson, 'Reconceptualising Health Security in Post-COVID-19 World'.
[179] Youde, 'High Politics, Low Politics, and Global Health'; Lawrence O Gostin, 'The Politics of Global Health Security', *Lancet (London, England)*, 386.10009 (2015), pp. 2134–35, doi:10.1016/S0140-6736(15)01059-4.
[180] Amanda McClelland and others, 'Multisectoral Resilience for the next Global Health Emergency', *BMJ Global Health*, 8.Suppl 6 (2023), p. e013320, doi:10.1136/bmjgh-2023-013320.
[181] Shiffman, 'A Social Explanation for the Rise and Fall of Global Health Issues'.
[182] Elbe, 'Haggling over Viruses: The Downside Risks of Securitizing Infectious Disease'.

support the claim is suspect or missing" (McInnes 2015,9)."[183]

These critiques expose tensions between political framings and empirical realities, and foreground the risks of exclusion and inequity in GHS agendas.

GHS draws its momentum from the high perceived severity of infectious disease threats, making this one of its most politically compelling features.[184] Pandemic risks are framed as existential dangers to national security, economic stability, and international peace.[185] This framing positions GHS as a high-stakes, high-priority agenda in both health and foreign policy arenas – even if the issues it is seen to encompass (e.g., pandemics, viral hemorrhagic fevers, etc.) may not end up significantly impacting morbidity and mortality at the population level compared to other issues like NCDs, raising important concerns about whether the severity of GHS issues corresponds to its actual effects.[186]

Interests

Prominent national actors – such as the US, United Kingdom (UK), and Australia – have strategically positioned themselves as champions of GHS, leveraging bilateral aid, defense funding, and diplomatic influence to elevate GHS in global forums.[187] The US Centers for Disease Control (CDC) has long played a key role leading GHS efforts; the US President's Emergency Plan for AIDS Relief (PEPFAR) – initially conceived as a global HIV/AIDS initiative – has increasingly supported GHS, investing in laboratory infrastructure and disease surveillance as well as emphasizing its key role in responding to major outbreaks of other disease.[188] More recently, PEPFAR was merged into a newly-established Bureau for Global Health Security and Diplomacy at the US State Department, reflecting the institutionalization of vertical disease programs and health diplomacy under one GHS umbrella.[189] Meanwhile, the UK's Foreign, Commonwealth & Development Office (FCDO) and

[183] Youde, 'High Politics, Low Politics, and Global Health'.
[184] Youde, 'High Politics, Low Politics, and Global Health'.
[185] Antoine de Bengy Puyvallée and Sonja Kittelsen, '"Disease Knows No Borders": Pandemics and the Politics of Global Health Security', *Pandemics, Publics, and Politics*, 2018, pp. 59–73, doi:10.1007/978-981-13-2802-2_5.
[186] Rebecca Katz and Daniel A Singer, 'Health and Security in Foreign Policy', *Bulletin of the World Health Organization*, 85.3 (2007), pp. 233–34, doi:10.2471/BLT.06.036889; Wenham, 'The Oversecuritization of Global Health'; Stephanie L Smith and others, 'Shifting Patterns and Competing Explanations for Infectious Disease Priority in Global Health Agenda Setting Arenas', *Health Policy and Planning*, 39.8 (2024), pp. 805–18, doi:10.1093/heapol/czae035.
[187] Sara E. Davies and Adam Kamradt-Scott, 'Health Security Policy and Politics: Contemporary and Future Dilemmas', *Australian Journal of International Affairs*, 72.6 (2018), pp. 492–94, doi:10.1080/10357718.2018.1537357.
[188] Anne Doble and others, 'The Role of International Support Programmes in Global Health Security Capacity Building: A Scoping Review', *PLOS Global Public Health*, 3.4 (2023), p. e0001763, doi:10.1371/journal.pgph.0001763.
[189] 'U.S. Launches Bureau for Global Health Security and Diplomacy' <https://www.ny1.com/nyc/all-boroughs/politics/2023/08/01/u-s--launches-bureau-for-global-health-security-and-diplomacy> [accessed 2 August 2023].

UK Health Security Agency have framed health security as a strategic foreign policy priority[190], while Australia's Indo-Pacific health partnerships reflect broader shifts toward regional engagement on GHS.[191]

Global health scholars often point out that GHS agendas are disproportionately promoted by HICs / Global North (GN) countries (a critique that indeed holds some merit) – view that has been reflected in the actions of some countries. Indonesia famously made a claim to viral sovereignty in response to what it perceived as "unfair and exploitative practices by some high-income states and pharmaceutical vaccine developers during the avian flu crisis," thus leading to what Elnaiem et al. characterize as a "more equitable and sustainable attempt at sample-sharing and vaccine manufacture" through the Pandemic Influenza Preparedness Framework.[192] However, a variety of LMICs / Global South (GS) countries have increasingly been at the forefront of GHS advocacy – responding to a range of potential interests such as increased funding for GHS-aligned activities or a desire to be seen as a leader in the GHS regime. Wenham highlights that, "beyond acting as a norm entrepreneur" on health security, Thailand "has taken on this leadership role and has been able to dominate the normative processes of subregional disease control and in doing so has strengthened its own economic and national security;"[193] beyond regional leadership, Thailand has also been a leading voice in global norm-setting on GHS, including as Steering Group Chair of the Global Health Security Agenda (detailed below).[194] Therefore, the leadership of GHS can be seen to be evolving; GS countries, while perhaps not fully aligned on all the same GHS approaches and principles promoted by their western-centric or GN counterparts, nonetheless play an important and ever-increasing role in which ideas are taken forward and institutionalized across the GHS regime.

Multilateral actors have also played a prominent role in guiding GHS. WHO has long played a central role in the evolution of the GHS regime[195], including normatively through its World Health Assemblies and operationally through its Health Emergencies Programme (WHE), which coordinates international responses to health crises, deploys emergency teams, and issues technical guidance.[196] However, WHO's authority as a leading coordinating institution on GHS efforts has routinely been challenged (particularly following high-profile health emergencies), including by

[190] Gagnon and Labonté, 'Understanding How and Why Health Is Integrated into Foreign Policy - a Case Study of Health Is Global, a UK Government Strategy 2008-2013'.
[191] Davies and Kamradt-Scott, 'Health Security Policy and Politics'.
[192] Elnaiem and others, 'Global and Regional Governance of One Health and Implications for Global Health Security'.
[193] Clare Wenham, 'Regionalizing Health Security: Thailand's Leadership Ambitions in Mainland Southeast Asian Disease Control', *Contemporary Southeast Asia*, 40 (2018), pp. 126–51, doi:10.1355/cs40-1f.
[194] Soawapak Hinjoy and others, 'Working beyond Health: Roles of Global Health Security Agenda, Experiences of Thailand's Chairmanship amidst of the Uncertainty of the COVID-19 Pandemic', *Global Security: Health, Science and Policy* 2023, 2023 <https://www.tandfonline.com/doi/abs/10.1080/23779497.2023.2213752>.
[195] Hoffman, 'The Evolution, Etiology and Eventualities of the Global Health Security Regime'.
[196] 'Health Emergencies' <https://www.who.int/our-work/health-emergencies> [accessed 22 April 2025].

pushbacks against perceived encroachments on state sovereignty and a lack of reliable financing.[197] More broadly, the United Nations Security Council (UNSC), has also played a growing role in defining GHS; UNSC Resolution 1308 on HIV/AIDS marked the first time the UN formally linked a public health issue to security, and UNSC Resolution 2177 claimed that the "unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security."[198] Sekalala, Williams, and Meier argue that, given the UNSC's "trend towards [health] securitization," that "the [UN] Security Council and the WHO should collaborate towards a rights-based response to COVID-19 that prioritises individual human rights alongside national security concerns, addressing underlying inequities in the global response to infectious disease.[199]

As described in earlier sections, the evolving global health landscape has also promoted the emergence of newer PPPs, including GFATM, GAVI, and CEPI, which have explicitly adopted GHS discourse and expanded their strategies to contribute towards issues like pandemic preparedness.[200] More recently, the World Bank launched the Pandemic Fund to help catalyze national investments in health security,[201] while a high-level G7 initiative was launched in 2024 to unite development finance institutions to better catalyze surge financing for pandemics and other health emergencies.[202]

Civil society's role in shaping the GHS agenda has comparatively limited than in other global health domains, such as UHC or maternal and child health. Since COVID-19, important grassroots coalitions have been launched, such as the Pandemic Action Network, while other existing civil society organizations like WACI Health, Amref, and Global Health Council have prominently featured GHS as a key priority area for advocacy.[203] However, while NGOs and advocacy coalitions have contributed to pandemic preparedness initiatives (particularly post-pandemic), most GHS

[197] Lawrence O. Gostin and others, 'The World Health Organization Was Born as a Normative Agency: Seventy-Five Years of Global Health Law under WHO Governance', *PLOS Global Public Health*, 4.4 (2024), p. e0002928, doi:10.1371/journal.pgph.0002928; Meier and Finch, 'Seventy-Five Years of Global Health Lawmaking under the World Health Organization'.

[198] Sekalala, Williams, and Meier, 'Global Health Governance through the UN Security Council'.

[199] Sekalala, Williams, and Meier, 'Global Health Governance through the UN Security Council'.

[200] 'Global Health Security', *Global Fund* <https://www.theglobalfund.org/en/global-health-security/> [accessed 29 January 2025]; 'African Union, Gavi and Japan Unite to Bolster Health Security and Universal Health Coverage in Africa'.

[201] Matthew R Boyce, Erin M Sorrell, and Claire J Standley, 'An Early Analysis of the World Bank's Pandemic Fund: A New Fund for Pandemic Prevention, Preparedness and Response', *BMJ Global Health*, 8.1 (2023), p. e011172, doi:10.1136/bmjgh-2022-011172.

[202] 'G7 DFIs, MedAccess, EIB, and IFC Announce MoU for Surge Financing Initiative for Medical Countermeasures' <https://www.dfc.gov/media/press-releases/g7-dfis-medaccess-eib-and-ifc-announce-mou-surge-financing-initiative-medical> [accessed 22 April 2025].

[203] World Bank-imf Annual Meetings, Health Security, and Challenge Fund, 'Pandemic Action Network Global Policy and Advocacy Priorities', no. June (2020); 'FutureProofing Healthcare Launches Whitepaper Focusing on Preparing African Health Systems for the Future - Newsroom', *Amref*, 12 November 2021 <https://newsroom.amref.org/news/2021/11/futureproofing-healthcare-launches-whitepaper-focusing-on-preparing-african-health-systems-for-the-future/>; '2023 Global Health Briefing Book – Global Health Council' <https://globalhealth.org/programs/2023ghbb/> [accessed 18 April 2023].

agenda-setting has been dominated by state and multilateral actors – perhaps an unsurprising reality, given that the GHS regime largely rests on state-centric intergovernmental cooperation on cross-border public health threats.[204]

GHS is therefore shaped by a policy community which, although diverse in composition (spanning multilateral institutions, national governments, and PPPs), is relatively cohesive in its orientation and commitment to key normative features.[205] These actors generally converge around the urgency of preventing and managing infectious diseases, although divergences remain regarding priorities, national approaches, and governance structures – particularly between HICs and LMICs.[206] It is important to further emphasize that many LMICs may appear to support GHS policies not because of significant internal alignment but because they believe this is where HIC donors are likely to provide additional funding.[207] Despite these tensions, the framing of GHS as an imperative for global stability, alongside an operational framework through legally-binding instruments like IHR (2005) (detailed below), has created a shared policy space for cooperation and coordination based on collective health threats and core capacities.[208]

Successive high-profile infectious disease outbreaks – SARS, H1N1, Ebola, COVID-19 – have served as catalytic policy windows that elevated GHS on the global agenda.[209] These crises demonstrated the rapid cross-border nature of pathogens, highlighting shared vulnerabilities in health systems.[210] As a result, they created conditions for institutional change, a stocktaking of health systems capacities that can better support GHS, new international agreements, and calls for increased funding and investments tied to GHS.[211] In particular, the 2014 Ebola outbreak and the COVID-19 pandemic (which visibly linked health crises not only to mortality and contagion, but

[204] Rushton, 'Global Health Security: Security for Whom? Security from What?'; Hoffman, 'The Evolution, Etiology and Eventualities of the Global Health Security Regime'.
[205] Hoffman, 'The Evolution, Etiology and Eventualities of the Global Health Security Regime'.
[206] Nora Y Ng and Jennifer Prah Ruger, 'Global Health Governance at a Crossroads.', *Global Health Governance : The Scholarly Journal for the New Health Security Paradigm*, 3.2 (2011), pp. 1–37; Aldis, 'Health Security as a Public Health Concept: A Critical Analysis'; Preslava Stoeva, 'Dimensions of Health Security—A Conceptual Analysis', *Global Challenges*, 4.10 (2020), p. 1700003, doi:10.1002/gch2.201700003; Rushton, 'Global Health Security: Security for Whom? Security from What?'
[207] Smith and others, 'Shifting Patterns and Competing Explanations for Infectious Disease Priority in Global Health Agenda Setting Arenas'.
[208] Lawrence O. Gostin and Rebecca Katz, 'The International Health Regulations: The Governing Framework for Global Health Security', *Milbank Quarterly*, 94.2 (2016), pp. 264–313, doi:10.1111/1468-0009.12186.
[209] Andreas Papamichail, 'The Global Politics of Health Security before, during, and after COVID-19', *Ethics & International Affairs*, 35.3 (2021), pp. 467–81, doi:10.1017/S0892679421000460.
[210] Gostin and Katz, 'The International Health Regulations: The Governing Framework for Global Health Security'.
[211] David L. Heymann and others, 'Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic', *The Lancet*, 385.9980 (2015), pp. 1884–901, doi:10.1016/S0140-6736(15)60858-3.

also to economic collapse and regional instability) shifted GHS from a technical concern to a core geopolitical issue.[212]

Institutions

A key framework that supports the GHS global governance structure is its codification of the revised International Health Regulations (IHR, 2005), a legally-binding agreement requiring all WHO Member States to ensure 'core capacities' for global preparedness and response to infectious disease outbreaks.[213] Initially revised in response to perceived failures observed during SARS, the IHR have undergone further amendments following the COVID-19 pandemic – including defining 'pandemic emergency,' promoting equity and solidarity, strengthening access to health products and financing, and establishing mechanisms for implementation monitoring and compliance (e.g., States Parties Committee and National IHR Authorities).[214] These provisions reflect an increasingly institutionalized approach to disease control, situating health security within a regulatory framework that is both legally enforceable and politically contested.

Yet, implementation of IHR core capacities suggests a politically fragile framework, with highly uneven implementation across countries. While HICs often demonstrate adequate GHS functions, they have not always complied with all IHR provisions, such as early alert and information-sharing; meanwhile, LMICs often lack the capacity and resources to meet obligations.[215] Acknowledging inconsistent national implementation, the Global Health Security Agenda (GHSA) was launched in 2014 as a multilateral initiative to accelerate progress through a whole-of-government and whole-of-society approach to GHS.[216] GHSA operates as a voluntary partnership involving over 70 countries and multiple international organizations and non-state actors.[217] Emphasizing its multisector approach, GHSA Action Packages target a range of areas including biosurveillance, laboratory networks, and emergency response coordination – broadening the governance of GHS to

[212] Suerie Moon and others, 'Will Ebola Change the Game? Ten Essential Reforms before the next Pandemic. the Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola', *The Lancet*, 386.10009 (2015), pp. 2204–21, doi:10.1016/S0140-6736(15)00946-0; Annamarie Bindenagel Šehović and Kaymarlin Govender, 'Addressing COVID-19 Vulnerabilities: How Do We Achieve Global Health Security in an Inequitable World', *Https://Doi.Org/10.1080/17441692.2021.1916056*, 16.8–9 (2021), pp. 1198–208, doi:10.1080/17441692.2021.1916056.

[213] WHO, *International Health Regulations (2005)*, 2005.

[214] Fidler, 'From International Sanitary Conventions to Global Health Security'; 'World Health Assembly Agreement Reached on Wide-Ranging, Decisive Package of Amendments to Improve the International Health Regulations' <https://www.who.int/news/item/01-06-2024-world-health-assembly-agreement-reached-on-wide-ranging--decisive-package-of-amendments-to-improve-the-international-health-regulations--and-sets-date-for-finalizing-negotiations-on-a-proposed-pandemic-agreement> [accessed 22 April 2025].

[215] Davies, *Disease Diplomacy*.

[216] 'What Is the Global Health Security Agenda?', *CDC*, 6 June 2023 <https://www.cdc.gov/globalhealth/security/what-is-ghsa.htm>.

[217] A Spring Update, 'Mapping the Global Health Security Agenda', no. Cdc (2016).

encompass emerging priorities spanning antimicrobial resistance (AMR), zoonotic threats, and biological risks.[218]

This structural asymmetry has prompted calls for greater international financing and support mechanisms for GHS.[219] As has been discussed in detail in the empirical chapters (particularly as a case study in Chapter 7), a suite of reforms to the governance of GHS were launched in the wake of COVID-19 – most notably amendments to the IHR and a separate pandemic agreement (sometimes referred to as an 'accord' or 'treaty').[220]

In practice, GHS features a relatively consistent set of public health measures designed to protect populations from pandemic threats, infectious disease outbreaks, and biological risks. These "core capacities" as they are often termed, largely enshrined in the IHR (2005) include surveillance, response coordination, risk communication, and infection prevention and control at borders.[221] More recently, issues like biosecurity, genomic editing, and R&D for medical countermeasures have become increasingly prominent elements of GHS.[222] An emerging approach is the "One Health" framework, which acknowledges the interdependence of human, animal, and environmental health in preventing zoonotic spillover events – a recognition reinforced by outbreaks of avian influenza, Zika virus, and COVID-19.[223] While the inclusion of these interventions as central to GHS is clear, their equitable deployment remains uneven, prompting new initiatives like the pandemic agreement to help improve their effectiveness.

Tools like the WHO Joint External Evaluation (JEE), and IHR benchmarks assess country-level readiness across 19 technical areas.[224] However, significant challenges remain in translating GHS commitments into sustained national investments, with critiques pointing to the episodic nature of

[218] Hinjoy and others, 'Working beyond Health'.
[219] 'Calling for a New Multilateral Financing Mechanism for Global Health Security and Pandemic Preparedness - Pandemic Action Network'.
[220] 'Draft Report of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to the Special Session of the World Health Assembly', *World Health Organization*, 15 November 2021 <https://apps.who.int/gb/wgpr/e/e_wgpr-5.html>.
[221] Gostin and Katz, 'The International Health Regulations: The Governing Framework for Global Health Security'; 'International Health Regulations (IHR) Core Capacity Index', *WHO* <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4824> [accessed 11 March 2022]; World Health Organization, *WHO Benchmarks for International Health Regulations (IHR) Capacities*, 2019 <http://apps.who.int/bookorders.%0Ahttps://www.who.int/ihr/publications/9789241515429/en/>.
[222] Josie Hornung, 'Norms and the Securitisation of Infectious Diseases', *E-International Relations*, 2016 <https://www.e-ir.info/2016/01/15/norms-and-the-securitisation-of-infectious-diseases/>; Matt Boyd and Nick Wilson, 'Failures with COVID-19 at the International Level Must Not Be Repeated in an Era Facing Global Catastrophic Biological Risks', *Australian and New Zealand Journal of Public Health*, 45.2 (2021), p. 184, doi:10.1111/1753-6405.13082.
[223] Elnaiem and others, 'Global and Regional Governance of One Health and Implications for Global Health Security'.
[224] World Health Organization, *WHO Benchmarks for International Health Regulations (IHR) Capacities*.

GHS funding cycles, which tend to surge in crisis periods and dissipate in their aftermath.[225] Data on GHS has therefore sometimes proven to be an inaccurate predictor of preparedness (as in the case of the Global Health Security Index), or reveal systemic weaknesses that go beyond just gaps in infectious disease control; without strong accountability or harmonized financing mechanisms, they struggle to incentivize change.[226] In response, new models like WHO's 'Health Systems for Health Security' framework[227] promote more integrated ways of implementing essential public health functions alongside primary health care to ensure more comprehensive, equitable, and resilient GHS capacities – potentially demonstrating emerging links with UHC functions.

Linking GHS to broader thesis objectives

Global health security, thus conceptualized and operationalized, has emerged as a dominant paradigm in GHD and global health governance, shaping policies, processes, and institutional mandates. Applying the above insights to Shiffman and Shawar's analysis[228] of how global health priorities are framed can provide useful guideposts for this thesis's subsequent examination of GHS and how to develop a fit-for-purpose conceptual framework and methodology to explore its integration with UHC: GHS most closely reflects a global health agenda focused on protecting populations from transnational health threats, making it closely aligned to the framing processes of "securitisation" and occassionally "technification."[229] GHS's dominant frames can therefore be considered as drawing from a mix of largely existential threats as well as investments to protect economies from major health shocks. Consequently, the principal actors involved are usually "powerful governments and international organizations."[230] GHS efforts are therefore expected to be motivated by fear around health emergencies, with inter-state collective action employing compulsory power through agreements like IHR (2005); they are also sometimes motivated by science, with epidemiologists or scientists using epistemic arguments to justify investments in GHS capacity-building or pandemic countermeasures.

[225] Moon and others, 'Will Ebola Change the Game? Ten Essential Reforms before the next Pandemic. the Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola'; Wenham, 'The Oversecuritization of Global Health'.

[226] Viola Burau and others, 'Health System Resilience and Health Workforce Capacities: Comparing Health System Responses during the COVID-19 Pandemic in Six European Countries', *The International Journal of Health Planning and Management* 2022, 2022, doi:10.1002/HPM.3446; Ahmed Razavi, Ngozi Erondu, and Ebere Okereke, 'The Global Health Security Index: What Value Does It Add?', *BMJ Global Health*, 5.4 (2020), p. e002477, doi:10.1136/bmjgh-2020-002477.

[227] World Health Organization, *Health Systems for Health Security: A Framework for Developing Capacities for International Health Regulations, and Components in Health Systems and Other Sectors That Work in Synergy to Meet the Demands Imposed by Health Emergencies* (World Health Organization, 2021) <https://iris.who.int/handle/10665/342006>.

[228] Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'.

[229] Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'.

[230] Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'.

As scholars have observed, the securitized framing of health promoted through GHS has produced both opportunities (e.g., mobilizing political attention and resources, providing clear imperatives for international cooperation and coordination on health issues) and critical tensions (e.g., fragmented initiatives, privileging emergency responses over systemic health investments).[231] Furthermore, Wenham argues that "the global health security narrative, associated governance regime, and the ensuing path dependencies have shifted" in recent years, altering the remit of GHS in a way that "poses important considerations for future developments in health security policy, particularly relating to the longevity of the concept and the need for greater sustainability in global health security interventions."[232] Addressing these concerns is central to this thesis, as the normative endeavor of integrating GHS and UHC hinges on a re-balancing of security imperatives with equity-driven approaches and GHS initiatives to be operationalized through more inclusive logics (as discussed in the following chapters).

2.3.2 Universal health coverage

This section outlines the conceptual, normative, and institutional dimensions of universal health coverage. Similarly structured under the 3Is framework, it emphasizes UHC's historical evolution, theoretical background, influential actors, multilateral processes, and key policy principles. Indeed, as Ho et al. reflect, "universal health coverage is a political challenge; it reflects the contestation of political interests, prevailing ideas and beliefs, and the decisions that are mediated through political institutions."[233] Relative to GHS, UHC has followed a broader, rights-based trajectory, characterized by greater normative flexibility and diverse interpretations. Clarifying the foundational ideas underpinning UHC – such as equity, financial protection, and comprehensive primary health care – is essential for later chapters, which critically explore normative interactions and potential alignments with GHS.

Ideas

Universal health coverage has emerged as a foundational agenda driving global health policy, rooted in principles of equity, the right to health, universality, accessibility, and affordability. According to WHO, universal health coverage (UHC) ensures that "all individuals and communities receive the health services they need without suffering financial hardship."[234] Conceptually, UHC encompasses a broad vision of health, including essential, safe, and quality health services across the life course, spanning health promotion, prevention, treatment, rehabilitation, and palliative care.[235]

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[231] Jens Holst and Remco van de Pas, 'The Biomedical Securitization of Global Health', *Globalization and Health*, 19.1 (2023), p. 15, doi:10.1186/s12992-023-00915-y; Aldis, 'Health Security as a Public Health Concept: A Critical Analysis'.
[232] Wenham, 'The Oversecuritization of Global Health'.
[233] Ho and others, 'The Politics of Universal Health Coverage'.
[234] WHO, 'Universal Health Coverage' <https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)>.
[235] WHO, 'Universal Health Coverage'.

Tracing its normative roots, scholars widely identify the emergence of UHC within longstanding discourses of the "right to health," embedded in international legal frameworks such as the WHO Constitution (1946), the Universal Declaration of Human Rights (1948), and International Covenant on Economic, Social and Cultural Rights (1966).[236] Sometimes characterized by the clarion call of "health for all" popularized during the Alma-Ata Declaration on Primary Health Care (1978) committed to by 134 countries[237], UHC was initially anchored within the broader global push for PHC, which explicitly linked universal access to care with human rights.[238] In the latter half of the 20th century, UHC was increasingly formalized as a technical and normative priority in international health governance, though this was accompanied by neoliberal shifts which reframed UHC more narrowly as "selective coverage" and health insurance schemes, and weakened its impact through structural adjustment programs.[239] The significance of UHC was reignited in the 2015 SDGs and further reified via 2019 and 2023 UN High-Level Meeting (HLM) Political Declarations on UHC, which reaffirmed global commitments to achieving universal access to healthcare services by 2030.[240] Yet, as Meier emphasizes, translating rights-based aspirations into concrete national policy remains challenging, especially when economic discourses dominate health financing debates – often at the expense of equity considerations.[241] Affirming this challenge, WHO "estimates that by 2030,

[236] Benjamin Mason Meier and Ashley M. Fox, 'International Obligations through Collective Rights: Moving from Foreign Health Assistance to Global Health Governance', *Health and Human Rights*, 12 (2010), p. 61; Ooms and others, 'Anchoring Universal Health Coverage in the Right to Health'; Gorik Ooms and others, 'Is Universal Health Coverage the Practical Expression of the Right to Health Care?', *BMC International Health and Human Rights*, 14.1 (2014), p. 3, doi:10.1186/1472-698X-14-3; Lisa Forman, Gorik Ooms, and Claire E. Brolan, 'Rights Language in the Sustainable Development Agenda: Has Right to Health Discourse and Norms Shaped Health Goals?', *International Journal of Health Policy and Management*, 4.12 (2015), pp. 799–804, doi:10.15171/ijhpm.2015.171.

[237] Janina Kehr, Jacinta Victoria Syombua Muinde, and Ruth J. Prince, 'Health for All? Pasts, Presents and Futures of Aspirations for Universal Healthcare', *Social Science & Medicine*, Health for all? Pasts, Presents and Futures of Universal Health Care and Universal Health Coverage, 319 (2023), p. 115660, doi:10.1016/j.socscimed.2023.115660.

[238] David A. Watkins and others, 'Alma-Ata at 40 Years: Reflections from the Lancet Commission on Investing in Health', *The Lancet*, 392.10156 (2018), pp. 1434–60, doi:10.1016/S0140-6736(18)32389-4; Gorik Ooms and others, 'Universal Health Coverage Anchored in the Right to Health', *Bulletin of the World Health Organization*, 91.1 (2013), pp. 2-2A, doi:10.2471/BLT.12.115808.

[239] Marlee Tichenor and Devi Sridhar, 'Universal Health Coverage, Health Systems Strengthening, and the World Bank', *BMJ (Online)*, 358 (2017), pp. 1–5, doi:10.1136/bmj.j3347; Labonté, Martin, and Storeng, 'Editorial'.

[240] Benjamin Mason Meier, Alexandra Finch, and Nina Schwalbe, 'Shaping Global Health Law through United Nations Governance: The UN High-Level Meeting on Pandemic Prevention, Preparedness and Response', *Journal of Law, Medicine & Ethics*, 51.4 (2023), pp. 972–78, doi:10.1017/jme.2024.14; Claire E Brolan and Peter S Hill, 'Universal Health Coverage's Evolving Location in the Post-2015 Development Agenda: Key Informant Perspectives within Multilateral and Related Agencies during the First Phase of Post-2015 Negotiations', *Health Policy and Planning*, 31.4 (2016), pp. 514–26, doi:10.1093/heapol/czv101; Susan P. Sparkes and others, 'Will the Quest for UHC Be Derailed?', *Https://Doi.Org/10.1080/23288604.2021.1929796*, 7.2 (2021), doi:10.1080/23288604.2021.1929796.

[241] MEIER, 'The World Health Organization, the Evolution of Human Rights, and the Failure to Achieve Health for All'.

up to 61% of the world's population will not have access to essential health services, and poor and marginalised people are most likely to be excluded."[242]

In contemporary discourse, UHC tends to be more generally framed in the language of social justice and inclusive health development, aligned with the SDGs[243]. Its human rights framing appeals broadly to civil society and development sectors – though it lacks the immediate, threat-based urgency of securitized narratives in GHS.[244] UHC is sometimes incorrectly viewed as synonymous with PHC or as a proxy for HSS[245] – while UHC certainly encompasses aspects of both concepts, viewing them as interchangeable loses the normative aspects of UHC like equity or affordability. Additionally, UHC is sometimes perceived as closely tied to noncommunicable diseases (NCDs) efforts rather than communicable diseases[246] – while this is not a holistic interpretation, it is understandable given the close alignment of GHS with infectious disease control. However, while GHS is indeed more explicitly operationalized around outbreak preparedness and response, UHC has a key role to play in responding to communicable diseases, and is viewed by many scholars as such.[247]

UHC, unlike GHS, does not focus on acute threats or prioritize specific diseases. Instead, it emphasizes chronic inequity, unmet healthcare needs, and catastrophic expenditures at the individual level. These challenges, while no less important, are often less politically galvanizing than sudden outbreaks which may be on a wider systemic level. Nevertheless, the scale of UHC's impact is profound. According to WHO and the World Bank, more than two billion people face financial hardship due to out-of-pocket healthcare costs, underscoring the urgency of addressing health-related impoverishment.[248] This aspect of UHC is particularly stark in LMICs, where out-of-pocket expenditures remain a dominant mode of health financing, increasing the risk of poverty and care

[242] Ho and others, 'The Politics of Universal Health Coverage'.
[243] Granmo and Fourie, *Health Norms and the Governance of Global Development*.
[244] Sonja Kristine Kittelsen, Sakiko Fukuda-Parr, and Katerini Tagmatarchi Storeng, 'Editorial: The Political Determinants of Health Inequities and Universal Health Coverage', *Globalization and Health*, 15.1 (2019), p. 73, doi:10.1186/s12992-019-0514-6; Sakiko Fukuda-Parr, 'Sustainable Development Goals (SDGs) and the Promise of a Transformative Agenda', in *International Organization and Global Governance*, 3rd edn (Routledge, 2023).
[245] Bertram and others, 'Confronting the Elephants in the Room'; Schmidt, Gostin, and Emanuel, 'Public Health, Universal Health Coverage, and Sustainable Development Goals: Can They Coexist?'; Abiiro and De Allegri, 'Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates'.
[246] Mahnaz Afshari and others, 'Global Health Diplomacy for Noncommunicable Diseases Prevention and Control: A Systematic Review', *Globalization and Health*, 16.1 (2020), p. 41, doi:10.1186/s12992-020-00572-5.
[247] Deliana Kostova and others, 'Synergies between Communicable and Noncommunicable Disease Programs to Enhance Global Health Security', *Emerging Infectious Diseases*, 23.December (2017), pp. S40–46, doi:10.3201/eid2313.170581; Mohsen Asadi-Lari and others, 'Opportunities and Challenges of Global Health Diplomacy for Prevention and Control of Noncommunicable Diseases: A Systematic Review', *BMC Health Services Research*, 21.1 (2021), p. 1193, doi:10.1186/s12913-021-07240-3.
[248] 'World Bank and WHO: Half the World Lacks Access to Essential Health Services, 100 Million Still Pushed into Extreme Poverty Because of Health Expenses' <https://www.who.int/news/item/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses> [accessed 31 January 2022].

avoidance.[249] The widespread risk of health-related impoverishment constitutes a major, ongoing public health and development concern which undermines economic stability; scholars further argue that the lack of attention to UHC makes it more difficult to respond to outbreaks and other public health threats (a key focus of this thesis).[250]

Reflecting the way that ideas "can set policy trajectories on new tracks," Ho and colleagues describe how, in Taiwan and South Korea, mainstreaming "the idea of redistributive social welfare contributed to the universalisation of health-care services during a time when most welfare states were cutting back."[251] Additionally, they note that the ability of ideas to serve as coalition magnets, deployed by policy entrepreneurs to bring together disparate actors by rallying them around a shared idea (e.g., expanded nutrition policies in Indonesia) has been seen to garner wider support over other ideas in health-related debates; more "expansive and inclusive ideas about social policies and universal health coverage can therefore generate normative support for universalist social programmes."[252]

Interests

A broad range of state actors have played a role in advancing UHC on the international stage, reflecting the increasingly complex nature of GHD and inherently decentralized governance logics of UHC.[253] National exemplars such as Thailand provide tangible evidence of successful UHC implementation. Thailand's Universal Coverage Scheme (UCS), introduced in 2002, has significantly expanded access to healthcare, reduced out-of-pocket expenditures, and strengthened PHC infrastructure.[254] The success of UCS has been attributed to strong political commitment, sustained public financing, and institutionalized community participation. Similarly, the UK's National Health Service (NHS) has long served as a model of tax-funded universal healthcare, demonstrating how publicly financed health systems can ensure comprehensive, accessible, and equitable service

[249] Kevin Croke and Osondu Ogbuoji, 'Health Reform in Nigeria: The Politics of Primary Health Care and Universal Health Coverage', *Health Policy and Planning*, 39.1 (2024), pp. 22–31, doi:10.1093/heapol/czad107; Viroj Tangcharoensathien and others, 'Health Systems Development in Thailand: A Solid Platform for Successful Implementation of Universal Health Coverage', *The Lancet*, 391.10126 (2018), pp. 1205–23, doi:10.1016/S0140-6736(18)30198-3.

[250] Foluke Esther Akinleye, Gbemisola Rebecca Akinbolaji, and Joseph Oladimeji Olasupo, 'Towards Universal Health Coverage: Lessons Learnt from the COVID-19 Pandemic in Africa', *The Pan African Medical Journal*, 35.Suppl 2 (2020), p. 128, doi:10.11604/pamj.supp.2020.35.2.24769; Sanjeet Bagcchi, 'Universal Healthcare "Shouldn't Cost the Earth"', *SciDev*, 19 November 2021 <https://www.scidev.net/global/news/universal-healthcare-shouldnt-cost-the-earth/>.

[251] Ho and others, 'The Politics of Universal Health Coverage'.

[252] Ho and others, 'The Politics of Universal Health Coverage'.

[253] Granmo, 'Health Norms in the Global Governance of Development : A Constructivist Analysis'.

[254] Tangcharoensathien and others, 'Health Systems Development in Thailand'.

provision.[255] Relatedly, Tediosi et al. reflect how several BRICS countries have been "increasingly influential players in global health," with some "proactively pushing UHC in the global agenda."[256]

Ho et al. stress that UHC is a deeply contested and political process by the very nature of the conflicting interests involved in its promotion:

> *"Universal health coverage involves the redistribution of resources across income groups, a political process that can rouse intense contestation between different groups. Governments, which have historically ignored poor and marginalised people, are more likely to maintain the status quo than legislate programmes on behalf of these groups. In addition, the implementation of universal health coverage requires substantial and sustained investments in physical infrastructure and human capacity, a process that is deeply affected by politics."*[257]

Notably, the expansion of UHC has often depended on the political strength of labour movements and social democratic parties, as seen in post-war Britain, Scandinavian welfare states, and Mexico up to the 1990s.[258] In contrast, weak labour organizations and the power of interest groups have consistently undermined UHC efforts in the United States. However, class-based mobilization alone is insufficient to explain UHC reforms: feminist and anti-racist scholars highlight how health systems have historically excluded informal workers, women, and racialized minorities, reinforcing intersectional inequities even under universalist policies.[259] Beyond mass movements, bureaucrats and professional actors – such as technocrats in Indonesia and physicians in Thailand – have played pivotal roles in shaping reform by navigating institutional politics and advancing principled commitments to health equity.[260]

At the multilateral level, WHO has long been a significant proponent of UHC, including through under previous Directors-General Maragaret Chan[261] and Gro Harlem Brundtland[262]. More recently, through its UHC2030 partnership (formerly International Health Partnership, or IHP+), WHO has played a central role in supporting collective international action on UHC, providing technical guidance and tracking progress on UHC implementation.[263] The platform regularly convenes

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[255] The Lancet, 'Lessons from the NHS for UHC and Health Security', *The Lancet*, 397.10288 (2021), p. 1859, doi:10.1016/S0140-6736(21)01056-4.
[256] Fabrizio Tediosi and others, 'BRICS Countries and the Global Movement for Universal Health Coverage', *Health Policy and Planning*, 31.6 (2016), pp. 717–28, doi:10.1093/heapol/czv122.
[257] Ho and others, 'The Politics of Universal Health Coverage'.
[258] Ho and others, 'The Politics of Universal Health Coverage'.
[259] Ho and others, 'The Politics of Universal Health Coverage'.
[260] Ho and others, 'The Politics of Universal Health Coverage'; Joseph Harris, '"Professional Movements" and the Expansion of Access to Healthcare in the Industrializing World', *Sociology of Development*, 3.3 (2017), pp. 252–72, doi:10.1525/sod.2017.3.3.252.
[261] Margaret Chan, 'Why the World Needs Global Health Initiatives', *WHO*, June 2009 <https://www.who.int/director-general/speeches/detail/why-the-world-needs-global-health-initiatives>.
[262] Brundtland, 'Public Financing for Primary Health Care Is the Key to Universal Health Coverage and Strengthening Health Security'.
[263] 'History', *UHC2030* <https://www.uhc2030.org/about-us/history/> [accessed 11 May 2023].

country leaders, multilateral agencies, and civil society organizations to collaborate on UHC advocacy; it also develops country profiles, accountability frameworks, and advocacy tools to assess national progress and support policy coherence across stakeholders.[264] However, similar to the challenges it faces in normatively guiding GHS efforts, WHO's mandate to guide UHC advocacy and norm-setting is constrained by its reliance on voluntary funding and limited enforcement capacity, as well as the inherent operationalization of UHC through subnational, context-specific implementation.[265] Given UHC's normative roots in UN human rights frameworks, other UN agencies like UNICEF and UN Development Programme (UNDP) have also supported efforts to strengthen UHC, but more often through targeted investments in key aspects of PHC and population development more closely aligned with their mission.[266]

Non-state actors, particularly philanthropic foundations and global financial institutions, have also played an influential role in shaping UHC discourse and financing strategies, in varying ways. The Rockefeller Foundation, for example, was instrumental in elevating UHC as a global policy priority, funding research and advocacy efforts that guided national-level health financing reforms.[267] Meanwhile, the World Bank has evolved in promotion of UHC, more recently seeking to integrate UHC objectives within its financing initiatives and encouraging LMICs to transition away from out-of-pocket payments toward pooled risk-sharing mechanisms.[268]

While civil society mobilization around UHC has been less visible at the global level compared to that of other more specific health agendas (e.g., HIV/AIDS), however country-level engagement through civil society has been vital to its success.[269] For example, from India to Mexico to Brazil, civil society has historically played a major role in shaping health legislation that has institutionalized

[264] 'State of UHC Commitment - UHC2030', *UHC2030* <https://www.uhc2030.org/what-we-do/voices/accountability/state-of-uhc-commitment/> [accessed 30 November 2021]; 'State of UHC Commitment - UHC2030'.
[265] MEIER, 'The World Health Organization, the Evolution of Human Rights, and the Failure to Achieve Health for All'.
[266] WHO and Unicef, 'Operational Framework for Primary Health Care: Trasforming Vision into Action', 2020, pp. 1–106.
[267] Robert Marten and others, 'An Assessment of Progress towards Universal Health Coverage in Brazil, Russia, India, China, and South Africa (BRICS)', *The Lancet*, 384.9960 (2014), pp. 2164–71, doi:10.1016/S0140-6736(14)60075-1.
[268] Tichenor and Sridhar, 'Universal Health Coverage, Health Systems Strengthening, and the World Bank'; '4 Priorities to Achieve Universal Health Coverage', *World Bank Blogs* <https://blogs.worldbank.org/en/health/4-priorities-achieve-universal-health-coverage> [accessed 29 January 2025].
[269] Bill Rau, 'The Politics of Civil Society in Confronting HIV/AIDS', *International Affairs*, 82.2 (2006), doi:10.1111/j.1468-2346.2006.00531.x; Stephanie L Smith, 'Civil Society Priorities for Global Health: Concepts and Measurement', *Health Policy and Planning*, 38.6 (2023), pp. 708–18, doi:10.1093/heapol/czad034; Ye Xu, Cheng Huang, and Uriyoán Colón-Ramos, 'Moving Toward Universal Health Coverage (UHC) to Achieve Inclusive and Sustainable Health Development: Three Essential Strategies Drawn From Asian Experience; Comment on "Improving the World's Health Through the Post-2015 Development Agenda: Perspectives from Rwanda"', *International Journal of Health Policy and Management*, 4.12 (2015), pp. 869–72, doi:10.15171/ijhpm.2015.156.

UHC.[270] Similarly, Ho et al. notes that civil society actors in the health policy space "were crucial in both Taiwan and South Korea, pressuring democratic governments to pursue universal health coverage policies and contributing to the design of national medical and health insurance schemes."[271] Meanwhile, Harris emphasizes the role of 'professional movements' comprised of health workers in securing advancements in UHC from the ground up.[272] Ho et al. adds to this feature of UHC with two other examples:

> *"Progressive bureaucrats in the [Taiwan and South Korea] health ministries, who had been long-term supporters of expanded health coverage, were empowered to lead social policy reform in the democratic era, a radical shift from previous practices in which social welfare (and health) policies were subsumed under the economic development ministries. In both countries, the idea of redistributive health policy was mainstreamed, as middle-class actors allied with workers, farmers, and vulnerable groups. Despite pressures to privatise or cut back the NHI programmes in Taiwan and South Korea, the two governments have maintained their commitment to universal health coverage."*[273]

Globally, UHC2030 and allied organizations have attempted to broaden civil society participation through accountability mechanisms and people-centered health movement language, but engagement remains variable across contexts – in part, by normative design.

UHC advocacy has benefited from relatively strong policy community cohesion at the global level, with robust normative support among key multilateral institutions and prominent national governments engaged in GHD on UHC.[274] For example, WHO, World Bank, and a variety of countries have generally aligned on UHC's broad goals of expanding access and reducing financial barriers to care.[275] However, there remains significant fragmentation in emphasis: while some actors highlight financing mechanisms (e.g., pooled risk-sharing, health insurance schemes), others center service delivery (e.g., essential health benefit packages, specific population groups), and still others foreground rights-based principles or more cross-cutting investments in comprehensive PHC.[276] Despite this variation and inadequate progress on fully realizing UHC, general coherence around a

[270] Sergio Meneses Navarro and others, 'Overcoming the Health Systems' Segmentation to Achieve Universal Health Coverage in Mexico', *The International Journal of Health Planning and Management*, 37.6 (2022), pp. 3357–64, doi:10.1002/hpm.3538; Marten and others, 'An Assessment of Progress towards Universal Health Coverage in Brazil, Russia, India, China, and South Africa (BRICS)'.
[271] Ho and others, 'The Politics of Universal Health Coverage'.
[272] Harris, '"Professional Movements" and the Expansion of Access to Healthcare in the Industrializing World'.
[273] Ho and others, 'The Politics of Universal Health Coverage'.
[274] Ghebreyesus, 'All Roads Lead to Universal Health Coverage'.
[275] Abiiro and De Allegri, 'Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates'.
[276] Bertram and others, 'Confronting the Elephants in the Room'; Ooms and others, 'Anchoring Universal Health Coverage in the Right to Health'; Yates, 'Pooled Public Financing Is the Route to Universal Health Coverage'; Croke and Ogbuoji, 'Health Reform in Nigeria'; Kieny and others, 'Strengthening Health Systems for Universal Health Coverage and Sustainable Development'.

commitment to "health for all" has largely sustained momentum among UHC's policy community.[277]

Institutions

UHC's global significance was cemented through its explicit inclusion within UN Sustainable Development Goal 3 (SDG3) of the 2030 Agenda for Sustainable Development.[278] The SDGs, adopted in 2015, marked a paradigm shift in global health governance – reifying a focus beyond vertical disease-specific interventions toward comprehensive health system strengthening; it thus providing an opportunity to align more closely with the broader goals of UHC than the disease-focused silos featured in the preceding Millennium Development Goals (MDGs).[279] SDG3 articulates the commitment to "ensure healthy lives and promote well-being for all at all ages," embedding UHC within wider development priorities such as health equity, financial protection, and access to essential medicines.[280] The political commitment to UHC was further institutionalized through two UN High-Level Meetings (UN-HLMs) on UHC – the first in 2019, which resulted in the adoption of what Barron and Koonin characterize as "the most ambitious and comprehensive political declaration on health in history,"[281] and the second in 2023 (examined in detail in Chapter 7), which sought to accelerate progress toward UHC implementation amid concerns of backsliding following the COVID-19 pandemic.[282]

At the national level, institutional arrangements (e.g., regime type, electoral incentives, and bureaucratic structures) significantly shape the feasibility and design of UHC reforms. In democratic settings, the plurality of voices can delay decision-making, while politicians may prioritize vote-buying or support over equitable distribution of resources.[283] In contrast, authoritarian regimes like China, Vietnam, and Cuba have been able to expand health coverage more decisively due to centralized authority. Mixed cases such as Taiwan and South Korea illustrate how institutional transitions – from selective, growth-oriented health coverage under authoritarian rule to inclusive

[277] Luke N. Allen, 'The Philosophical Foundations of "Health for All" and Universal Health Coverage', *International Journal for Equity in Health*, 21.1 (2022), p. 155, doi:10.1186/s12939-022-01780-8.
[278] Jeanette Vega, 'Universal Health Coverage: The Post-2015 Development Agenda', *The Lancet*, 381.9862 (2013), pp. 179–80, doi:10.1016/S0140-6736(13)60062-8.
[279] Xu, Huang, and Colón-Ramos, 'Moving Toward Universal Health Coverage (UHC) to Achieve Inclusive and Sustainable Health Development'; Kieny and others, 'Strengthening Health Systems for Universal Health Coverage and Sustainable Development'; Md. Jahir Uddin Palas, Mahfuz Ashraf, and Pradeep Kumar Ray, 'Financing Universal Health Coverage: A Systematic Review', *The International Technology Management Review*, 6.4 (2017), p. 133, doi:10.2991/itmr.2017.6.4.2.
[280] Maike Voss, Robert Marten, and Daniel Gulati, 'Accelerating the SDG3 Global Action Plan', *BMJ Global Health*, 4.5 (2019), p. e001930, doi:10.1136/bmjgh-2019-001930; WHO, 'Sustainable Development Goals'.
[281] Gabriela Cuevas Barron and Justin Koonin, 'A Call to Action on UHC Commitments', *The Lancet*, 397.10292 (2021), pp. 2335–36, doi:10.1016/S0140-6736(21)01014-X.
[282] 'UHC-HLM - WHO DG Report' (World Health Organization) <https://apps.who.int/gb/ebwha/pdf_files/EB152/B152_5-en.pdf>.
[283] Ho and others, 'The Politics of Universal Health Coverage'.

single-payer systems under democratization – enabled the pursuit of broader social policy goals once electoral incentives aligned with public demand.[284]

Several high-level convenings on UHC, both regionally and globally, underscore the central role of political will, multi-sectoral collaboration, and sustainable financing as crucial preconditions for supporting effective governance for UHC.[285] However, challenges remain in translating these commitments in global governance into concrete national policies, particularly given complex and ambiguous obligations at the international level, and context-specific legislation and varied political support at the domestic level.[286] Additionally, many UHC-related agreements at the global level tend to take the form of high-level political declarations and resolutions, and may serve more as political pasturing without resulting in tangible actions (unlike GHS, which may be more legally-binding, as noted above).[287] Ultimately, given UHC's fundamental need to be operationalized from local and subnational levels, such as through national legislation or community-based programs, it is country governments that have the greatest obligation to implement UHC – making a coherent global governance structure for effective collective action difficult to sustain at scale.[288]

UHC is operationalized through a comprehensive range of interventions including accessible health facilities, comprehensive health services, and well-structured health financing systems.[289] Notably, these interventions are seen as most effective when they are closely linked to UHC principles like equity and access that better enable UHC-related efforts to reduce barriers to care and improve health outcomes.[290] UHC policy often emphasizes primary health care (PHC) as an important foundation for health systems, with Kendall et al. affirming WHO's characterization of PHC as "the most inclusive, effective, and efficient approach to enhance people's physical and mental health, as well as social well-being."[291] Strengthening PHC has therefore been identified as one of the most

[284] Ho and others, 'The Politics of Universal Health Coverage'.
[285] Meier, Finch, and Schwalbe, 'Shaping Global Health Law through United Nations Governance'; Tediosi and others, 'BRICS Countries and the Global Movement for Universal Health Coverage'; Aklilu Endalamaw and others, 'Universal Health Coverage—Exploring the What, How, and Why Using Realist Review', *PLOS Global Public Health*, 5.3 (2025), p. e0003330, doi:10.1371/journal.pgph.0003330; Téa E. Collins and others, 'Converging Global Health Agendas and Universal Health Coverage: Financing Whole-of-Government Action through UHC+', *The Lancet Global Health*, 11.12 (2023), pp. e1978–85, doi:10.1016/S2214-109X(23)00489-8.
[286] WD Savedoff, 'Transitions in Health Financing and Policies for Universal Health Coverage', *Results for Development Institute.*, 2012; Sparkes and others, 'Will the Quest for UHC Be Derailed?'; Abiiro and De Allegri, 'Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates'.
[287] Kehr, Muinde, and Prince, 'Health for All?'
[288] Jesse B. Bump, 'The Long Road to Universal Health Coverage: Historical Analysis of Early Decisions in Germany, the United Kingdom, and the United States', *Health Systems & Reform*, 1.1 (2015), pp. 28–38, doi:10.4161/23288604.2014.991211; Meneses Navarro and others, 'Overcoming the Health Systems' Segmentation to Achieve Universal Health Coverage in Mexico'.
[289] Kieny and others, 'Strengthening Health Systems for Universal Health Coverage and Sustainable Development'.
[290] Ooms and others, 'Universal Health Coverage Anchored in the Right to Health'; Phelan and Katz, 'Legal Epidemiology for Global Health Security and Universal Health Coverage'.
[291] Sally Kendall, Ros Bryar, and Katie Henderson, 'Celebrating the First 20 Years of Publication of Primary Health Care Research & Development!', *Primary Health Care Research & Development*, 20 (2019), p. e1, doi:10.1017/S1463423618000956.

cost-effective strategies for ensuring comprehensive health service coverage and resilience against emerging health threats, and has therefore been increasingly framed as a foundation for both UHC and GHS.[292] However, despite international endorsement, the translation of PHC commitments into sustained national investments remains uneven, often undermined by short-term financing and fragmented service delivery – and more commonly associated with advancements in UHC rather than GHS.[293]

Of note, achieving UHC hinges on principles including universality, equity, and people-centered care.[294] Central to these principles is the idea that access to healthcare should not be determined by socioeconomic status, geographic location, or political context, but rather treated as a fundamental human right.[295] However, these relatively ambiguous principles can be difficult to translate into credible indicators to trace severity and progress, relegating UHC to a normative goal rather than operational framework.[296] In response, some scholars refer to the 'UHC cube', comprising of population coverage, financial protection, and service coverage dimensions of health systems.[297] For example, financial risk protection indicators have been used to prevent individuals and households from experiencing catastrophic health expenditures,[298] while WHO's UHC Service Coverage Index "combines 14 tracer indicators of service coverage into a single summary measure" to help clarify broader trends.[299] Together, these indicators can help quantify both coverage and protection over

[292] Ngashi Ngongo and others, 'Reinforcing Community Health Workers Program in Africa for Universal Health Coverage and Global Health Security: A Call for Concerted Efforts', *PLOS Global Public Health*, 4.9 (2024), p. e0003727, doi:10.1371/journal.pgph.0003727; Brundtland, 'Public Financing for Primary Health Care Is the Key to Universal Health Coverage and Strengthening Health Security'; de Claro and others, 'The Role of Local Health Officers in Advancing Public Health and Primary Care Integration'.
[293] Sooyoung Kim, Tyler Y. Headley, and Yesim Tozan, 'Universal Healthcare Coverage and Health Service Delivery before and during the COVID-19 Pandemic: A Difference-in-Difference Study of Childhood Immunization Coverage from 195 Countries', *PLOS Medicine*, 19.8 (2022), p. e1004060, doi:10.1371/journal.pmed.1004060; Asaf Bitton and others, 'Primary Healthcare System Performance in Low-Income and Middle-Income Countries: A Scoping Review of the Evidence from 2010 to 2017', *BMJ Global Health*, 4.Suppl 8 (2019), p. e001551, doi:10.1136/bmjgh-2019-001551.
[294] Abiiro and De Allegri, 'Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates'; Bertram and others, 'Confronting the Elephants in the Room'.
[295] Ooms and others, 'Anchoring Universal Health Coverage in the Right to Health'; Benjamin Mason Meier and Lawrence O. Gostin, 'Human Rights for Health across the United Nations', *Health and Human Rights*, 21.2 (2019), pp. 199–204.
[296] Devi Sridhar and others, 'Universal Health Coverage and the Right to Health: From Legal Principle to Post-2015 Indicators', *International Journal of Health Services: Planning, Administration, Evaluation*, 45.3 (2015), pp. 495–506, doi:10.1177/0020731415584554.
[297] 'What Are the Overall Principles of HBP Design' <https://www.who.int/teams/health-financing-and-economics/economic-analysis/health-technology-assessment-and-benefit-package-design/resource-guide-for-the-use-of-hta-and-hbp-design-processes/what-are-the-overall-principles-of-hbp-design> [accessed 30 May 2025].
[298] Jonathan Cylus and others, 'Assessing the Equity and Coverage Policy Sensitivity of Financial Protection Indicators in Europe', *Health Policy*, 147 (2024), p. 105136, doi:10.1016/j.healthpol.2024.105136.
[299] 'UHC Service Coverage Index (3.8.1)' <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4834> [accessed 22 April 2025].

time – though comparability and implementation vary across contexts, limiting their feasibility and political traction.[300]

Linking UHC to broader thesis objectives

Overall, UHC represents a fundamentally ambitious global health goal, deeply anchored in normative commitments to equity, financial protection, and comprehensive health systems. Drawing on Shiffman and Shawar's analysis, UHC most closely reflects a global health agenda focused on equitable access to healthcare, making it closely aligned to the framing processes of "moralisation" and occassionally "technification."[301] UHC's dominant frames can therefore be considered as drawing from a mix of largely ethical imperatives as well as cost effectiveness or efficiency, largely utilized by principal actors including civil society networks and experts, who are "commonly allied with governments and international organisations."[302] Based on their insights and the ones detailed above, UHC efforts might be seen as often motivated by indignation around lack of access to equitable care, with social movements or transnational advocacy campaigns employing normative power; they are also sometimes motivated by technical problem-solving, with economists or medical experts using epistemic arguments to justify UHC reforms.

However, significant challenges persist in achieving universal access amidst fragmented governance and constrained financial resources. Addressing these tensions is central to this thesis, which investigates how integrating the equity-oriented norms of UHC with the securitized norms of GHS can support more coherent, inclusive forms of global health, including through multilateral diplomacy and strengthened domestic policies. The normative clarity and flexibility of UHC thus serve as foundational points of reference for examining its alignment – and at times friction – with the norms underpinning GHS, including international cooperation for pandemic preparedness and outbreak response.

2.4 Fragmentation and integration between global health security and universal health coverage

The previous section provided important background on GHS and UHC, unpacking key features of both agendas including actor power, ideas, political contexts, and issue characteristics. Building on this foundation, the thesis now turns to understand how fragmentation between GHS and UHC manifest across interlinked dimensions of the global health architecture (reflecting Section 2.2), where structural silos have proven especially difficult to overcome. By briefly reviewing how fragmentation between GHS and UHC is reinforced within routine and crisis contexts through divergent mandates, funding flows, and diplomatic priorities, the section then details where

[300] Jeremy Shiffman and Yusra Ribhi Shawar, 'Strengthening Accountability of the Global Health Metrics Enterprise', *The Lancet*, 395.10234 (2020), pp. 1452–56, doi:10.1016/S0140-6736(20)30416-5.
[301] Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'.
[302] Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'.

integration between both agendas has already begun. In doing so, it outlines the current state of GHS-UHC alignment, elaborates on key concepts and systemic divisions, and contextualizes the critical problems this thesis seeks to address – laying the groundwork for understanding the emergence of hybrid norms and the politics of integration explored in Chapter 4.

2.4.1 Fragmentation between GHS and UHC across routine and crisis contexts

Fragmentation is a growing challenge in global health, with implications that extend beyond GHD to affect policy processes, governance arrangements, financing mechanisms, and health systems strengthening. As Tedros has warned, "the reality is, we're off track to achieve these ambitious goals by 2030. Fragmentation, duplication and inefficiency are undermining progress."[303]

Noting that "the terms fragmentation or fragmented are commonly used in global health scholarship, but are not often defined,"[304] Agyepong et al. provide a deeper glimpse into the concept:

> *"Fragmentation, whether at global, national, or subnational levels, results from ignoring intersections, synergies, and the whole health system, within which specific health agendas are implemented. Policies, programmes, and interventions are skewed to maximise the achievement of specific goals and agendas at the expense of others that are also essential for health outcome improvement [...] We argue that a high level of fragmentation makes coordination between actors, programmes, initiatives, and policies with related or similar goals more necessary and more challenging."*[305]

Spicer and colleagues further suggest that addressing fragmentation requires greater coordination (i.e., harmonization and alignment) of key global health components:

> *"We define fragmentation as poor, or a lack of, coordination. In understanding coordination, we distinguish between the terms harmonisation and alignment embraced by the Paris Declaration on Aid Effectiveness. Harmonisation includes coordination of priorities, procedures and programmes and transparency among global health actors. Alignment means coordination between global health actors' priorities, systems and interventions and those of low- and middle-income countries receiving DAH."*[306]

This section examines the impacts of fragmentation between GHS and UHC across both routine and acute crisis settings, highlighting its real-world consequences on global health. The first part of this section focuses on how fragmentation between GHS and UHC appears in routine contexts,

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[303] Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health'.
[304] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'.
[305] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'.
[306] Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health'.

where competing priorities, parallel programming, and institutional silos create inefficiencies and undercut efforts to build coherent health systems. The second part explores how these divisions become even more pronounced during public health emergencies, where incoherence between GHS and UHC responses can exacerbate challenges, result in duplicative efforts, and lead to inequitable health outcomes. Together, these issues illustrate why fragmentation, particularly between GHS and UHC, is a central problem for global health – and why it warrants this thesis's broader investigation of integration and the emergence of hybrid norms to better link both frameworks.

Routine fragmentation between global health security and universal health coverage

Although various global health actors attempt to holistically coordinate policy solutions for both GHS and UHC in principle, they are often unable to ensure this in practice. Recent critiques highlight emerging blindspots and gaps in synergizing these agendas, pointing to fundamental rifts in the underlying motives, ideas, and beliefs intrinsic to the varying conceptualizations of GHS and UHC themselves.[307] Varying discourses underpinning GHS and UHC further exacerbate gaps and tensions between state and non-state actors, with Wenham et al. asserting that "divergence appears in the conceptualization of risk […] and the prioritization of domestic or global activity."[308] Such prioritizations exacerbate disparities, as demonstrated by the disproportionate funding allocated to pandemic response compared to routine health services.[309]

This misalignment is evident across governance structures at national and international levels. Typically, ministries of foreign affairs or defense are likely to oversee key aspects of GHS, whereas ministries of health largely manage UHC, producing legal and policy incoherence.[310] For example, GHS priorities like pathogen surveillance (inherently tied to international commitments) may be more closely enforced by global agreements and foreign policy priorities, while governance for UHC is far more likely to be influenced by domestic concerns, including local health systems contexts and population demographics. This raises a potential area of divergence: 'success' in UHC may more likely be attributable to a domestic policy reform, while GHS 'success' is more likely attributable to foreign policy efforts; actual implementation can often look different simply because UHC obligations often manifest as individual countries conducting this work fairly independently, while GHS obligations often involve collective acion among several countries at the same time. As

[307] Ooms and others, 'Synergies and Tensions between Universal Health Coverage and Global Health Security: Why We Need a Second "Maximizing Positive Synergies" Initiative'; Clare Wenham and others, 'Global Health Security and Universal Health Coverage: From a Marriage of Convenience to a Strategic, Effective Partnership', *BMJ Global Health*, 4.1 (2019), p. e001145, doi:10.1136/bmjgh-2018-001145; Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health'; Gorik Ooms and others, 'Addressing the Fragmentation of Global Health: The Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion', *The Lancet*, 392.10153 (2018), pp. 1098–99, doi:10.1016/S0140-6736(18)32072-5.

[308] Wenham and others, 'Global Health Security and Universal Health Coverage: From a Marriage of Convenience to a Strategic, Effective Partnership'.

[309] Uzma Alam and others, 'Redesigning Health Systems for Global Heath Security', *The Lancet Global Health*, 9.4 (2021), pp. e393–94, doi:10.1016/S2214-109X(20)30545-3.

[310] Phelan and Katz, 'Legal Epidemiology for Global Health Security and Universal Health Coverage'.

detailed in Section 2.3, governance and accountability mechanisms have historically reinforced this division, with distinct agreements like the IHR (2005) to manage GHS on one hand, and SDG3.8 to advance UHC on the other; progress for each has also historically been tracked separately through different metrics and indices. Of note, because of the legally-binding nature of IHR (2005), governments for the most part are likely to at least attempt to comply with GHS-related obligations.[311] Meanwhile, given that most UHC-related targets like SDG3.8 are largely normative and aspirational, there may be less pressure on states to fully comply with resulting obligations.[312] Finally, one recent analysis noted that, "although WHO approaches these agendas in principle as imminently convergent inputs towards a strong health system, scarce resources and political realities force policymakers to make tough choices," leading to the prioritization of one over the other.[313] Consequently, institutional silos have entrenched redundancies and gaps rather than fostering complementary strategies.[314]

The financial architecture of global health is similarly fragmented, with separate budget lines, funding mechanisms, and donor priorities driving disjointed investments in health systems.[315] For example, the World Bank has established various pandemic-specific financing instruments distinct from broader health investments and ODA funding, with varying level attention to resources based on context.[316] Donor-driven financing structures reinforce this fragmentation, with earmarked funding for disease-specific programs (such as HIV/AIDS, malaria, and tuberculosis) often prioritized over cross-cutting investments in PHC.[317] Agyepong and colleagues note that:

> *"The UK and the USA tend to emphasise vertical-health programmes; 47% of the UK's development assistance for health went on maternal and child health programmes, and only 4·8% to sector-wide approaches or health systems strengthening work. The USA invested more than 94% of its development assistance for health on infectious-disease programmes, particularly for HIV/AIDS, tuberculosis, and malaria, and maternal and child health. Less than 1% of US investments was channelled through sectorwide*

[311] Davies, *Disease Diplomacy*.
[312] Endalamaw and others, 'Universal Health Coverage—Exploring the What, How, and Why Using Realist Review'.
[313] Lal and others, 'Fragmented Health Systems in COVID-19: Rectifying the Misalignment between Global Health Security and Universal Health Coverage'.
[314] Irene Akua Agyepong and others, 'Synergies and Fragmentation in Country Level Policy and Program Agenda Setting, Formulation and Implementation for Global Health Agendas: A Case Study of Health Security, Universal Health Coverage, and Health Promotion in Ghana and Sierra Leone', *BMC Health Services Research*, 21.1 (2021), pp. 1–15, doi:10.1186/s12913-021-06500-6; Gatome-Munyua and others, 'Reducing Fragmentation of Primary Healthcare Financing for More Equitable, People-Centred Primary Healthcare'.
[315] Brundtland, 'Public Financing for Primary Health Care Is the Key to Universal Health Coverage and Strengthening Health Security'.
[316] Boyce, Sorrell, and Standley, 'An Early Analysis of the World Bank's Pandemic Fund'.
[317] Kara Hanson and others, 'The Lancet Global Health Commission on Financing Primary Health Care: Putting People at the Centre', *The Lancet Global Health*, 10.5 (2022), pp. e715–72, doi:10.1016/S2214-109X(22)00005-5.

approaches or on health systems strengthening in LMICs, although more recent investments have included health systems strengthening-related activities."[318]

Gatome-Munyua et al. highlight the effect of these in recipient countries:

"As an example of the potential scale of donor-driven fragmentation in a single country, a recent public expenditure review in Tanzania found that in 2017 alone, there were 504 separate health projects funded by development partners. As another example, in 2020 in Malawi, 55% of total health expenditure was funded externally across 166 financing sources and 265 implementing partners; contributing to poor coordination and misalignment between government priorities and donor projects."[319]

Furthermore, PPPs – including the Global Fund, GAVI, and CEPI – have also been criticized for reinforcing vertical approaches through major funding replenishments, which have significantly skewed global health financing in recent years toward specific disease areas rather catalyzing domestic, comprehensive system-wide investments.[320] Such fragmented financial approaches perpetuate structural trade-offs[321], reifying dichotomies between GHS and UHC initiatives. These can have particularly negative impacts on LMICs, as described by Wiyeh et al.:

"...aid to Africa has largely reinforced path dependency, perpetuating poverty and governance challenges. PEPFAR exemplifies how external funding dominates HIV/AIDS programs in some African countries, covering over 95% of services. This heavy reliance creates structurally fragile health programs that remain dependent on external support, limiting their ability to function independently [...] Its vertical, disease-specific approach has further fragmented healthcare delivery, preventing HIV/AIDS programs from fully integrating into national health infrastructures."[322]

The lack of coordination between GHS and UHC has direct consequences for HSS efforts, as duplicative programmes, poor planning, and misaligned priorities hinder long-term progress.[323] Key

[318] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'.
[319] Gatome-Munyua and others, 'Reducing Fragmentation of Primary Healthcare Financing for More Equitable, People-Centred Primary Healthcare'.
[320] Angela E Micah and others, 'Global Investments in Pandemic Preparedness and COVID-19: Development Assistance and Domestic Spending on Health between 1990 and 2026', *The Lancet Global Health*, 11.3 (2023), pp. e385–413, doi:10.1016/S2214-109X(23)00007-4; 'Time For Sunset Strategy? Global Health After GAVI and The Global Fund [Guest Essay]' <https://genevahealthfiles.substack.com/p/time-for-sunset-strategy-global-health-gavi-vaccine-alliance-global-fund-aids-tuberculosis-malaria-financing-olusoji-adeyi-guest-essay> [accessed 31 March 2025].
[321] Røttingen and others, 'Shared Responsibilities for Health'.
[322] Alison Wiyeh and others, 'A Critical Juncture in Global Health: Leveraging Historical Institutionalism to Examine PEPFAR Dependency and Inform the Development of Self-Reliant Public Health Systems', *PLOS Global Public Health*, 5.4 (2025), p. e0004440, doi:10.1371/journal.pgph.0004440.
[323] Agyepong and others, 'Synergies and Fragmentation in Country Level Policy and Program Agenda Setting, Formulation and Implementation for Global Health Agendas: A Case Study of Health Security, Universal Health Coverage, and Health Promotion in Ghana and Sierra Leone'.

stakeholders involved in HSS planning and implementation often reflect technical or normative leanings toward either GHS or UHC, contributing to uncoordinated efforts, or the exclusion of specific stakeholders altogether.[324] For example, Ooms et al. highlight that "in an underfunded and underdeveloped health system, the obvious 'next step' on the path towards UHC is not always the obvious 'next step' in the direction of GHS."[325] These disjointed approaches create inefficiencies, reducing the effectiveness of both GHS and UHC initiatives. Mansour et al. emphasize how fragmentation between both agendas undermines HSS:

> *"Between 2021 and 2023, [US] funding for pandemic preparedness rose over 60%, while support for maternal and child health remained stagnated. Yet, sustained investments in workforce development, supply chains and diversified financing mechanisms remain urgently needed. This securitised approach risks undermining long-term goals like UHC and maternal mortality reduction, representing a betrayal of global health commitments. By prioritising short-term national security concerns over structural investments in health system strengthening, the U.S. compromises the capacity of LMICs to build self-sustaining systems. These systems are not only essential for routine service delivery but also serve as the foundation of global health [security] (i.e., early detection, preparedness and effective response to public health crises)."*[326]

Achieving effective integration (i.e., actively coordinating these global health agendas) thus requires addressing entrenched structural and political barriers that perpetuate silos and undermine health outcomes. Without confronting these underlying drivers, global health initiatives will remain inefficient and inequitable[327], perpetually falling short of transformative systemic change. As such, this section has established crucial context for appreciating the areas in which chronic fragmentation between GHS and UHC requires urgent solutions through GHD and explicit norm-setting around intergation.

GHS-UHC fragmentation during crises

Public health emergencies can reveal particularly stark consequences of routine fragmentation between GHS and UHC (chronicled further in empirical Chapters 6 and 7). Sekalala and colleagues attribute part of this issue to the normative dynamics underpinning both frameworks, noting that "global health governance under WHO and the Security Council has highlighted the tension between the human rights and health security framings across four global health crises: HIV/AIDS,

[324] Travis and others, 'Overcoming Health-Systems Constraints to Achieve the Millennium Development Goals'; van Olmen and others, 'Health Systems Frameworks in Their Political Context'; Kutzin and Sparkes, 'Health Systems Strengthening, Universal Health Coverage, Health Security and Resilience'.
[325] Ooms and others, 'Synergies and Tensions between Universal Health Coverage and Global Health Security: Why We Need a Second "Maximizing Positive Synergies" Initiative'.
[326] Wesam Mansour and others, 'The Shock Effect: How U.S. Global Health Policy Shifts Reshape Health Systems and Research', *The International Journal of Health Planning and Management*, n/a.n/a, doi:10.1002/hpm.3936.
[327] FHGI, 'The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process – FGHI' <https://futureofghis.org/final-outputs/lusaka-agenda/> [accessed 28 August 2024].

SARS, Ebola, and COVID-19."[328] As previous sections have outlined, this leads to epidemic preparedness and response interventions (associated with GHS frameworks) to often be prioritized over sustained investments in everyday health services – the result of political choices and framing processes. This cycle of reactive attention – commonly termed "panic and neglect" – results in bursts of emergency funding during crises followed by prolonged periods of underinvestment, perpetuating systemic vulnerabilities.[329] As Naimoli and colleagues warn that misaligned "technical, managerial, financial, and political responses to unpredictable public health crises [...] imperil the routine functioning of health systems."[330] In light of overlapping crises that stress health systems, this section underscores the urgency of integrating GHS and UHC norms and practices, establishing a conceptual context for subsequent chapters.

During the 2014-2016 West Africa Ebola outbreak, the diversion of health system resources toward emergency response resulted in a collapse of essential health services. Already-overstretched health facilities in Guinea, Liberia, and Sierra Leone experienced sharp declines in routine immunization, maternal care, and malaria treatment.[331] Kim synthesized the findings from various studies that demonstrated major disruptions across the region:

> *"For Liberia, Shannon et al. (2017) showed in a nationwide study that antenatal care visits and childbirth assisted by skilled attendants decreased by 50% and 32%. Wesseh et al. (2017) reported that childhood full vaccination coverage declined by half, which might have led to an increase of measles cases by five times in the post-Ebola period. Sierra Leone also reported reductions in the utilization of non-Ebola health services during the outbreak. The United Nations reported that, across all primary health facilities, antenatal care visits at least four times and institutional delivery decreased by 27% and the number of children who received three doses of Pentavalent vaccines and malaria treatment declined by 21% and 39%, respectively. The utilization of services for the prevention of mother-to-child transmission of HIV declined by 23% (Brolin Ribacke et al., 2016)."*[332]

Therefore, the estimated excess deaths from disruptions to non-Ebola related services at times outstripped the number of Ebola fatalities in the same period – a critical paradox that underscores how effective outbreak response requires not only rapid emergency measures but also the institutional foundations necessary for continuity of essential care. As Kehr et al. further affirm, "the medical and economic havoc caused by the virus refocused attention on health systems, and

[328] Sekalala, Williams, and Meier, 'Global Health Governance through the UN Security Council'.
[329] Satoshi Ezoe and others, 'Health Outcomes of the G7 Hiroshima Summit: Breaking the Cycle of Panic and Neglect and Achieving UHC', *The Lancet*, 401.10394 (2023), pp. 2091–93, doi:10.1016/S0140-6736(23)01230-8.
[330] Joseph F Naimoli and others, 'Health System Strengthening: Prospects and Threats for Its Sustainability on the Global Health Policy Agenda', *Health Policy and Planning*, 33.1 (2018), pp. 85–98, doi:10.1093/heapol/czx147.
[331] Heymann and others, 'Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic'.
[332] Young Eun Kim, 'Child Mortality after the Ebola Virus Disease Outbreak across Guinea, Liberia, and Sierra Leone', *International Journal of Infectious Diseases*, 122 (2022), pp. 944–52, doi:10.1016/j.ijid.2022.06.043.

highlighted the vital role of both public healthcare, and arguments for creating truly universal, publicly-funded health services that reach and include everyone."[333]

Similarly, the 2016 Zika epidemic further illuminated repercussions from GHS-UHC fragmentation. Public health measures predominantly emphasized vector control and fumigation, while neglecting important system-wide investments. For example, as detailed further in Chapter 6, the reliance on GHS-related frameworks contributed to health officials overlooking vital maternal and reproductive care services – a major oversight for a virus which disproportionately affected pregnant women and newborn infants[334]; women encountered severe disruptions to antenatal and postnatal care, increasing the risks of adverse health outcomes, including congenital Zika syndrome.[335] Notably, the deployment of security personnel (echoing civil-military cooperation used during the West Africa Ebola outbreak) had a chilling effect on vulnerable or marginalized communities seeking public health advice from local clinics.[336]

Shortly after, the 2018 Democratic Republic of Congo (DRC) Ebola epidemic unfolded against a backdrop of armed conflict and political unrest, highlighting not only the limitations of effective GHS in fragile settings[337], but also how health security interventions themselves can provoke or amplify traditional security threats in such contexts[338]. Furthermore, the lack of accessible and trusted health workers, coupled with weaker government institutions and historical grievances linked to previous flawed outbreak responses, fueled a distrust of state authorities and ineffective community engagement which undermined vaccine uptake and other public health interventions.[339] For example, Balikuddembe warned that "DRC has only 401 hospitals (owned by both government and non-governmental entities)" and only as well as the 10.5 skilled health professionals per 10, 000 people serving a population of over 80 million people."[340] These cases reinforce that while surveillance and rapid response are essential, they cannot substitute for the institutional foundations required to ensure long-term health security (linked to GHS) or even short-term health service continuity (linked to UHC).

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[333] Kehr, Muinde, and Prince, 'Health for All?'
[334] Wenham and others, 'Zika, Abortion and Health Emergencies: A Review of Contemporary Debates'.
[335] Syed Khurram Azmat and others, 'Scoping Review on the Impact of Outbreaks on Sexual and Reproductive Health Services: Proposed Frameworks for Pre-, Intra-, and Postoutbreak Situations', *BioMed Research International*, 2021 (2021), doi:10.1155/2021/9989478.
[336] Wenham and others, 'Zika, Abortion and Health Emergencies: A Review of Contemporary Debates'.
[337] Balikuddembe, 'Re-Emergency of Ebola in the Democratic Republic of Congo: Synergizing the Preparedness and Response Measures with the Sustainable Development Goals'.
[338] Wenham, 'The Oversecuritization of Global Health'.
[339] Arush Lal and others, 'Optimizing Pandemic Preparedness and Response Through Health Information Systems: Lessons Learned From Ebola to COVID-19', *Disaster Medicine and Public Health Preparedness* 2020, 2020, pp. 1–8, doi:10.1017/dmp.2020.361.
[340] Balikuddembe, 'Re-Emergency of Ebola in the Democratic Republic of Congo: Synergizing the Preparedness and Response Measures with the Sustainable Development Goals'.

The COVID-19 pandemic presented arguably the most severe stress test for global health systems in modern history. It revealed the "well-worn fault-lines"[341] within health governance – exposing stark inequities between and within countries (i.e., along racial, class, gendered, and geographic divides) – and demonstrated the consequences of chronically fragmented health systems.[342] Just as in previous crises, emergency containment measures linked to GHS (e.g., lockdowns, contact tracing, vaccinations) were frequently enacted at the expense of, or parallel to, routine PHC services linked with UHC – rather than together. In the early months of the pandemic, countries around the world reported that almost "half of essential health services were disrupted"; a WHO-led global pulse survey in 2021 found that even a year later, about 90% of countries still reported ongoing disruptions, with things like cancer screenings and maternal health services among the hardest hit.[343] UNICEF further reported that 67 million children missed out on routine immunizations between 2019 and 2021 – a setback not seen since the early 2000s.[344] These disruptions contributed to a global surge in preventable morbidity and mortality – not only from COVID-19, but also from untreated chronic conditions like HIV, diabetes, and heart disease.[345] Crucially, many of these outcomes could have been mitigated through better-integrated health information systems, universal access to testing and treatment, and context-sensitive community health guidance – features that are cross-cutting between GHS and UHC agendas.[346] The disjointed deployment of GHS and UHC tools during the pandemic thus exemplifies the costs of fragmented planning and reinforces the imperative of structural integration.

2.4.2 Why integration? Rationale, relevance, and rising overlaps

These above illustrative cases expose a recurring and compounding pattern of fragmentation across the global health architecture, underscoring a central claim of this thesis: sustained progress in global

[341] Kehr, Muinde, and Prince, 'Health for All?'
[342] Boyd and Wilson, 'Failures with COVID-19 at the International Level Must Not Be Repeated in an Era Facing Global Catastrophic Biological Risks'; Šehović and Govender, 'Addressing COVID-19 Vulnerabilities: How Do We Achieve Global Health Security in an Inequitable World'; Independent Panel for Pandemic Preparedness and Response, 'COVID-19: Make It the Last Pandemic', *IPPPR*, May 2021 <https://recommendations.theindependentpanel.org/main-report/>.
[343] 'COVID-19 Continues to Disrupt Essential Health Services in 90% of Countries'.
[344] tkarino, 'Zero-Dose: The Children Missing out on Life-Saving Vaccines', *UNICEF DATA*, 1 May 2023 <https://data.unicef.org/resources/zero-dose-the-children-missing-out-on-life-saving-vaccines/>.
[345] 'The Cost of Inaction: COVID-19-Related Service Disruptions Could Cause Hundreds of Thousands of Extra Deaths from HIV', *World Health Organization*, 11 May 2020 <https://www.who.int/news/item/11-05-2020-the-cost-of-inaction-covid-19-related-service-disruptions-could-cause-hundreds-of-thousands-of-extra-deaths-from-hiv?utm_campaign=65d4ffb7df-MR_COPY_01&utm_medium=email&utm_source=STAT%20Newsletters&utm_term=0_8cab1d7961-65d4ffb7df-134140705>.
[346] Sumegha Asthana and others, 'Governance and Public Health Decision-Making During the COVID-19 Pandemic: A Scoping Review', *Public Health Reviews*, 45 (2024), p. 1606095, doi:10.3389/phrs.2024.1606095; Akinleye, Akinbolaji, and Olasupo, 'Towards Universal Health Coverage'; Matthew M Kavanagh and others, 'Access to Lifesaving Medical Resources for African Countries: COVID-19 Testing and Response, Ethics, and Politics.', *Lancet (London, England)*, 0.0 (2020), doi:10.1016/S0140-6736(20)31093-X.

health demands deliberate normative alignment and operational integration between GHS and UHC. This section builds directly on that view by turning to the question of integration itself – why it is seen as necessary, how it is conceptualized in existing scholarship, and in what ways it is already being applied to GHS and UHC efforts.

Global health scholars have increasingly sought to examine why and how major global health initiatives have led to inefficiencies, duplications, and weakened system resilience. Storeng and Béhague observe a:

> *"...long-standing recognition that global health initiatives have often been unproductively fragmented according to disease-based expertise and that to remedy this problem, greater attention to 'integration' at the level of policy, governance, financing strategies, research and actual programme implementation is needed (Travis et al. 2004; McCoy 2009; Atun et al. 2010). Much of this debate about integration concerns how to reconcile the tension between narrowly targeted interventions and those providing broader system-wide support (Buffardi 2014)."*[347]

Theories of integration will be further defined and elaborated in Chapter 3, but here, scholarship on integration in health systems can provide a helpful entry point to understand contemporary responses to global health fragmentation, particularly in relation to GHS and UHC. Integration in global health refers to the process by which different components of the health system – such as service delivery, financing, governance, and workforce[348] – are aligned to create more coordinated, efficient, and equitable health outcomes.[349] However, integration in global health remains challenging in practice, reflecting entrenched political, institutional, and financial barriers.[350] Indeed, Storeng and Béhague argue that "rhetoric in support of partnership and integration often masks continued structural drivers and political dynamics that bias the global health field towards vertical goals."[351] Reflecting on recent research efforts to better examine this issue, Marten contended "more attention should be devoted to strengthening health systems which could also encourage better alignment and integration between [global health initiatives] and health systems."[352]

The integration of GHS and UHC in particular has increasingly drawn scholarly attention, with several initiatives working to identify areas of convergence and tension. This has important impacts given changes in the global disease burden, with Shroff et al. asserting that because "more than 70%

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[347] Katerini T Storeng and Dominique P Béhague, '"Lives in the Balance": The Politics of Integration in the Partnership for Maternal, Newborn and Child Health', *Health Policy and Planning*, 31.8 (2016), pp. 992–1000, doi:10.1093/heapol/czw023.

[348] Atun and others, 'Integration of Targeted Health Interventions into Health Systems: A Conceptual Framework for Analysis'.

[349] Travis and others, 'Overcoming Health-Systems Constraints to Achieve the Millennium Development Goals'.

[350] Frenk and Gómez-Dantés, 'False Dichotomies in Global Health'.

[351] Storeng and Béhague, '"Lives in the Balance"'.

[352] Robert Marten, 'State Power in Global Health Policymaking: Case-Studies of Japanese and Indonesian Engagement in the Development of the Sustainable Development Goal for Health (SDG3)'.

of deaths are now caused by non-communicable diseases," policy decisions should overcome the "false dichotomy obscuring the interconnected and central role of health systems in addressing both [GHS and UHC]."[353] They go on to note that, "when health systems contribute to managing epidemics, they create healthy populations, which in turn are better able to mitigate continuing and future epidemics."[354]

A WHO white paper further laid out the rationale for this type of work, with clear links to the focus of this thesis:

> *"Efforts to strengthen health security and health systems need to be integrated to promote sustainability, efficiency and effectiveness of a country's preparedness efforts, while avoiding the creation of a vertical health security silo. Strong comprehensive health systems are essential for health security while in turn better health security strengthens health systems. Integrated, multi-stakeholder, multi-sectorial approaches are beneficial in that they work to strengthen global health security and national capacities by involving key players to help prepare for prevention, detection and response to public health emergencies. Such approaches help to build strong resilient health systems based on quality universal health coverage for equitable health outcomes and wellbeing. Indeed, local health security based on essential public health functions forms the bedrock for global health security."*[355]

Recent research collaborations have thus begun to assess this critical nexus, while others are growing the evidence base for how integrated governance and policies can foster resilient health systems more broadly.[356] These ontological debates examining the underlying foundations of GHS and UHC aim to solidify and contribute toward a growing imperative to understand the politics of integrating distinct health policy agendas, as a way to offer joint solutions that better address international health challenges.

One research initiative that has closely examined this topic is *The Lancet Commission on synergies between UHC, health security, and health promotion* – which significantly advanced this discussion during the course of writing this thesis, and was published in 2023.[357] It emphasized the ways in which a lack of

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[353] Zubin Cyrus Shroff and others, 'Time to Reconceptualise Health Systems', *The Lancet*, 397.10290 (2021), p. 2145, doi:10.1016/S0140-6736(21)01019-9.
[354] Shroff and others, 'Time to Reconceptualise Health Systems'.
[355] World Health Organization, 'Health Security and Health Systems Strengthening: An Integrated Approach', 2011, pp. 1–3.
[356] Ooms and others, 'Synergies and Tensions between Universal Health Coverage and Global Health Security: Why We Need a Second "Maximizing Positive Synergies" Initiative'; Collins and others, 'Converging Global Health Agendas and Universal Health Coverage'; Lancet, 'Lessons from the NHS for UHC and Health Security'; Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'; 'Driving Universal Health Reforms through Crises and Shocks | Chatham House – International Affairs Think Tank', 20 June 2024 <https://www.chathamhouse.org/2024/06/driving-universal-health-reforms-through-crises-and-shocks>.
[357] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'.

coherence between WHO's three overarching goals in GPW13 leads to inefficiencies across the global health architecture. One study within the Commission cited "multiple interconnected factors causing fragmentation at the global level."[358] Building upon these efforts and beyond of the empirical studies conducted for this thesis, I have further examined key developments in GHS and UHC integration, including one study on how health systems with varying degrees of GHS-UHC integration fared during the first few months of the COVID-19 pandemic[359], and another on the role of UHC in strengthening recent pandemic preparedness and response reforms[360] (additional relevant works have been included at the start of the thesis).

Finally, several other studies have sought to advance scholarship on the alignment of GHS and UHC in different ways, demonstrating growing and diverse interest in this line of inquiry. These have included broad reviews of synergies and cross-cutting interventions (often calling for priority investments in community health workers and interoperable data systems)[361]; implications for migrant health (emphasizing that the threat of AMR and experience with poor COVID-19 vaccination rates among refugees can be mitigated through greater health systems that jointly promote GHS, UHC, and health promotion)[362]; a quantitative study using difference-in-difference models (finding that "high UHC capacity needed to be augmented with high GHS capacity to prevent a decline in immunization coverage across 192 countries")[363]; and several analyses on how both agendas are operationalized at the regional level (e.g., Western Pacific, African continent) and national level (e.g., Ethiopia, Cambodia, Bangladesh)[364].

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[358] Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health'.

[359] Lal and others, 'Fragmented Health Systems in COVID-19: Rectifying the Misalignment between Global Health Security and Universal Health Coverage'.

[360] Arush Lal and others, 'Pandemic Preparedness and Response: Exploring the Role of Universal Health Coverage within the Global Health Security Architecture', *The Lancet Global Health*, 10.11 (2022), pp. e1675–83, doi:10.1016/S2214-109X(22)00341-2.

[361] Debie, Khatri, and Assefa, 'Successes and Challenges of Health Systems Governance towards Universal Health Coverage and Global Health Security'; Assefa and others, 'Global Health Security and Universal Health Coverage'; Vageesh Jain and Azeem Alam, 'Redefining Universal Health Coverage in the Age of Global Health Security', *BMJ Global Health*, 2.2 (2017), p. e000255, doi:10.1136/bmjgh-2016-000255.

[362] Saverio Bellizzi and Santino Severoni, 'Refugees and Migrants at the Heart of the Synergies between Universal Health Coverage, Health Security and Health Promotion', *Journal of Travel Medicine*, 31.1 (2024), p. taad137, doi:10.1093/jtm/taad137.

[363] Sooyoung Kim, Tyler Y. Headley, and Yesim Tozan, 'The Synergistic Impact of Universal Health Coverage and Global Health Security on Health Service Delivery during the Coronavirus Disease-19 Pandemic: A Difference-in-Difference Study of Childhood Immunization Coverage from 192 Countries', *PLOS Global Public Health*, 4.5 (2024), p. e0003205, doi:10.1371/journal.pgph.0003205.

[364] Ngongo and others, 'Reinforcing Community Health Workers Program in Africa for Universal Health Coverage and Global Health Security'; Amare Worku Tadesse and others, 'Analyzing Efforts to Synergize the Global Health Agenda of Universal Health Coverage, Health Security and Health Promotion: A Case-Study from Ethiopia', *Globalization and Health*, 17.1 (2021), pp. 1–13, doi:10.1186/S12992-021-00702-7/FIGURES/1; Olushayo Olu and others, 'Community Participation and Private Sector Engagement Are Fundamental to Achieving Universal Health Coverage and Health Security in Africa: Reflections from the Second Africa Health Forum', *BMC Proceedings*, 13.9 (2019), p. 7, doi:10.1186/s12919-019-0170-0; Getzzg, 'Synergising Universal Health Coverage and Global Health

However, in response to Storeng and Béhague's challenge that "integration may only be possible with a more radical conceptualization of global health governance," the subsequent chapters of this thesis aim to offer fresh insights into how hybrid norms might help achieve this.

2.4.3 Review of existing integration initiatives and reform efforts

This section provides a contemporaneous review of recent integration initiatives and reform efforts, with a special focus on those that promote GHS and UHC together. It is similarly structured to the preceding section, moving across key dimensions of the global health architecture – policy, governance, financing, and health systems strengthening. However, it provides additional context for subsequent chapters and the empirical studies by laying out the extent to which integration of GHS and UHC is already underway and being actively promoted through GHD – even if stakeholders aren't always aware it is happening or don't explicitly use the terms 'global health security' or 'universal health coverage.'

Many global health initiatives increasingly recognize the need for closer alignment between GHS and UHC, driven by greater understanding that sustainable resilience and equitable health systems require bridging historically fragmented governance and financing structures across both frameworks.[365] The immediate post-2015 context is crucial to appreciate here, serving as a pivotal year for paving the way, captured in this quote from the period:

> *"2015 was also a major turning point in global health policy. The UN General Assembly adopted the 2030 Agenda for Sustainable Development and Sustainable Development Goals (SDGs), emphasising universality, sustainability, and cross-sector global partnerships. The scope of health challenges has expanded from infectious diseases and child and maternal health, outlined in the 2000 Millennium Development Goals (MDGs), to include non-communicable diseases (NCDs) as a result of demographic and epidemiological*

Security in the Western Pacific Region', *JOGH*, 14 February 2025 <https://jogh.org/2025/jogh-15-04037/>; Yuhua Lai and others, 'Fragmentations between Universal Health Coverage and Global Health Security: A Quantitative Study in the Western Pacific Region' (Social Science Research Network, 24 October 2023), doi:10.2139/ssrn.4609999; Lo Yan Esabelle Yam and others, 'Synergies and Dis-Synergies between Universal Health Coverage and Global Health Security: A Case Study of Cambodia', *Journal of Global Health*, 14, p. 04218, doi:10.7189/jogh.14.04218; Malabika Sarker and others, 'A Critical Look at Synergies and Fragmentations of Universal Health Coverage, Global Health Security, and Health Promotion in Delivery of Frontline Health Care Services: A Case Study of Bangladesh', *The Lancet Regional Health - Southeast Asia*, 7 (2022), doi:10.1016/j.lansea.2022.100087.

[365] Arush Lal and Richard Gregory, *Action on Health Systems, for Universal Health Coverage and Health Security - UHC2030*, *UHC2030* (UHC2030, 29 November 2021) <https://www.uhc2030.org/blog-news-events/uhc2030-news/action-on-health-systems-for-universal-health-coverage-and-health-security-555531/>; Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'; 'An Assessment of Interactions between Global Health Initiatives and Country Health Systems'.

> *transitions. The focus of global health policy has expanded beyond disease-specific programmes to embrace health systems strengthening (HSS), universal health coverage (UHC), and its sustainability."*[366]

At the multilateral level, GHS and UHC have begun to be viewed as goals at least of equal importance, and that they are interconnected in important ways. The G7's 2016 Ise-Shima Vision for Global Health was an early political marker in this direction, committing leaders to "attaining UHC with strong health systems and better preparedness for public health"[367]; a linked article by its conveners said the following:

> *"Promoting [UHC] will help prevent another disease outbreak similar to the recent Ebola outbreak in west Africa, and create robust health systems, capable of withstanding future shocks. Robust health systems, in turn, are the prerequisites for achieving UHC. We propose [...] restructuring of the global health architecture so that it enables preparedness and responses to health emergencies; development of platforms to share best practices and harness shared learning about the resilience and sustainability of health systems; and strengthening of coordination and financing for research and development and system innovations for global health security. Rather than creating new funding or organisations, global leaders should reorganise current financing structures and institutions so that they work more effectively and efficiently."*[368]

Additionally, as mentioned in the preamble, WHO's Thirteenth General Programme of Work (GPW13) listed health emergencies (GHS) and UHC two of the three programmatic priorities for 2019 – 2023 (the third being health promotion).[369] Ooms et al. had initially cautioned that "although the SDGs and WHO's GPW come with great potential for integration, they could also give rise to further fragmentation. Given the ambition of the wide-ranging SDGs, which are much broader than the preceding Millennium Development Goals, some actors might justify prioritising UHC with reference to SDG 3.8, whereas others might prioritise health security with reference to SDG 3.d."[370] However, co-promotion of GHS and UHC has continued through the next iteration seven years, with WHO's Fourteenth General Programme of Work 2025-2028 (GPW14) emphasizing as its very first principle: "primary health care as the foundation for UHC and health security."[371]

The COVID-19 pandemic also led to multiple new reform efforts at the multilateral level, including the WHO pandemic agreement negotiations, amendments to the IHR (2005), and subsequent UN-

[366] 'Protecting Human Security: Proposals for the G7 Ise-Shima Summit in Japan', *The Lancet*, 387.10033 (2016), pp. 2155–62, doi:10.1016/S0140-6736(16)30177-5.
[367] '2016 G7 Ise-Shima Vision for Global Health' <https://g7.utoronto.ca/summit/2016shima/health.html> [accessed 23 April 2025].
[368] 'Protecting Human Security'.
[369] 'Thirteenth General Programme of Work 2019-2023'.
[370] Ooms and others, 'Addressing the Fragmentation of Global Health: The Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'.
[371] WHO, 'WHO Fourteenth General Programme of Work, 2025-2028' <https://www.who.int/about/general-programme-of-work/fourteenth> [accessed 29 January 2025].

HLMs on both GHS (referred to as pandemic preparedness and response) and UHC.[372] While the empirical chapters explore these more deeply, it is important to note that in all four of these high-level diplomatic initiatives, important strides were made in explicitly linking the principles and core capacities associated with GHS and UHC. Indeed, Tollefson et al. emphasize that "ongoing pandemic preparedness efforts such as the Pandemic Treaty, the Pandemic Fund, and pandemic preparedness plans have advocated for the alignment, synergies and integration of global health security with efforts to strengthen robust health systems, including Universal Health Coverage."[373] For example, the IHR amendments for the first-time codified language around equity and access (dimensions closely aligned with UHC objectives) in what has long been considered a bedrock of GHS.[374]

Global health organizations have increasingly published strategies and statements articulating how their programs simultaneously address both GHS and UHC. For example, GAVI, traditionally focused on routine immunization, has reworked its strategy to earmark financing for pandemic preparedness and outbreak response as part of GHS[375], while simultaneously sharing op-eds on how its focus on immunization contributes to UHC[376]. Similarly, the GFATM has repeatedly emphasized "cross-cutting" investments in HSS, including establishing a dedicated office on "Resilient and Sustainable Health Systems," and has highlighted how its work addressing HIV/AIDS, tuberculosis, and malaria is vital to both GHS and UHC in its implementing countries; various scholars have further helped analyse GFATM contributions to these agendas.[377] Regional health organizations have echoed this convergence: PAHO has launched a number of initiatives

[372] Meier, Finch, and Schwalbe, 'Shaping Global Health Law through United Nations Governance'.
[373] Tollefson and others, 'Lessons Learned from the COVID-19 Pandemic'.
[374] 'Draft Report of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to the Special Session of the World Health Assembly'; Roojin Habibi, Mark Eccleston-Turner, and Gian Luca Burci, 'The 2024 Amendments to the International Health Regulations: A New Era for Global Health Law in Pandemic Preparedness and Response?' (Rochester, NY, 24 August 2024), doi:10.2139/ssrn.4962876; Lisa Forman and others, 'How Did Human Rights Fare in Amendments to the International Health Regulations?', *Journal of Law, Medicine & Ethics*, 52.4 (2024), pp. 907–21, doi:10.1017/jme.2024.172.
[375] 'Pandemic Preparedness Cannot Wait' <https://www.gavi.org/vaccineswork/pandemic-preparedness-cannot-wait> [accessed 23 April 2025].
[376] 'How Universal Health Coverage Underpins Pandemic Prevention, Preparedness and Response' <https://www.gavi.org/vaccineswork/how-universal-health-coverage-underpins-pandemic-prevention-preparedness> [accessed 3 May 2024].
[377] World Health Organization, 'The Global Fund and Health System Strengthening: How to Make the Case , in a Proposal for Round 8,9,10', 2011; 'Global Fund Partnership Launches Investment Case for Eighth Replenishment' <https://www.theglobalfund.org/en/news/2025/2025-02-18-global-fund-partnership-launches-investment-case-eighth-replenishment/> [accessed 23 April 2025]; Aria Vyas, 'Report: The Global Fund's Unique Contribution to Universal Health Coverage and Stronger Health Systems', *Friends of The Global Fight*, 9 November 2023 <https://www.theglobalfight.org/report-the-global-funds-unique-contribution-to-universal-health-coverage-and-stronger-health-systems/>; Ashley E. Warren and others, 'Global Health Initiative Investments and Health Systems Strengthening: A Content Analysis of Global Fund Investments', *Globalization and Health*, 9.1 (2013), p. 30, doi:10.1186/1744-8603-9-30; Stephanie Eaneff and others, 'Financing Global Health Security: Estimating the Costs of Pandemic Preparedness in Global Fund Eligible Countries', *BMJ Global Health*, 8.1 (2023), doi:10.1136/bmjgh-2022-008960.

around resilient PHC and equitable access to essential medicines during health emergencies[378], while the African Union through Africa CDC has called for a "new public health order" and "new deal" that explicitly includes enhanced health security and UHC alignment through bolstered health workforce, health information systems, and PHC infrastructure.[379]

The influential roles of international financial institutions (IFIs) and philanthropic donors, particularly the World Bank and the Gates Foundation, have drawn criticism for skewing health financing and governance priorities toward siloed health priorities.[380] However, recent reforms show signs of more integrated thinking. The World Bank's recently-launched Pandemic Fund explicitly prioritized investments in health workforce and laboratory systems – a capacities that offer cross-cutting benefits for both GHS and UHC.[381] The institution has also worked with UNICEF to issue robust technical guidance on operationalizing PHC and strengthening resilient health systems through greater domestic resource mobilization across the health sector.[382] Meanwhile, the Gates Foundation – while it continues to avoid explicit use of "universal health coverage" – has recently launched portfolios for integrated PHC, and begun supporting initiatives that aim to bridge pandemic preparedness and routine HSS.[383]

Country-led efforts also reflect growing acknowledgment of GHS-UHC interconnectedness. Historically, countries like the US championed GHS strategies that were deeply entrenched in conventional health security frames and approaches, best exemplified by successive US National and

[378] 'New PAHO Director: Ending the COVID-19 Pandemic and Building Resilient Health Key Priorities - PAHO/WHO | Pan American Health Organization', 31 January 2023 <https://www.paho.org/en/news/31-1-2023-new-paho-director-ending-covid-19-pandemic-and-building-resilient-health-key>; Lal and others, 'Minimizing COVID-19 Disruption: Ensuring the Supply of Essential Health Products for Health Emergencies and Routine Health Services'; 'PAHO Strategic Fund - PAHO/WHO | Pan American Health Organization', *PAHO/WHO* <https://www.paho.org/en/paho-strategic-fund> [accessed 11 March 2022]; Cristian A. Herrera and others, 'The World Bank – PAHO Lancet Regional Health Americas Commission on Primary Health Care and Resilience in Latin America and the Caribbean', *The Lancet Regional Health – Americas*, 28 (2023), doi:10.1016/j.lana.2023.100643.
[379] Africa CDC, 'The New Public Health Order: Africa's Health Security Agenda', *Africa CDC* <https://africacdc.org/news-item/the-new-public-health-order-africas-health-security-agenda/> [accessed 29 January 2025]; 'A New Deal for African Health Security', *Africa CDC* <https://africacdc.org/news-item/a-new-deal-for-african-health-security/> [accessed 23 April 2025].
[380] Tichenor and Sridhar, 'Universal Health Coverage, Health Systems Strengthening, and the World Bank'; Harman, 'The Bill and Melinda Gates Foundation and Legitimacy in Global Health Governance'; Storeng, 'The GAVI Alliance and the "Gates Approach" to Health System Strengthening'.
[381] Boyce, Sorrell, and Standley, 'An Early Analysis of the World Bank's Pandemic Fund'.
[382] Enis Barış and others, *Walking the Talk* (World Bank, Washington, DC, 2021), doi:10.1596/978-1-4648-1768-7; 'Change Cannot Wait: Building Resilient Health Systems in the Shadow of COVID-19', *World Bank* <https://www.worldbank.org/en/topic/health/publication/change-cannot-wait-building-resilient-health-systems-in-the-shadow-of-covid-19> [accessed 16 April 2023].
[383] 'Primary Health Care' <https://www.gatesfoundation.org/our-work/programs/global-development/primary-health-care> [accessed 23 April 2025].

Global Health Security Strategies[384]. More recently, however, US global health policy has begun situating GHS within broader HSS frameworks, centering themes like PHC, health equity, and even UHC (the latter of which is particularly notable given its politically sensitive nature in US domestic and foreign policy) as foundational to health security objectives.[385] Similarly, the UK's FCDO released a 2021 position paper titled "Health systems strengthening for global health security and universal health coverage," signaling a departure from prior compartmentalization to frame GHS and UHC as interdependent goals.[386] Gatome-Munyua et al. further highlight how "Japan, the Netherlands and South Korea have used regulation and institutional arrangements to delineate and coordinate functions of different financing arrangements."[387]

This trend holds true in LMICs as well. Thailand, previously noted for its effective Universal Coverage Scheme, also offers a compelling case; its National Health Security Office has long overseen both PHC expansion alongside outbreak preparedness, serving as replicable model for other LMICs.[388] Meanwhile, Indonesia's Presidential Management Unit has emphasized joint donor financing mechanisms to support integrated service delivery reforms. Additionally, along with Rwanda, these three countries have consolidated multiple financing pools and better aligned multiple purchasers.[389] Additionally, Rasanathan et al. described how "in Uganda, the Government is mandating integration of HIV/AIDS, tuberculosis, hepatitis B, hypertension, and diabetes services into routine services and streamlining health systems functions to increase efficiencies."[390]

Furthermore, during the COVID-19 pandemic, countries like Costa Rica, Singapore, and Bangladesh all demonstrated various efforts to strengthen service integration and PHC systems as essential to overcoming fragmentation and building resilient, inclusive health systems.[391] Tollefson et al. captured an interesting example in South Africa, noting that patients "attending fever clinics

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[384] 'Using a Whole-of-Government Approach To Advance Health Objectives', *United States Department of State* <https://2017-2021.state.gov/key-topics-office-of-international-health-and-biodefense/using-a-whole-of-government-approach-to-advance-health-objectives/> [accessed 23 April 2025].
[385] 'Release of 2024 U.S. Global Health Security Strategy', *United States Department of State* <https://2021-2025.state.gov/release-of-2024-u-s-global-health-security-strategy/> [accessed 23 April 2025]; Office of Global Affairs (OGA), 'HHS Global Strategy', 23 March 2016 <https://www.hhs.gov/about/agencies/oga/about-oga/why-hhs-works-globally/hhs-global-strategy/index.html>.
[386] FCDO, 'Health Systems Strengthening for Global Health Security and Universal Health Coverage: FCDO Position Paper', *GOV.UK* <https://www.gov.uk/government/publications/health-systems-strengthening-for-global-health-security-and-universal-health-coverage/health-systems-strengthening-for-global-health-security-and-universal-health-coverage-fcdo-position-paper> [accessed 28 March 2023].
[387] Gatome-Munyua and others, 'Reducing Fragmentation of Primary Healthcare Financing for More Equitable, People-Centred Primary Healthcare'.
[388] Wenham, 'Regionalizing Health Security'.
[389] Gatome-Munyua and others, 'Reducing Fragmentation of Primary Healthcare Financing for More Equitable, People-Centred Primary Healthcare'.
[390] Rasanathan and others, 'Navigating Health Financing Cliffs'.
[391] Lal and others, 'Fragmented Health Systems in COVID-19: Rectifying the Misalignment between Global Health Security and Universal Health Coverage'; Lal and others, 'Health System Response to the COVID-19 Pandemic'.

traditionally run by the malaria programme were screened for malaria and COVID-19."[392] They go on to note:

> *"Early on, as HIV, TB and malaria resources were diverted to the pandemic response, this resulted in reduced clinic hours and decreased in testing and case finding for those three diseases. However, programmes that were leveraged for COVID-19 noted their engagement in the response led to strengthened surveillance systems, increased community engagement and expanded testing capacity due to increased investments in HIV, TB and malaria infrastructure, including investments meant to mitigate the negative impact on those programmes [...] Integrated systems would enable better pandemic response."*[393]

Phelan and Katz provide a broader reflection the role of country governments in strengthening GHS-UHC integration:

> *"Ensuring a legal environment that empowers a government to protect public health, including realization of the right to health and other human rights, is central to both global health security and universal health coverage. Immunization is a particularly powerful example of the synergy between these two approaches, which are often otherwise framed as competing, but, through appropriately tailored laws and budgetary prioritization, can propel advancements in both global health security and universal health coverage."*[394]

Gatome-Munyua et al. note that while sector-wide approaches like the Paris Declaration on Aid Effectiveness and the Maximizing Positive Synergies initiative aimed to improve aid effectiveness "through greater alignment and coordination with government priorities," these "top-down, donor-driven mechanisms have not borne fruit, however, in terms of defragmenting overall health financing systems across countries."[395] The Lusaka Agenda and the linked Future Global Health Initiatives (FGHI) represents one of the most recent attempts to structurally realign global health financing and international assistance with country priorities. They signal a deliberate effort among a variety of major global health stakeholders to reduce the proliferation of parallel funding streams and align major priorities like GHS and UHC – a notable shift from earlier traditional models of vertical, donor-driven assistance that instead seeks to empower LMICs to drive their own strategies to better coordinate priorities like PHC and pandemic preparedness.[396] While still in its early stages, these efforts signal an emerging consensus around integration and coherence between competing global health agendas – with clear implications for the politics of GHD explored in this thesis.

Therefore, while significant barriers to sustainable integration in global health remain – including fragmented governance, donor misalignment, and entrenched political interests – the trajectory

[392] Tollefson and others, 'Lessons Learned from the COVID-19 Pandemic'.
[393] Tollefson and others, 'Lessons Learned from the COVID-19 Pandemic'.
[394] Phelan and Katz, 'Legal Epidemiology for Global Health Security and Universal Health Coverage'.
[395] Gatome-Munyua and others, 'Reducing Fragmentation of Primary Healthcare Financing for More Equitable, People-Centred Primary Healthcare'.
[396] FHGI, 'The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process – FGHI'.

toward alignment between GHS and UHC is increasingly evident across the global health landscape. Continued progress hinges upon translating high-level government and organizational commitments into tangible, nationally-led implementation strategies that explicitly reconcile health security imperatives with universal coverage objectives. The empirical studies featured in this thesis build on this context, examining how these advancements in GHS-UHC integration, despite their varying scope and impact, have been able to seed an emerging hybrid norm linking GHS and UHC – and what this process says about future integration efforts.

2.4.4 Normative fragmentation and integration: the need for a new analytical lens

This chapter has demonstrated how GHS and UHC have developed in parallel through processes of GHD, often driven by distinct imperatives, values, institutional logics, and political contexts. Drawing on the 3Is framework to examine key characteristics of both agendas, it has also offered important insights into the framing processes involved – a key concept for understanding how norm contestation between GHS and UHC, which will be further unpacked in later sections. While the preceding sections illustrate their growing alignment across the global health architecture (e.g., policy, governance, financing, health systems), they also reveal why integration efforts – despite rhetorical commitments and structural reforms – often remain partial, incomplete, politically constrained, and deeply fragmented. These initiatives have largely promoted coordination mechanisms and institutional fixes, yet they still struggle to reconcile deeper normative tensions between what each agenda ultimately seeks to achieve, and how.

Existing scholarship on addressing fragmentation in global health, including between GHS and UHC, similarly remains predominantly oriented toward technocratic and operational barriers to integration – focusing on issues like vertical program design, financing alignment, or institutional streamlining while neglecting to adequately contend with the deeper ideas and contested priorities that underpin global health reforms. For example, many current studies on health system integration tend to frame misalignment as a problem of coordination, rather than one of conflicting worldviews or structural inequality (e.g., national security vs. right to health). In reflecting on how evidence-informed decision making often overlooks the political context, Parkhurst points to a much broader pattern in policymaking:

> *"There has been an enormous increase in interest in the use of evidence for public policymaking, but the vast majority of work on the subject has failed to engage with the political nature of decision making and how this influences the ways in which evidence will be used (or misused) within political areas."*[397]

These blindspots are directly relevant to this thesis; insufficient attention has been paid to the underlying assumptions, political incentives, discursive fault lines, and opportunities that might shape how stakeholders conceptualize GHS and UHC together, or the conditions under which they

[397] Justin Parkhurst, *The Politics of Evidence: From Evidence -Based Policy to the Good Governance of Evidence* (Taylor & Francis, 2017) <https://library.oapen.org/handle/20.500.12657/31002>.

are willing (or able) to align them. These gaps in research are particularly consequential in a post-pandemic context where both agendas are evolving in meaning and scope, and where integration is increasingly pursued under conditions of geopolitical uncertainty, economic constraints, and rising global inequality.

In response, this thesis contends that integration between GHS and UHC must be approached not just as an institutional fix or policy mechanism, but as a political and normative project shaped by GHD. As Shiffman and Shawar have described, the framing of health priorities – what counts as urgent, equitable, legitimate – is not neutral; it significantly influences whether and how agendas like GHS and UHC are brought together in practice. Of note, while critiques of securitized framings have rightly cautioned how GHS may marginalize equity or prioritize the interests of HICs and the Global North over others, or that UHC is best left for interpretation at the local level given different contextual needs, this thesis takes a more pragmatic position. In a geopolitical moment marked by shrinking civic space, waning multilateralism, and mounting polycrisis – from pandemics to climate change to armed conflict – it appears increasingly untenable to continue viewing GHS and UHC as inherently incompatible. This research therefore asks how they are being (re)framed and negotiated as linked agendas in real time, and what pathways exist to foster normative alignment without eroding their core approaches.

To that end, this thesis advances fresh perspectives to understand the politics of normative integration, foregrounding the discursive dynamics, institutional incentives, and the evolving diplomatic landscape of global health. While a deeper engagement with theoretical traditions and the role of norms will next follow in Chapter 3, and a dedicated conceptual framework (hybrid norms) is presented in Chapter 4, this chapter has made clear that current integration efforts often fall short – not due to lack of effort or institutional innovation, but because they fail to address the competing ideas and asymmetries that shape the global health architecture from the ground up. Bridging this gap is both an analytical and practical imperative – one that this thesis takes up directly in the chapters that follow.

Chapter 3: Theoretical foundations

The fragmentation of GHS and UHC reflects deeper questions about how global health agendas are constructed, contested, and institutionalized. In order to better unpack these, this chapter introduces the theoretical foundations that guide this thesis, drawing primarily from constructivist international relations (IR) and complemented by key insights from political science and public policy literature. Section 3.1 begins by outlining constructivism's core contribution: the idea that international politics is shaped by shared beliefs and contested meanings. From this foundation, the section explores how norms are formed, framed, and embedded through diplomatic processes, highlighting models such as the norm life cycle and newer approaches that see norms as dynamic, iterative, and deeply political. While constructivism provides tools to analyze the normative dimensions of global health agendas like GHS and UHC, it has limitations in explaining how already-embedded norms interact and integrate. To address this, the chapter turns to Section 3.2, which briefly reviews supplementary literature in political science that illuminates how concepts like institutional path dependency, governance structures, and timing shape the feasibility of policy integration. Together, these bodies of theory lay the groundwork for the hybrid norms framework developed in Chapter 4 – an approach that seeks to explain how global health agendas can move from fragmentation toward alignment through negotiated, strategic processes of normative integration.

3.1 Constructivist international relations and norm theory

As the previous chapter highlighted, the global health architecture is deeply fragmented, shaped by overlapping mandates and competing priorities. This section introduces international relations theory – particularly constructivism – as a way to explore how global health agendas develop. Constructivism focuses on how shared ideas and meanings influence international politics, offering a valuable lens for analyzing the ways in which health is framed, negotiated, and institutionalized through diplomacy. In the context of this thesis, it provides a foundation for examining how GHS and UHC evolve, and how efforts to align them reflect normative dynamics.

3.1.1 The role of constructivism in understanding global health

Situating health in international relations

The study of global health within international relations (IR) has only recently been seriously explored, evolving alongside broader shifts in global governance and foreign policy to reflect increasing intersections between political, economic, and social determinants of health. As Stoeva asserts, health was historically treated as a matter of "low politics," perceived as peripheral to strategic state interests (compared to other priorities like military or economic concerns), and thus largely marginalized in conventional IR scholarship.[398] This neglect may, in part, be explained by the

[398] P Stoeva, 'International Relations and the Global Politics of Health: A State of the Art?', *Global Health Governance - The Scholarly Journal for the New Health Security Paradigm*, 10.3 (2016), pp. 97–109.

tendency of mainstream IR theories to focus on the role of states as the primary unit of analysis in international affairs, thus excluding domestic health issues unless they posed an immediate threat to global trade or security. The International Sanitary Conferences of the 19th century marked early attempts at multilateral health cooperation, but only in the late 20th century did health become a staple in foreign policy discussions.[399] As Davies notes, "globalization had a profound impact on health risks and services," pushing health onto the international agenda as a shared challenge that required coordinated solutions.[400] Today's interdependence of states to counter transnational health threats – such as pandemics, antimicrobial resistance, and NCDs – has blurred the lines between domestic health policy and international security concerns, positioning health as a central issue for global diplomacy necessitating meaningful exploration through IR research.[401] This context reveals an important insight pertinent to later sections on the perceived priority of GHS and UHC norms – while the creation of WHO and UN health-related human rights indeed elevated health within international affairs, it was only after the heavily securitized discourse of the Cold War that health began to surface more explicitly in IR scholarship.[402] Though other factors played a role in this process, it is apparent that security framings (and not necessarily the right to health alone) played a crucial role in the perception of health as a "high politics" issue warranting space in IR studies and practice.[403]

Scholars have since reflected that applying IR theories to health exposes deeper tensions in the international order. Davies highlights that placing health at the center of international analysis challenges foundational IR assumptions.[404] For example, effectively addressing cross-border disease threats through GHD necessitates new governance mechanisms equipped to bridge security and development interests.[405] Similarly, other scholars have argued that the study of global health within IR demonstrates that so-called "low politics" issues, such as environmental degradation and gender inequity, can have profound implications for international stability and destabilize simplistic dichotomies of power and vulnerability.[406] Marten reinforces this, noting that "accepting the assumption that states are self-interested and have conflicts of interest with one another" was crucial in establishing global health cooperation, as it acknowledges the competing priorities and oft-

[399] Fidler, 'From International Sanitary Conventions to Global Health Security'; Hoffman, 'The Evolution, Etiology and Eventualities of the Global Health Security Regime'.
[400] Davies, *Disease Diplomacy*.
[401] Davies, 'What Contribution Can International Relations Make to the Evolving Global Health Agenda?'; Stoeva, 'International Relations and the Global Politics of Health: A State of the Art?'
[402] Kelley Lee and Colin McInnes, *Global Health and International Relations*, *Wiley* (Wiley, 2012) <https://www.wiley.com/en-gb/Global+Health+and+International+Relations-p-9780745649467>.
[403] Granmo, 'Health Norms in the Global Governance of Development : A Constructivist Analysis'.
[404] Davies, 'What Contribution Can International Relations Make to the Evolving Global Health Agenda?'
[405] Davies, *Disease Diplomacy*.
[406] Stoeva, 'International Relations and the Global Politics of Health: A State of the Art?'; Marten, 'How States Exerted Power to Create the Millennium Development Goals and How This Shaped the Global Health Agenda'; Gostin, 'The Politics of Global Health Security'; Davies and Kamradt-Scott, 'Health Security Policy and Politics'.

divergent interests that routinely shape diplomatic negotiations.[407] As a result, IR scholars increasingly acknowledge that health intersects with strategic concerns such as national security, global trade, and migration – transforming it into a high-stakes diplomatic domain.[408]

Constructivism in international relations

Constructivism, prominently explored by Wendt, posits that the construction of ideas and values through social and cultural interaction is the key driver of the international system.[409] As Wendt put it, "anarchy is what states make of it," underscoring that behavior in international politics is shaped and conditioned by collective meanings rather than purely material calculations.[410] Constructivism emerged as a response to rationalist paradigms in IR, emphasizing that state interests and international institutions are not exogenously given, but rather socially constructed and perceived through shared understandings, discourses, and identities.[411] This enables a more nuanced appreciation for the diversity of motives and principles often at play in global policymaking.

Finnemore and Sikkink echo that, from a constructivist perspective, the "international structure is determined by the international distribution of ideas."[412] This suggests that the contestation and development of expectations and beliefs about the way state (and increasingly non-state) actors can and should behave has enormous influence on the way global governance is organized and sustained. In arguing that constructivism allows for "the study of how social construction shapes state behavior as well as the construction of state interests," Marten extends its applications to consider how ideas and state interests can cyclically restructure each other – with important implications on diplomacy.[413] Reflecting on these features, Stoeva posits that constructivism may be better understood as an *approach* rather than a traditional IR theories, as it enables a comprehensive, and often reflexive, examination of how identities, norms, and discourses influence state behavior.[414]

Constructivist approaches to global health

Constructivism's relevance to global health lies in its ability to explain how health issues are strategically framed, contested, prioritized, and embedded by states and international institutions. It allows a richer exploration of not only which health problems are addressed, but also how those

[407] Marten, 'How States Exerted Power to Create the Millennium Development Goals and How This Shaped the Global Health Agenda'.
[408] Labonté and Gagnon, 'Framing Health and Foreign Policy'.
[409] Alexander Wendt, 'Anarchy Is What Sates Make of It', *International Organization*, 46.2 (1992), pp. 391–425, doi:10.2307/2706858.
[410] Wendt, 'Anarchy Is What Sates Make of It'.
[411] Sarina Theys, 'Introducing Constructivism in International Relations Theory', *E-International Relations*, 23 February 2018 <https://www.e-ir.info/2018/02/23/introducing-constructivism-in-international-relations-theory/>.
[412] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.
[413] Marten, 'How States Exerted Power to Create the Millennium Development Goals and How This Shaped the Global Health Agenda'.
[414] Stoeva, 'International Relations and the Global Politics of Health: A State of the Art?'

problems are understood, who gets to define them, and what assumptions underpin domestic and international responses.[415] Constructivist analysis can therefore be particularly valuable for tracing the dynamic processes via GHD through which health issues come to be seen as matters of global importance. It provides theoretical grounding to examine how global health agendas such as GHS and UHC are constituted (i.e., through narratives of risk, security, equity, or rights), and how these framings shift in relation to each other and to evolving political and diplomatic contexts. For example, Shiffman's extensive work on framing and agenda-setting in global health builds on this premise, illustrating how norms, leadership, and discourse shape which health issues rise to prominence.[416] By tying this assertion to Finnemore's claim that the "dense networks of transnational and international social relations" in which states are embedded ultimately "shape their perceptions of the world,"[417] constructivism is well-positioned to describe how state and non-state actors contest varying identities and framings in global health policymaking in order to exert power through GHD. This makes its applications useful for unpacking the relational and ideational processes involved when stakeholders attempt to develop ideas from interests, negotiate meanings, legitimize agendas, and construct priorities in global health.

Despite being a relatively newer theory within IR, constructivist approaches vary widely, providing a flexible toolkit to draw from for the purposes of this thesis. A traditional Wendtian approach emphasizes the formation of social identities, as described by Marten in his evaluation of China's reluctance to acknowledge SARS given concerns it would affect other countries' perceptions of the its ability to govern effectively. [418] Adler and Haas examine the role of epistemic communities in discursively shaping international cooperation, while Schmidt unpacks how discursive ideas are translated into institutions and policy norms.[419] Harmer explores how global health networks have been constituted through GHD framing mechanisms, offering unique insights into the role of competing discourses in global health policymaking and governance.[420] Together, these perspectives provide a foundation for this thesis's analysis of GHS and UHC – not just as policy agendas, but as normative architectures embedded in diplomacy.

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[415] Martha Finnemore and Kathryn Sikkink, 'Taking Stock: The Constructivist Research Program in International Relations and Comparative Politics', *Annual Review of Political Science*, 4 (2001), pp. 391–416, doi:10.1146/annurev.polisci.4.1.391.

[416] Shiffman, 'A Social Explanation for the Rise and Fall of Global Health Issues'; Jeremy Shiffman and Stephanie Smith, 'Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality', *The Lancet*, 370.9595 (2007), pp. 1370–79, doi:10.1016/S0140-6736(07)61579-7; Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'.

[417] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.

[418] Marten, 'How States Exerted Power to Create the Millennium Development Goals and How This Shaped the Global Health Agenda'.

[419] Emanuel Adler and Peter M. Haas, 'Conclusion: Epistemic Communities, World Order, and the Creation of a Reflective Research Program', *International Organization*, 46.1 (1992), pp. 367–90, doi:10.1017/S0020818300001533; Vivien A. Schmidt, 'Discourse as Framework for Analysis: Policy Construction and Legitimization for Changing Policies and Practices', in *The Futures of European Capitalism*, ed. by Vivien A. Schmidt (Oxford University Press, 2002), p. 0, doi:10.1093/0199253684.003.0006.

[420] Harmer, 'Understanding Change in Global Health Policy: Ideas, Discourse and Networks'.

This understanding is important for examining how GHS and UHC have been fragmented, with Shawar et al. underscoring that "the process of productive deliberation is necessary for optimal decision-making and collective action, which may ultimately help improve global health's existing fragmentation and dysfunction."[421] Constructivism can thus provide a critical lens for exploring how these architectures evolve, align, and collide across global health.

3.1.2 Norms and their role in shaping global health

Norms in international relations

Building on the constructivist foundation outlined in the previous section, this section dives deeper into how on how ideas and interests shape the international system. As Granmo argues, "the constructivist endeavour is, in essence, to uncover the meanings that underlie the behaviours of the constituent actors that comprise the field."[422] One of the core features in constructivist scholarship is the role of norms. Florini defines international norms as the "standards of behavior that are considered or seen to be legitimate in the global policy space,"[423] emphasizing their role in establishing expectations for appropriate conduct and shaping the boundaries of acceptable action. Norms help explain how particular principles and approaches come to be embedded in international institutions, diplomatic practice, and policy outcomes.[424] Their influence, therefore, extends across global governance by shaping actor preferences, thus legitimizing specific courses of action and framing the terms of discussion.[425]

Given the inherent differences in norm content and the diversity of actors involved, it is essential to examine how distinct norms are articulated and debated. Indeed, as Onuf argues, "fundamental to constructivism is the proposition that human beings are social beings [...] Saying is doing: talking is undoubtedly the most important way that we go about making the world what it is."[426] Consequently, a discursive approach highlights the active role of agents – such as 'norm entrepreneurs' and 'antipreneurs' – in defining policy problems and mobilizing support for or against a norm, respectively.[427] Given that new norms do not emerge "in a normative vacuum" but rather develop among other preexisting norms and competing interests, norm agents must work within (or against) prevailing normative environments that may constrain their efforts or the scope

[421] Shawar and others, 'Understanding Resilience, Self-Reliance and Increasing Country Voice'.
[422] Granmo, 'Health Norms in the Global Governance of Development : A Constructivist Analysis'.
[423] Florini, 'The Evolution of International Norms'.
[424] Phil Orchard and Antje Wiener, 'Norm Research in Theory and Practice' (Rochester, NY, 26 June 2023), doi:10.2139/ssrn.4499020.
[425] Florini, 'The Evolution of International Norms'.
[426] Nicholas Onuf, 'World of Our Making: Rules and Rule in Social Theory and International Relations', *Routledge & CRC Press* <https://www.routledge.com/World-of-Our-Making-Rules-and-Rule-in-Social-Theory-and-International-Relations/Onuf/p/book/9780415630399> [accessed 11 May 2023].
[427] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.

of their ideas.[428] Such contestation, as Lantis and Wunderlich propose, may lead to the formation of "norm clusters," or "collections of aligned, but distinct norms or principles at the center of a regime."[429] These norm clusters allow for greater flexibility as well as strengthen internal coherence and institutional legitimacy, comprising normative regimes that can be remarkably durable and resilient even amid significant contestation.[430] While this fluidity facilitates norm diffusion and consensus-building as norms evolve into broader regimes, it also complicates efforts to clearly identify when a norm has been violated – or even whether it still exists in its original form.[431] Some constructivists further argue that norms are "subject to ongoing attempts to reconstitute their meanings, even as they simultaneously influence patterns of social behavior that further shape their development."[432] As such, the development of norms can be understood as a constant negotiation of meaning, shaped by both material conditions and ideational strategies.

Framing norms

The inherent ambiguity of norms brings attention to the politics of framing, which constructivist theorists identify as central to norm development. According to Payne:

> *"A frame is a persuasive device used to 'fix meanings, organize experience, alert others that their interests and possibly their identities are at stake, and propose solutions to ongoing problems' (Barnett, 1999: 25, 1998). For the purpose of norm-building, frames provide a singular interpretation of a particular situation and then indicate appropriate behavior for that context."*[433]

Scholars describe framing as an intentional and strategic process of positioning new normative ideas by connecting them to previously established ones.[434] Framing is viewed as a "central element of successful persuasion," where effective 'norm entrepreneurs' are able to 'frame' emerging norms in a way that resonates with relevant audiences.[435] To add another layer, Benford and Snow contend that if there are no 'objective' definitions of norms, then the frames employed by stakeholders to

[428] Rodger A. Payne, 'Persuasion, Frames and Norm Construction', *European Journal of International Relations*, 7.1 (2001), pp. 37–61, doi:10.1177/1354066101007001002.
[429] Jeffrey S. Lantis and Carmen Wunderlich, 'Resiliency Dynamics of Norm Clusters: Norm Contestation and International Cooperation', *Review of International Studies*, 44.3 (2018), pp. 570–93, doi:10.1017/S0260210517000626.
[430] Lantis and Wunderlich, 'Resiliency Dynamics of Norm Clusters'; Hoffman, 'The Evolution, Etiology and Eventualities of the Global Health Security Regime'.
[431] Tana Johnson and Johannes Urpelainen, 'A Strategic Theory of Regime Integration and Separation', *International Organization*, 66.4 (2012), pp. 645–77, doi:10.1017/S0020818312000264; Karen J. Alter and Kal Raustiala, 'The Rise of International Regime Complexity', *Annual Review of Law and Social Science*, 14.Volume 14, 2018 (2018), pp. 329–49, doi:10.1146/annurev-lawsocsci-101317-030830.
[432] Krook and True, 'Rethinking the Life Cycles of International Norms'.
[433] Payne, 'Persuasion, Frames and Norm Construction'.
[434] Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'; Robert D. Benford and David A. Snow, 'Framing Processes and Social Movements: An Overview and Assessment', *Annual Review of Sociology*, 26 (2000), pp. 611–39.
[435] Payne, 'Persuasion, Frames and Norm Construction'.

influence normative development can be similarly subjective and transitory.[436] Payne offers a helpful description of this:

> *"In practice, greatly disputed, arbitrarily selected, and even contradictory frames might be employed by those trying to build a given norm. Framing agents compete with others using counterframes to provide singular interpretations of problems and appropriate solutions. Serious scholarly attention is devoted to resolving these 'frame contests' (Meyer, 1995) since those who embrace one frame over a counterframe 'see different things, make different interpretations of the way things are, and support different courses of action concerning what is to be done, by whom and how to do it' (Rein and Schön, 1993: 147)."*[437]

Framing thus shapes how norms are defined and interpreted – and are therefore often highly contested, strategically selected, and politically consequential.

Applying norms and framing processes in global health

In global health, norms play a crucial role by influencing everything from the prioritization of specific issues to how actors conceptualize and operationalize health policies.[438] This has implications across the global health architecture, from the governance mechanisms to funding pathways to HSS approaches (detailed in Chapter 2). Furthermore, health norms are contested and negotiated through processes of GHD involving the diverse array of actors previously discussed (e.g., states, multilateral organizations, donors, civil society groups).[439] These dynamics underscore the political nature of norm evolution, as competing norms vie for legitimacy and influence within various global health institutions through evolving narratives – making norms a particularly relevant unit of analysis for GHD processes.[440] Consequently, global health scholars urge paying "particular attention to norms" when seeking to examine how specific principles or interventions used advancing particular health agendas.[441] Indeed, in describing the subjective understandings of specific terms in global health. Shawar et al. diagnose a larger pattern:

> *"Differences in how these terms are employed and framed are not just linguistic; the language that is used is reflective of underlying ideological differences among global health actors, with implications for the way programmes are designed and implemented, the knowledge that is produced and engagement with stakeholders.*

[436] Benford and Snow, 'Framing Processes and Social Movements'.
[437] Payne, 'Persuasion, Frames and Norm Construction'.
[438] Granmo and Fourie, *Health Norms and the Governance of Global Development*.
[439] Davies, *Disease Diplomacy*; Kamradt-Scott and Rushton, 'The Revised International Health Regulations'; Granmo and Fourie, *Health Norms and the Governance of Global Development*.
[440] Davies, *Disease Diplomacy*; Granmo, 'Health Norms in the Global Governance of Development : A Constructivist Analysis'.
[441] Stephanie L Smith and Mariela A Rodriguez, 'Agenda Setting for Maternal Survival: The Power of Global Health Networks and Norms', *Health Policy and Planning*, 31.suppl_1 (2016), pp. i48–59, doi:10.1093/heapol/czu114.

Laying these distinct ideologies bare may be crucial for managing actor differences and advancing more productive discussions and actions towards achieving global health equity."[442]

Framing plays a major role in the shaping of global health norms, directly influencing the types of health interventions and policy responses prioritized within specific contexts.[443] In many cases, framing determines not just how a health issue is understood, but whether it is addressed at all. As theorized by Shiffman and Shawar, this premise suggests that how health norms are framed – such as a security concern, a moral issue, or an economic or technocratic imperative – plays a decisive role in shaping subsequent priorities and policy outcomes.[444] For example, the idea of 'health as investment' has gained traction not because of an inherent ideational claim, but because it aligns with dominant economic discourses. As these frames gain traction, they may expand or reshape existing health norms. For example, cancer control, often promoted through UHC frameworks, has increasingly been reframed as a threat to economic productivity and even societal stability – thereby introducing securitized language into a traditionally rights-based domain.[445] Such discursive shifts may amplify institutional commitments in new areas or create unexpected normative alliances, reinforcing the importance of examining associated principles as well as expected policy actions in tandem.[446] This approach of "using ideas strategically,"[447] as Sell and Prakash describe, demonstrates how normative frames can serve as important analytical tools for tracing the complex processes involved in constructing, converging, and making coherent previously-siloed norms – as presented in Chapters 4-8 of this thesis.

3.1.3 Mapping the norm life cycle

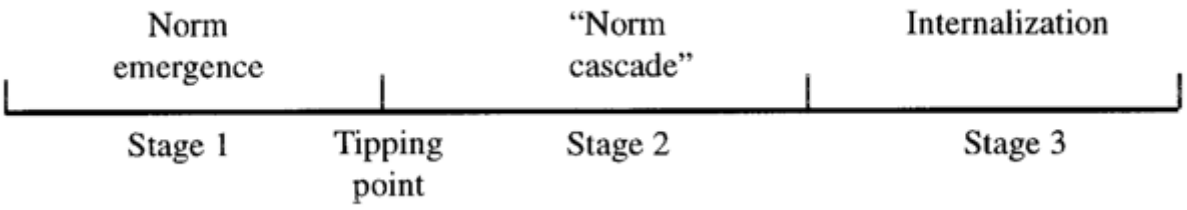
Building on the broader discussion of how norms shape GHD, this section turns to one of the most influential conceptual models for understanding normative evolution in IR: the norm life cycle. Introduced by Martha Finnemore and Kathryn Sikkink, the norm life cycle offers a structured account of how norms emerge, gain influence, and become internalized in global politics.[448] This framework was originally developed to explain the spread of human rights norms across the international system, and has since been widely adopted across multiple fields, including

[442] Shawar and others, 'Understanding Resilience, Self-Reliance and Increasing Country Voice'.
[443] Shawar and others, 'Understanding Resilience, Self-Reliance and Increasing Country Voice'.
[444] Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'.
[445] 'General Assembly High-Level Meeting on Non-Communicable Diseases Urges National Targets, Global Commitments to Prevent Needless Loss of Life | UN Press' <https://press.un.org/en/2014/ga11530.doc.htm> [accessed 19 May 2023].
[446] Payne, 'Persuasion, Frames and Norm Construction'; Lantis and Wunderlich, 'Resiliency Dynamics of Norm Clusters'; Kamradt-Scott and Rushton, 'The Revised International Health Regulations'.
[447] Susan K. Sell and Aseem Prakash, 'Using Ideas Strategically: The Contest Between Business and NGO Networks in Intellectual Property Rights', *International Studies Quarterly*, 48.1 (2004), pp. 143–75, doi:10.1111/j.0020-8833.2004.00295.x.
[448] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.

environmental regulations[449] and gender equality[450]. More recently, the norm life cycle has been applied to various aspects of global health, including reproductive health[451], infectious disease control[452], and even the evolving influence of think tanks[453].

The norm life cycle model (Figure 2) delineates three distinct stages through which norms progress: emergence**,** cascade, and internalization. Each stage corresponds to a different set of actors, mechanisms, and conditions that influence how norms take hold or fail to gain traction.

Figure 2. Norm life cycle. Reproduced from Finnemore and Sikkink (1998), *International Organization* 52, 4, p. 896.



The first stage, *norm emergence*, is marked by the role of norm entrepreneurs as they advocate for new understandings of appropriate behavior in the international system.[454] These actors often seek to frame the norm in a way that resonates with prevailing values and interests, drawing strategic connections between emerging ideas and already-legitimized principles. As Finnemore and Sikkink observe, in this first step of norm development, "norm entrepreneurs with organizational platforms and strong personal conviction attempt to persuade a critical mass of states to embrace new normative standards."[455] During this phase, persuasion and rhetorical contestation are central, and success depends heavily on issue salience, institutional support, and strategic framing.

The second stage, *norm cascade*, begins with a "tipping point," where a critical mass of stakeholders begins to take up the norm after it has gained sufficient momentum.[456] Adoption begins to accelerate as a broader range of states and other actors join the movement – not necessarily because of shared convictions, but also due to increasing peer pressure, reputational concerns, or institutional incentives. This stage often coincides with increased international cooperation, the formation of new legal instruments, multilateral declarations, and support from increasingly diverse

[449] Bailey, 'Arrested Development'.
[450] Krook and True, 'Rethinking the Life Cycles of International Norms'.
[451] Granmo, 'Health Norms in the Global Governance of Development : A Constructivist Analysis'.
[452] Davies, *Disease Diplomacy*.
[453] Yiwen Zhang and others, 'Norm Diffusion in Global Health Governance: The Role of Think Tanks', *BMJ Global Health*, 10.3 (2025), doi:10.1136/bmjgh-2024-017321.
[454] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.
[455] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.
[456] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.

coalitions. Key triggers include agenda-setting moments (e.g., crises, political elections, or global summits) which help shift normative expectations and reframe what constitutes legitimate action. This stage mirrors important moments for change that other health policy scholars agree provide strategic value (e.g., "windows of opportunity" described by Kingdon[457]), and provides a particularly apt focus for empirical Chapters 7 and 8 given their emphasis on GHS and UHC normative development in the wake of the COVID-19 pandemic.

The third stage, *norm internalization*, is reached when the norm becomes widely socialized and accepted, institutionalized in policies and legal frameworks, and largely 'taken for granted' as a routine practice (e.g., women's suffrage, anti-slavery, etc.).[458] At this point, contestation diminishes significantly, and compliance becomes routine. Internalized norms often manifest through regulatory mechanisms, global bureaucracies, professional standards, and influential diplomatic norms – which in turn can shape the behavior of actors even in the absence of direct enforcement. However, as Bailey notes, not all norms reach this stage, and some stagnate or even reverse due to shifts in power or competing normative claims.[459] Still, Smith and Rodriguez contend that "institutionalization in international organizations and rules increases the likelihood that norms will progress through the full cycle."[460]

The norm life cycle offers a useful starting point to trace the evolution of norms, as the heuristic enables researchers to relatively neatly unpack distinct stages of normative development, and has been used to examine important shifts in international cooperation. However, while it offers valuable insight into the progression of individual norms, it is less equipped to explain what happens when multiple, already-institutionalized norms come into contact or begin to converge. Furthermore, this model largely assumes a relatively linear and singular trajectory, with limited attention to how intersecting or competing norms interact, especially across broader normative regimes. This poses a challenge for meaningfully analysing complex domains such as GHD, where normative landscapes are increasingly defined by overlapping agendas and cross-sectoral mandates. This gap is especially relevant for this thesis, which examines the intersection of two distinct global health agendas, GHS and UHC, and the normative logics that underpin them. Although both have progressed through various stages of normative development, their interaction presents a more complicated picture than the norm life cycle alone can fully capture. This means that while the norm life cycle may help explain the trajectories of GHS and UHC individually, it offers limited insight into how two distinct norms interact or integrate. These limitations underscore the need for a conceptual framework that can address not only norm emergence or diffusion, but also the integration of distinct normative regimes – which is taken up in Chapter 4.

[457] Richard Hoefer, 'The Multiple Streams Framework: Understanding and Applying the Problems, Policies, and Politics Approach', *Journal of Policy Practice and Research*, 3.1 (2022), pp. 1–5, doi:10.1007/s42972-022-00049-2.
[458] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.
[459] Bailey, 'Arrested Development'.
[460] Smith and Rodriguez, 'Agenda Setting for Maternal Survival'.

3.1.4 Advances in constructivist norm theory

Reconceptualizing norms 'as processes'

Building on the foundational framework of the norm life cycle described above, recent scholarship has turned toward more dynamic conceptualizations of norm development – emphasizing contestation, reinterpretation, and institutional complexity. These advancements in norm theory are essential for understanding the evolving and overlapping nature of GHS and UHC through diplomatic processes.

Recent scholars have critiqued the norm life cycle model for what they argue amounts to a relatively simplistic depiction of norms as "fixed concepts."[461] A key contribution to this evolving literature is the work of Krook and True, who challenge the notion of norms as static, discrete entities. They instead propose a view that approaches "norms as processes, as works-in-progress, rather than as finished products."[462] They emphasize that the meanings of norms are continuously reconstituted, even as they shape – and are further reshaped by – patterns of social behavior. As Krook and True continue, "attending to the fluid and somewhat evasive nature of norms [...] offers greater analytical leverage for explaining why norms emerge and appear to diffuse rapidly, at the same time that they rarely achieve their intended aims[463]

These insights extend beyond earlier linear models by focusing on how norms are embedded and institutionalized in real-world governance, and then invariably contested among other norms. Rather than assuming a straightforward trajectory, constructivist scholars now highlight that the "trajectories of norms are often fraught with contestation and reversals as state and non-state actors compete to identify, define and implement these norms" – even after they pass through the norm life cycle.[464] In their view, norms are constantly constructed and (re)constructed through repeated interactions and negotiations among states, international organizations, advocacy networks, and expert communities – each with their own varying set of interests, resources, and interpretive frameworks.

Meta-norms and supernorms

[461] Krook and True, 'Rethinking the Life Cycles of International Norms'; R. Charli Carpenter, 'Studying Issue (Non)-Adoption in Transnational Advocacy Networks', *International Organization*, 61.3 (2007), pp. 643–67, doi:10.1017/S002081830707021X; Kees Van Kersbergen and Bertjan Verbeek, 'The Politics of International Norms: Subsidiarity and the Imperfect Competence Regime of the European Union', *European Journal of International Relations*, 13.2 (2007), pp. 217–38, doi:10.1177/1354066107076955.
[462] Krook and True, 'Rethinking the Life Cycles of International Norms'.
[463] Krook and True, 'Rethinking the Life Cycles of International Norms'.
[464] Krook and True, 'Rethinking the Life Cycles of International Norms'.

Scholars such as Granmo and Fourie have drawn attention to a further dimension of norm development highly relevant to this thesis: the role of meta-norms, which serve as foundational and prerequisite paradigms for subsequent emerging norms.[465] As Granmo observes:

> *"Meta-norms are, in essence, normative paradigms that are based on one core imperative, such as the inherent equality of all human beings. They can be viewed as a branch of an ideological tree on which leaves (norms) of different sizes and significance can grow. The important point is that the existence (and general internalisation of) the meta-norm is necessary for its associated norms to follow. Meta-norms are characterised by generality; they make explicit and implicit sweeping statements from which other – more specific – norms are borne, can latch onto, and evolve from".*[466]

This framing holds that meta-norms provide the conceptual architecture for broader regime development. Such meta-norms anchor subsequent norms but do not dictate their form, leaving room for divergence and contestation. These dynamics are central to the empirical focus of this thesis, which traces how GHS and UHC evolved not as isolated norms on their own, but as shifting constellations of ideas and institutions rooted in well-established meta-norms like security and human rights.

On the opposite end, Fukuda-Parr and Hulme introduce the concept of supernorms, which they define as "a cluster of inter related norms grouped into a unified and coherent framework."[467] They further note that supernorms can be seen to capture "complex, multiple goal norms [...] carefully structured sets of interrelated norms that pursue a grand prescriptive."[468] In this view, GHS and UHC may be considered to represent supernorms (consisting of clusters of more specific norms, such as surveillance and outbreak preparedness, or health insurance schemes and accessible health products, respectively).

Regime complexity

Such dynamism inherent in norm evolution helps better account for regime complexity – an array of multiple partially overlapping governance structures (each with respective institutions, agreements, and norm clusters).[469] As Wenham notes:

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[465] Sakiko Fukuda-Parr and David Hulme, 'International Norm Dynamics and the "End of Poverty": Understanding the Millennium Development Goals', *Global Governance*, 17.1 (2011), pp. 17–36.
[466] Granmo, 'Health Norms in the Global Governance of Development : A Constructivist Analysis'.
[467] Fukuda-Parr and Hulme, 'International Norm Dynamics and the "End of Poverty"'.
[468] Fukuda-Parr and Hulme, 'International Norm Dynamics and the "End of Poverty"'.
[469] Alter and Raustiala, 'The Rise of International Regime Complexity'; Wenham, Clare, 'Forum Shifting in Global Health Security'; Lantis and Wunderlich, 'Resiliency Dynamics of Norm Clusters'.

> *"...on the one hand, a regime complex can foster the sharing of knowledge, resources and best practices across different sectors. On the other hand, the complexity and overlapping nature of regimes can lead to fragmentation, duplication and coordination challenges."*[470]

These interactions do not merely complicate institutional design; they actively influence which norms are elevated, which are sidelined, and how ideas evolve over time.[471] In global health, these processes are especially salient. Both GHS and UHC may be described as featuring overarching normative regimes, composed of smaller norm clusters – such as the International Health Regulations (IHR) or Sustainable Development Goal (SDG) 3.8, respectively – that are themselves subject to reinterpretation, hybridization, and competing claims.

Applying advancements in norm theory to thesis

Taken together, these concepts help illuminate how norm development unfolds within highly contested, complex, and overlapping normative environments through multiple 'norm life cycle' processes: meta-norms – often rooted in earlier, distinct normative traditions – can provide foundational principles and behaviors that guide the emergence of new norms. These, in turn, may coalesce into clusters of increasingly aligned norms, which over time can solidify into broader supernorms with well-established normative regimes. This progression is crucial for understanding the layered and iterative processes that shape norm evolution – an analytical challenge that the following chapters address by tracing the complex pathways toward a hybrid norm linking GHS and UHC.

These insights challenge traditional, more linear models of norm evolution and offer a fresh starting point for theorizing how multiple norms can interact, reinforce, or resist each other in fragmented global governance settings. Reconceptualizing norms as processes, as Krook and True posit, enables a deeper understanding of how norms progress over iterative stages of the norm life cycle, and what windows exist for integration that may not have been previously possible. This also provides essential theoretical grounding to understand the hybrid norm framework, and how hybridization and regime interaction play important roles in GHS-UHC advancement.

3.1.5 Applying norms theory to GHS and UHC

This section has traced the theoretical foundations of constructivism in international relations, outlining its focus on the social development of ideas, interests, and identities – and its particular relevance to global health diplomacy. It has introduced key concepts such as norms and framing, and examined the evolution of norm theory through established models like the norm life cycle and recent advancements in analysing normative development. Together, these approaches offer

[470] Wenham, Clare, 'Forum Shifting in Global Health Security'.
[471] Janne Mende, 'Norm Convergence and Collision in Regime Overlaps. Business and Human Rights in the UN and the EU', *Globalizations*, 19.5 (2022), pp. 725–40, doi:10.1080/14747731.2021.1983342.

conceptual tools for subsequently analyzing how health-related norms like GHS and UHC emerge, evolve, and become embedded across the global health architecture.

By applying the constructivist norm theories presented above, the trajectory of GHS and UHC can now be better articulated (a process that is analysed in detail in the empirical and discussion chapters): As articulated by scholars like Meier, Gostin, and Ooms, human rights frameworks (understood here as a meta-norm) have anchored the right to health as a foundational norm for UHC, promoting principles such as health equity and reinforcing ideas like universal access to care.[472] These interconnected norms and their associated frames have gradually clustered to form a broader UHC supernorm and an associated normative regime, which is a central focus of this thesis. Similarly, as discussed by Scholars like Fidler, Davies, Rushton, and Vieira, the meta-norm of securitization has driven the development of GHS norms by framing infectious disease threats as matters of international security.[473] This has created norm clusters around obligations like outbreak surveillance, disease containment, and emergency response capacities to comprise a broader GHS supernorm and its own normative regime. Applying the wide range of norm typologies explored here, this framing provides a richer foundation for analyzing what GHS and UHC may be seen to encompass, how these norms (and their associated regimes) have developed, and how intersect in the chapters that follow.

Therefore, while the thesis largely refers to GHS and UHC as 'norms,' they should be seen to encompass their wider architectures comprised of related norm clusters and associated regimes, emphasizing a 'degree of continuity' among these concepts on the basis that these norms are dynamic and contested processes, even as they become embedded through institutional practices in across global health and foreign policy.[474] This presents a complexity that is not just unavoidable, but necessary to fully appreciate the nuanced arguments made in this thesis, and to understand the hybrid norms framework proposed in Chapter 4.

Despite advances in constructivist norm theory, major blindspots remain – particularly in explaining how ideologically distinct norms interact when they are already institutionally entrenched and embedded in separate (sometimes overlapping) governance regimes. The norm life cycle model has offered valuable insights into how individual norms gain traction, but it is less well equipped to explain what happens when two or more established norm regimes interact, overlap, or converge. Such encounters are not simply additive or sequential; they require complex negotiation, adaptation, translation, and socialization across diverse actors and institutional settings. Existing theories thus fall short in providing conceptual tools to analyze these dynamic processes – especially when

[472] Meier and Gostin, 'Human Rights for Health across the United Nations'; Ooms and others, 'Universal Health Coverage Anchored in the Right to Health'.
[473] Fidler, 'From International Sanitary Conventions to Global Health Security'; Davies, *Disease Diplomacy*; Rushton, 'Global Health Security: Security for Whom? Security from What?'; Marco Antonio Vieira, 'The Securitization of the HIV/AIDS Epidemic as a Norm: A Contribution to Constructivist Scholarship on the Emergence and Diffusion of International Norms', *Brazilian Political Science Review (Online)*, 2.se (2007), pp. 0–0.
[474] Krook and True, 'Rethinking the Life Cycles of International Norms'.

integration is driven not by consensus but by crisis or even political expediency. Addressing these theoretical gaps requires both refining constructivist approaches as well as drawing on adjacent scholarship that examine how institutions, ideas, and actors coordinate (or fail to coordinate) across fragmented systems. The next section addresses this gap by examining supplementary perspectives from political and social sciences that can help build a more complete account of normative integration.

3.2 Complementary approaches from political science

Global health is neither apolitical nor divorced from the institutional and historical forces that govern policy change. While IR theories provide the foundation for this thesis by elucidating the role of strategic interests and diplomacy in shaping global health norms, concepts from political science and public policy offer critical insights into the persistence of fragmented agendas, the mechanisms through which policy ideas spread, and the barriers to integration that often appear in deeply entrenched institutional frameworks. Indeed, as Shearer et al. attest, the complexity of studying global health policy in diverse contexts "calls for greater integration of multiple policy theories for a given case of policy change."[475] Many of the theories presented in this section therefore similarly draw on constructivist approaches, but shift the focus to other structural factors that shape international norms, including in global health. Examining GHS and UHC through these lenses reveals not only the institutional logics that influence governance, but also the path-dependent processes that may 'lock in' certain ways of working – even when they prove ineffective in practice.

3.2.1 Key concepts in political science

Within the broad field of politics and public policy scholarship, two key approaches are particularly relevant for this thesis: policy transfer and institutionalism, both of which offer important insights on why GHS and UHC remain fragmented, and the challenges facing their integration.

Policy transfer, defined by Dolowitz and Marsh, occurs when "knowledge about policies, administrative arrangements, institutions and ideas in one political setting (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting."[476] Applied to this thesis, a focus on policy transfer processes can illustrate the ways in which key normative features (e.g., "policy goals, policy content, policy instruments, policy programs, institutions, ideologies, ideas and attitudes and negative lessons"[477]) from the GHS regime might be transferred to the UHC regime (or vice-versa) in varying degrees (copying - direct and complete transfer; emulation - transfer of the ideas behind the policy or program; combinations - mixtures of several different policies; and inspiration - policy in one jurisdiction inspires change in

[475] Shearer and others, 'Why Do Policies Change?'
[476] David P. Dolowitz and David Marsh, 'Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making', *Governance*, 13.1 (2000), pp. 5–23, doi:10.1111/0952-1895.00121.
[477] Dolowitz and Marsh, 'Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making'.

another without actually drawing upon the original[478]). For instance, the IHR (2005) may demonstrate policy transfer (via emulation/inspiration processes) of key dimensions like emergency preparedness or cross-border threats into UHC-related legislation. March and Sharman further note that "hybridized combinations of outside and local knowledge much more common" that "complete 'cut and paste' transfers,"[479] – a reflection that affirms this thesis's view that norm integration between GHS and UHC is likely to occur in varying degrees in different contexts[480].

Institutionalism (building on 'institutions' first introduced as part of the 3Is in Section 2.3) shifts the focus to how formal and informal rules, bureaucratic behaviors, and normative structures influence and entrench certain pathways of global policymaking. Hall and Taylor unpack three major schools of thought within this space[481]: Historical institutionalism clarifies why early interventions entrench behaviors and created barriers to subsequent change. Rational choice institutionalism highlights strategic interactions among stakeholders navigating competing interests within existing frameworks. Sociological institutionalism foregrounds how norms and legitimacy shape preferences, explaining why particular narratives gain prominence; a related concept of discursive institutionalism differentiates slightly by emphasizing the agency of actors in actively incorporating and adapting global ideas discourse, while the former tends to view actors as largely shaped by "the scripts of a rationalist world culture."[482] All three overarching theories of institutionalism are pertinent to this thesis, shedding light on different aspects for why fragmentation or integration between GHS and UHC may occur. For example, both agendas are deeply-rooted in different normative histories (e.g., infectious disease control programmes versus human rights agreements); they may be jointly pursued as a way to optimize finite health resources; divergences between securitization or right-to-health approaches challenge whose ideas are prioritized and appropriate pathways for implementation.

Extending our understanding of institutionalism, Pierson argues that initial policy choices increase the cost of shifting toward alternatives, leading to "lock-in effects."[483] This creates path dependency, which "describes how past decisions and institutional legacies establish self-reinforcing mechanisms that limit future policy options."[484] These patterns are especially visible in global health, where vertical programs have entrenched disease-specific models, reinforcing narrow mandates. Despite

[478] Dolowitz and Marsh, 'Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making'.
[479] David Marsh and J. C. Sharman, 'Policy Diffusion and Policy Transfer', *Policy Studies*, 30.3 (2009), pp. 269–88, doi:10.1080/01442870902863851.
[480] Garrett Wallace Brown, 'Norm Diffusion and Health System Strengthening: The Persistent Relevance of National Leadership in Global Health Governance', *Review of International Studies*, 40.5 (2014), pp. 877–96, doi:10.1017/S0260210514000333.
[481] Hall and Taylor, 'Political Science and the Three New Institutionalisms'.
[482] Ninni Wahlström and Daniel and Sundberg, 'Discursive Institutionalism: Towards a Framework for Analysing the Relation between Policy and Curriculum', *Journal of Education Policy*, 33.1 (2018), pp. 163–83, doi:10.1080/02680939.2017.1344879; 'The Discursive Side of New Institutionalism - Pertti Alasuutari, 2015' <https://journals.sagepub.com/doi/abs/10.1177/1749975514561805> [accessed 30 May 2025].
[483] Pierson, 'Increasing Returns, Path Dependence, and the Study of Politics'.
[484] Wiyeh and others, 'A Critical Juncture in Global Health'.

recent efforts to prioritize horizontal, cross-cutting investments, path dependency explains why many researchers and advocates remain skeptical of meaningful change.[485] Candel and Biesbroek therefore note that "preexisting elements, such as dominant subsystems or policy instruments, are often remarkably resilient [...] they often remain in place because they serve vested interests."[486] Of note, UHC may be somewhat less vulnerable to this problem relative to GHS, as it is already built on principles of adaptive implementation and 'progressive realization'; still. UHC still faces internal fragmentation in delivery, financing, and governance structures that call for deeper inquiry.

3.2.2 Applying political science to integration

Building on the previous theoretical concepts of policy transfer and institutionalism, policy integration – which Underdal describes as a process in which "the constituent elements are brought together and made subject to a single, unifying conception"[487] – focuses on how stakeholders seek to align overlapping agendas. Unlike constructivism, which emphasizes normative meaning, this work further highlights the governance mechanics and organizational tensions involved in integration. Similar to Krook and True's conceptualization of 'norms as processes,' Candel and Biesbroek assert that policy integration "should be understood as a process that entails various elements that do not necessarily move in a concerted manner but may develop at different paces or even in opposite directions."[488] They detail several important reflections on policy integration that are particularly relevant to the empirical chapters in this thesis on GHS-UHC integration:

> *'It is easier to change policy instruments than to change policy paradigms or core belief systems (Hall 1993; Pierson 1993) [...] governments or organizations may lack the political will or resources to proceed beyond discursive or symbolic action (Jacob et al. 2008; Jordan and Lenschow 2010) [...]integration strategies that are '…merely cosmetic or introduced in order to diffuse attention and resist change should be distinguished from genuine policy' [...] for new cross-cutting policy issues, such as climate change, governments are often risk averse and use blame avoidance tactics, including reverting to discursive forms of integration, thereby seriously hampering policy success. In addition to willingness, both administrations and individual policy officers may lack the capacity and skills to work in an integrative manner, for example to facilitate linkages with new subsystems or to pursue overarching goals (Bardach 1998; Hoppe 2010; Jordan and Schout 2006). In sum, asynchrony between different dimensions of policy integration is the rule, rather than the exemption when we consider policy integration as a process.'*[489]

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[485] Neil Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health', *Globalization and Health*, 16.1 (2020), pp. 1–13, doi:10.1186/S12992-020-00592-1/FIGURES/1.

[486] Jeroen J. L. Candel and Robbert Biesbroek, 'Toward a Processual Understanding of Policy Integration', *Policy Sciences*, 49.3 (2016), pp. 211–31, doi:10.1007/s11077-016-9248-y; 'A Theory of Gradual Institutional Change', in *Explaining Institutional Change: Ambiguity, Agency, and Power*, ed. by James Mahoney and Kathleen Thelen (Cambridge University Press, 2009), pp. 1–37, doi:10.1017/CBO9780511806414.003.

[487] Arild Underdal, 'Integrated Marine Policy: What? Why? How?', *Marine Policy*, 4.3 (1980), pp. 159–69, doi:10.1016/0308-597X(80)90051-2.

[488] Candel and Biesbroek, 'Toward a Processual Understanding of Policy Integration'.

[489] Candel and Biesbroek, 'Toward a Processual Understanding of Policy Integration'.

Given that efforts to integrate entrenched agendas like GHS and UHC must contend with structural legacies, power asymmetries, and coordination challenges that span multiple levels of governance (e.g., macro-, meso-, and mirco-levels, as discussed by Kentikelenis and Rochford[490]), understanding top-down and bottom-up approaches helps account for this. As Sabatier's multi-level policymaking framework[491] argues, the interaction between local, national, and international actors is shaped not just by technical capacity but by belief systems and political alignments. For example, GHS, driven by mandates around surveillance and emergency response, is typically promoted through hierarchical, top-down institutions. In contrast, UHC, which emphasizes equity and context-specific responsiveness, is often pursued through grassroots advocacy and decentralized policymaking. As a result, the two normative regimes rely on different forms of authority and accountability, making coordination structurally and politically difficult. This can produce friction even when overarching goals appear aligned. For instance, a government may endorse UHC in principle but remain locked into vertical surveillance programs tied to GHS funding, leading to policy incoherence at the point of service delivery.

Finally, this thesis contends that Kingdon's multiple streams framework offers a helpful lens for understanding when and how policy integration becomes possible – particularly in the global health architecture. Kingdon explains that change occurs when problems, policies, and politics align to create a "window of opportunity," highlighting that political feasibility and institutional readiness are essential – thus providing the thesis with key analytical features to identify in the empirical chapters. Notably, Kingdon's emphasis on the significance of policy windows required for change echoes the related concept of critical junctures, which Sorenson describes as "relatively brief periods in which previously relatively stable institutions are transformed and new approaches established."[492] As Chapter 2 has established, GHS and UHC alignment has often been catalyzed in the wake of pandemics and other health emergencies, and the 2015 period in particular offered a critical juncture that opened normative space for rethinking governance in more integrated ways. Examining GHS and UHC convergence therefore requires focusing on how critical junctures have created opportunities for normative integration – or whether these efforts have faded as path dependencies and competing interests reassert themselves without sustained alignment and institutional support. Ultimately, as Wiyeh et al. emphasize, while critical junctures can have a "a profound and lasting impact on institutional trajectories," institutional change is not limited to these windows of opportunity, but "can also unfold gradually over time through adaptive evolution" – suggesting various ways that GHS-UHC alignment may be catalyzed.[493]

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[490] Kentikelenis and Rochford, 'Power Asymmetries in Global Governance for Health'.
[491] Paul A. Sabatier, 'Top-Down and Bottom-Up Approaches to Implementation Research: A Critical Analysis and Suggested Synthesis', *Journal of Public Policy*, 6.1 (1986), pp. 21–48, doi:10.1017/S0143814X00003846.
[492] Andre Sorensen, 'Taking Critical Junctures Seriously: Theory and Method for Causal Analysis of Rapid Institutional Change', *Planning Perspectives* 2023, 2023 <https://www.tandfonline.com/doi/abs/10.1080/02665433.2022.2137840>.
[493] Wiyeh and others, 'A Critical Juncture in Global Health'.

Together, these dynamics highlight that integration – whether between policies or normative regimes – is a process requiring careful attention to institutional legacies as well as operational constraints. Furthermore, overcoming path dependencies involves navigating competing incentives and embedded routines that resist change, as well as consideration of political contexts and critical junctures that may catalyze progress in ways previously not possible. Understanding these concepts is essential to explaining how and why GHS and UHC might remain separate – and what kind of political and institutional innovations are required to more meaningfully align them.

3.2.3 Summarizing theoretical gaps: integrating across entrenched normative and policy domains

This chapter has reviewed the core theoretical literatures relevant to this thesis. Constructivist international relations theory provides valuable insights into how norms are constructed, contested, and institutionalized. Yet it remains limited in its ability to explain what happens when two well-established norms – a such as global health security and universal health coverage – must interact, overlap, or be brought into alignment. Political and social science literature, particularly on policy transfer, institutionalism, and policy integration, offers a complementary perspective, shedding additional light on the structural and historical barriers to integration as well as windows of opportunity that accelerate alignment. However, it engages less with the normative dimensions of global agendas and how these cycle through diplomatic mechanisms.

Bringing these insights together reveals a critical gap: existing theories fall short when it comes to accounting for how distinct, partially-overlapping norms evolve into more coherent and integrated regimes. As this thesis argues, the alignment of GHS and UHC is not just a technical or rhetorical exercise, but a complex political and normative process – one that unfolds through framing, negotiation, and institutional adaptation. The next chapter introduces the hybrid norms framework as a response to this challenge, offering a new conceptual tool to better understand how integration might occur in a fragmented global health architecture.

Chapter 4: Conceptual framework - Hybrid norms and the politics of integration

This chapter presents the conceptual framework that anchors the thesis: the hybrid norms model. It builds on Chapter 3's theoretical foundations to explain how entrenched global norms – such as GHS and UHC – can be strategically aligned through three stages: construction, convergence, and coherence. Existing frameworks trace norm evolution individually, but few account for sustained interaction between multiple co-evolving normative regimes. What is missing is a theory of normative integration – an account of how distinct norms influence one another and become mutually reinforcing. This chapter addresses that gap by offering a structured approach to analyze how framing, negotiation, and institutionalization drive synergies without collapsing normative diversity – providing a better understanding of the politics of integration. In doing so, it sets the stage for the empirical chapters that follow, providing a clear lens to assess how global health actors navigate alignment across a fragmented architecture.

4.1 Conceptualizing 'hybrid norms'

To capture the evolving integration between GHS and UHC, this thesis introduces the concept of 'hybrid norms' – norms that draw from multiple parent regimes, reconcile competing principles, and serve as adaptive tools of diplomacy and governance. This approach builds on Meier et al.'s view that:

> *"Accounting for the diverse means through which norms are developed, socialized, enforced, and implemented among state and non-state actors, many contemporary legal scholars have abandoned the binary distinction between hard and soft law [...both] — together — are necessary to prevent disease and promote health, raising a research imperative to analyze how these normative frameworks interact in global health."*[494]

Current relevant theories on integration or hybridity, rooted in the constructivist literature detailed in Chapter 3, struggle provide a clear process of normative integration. For example, Candel and Biesbroek's description of integration as a process where different constituent elements are united into an altogether new formation implies a merging of previously-explicit elements into a sort of 'melting pot.'[495] This approach inadequately captures scenarios where integration between different regimes can (and often must) involve preserving distinct normative identities, principles, discourses, and core functions – while promoting mutual reinforcement rather than displacement (as appears to be the case with GHS and UHC). Meanwhile, current conceptualizations of hybridity similarly fail to fully account for normative integration in the context of this thesis; Heyvaert's notion of hybrid norms focuses primarily on merging hard and soft legal commitments to balance binding obligations

[494] Benjamin Mason Meier, Alexandra Finch, and Roojin Habibi, 'Global Health Law: Between Hard and Soft Law', *Journal of Law, Medicine & Ethics*, 2025, pp. 1–5, doi:10.1017/jme.2025.21.
[495] Candel and Biesbroek, 'Toward a Processual Understanding of Policy Integration'.

with flexible cooperation mechanisms[496], while Ginty and Richmond's analysis of hybridity as contextually negotiated political arrangements between international and local actors is more appropriate for examining global-local hybrid orders[497].

Hybrid norms differ from these traditional concepts in important ways, responding to important gaps in scholarship discussed above and in Chapter 3. While current integration theories imply the collapse of multiple logics into a new, unified construct, hybrid norms retain distinguishable features from each contributing regime, allowing for coexistence rather than replacement. Additionally, although prevailing norm theories and institutionalism models are best equipped to study the evolution of singular elements, hybrid norms can be used to describe the integration of two or more norms as well as their broader, overlapping normative regimes. Unlike hybridity (which often implies structural integration across institutions) or policy transfer (which may focus more on operationalization and technocratic processes), hybrid norms equally function at the ideational and strategic level. They serve as connective tissue between discourses and core functions that remain partially autonomous, enabling coordination without requiring complete unification.

This thesis holds that just like norms, hybrid norms can be both socially structured as well as structur*ing*.[498] In this way hybrid norms can be views as both outcomes of as well as pragmatic tools for alignment, emerging not from theoretical coherence but from the pressures and necessities of fragmented governance and implementation. As in the case of GHS and UHC, they often arise during moments of political uncertainty or institutional flux, when actors must bridge historically distinct agendas to address complex global challenges. As such, hybrid norms reflect an ongoing negotiation of meaning, priorities, and institutional design – anchored in existing architectures but reaching toward new strategic configurations.

4.2 Adapting existing frameworks

As Chapter 3 has noted, prevailing constructivist frameworks for understanding normative evolution, while foundational, each exhibit critical limitations, particularly when analyzing complex interactions between multiple established norms such as GHS and UHC. For example, Finnemore and Sikkink's structured norm life cycle model excels at tracing the progression of largely singular norms, but inadequately addresses situations where two distinct norms simultaneously evolve within overlapping governance spaces. Its linear perspective overlooks the dynamic interplay and mutual influences that co-evolving normative agendas exert upon each other – a central issue explored in this thesis. Complementing this model, Fidler's framework on mapping GHD highlights diplomatic processes where "actors refine and amplify" interests into collective action, but pays less attention to

[496] Veerle Heyvaert, 'Hybrid Norms in International Law' (Social Science Research Network, 13 February 2009), doi:10.2139/ssrn.1342366.
[497] Roger Mac Ginty and Oliver Richmond, 'The Fallacy of Constructing Hybrid Political Orders: A Reappraisal of the Hybrid Turn in Peacebuilding', *International Peacekeeping* 2016, 2016 <https://www.tandfonline.com/doi/abs/10.1080/13533312.2015.1099440>.
[498] Krook and True, 'Rethinking the Life Cycles of International Norms'.

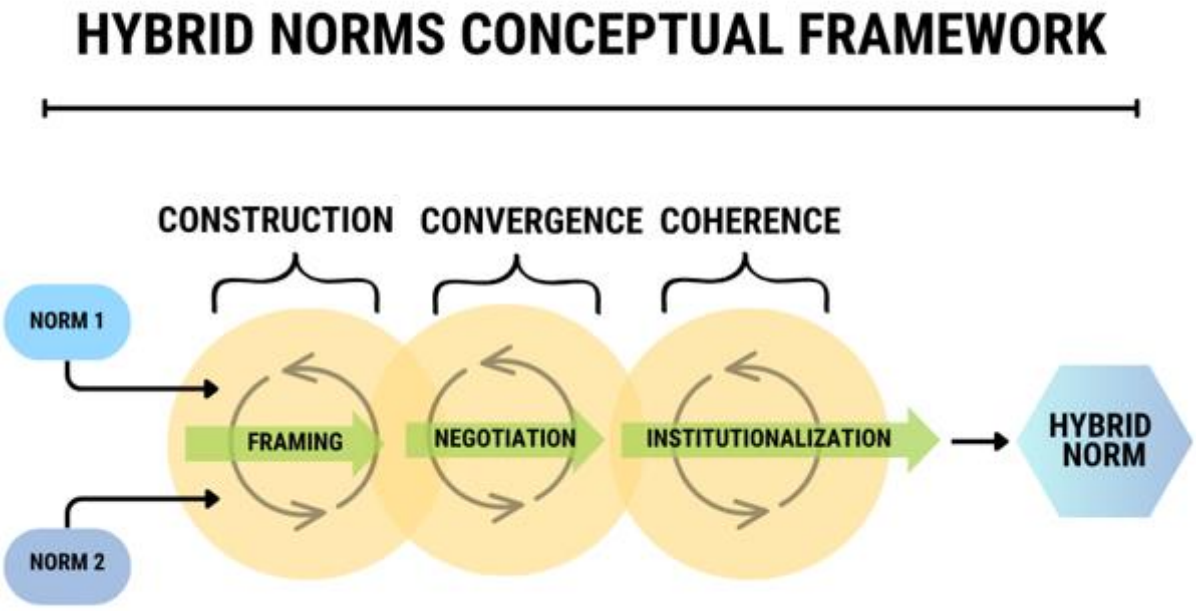
the normative dimensions underpinning these interactions, particularly how ideas mitigate contestation and balance divergent approaches. Finally, although Krook and True's reconceptualization of norms as continually evolving 'processes' enables greater nuance and flexibility in tracing normative development, their approach lacks the analytical precision necessary to adequately evaluate repeated contestation and interaction between two simultaneously evolving normative regimes.

Current scholarship on normative integration therefore remains limited, and fails to provide a clear conceptual model to analyze the hybridization of two established norms (like GHS and UHC) – each supported by deeply institutionalized regimes – in a way that doesn't subsume, obfuscate, or overpower the other. In order to address this gap, this thesis proposes a novel framework that combines the structured progression described by Finnemore and Sikkink, the diplomatic complexity articulated by Fidler, and the normative fluidity conceptualized by Krook and True in order to examine the integration of evolving GHS and UHC norms. This refined analytical lens, proposed in the following sections, thus contributes substantially to understanding the dynamics of normative integration through GHD processes across the global health architecture in an innovative way.

4.3 Hybrid Norms Model and processes of normative integration

The hybrid norms framework proposed here (Figure 3) is structured along a three-stage model – construction, convergence, and coherence – that can be empirically tested and analytically extended for other contexts.

Figure 3: Hybrid Norms Conceptual Framework. *(Author's own).*



Construction: framing evolving normative regimes

The first stage of 'norm construction' refers to the phase in which distinct norms and their associated normative regimes – each with their own set of principles, approaches, policy priorities, and institutional backers – are initially framed and subsequently (re)framed as they increasingly come into contact with each other. This may be due to deliberate interactions or indirect contestation due to overlapping actors and contexts. This first stage aligns closely with the 'emergence' phase in the norm life cycle and the agenda-framing and problem identification/interest amplification phase in the GHD model. It sets the ideological scaffolding and power terrain upon which future normative integration must unfold.

Drawing from constructivist insights, norm entrepreneurs – including states, international organizations, or epistemic communities – are central to this process, strategically framing policy issues to advance particular normative solutions.[499] Shiffman and colleagues highlight the importance of these agents' ability to leverage transnational advocacy networks[500], shaping discourse and mobilizing support to solidify cross-cutting normative positions within their increasingly overlapping spaces. Of note, given that norms are often institutionalized through global governance

[499] Payne, 'Persuasion, Frames and Norm Construction'; Benford and Snow, 'Framing Processes and Social Movements'.
[500] Jeremy Shiffman and others, 'A Framework on the Emergence and Effectiveness of Global Health Networks', *Health Policy and Planning*, 31.suppl_1 (2016), pp. i3–16, doi:10.1093/heapol/czu046.

mechanisms[501], states and multilateral organizations play a key role at this stage through processes of GHD, though the framing processes can be significantly influenced by a variety of engaged actors.

Importantly, this phase involves significant interaction and contestation (both within and between) the two normative regimes, as stakeholders may compete to define core principles, obligations, and strategic objectives that (re)structure the emerging normative landscape and the scope of expected behaviors. Such contestation is especially apparent in global health, where framing health as either a security imperative (demanding rapid, targeted responses) or as a universal right (requiring comprehensive health systems investments) profoundly influences the approaches and core functions subsequently established[502], as the empirical review in Chapter 6 extensively details. Understanding this stage is thus crucial, as it clarifies how initial discursive battles and strategic alignments set the foundation for subsequent attempts at convergence and coherence between the distinct normative regimes.

Convergence: negotiating shared discourse and functions

The second stage of 'norm convergence' captures the dynamic processes through which previously distinct normative regimes begin to be intentionally united into a shared normative framework, driven by common global challenges, diplomatic negotiations, and mutual recognition of interdependencies. This stage corresponds to the 'tipping point/cascade' phase of the norm life cycle and the contestation/refinement phase of the GHD model. It is analytically significant for identifying how partial alignment and discursive overlap can produce new normative possibilities without full institutional reform.

Convergence is often catalyzed by critical junctures (i.e., events or crises that highlight the interdependence of the two norms) which provide windows of opportunity for normative alignment.[503] These moments provide a 'tipping point' that Finnemore and Sikkink argue is crucial to norm progression. Following this, convergence arises through what Bennett describes as "interaction and consensus amongst an elite," facilitated by "intergovernmental and supranational institutions," around "sets of implicit or explicit principles, norms, rules, and decision-making procedures. "[504] Additionally, Acharya's concept of "norm localization" adds another layer at this stage, emphasizing how global norms are not passively adopted but require active adaption within local contexts through negotiation, dialogue, and strategic reconciliation between global and local imperatives.[505] This adaptation is particularly crucial in GHD, where international negotiations seek

[501] Antje Wiener, 'Contested Compliance: Interventions on the Normative Structure of World Politics', *European Journal of International Relations*, 10.2 (2004), pp. 189–234, doi:10.1177/1354066104042934.
[502] Shiffman and Shawar, 'Framing and the Formation of Global Health Priorities'.
[503] Sorensen, 'Taking Critical Junctures Seriously'.
[504] Colin J. Bennett, 'What Is Policy Convergence and What Causes It?', *British Journal of Political Science*, 21.2 (1991), pp. 215–33.
[505] Amitav Acharya, 'How Ideas Spread: Whose Norms Matter? Norm Localization and Institutional Change in Asian Regionalism', *International Organization*, 58.2 (2004), pp. 239–75, doi:10.1017/S0020818304582024.

to balance global commitments with domestic priorities and local health system realities – a particular challenge for reconciling established normative regimes like GHS and UHC that feature inherently diverging operational logics.

Diplomatic venues thus become critical spaces for convergence, providing structured opportunities to negotiate shared discourse, establish common principles, and align core policy functions. This stage is particularly relevant to analysing the convergence of divergent norm clusters within high-level negotiations, as the empirical case studies in Chapter 7 demonstrates. Nevertheless, convergence inherently involves complex political and operational trade-offs, often requiring stakeholders to confront entrenched institutional path dependencies, funding models, and bureaucratic interests that historically reinforced normative separation. Recognizing these challenges, the convergence stage thus does not imply complete alignment or harmonization, but rather denotes a reframing of previously distinct agendas with careful intertwining of discourse and core functions in a way that enhances normative complementarity and interdependence without negating context-specific needs.

Coherence: institutionalizing a 'hybrid' norm

The third and final stage, norm coherence, refers to the institutional embedding of two previously distinct norms and associated normative regimes into a unified architecture, thus establishing lasting integration. This stage aligns with the 'internalization' phase of the norm life cycle and the collective action phase of the GHD model. The end of this phase represents the socialization of normative integration and the clearest expression of a new hybrid norm emerging.

Drawing on institutionalist perspectives, particularly those of Hall and Taylor, coherence emphasizes the critical role of institutional legacies, shared legitimacy, and collective values in anchoring new normative configurations within existing structures.[506] Practitioners largely agree that coherence implies "the systematic promotion of mutually reinforcing policy actions"[507] that transcend surface-level alignment to meaningfully embed strategic compatibility across institutions, governments, donors, and civil society. Achieving true coherence for GHS and UHC thus necessitates structural reforms and shared obligations which are diffused across international and domestic levels – including integrated governance mechanisms and funding streams – that permanently institutionalize hybrid norms, ensuring their resilience against geopolitical tensions and resource scarcity.

Similar to previous stages, coherence does not imply the erasure of specific normative features from either parent regime; rather, it strategically merges discourses and principles as well as core functions and obligations into an enduring model that is well equipped to foster better coordination across

[506] Hall and Taylor, 'Political Science and the Three New Institutionalisms'.
[507] OECD, 'Driving Policy Coherence for Sustainable Development', *OECD*, 19 July 2023 <https://www.oecd.org/en/publications/driving-policy-coherence-for-sustainable-development_a6cb4aa1-en.html>.

global institutions and cooperation across governments. This stage is perhaps the hardest to achieve, but also the most consequential – marking the transition from negotiated alignment to operational integration. If done well, coherence can sustain both normative regimes through turbulent periods, creating a mutually-reinforcing hybrid norm that is sustainable.

Implications of Hybrid Norm Framework on the politics of integration

To analyze how two established norms come to be integrated, this thesis extends the classic norm life cycle and GHD models by introducing a three-stage model of normative integration: construction, convergence, and coherence. In this model, construction refers to the historical formation, contestation, and interaction of overlapping norms through strategic framing; convergence captures how actors align discourses and core functions across previously distinct regimes into a shared normative framework through negotiation; and coherence reflects the embedding of these integrated norms into mutually-reinforcing processes through institutionalization. At the conclusion of this final stage, a hybrid norm (with an associated hybrid regime) is seen to be emerging, and may even re-enter new cycles of integration with other established norms. Therefore, by moving beyond the linear trajectory of a single norm, this adapted cycle enables analysis of how multiple norms and normative regimes evolve in relation to one another, reorienting scholarly attention toward integration as a politically mediated and analytically iterative process.

Chapters 6-8 will apply this framework to the integration of GHS and UHC, revealing how they are constructed, converged, and made coherent across the global health architecture. The processes of framing, negotiation, and institutionalization further advance understanding of the politics of integration relevant for analyses like this one. The following chapter turns to the empirical methodology used to study this framework through real-world applications.

Chapter 5: Methodology and research design

This chapter outlines the methodology of the thesis, presenting the empirical research design used to investigate the integration of global health security and universal health coverage into an emerging hybrid norm. It begins by restating the research aims and conceptual framework, before outlining the various qualitative methods applied across three studies. Structured along the three stages of the hybrid norm framework, each empirical chapter strategically draws on a distinct dataset and analytical approach to best capture how norms are constructed, converge, and cohere in practice. The chapter closes by detailing triangulation and reflexivity strategies, ethical approval, positionality, and a roadmap showing how the empirical studies build toward the thesis's central argument.

5.1 Restating research questions, objectives, and conceptual framework

As outlined in previous chapters, this thesis investigates the normative integration of GHS and UHC. It has been driven by a central research question:

How have global health security and universal health coverage been integrated through global health diplomacy – and what are the implications on the broader global health architecture?

While current research emphasizes aspects of health system integration or policy coherence, it inadequately addresses how two established global health norms (each with associated regimes of overlapping actors, mechanisms, and funding streams) interact and subsequently evolve through processes of global health diplomacy.

Therefore, the overall objective of this thesis is:

To develop and apply a conceptual framework of 'hybrid norms' to explain how global health security and universal health coverage are constructed, converged, and made coherent through global health diplomacy – and to advance a greater understanding of the 'politics of integration' and how its iterative processes of framing, negotiation, and institutionalization influence the broader global health architecture.

To answer these questions, the thesis applies the **hybrid norms framework**, introduced in Chapter 4, which extends constructivist international relations and political science theories to examine normative integration across entrenched regimes. It conceptualizes integration as a strategic and contested process that unfolds through three interlinked stages:

- **Norm construction**: The evolving framing of GHS and UHC as distinct norms into increasingly overlapping normative regimes.

- **Norm convergence**: The negotiation of shared discourse and functions through a shared normative framework marked by increasing complementarity and interdependency.

- **Norm coherence**: The emergence and institutionalization of a hybrid norm, embedding both normative regimes into governance structures, institutional priorities, and diplomatic agendas in a mutually-reinforcing manner.

To address the central research question, the thesis is therefore structured along three interrelated sub-questions, each aligned to a corresponding empirical chapter and linked to an iterative stage in the hybrid norm framework (Chapter 4):

- **Construction (Chapter 6)**: How have GHS and UHC emerged as distinct but increasingly overlapping normative agendas in global health? What discursive, political, and institutional

milestones have (re)constructed their development over time, and how has their contestation and interaction contributed to evolving, mutually-reinforcing framings?

- **Convergence (Chapter 7)**: How are GHS and UHC being aligned through contemporary diplomatic negotiations? What strategies and political dynamics have enabled or constrained normative convergence via global agreements?

- **Coherence (Chapter 8)**: How do actors across governments, multilateral institutions, donors, and civil society understand and enact GHS-UHC integration in practice? What tensions, power asymmetries, and opportunities shape the institutionalization of coherence at various levels of global health governance and diplomacy?

Together, these sub-questions enable a multi-layered exploration of normative evolution for GHS and UHC – from their historical origins, to contemporary alignment, to practical implementation across the global health architecture. This also helps to unpack the key processes of framing, negotiation, and institutionalization that inform a greater understanding of the **politics of integration** in contexts such as this one. Each stage is empirically investigated using a corresponding methodological approach outlined below.

5.2 Methods structured by paper

Case selection, data collection, and analytical methods were strategically tailored for each empirical chapter to illustrate successive stages of the hybrid norm framework. As the thesis is structured around three standalone but interrelated papers (two already published, one under peer review), the methodology reflects a cumulative logic: each case and method builds upon the last to illuminate how distinct global health norms – specifically GHS and UHC – are constructed, converged, and made coherent through diplomacy. Importantly, this approach captures how normative integration evolves not as a linear process, but through dynamic interaction between actors, agendas, and governance structures, reflecting important theoretical insights presented in Chapter 3.

As past scholarship has demonstrated, research on fragmentation and integration in global health has lacked theoretical and analytical rigor in accounting for the political and ideological factors that shape alignment.[508] By contrast, this study foregrounds norms as the central unit of analysis for GHS-UHC integration. As a result, this thesis necessitates attention on both discourse *and* core functions as primary features for examining progress in normative integration. The rationale behind this is because as GHS and UHC norms evolve, so too do the key interventions and approaches they obligate. For example, as diabetes – typically situated within UHC as a matter of chronic care

[508] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'; Ooms and others, 'Synergies and Tensions between Universal Health Coverage and Global Health Security: Why We Need a Second "Maximizing Positive Synergies" Initiative'; Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health'; Storeng and Béhague, '"Lives in the Balance"'.

and access to affordable treatment – begins to be increasingly framed as a threat to economic security, elements of securitization may be introduced into diabetes prevention programs, which may in turn insert new framings into the broader UHC normative sphere. This reframing can shift priorities, introduce new stakeholders, alter institutional arrangements, and mandate new forms of health services, thus expanding UHC to include core capacities and logics more traditionally associated with GHS. This follows the rationale of previous studies that have aimed to examine convergence of norms across different sectors.[509] Such examples underscore the political and discursive nature of normative integration, as actors negotiate both framing and institutional function across policy agendas – and that these in turn may further reconstitute the norms of both regimes.

5.2.1 Chapter 6 (Paper 1): Norm reconstruction

Justification and link to framework

The first empirical paper focuses on the construction of GHS and UHC as distinct but interactive norms. It lays the conceptual foundation for GHS-UHC integration by examining how these agendas historically emerged into overlapping, yet contested, policy spaces – often in response to global health crises and institutional imperatives. This understanding departs from conventional views that treat GHS and UHC as entirely separate and distinct policy paradigms. By revisiting their historical interactions, it becomes more feasible for norm entrepreneurs to envision how integration between GHS and UHC might be achieved moving forward, as well as to better pinpoint where and how persistent gaps between them continue to exist. This chapter corresponds to the first stage of the hybrid norm framework, construction, which centers on the discursive formation, contestation, and legitimation of norms through framing processes.

Document selection and data collection

In aiming to provide a historical narrative review of the evolution and interaction of GHS and UHC norms, this study drew on foundational global health texts that have shaped both agendas over time. While chronicling a complete list of all possible documents linked to both agendas was not feasible, key texts were selected through a relatively flexible purposive and snowball sampling strategy, and were chosen to illuminate how normative discourses were shaped by – and responded to – major crises and evolving global health governance priorities spanning multiple decades. By laying these out in a chronological genealogy, the data collection strategy aimed to redefine prevailing accounts by demonstrating how both agendas have come to shape one another more significantly than previous scholarship suggests.

[509] Drope and Lencucha, 'Evolving Norms at the Intersection of Health and Trade'.

Relevant texts were organized and examined based on their relevance to the three stages of Finnemore and Sikkink's norm life cycle: emergence, cascade, and internalization.[510] This allowed for a relatively structured account following the origins of GHS and UHC norms through iteratively increasing stages of normative alignment along the norm life cycle model. Patterns of norm development were identified through particular triggers and signifiers[511] indicating progression across subsequent stages of development (e.g., emergence - social contexts in which they originated; tipping points - catalytic windows of opportunity, and norm cascades - rapid socialization among a majority of key actors; internalization - implementation through explicit policy expressions).

Although non-state actors play an important role in global health diplomacy, the study primarily focused on documents published by WHO and related UN agencies – widely regarded as the most prominent actors through which global health norms (including GHS and UHC) are developed and legitimized.[512] Their legal texts provide a useful entry for exploring norm change, serving as the primary method for states in codifying and expressing global norms. These included documents related to three key stages of GHS and UHC development (key examples listed in Table 1), including:

- **Norm emergence (1851 – 2000):** major WHO and UN legal texts through the turn of the 21st century linked to the origins of security and human rights norms and impacts of globalization and neoliberalism on emerging GHS and UHC norms;
- **Norm tipping points and cascade (2000 – 2013):** key World Health Assembly declarations and UNSC resolutions related to crises like HIV/AIDS and health financing reforms, as well as legally-binding obligations like IHR (2005);
- **Norm internalization (2013 – 2019):** government strategies and global policy documents in the wake of major health emergencies (e.g., Ebola and Zika) reflecting GHS-UHC integration, as well as new cross-cutting institutional frameworks like SDGs.

Table 1: Select list of documents collected related to GHS, UHC, and/or both (non-exhaustive list). (*Author's own).*

Normative Agenda	Document Title	Year
Global Health Security	International Sanitary Convention	1893
	International Health Regulations (IHR)	1969
	UN Security Council Resolution 1308 on HIV/AIDS	2000
	Revised International Health Regulations (IHR)	2005

[510] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.
[511] Granmo, 'Health Norms in the Global Governance of Development : A Constructivist Analysis'.
[512] Drope and Lencucha, 'Evolving Norms at the Intersection of Health and Trade'.

	WHO World Health Report – *A Safer Future: Global Public Health Security in the 21st Century*	2007
	UNGA Resolution on Health and Foreign Policy	2009
	UN Security Council Resolution 2177 on Ebola	2014
	UNGA Resolution on Ebola	2014
	Zika Strategic Response Plan	2016
	WHO Health Emergencies Programme (WHE) Reports	2017–2019
Universal Health Coverage	WHO Constitution	1948
	Universal Declaration of Human Rights (UDHR)	1948
	International Covenant on Economic, Social and Cultural Rights (ICESCR)	1966
	Declaration of Alma-Ata	1978
	General Comment 14 of the Committee on Economic, Social and Cultural Rights	2000
	WHA Resolution 58.33 – *Sustainable Health Financing, Universal Coverage and Social Health Insurance*	2005
	WHO World Health Report – *Health Systems Financing: The Path to Universal Coverage*	2010
	UNGA Resolution on UHC	2012
	WHO Discussion Paper on UHC	2012
	UN High-Level Meeting Political Declaration on UHC	2019
Both (documents expressing both normative agendas)	Doha Declaration on TRIPS and Public Health	2001
	UN Commission on Human Security	2003
	WHO Executive Board Special Session on Ebola	2015
	UN Sustainable Development Goals (SDGs)	2015
	WHO Thirteenth General Programme of Work (GPW13)	2019

Analytical approach

Rather than viewing GHS and UHC simply as individual norms, the analysis approached them as broader normative regimes comprised of relevant actors, principles, and policies. The analytical emphasis was therefore placed on: 1) discourse (i.e., dominant principles, ideas, and frames consistently evoked by norm entrepreneurs or embedded in key texts), and 2) core functions (i.e., specific sets of capacities, obligations, services, or interventions). This is consistent with previous

analyses of norms in development[513] and health[514] which consider underlying values as well as resultant technical practices that are institutionalized through formal international agreements.

Discursive analysis was selected for its ability to surface how actors framed GHS and UHC at each stage (using Krook and True's fluid conceptualization of 'norms as processes'[515]), and to better capture how these framings influenced normative development.[516] While full details are provided in Chapter 6, this method broadly enabled greater attention to:

- The use of securitization language in GHS (e.g., "threats," "surveillance," "preparedness"), which emphasized urgency and existential framings;
- The deployment of rights-based language in UHC (e.g., "access," "equity," "affordability"), which emphasized health services and human rights framings;
- The interaction of these discourses and core functions, where elements of both norms were increasingly blended, reinterpreted, or reframed together (e.g., "integration of UHC and health security").

This discursive mapping of GHS and UHC revealed how both agendas have been (re)constructed as parallel yet increasingly intersecting norms. By examining key normative shifts, particularly during crises and other major milestones, the chapter identifies key norm triggers and periods of contestation, offering insight into the political dynamics underpinning normative evolution and subsequent realignments.

5.2.2 Chapter 7 (Paper 2): Normative convergence

Justification and link to framework

The second empirical paper explores the process of convergence – the strategic alignment of GHS and UHC within international negotiation settings. It examines how discourses and policy functions from each norm are brought into interaction through diplomacy and iterative negotiation. This chapter corresponds to the second stage of the hybrid norms framework, convergence, where distinct norms begin to co-evolve through co-promotion and selective alignment via negotiation processes.

Case selection and data collection

This study examines two major intergovernmental agreements – the WHO-led Pandemic Agreement (PA) and the UNGA-led Political Declaration on Universal Health Coverage (PD) – selected for their significance as forums for global health diplomacy and their perceived importance in

[513] Drope and Lencucha, 'Evolving Norms at the Intersection of Health and Trade'.
[514] Parkhurst, Chilongozi, and Hutchinson, 'Doubt, Defiance, and Identity'.
[515] Krook and True, 'Rethinking the Life Cycles of International Norms'.
[516] Payne, 'Persuasion, Frames and Norm Construction'.

addressing post-COVID health system gaps. The PA focused on codifying reforms to GHS, while the PD sought to advance UHC commitments. Both cases involved multi-stage negotiations with multiple draft revisions, enabling discursive analysis of normative positions over iterative stages – providing a unique window into how normative convergence takes shape in practice. Unlike finalized declarations or static policy documents, negotiation drafts enable researchers to capture the incremental shifts in language, framing, and compromise across multiple rounds – closely aligned with this thesis' conceptualization of 'norms as processes' (as proposed by Krook and True)[517].

Using a within-case comparative design, the study leverages the contrasting institutional contexts – WHO's Intergovernmental Negotiating Body (INB) rooted in the GHS regime and the UN's High-Level Meeting (HLM) process rooted in UHC-relevant institutions – to assess how norms related to GHS and UHC were inserted into each other's domains, offering new insights into normative convergence and integration. This approach offered a rare opportunity to observe how norms are brought into interaction in real-time across different institutional processes, and how convergence is shaped by political trade-offs, institutional mandates, and evolving global health priorities through diplomatic mechanisms.

Analytical approach

This study used a two-step methodological approach combining qualitative content analysis (QCA) and discourse analysis – particularly drawing from Alejandro and Zhao as well as other constructivist interpretive traditions.[518] QCA was applied to provide breadth by identifying the presence, absence, and frequency of GHS and UHC-related elements across successive negotiation texts, while discourse analysis offered depth by unpacking the rhetorical strategies, subject positions, and implicit meanings shaping normative positions. This approach was novel in its application to iterative negotiation drafts, and particularly well-suited to capture both ideational convergence (in framing through discourse) and functional convergence (in institutional commitments and policy design through core functions).

The primary data consisted of six successive WHO INB draft texts for the PA and five successive UNGA draft texts culminating in the PD. Guided by Hsieh and Shannon's[519] directed content analysis approach, the analysis used predefined codes drawn from a scanning of all primary documents and related literature on GHS and UHC. These key terms were used as guidance for

[517] Krook and True, 'Rethinking the Life Cycles of International Norms'.
[518] Audrey Alejandro and Longxuan Zhao, 'Multi-Method Qualitative Text and Discourse Analysis: A Methodological Framework', *Qualitative Inquiry* 2023, 2023, p. 10778004231184421, doi:10.1177/10778004231184421; Tracey Feltham-King and Catriona Macleod, 'How Content Analysis May Complement and Extend the Insights of Discourse Analysis: An Example of Research on Constructions of Abortion in South African Newspapers 1978–2005', *International Journal of Qualitative Methods*, 15.1 (2016), p. 1609406915624575, doi:10.1177/1609406915624575.
[519] Hsiu-Fang Hsieh and Sarah E. Shannon, 'Three Approaches to Qualitative Content Analysis', *Qualitative Health Research*, 15.9 (2005), pp. 1277–88, doi:10.1177/1049732305276687.

initial codes (summarised in Table 2), and organized into discourse and core functions to examine how these norms evolved across negotiations and how they were strategically embedded or contested over time.

Table 2: Key terms related to the norms of global health security and universal health coverage, including dominant discourse and commonly-associated core functions of each (non-exhaustive list). Reproduced from Lal, Wenham, and Parkhurst (2025), *Globalization and Health*. 21:5.

Identifying and unpacking GHS and UHC norms	
Global health security (GHS)	*Universal health coverage (UHC)*
Discourse (shared / dominant principles, ideas, motives, and issue frames)	
Securitization • Health as a foreign policy issue • Protection against external threats (e.g., national or international security) • Infectious disease control • Emergencies/crises/disasters • War-related terminology (threat, risk, fight/battle) • Outbreaks/epidemics/pandemics • All-hazards • Resilience • Population-level or collective health risk • "Statist" international security • Top-down power structures	**Right to health** • Health as a human rights issue • Equity • Accessibility • Affordability • Availability • Acceptability • Quality • 'Health for all' and inclusivity • Social determinants of health • Economic and sustainable development • Individual health • "Globalist" human security • Bottom-up power structures
Core functions (Key capacities, interventions, components, obligations, services, and implementation approaches)	
"Core capacities" (e.g., International Health Regulations, 2005): • Laboratories • Surveillance • Preparedness • Response • Risk communication • Coordination and National IHR Focal Point • Zoonotic events • Food safety • Radiation emergencies • Chemical events • Points of entry **Related health interventions and services:**	**"Core obligations" (e.g., General Comment 14):** • Ensuring non-discriminatory access to health facilities, goods and services, especially for vulnerable or marginalized people • Ensuring access to food, basic shelter, housing, sanitation and water • Providing essential drugs as defined by WHO • Ensuring equitable distribution of all health facilities, goods and services • Adopting a national public health strategy and plan of action addressing the concerns of all **Related health interventions and services:** • Primary health care • Sexual and reproductive health and rights

• Biosafety and biosecurity • Antimicrobial resistance • Emergency preparedness and response • Deployment of medical countermeasures • Essential public health functions • One Health	• Maternal and child health • Routine immunization • Noncommunicable diseases • Health education and promotion • Essential health benefit packages

Building on this predefined list of GHS and UHC discourses and core functions, the analysis proceeded by identifying patterns of normative expression across both sets of negotiation texts. Using a deductive approach, relevant text segments were classified into thematic categories (see Table 3), focusing on the presence and frequency of UHC norms within the PA drafts and GHS norms within the PD drafts. This directed QCA enabled the identification of dominant themes and revealed how specific normative elements evolved across successive negotiation rounds.

Table 3. Emerging themes covering key expressions of universal health coverage found in the Pandemic Agreement and global health security found in the Political Declaration.
Reproduced from Lal, Wenham, and Parkhurst (2025), *Globalization and Health*. 21:5.

PA				
UHC discourse	Explicit references to UHC as part of discourse and core functions	Rights-based narratives	Equity frames	Focus on social determinants of health
UHC core functions		Accessible and affordable health commodities	Prioritizing vulnerable populations	Primary health care approach
PD				
GHS discourse	Explicit references to GHS as part of discourse and core functions	Existential threat narratives	Resilience frames	Focus on infectious diseases
GHS core functions		Outbreak preparedness	Health emergency response	One Health approach

The final step involved applying discourse analysis to critically examine how the identified normative themes were expressed across successive drafts. This analysis focused on both the presence and frequency of GHS and UHC language, as well as the weight, centrality, and implicit meanings of normative positions in context. Particular attention was paid to signs of complementarity (similarity over time) and interdependency (cross-sectoral awareness) as indicators of norm convergence – reflecting the emergence of a shared normative framework and in line with the thesis' conceptualization of "norm convergence" (explained in further detail in Chapter 4 and 7). By tracing

how specific language was mainstreamed, transformed, or sidelined – and by accounting for shifts, contradictions, and tensions – the analysis generated novel insights into how convergence between GHS and UHC norms evolved across both the PA and PD negotiations.

5.2.3 Chapter 8 (Paper 3): Normative coherence

Justification and link to framework

The third empirical paper focuses on coherence – the final stage in the hybrid norms framework, where distinct norms become embedded within institutions, governance structures, and operational practices. This chapter examines how GHS and UHC are jointly operationalized across the global health architecture, identifying the strategic choices, political asymmetries, and institutional arrangements that either enable or constrain sustained alignment. It provides critical insights into how global actors translate various (re)negotiated norms into practice, revealing the conditions for sustainable normative integration and reflecting the emergence of a hybrid norm.

Case selection and data collection

Between May and July 2024, thirty-one semi-structured interviews were conducted with senior officials from four key actor types: multilateral and global health organizations, country governments, donors and international finance institutions, and civil society organizations. Participants were selected for their active role in global health policy and practice – particularly in the COVID-19 response and major HSS initiatives – and represent a wide range of perspectives of those involved in shaping GHS and UHC integration. The interviews were conducted during a moment of significant reforms in global health, aligning with intensified debates in the wake of the pandemic and the mid-point review of the 2030 SDG agenda.

Using purposive and snowball sampling, the study ensured diverse representation across actor types (Table 4) as well as relative balance across Global North and Global South contexts (Table 5), allowing for nuanced analysis of coherence dynamics amid shifting institutional and geopolitical conditions. This diversity enabled the analysis to interrogate both the shared challenges and the asymmetrical power relations that shape normative coherence between GHS and UHC. After providing informed consent (Annex 1), each interview was anonymized, transcribed, and structured around pre-defined themes aligned to the research questions (Annex 2).

Table 4. Number of key informants interviewed per actor grouping. Reproduced from Lal (Under Peer Review).

Actor Type	# of participants
Multilateral and global health organizations	9

Country governments	**10**
Donors, foundations, and international finance institutions	**6**
Civil society organizations	**6**
Total	***31***

Table 5. Number of key informants interviewed per geopolitical grouping, based on the primary affiliation most relevant to their work on GHS and/or UHC. Reproduced from Lal (Under Peer Review).

Geopolitical Group	# of participants
Global South	**13**
Global North	**18**
Total	***31***

Data analysis

Thematic analysis followed Braun and Clarke's systematic approach, beginning with repeated readings of interview transcripts to identify recurring ideas, tensions, and narrative patterns. Thematic analysis is particularly effective in studies exploring the complexity of actor-driven processes, such as the joint operationalization of distinct global health frameworks like GHS and UHC. Braun and Clarke's framework provided the most suitable methodological approach for "identifying, analysing and reporting"[520] the nuanced perspectives and institutional views of varying global health stakeholders while maintaining flexibility to respond to the contextual specifics of the research.

A key strength of thematic analysis lies in its ability to explore latent, rather than merely semantic, meanings within qualitative data, making it especially suited to studies where power dynamics and political economy considerations are critical, such as navigating actor-driven processes within institutional and diplomatic contexts. This enabled the identification of differences in how GHS and UHC coherence is understood across various actors from GN and GS contexts, highlighting inequities that have otherwise been overlooked in previous policy-focused analyses on this topic.[521]

[520] Virginia Braun and Victoria Clarke, 'Using Thematic Analysis in Psychology', *Qualitative Research in Psychology*, 3.2 (2006), pp. 77–101, doi:10.1191/1478088706qp063oa.

[521] Pai, Bandara, and Kyobutungi, 'Shifting Power in Global Health Will Require Leadership by the Global South and Allyship by the Global North'; Nadja Meisterhans, 'Health for All: Implementing the Right to Health in the Post-2015 Agenda. Perspectives from the Global South', *Social Medicine*, 9.3 (2016), pp. 109–25; Veena Sriram and

Furthermore, unlike content analysis or more structured qualitative methodologies, thematic analysis permits a balance between inductive exploration of emergent themes and deductive alignment with pre-defined research questions. Combining these approaches enabled moving beyond superficial descriptions of stakeholder perspectives to identify deeper patterns of thought, competing priorities, and emerging best practices in governance, financing, and health system strengthening.

Coding was conducted using NVivo 14 software, combining inductive insights from the data with deductive themes drawn from the study's research focus and interview guide (also informed by the previous themes and codes from Chapters 6 and 7). Codes were iteratively grouped into subthemes and then overarching categories to structure the findings around the politics of GHS-UHC coherence – such as how actors navigated competing mandates, donor conditionalities, and evolving priorities. To ensure analytical rigor, findings were triangulated with field notes and global health policy documents, enabling a credible synthesis of diverse stakeholder perspectives and revealing overlooked power dynamics and political economy dimensions in institutionalizing hybrid norm development in the post-COVID-19 global health landscape.

5.3 Triangulation, validity, and analytical layering

Each empirical paper in this thesis was designed to investigate a distinct stage of the hybrid norms framework. Taken together, they offer a layered and complementary analysis of how normative integration unfolds across the global health architecture. Methodological triangulation was central to this design: historical review and document analysis in Chapter 6, negotiation draft comparison in Chapter 7, and key informant interviews in Chapter 8. Each method generated different types of insights into the politics of normative integration through construction, convergence, and coherence.

Triangulation across sources – spanning multilateral institutions, national governments, donors, and civil society actors – helped mitigate reliance on any single actor type or geopolitical region, although the focus on global health diplomacy inevitably foreground states and intergovernmental actors most actively engaged in GHS-UHC integration efforts on the global level. Within-case triangulation was also applied, for example through iterative comparison of negotiation drafts in Chapter 7 and multi-actor coding in Chapter 8.

Importantly, the conceptual framework itself served not just as a retrospective lens, but as a dynamic guide throughout empirical inquiry, including to contextualize key contributions and implications. Reflexive engagement with emerging patterns helped sharpen the framework in real time, allowing the research to evolve analytically alongside the data.

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others, '10 Best Resources on Power in Health Policy and Systems in Low- and Middle-Income Countries', *Health Policy and Planning*, 33.4 (2018), pp. 611–21, doi:10.1093/heapol/czy008; Stephanie M. Topp and others, 'Power Analysis in Health Policy and Systems Research: A Guide to Research Conceptualisation', *BMJ Global Health*, 6.11 (2021), p. e007268, doi:10.1136/bmjgh-2021-007268.

5.4 Ethical considerations and approvals

This thesis was conducted in accordance with the London School of Economics and Political Science (LSE), with formal approval granted by the LSE Research Ethics Committee (Reference No. 58402). Interview participants were given detailed information sheets and informed consent forms outlining their rights (Annex 1), including the option to withdraw at any time. Interview data were anonymized and kept confidential in full compliance with GDPR and institutional data protocols.

Because many interviewees held senior positions in global health governance, particular care was taken to avoid reputational or political risk. Quotes were only included when permission was explicitly granted, and no personally identifiable information was used. Participants were informed that the research focused on institutional dynamics and normative processes, not individual or even actor-specific characterizations.

Attention was also paid to illuminating power asymmetries between Global North and Global South respondents. Therefore, actor selection, coding, and analysis were designed to ensure equitable representation (e.g., ensuring relative balance between GN and GS participants based on the primary geopolitical affiliation most relevant to their work on GHS and/or UHC; equal spread across actor types, with governments as the largest category to allow for greater balance between GN and GS respondents; gender balance based on assumed understanding given past expressions). Additionally, particular care was taken to interpret quotes in context, respecting the institutional and geopolitical positionality of respondents as best as possible. However, I recognize that, given the constraints of the study and my own positionality, new biases may have been introduced that real-world power biases (e.g., my positionality as a GN-based academic may have influenced my perception of who is considered GN versus GS and how best to interpret their responses in context of their work; gender ascriptions may not have exactly correlated with self-identity, etc.).

5.5 Positionality

I am a man of Indian origin, born and raised in the United States, with postgraduate training from elite institutions in both the US and the UK. My academic background spans business, health policy, and the social sciences, and my professional experiences have taken me across a range of settings – including the US, the UK, and several low- and middle-income countries. These experiences, while offering valuable insights into how health systems function across different contexts, also shape how I see the world and influence how I engage as a researcher: from how I frame problems, to how I conduct interviews, to how I interpret discursive meaning and power. I therefore carry with me conscious and unconscious biases shaped by my education, my cultural heritage, and my professional networks which necessitated ongoing reflexivity for how they influenced my research process. This perspective provided analytical strengths, particularly in navigating contemporary debates in global health and international relations, but also demanded careful attention to bias –

especially when interpreting key informant interviews and analyzing shifting normative framings in global health diplomacy.

Chapter 6: Construction (Empirical Paper 1)

(Re)constructing global health security and universal health coverage: norm contestation and interaction

ARUSH LAL, JUSTIN PARKHURST AND CLARE WENHAM*

The role of norms has been increasingly examined in International Relations, given their influence on driving policy goals, strategies and governance arrangements. Norms are defined as concepts or ideas that encompass a spectrum of shared values, organizing principles and standardized procedures.[1] Wiener argues that 'norms have a dual quality insofar as they are socially constructed as well as structuring',[2] with Wendt further asserting that norms shape interactions among states and non-state actors.[3] While norms may take different forms, their content can be identified by a common definition that includes expected behaviours and collective understandings seen as legitimate in global policy.[4] International agreements are therefore viewed by states as key mechanisms through which to codify and socialize norms.[5]

However, norms rarely exist in isolation. Instead, they develop alongside multiple other norms, many of which may be seen as either complementary or antagonistic.[6] Thus, understanding how norms engage with each other provides important insights for policy and practice. While recent studies have highlighted the complex processes involved in norm change, much of this has focused either on the interaction of a singular norm amid broader contextual factors,[7] or on contestation between one prevailing norm and another that ultimately results in either's obsolescence.[8] Limited scholarship exists to account for what happens

* Arush Lal received funding support through a doctoral studentship from the London School of Economics and Political Science.

1 Ann Florini, 'The evolution of international norms', *International Studies Quarterly* 40: 3, 1996, pp. 363–89, https://doi.org/10.2307/2600716.

2 Antje Wiener, 'The dual quality of norms and governance beyond the state: sociological and normative approaches to "interaction"', *Critical Review of International Social and Political Philosophy* 10: 1, 2007, pp. 47–69, https://doi.org/10.1080/13698230601122412.

3 Alexander Wendt, 'Anarchy is what states make of it: the social construction of power politics', *International Organization* 46: 2, 1992, pp. 391–425, https://doi.org/10.1017/S0020818300027764.

4 Florini, 'The evolution of international norms'.

5 Jeffrey Drope and Raphael Lencucha, 'Evolving norms at the intersection of health and trade', *Journal of Health Politics, Policy and Law* 39: 3, 2014, pp. 591–631, https://doi.org/10.1215/03616878-2682621.

6 Wayne Sandholtz, 'International norm change', in *Oxford research encyclopedia of politics*, publ. online 28 June 2017, https://doi.org/10.1093/acrefore/9780190228637.013.588.

7 Judith Kelley, 'Assessing the complex evolution of norms: the rise of international election monitoring', *International Organization* 62: 2, 2008, pp. 221–55, https://doi.org/10.1017/S0020818308080089.

8 Jennifer L. Bailey, 'Arrested development: the fight to end commercial whaling as a case of failed norm change', *European Journal of International Relations* 14: 2, 2008, pp. 289–318, https://doi.org/10.1177/1354066108089244.

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when two or more norms evolve alongside each other—or indeed, *in response to* each other—with researchers calling for greater 'exploration of competition and alignment among multiple norms'.[9]

Norms have emerged to be powerful drivers for international health cooperation[10]—with intergovernmental organizations such as the World Health Organization (WHO) serving as primary venues through which states can shape global health norms. Arguably two of the most widely influential norms in this space are global health security (GHS) and universal health coverage (UHC). The WHO defines GHS as the activities required to minimize the threat of acute public health events,[11] and UHC as ensuring that all people have access to a full range of health services without financial hardship.[12] Both GHS and UHC serve as central concepts in global health;[13] each is characterized by its own dominant goals and framings that ultimately shape the stakeholders involved, processes followed and policies pursued. The co-production of these two relatively distinct, yet inherently interlinked, norms provides a unique context through which to analyse how norms evolve in the international arena.

GHS and UHC have traditionally been understood as distinct policy domains, given fundamental differences in their core approaches. Wenham et al. explain that 'divergence [between GHS and UHC] appears in the conceptualisation of risk … and the prioritisation of domestic or global activity',[14] while Ooms et al. argue that 'in an underfunded and underdeveloped health system, the obvious "next step" on the path towards UHC is not always the obvious "next step" in the direction of GHS'.[15] However, viewing these norms as dichotomous can lead to conflicting strategies, disjointed funding structures and divergent governance arrangements—fuelling disparities in health outcomes.[16] Chronic gaps resulting from fragmentation have been particularly detrimental during health emergencies like the COVID–19 pandemic.[17] Because GHS and UHC are ultimately delivered

[9] Mona Lena Krook and Jacqui True, 'Rethinking the life cycles of international norms: the United Nations and the global promotion of gender equality', *European Journal of International Relations* 18: 1, 2012, pp. 103–27, https://doi.org/10.1177/1354066110380963.

[10] Dean T. Jamison, Julio Frenk and Felicia Knaul, 'International collective action in health: objectives, functions, and rationale', *The Lancet* 351: 9101, 1998, pp. 514–17, https://doi.org/10.1016/S0140-6736(97)11451-9.

[11] World Health Organization, *The world health report 2007: a safer future: global public health security in the 21st century* (Geneva: WHO, 2007), https://www.who.int/publications-detail-redirect/9789241563444. (Unless otherwise noted at point of citation, all URLs cited in this article were accessible on 30 Aug. 2024.)

[12] World Health Organization, 'Universal health coverage (UHC)', 5 Oct. 2023, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

[13] Melissa Salm, Mahima Ali, Mairead Minihane and Patricia Conrad, 'Defining global health: findings from a systematic review and thematic analysis of the literature', *BMJ Global Health* 6: 6, 2021, https://doi.org/10.1136/bmjgh-2021-005292.

[14] Clare Wenham et al., 'Global health security and universal health coverage: from a marriage of convenience to a strategic, effective partnership', *BMJ Global Health* 4: 1, 2019, https://doi.org/10.1136/bmjgh-2018-001145.

[15] Gorik Ooms et al., 'Synergies and tensions between universal health coverage and global health security: why we need a second "maximizing positive synergies" initiative', *BMJ Global Health* 2: 1, 2017, https://doi.org/10.1136/bmjgh-2016-000217.

[16] Phyllida Travis et al., 'Overcoming health-systems constraints to achieve the Millennium Development Goals', *The Lancet* 364: 9437, 2004, pp. 900–906, https://doi.org/10.1016/S0140-6736(04)16987-0.

[17] Arush Lal et al., 'Fragmented health systems in COVID–19: rectifying the misalignment between global health security and universal health coverage', *The Lancet* 397: 10268, 2021, pp. 61–7, https://doi.org/10.1016/S0140-6736(20)32228-5.

through the same national structures, conceptualizing them as separate fails to adequately reflect the realities of implementation.

Increasingly, global health actors have attempted to align GHS and UHC—both in principle and in practice. WHO Director-General Tedros Ghebreyesus characterized GHS and UHC as 'two sides of the same coin', arguing that 'the greatest threat to [GHS] is the fact that billions of people lack access to essential health services'.[18] This view has been affirmed by recent initiatives that call for jointly advancing GHS and UHC, such as the Universal Health and Preparedness Review[19] and *The Lancet* Commission on synergies between universal health coverage, health security and health promotion.[20]

This article informs efforts to integrate GHS and UHC by tracing how their normative foundations have been (re)constructed over time—as they evolved in tandem. Using the norm life-cycle, we discursively analyse key global health texts following major crises and international agreements to unpack how both norms, with their underlying discourse and core functions, have transformed each other through repeated contestation and interaction. The article draws a distinction from the literature by viewing GHS and UHC not as stand-alone, static concepts, but rather as co-evolving 'processes' that continue to significantly shape each other.

Not only does this examination demonstrate the value of norm integration in the realm of global health diplomacy, it also underscores the significance of viewing global health norms as dynamic, ongoing processes that are inherently interlinked—with implications for managing future multifaceted health crises. The findings also advance theories of norm change by focusing on an understudied area—that of the overlapping and fluid mechanisms inherent in norm contestation and interaction; where distinct and influential norms (and norm regimes) repeatedly (re)construct each other to maintain joint prominence.

Conceptualizing norm evolution

Finnemore and Sikkink propose a three-stage 'norm life cycle'[21] model to help recognize patterns in international norm development. Their model has been applied widely in global health analyses.[22] First, norms originate from influential 'norm entrepreneurs' (*norm emergence*), often through persuasion motivated by self-interest or ideational commitment. Second, norms gain acceptance among a critical

[18] Tedros Ghebreyesus, 'Exchange of views on the importance of health in development', speech at the European Parliament Committee on Development, 19 March 2018, https://www.who.int/director-general/speeches/detail/exchange-of-views-on-the-importance-of-health-in-development-european-parliament-committee-on-development.

[19] World Health Organization, 'Universal health and preparedness review', https://www.who.int/emergencies/operations/universal-health---preparedness-review.

[20] Irene Agyepong et al., 'Lancet Commission on synergies between universal health coverage, health security, and health promotion', *The Lancet* 401: 10392, 2023, pp. 1964–2012, https://doi.org/10.1016/S0140-6736(22)01930-4.

[21] Martha Finnemore and Kathryn Sikkink, 'International norm dynamics and political change', *International Organization* 52: 4, 1998, pp. 887–917, https://doi.org/10.1162/002081898550789.

[22] Sara E. Davies, Adam Kamradt-Scott and Simon Rushton, *Disease diplomacy: international norms and global health security* (Baltimore, MD: Johns Hopkins University Press, 2015); Anders Granmo and Pieter Fourie, *Health norms and the governance of global development: the invention of global health* (Abingdon and New York: Routledge, 2021).

mass of actors (*tipping-point*) before diffusing across the international community (*norm cascade*), often through socialization via states and intergovernmental organizations to ensure legitimization. Finally, norms are widely embedded through global policies (*norm internalization*), often through institutionalization to ensure compliance. This framework underscores the view that 'norms do not appear out of thin air [but are] actively built by agents'.[23]

Ambiguity in norm content can lead to definitional disputes, creating opportunities for different interpretations as to what a norm is and how it should be applied. Notably, some norms are adopted precisely *because* they are vague, allowing for context-specific applications to facilitate consensus and implementation.[24] Meanwhile, this same ambiguity may be exploited by opponents who promote alternative meanings to undermine utilization. Brunnée and Toope argue that the application of international law can further influence norm development by stabilizing, maintaining, or shifting norms 'through the dynamics of daily contestation and reconstruction'.[25] Particularly in environments where multiple norms coexist and are influenced by a constellation of actors, so-called norm 'regimes' may characterize synergies across norms within overlapping institutions, agreements and legal procedures.[26]

The process of framing norms is inherently strategic—whether driven by deliberate choice or shaped by contextual events. Consequently, conventional applications of the norm life-cycle have been challenged, with some arguing that if there are no 'objective' definitions of norms, then corresponding normative frames may be similarly subjective and transitory.[27] This suggests that norms and their underlying features may be (re)constructed even after their apparent 'emergence'. Orchard and Weiner argue this process of norm contestation provides important theoretical grounding to explore how norm entrepreneurship leads to norm change, by 'proactively creat[ing] clearer and more legitimate normative understandings'.[28]

The traditional life-cycle model may therefore struggle to capture the contested spaces *within* and *among* norms, or may inadequately contend with the definitional malleability and constant state of change in which many seemingly 'established' norms exist. Thus, recent scholarship has critiqued certain elements of the norm life-cycle,[29] particularly the assumption that the content of norms remains static

[23] Finnemore and Sikkink, 'International norm dynamics and political change'.

[24] Kees van Kersbergen and Bertjan Verbeek, 'The politics of international norms: subsidiarity and the imperfect competence regime of the European Union', *European Journal of International Relations* 13: 2, 2007, pp. 217–38, https://doi.org/10.1177/1354066107076955.

[25] Jutta Brunnée and Stephen J. Toope, 'Norm robustness and contestation in international law: self-defense against nonstate actors', *Journal of Global Security Studies* 4: 1, 2019, pp. 73–87, https://doi.org/10.1093/jogss/ogy039.

[26] Jeffrey S. Lantis and Carmen Wunderlich, 'Resiliency dynamics of norm clusters: norm contestation and international cooperation', *Review of International Studies* 44: 3, 2018, pp. 570–93, https://doi.org/10.1017/S0260210517000626.

[27] Robert D. Benford and David A. Snow, 'Framing processes and social movements: an overview and assessment', *Annual Review of Sociology*, vol. 26, 2000, pp. 611–39, https://doi.org/10.1146/annurev.soc.26.1.611.

[28] Phil Orchard and Antje Wiener, 'Norm research in theory and practice', in Phil Orchard and Antje Wiener, eds, *Contesting the world: norm research in theory and practice* (Cambridge, UK: Cambridge University Press, forthcoming), https://doi.org/10.2139/ssrn.4499020.

[29] Antje Wiener, 'Contested compliance: interventions on the normative structure of world politics', *European Journal of International Relations* 10: 2, 2004, pp. 189–234, https://doi.org/10.1177/1354066104042934.

across stages of development. Krook and True attempt to better capture nuanced shifts by viewing norms as dynamic 'processes' rather than fixed concepts.[30] This approach contends that norms are not necessarily stable once constructed, but rather moulded by internal disputes and external conflicts.

Methods

Our study specifically examines how GHS and UHC norms have been (re) constructed following international agreements and high-profile health emergencies, in order to understand how repeated interactions and contestation influence subsequent normative development. While civil society organizations and other non-state actors play an important role in global health discourse, we primarily focus on WHO and related United Nations agencies, which are widely regarded as the most prominent institutions through which global health norms (including GHS and UHC) are created and enshrined.[31] Therefore, their legal texts provide a useful entry for exploring norm change, by serving as the primary method for states to codify and express global norms.

The article is chronologically structured around the three stages of Finnemore and Sikkink's norm life-cycle to unpack relatively distinct stages of normative development. However, we conceptualize GHS and UHC norms as ongoing processes, utilizing Krook and True's adaptation to acknowledge nuanced dynamics inherent in norm evolution. This approach equips us to trace significant moments of contestation and interaction, providing novel insights into norm development following subsequent (re)constructions and identifying milestones for integration as both norms simultaneously evolve within the same normative landscape.

We analyse patterns of norm development by identifying particular triggers and signifiers[32] indicating progression across respective life-cycles. First, we examine emergence of GHS and UHC by detailing the social contexts in which they originated. Second, we trace tipping-points (a catalytic window of opportunity after which a norm is likely to be favoured) and norm cascades (rapid socialization among a majority of key actors) from 'securitization' and 'right-to-health' discourse into increasingly institutionalized norms. Third, we explore how subsequent GHS and UHC norms were widely internalized (implementation through explicit policy expressions) following major health emergencies and—importantly—the emergence of new, more integrative reconstructions of GHS and UHC.

Analytical approach

Our framework recognizes the utility of the norm life-cycle in chronicling broad patterns of development in international affairs. However, following Krook and True, we contend that norms cannot be identified through rigid commitments

[30] Krook and True, 'Rethinking the life cycles of international norms'.
[31] Drope and Lencucha, 'Evolving norms at the intersection of health and trade'.
[32] Anders Granmo, *Health norms in the global governance of development: a constructivist analysis*, PhD diss., Stellenbosch University, 2019.

alone, and that the trajectories of norms are often 'fraught with contestation and reversals'.[33] Therefore, we utilize both theories through a discursive approach which conceptualizes norms as 'sense-making practices' and emphasizes the active role that actors play in (re)inscribing normative concepts that simultaneously (re)shape existing norms, cognitive frames and social behaviour which, in turn, further influence the norm life-cycle.

Rather than viewing GHS and UHC simply as individual norms, we approach them as broader 'regimes'[34] comprised of relevant actors, principles and policies. Thus, we identify GHS and UHC norms by placing an analytical emphasis on: 1) discourse (i.e. dominant principles, ideas and frames consistently evoked by norm entrepreneurs or embedded in key texts), and 2) core functions (i.e. specific sets of capacities, obligations, services, or interventions). This is consistent with previous analyses of norms in development[35] and health[36] which consider underlying values as well as resultant technical practices that are institutionalized through formal international agreements.

Examining norm life-cycles in GHS and UHC

Norm emergence: origins in securitization and the right to health (1851–2000)

Contemporary conceptualizations of GHS emerged in the late twentieth century. However, its precursors in infectious disease control can be traced to the International Sanitary Conferences, convened by states concerned about diseases spread by international travel and trade.[37] The 1893 International Sanitary Convention urged states to 'establish common measures for protecting public health … without uselessly obstructing commercial transactions and passenger traffic',[38] setting forth new expectations for cooperation in disease mitigation. These obligations were further institutionalized into the International Health Regulations (IHR) (1969), reflecting an 'increasing emphasis on epidemiological surveillance'.[39]

Meanwhile, the constitution of WHO, established in 1948,[40] stated that its overarching objective was the 'attainment by all peoples of the highest possible level of health'—indicating new priorities beyond infectious diseases following the rise

[33] Krook and True, 'Rethinking the life cycles of international norms.

[34] Steven J. Hoffman, 'The evolution, etiology and eventualities of the global health security regime', *Health Policy and Planning* 25: 6, 2010, pp. 510–22, https://doi.org/10.1093/heapol/czq037.

[35] Drope and Lencucha, 'Evolving norms at the intersection of health and trade'.

[36] Justin O. Parkhurst, David Chilongozi and Eleanor Hutchinson, 'Doubt, defiance, and identity: understanding resistance to male circumcision for HIV prevention in Malawi', *Social Science & Medicine*, vol. 135, 2015, pp. 15–22, https://doi.org/10.1016/j.socscimed.2015.04.020.

[37] David P. Fidler, 'From international sanitary conventions to global health security: the new International Health Regulations', *Chinese Journal of International Law* 4: 2, 2005, pp. 325–92, https://doi.org/10.1093/chinesejil/jmi029.

[38] International Sanitary Convention, 1893, https://api.parliament.uk/uk-treaties/treaties/12572.

[39] World Health Assembly, *International Health Regulations (1969)*, adopted by the 22nd WHA in 1969 and amended by the 26th WHA in 1973 and the 34th WHA in 1981, 3rd annotated edn (Geneva: WHO, 1983), https://apps.who.int/iris/handle/10665/96616, p. 5.

[40] World Health Organization, 'Constitution of the World Health Organization', 1948, https://www.who.int/about/governance/constitution.

of international human rights law. The most salient origins of UHC norms lie in this rights-based discourse. The Universal Declaration of Human Rights (1948)[41] introduced the concept of a 'right to health' by affirming 'the right to a standard of living adequate for health and well-being'. This was advanced through article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966),[42] obligating states to 'achieve the full realization of the highest attainable standard of physical and mental health', and the Declaration of Alma-Ata (DAA) (1978),[43] which proposed similar right-to-health obligations through an emphasis on primary health care (PHC) and principles of equity, community participation and multisectoral health promotion.

Divergence in the normative roots of GHS and UHC can be seen at these early stages. For example, the ICESCR softened obligations on states for the '*full* realization' of health by permitting health service provision based on 'the maximum of … available resources', through 'progressive' implementation.[44] This conceptualization of health as a context-specific endeavour when advanced through rights-based declarations stood in contrast with comparatively stringent obligations enshrined in infectious disease legislation (e.g. successive IHR revisions in 1973 and 1981). This suggests that different levels of norm compliance among states were acceptable with respect to controlling infectious diseases versus delivering health services. Furthermore, the IHR obligated international collaboration to achieve its goals, while the DAA did not (or could not) have such mandated obligations.

Globalization and disease-specific silos Following the DAA, geopolitical developments pushed states to radically reimagine health norms, with neo-liberalism coinciding with limited success of PHC in resource-constrained settings.[45] Cairncross et al. argue that the political climate shifted away from promoting holistic health in right-to-health declarations, towards favouring disease-specific programmes.[46] Under the direction of international finance institutions like the World Bank, global health initiatives were increasingly structured through discrete, vertical health programmes—reflecting a different framing of health focused on selective coverage for specific populations and infectious diseases that aligned better with subsequent GHS approaches.

Hornung argues that 'it is near impossible to understand the emergence of the norms associated with [GHS] without taking into account the 'crucial zeitgeist

[41] United Nations, *Universal Declaration of Human Rights* (New York: UN General Assembly, 1948), https://www.un.org/en/about-us/universal-declaration-of-human-rights.

[42] Office of the UN High Commissioner for Human Rights, *International Covenant on Economic, Social and Cultural Rights* (New York: United Nations General Assembly, 1966), https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights.

[43] World Health Organization, *Declaration of Alma-Ata* (Geneva: WHO, 1978), https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata.

[44] OHCHR, *International Covenant on Economic, Social and Cultural Rights*, art. 2 (emphasis added).

[45] Rebecca Katz et al., 'Defining health diplomacy: changing demands in the era of globalization', *Milbank Quarterly* 89: 3, 2011, pp. 503–23, https://doi.org/10.1111/j.1468-0009.2011.00637.x.

[46] Sandy Cairncross, Hervé Periès and Felicity Cutts, 'Vertical health programmes', *The Lancet* 349: S20–S21, 1997, https://doi.org/10.1016/S0140-6736(97)90079-9.

[surrounding] the securitization of infectious disease' that occurred in the 1990s, reflecting a broader security agenda from the post-Cold War era.[47] This centred on the construction of disease as a threat to national security interests,[48] and the need for extraordinary measures to mitigate perceived risks.[49] The UN Development Programme's 1994 Human Development Report[50] illustrates this ideational mainstreaming of securitization, which introduced 'human security' and framed 'security in [people's] daily lives' as a strategic way to advance development in an age of 'conflict' and 'crisis', signifying a reorientation by key actors to (re-)elevate traditional infectious disease framings—this time using securitized discourse.

The UN Millennium Development Goals (MDGs),[51] adopted in September 2000, demonstrated a consolidation of these emerging themes, reifying a preference among states for stratified, disease-specific initiatives fuelled by securitization discourse. While many MDGs maintained an ethos of rights-based health (e.g. 'universal access'), their approach often referenced human security (e.g. 'protecting the vulnerable') and was narrowly focused on key targets and donor-based priorities. Ooms has argued that 'even the *sum* of efforts required to achieve MDG4 (child mortality), MDG5 (maternal health), and MDG6 (HIV/AIDS, malaria and other diseases)' neglected crucial capacities to meaningfully advance UHC, such as social determinants of health.[52]

In the same year that the MDGs were adopted, however, General Comment 14 (GC14)[53] was passed by UN members to strengthen compliance with ICESCR, which had diminished in prominence over the preceding two decades. By recentring the right to health, GC14 represented an important normative advancement for UHC, prescribing 'minimum core obligations' for states to enact a 'broader range of actions required for the progressive realization of this right' (e.g. access to health facilities, essential medicines) and compelling international assistance to support lower-income countries.[54] Thus, while right-to-health norms retained a preference for being context-specific (certainly more so than infectious disease norms), for the first time there was common language among states to shape collective behaviour on accessible health services.

By the end of the twentieth century, the normative roots of GHS and UHC had not only evolved significantly, but importantly, had developed in response to

[47] Josie Hornung, 'Norms and the securitisation of infectious diseases', *E-International Relations*, 15 Jan. 2016, https://www.e-ir.info/2016/01/15/norms-and-the-securitisation-of-infectious-diseases. See also Davies et al., *Disease diplomacy*.

[48] The Institute of Medicine, *America's vital interest in global health: protecting our people, enhancing our economy, and advancing our international interests* (Washington DC: National Academy Press, 1997), https://doi.org/10.17226/5717.

[49] Barry Buzan, Ole Wæver and Jaap de Wilde, *Security: a new framework for analysis* (Boulder, CO: Lynne Rienner Publishers, 1998).

[50] UN Development Programme, *Human development report 1994* (New York: UNDP, 1994), https://www.undp.org/publications/human-development-report-1994.

[51] United Nations, *United Nations Millennium Declaration*, 2000, https://www.ohchr.org/en/instruments-mechanisms/instruments/united-nations-millennium-declaration.

[52] Gorik Ooms et al., 'Is universal health coverage the practical expression of the right to health care?', *BMC International Health and Human Rights* 14: 3, 2014, https://doi.org/10.1186/1472-698X-14-3 (emphasis in original).

[53] Gorik Ooms and Rachel Hammonds, *Anchoring universal health coverage in the right to health* (Geneva: WHO, 2015), https://www.who.int/publications/i/item/9789241509770.

[54] Ooms et al., 'Is universal health coverage the practical expression of the right to health care?'

each other—with shifts in expected state behaviours. Indeed, Granmo has argued that *new* framings of health-related norms since the DAA would eventually 'form the ideational crux of UHC advocacy … based entirely on an *ethos* equivalent to that of human security', and thus more closely aligned with securitization.[55] This period provides early indications that both norms may not have originated from entirely distinct silos. Rather, securitization and rights-based discourses were simultaneously shaped by overlapping actors operating within the same normative landscape in response to complex and often interlinked challenges. Indeed, these specific interactions may have been crucial to their subsequent development into GHS and UHC norms.

Tipping-points and norm cascades: socializing GHS and UHC (2000–2013)

The HIV/AIDS crisis paved the way for GHS socialization as the most visible early example of a global health issue that widely utilized security discourse. Scholars argue that 'the securitisation of AIDS reached its zenith in 2000',[56] with others contending that portraying AIDS as a security threat had become 'a recognized international norm' by this point.[57] Key to this contention was UN Security Council (UNSC) Resolution 1308 (2000), which determined that HIV/AIDS 'may pose a risk to stability and security'.[58]A pivotal turning point for GHS norm entrepreneurs, this landmark resolution justified policy pathways for states to utilize security architecture and logics for public health. A 'grammar of securitization' (e.g. the metaphor of an 'enemy' to be 'battled') was deliberately used by major health actors to elevate HIV/AIDS from low to high politics.[59] This helped secure unparalleled resources for the epidemic through programmes including the US President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria—further solidifying securitization as an effective frame for fundraising and mobilizing political will for global health.[60]

However, the HIV/AIDS response was simultaneously influenced by normative developments in UHC. Many argue that negotiators for UNSC Resolution 1308 needed to strike a balance between security-based language (e.g. 'risk to stability and security') and rights-based language (e.g. 'access to treatment and care') to ensure its adoption.[61] This created tension among stakeholders, with some

[55] Granmo, *Health norms in the global governance of development* (emphasis in original).
[56] Granmo, *Health norms in the global governance of development*.
[57] Marco Antonio Vieira, 'The securitization of the HIV/AIDS epidemic as a norm: a contribution to constructivist scholarship on the emergence and diffusion of international norms', *Brazilian Political Science Review* 1: 2, 2007, pp. 137–81, https://www.redalyc.org/articulo.oa?id=394341991005.
[58] UN Security Council, *Resolution 1308 (2000) adopted by the Security Council at its 4172nd meeting, on 17 July 2000*, 2000, https://digitallibrary.un.org/record/418823.
[59] Pieter Fourie, 'AIDS as a security threat: the emergence and the decline of an idea', in Simon Rushton and Jeremy Youde, eds, *Routledge handbook of global health security* (Abingdon and New York: Routledge, 2014).
[60] Jeremy Shiffman, 'A social explanation for the rise and fall of global health issues', *Bulletin of the World Health Organization*, vol. 87, 2009, pp. 608–13, https://doi.org/10.2471/BLT.08.060749.
[61] UN Security Council, *Resolution 1308*; Fourie, 'AIDS as a security threat'.

appealing to state survival and others appealing to human rights. Thus, the 'right to health' narrative provided an important counterweight to GHS at a moment of increasing securitization. Granmo contends that the resurgence of right-to-health norms during this period was largely the result of grassroots-level activism for HIV/AIDS patients to secure affordable medicines, with 'UHC [serving] as an important step in … fulfilling this right'.[62]

The Doha Declaration of 2001[63] provides another example of how GHS and UHC frames were increasingly employed together, with important implications for expected state behaviours. The declaration's provision for states to develop generic versions of patented medicines during health emergencies 'in a manner supportive of WTO members' right to protect public health *and* … promote access to medicines for all' was considered by some to be an 'unprecedented move towards the securitisation of severe epidemic diseases'[64] by connecting diseases to state security (GHS), while simultaneously invoking the GC14 obligations by encouraging universal access to lifesaving treatments (UHC).

The rise of securitization discourse in foreign policy circles was further institutionalized post-9/11, accompanied by new health capacities like biosecurity.[65] Notably, the UN Commission on Human Security endorsed 'universal access to basic health care' in May 2003,[66] but framed this as *complementary* to state security, suggesting that states viewed securitization as useful for mainstreaming even many rights-based norms—a profound development in the constantly shifting dynamics between GHS and UHC.

Tipping-point for GHS and advancing UHC The outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003 is viewed as a prominent 'tipping-point' for GHS norms.[67] The crisis 'created a "sense of urgency" that amplified the … security framework',[68] ultimately catalysing IHR revision that had stalled since the late 1990s. Formally adopted by WHO members in 2005, the expanded IHR saw the 'emergence of a new package of norms that underpin the contemporary [global health security] regime'.[69] This suite of state obligations (e.g. sharing surveillance data, reporting outbreaks, cooperating on emergency response) was complemented by additional powers granted to the WHO Director-General to determine a public health emergency of international concern (PHEIC).[70] The subsequent construction of pandemic influenza as a security threat affirms that GHS had passed its tipping-point, with 2005 considered by some 'a peak year

[62] Granmo, *Health norms in the global governance of development*.
[63] World Trade Organization, 'Declaration on the TRIPS agreement and public health', 20 Nov. 2001, https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm.
[64] Vieira, 'The securitization of the HIV/AIDS epidemic as a norm' (emphasis added).
[65] Hornung, 'Norms and the securitisation of infectious diseases'.
[66] Commission on Human Security, *Human security now: protecting and empowering people* (New York: Commission on Human Security, 2003), https://digitallibrary.un.org/record/503749.
[67] Lawrence O. Gostin and Rebecca Katz, 'The International Health Regulations: the governing framework for global health security', *Milbank Quarterly* 94: 2, 2016, pp. 264–313, https://doi.org/10.1111/1468-0009.12186.
[68] Hornung, 'Norms and the securitisation of infectious diseases'.
[69] Davies et al., *Disease diplomacy*.
[70] World Health Organization, *International Health Regulations* (2005), 2005.

for [GHS] portrayal' following head-of-state level speeches at the UN General Assembly (UNGA) and international pledges totalling US$4.3 billion.[71]

Simultaneously, in 2005, Resolution WHA58.33[72] signalled a major ideational shift in UHC norms. Among the earliest 'authoritative formulations'[73] for UHC in terms of financial protection, the resolution called on WHO members to avoid catastrophic health expenditures by enabling 'prepayment of financial contributions … with a view to sharing risk'. While WHA58.33 demonstrated a resurgence in socio-economic principles enshrined in right-to-health predecessors like the DAA, more recent GC14 commitments were conspicuously absent, indicating that states believed such concrete commitments to UHC financing may obligate risk-sharing at levels deemed unfeasible. This stands in contrast to the IHR (2005), which indeed managed to strengthen legally binding obligations for risk-sharing across countries in the wake of SARS—reifying a divergence in GHS and UHC norms based on the scope of core functions required for implementation.

Norm cascade for GHS and tipping-point for UHC Evidence of rapid socialization indicative of a GHS norm cascade can be observed following SARS and the adoption of the IHR (2005). For example, the 2007 *World health report* marked the most explicit endorsement of GHS by WHO until then, promoting GHS discourse and core capacities under the title *A safer future*.[74] Meanwhile, the 2009 determination of H1N1 as the first PHEIC under the revised IHR (2005) signalled strengthened compliance with GHS norms among WHO member states.[75] Finally, efforts to elevate the position of global health in international affairs, exemplified by a 2009 UNGA resolution which (re)framed infectious diseases as a priority for foreign policy,[76] demonstrated further changes in the content of GHS norms, which were increasingly influenced by military and biosecurity discourse. These shifts were reflected in several national security initiatives, such as the 2008 UK Government strategy 'Health is global'[77]—which grouped the threat of pandemics alongside 'international terrorism, weapons of mass destruction, conflicts and failed states'—and the launch of the Global Health Security Agenda.[78]

Simultaneously, the UHC norm was advancing, yet the material and ideational factors shaping its development did not occur in isolation. Rather, progression

[71] Jeremy Shiffman and Yusra Ribhi Shawar, 'Framing and the formation of global health priorities', *The Lancet* 399: 10339, 2022, pp. 1977–90, https://doi.org/10.1016/S0140-6736(22)00584-0.

[72] 58th World Health Assembly, *Sustainable health financing, universal coverage and social health insurance* (Geneva: WHO, 2005), https://iris.who.int/handle/10665/20383.

[73] Ooms et al., 'Is universal health coverage the practical expression of the right to health care?', p. 201.

[74] World Health Organization, *The world health report 2007: a safer future: global public health security in the 21st century* (Geneva: WHO, 2007), https://iris.who.int/handle/10665/43713.

[75] Daniel Tarantola et al., 'H1N1, public health security, bioethics, and human rights', *The Lancet* 373: 9681, 2009, pp. 2107–8, https://doi.org/10.1016/S0140-6736(09)61143-0.

[76] UN General Assembly, *Global health and foreign policy: resolution adopted by the General Assembly*, 2009, https://digitallibrary.un.org/record/642456.

[77] HM Government, Department of Health, *Health is global: a UK government strategy 2008–13*, 2008, https://webarchive.nationalarchives.gov.uk/ukgwa/20130105191920/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702.

[78] See U.S. Centers for Disease Control and Prevention, 'Global health security', 2023, https://www.cdc.gov/global-health/topics-programs/global-health-security.html.

appears to have occurred in large part *because* of the proliferation of GHS norms. A growing number of actors questioned the efficacy of proliferating infectious disease-specific partnerships (GHS) at the expense of comprehensive health system strengthening (HSS),[79] which many believed could be better addressed through newer conceptualizations of UHC.[80] For example, Vega argued that MDG-related initiatives 'fragmented health systems [and] contributed to inequities in health'.[81]

This context appears to have catalysed a tipping-point for UHC norms, which began with the 2010 *World health report*.[82] By explicitly advising countries to 'raise sufficient funds [and] improve efficiency and equity', the report placed a normative emphasis on financing accessible health services for all, including by obligating international assistance. Language across concurrently adopted regional commitments on UHC (e.g. the Bangkok Statement on UHC and the Mexico International Forum on UHC)[83] suggests that, even domestically, pushback of GHS norms coincided with renewed interest in health promotion and social determinants of health—reflecting a broader (re)commitment to the core principles of the DAA and signalling further adjustments to the content of UHC norms. Finally, a 2012 WHO discussion paper (stating people should have access to '*all* the services' they need)[84] and a 2012 UNGA resolution (stating '*all people*' should have access to nationally determined health services)[85] provide further evidence of a norm cascade. Indeed, Vega contends that UHC became a constant in the world of global health following the 2012 UNGA resolution.[86]

Early signs of convergence Analysis of this crucial period illustrates that GHS and UHC norms were not evolving independently, despite much literature holding them as separate. For example, a human rights frame was not the sole factor carrying UHC over its tipping-point in 2010; instead, new links sparked by 'health-in-all-policies' campaigns[87] alongside increasing calls for aid effectiveness[88] helped (re)construct a formulation of UHC that Granmo argues fell 'more in line with the traditional notion of *hard politics* and the interests of states'[89]—a consequence of securitized policy pathways (albeit, increasingly contested)

[79] Jeremy Shiffman, 'Donor funding priorities for communicable disease control in the developing world', *Health Policy and Planning* 21: 6, 2006, pp. 411–20, https://doi.org/10.1093/heapol/czl028.

[80] Josefien van Olmen et al., 'Health systems frameworks in their political context: framing divergent agendas', *BMC Public Health* 12: 774, 2012, pp. 774–87, https://doi.org/10.1186/1471-2458-12-774.

[81] Jeanette Vega, 'Universal health coverage: the post-2015 development agenda', *The Lancet* 381: 9862, 2013, pp. 179–80, https://doi.org/10.1016/S0140-6736(13)60062-8.

[82] World Health Organization, *The world health report: health systems financing: the path to universal coverage* (Geneva: WHO, 2010), https://apps.who.int/iris/handle/10665/44371.

[83] Granmo, *Health norms in the global governance of development*.

[84] World Health Organization, *Positioning health in the post-2015 development agenda* (Geneva: WHO, 2012), https://www.stoptb.org/2-12-111positioning-health-post-2015-development-agenda-who-discussion-paper-october-2012 (emphasis in original).

[85] UN General Assembly, *Global health and foreign policy: resolution adopted by the General Assembly*, 2012, https://digitallibrary.un.org/record/747119 (emphasis added).

[86] Vega, 'Universal health coverage'.

[87] World Health Organization and Government of Finland, Ministry of Social Affairs and Health, *Health in all policies: Helsinki statement. Framework for country action* (Geneva: WHO, 2014), https://apps.who.int/iris/handle/10665/112636.

[88] Shiffman and Shawar, 'Framing and the formation of global health priorities'.

[89] Granmo, *Health norms in the global governance of development* (emphasis in original).

resulting from GHS norm proliferation. By 2009, both were beginning to be viewed as synergistic goals. WHO Director-General Margaret Chan encapsulated this, arguing that disease-specific interventions (GHS) and HSS (UHC) 'are not mutually exclusive but rather mutually reinforcing'.[90] This period marked the nascent 'emergence' of conceptualizing GHS and UHC as an integrated package of norms for states to enact.

Norm internalization and integrated conceptualizations: ideational shifts following GHS and UHC institutionalization (2013–2019)

The west Africa Ebola outbreak and interactions with UHC Observers saw the 2014 west Africa Ebola outbreak as a crucial moment for GHS norm diffusion.[91] The determination of the crisis as a PHEIC requiring support 'on the most urgent basis possible'[92] marked a noteworthy advancement in GHS operationalization. One month later, the UNSC characterized the Ebola outbreak as 'a threat to international peace and security',[93] amplifying security rhetoric beyond the wording of UNSC Resolution 1308. This advancement in GHS discourse reflected not just a deeper internalization of GHS norms, but also a heightened securitization logic. The impact of this progression on GHS norms can be demonstrated by the UN's deployment of its first emergency health mission (the UN Mission for Ebola Emergency Response—UNMEER), which cited 'the unprecedented nature and scope' of the Ebola outbreak[94] as justification for seemingly sidelining WHO to mitigate the crisis—a sign of increasing encroachment by non-health (often securitized) actors into conventional health spaces.

Meanwhile, throughout the Ebola response, WHO reports simultaneously encouraged member states to 'facilitate progress towards UHC'.[95] Notably, post-MDG discourse emerged as a dominant influence on several resolutions at the 67th World Health Assembly, with important implications for states to subtly (re)frame UHC norms. For example, WHA 67/25 urged countries to 'consider the contribution of health promotion in the renewal and reform of [PHC]', while WHA 67/30 encouraged medicines reimbursement lists to 'promote access to essential

[90] Margaret Chan, 'Why the world needs global health initiatives', speech, 22 June 2009, https://www.who.int/director-general/speeches/detail/why-the-world-needs-global-health-initiatives.

[91] David L. Heymann et al., 'Global health security: the wider lessons from the West African Ebola virus disease epidemic', *The Lancet* 385: 9980, 2015, pp. 1884–901, https://doi.org/10.1016/S0140-6736(15)60858-3; Tim K. Mackey, 'The Ebola outbreak: catalyzing a "shift" in global health governance?', *BMC Infectious Diseases* 16: 699, 2016, https://doi.org/10.1186/s12879-016-2016-y.

[92] Maev Kennedy, 'WHO declares Ebola outbreak an international public health emergency', *Guardian*, 8 Aug. 2014, https://www.theguardian.com/society/2014/aug/08/who-ebola-outbreak-international-public-health-emergency.

[93] United Nations, 'With spread of Ebola outpacing response, Security Council adopts Resolution 2177 (2014) urging immediate action, end to isolation of affected states', 18 Sept. 2014, https://press.un.org/en/2014/sc11566.doc.htm.

[94] Gian Luca Burci and Jakob Quirin, 'World Health Organization and United Nations documents on the Ebola outbreak in West Africa', *International Legal Materials* 54: 3, 2015, pp. 532–60, https://doi.org/10.5305/intelegamate.54.3.0532.

[95] World Health Organization, 'Access to essential medicines: report by the secretariat', 14 Jan. 2014, https://apps.who.int/gb/ebwha/pdf_files/EB134/B134_31-en.pdf.

medicines' as part of UHC.[96] Together, these resolutions portray a configuration of UHC norms that attempted to institutionalize rights-based frames from the DAA alongside more contemporary financing approaches (e.g. the 2010 *World health report*).

The gradual intermixing of GHS and UHC norms became more visible during this period, as parallel gaps in access and affordability between the Ebola and AIDS responses emerged, and multisectoral approaches like HSS were embraced over disease-specific interventions. In December 2014, high-level leaders of the Ebola response agreed to concurrently 'rebuild essential health services [and] build the foundation for universal health coverage'.[97] Meanwhile, then UN Secretary-General Ban Ki-moon noted in his remarks to the UN Economic and Social Council that 'Ebola has brought hard lessons, including the importance of functioning health systems and universal quality health coverage'.[98] This also played out regionally, with African Union Chairperson Nkosazana Dlamini-Zuma claiming the 'Ebola crisis highlighted the weaknesses of our public health systems, and the reasons for our frameworks that call for universal access'.[99]

The 2015 Special Session of the WHO Executive Board was catalytic in conceptualizing GHS and UHC together; the convening itself demonstrated profound internalization of GHS norms by uniting countries against the 'threat' of Ebola, while its report visibly promoted UHC core functions *alongside* emergency response.[100] The session framed the Ebola outbreak as a 'window of opportunity' for HSS 'that lays the groundwork … for universal access to safe, high quality health services'.[101] Complementing this was the promotion of 'resilience', a capacity focused on well-functioning health systems (UHC) during health crises (GHS), which opened a new normative space for states to envision areas of overlap, rather than prioritization of one over the other.

The joint advancement of GHS and UHC norms similarly emerged outside the Ebola response. A 2014 UNGA High-Level Meeting saw states frame non-communicable diseases as a 'great threat to economic and social structures'[102] while simultaneously affirming accessible and affordable chronic health care services through UHC. Similarly, Resolution WHA67.1[103] linked progress for UHC with improved tuberculosis outbreak notifications (GHS). Together, these reflect an evolution in how states viewed vulnerability to both infectious and non-infectious

[96] World Health Organization, 'WHA67', 2014, https://apps.who.int/gb/e/e_wha67.html.

[97] World Health Organization Executive Board, special session on Ebola, *Building resilient health systems in Ebola-affected countries: special session of the Executive Board on the Ebola Emergency* (Geneva: WHO, 2015), https://apps.who.int/iris/handle/10665/251741.

[98] United Nations, 'Secretary-General tells Economic and Social Council Ebola's "hard lessons" show universal quality health coverage critical to post-2015 development agenda', 5 Dec. 2014, https://press.un.org/en/2014/sgsm16398.doc.htm.

[99] African Union, 'Statement of the chairperson of the African Union Commission, HE Dr Nkosazana Dlamini Zuma to the emergency meeting of the African Union Executive Council on Ebola', 8 Sept. 2014, https://au.int/ar/node/25402.

[100] World Health Organization, 'EBSS3: main documents', 2015, https://apps.who.int/gb/e/e_ebss3.html.

[101] World Health Organization Executive Board, *Building resilient health systems in Ebola-affected countries*.

[102] UN General Assembly (68), 'General Assembly high-level meeting on non-communicable diseases urges national targets, global commitments to prevent needless loss of life', 10 July 2014, https://press.un.org/en/2014/ga11530.doc.htm

[103] 67th session of the World Health Assembly, *Global strategy and targets for tuberculosis prevention, care and control after 2015* (Geneva: WHO, 2014), https://apps.who.int/iris/handle/10665/162760.

disease threats, given changes to the content and operationalization of GHS and UHC norms.

Consensus among UN member states to radically move beyond the MDGs arguably had the most significant impact on the integration of GHS and UHC. For example, a resolution titled 'Health in the post-2015 development agenda' urged states to build 'capacities for broad public health measures, health protection and … equitable universal coverage', while identifying the 'synergies between policy objectives in the health sector and other sectors through a whole-of-government, whole-of-society approach'.[104] These efforts culminated in the September 2015 adoption of the Sustainable Development Goals (SDGs), of which SDG3 aimed to 'ensure healthy lives and promote well-being for all'.[105] Achieving UHC was codified as a specific target (3.8), marking a major milestone in legitimizing UHC as a stand-alone obligation for states. Meanwhile, health emergencies and IHR capacity-strengthening were promoted under another target (3.D.1). Granmo argues that the integrative framing of SDG3 was a reflection of states' preferences for 'inclusivity' and 'sustainability', two 'super-norms' that were well positioned to foster international cooperation across health-specific silos, including between GHS and UHC.[106] Kickbusch further asserts that the design of the SDGs to enable cross-cutting linkages suggested a broader shift towards policy coherence and integrative diplomacy, with implications on the content of subsequent global health norms.[107] However, the lack of explicit references to health 'security' is notable (especially given the backdrop of Ebola), suggesting hesitation among some states to further mainstream security discourse in SDG3, with a growing consensus that UHC may be better equipped to address the 'blind spots' of the MDGs.

The Zika outbreak and the introduction of GPW13 Five months after the SDGs were adopted, a new PHEIC was determined for clusters of microcephaly associated with Zika. Scholars have attributed its rapid securitization as a sign that GHS norms were still deeply internalized, particularly among emergency actors.[108] However, the WHO Zika strategic response plan[109] recommended improving access to health services in affected countries (UHC) *alongside* strengthening surveillance and risk assessments (GHS). Several resolutions during the 69th World Health Assembly in 2016 (which coincided with the peak of Zika response and followed a year of SDG3 socialization) affirmed that states were actively

[104] 67th session of the World Health Assembly, *Health in the post-2015 development agenda* (Geneva: WHO, 2014), https://apps.who.int/gb/ebwha/pdf_files/wha67/a67_r14-en.pdf.

[105] World Health Organization, 'Monitoring health for the SDGs', 2024, https://www.who.int/health-topics/sustainable-development-goals.

[106] Granmo, *Health norms in the global governance of development*.

[107] Ilona Kickbusch, Haik Nikogosian, Michel Kazatchkine and Mihály Kökény, *A guide to global health diplomacy: better health—improved global solidarity—more equity* (Geneva: Graduate Institute of International and Development Studies, Global Health Centre, 2021), https://repository.graduateinstitute.ch/record/298891.

[108] Clare Wenham et al., 'Zika, abortion and health emergencies: a review of contemporary debates', *Globalization and Health* 15: 49, 2019, https://doi.org/10.1186/s12992-019-0489-3.

[109] 69th session of the World Health Assembly, *WHO response in severe, large-scale emergencies: report of the Director-General* (Geneva: WHO, 2016), https://apps.who.int/iris/handle/10665/252685.

promoting interrelated GHS–UHC framings. For example, WHA69.1[110] heavily referenced previous agreements central to the advancement of *both* GHS and UHC, noting that 'the integrated, cross-cutting nature of the [SDGs], which call for multisectoral action', compelled states to integrate GHS and UHC capacity-strengthening.

Shortly thereafter, the launch of WHO's Thirteenth General Programme of Work (GPW13) placed health emergencies (GHS) and UHC on equal footing as two overarching goals for 2019–2023. Championed by Ghebreyesus, GPW13 urged global health actors to 'bring health emergencies and UHC closely together', observing the relationship between weak health systems and health crises.[111] It further stated 'WHO will track the impact of its emergency response work … by measuring access to and delivery of … the UHC objective', essentially connecting the monitoring of GHS with UHC implementation. Ghebreyesus, and WHO more broadly, can thus be viewed as norm entrepreneurs of an emerging 'integrated' package of GHS and UHC norms, emblematic of SDG3 and post-Ebola resolutions that endeavoured towards whole-of-society, interlinked health systems.

UHC Political Declaration and WHO Health Emergencies Reports The UN High-Level Meeting on UHC (UHC HLM) in September 2019, the first convening among UNGA member states dedicated to this topic, aimed to 'strongly recommit to achieve universal health coverage by 2030'.[112] However, the simultaneous embrace of GHS discourse by states conveys an alternative, frequently overlooked narrative—that UHC norms had continued to evolve, often in response to concurrent advancements in GHS. For instance, the WHO's preparatory document for the UHC HLM's political declaration in March 2019 urged 'a shift in traditional development thinking' long focused on 'fighting disease', and suggested that UHC 'is both a goal in itself and a means for implementing other goals', including disease prevention and health promotion.[113] This document made no reference to 'health security' or 'health emergencies', and was relatively consistent with preceding UHC-related texts such as WHA 67/25. However, by May 2019, the preliminary draft signalled that states were intentionally introducing GHS-specific language, explicitly mentioning health security and emergencies and alluding to epidemics, pandemics and other threats[114]—a noteworthy shift which was likely catalysed by the simultaneous new PHEIC for Ebola in the Democratic Republic of the

[110] 69th session of the World Health Assembly, *Strengthening essential public health functions in support of the achievement of universal health coverage* (Geneva: WHO, 2016), https://apps.who.int/iris/handle/10665/252781.

[111] World Health Organization, 'Thirteenth general programme of work 2019–2023', https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf.

[112] UHC 2030, 'Political declaration for the UN high-level meeting on UHC', 16 Sept. 2019, https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf.

[113] World Health Organization, *Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage*, 2019, https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_14-en.pdf.

[114] HE Mr Kaha Imnadze and HE Mr Vitavas Srivihok, 'Zero draft of the political declaration of the high-level meeting on universal health coverage', UNGA, 17 May 2019, https://www.un.org/pga/73/2019/05/17/universal-health-coverage-8.

Congo.[115] The adopted UHC HLM political declaration featured the most frequent and robust references to GHS in a UHC-focused document, repeatedly drawing links to communicable disease control, health emergency response, health security and pandemic preparedness.[116]

Meanwhile, the WHO Director-General's health emergency reports similarly reflect incremental integration of UHC discourse into the traditionally GHS-focused series. After years of exclusively detailing progress on IHR core capacities, the 2017 report recognized how infectious diseases stem from 'weak health systems *and* inadequate preparedness and response capacities', and acknowledged a 'greater focus on preventing and managing medical complications caused by Zika virus infection *and* expanding health systems' capacities'.[117] Consequently, WHO committed to supporting countries' health emergencies response through HSS. The 2018 report introduced UHC language for the first time, saying:

> The interrelated issues of safeguarding our health security while promoting our health through universal health coverage are WHO's top priority … Strong health systems are our best defence to prevent disease outbreaks from becoming epidemics … based on principles of universal access, readiness and resilience.[118]

This passage illustrates the harmonization of previously distinct GHS and UHC discourse in a way that transforms the 'content' of both norms, shaped by the concurrent management of the DRC Ebola PHEIC alongside negotiations for the first PHC political declaration since the DAA. These ideational shifts were consolidated in the 2019 WHA report, which explicitly championed 'the integration of universal health coverage and health security', closely reflecting GPW13 framings in a way that obligated state behaviour to address both synergistically.[119]

A new approach: understanding GHS and UHC norms as ongoing processes

Our analysis extends current interpretations of GHS and UHC norms by examining how they have been (re)constructed through contestation and interaction. We therefore propose three major insights: 1) the 'content' of GHS and UHC norms is constantly evolving, even after both have passed through respective norm life-cycles, 2) GHS and UHC norms have significantly influenced each

[115] World Health Organization, 'Statement on the meeting of the International Health Regulations (2005) Emergency Committee for Ebola virus disease in the Democratic Republic of the Congo on 17 July 2019', 17 July 2019, https://www.who.int/news/item/17-07-2019-statement-on-the-meeting-of-the-international-healthregulations-(2005)-emergency-committee-for-ebolavirus-disease-in-the-democratic-republic-of-the-congo-on-17-july-2019.

[116] UHC 2030, 'Political declaration for the UN high-level meeting on UHC'.

[117] 70th session of the World Health Assembly, *Health emergencies: WHO response in severe, large-scale emergencies: report by the Director-General* (Geneva: WHO, 2017), https://apps.who.int/iris/handle/10665/274705 (emphasis added).

[118] 71st session of the World Health Assembly, *Public health preparedness and response: WHO's work in health emergencies: report by the Director-General* (Geneva: WHO, 2018), https://iris.who.int/handle/10665/276289.

[119] 72nd session of the World Health Assembly, *Public health emergencies: preparedness and response: WHO's work in health emergencies: report by the Director-General* (Geneva: WHO, 2019), https://apps.who.int/iris/handle/10665/328553.

other as they developed together, and 3) GHS and UHC norms have been increasingly conceptualized in integrated ways over recent years.

Our analysis demonstrates potential limitations in Finnemore and Sikkink's norm life-cycle model, which sees norms as 'settled' once the tipping-point and cascade have been reached. Krook and True's conceptualization of norms 'as processes' may explain how both norms evolved from distinct policy domains into increasingly synergistic regimes—a phenomenon that is relatively unexplored in International Relations. This is particularly applicable to inherently complex normative situations like GHS and UHC—where multiple norms compete for influence and where, in this case, rather than emerging from the tension as alternative or hierarchical norms, both adapt to each other to maintain relevance.

Continuously evolving norm life-cycles

A re-examination of GHS and UHC norms as ongoing processes suggests that their life-cycles and underlying frameworks have always been—and will likely continue to be—in a state of flux. While this does not negate progressive stages of norm development, it suggests that norm progression is more fluid, marked by periods of reversal, transformation and advancement. Our analysis demonstrates that the content of GHS norms has been continually reconstituted, from the International Sanitary Conferences to the post-Cold War and 9/11 securitization, to HIV/AIDS and the proliferation of vertical disease programmes following the MDGs. Today, a lack of IHR compliance[120] calls for a 'One Health' approach,[121] and rising socio-economic inequities during health emergencies like the COVID–19 pandemic portend future (re)constructions of GHS norms. Meanwhile, early rights-based commitments for UHC characterized as 'health for all' gave way to 'selective coverage' considering economic constraints and globalization, followed by a focus on financial protection and HSS, and ultimately reconfiguration as a cross-cutting target via SDG3.8 based on 'sustainability'. Today, new conceptualizations of UHC norms, reinvigorated by renewed attention on PHC and community-level resilience, have been promoted in the 2023 UHC HLM.[122] As reflected in the texts, these shifts in the content of GHS and UHC norms influenced state behaviour and obligations; evolution is ongoing, as manifested by continued subtle and profound changes.

The findings demonstrate that securitization served as an enabling condition for the emergence of GHS norms,[123] while the right to health served as an enabling condition for the emergence of UHC norms.[124] Both norms have further

[120] Sadia Mariam Malik, Amy Barlow and Benjamin Johnson, 'Reconceptualising health security in post-COVID–19 world', *BMJ Global Health* 6: 7, 2021, https://doi.org/10.1136/BMJGH-2021-006520.
[121] Yibeltal Assefa et al., 'Global health security and universal health coverage: understanding convergences and divergences for a synergistic response', *PLoS ONE* 15: 12, 2020, https://doi.org/10.1371/journal.pone.0244555.
[122] UN General Assembly, 'Political declaration of the high-level meeting on universal health coverage', 25 Sept. 2023, https://documents.un.org/doc/undoc/ltd/n23/272/29/pdf/n2327229.pdf.
[123] Preslava Stoeva, 'Dimensions of health security—a conceptual analysis', *Global Challenges* 4: 10, 2020, https://doi.org/10.1002/gch2.201700003.
[124] Gorik Ooms et al., 'Universal health coverage anchored in the right to health', *Bulletin of the World Health*

evolved since their respective ideational origins, but it is precisely *because* of (not in spite of) their dynamic and iterative histories that they persist today. Understanding GHS and UHC norms as continuously evolving processes thus helps to: 1) upend the view that normative development in GHS and UHC follows a linear path, 2) characterize GHS and UHC both as norms themselves *and* as a means for shaping other (re)constructed norms (and corresponding regimes), and 3) suggest that recurring patterns observed after significant international agreements and health crises are likely to persist in shaping future shifts in GHS and UHC.

Interlinkages through interaction and contestation

GHS norms have traditionally maintained a narrow focus on infectious disease control and health emergency response, further reinforced by IHR core capacities; increased support for UHC norms is routinely preceded by the elevation of underlying principles like equity and inclusivity. However, our analysis also suggests that the resurgence of rights-based discourse from UHC often fuels critiques of GHS (e.g. as being overly accommodating of national security interests at the expense of vulnerable populations), which has sometimes resulted in a deprioritization of GHS (e.g. within SDG3) or a transformation in the content of GHS (e.g. within the 2014 Ebola response). This discursive view of norm change also helps explain ideational shifts in UHC. For example, UHC norm entrepreneurs responded to critiques over ambiguous 'context-specific' definitions and the glacial pace of 'progressive realization' by increasingly drawing on 'high politics' framings conventionally associated with GHS[125] (e.g. 'front-line' health workers, characterizing non-communicable diseases as a 'threat' to national and economic security, mainstreaming UHC in emergency preparedness).[126]

Interestingly, repeated contestation and interaction between GHS and UHC has not led to the obsolescence of either norm, as is often expected in fraught normative landscapes, but has in fact helped both norms adapt to maintain relevance—with different framings emphasized at different times. This was the case with the SDGs agenda, which pushed GHS norm entrepreneurs to promote HSS following decades of siloed disease-specific programming, while also enabling UHC norm entrepreneurs to move beyond the confines of selective health insurance to re-emphasize UHC's roots in social determinants of health. Moving forward, GHS and UHC advocates could capitalize on each other's unique strengths. Our analysis suggests that GHS norms have generally enjoyed significant inertia due to perceived 'high politics' and conventional top-down governance structures, thereby catalysing global investments in ways that UHC norms have struggled to mobilize. Meanwhile, UHC norms traditionally enjoy broader support among global South and civil society actors given rights-based foundations, a blind spot of the GHS

Organization 91: 1, 2013, pp. 2–2A, https://doi.org/10.2471/BLT.12.115808.

[125] Jeremy Youde, 'High politics, low politics, and global health', *Journal of Global Security Studies* 1: 2, 2016, pp. 157–70, https://doi.org/10.1093/jogss/ogw001.

[126] World Health Organization, 'Communicable and noncommunicable diseases, and mental health', n.d., https://www.who.int/our-work/communicable-and-noncommunicable-diseases-and-mental-health.

regime. Building off their complementary (re)constructions may help both GHS and UHC norm entrepreneurs advance their goals in the face of new challenges.

Mutually reinforcing integration

A 'norms as processes' approach helps unpack the ways in which GHS and UHC norms continue to be constructed through integrated discourse and core functions. Our analysis traces the diffusion of UHC norms within GHS documents (e.g. WHO health emergency reports) alongside concurrent diffusion of GHS norms within UHC documents (e.g. iterative drafts of the 2019 UHC HLM political declaration)—both examples of meaningful incorporation in spaces where they were once excluded. The positioning of GHS and UHC as mutually reinforcing norms intensified as a result of the post-MDG agenda. This may suggest further integration and potentially new (re)constructions as the SDGs approach their own deadline in 2030, which has been further shaped by negotiations for a new pandemic agreement, IHR amendments, and subsequent UN HLMs related to GHS and UHC.[127]

Moving forward, challenges remain in reconciling fundamental differences between GHS and UHC norm regimes due to their diverse constituencies and conceptualizations. Our analysis shows that GHS norms, rooted in securitized approaches often favoured among foreign policy circles, are better primed to be operationalized through international legislation. Meanwhile UHC norms, rooted in human rights, are primarily framed as domestic issues warranting local, context-specific interventions. This creates divergences in how epistemic and ontological communities conceptualize GHS and UHC, and how both are implemented (e.g. GHS actors may approach antimicrobial resistance through global surveillance, while UHC actors may respond through local health worker training). Furthermore, the legally binding mechanisms through which GHS norms are codified tend to more explicitly obligate specific steps for capacity-strengthening (e.g. IHR). In comparison, UHC norms often have broader human rights implications, and therefore may be more challenging to pass through targeted international law; this sometimes leads to relatively ambiguous commitments that lack rigorous technical guidance (e.g. the UN Convention on the Rights of Persons with Disabilities promotes principles of access and non-discrimination, but makes no explicit mention of UHC, nor of strategies for financial protection).[128] This poses challenges for the holistic pursuit of both norms: global commitments towards the 'right to health' cannot be well protected because states ultimately decide their own levels of UHC, while GHS is undermined internationally by inequitable access to health services domestically.

[127] Arush Lal et al., 'Pandemic preparedness and response: exploring the role of universal health coverage within the global health security architecture', *The Lancet Global Health* 10: 11, 2022, pp. e1675–83, https://doi.org/10.1016/S2214-109X(22)00341-2.

[128] UN Division for Inclusive Social Development, 'Convention on the Rights of Persons with Disabilities (CRPD)', https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd.

GHS norms may initially appear to hold greater normative weight in international forums, given relatively clearer obligations through legally binding instruments. However, while the securitization narratives associated with GHS can be effective catalysts for tangible policy actions, this framing often proves reactionary and short-termist; meanwhile, rights-based frames can be powerful motivators for longer-term, sustainable action.[129] For the moment, however, UHC advocates appear to be more accommodating of GHS norms than vice versa. Similarly, the relatively anaemic embrace of UHC discourse into the GHS regime (as opposed to GHS discourse into UHC initiatives) may suggest that GHS has undergone more rigorous normative grounding than UHC (possibly due to perceived urgency of GHS discourse during crises and/or the 'robustness' of GHS core functions institutionalized by security actors). The GHS regime may therefore be more resistant to integrate UHC norms than the other way around.

The variation in normative weight among different actors also means there may be occasions where integration appears (e.g. evoking UHC discourse during recent health emergencies) but is not meaningfully operationalized for political or operational reasons, implying the need to distinguish between 'lip service' and sustained uptake (i.e. their co-presence in a document may not be enough to substantiate convergence). Solely relying on the norm life-cycle would suggest that GHS and UHC norms (and their emerging intersections) are only influential *after* they have 'emerged' and been internalized. However, our view of GHS and UHC norms as ongoing processes posits that interaction and contestation matter more to normative development—and indeed to subsequent integration—than conventional literature suggests. This means that even if a major negotiation fails to ensure norm compliance with GHS, or a crisis struggles to immediately advance UHC reforms, the very process of norm (re)construction can inevitably 'connect [policy-makers] with deeper normative paradigms that subtly shape policy solutions' in ways that warrant deeper study.[130]

Implications for broader International Relations theory

These findings have broader implications for International Relations, and for the strategic development of co-evolving norms in other spheres of governance. This article demonstrates that norms are dynamic—not only in the temporal sense, but also in the sense that normative development occurs in response to both internal and external factors. Indeed, norms evolve through contestation and interaction with each other and, importantly, as a consequence of strategic determination by norm entrepreneurs who seek to interlink and integrate normative positions within broader norm regimes.[131] This might be for agenda-raising reasons for a

[129] Fourie, 'AIDS as a security threat'.

[130] Martha Finnemore and Kathryn Sikkink, 'Taking stock: the constructivist research program in international relations and comparative politics', *Annual Review of Political Science*, 4: 1, 2001, pp. 391–416, cited in Lisa Forman, Gorik Ooms and Claire E. Brolan, 'Rights language in the Sustainable Development agenda: has right to health discourse and norms shaped health goals? *International Journal of Health Policy and Management* 4: 12, 2015, pp. 799–804, https://doi.org/10.15171/ijhpm.2015.171. _

[131] Clare Wenham, 'Forum shifting in global health security', *Bulletin of the World Health Organization*, vol. 102,

norm which has less saliency—to 'hitch' it to a more politically dominant norm so that both policy areas are developed in tandem—or to ensure that norm evolution does not lead to a 'siloization' of policy pathways.

This work therefore demonstrates the agency of diverse actors to push for normative alignment seen to be of value (albeit not necessarily for the same reasons) in recognition of the strategic purpose of norm integration where two powerful norms each co-produce greater stability when co-evolution occurs. It also points to the importance of interactive norm regimes, and proposes that once a tipping-point for normative integration has been reached, expectations for such interlinked approaches may become self-fulfilling. As such, it may not be that newly emergent norms simply supersede or replace 'older' norms. Rather, a dynamic process of norm (re)construction is likely to enable more nuanced positions.

The findings of this article also have implications for other sectors, which see an opportunity to integrate different normative positions collectively, rather than considering diverging framings to be a zero-sum contest. Multiple forums in global governance could benefit from understanding the political and practical feasibility of this—particularly areas facing interlinked challenges, including climate change, conflict resolution, human rights, economic inequality, humanitarian crises and nuclear non-proliferation. Policy-makers and advocates in each area might benefit by pushing for greater interaction between their normative positions and those that offer new strategic advantages, to ensure mutual reinforcement amid growing resource constraints and fluctuating policy priorities.

Conclusion

In tracing their origins from securitization and right-to-health frames through subsequent development following major international agreements and crises, we ultimately characterize GHS and UHC norms as continuously evolving, closely interlinked and increasingly integrated. We argue that both norms have been iteratively (re)constructed after significantly shaping each other, and have subsequently constituted new sets of obligations for states and non-state actors to jointly pursue public health efforts. In doing so, we provide a wider conceptual contribution to both global health and International Relations, conducting a careful genealogy of these two norms covering not just where and when they were invoked, but also the ways in which this represented a shifting of their content.

Our analysis demonstrates that examining the intersections between GHS and UHC reveals more about their nature (which is inherently interconnected) than studying their distinct pathways (which appear initially dichotomous). Thus, we find that the norm life-cycles of GHS and UHC do not follow a linear course from emergence to internalization: rather, the trajectory of their underlying components, including discourse and core functions, are fraught with points of interaction and contestation, as domestic and global stakeholders attempt to redefine, reshape and reposition them in light of internal and external dynamics. This contributes

2024, pp. 123–9, https://doi.org/10.2471/BLT.23.290480.

to the wider norms literature, arguing that the 'content' of GHS and UHC norms is constantly evolving (including after both have passed through respective norm life-cycles), allowing practitioners to account for nuanced changes in normative development.

By analysing the development of GHS and UHC norms together—rather than separately, as is usually done—this study offers a more comprehensive understanding of their respective life-cycles and increasingly synergistic (re)constructions. We therefore argue that GHS and UHC norms should not be viewed as stand-alone or independent concepts, but rather as interrelated and mutually reinforcing normative regimes. Furthermore, their co-evolution does not reflect a straightforward accumulation of insights. Instead, GHS and UHC norms appear to develop in reaction to one another, partly in line with prevailing paradigms and partly as a response to the very different needs of their stakeholders. Most importantly, both norms appear to thrive on each other as they have co-evolved, with different weightings and narratives being leveraged at different points in time. So, while GHS and UHC may still be considered separate norms with respective regimes (indeed, in practice they often require individual policies and budget lines), both are ultimately delivered through the same health system, and it may be strategically salient to approach them together.

Noting the challenges of identifying precise characteristics for each stage of norm development, further research is needed to examine how non-health norms affect GHS and UHC emergence; how legal instrumentalization or regime politics influence subsequent internalization; and how the COVID–19 pandemic affects the convergence and coherence of GHS and UHC norms. Additionally, while this study was intentionally focused on examining discursive shifts in GHS and UHC largely codified by states through high-profile international agreements (which arguably may be relatively susceptible to normative integration from other policy areas), further research could focus on the more 'mundane' day-to-day shifts in normative development, as well as the crucial role of non-state actors (e.g. civil society and donors) in constructing GHS and UHC norms.

This account of how multiple norms compete in a dynamic interplay to continually influence and reshape each other offers crucial insights to forecast normative development in the face of novel, interlinked challenges. By advancing our understanding of how two powerful norms (each embedded within distinct, yet overlapping, regimes) inevitably engage in intricate processes of norm contestation and interaction resulting from proximity and politics, this study allows us to envision a more constructive pathway for norm change—one that does not result in the ultimate obsolescence of either norm, but rather one that enables harmonization and resilience of (re)constructed norms through strategic integration. The lessons derived from this work not only contribute to the scholarly discourse on international norms theory, but also offer pragmatic implications for practitioners navigating the complexities of global health governance and other areas of foreign policy in an ever-shifting normative landscape.

Chapter 7: Convergence (Empirical Paper 2)

Lal *et al. Globalization and Health* (2025) 21:5
https://doi.org/10.1186/s12992-025-01099-3

Globalization and Health

RESEARCH Open Access

Normative convergence between global health security and universal health coverage: a qualitative analysis of international health negotiations in the wake of COVID-19

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Abstract

Background The UN Sustainable Development Goals (SDGs) and WHO Thirteenth General Programme of Work underscored the importance of mitigating health emergencies while ensuring accessible and affordable health services. Central to these efforts are global health security (GHS) and universal health coverage (UHC), which act both as standalone goals and as cross-cutting approaches to health policy and practice. While GHS and UHC each operate as distinct norms, global health stakeholders increasingly advocate for advancing them synergistically to address interconnected health challenges amid limited resources. However, the current extent of alignment between GHS and UHC remains unclear, especially post-COVID-19. This qualitative study assesses normative convergence between GHS and UHC by tracing their development through iterative draft texts across two major international health negotiations – specifically examining how UHC norms are expressed in the WHO Pandemic Agreement, and how GHS norms are expressed in the 2023 UNGA Political Declaration on Universal Health Coverage.

Results UHC was promoted in the WHO Pandemic Agreement through three closely-associated discourse themes (rights-based narratives, equity frames, focus on social determinants of health) and three closely-associated core functions (accessible and affordable health commodities, prioritizing vulnerable populations, primary health care approach). Meanwhile, GHS was reciprocally promoted in the 2023 UHC Political Declaration through three related discourse themes (existential threat narratives, resilience frames, focus on infectious diseases) and three related core functions (outbreak preparedness, health emergency response, One Health approach).

Conclusions The findings indicate that the COVID-19 pandemic created a policy window uniquely-positioned to accelerate normative convergence between GHS and UHC. Both international agreements advanced convergence by demonstrating increased complementarity and interdependency between the two norms through the co-promotion of their underlying features. However, negotiators agreed to political and operational trade-offs which made it difficult to sustain progress. This study provides a nuanced account of how global health norms evolve through integration in complex policy environments – finding that normative convergence may not always be explicit, but rather implicit through incremental linkages in their underlying discourse and core functions. This research contributes to pragmatic

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efforts by global health actors seeking consensus amidst an era of polycrisis, and highlights the importance of navigating geopolitics and overcoming path dependencies. It also deepens scholarly understanding on how 'hybrid norms' develop through the dynamic process of normative convergence via diplomacy.

Keywords Global health diplomacy, Global health security, Universal health coverage, Politics, Governance, Health systems, Negotiations, International affairs, Norms

Introduction

As public health has become a priority for international cooperation, researchers have increasingly sought to analyse the role of norms in shaping global health politics and practice. Norms are seen to capture broad ideas identified by collective understandings, organizing principles, and expected behaviors [1]. Given the influence of norms on both the conceptualisation of major health challenges and the policy solutions to address them, global health stakeholders often turn to international agreements to institutionalize and legitimize emerging health norms [1–3].

Previous studies have identified global health security (GHS) and universal health coverage (UHC) as two major concepts driving health policy [4, 5]. A subset of this literature has examined their associated norms separately, perceiving them to entail distinct sets of underlying discourse and core functions. For example, GHS typically emphasizes securitization frames to address infectious disease outbreaks [6], while UHC emphasizes rights-based frames through accessible and affordable health services [7].

Global health stakeholders have increasingly sought to identify synergies between GHS and UHC as a way to maximize limited resources while addressing multifaceted health challenges [8]. An emerging body of work has attempted to advance scholarship on the integration of GHS and UHC, viewing them not as separate, 'fixed' norms, but instead as dynamic 'processes' that are continually-evolving and contested [9]. By tracing how GHS and UHC have been (re)constructed over several decades, this view conceptualizes both as individual norms as well as broader normative regimes comprised of overlapping actors, policies, and governance structures that are more interconnected than previously thought. However, what has not yet been explored is how GHS and UHC norms converge, nor what their current state of normative alignment looks like in the wake of the COVID-19 pandemic. This has important implications for policy formulation in response to complex crises, as well as for fostering consensus through overlapping global health diplomacy mechanisms.

This paper addresses this gap by analysing the convergence between GHS and UHC norms to uncover recent shifts in their evolution and subsequent impact on global health policy. Through a multimethod qualitative analysis of two major international health agreements launched after the pandemic, we examine the positioning of specific GHS and UHC norms across successive negotiation drafts, thus helping determine how, to what degree, and to what level of sustainability there has been normative convergence. This mapping exercise, which focuses on an under-examined area of global health, holds important implications for health diplomacy and governance, where policymakers often grapple with how to reconcile fragmented policies and investments stemming from longstanding silo-isation [10] of public health initiatives. By providing an interpretation of how convergence processes unfold and to what end, our analysis helps to better understand how GHS and UHC, with their established histories of co-evolving reconstructions, can be pursued alongside each other as mutually-reinforcing norms. Furthermore, this work contributes to broader global health policy and international relations scholarship on the unique 'politics of integration' that may occur when two or more powerful norms are pursued, not as hierarchical or inherently incompatible, but rather through a dynamic (and ultimately more productive) process of strategic convergence as 'hybrid norms' via diplomacy.

Background

Brief review of GHS and UHC norms

Global health security (GHS) is defined as the activities required to minimize the impact of acute public health events across international borders [11]. GHS norms stem from historical linkages between health and security concerns [12], and tend to focus on risks to state interests necessitating international cooperation [13–15]. They often employ discourse themes such as existential threats [6], resilience [16], and infectious diseases [4]. Consequently, GHS norms are typically enshrined in agreements such as the International Health Regulations (2005) (IHR) [12], and operationalized through core functions related to outbreak preparedness [17], health emergency response [18], and a One Health approach [19].

Meanwhile, universal health coverage (UHC) is defined as ensuring all people have access to a comprehensive range of quality health services without posing financial hardship [20]. UHC norms stem from the recognition of a right to health [21], and tend to focus on gaps in local or community healthcare necessitating domestic health system strengthening [22]. They often employ discourse themes such as human rights [23], equity [24], and social

determinants of health (SDH) [25]. Consequently, UHC norms are typically operationalized through agreements such as the UN Sustainable Development Goals (SDGs) [26], and include core functions related to prioritizing support for vulnerable populations [25], accessible and affordable health commodities [27], and a primary health care (PHC) approach [28].

Traditionally, global health actors have treated GHS and UHC as distinct concepts, highlighting fundamental differences in the principles and approaches underpinning them [29]. However, recent scholarship [30] argues that fragmentation between these concepts – often cyclically exacerbated by competition for attention [31] and vertically-siloed investments [32] – potentially leads to poorer health outcomes. This may be the result of divergent conceptualisations of 'risk' between GHS and UHC, leading to varying views on policy solutions [29]. Furthermore, priorities of 'what' to improve in health systems often differ between the two, thereby perpetuating divergence. Misalignment between GHS and UHC norms can be particularly detrimental during health emergencies, as witnessed in the 2014 West Africa Ebola outbreak [33] and the 2016 Zika epidemic [34], where disjointed and poorly coordinated health system interventions weakened response efforts. In the wake of these crises, and amidst broader resource constraints, global health actors have increasingly sought to align GHS and UHC, with WHO Director-General Ghebreyesus even characterizing GHS and UHC as "two sides of the same coin." [35] Recent frameworks [36] and technical reports [37] published by WHO further demonstrate their efforts to operationalize coherent health systems that better connect GHS and UHC.

However, there persists a lack of clarity on how to effectively harmonize GHS and UHC norms, thus posing significant challenges to public health implementation. Researchers point out that, "although WHO approaches [GHS and UHC] agendas in principle as imminently convergent inputs towards a strong health system, scarce resources and political realities force policymakers to make tough choices," leading to prioritisation of one over the other [30]. Therefore, understanding the current extent of convergence between GHS and UHC norms – particularly in the wake of a crisis – provides important implications for the way both are pursued moving forward, with repercussions for which policies are prioritized by whom, at what levels of investment, and with which types of governance arrangements.

Current context

The context of international negotiations provides crucial insights into the challenges facing states, motivations for crafting specific commitments, and the normative landscape surrounding diplomatic efforts. Because this study focuses on the state of convergence between GHS and UHC norms following the COVID-19 pandemic, it is crucial to first appreciate recent trends in their development prior to the crisis and in its immediate aftermath.

The global health landscape witnessed significant normative shifts in response to the SDGs and post-2015 development agenda. The midpoint of the MDGs (circa 2007–2010) was marked by various stocktaking initiatives and strategic realignments following perceived failures of the MDGs [38]. Changes to global health initiatives during this period had notable implications on GHS and UHC norms, such as the push from vertical disease programming to horizontal health system strengthening [32] and an emphasis on financial protection for health services [20]. This transition laid the groundwork for (re)constructed GHS and UHC norms that were eventually reflected in the SDGs, alongside the promotion of normative frames such as 'sustainability' that have since heavily influenced contemporary global health policy [39]. Echoing this introspective phase observed halfway through the MDGs, global health stakeholders similarly found themselves grappling with still-unresolved 'wicked problems' as they approached an analogous midpoint – the 2030 SDGs deadline – just as the first cases of COVID-19 were reported.

The COVID-19 pandemic, which began in early 2020, revealed new dynamics in GHS and UHC which reflected vulnerabilities in both frameworks [37]. In the realm of GHS, the pandemic ushered outbreak responses through heavily securitized discourse [40]. The crisis exposed gaps in conventional GHS core capacities (e.g., surveillance, zoonotic spillover, early warning and alert), but also significant weaknesses in health systems that undermined existing GHS functions (e.g., disruptions to essential health services, inequitable delivery of pandemic countermeasures, poor community engagement) [41]. Conversely, within the UHC domain, the pandemic catalyzed attention on equity and access through rights-based discourses [42]. Chronic gaps in affordable healthcare and SDH were brought to the forefront, while exposing neglected shortcomings (e.g., inadequate health worker protections, disjointed emergency management, and complications due to noncommunicable diseases) [43, 44]. The pandemic therefore demonstrated how pervasive fragmentation across health systems necessitated urgent and comprehensive reforms to global health governance, including between GHS and UHC.

In response to the challenges posed by COVID-19, various efforts were launched to mitigate the ongoing crisis and address future public health challenges. The Working Group on Strengthening WHO Preparedness and Response to Health Emergencies played a pivotal role in synthesizing emerging lessons by recommending amendments to the IHR (2005) and establishing an

International Negotiating Body (INB) to develop a new instrument on pandemic prevention, preparedness, response, and recovery (the 'Pandemic Agreement') [45]. Member States intentionally designated the scope of the INB to extend beyond the purview of existing IHR in order to address GHS gaps through a novel mechanism capable of strengthening equity and global solidarity in future pandemics.

Simultaneously, the 2023 UN General Assembly (UNGA) High-Level Meeting on Universal Health Coverage, long-planned as a follow-up to the landmark 2019 UNGA High-Level Meeting (HLM) on Universal Health Coverage, gained renewed significance in the aftermath of COVID-19 [46]. Its resulting Political Declaration grappled with challenges exposed by the crisis and stalled progress to achieve UHC targets by 2030. Notably, numerous other efforts were also underway which further complicated the normative landscape, including simultaneous planning for two other health-related HLMs during the same UNGA – one on Pandemic Prevention, Preparedness, and Response (PPR) and the other on Tuberculosis.

Conceptual Approach and methods

The WHO Pandemic Agreement (PA), and the 2023 UNGA Political Declaration on Universal Health Coverage (PD) present two key international negotiations in the wake of COVID-19 through which to analyse the ways in which GHS and UHC norms have been shaped – and are ultimately converging.

Conceptualising norms

In international relations, norms are seen to encompass a spectrum of shared values and standardized procedures that shape interactions among State and non-State actors [1, 47]. Analyzing the evolution of norms can therefore offer fresh perspectives on various intersecting, complementary, and oppositional understandings of what *is* happening versus what *ought* to happen in complex policy environments like global health [3]. International actors contend that in order for norms to be strengthened or "seen as legitimate," they must first gain widespread acceptance, often through legal codification [2]. This makes international agreements or treaties particularly useful for tracing normative shifts.

A discursive approach [48] focused on norms as "sense-making practices" [49] offers helpful insights to examine patterns in their origins, adoption, and operationalization. As Epstein argues, discourses shape what people do and who they are by fixing meanings and opening subjective spaces through which norms are developed [50]. A discursive approach helps highlight the active role that global health actors play in reinscribing particular normative concepts (e.g., relevant frames or policies) through legal mechanisms via global health diplomacy [51]. This study therefore conceptualizes GHS and UHC norms as evolving 'processes' [49], adopting this discursive approach to better appreciate the relative weightings of various discourses as well as subtle changes in the deployment of these discourses across both international agreements.

Norms are traditionally analysed through expressions of core ideals and value statements. However, in contexts where the exercise of norms is inextricably linked with technical interventions, it may also be necessary to examine how they are operationalized through specific legal or policy commitments [26]. For example, Drope and Lencucha argue that the operationalization of norms fundamentally shapes discourse, thus further influencing norm development [3]. Therefore, this analysis conceptualizes norms as comprised of normative frames and guiding principles (referred to as 'discourse') as well as resultant capacities and policy actions central to implementation (referred to as 'core functions'). This approach recognizes that as GHS and UHC evolve to take on new meanings, so too do the activities they are seen to encompass. In doing so, we aim to provide a fuller account of GHS and UHC norm development, including how ideas and frames define the set of health services expected, and how prioritization of specific health issues leads to new obligations for stakeholders.

Defining norm convergence

Few scholars have examined in-depth the specific form of norm convergence analysed in the context of this study. For example, much of the available literature on norm convergence focuses on the diffusion of a particular norm across multiple institutions [52], or the integration of multiple policies across a broader norm regime or context [53]. However, limited research examines the convergence of two relatively distinct (yet equally influential) norms and their associated regimes, nor clearly traces this form of normative convergence through diplomatic forums. Drawing on existing conceptualizations of norm convergence, we provide a new definition that is more appropriate for this type of analysis.

Convergence, as described by Knill, refers to the tendency of policies to "develop similarities in structures, processes, and performances." [54] Scholars further contend that convergence usually entails "moving from different positions toward some common point," [55] as well as what Mende refers to as "complementarity [...] via inclusion" of previously-external elements [56]. Furthermore, international agreements are often considered as useful contexts for examining convergence, given that nations utilize these mechanisms to jointly address cross-border issues [52, 55]. Therefore, one aspect of normative convergence may be indicated by similarity over time,

evidenced through increased complementarity following inclusion of previously-distinct norms within international agreements.

Another element of norm convergence involves integration through a "shared normative framework." [56] Candel and Biesbroek describe integration as a process in which "constituent elements are brought together and made subject to a single, unifying conception." [57] Tosun and Lang extend this to suggest that "certain domains take policy goals of other, arguably adjacent, domains into account," [58] thereby creating "interdependencies between different policy sectors and [then coordinating] these." Thus, another aspect of normative convergence may be indicated by interdependency, evidenced through increased interlinkages with an awareness of cross-sectoral implications.

Norm convergence can therefore be defined as a process in which there is demonstrated commitment to a shared normative framework, through meaningful incorporation of distinct norms across reciprocal domains as well as integration of underlying discourse and core functions. In the context of this study, norm convergence can be evidenced within the international agreements by clear: (1) complementarity (e.g., diffusion of UHC norms within the PA and diffusion of GHS norms within the PD), and (2) interdependency (e.g., interlinkages between GHS and UHC norms that demonstrate cross-sectoral awareness).

Methodological approach

Case selection

The specific cases of the PA and PD were selected based on two criteria. First, the agreements were negotiated through the WHO and UNGA, respectively – two institutions recognized as the most prominent mechanisms for global health diplomacy [3]. Both intergovernmental organizations are alike in their liberal democratic view of international health cooperation, but also diverge slightly between core mandates, governance procedures, and internal politics–providing complementary locations to examine normative development. Second, both agreements were perceived by global health actors as significant forums to address health systems gaps made prominent by the COVID-19 pandemic – with the PA serving as one of the most high-profile efforts to codify reforms to GHS, and the PD serving as one of the most high-profile efforts to redress inaction on UHC [59]. Notably, the adoption of both agreements necessitated achieving consensus through similar processes following multiple draft revisions, leading to discursively-rich debates on normative positions.

Taken together, the two case studies offer a unique opportunity for nuanced analysis of how norms may shift through integration. We thus use a within-case comparative design [60], enabling insights from cross-case variation, while retaining comparability between cases due to similar background conditions. For example, the WHO-led INB process was more deeply embedded in the GHS regime, having been specifically initiated to address inadequate pandemic preparedness and response mechanisms as well as related capacities outside the scope of the IHR (2005) [61]. Meanwhile, the UN-led UHC-HLM negotiations were heavily rooted in UHC norms, given the aim of advancing right-to-health obligations and re-invigorating stalled progress since the 2019 UHC-HLM [62]. The intentional insertion of UHC norms into the PA texts and GHS norms into the PD texts would therefore suggest noteworthy changes in the way stakeholders conceptualize the scope of both, thereby demonstrating normative evolution and convergence. Neither mechanism has been studied with regard to its potential impact on the convergence of GHS and UHC; assessing both together provides novel insights on how integration may occur between these influential agendas.

Data collection and analysis

Adapting methodological approaches outlined by Alejandro and Zhao, we applied a two-step process comprising of a qualitative content analysis (QCA) – which includes "systematically classifying material by assessing the presence/absence and frequency of relevant elements" – alongside discourse analysis – which helps "unpack the linguistic mechanisms at play and their potential sociopolitical effects." [63] By conducting QCA (to provide breadth) in parallel with discourse analysis as the analytical framework (to provide depth), we were able to reveal both "the components of interest," as well as "inconsistencies or implicit meanings with regards to attitudes." [64] As Alejandro and Zhao note, "for QCA, the addition of discourse analysis can bring a critical perspective to investigate meaning in context, while for discourse analysis, the addition of QCA can provide a broad dataset to help researchers focus on the temporal and spatial changes in discourse." [63] This is consistent with previous studies that examine shifting policies and normative positions, which similarly set out to understand "the extent to which various discourses [are] deployed across the data set and changes in usage over time." [65].

The first step of the analysis involved the QCA, which examined content from official documents published in WHO and UN repositories related to the INB and UHC-HLM. Specifically, the primary data for analysis centered on the first six successive negotiation drafts pertaining to the development of the PA, and five successive negotiation texts culminating in the adopted PD. Guided by a similar method demonstrated by Hsieh and Shannon [66], and developed as part of a wider study [67] on the integration of GHS and UHC norms, the directed QCA

began with a scanning of all primary documents and related literature on GHS and UHC to identify key terms as guidance for initial codes (summarised in Table 1). Representing dominant expressions of GHS and UHC norms, these terms were organized into discourse and core functions by considering the "categorization, subject positions, rhetorical strategies, and lexical fields" enabled by a discursive reading of the documents [64].

Having completed this initial list of specific forms of GHS and UHC discourse and core functions to search for, we could then proceed by identifying emerging patterns of normative positions across both sets of negotiation texts, classifying relevant text segments into thematic categories (see Table 2). This deductive search aimed to qualitatively identify the presence and frequency of discourse and core functions from one domain across reciprocal draft texts of the other (i.e., UHC norms within PA drafts and GHS norms within PD drafts). Through this directed QCA, we were able to determine major themes in the dominant expressions of GHS and UHC over successive drafts.

The subsequent step involved utilizing discourse analysis to more critically unpack the normative themes identified from negotiation texts. In presenting our findings, we discursively analyzed relevant text segments that expressed the thematic categories, with an emphasis on revealing "the shifts, changes, and the pervasiveness of particular positions" [65] across successive drafts. In line with our definition of norm convergence, this involved identifying examples of similarity over time (complementarity) and cross-sectoral awareness (interdependency). Together, evidence along both dimensions would demonstrate advancement of a shared normative framework, thus indicating normative convergence.

Because normative themes examined across iterative draft revisions were often subject to significant "variability, contradiction, and tension," [65] the same terms were occasionally used in different ways and at different times. Thus, the focus of this dual-faceted analysis was to qualitatively explore how often normative positions were included and repeated across drafts (presence, frequency), but more importantly, how they were expressed in context (weight, centrality, implicit dimensions). This approach enabled us to systematically explore the depth *and* breadth of GHS and UHC norms as they were either mainstreamed, transformed, or altogether excluded across iterative negotiation drafts – from initial concept to final available text. In this way, we drew novel insights on the evolution and extent of normative convergence between both norms across these significant international agreements.

Results

UHC norms in the Pandemic Agreement

Six iterative negotiation drafts pertaining to the development of the Pandemic Agreement were analysed (Table 3):

Explicit references to UHC

One of the clearest ways to identify normative convergence with UHC in the GHS-focused Pandemic Agreement is through explicit references to 'universal health coverage.' Overall, direct references to UHC generally increased in prominence until the Zero Draft (PA4), after which they somewhat diminished.

While all negotiation texts appear to link UHC with GHS, these references become less explicit in later drafts. PA1 calls for "resilient health systems for UHC and health security," while the PA4 shifts language to "*recognize* the need for resilient health systems, *rooted in* UHC" to mitigate pandemic shocks (not "health security"); PA6 ultimately calls for each Party to "strengthen its health system" for sustainable PPR, "*with a view to the progressive realization* of UHC" [emphasis added]. Relatedly, PA2 reiterated "universal health coverage as an essential foundation for effective pandemic prevention, preparedness and response" – a phrase repeated in the subsequent drafts. Although PA6 elevated this point higher in the preamble (suggesting increased importance), it was no longer framed as a "foundation" for PPR.

Early drafts signaled that the PA would be "guided by the goal of achieving UHC as an overarching principle." [69] This was iteratively amended to "the *aim* of achieving UHC," [71] [emphasis added] until PA6 excluded UHC as a guiding principle (though it remained defined as a key term). A similar pattern played out in revised objectives statements, with initial drafts committing to "a view to achieving UHC," [69] followed by "the progressive realization of UHC," [72] and the ultimate removal of "universal health coverage" from the scope of work.

Initial drafts warned that the "disproportionally heavy impact" [69] of pandemics "hamper[ed] the achievement of universal health coverage" and emphasized related UHC ideas like "equitable access to high quality health services without financial hardship." [70] These were largely cut by PA6. This fluctuation corresponded to changes in the types of interventions linked with UHC, with PA1 advocating for "access to quality, agile, and sustainable health services for universal health coverage," PA2 expanding to include clinical and mental care, PA3 calling for "continuity of PHC and UHC" by "maintaining" service availability and addressing backlogs – yet later texts reduced these explicit mentions of UHC capacities.

Finally, almost all drafts discuss some version of "enhanced collaboration between the health and finance

Table 1 Key terms related to the norms of global health security and universal health coverage, including dominant discourse and commonly-associated core functions of each (non-exhaustive list)

Identifying and unpacking GHS and UHC norms	
Global health security (GHS)	*Universal health coverage (UHC)*
Discourse (shared / dominant principles, ideas, motives, and issue frames)	
Securitization • Health as a foreign policy issue • Protection against external threats (e.g., national or international security) • Infectious disease control • Emergencies/crises/disasters • War-related terminology (threat, risk, fight/battle) • Outbreaks/epidemics/pandemics • All-hazards • Resilience • Population-level or collective health risk • "Statist" international security • Top-down power structures	**Right to health** • Health as a human rights issue • Equity • Accessibility • Affordability • Availability • Acceptability • Quality • 'Health for all' and inclusivity • Social determinants of health • Economic and sustainable development • Individual health • "Globalist" human security • Bottom-up power structures
Core functions (Key capacities, interventions, components, obligations, services, and implementation approaches)	
"Core capacities" (e.g., International Health Regulations, 2005): • Laboratories • Surveillance • Preparedness • Response • Risk communication • Coordination and National IHR Focal Point • Zoonotic events • Food safety • Radiation emergencies • Chemical events • Points of entry **Related health interventions and services:** • Biosafety and biosecurity • Antimicrobial resistance • Emergency preparedness and response • Deployment of medical countermeasures • Essential public health functions • One Health	**"Core obligations" (e.g., General Comment 14):** • Ensuring non-discriminatory access to health facilities, goods and services, especially for vulnerable or marginalized people • Ensuring access to food, basic shelter, housing, sanitation and water • Providing essential drugs as defined by WHO • Ensuring equitable distribution of all health facilities, goods and services • Adopting a national public health strategy and plan of action addressing the concerns of all **Related health interventions and services:** • Primary health care • Sexual and reproductive health and rights • Maternal and child health • Routine immunization • Noncommunicable diseases • Health education and promotion • Essential health benefit packages

Table 2 Emerging themes covering key expressions of universal health coverage found in the Pandemic Agreement and global health security found in the Political Declaration

PA				
UHC discourse	Explicit references to UHC as part of discourse and core functions	Rights-based narratives	Equity frames	Focus on social determinants of health
UHC core functions		Accessible and affordable health commodities	Prioritizing vulnerable populations	Primary health care approach
PD				
GHS discourse	Explicit references to GHS as part of discourse and core functions	Existential threat narratives	Resilience frames	Focus on infectious diseases
GHS core functions		Outbreak preparedness	Health emergency response	One Health approach

Table 3 Document title and corresponding draft abbreviation used for analysis of UHC norms in the Pandemic Agreement

Document Title	Outline (67)	Working Draft (68)	Conceptual Zero Draft (69)	Zero Draft (70)	Bureau's Text (71)	Proposal for Negotiating Text (72)
Draft #	PA1	PA2	PA3	PA4	PA5	PA6* * Given that INB negotiations are ongoing, this was the last draft included in the scope of this paper

sectors in support of UHC, and as a means to support [PPR]." [68] One interim text urges the enhancement of financial and technological assistance "to strengthen health systems consistent with the goal of [UHC]," [72] which is largely retained by PA6 but caveated by "within available means and resources." Meanwhile, a PA4 commitment to "prioritize and increase or maintain" domestic funding on PPR emphasizes "working to achieve UHC," while PA6 ultimately excludes such direct references to UHC.

UHC discourse

Overall, there were three main ways that UHC discourses were expressed across draft texts of the PA: (1) rights-based narratives, (2) equity frames and (3) a focus on SDH.

Rights-based narratives

Human rights narratives are prominently featured across PA drafts. For example, all texts from PA2 through PA6 evoke the WHO Constitution, stating that "the highest attainable standard of health is one of the fundamental rights of every human." However, a distinction is drawn over successive drafts between "respect for human rights" (appearing in all versions) and the "right to health" (appearing until PA4 as a guiding principle, yet removed in PA5). This shift in language appears to alleviate concerns around obligations to "protect and promote" the right to health, which is also absent by PA6.

Expressions of other rights-based narratives further demonstrate principles commonly associated with UHC. For example, "inclusiveness" is defined in all texts after PA2 as "the full and active engagement with, and participation of, communities and relevant stakeholders across all levels." Other related examples include references to

community engagement, gender equality, nondiscrimination, and respect for diversity. Though PA5 neglects to individually name these principles, it instead retains a broader section on "people in vulnerable situations," under which these concepts are implicitly grouped.

Equity frames

Equity frames are largely promoted in two discursive ways. First, equity is explicitly framed as a "cross-cutting strategic theme," [68] with interim drafts arguing that "equity should be a principle, an indicator and an outcome of pandemic prevention, preparedness and response." [71] Equity is characterized in PA6 as the "centre of [PPR]," reflected in calls for "unhindered, fair, […] access to […] affordable pandemic-related products and services […] and social protection" – providing linkages to conventional UHC discourses. Second, equity is promoted as an underlying principle for the operationalization of the PA, serving as a departure point for broader concepts seen to improve solidarity during pandemics. For example, the principle of "common but differentiated responsibilities" (CBDR) is repeated throughout draft texts, urging states to implement PPR measures that consider "the specific needs and special circumstances of developing country Parties" and that "Parties that hold more capacities and resources relevant to pandemics should bear a commensurate degree of differentiated responsibility" [71] (n.b., while PA5 softens CBDR provisions to instead "provide such support voluntarily," they remain rooted in equity).

Social determinants of health

Draft texts across the PA underscore UHC discourse themes related to SDH, offering broader links to health promotion and intersectoral collaboration. PA1 emphasizes the objective to "save lives and protect livelihoods," a sentiment preserved throughout successive drafts. Acknowledging the "catastrophic health, social, economic and political consequences" of pandemics, PA2 urges "action on social determinants of health […] by a comprehensive intersectoral approach" and a "whole-of-society" perspective that considers PPR impacts on "economic growth, employment, trade, transport, gender inequality, food insecurity, education and culture." PA4 even alluded to SDH in its definition of "pandemic," noting "social and economic disruptions" and emphasizing "resolute action on social, environmental, cultural, political and economic determinants of health."

Later drafts advance UHC discourse via SDH through commitments to One Health, such as recognizing the "interconnection between people, animals, plants and their shared environment" and acknowledging "that economic and social development and poverty eradication are the first and overriding priorities of developing country Parties." PA6 further mainstreams SDH, advocating for "clean water, energy and air, safe and nutritious food, taking action on climate change, and contributing to sustainable development" in the PA.

UHC core functions

Core functions of UHC provide particular insights into how UHC is being operationalized as specific actions. These can be grouped in three ways: (1) accessible and affordable health commodities, (2) prioritizing vulnerable populations, and (3) a PHC approach.

Accessible and affordable health commodities

One of the primary ways UHC is operationalized in the PA is through commitments to ensure "timely access to affordable, safe and effective pandemic response products." [69] This is echoed by interim drafts, which call for a "coordinated approach to the availability and distribution of, and equitable access to, pandemic response products" [70] as well as the development of a mechanism to ensure their "fair and equitable allocation." [71] PA6 proposes giving WHO "real-time access" to 20% of production of these products, and advocates for cost-related arrangements such as "tiered-pricing" based on country income levels.

Efforts to ensure affordable access healthcare commodities extend to "health technologies that promote the strengthening of national health systems and mitigate social inequalities." For example, later drafts propose a WHO Pathogen Access and Benefit-Sharing System (PABS) System – a mechanism to promote the rapid and transparent sharing of pandemic pathogens and genetic data while ensuring fair access to the resulting benefits [70]. Related capacities commonly associated with UHC also include "time-bound waivers of intellectual property rights," [72] technology transfer, "training of clinical research networks" [73], regulatory approvals for quality and safety, and cost and pricing transparency.

Prioritizing vulnerable populations

All PA drafts demonstrate varying commitments to prioritize vulnerable populations – an obligation inherent in previous texts foundational to UHC, such as General Comment 14 [74]. The PA1 emphasizes resource allocation "based on public health need" and a "policy to safeguard vulnerable populations most affected by pandemics." Subsequent drafts expand this to include "access to pandemic response products by […] frontline workers" [69] as well as refugees, the elderly, persons with disabilities, pregnant women, and infants [70]. PA5 ultimately streamlines these references upfront under "persons in vulnerable situations," characterizing neglect of their needs as "threats and barriers to the full realization of the right to health."

Table 4 Document title and corresponding draft abbreviation used for analysis of GHS norms in the UHC Political Declaration

Document Title	WHO Director-General's Report on Preparations for the UN-HLM (75)	Zero Draft (76)	Revision 1 (77)	Revision 2 (78)	Adopted Political Declaration (79)
Draft #	PD1	PD2	PD3	PD4	PD5

Capacities linked to this UHC theme are seen in references to "equitable gender, geographical and socio-economic status representation and participation." [68] Another draft advocates for inclusive policies for women health workers and "addressing discrimination, stigma and inequality" with "data disaggregated by gender." [70] PA4 emphasizes "gender equality" as a guiding principle and calls to center "youth and women," while PA5 calls for further data disaggregation by "age, geography, socio-economic status." PA6 stresses that clinical trials consider "racial, ethnic and gender diversity across the life cycle."

Community engagement, another function historically linked to UHC, receives mixed uptake. Building on an earlier draft urging "measures to mobilize social capital in the community […] especially to vulnerable populations," [69] PA3 underscores community engagement to ensure "ownership of, and contribution to, community readiness and resilience." PA4 further calls for national multisectoral mechanisms "with meaningful" community representation. However, PA5 introduces caveats such as "in keeping with national capacities" and "as appropriate" when discussing engagement with civil society. Ultimately, PA6 only explicitly references community engagement in articles on R&D, One Health, and whole-of-society approaches.

Primary health care approach

Another way UHC is expressed in the PA is through commitments to a PHC approach. PA1 emphasizes "access to lifesaving, scalable and safe clinical care […and…] continuity of health services and palliative care." A subsequent draft urges financing to "maintain and restore routine public health functions" and "prevention strategies for epidemic-prone diseases." [70] PA4 reiterates "a focus on [PHC] and community-level interventions," echoed in PA5 that calls for "rehabilitation and post-pandemic health system recovery." However, PA6 removes some PHC capacities while simultaneously enhancing a focus on "essential" health services.

Capacity-building for service delivery further advances UHC through a PHC approach, which PA2 states is "core to achieving and sustaining [PA] objective(s)." PA1 stresses "an adequate number of health workforce with public health competency" and "mobile laboratories [and] diagnostic networks." Subsequent drafts expand these commitments, with PA6 calling for "coordinated data interoperability," "integrated public health surveillance," and prevention of "violence and threats against health workers." Yet, PA6 omits previous language [70] on universal forecasting platforms, "engagement of communities in surveillance," and safeguards against "substandard and falsified medical products."

A third way that UHC is advanced through a PHC approach is by focusing on intersectoral collaboration in health systems, reflecting commitments enshrined in the 1978 Alma-Ata Declaration on PHC [75]. PA1 emphasizes "comprehensive multisectoral" PPR strategies, including for "infection prevention and control, water, sanitation and hygiene, antimicrobial resistance, transfer and treatment of patients, travel and movement of front-line workers" as well as multistakeholder engagement to include threats "resulting from climate change and environmental factors." Subsequent iterations narrowed this language, such as only covering pathogens under the IHR in multisectoral public health surveillance or omitting "timely access […] for diagnosis or treatment." [73] Despite this, PA6 continues to "promote and enhance synergies between multisectoral and transdisciplinary collaboration," including by strengthening "science, public health and pandemic literacy [to] combat false, misleading, misinformation or disinformation."

GHS norms in the UHC-HLM Political Declaration

Five iterative documents relevant to the UHC-HLM Political Declaration negotiations were compiled (Table 4):

Explicit references to GHS

Among the various drafts of the Political Declaration, only PD1 explicitly references 'global health security' as a discourse theme. It does so by prominently featuring the heading: "reorient unified national health systems towards primary health care as a foundation for universal health coverage, health security and better health."

Although subsequent iterations do not directly mention GHS as a guiding concept, its impact as a discourse strategy is still retained in other ways described below.

Meanwhile, although PD1 also stands out as the only draft to explicitly reference GHS capacities, it does so rather prominently. For example, it emphasizes that "scaling up and sustaining essential public health functions are vital to the recovery and resilience of national health systems for UHC and health security," asserting that PHC "explicitly […] provides this integrative link." Furthermore, PD1 identifies ongoing initiatives, programs, and actors contributing to "reorienting health systems to PHC as a foundation for UHC and health security." These range from WHO programmes to other major development partners at global, regional and country levels reviewing "progress towards UHC and related issues concerning health security." It also mentions the involvement of global and regional economic and financial institutions (e.g., World Bank, International Monetary Fund) that encourage "long-term, sustainable investment in UHC and health security." While subsequent PD drafts do not directly cite GHS, there remain numerous linkages to core functions.

GHS discourse

Overall, there were three main ways that GHS discourses were expressed across draft texts of the PD: (1) existential threat narratives, (2) resilience frames, and (3) a focus on infectious diseases.

Existential threats

PD1 opened with a focus on existential threats to health and state security, noting a backdrop including the COVID-19 pandemic alongside "crises resulting from climate change and natural disasters, national and regional conflicts, profound economic recession" which impact "the health and well-being of the world's 8 billion people." It emphasized countering "inequalities among and within countries […] through global solidarity," and "aligned collective action at the halfway point to the 2030 Agenda for Sustainable Development." The subsequent PD2 urged "[strengthened] international cooperation" in response to "serious concern" over vaccine disparities hindering global COVID-19 control efforts. PD3 emphasized health financing bolstered by "national, regional and multilateral initiatives" to recover from pandemics, while PD4 underscored that "humanitarian emergencies and armed conflicts have a devastating impact on health systems" which expose vulnerable populations "to preventable diseases and other health risks." Finally, PD5 further stressed "the global concern about the high prices of some health products," recognizing that "inequitable access to such products impedes progress towards achieving UHC," thus urging international cooperation particularly to mitigate the risk this poses to developing countries through securitized discourse.

Resilience frames

Another emerging GHS discourse theme is the promotion of resilience frames [81]. The opening sections of PD1 emphasize that the UHC-HLM "presents an opportunity to go beyond the status quo" to "build resilience against global shocks," thereby ensuring "preparedness for pandemics and other crises, including climate change." PD1 further recognizes essential service delivery as "central to countries' recovery from previous conflicts and crises," a point echoed by the subsequent PD2, which notes an "increasing number of complex emergencies is hindering the achievement of UHC" and introduces risks like "the adverse impact of climate change, natural disasters, extreme weather events" to advocate for "resilient and people-centred health systems." Its call for "a whole-of-government and health-in-all-policies approach," is reflected in subsequent drafts, including PD3 which stresses "water, sanitation, hygiene and electricity services in health care facilities for health promotion, disease prevention" and PD4 which urges "a coherent approach to strengthen the global health architecture as well as health system resilience and UHC," underlining linkages to PPR and One Health. Finally, all drafts affirm health workers as "as fundamental to strong and resilient health systems," although PD5 tones down related language on climate change impact and community engagement.

Infectious diseases

The PD also employs narratives on infectious diseases and their impacts, with PD1 cautioning that "countries continue to rely on fragmented disease and service-specific programmes and interventions." It also notes that the "COVID-19 pandemic took a significant toll on progress towards the SDGs," highlighting that the "combined macroeconomic, fiscal and health impact of COVID-19 point to worsening of financial protection globally." By arguing that "experiences from COVID-19, Ebola virus, conflicts and disasters in 2022 have demonstrated that this requires multisectoral, whole-of-government action," PD1 sets the stage for PD2, which cites mixed progress on major communicable diseases like HIV/AIDS, tuberculosis, malaria, and antimicrobial resistance as justification for PD negotiations. PD3 added language on the "importance of pandemic prevention, preparedness and response as a key component of UHC." All subsequent drafts emphasized the "importance of coordination" and "promoting alignment and synergies across […] the High-level Meetings on Tuberculosis and Pandemic Prevention, Preparedness and Response" taking place alongside the UHC-HLM, noting that "all three political

declarations should be viewed as complementary and interlinked."

GHS core functions

Core functions of GHS provide particular insights into how GHS is being operationalized in the PD as specific actions. These can be grouped in three ways: (1) outbreak preparedness, (2) health emergency response, and (3) a One Health approach.

Outbreak preparedness

One category of GHS core functions described across PD texts centers on outbreak preparedness. PD1 highlights that "lessons and innovations from the COVID-19 pandemic are providing opportunities to scale up PHC approaches, for example by using digital health technologies, and promoting public health literacy, self-testing and use of community-based services." This emphasis on essential public health functions linked to preparedness is reflected in subsequent drafts. PD2 advocates for "countering vaccine hesitancy […] to prevent outbreaks as well as the spread and re-emergence of communicable diseases," "public health surveillance," and ensuring that "essential public health functions are among the core components of preparedness for health emergencies." PD3 introduces "risk communication and community engagement" as well as "prevention, early detection and control of diseases." Additionally, by recommending "continuity of care in national and cross-border contexts," PD3 visibly promotes a UHC approach in an area traditionally covered by GHS. PD4 builds on earlier calls to "implement the IHR (2005)" and "[integrate] disaster and health risk management systems." Finally, the ADP largely retains these outbreak preparedness functions, and importantly inserting language on their affordability and accessibility as part of strengthening the "resilience of health systems."

Health emergency response

The PD also incorporates GHS core functions through language on health emergency response. PD1 notes that "inequitable access to medical products is among the main causes of financial hardship," urging the provision of "critical countermeasure[s]" such as "COVID-19 vaccination [for] high priority groups," "recovery and strengthening of the essential immunization programme," and "essential services relating to HIV […] to end AIDS as a public health threat." PD2 further calls for "integrated service delivery [for] HIV/AIDS, tuberculosis, malaria, hepatitis, and neglected tropical diseases," while specifically advocating for "the production and timely and equitable distribution of COVID-19 vaccines, therapeutics, diagnostics and other health technologies." Added language on "availability and equitable" access in PD3 concerning the "manufacturing, regulation, procurement," and deployment of essential medical products and services is retained in PD4 and further strengthened in PD5, which "promote[s] the transfer of technology and know-how and encourage research, innovation and commitments to voluntary licensing" as critical components of pandemic response.

One Health approach

While PD1 briefly mentions One Health as part of an "integrated health tool […] for national strategic health planning and costing," subsequent PD drafts significantly develop a focus on this key aspect of GHS. For example, PD2 affirms the need to "enhance cooperation at the national, regional and global levels for an integrated and systems-based One Health approach." PD2 goes on to detail specific features of One Health that are vital for achieving UHC, including "to improve the prevention, monitoring, detection, control and containment of zoonotic diseases and pathogens, threats to health and ecosystems, the emergence and spread of antimicrobial resistance, and future health emergencies, by fostering cooperation and a coordinated approach between the human health, animal health and plant health sectors, environmental and other relevant sectors." Successive iterations in PD3, PD4, and PD5 largely retain the same language, and more broadly urge Member States "to adopt an all-hazard, multisectoral and coordinated approach to prevention, preparedness and response for health emergencies."

Discussion

This analysis advances current interpretations of GHS and UHC norms by examining how they are converging following the COVID-19 pandemic, tracing their expression and influence on two key negotiation processes – the WHO Pandemic Agreement and the 2023 UNGA Political Declaration on Universal Health Coverage. The findings provide three major insights: (1) the COVID-19 pandemic catalyzed a policy window uniquely favorable to accelerating normative convergence between GHS and UHC; (2) convergence between GHS and UHC norms was advanced through increased complementarity and interdependency between their respective discourse and core functions; and (3) sustaining GHS and UHC convergence remains a dynamic and contentious process heavily influenced by political and operational trade-offs.

This study highlights the hidden role of incremental and implicit shifts in shaping global health norms (rather than more visible advancements through explicit references). By detailing a nuanced 'politics of integration,' these findings offer practical lessons for policymakers and diplomats seeking synergistic approaches to strengthen GHS and UHC. It also provides fresh insights

for foreign policy researchers studying norm theory in contested policy environments, who seek to understand the understudied, fluid process of normative convergence between two sets of influential norms and their associated political dynamics via diplomatic channels.

COVID-19 as a catalyst for GHS and UHC convergence

This analysis suggests that the COVID-19 pandemic created a policy window particularly favorable for normative convergence between GHS and UHC. While key actors like WHO had already begun to connect these norms prior to the pandemic, increased international cooperation and political momentum driven by the crisis accelerated this phenomenon. The draft texts demonstrate that negotiators viewed COVID-19 as a driving force for both agreements; the PA acknowledged "serious shortcomings in preparedness at national and global levels," [73] while the PD emphasized that COVID-19 "created new obstacles to [.] the 2030 Agenda for Sustainable Development." [80] In effect, both agreements indicated intent among negotiators to move beyond the status quo, ushering a reconceptualization of global health norms and a fast-tracking of joint GHS-UHC frameworks already underway prior to the pandemic [82, 83]. This was further influenced by reassessments sparked by the midpoint of the SDGs and pressure to "promote alignment and synergies" [78] across the HLMs Thus, repeated commitments to 'coherence' do not appear incidental, but rather deliberate insertions intended to alleviate a politically-fraught normative landscape, with the PA and PD striving to advance simultaneous global health goals.

The emerging themes, particularly the promotion of equity and resilience frames, demonstrate new overlapping priorities following COVID-19 which favored convergence between GHS and UHC in ways previously not possible. For instance, the striking inequalities in accessing pandemic countermeasures appear to have enabled a repositioning of 'equity' as a core objective of the PA [71] – despite the reality that GHS documents historically privilege national security interests over human rights [84]. Thus, in a notable departure from previous GHS agreements (e.g., IHR), PA negotiators centered equity (a concept "hard-wired into the definition of universal health coverage" [76]) as a key discursive tool in response to challenges such as vaccine hoarding. This helped expand the scope of the PA beyond traditional GHS capacities, including acknowledging how pandemics affect vulnerable populations. The prominence of equity frames also facilitated an entry point for other UHC norms into the GHS regime. For example, although GHS is conventionally operationalized via state-centric international security frameworks, equity framings reconfigured PA priorities to more carefully consider other UHC core functions (e.g., affordability of medical products, SDH). Meanwhile, given that 'resilience' is primarily utilized in the context of health emergencies [16], its promotion in the UHC-focused PD texts carried important associations with GHS, such as a focus on existential threats and infectious disease narratives. Moreover, resilience frames were strategically employed to help bridge implementation between GHS norms at an international level (e.g., pandemic preparedness) and UHC norms at a community level (e.g., PHC approach).

This demonstrates two important lessons. First, in the foreign policy community, discussions of norm development often assume that fraught normative environments inevitably lead to further fragmentation and silo-isation [85]. Yet in the case of GHS and UHC, we see that such contested landscapes may actually *foster* normative convergence when there is scope for overlapping priorities to build consensus, or when the status quo appears insufficient and policy constraints push stakeholders to work in new, more collaborative ways. This reflects prevailing theories of risk society, which posit that perceptions of risk during crises help to encourage policymakers to achieve consensus [86]. As the world faces increasingly multifaceted challenges in an era of "polycrisis" [87] – from climate change to rising inequality to armed conflict – fostering normative convergence in this way between multiple health and foreign policy goals may provide a strategic path for health diplomats to collectively address interconnected, 'wicked' problems. Second, equity and resilience, given their transecting features, may serve as overarching normative frames for future global health efforts. Their co-promotion in both PA and PD negotiations (e.g., "taking into account the need for equity and resilience" [73]) opened the door for joint elaboration of GHS and UHC norms by serving as the foundation upon which their respective discourse and core functions could be meaningfully introduced and debated – *together*. Furthermore, the preservation of equity and resilience across successive drafts serves as a testament to the significant normative weight they carry both individually and jointly. Just as powerful normative frames like 'inclusivity' and 'integration' [39] emerged halfway through the MDGs to significantly influence subsequent global health policy, 'equity' and 'resilience' may be well-positioned as powerful normative frames for global health advocates to leverage in future initiatives.

Towards a shared GHS-UHC normative framework

In the wake of COVID-19, there was indeed notable convergence between GHS and UHC norms, indicated by: (1) increased complementarity (diffusion of UHC norms within the PA and diffusion of GHS norms within PD), and (2) increased interdependency (interlinkages between GHS and UHC norms that demonstrate cross-sectoral awareness). The establishment of a shared

normative framework linking the discourse and core functions of GHS and UHC in these major international agreements portends a significant development for global health diplomacy – laying the groundwork for the emergence of a new 'hybrid norm' between GHS and UHC.

Text segments which specifically situate GHS and UHC together serve as some of the clearest examples of norm convergence. For example, early drafts of the PA repeatedly urged States to develop "health systems for UHC and health security," while early drafts of the PD advocated "a foundation for universal health coverage, health security." [76] Although subsequent versions slowly phased out such explicit references to jointly advance GHS and UHC, their significance in the foundational drafts of both the PA and PD appears to indicate that States (at least initially) regarded them as interconnected priorities. This is notable because previous international agreements centered on GHS or UHC lacked a comparable level of integrative language at their outset, signifying a novel shift in the co-conceptualization of both norms [67].

The removal of many of these most obvious manifestations of GHS-UHC integration in subsequent drafts may be perceived by some as a failure to fully realize normative convergence. Indeed, the disappearance of key elements of both norms during negotiations provides evidence of a significant degree of contestation between how GHS and UHC might ultimately be expressed. However, *implicit* references to GHS and UHC convergence – through novel interlinkages between their underlying discourse and core functions – offer equally powerful insights into how global health norms evolve. We argue that rather than highly visible commitments which explicitly reference two norms together, the process of normative convergence may often involve more subtle advancements, affirming the oft-overlooked value of radical incrementalism [88] in progressing and reshaping global health policy, diplomacy, and governance.

Discourses used to implicitly promote UHC – equity, human rights, and SDH – exerted a profound influence on the scope of the GHS-focused PA. Equity considerations allowed for commitments aimed at mitigating disparities between high-income and low-income countries, rights-based narratives stressed inclusivity and UHC as "the practical expression of the right to health," [7] and SDH approaches focused on "protect[ing] lives and livelihoods" [73] demonstrated a long overdue focus on the socioeconomic needs of communities during pandemics. Together, these themes represented a firm ideational commitment to UHC, even while explicit language on UHC diminished. Furthermore, core functions associated with UHC – prioritizing vulnerable populations, ensuring affordability and accessibility of health products, and strengthening PHC – facilitated the operationalization of UHC within a GHS framework. This is significant, as previous GHS texts seldom addressed topics like price transparency, routine service delivery, and equitable access to countermeasures. Even core capacities referenced from the IHR (2005) (a hallmark of GHS), such as zoonotic events and laboratory networks, often drew on UHC for their operationalization in PA drafts, such as embedding community engagement into One Health initiatives and recommending accessibility provisions for pandemic-related diagnostics. The integration of UHC core functions into the GHS regime represents a significant paradigm shift for global health policymakers, fundamentally reshaping the scope of GHS norms as necessitating a simultaneous advancement of (at least some) central UHC principles and obligations for States.

Meanwhile, discourses implicitly promoting GHS in the PD – resilience, existential threats, and infectious diseases – elevated UHC to the realm of 'high politics' purportedly occupied by GHS [89] in an effort to rejuvenate stalled progress. This often relied on a "grammar of securitization," [90] utilizing language like "threat" and "shadow pandemic" even when referring to health conditions primarily associated with UHC (e.g., non-communicable diseases). Core functions associated with GHS – outbreak preparedness, health emergency response, and One Health – underscore the profound impact COVID-19 had on the conceptualization of UHC. A robust emphasis on integrating PHC with traditional IHR core capacities and newer PPR functions like mitigating outbreak disinformation comprise much of the operational backbone of the document. Meanwhile, references to major GHS actors (e.g., Pandemic Fund) and multiple references to ongoing epidemics demonstrate that infectious disease control was viewed as an integral aspect of sustainable UHC. Finally, the inclusion of entire sections on One Health, integrated public health surveillance, and healthcare during armed conflicts – noteworthy additions rarely seen in previous UHC agreements – indicate substantial areas for converging global health governance across human, animal, environmental, and humanitarian health in ways that fundamentally infuse GHS into UHC initiatives.

Barriers to sustaining convergence

Despite noticeable progress towards integrating GHS and UHC norms, mixed uptake over successive PA and PD drafts suggests that sustaining convergence from principle to practice remains a dynamic and contentious process. Both sets of documents demonstrated increasing normative convergence until their respective Zero Drafts, but lost many crucial linkages in subsequent iterations (i.e., reduced references to complementary norms). Scholars have previously described how, as negotiations approach deadlines, a variety of linguistic and strategic compromises may be sought by negotiators to facilitate

consensus [91]. Our findings demonstrate this use of specific negotiation tactics (caveats and qualifiers, 'palatable' proxies, and forum-shifting), which, although applied for broader political purposes, ultimately limited the extent of GHS-UHC norm convergence possible in both international agreements. Mitigating these tradeoffs will be crucial for policymakers and negotiators seeking normative convergence in future diplomatic efforts.

Firstly, the insertion of caveats and qualifiers as negotiations progressed resulted in increasingly ambiguous commitments. While many preambular sections demonstrated relatively greater evidence of integrated discourse in principle, operative paragraphs in both agreements were eventually peppered with caveats like "as appropriate," "in accordance with," and "within available means and resources" in lieu of previous iterations which more concretely strengthened obligations. This pattern, explained by observers [92] as concessions to facilitate consensus, was applied to a range of topics beyond just GHS or UHC; however, their insertion undercut notable advancements in GHS-UHC convergence featured in earlier drafts. Additionally, later PA texts qualified references to UHC as only pertaining to PPR contexts (previous versions promoted GHS and UHC as twin goals for broader contexts), while the PD featured qualifiers like "potential" and "striving to"; these narrowed the scope and strength of commitments. While such linguistic amendments may be inevitable outcomes in consensus-based negotiations, this phenomenon nonetheless exhibited how normative convergence can quickly be undermined if operational language is weakened – an issue future negotiators should play close attention to.

Secondly, the replacement of direct references to GHS and UHC with less contentious substitutes demonstrates another way convergence can be undermined, a process documented by scholars in other similar international negotiations [93]. As time passed, negotiators in both drafting cycles were forced to cherry-pick specific aspects of complementary norms to retain (e.g., PHC in the PA, or One Health in the PD), rather than maintain explicitly-joint references or comprehensively advance the shared normative framework (i.e., integrated governance and financing for GHS and UHC was quickly abandoned). For example, while direct references to UHC were largely negotiated out of the PA, discourse themes like equity (which has been characterized as a "measurable component of UHC" [24]) could be used as a more 'palatable' proxy for UHC, thus implicitly expressing some aspects of the norm while avoiding some of the political baggage carried by the term. Meanwhile, various commitments to PPR enabled later PD texts on UHC to continue evoking GHS norms without explicit mention, given that PPR has been characterized as a more agreeable substitute for GHS in places where 'security' illicits negative connotations [6]. This was compounded by negotiators strategically 'trading-off' [94] explicit references to GHS or UHC in favor of other priorities as a source of leverage, particularly if more acceptable alternatives could be used in their place. For example, initial PA texts prominently emphasized UHC through discourses around human rights, but later versions scaled back provisions around community engagement – essentially handicapping meaningful implementation of UHC. The strategic use of proxies suggests a complex reality – that negotiators were largely united on the initial vision of aligning GHS and UHC norms, but divided on the extent to which they should be integrated and operationalized. Future policymaking and diplomacy aimed at fostering normative convergence, such as between GHS and UHC, should be weary of 'trading' away core principles and functions in pursuit of consensus, which may ultimately render final obligations meaningless.

Finally, given a politically-fraught environment, forum-shifting [95] was routinely used to mitigate deadlock, resulting in weakened GHS and UHC norm convergence. Concrete commitments on difficult topics were postponed under the justification of "policy coherence" with other processes, such as parallel IHR amendments and two other simultaneous UNGA HLMs on health. The text edits suggest that negotiators believed other venues may potentially yield better results or could facilitate trade-offs for disputed topics – indirectly diminishing normative convergence between GHS and UHC in areas that were particularly contentious. For example, while previous iterations of the PD had numerous explicit references to GHS, the final versions prioritized themes such as resilience, while ostensibly leaving more direct normative expressions of GHS for the HLM on PPR [96]. This strategic shift reveals a nuanced politicking in global health diplomacy, where considerations of coherence and synergies across concurrent high-level negotiations play a pivotal role in shaping uptake, with only the most politically-feasible aspects of a norm ultimately retained. Furthermore, given that the preparatory documents of both sets of agreements (largely drafted by technical specialists at WHO) provided the most explicit language promoting GHS and UHC integration, advocates should consider how to preserve such negotiating texts *after* they leave the technocrats who drafted earlier iterations and enter the political realm of UN or country-level diplomats.

Future implications

As Shany argues, the evolution of international norms and institutions is "ultimately deferential to State sovereignty and relative power considerations." [97] Reflecting this realpolitik inherent in global health diplomacy, as negotiations progressed, disagreements around financing [98], health system capacity [99], and operationalization

[100] chipped away at negotiating language that could have more meaningfully advanced an emerging GHS-UHC hybrid norm. Looking ahead, it will be important for global health diplomats and researchers to better account for the broader political and material factors which led to various tradeoffs that ultimately weakened GHS-UHC convergence. Furthermore, policymakers and advocates should more carefully consider the role of complex geopolitics and entrenched path dependencies when seeking greater synergies across previously-distinct agendas like GHS and UHC.

Amended language over successive drafts of both the PA and PD reveals how geopolitical rifts fuel major disagreements – many of which have implications on the convergence of GHS and UHC norms. For example, PA debates between high-income and low-income countries around contentious topics like PASB and CBDR fell along long-standing divides between related GHS and UHC norms [101], with the former pushing for strong language on human rights (UHC norm) and robust data-sharing during pandemics (GHS norm) while the latter urged clear obligations on richer nations to provide technologies and financial assistance to meaningfully ensure equity and resilience. The creation of the so-called Group of Equity [102] (conspicuously comprised of largely Global South countries) in the PA demonstrates this rise of regional or issue-based blocks trying to concretize specific aspects of UHC in an agreement that had originated among Global North countries. Weakened language and debates over operationalizing rights-based approaches suggest that diplomatic efforts were ultimately unsuccessful in moving from rhetoric to action – resulting in weakened GHS and UHC norm convergence. Similarly, geopolitics surrounding PD, particularly removal of language around climate change and armed conflict (which would have implicated greater convergence with the GHS norm regime), suggest that challenges remain in rectifying major rifts across the international community on legitimizing "security" norms in public health. As a result, only the most palatable and technocratic health interventions (i.e., non-controversial principles unencumbered by concrete obligations) were advanced during negotiations.

This also suggests a related consideration, with some scholars contending that entrenched path dependencies [103] may have made it challenging for negotiators to sustain proposed language outside of the primary regime they were operating under. The drastic reduction of direct references to UHC in the PA and GHS in the PD over time provide the most obvious manifestations of path dependencies reifying preexisting fragmentation, while trade-offs that reduced reciprocal discourse and core functions further demonstrate this phenomenon. However, Göpel suggests that radical incrementalism can provide an effective and sustainable path to break longstanding structural siloes which perpetuate path dependencies [104]. Global health diplomats and policymakers could therefore prioritize targeted policies, investments, and systems strengthening efforts that intentionally (even if incrementally) foster convergence between cross-cutting agendas like GHS and UHC.

Conclusion

This paper tests the proposition that UHC may be shaping policy solutions traditionally negotiated in GHS spaces (and vice versa), by analysing the extent of convergence between both norms through two case studies: the WHO Pandemic Agreement and the 2023 UNGA Political Declaration on Universal Health Coverage. Using a multimethod qualitative analysis, we traced the promotion of UHC through three related discourse themes and three related core functions in the PA (and vice versa for expressions of GHS in the PD). Holistically analysing both discourse and core functions enabled a more nuanced view into the inclusion of GHS and UHC norms into previously-distinct spaces, and the complex path toward normative convergence. The findings demonstrate a transformative shift, with the post-COVID-19 context providing a policy window uniquely positioned to accelerate normative convergence between GHS and UHC. They also indicate that, while convergence between both norms was significantly promoted at the start of negotiations, sustaining a shared GHS-UHC normative framework was ultimately undermined by a variety of political and operational trade-offs, with ongoing debates and shifting language suggesting tenuous progress as a result of power politics. Health diplomats and policymakers should consciously reject such forms of constructed ambiguity which may weaken hard-won progress on normative convergence.

Mainstreaming UHC in the PA was novel given the agreement's roots in the GHS regime. However, as attention increasingly turned to details of operationalizing equity, concrete commitments to UHC were gradually cut as a negotiating provision to achieve consensus on other more controversial articles. Meanwhile, GHS capacities were inextricably linked with the exercise of UHC in the PD, with PPR a central aspect. However, critiques about the efficacy of threat-based narratives which may override human rights protections require further deliberation. Moving forward, the narrowing of equity's scope in the PA and the lack of consideration for "bad' resilience [105] in the PD need careful consideration. Furthermore, evaluations are required to assess how effective the PA (which is still being negotiated) and PD ultimately are in terms of sustainably promoting a hybrid norm linking GHS and UHC. Additionally, the ability of normative convergence to disrupt chronic cycles of 'panic and neglect' well after a crisis has passed needs further

study. Finally, as Payne argues, given the highly contested political contexts surrounding normative development, "it can be essentially impossible [.] for scholars in retrospect to ascertain the resonance of any particular frame or counterframe," [51] portending future areas for research on the evolution of global health norms.

The research underscores the importance of incremental advancements in reshaping norms, and recognizes that in the absence of explicit commitments, expressions of what they *represent* may be just as important. In doing so, we highlight the significance of advancing key aspects of GHS and UHC norms through progressive realization of their underlying discourse and core functions, with specific principles or obligations persisting even where ideal wording or definitions may be lost. We also argue that in politically-fraught diplomatic negotiations, the process of norm convergence may not only be an inevitable outcome for achieving consensus, but can also offer strategic advantages by promoting synergies across previously-siloed domains. This constructive approach to global health diplomacy, which aims to simultaneously advance interconnected GHS and UHC priorities, requires negotiators to better articulate "a radical vision combined with an incremental approach" [106] by navigating complex geopolitics in global health (e.g., striking a balance between international solidarity on one hand and national self-interests on the other) while overcoming entrenched path dependencies (e.g., intentionally financing and operationalizing overlapping areas of GHS and UHC). Ultimately, we argue that states should strategically view norm convergence as being inherently within their interests (both in terms of bridging geopolitical divides and breaking siloed thinking) – and codify this through diplomatic mechanisms.

This novel study has traced normative convergence through two sets of international negotiations situated across two complementary norm regimes, offering important contributions to global health and foreign policy. Public health policymakers and advocates can pragmatically apply its lessons by synergistically advancing both GHS and UHC, including the active promotion of 'equity' and 'resilience' as overarching frames for future discourse and implementation. Given the tendency in global health to retreat into silos in the face of competing priorities, ensuring integrated goals and approaches between GHS and UHC will require diplomats to meaningfully incorporate these across the guiding principles, scope, and operative paragraphs of international health agreements – and to consider where the promotion of strategic convergence between GHS and UHC may be best suited given the political context. Meanwhile, our analysis advances theoretical insights on the dynamic process of normative convergence between two broader norm regimes, suggesting that the development of hybrid norms can be expected and indeed leveraged in other environments, particularly in contexts rife with politics and contestation (e.g., climate change, humanitarian crises).

There is a tendency among policymakers to assume that if we cannot see explicit references or concrete commitments, that progress is not happening. But the way norms evolve represents important precursors crucial to subsequent policy and practice; how we frame these concepts matters profoundly to the way we institutionalize and operationalize them. Global health scholars, practitioners, and diplomats must appreciate the incremental advancements in norms that more often characterizes progress in global health. This requires a "willingness to accept small changes that together accrete to create bigger change, one step at a time." [106] In the context of GHS and UHC, this means pushing for progressive realization of their underlying discourse and core functions where the full codification of either norm appears untenable. As resources become constrained amidst an era increasingly characterized by polycrisis and hard security politics, this paper concludes that pursuing normative convergence as a way to address multifaceted challenges will be crucial to future global health diplomacy efforts – and potentially more productive and strategic in the long run.

Author contributions
A.L. conceptualized this manuscript, with support on methodological approaches from C.W. and J.P. The majority of analysis and subsequent drafting was authored by A.L., while C.W. and J.P provided crucial edits on key sections. All authors reviewed the manuscript.

Funding
Arush Lal received funding support through a doctoral studentship from the London School of Economics and Political Science.

Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
Not applicable.

Competing interests
The authors declare no competing interests.

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Received: 5 August 2024 / Accepted: 27 January 2025
Published online: 24 February 2025

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Chapter 8: Coherence (Empirical Paper 3)

Manuscripts submitted to Health Policy and Planning

Pathways to coherence: perspectives on integrating global health security and universal health coverage

Journal:	*Health Policy and Planning*
Manuscript ID	Draft
Manuscript Type:	Original Article
Keywords:	Universal Health Coverage, integration, governance, policy analysis, Health system resilience, health systems, donor coordination, epidemic, equity, international health policy
Country of Expertise:	United Kingdom, USA, Africa, Asia/Pacific, Latin America

Authorship and contributor statement: Arush Lal (AL) is the sole author of this manuscript and was responsible for all aspects of the research, including study conception and design, data collection, analysis, and interpretation. AL drafted the full manuscript, conducted critical revisions, and submitted the final version.

Ethical Approval: Ethical approval for this study was obtained from the London School of Economics & Political Science (LSE) Research Ethics Committee (Reference No. 58402).

Funding: This work was supported by an LSE doctoral studentship.

Acknowledgements: I am grateful to Dr. Justin Parkhurst and Dr. Clare Wenham for their invaluable insights and support throughout the development of this research. While I was the sole author, responsible for conceiving, drafting, and finalizing the full manuscript, their guidance and critical feedback greatly enriched the conceptual and analytical depth of this work. I am also thankful to all informants for their unique insights and participation in this study.

Conflicts of interest: No applicable conflicts of interest.

Pathways to coherence: perspectives on integrating global health security and universal health coverage

Keywords: global health policy, health systems strengthening, global health security, universal health coverage, coherence, integration, governance, diplomacy, norms

Conflicts of interest: No applicable conflicts of interest.

Abstract

Within the global health landscape exists a complex interplay between global health security (GHS) and universal health coverage (UHC) – two influential norms with profound influence on health system strengthening initiatives. There is a need to understand why and how coherence between GHS and UHC is being pursued in health policy and planning, particularly in the wake of the COVID-19 pandemic, which profoundly reshaped the field of global health. This paper presents one of the first detailed analyses of contemporary efforts to conceptualize and operationalize GHS-UHC coherence – through the perspectives of key actors responsible for its implementation. The study employed thirty-one interviews with senior officials across four major types of global health actors: multilateral and global health organizations, country governments, donors and international finance institutions, and civil society organizations. It reveals important insights in the way specific actor and geopolitical groups varied in terms of shifting perceptions of GHS and UHC, as well as major factors influencing GHS-UHC coherence (e.g., strategic considerations including motivations and concerns, and structural considerations including enablers and barriers). The analysis suggests that an emerging 'hybrid norm' linking GHS and UHC appears well-underway. It further contends that strengthening coherence between GHS and UHC not only depends on, but also enhances, three key strategies: 1) overcoming geopolitical power asymmetries, 2) leveraging strategic collaboration across actor types, and 3) pursuing integrative health diplomacy amid polycrisis. While this study centers on GHS-UHC alignment, its broader objective is to foster a more equitable and resilient global health architecture by tackling the interconnected causes of fragmentation through hybrid normative frameworks. By focusing on the politics of norms underpinning GHS and UHC integration, this work contributes to rethinking how global health institutions collaborate, ultimately helping to build more sustainable global health governance fit to withstand future political, economic, and social challenges.

Key messages

- Despite recent calls to understand how global health security (GHS) and universal health coverage (UHC) contribute to health system fragmentation, the processes that foster their coherence remain underexplored – particularly how different actors navigate political dynamics and normative alignment to integrate these frameworks in health policy and planning.

- Variations in how GHS-UHC coherence is conceptualized, negotiated, and implemented reflect geopolitical divides, institutional priorities, and actor-specific strategic interests.

- Strengthening GHS-UHC coherence both requires and reinforces efforts to overcome geopolitical power asymmetries, harness strategic collaboration across actor types, and navigate polycrisis through integrative health diplomacy.

- The GHS-UHC hybrid norm provides a strategic framework to enhance coordination across global health governance, offering a pathway toward a more resilient and equitable global health architecture.

Introduction

The global health landscape today is characterized by increasing and persistent tension between competing priorities, mechanisms, and institutions. In few areas is this tension more evident than in the complex interplay between global health security (GHS) and universal health coverage (UHC). Both frameworks aim to strengthen health systems and improve public health outcomes, yet their divergent approaches – the former rooted in securitization, the latter in human rights – often result in fragmented governance, disjointed financing, and inconsistent implementation. This incoherence between GHS and UHC undermines equity in health systems, limiting progress toward their shared goal of more resilient populations.(Lal *et al.*, 2021)

Significant attempts have already been made to enhance coherence across major global health agendas and initiatives, including by fostering synergies between GHS and UHC.(Oliveira-Cruz, Kurowski and Mills, 2003; Balikuddembe, 2020; Tadesse *et al.*, 2021; Agyepong *et al.*, 2023) However, most have fallen short of sustained impact. While related empirical studies utilize widely-acknowledged concepts like health system integration(Atun *et al.*, 2010; Cooper *et al.*, 2015) to better coordinate limited resources and harmonize competing health priorities, these often struggle to account for the politics underpinning persistent fragmentation. Drawing on recent calls(Gómez *et al.*, 2022) to recognize the role of "political power dynamics" in explaining "why certain public health policies might be more likely to succeed in adoption and implementation," a focus on how different actors pursue normative coherence between GHS and UHC may provide fresh insights to address this research gap.

This paper presents one of the first detailed analyses of contemporary efforts to conceptualize and operationalize GHS-UHC coherence, through the perspectives of key actors shaping their implementation at various levels of health policy and planning. Building on prior work on the historical construction(Lal, Parkhurst and Wenham, 2024) and convergence(Lal, Wenham and Parkhurst, 2024) of GHS and UHC norms, this study examines recent developments towards their integration by engaging with senior officials through in-depth interviews – capturing their insights on the evolving relationship between both frameworks, key factors enabling or obstructing their coherence, and the practical implications on the broader global health architecture. The conclusions emphasize the emergence of a GHS-UHC 'hybrid norm,' which both depends on and further enhances: 1) addressing geopolitical power imbalances, 2) fostering strategic collaboration across diverse actor types, and 3) pursuing integrative health diplomacy amid today's era of polycrisis. In doing so, this research seeks to advance broader scholarship on the politics of integrating contested global health agendas in other areas of governance, and role of 'hybrid norms' as powerful tools for pursuing collective action through future global initiatives.

Background

GHS and UHC can be understood not just as important concepts, but also as influential 'norms' – each comprised of core ideas, decision-making processes, and organizing principles that shape the behavior of domestic and international actors.(Florini, 1996; Finnemore and Sikkink, 1998; Lal, Parkhurst and Wenham, 2024) GHS – defined as the activities necessary to mitigate acute public health events that transcend national borders – emphasizes national security and core capacities related to health emergencies.(WHO, 2007; Stoeva, 2020) In contrast, UHC – defined as ensuring all individuals can access a comprehensive range of quality health services without financial hardship – emphasizes the right to health and core capacities related to health equity and primary health care (PHC).(Abiiro and De Allegri, 2015; WHO, no date b) Examining GHS and UHC as norms, rather than as a set of technical interventions, unlocks new ways of exploring their advancement (and potential for coherence) through greater consideration of underlying principles, values, normative approaches, and obligations on state behavior.(Smith and Rodriguez, 2016)

Scholars argue that over time, GHS and UHC have been (re)constructed as their inherent linkages have become more apparent.(Lal, Parkhurst and Wenham, 2024) This suggests that both norms (and their associated 'regimes'(Hoffman, 2010) or 'networks of governance,'(Shiffman, Quissell, *et al.*, 2016) comprised of overlapping institutions and actors) should not be considered as static or isolated, but rather as dynamic processes which continuously influence and reinforce one another. Following the COVID-19 pandemic, GHS and UHC have further converged in what has been described as a 'hybrid norm' – representing the holistic and interlinked pursuit of two previously-distinct norms – with contemporary international agreements featuring growing complementarity and interdependency between their underlying discourse and core functions.(Lal, Wenham and Parkhurst, 2024)

The uptake of a hybrid norm promoting both GHS and UHC is increasingly manifest across recent developments in global health governance, financing, and programming – from multilateral health resolutions(WHO, no date c) to government strategies(FCDO, no date) to new initiatives like the Lusaka Agenda(FHGI, no date). Given the profound influence of both frameworks on shaping health systems strengthening and broader global health efforts, previous research has attempted to advance GHS and UHC synergies, including through case studies unpacking "multiple interconnected factors causing fragmentation at the global level."(Agyepong *et al.*, 2023) However, without analyzing the politics of norms in shaping why and how actors choose to collaborate on different global health agendas, these studies have overlooked key insights into power dynamics and institutional behaviors vital to sustaining normative coherence – particularly in a post-pandemic landscape where both GHS and UHC have undergone significant conceptual shifts.

Recognizing that opportunities are "created when demonstrable synergies and benefits can be achieved by integration,"(Atun *et al.*, 2010) this analysis draws on collective action frameworks theoretically-grounded in political science and international affairs(Shiffman, Peter Schmitz, *et al.*, 2016; Smith and Rodriguez, 2016) – particularly the concept of 'policy coherence,' which is characterized by "mutually reinforcing policy actions" across "different types of public policies, between different levels of government, between different stakeholders and at an international level."'(OECD, 2023) By advancing scholarship on hybrid norms in global health, it importantly places the analytical emphasis on what Barnett and Duvall on termed 'constitutive relations' – "the social processes that define the identity of actors and their relationships, with consequent effects on what these actors can do."(Gómez *et al.*, 2022) This study therefore further contributes to systems thinking in health policy(Kwamie *et al.*, 2024), positing that GHS-UHC coherence can foster necessarily integrated global health solutions amid interrelated external threats and geopolitical headwinds.

Methods

Data Collection

Between May and July 2024, thirty-one in-depth, semi-structured interviews were conducted with key informants across four institutional types: multilateral and global health organizations, country governments, donors and international finance institutions, and civil society organizations. All actors were selected for their active role in the governance of global health initiatives and diplomacy, particularly in the response to COVID-19 and ongoing health system strengthening (HSS) efforts. Together, these groups represent the diverse and often divergent views influencing GHS and UHC – actors whose decisions are shaped not only by technical considerations, but also by power, influence, and politics – offering vital lessons for fostering policy coherence across various global health institutions, donors, and practitioners. The timing of this study is significant, given major reforms to global health architecture launched after the COVID-19 pandemic and sparked by stocktaking at the midpoint of the 2030 SDGs deadline – when discussions about coherence between GHS and UHC have intensified.

The sampling strategy was designed to reach senior officials directing efforts in GHS, UHC, and/or health system strengthening (HSS) at major global health institutions. This was done using a combination of purposive sampling and snowball sampling to reach relevant participants (see Table 1 and Table 2). Careful consideration was taken to ensure a relative balance across actor type as well as Global South (GS) versus Global North (GN) representation to provide unique insights on GHS-UHC coherence based on varying institutional and geopolitical dynamics (Sriram *et al.*, 2018; Topp, 2020).

[Insert Table 1 here] *[Insert Table 2 here]*

Data Analysis

To analyze the data, Braun and Clarke's systematic approach to thematic analysis (Braun and Clarke, 2006) was employed, beginning with repeated readings of the transcripts to ensure familiarity with the narratives and identify recurring ideas and contradictions. NVivo software was utilized to develop and refine codes both inductively from the data and deductively based on the research focus and interview questions. These codes were iteratively grouped into subthemes, themes, and broader categories to structure the results section and align with the study's aim of unpacking the politics of GHS-UHC coherence. To ensure robustness, findings were triangulated by cross-referencing interview data with field notes and global health policy documents, enhancing credibility and minimizing bias. This rigorous, iterative approach effectively synthesized diverse stakeholder perspectives, revealing previously-overlooked power dynamics which shape GHS-UHC coherence and political economy implications of hybrid norms within the post-COVID-19 global health landscape.

Results

The findings from the elite interviews are structured into two overarching categories: evolving perceptions of GHS and UHC (post-pandemic shifts and conceptual relationships), and key factors influencing coherence (strategic and structural considerations). Each category is broken down into themes and subthemes, which highlight emerging insights and direct quotes from participants (see Table 3).

[Insert Table 3 here]

Post-pandemic shifts

GHS emphasis on equity and community-level health services

The COVID-19 pandemic prompted a paradigm shift in the perception of GHS, with increasing emphasis on equity and the continuity of community health services.

One GN civil society advocate articulated this evolution: *"Health equity is a big component of global health security, which I don't think necessarily falls in the standard definition. But security is about protection, right? And so that's protection for all people."*

While GN actors often focused on aligning GHS with global strategies, GS voices emphasized new imperatives for grounded, bottom-up approaches that resonate with communities. For example, a GS civil society representative argued, *"Global health security must be solved in communities [...] there is no security in global health if there is no security in communities."*

UHC as key to resilience, despite recent deprioritization

Although the pandemic underscored UHC as a foundation for GHS, it also diverted political attention and financial resources away from UHC efforts, with a former GN government official lamenting that UHC was *"forgotten [and] deprioritized."* A GN civil society advocate further highlighted:

"Unfortunately for the UHC movement, it was just getting its legs when COVID-19 hit [...but...] if you don't have a strong health system that you built through UHC or have people being able to access the system, pandemic response doesn't really work."

Meanwhile, GS actors emphasized UHC's role in supporting resilience, with a multilateral official arguing that, in countries facing frequent shock events, "*you cannot achieve UHC, because you are draining your resources on fighting the fire in lieu of making your house fire-protected."*

Conceptual relationships

UHC as a foundation for GHS

One way that key informants frequently conceptualized the relationship between both goals was by arguing that UHC was a broader framework, under which GHS was one element.

As one GN government official explained, *"global health security is a part of the overarching universal health coverage framework [...] if done correctly, [UHC] can mitigate the need for a whole bunch of security efforts."*

Several GS actors agreed, with one donor stating, "*there is no way you can get global health security without universal health coverage*," and a former GS government official suggesting, *"what comes first is universal health coverage. That's the big umbrella for anything else. I see global health security within that."*

Clear interrelatedness between GHS and UHC

The post-pandemic era also catalyzed greater recognition of the interdependence between GHS and UHC, with stakeholders increasingly viewing them as complementary norms.

Two multilateral officials encapsulated this best, with a GN-based representative remarking that their "*relationship is unavoidable and is fully interdependent,*" and a GS-based counterpart reflecting: "*the two constructs are intertwined, interlinked via the health system [...] they are two goals.*"

Strategic considerations: concerns for increasing GHS-UHC coherence

Harder to demonstrate progress

Integrating GHS and UHC presents challenges in relation to GN actors' reliance on tangible outcomes for funding justification. One GN donor representative noted:

"You can rattle off a list of community health workers and surveillance [...] where it feels there is overlap between UHC and pandemic preparedness [...] but whether that is genuinely tracking through to the way in which work is being [...] planned and done is a very different question."

GS actors, in contrast, emphasized the need for equity-focused metrics to ensure that marginalized populations are not left behind during integration efforts, with a civil society representative pointing out: *"you could overlook certain elements [...] when you try to talk about UHC [...and...] global health security [...] You don't have indicators for who is covered."*

Internal resistance and competition

Resistance to integrating GHS and UHC appeared to stem from entrenched institutional structures and competition for resources, with one GN government official arguing that *"people do not want to understand or collaborate because [they] are very keen to deliver on their own agenda."* A GN donor further reflected:

"People's jobs exist to perpetuate the status quo. The GHIs have been designed this way. Ministries of health have been redesigned to interface with that [...] whilst there may be theoretical high-level support for integration, people's individual jobs and incentives often don't align with that."

A GS health multilateral echoed: *"You have a small pot of money, [...] as we talk about harmonizing, we also need to talk about bringing [...] the stakeholder groups that are purposely fighting for specific disease areas together."* A GS government official further explained how *"too many cooks in the kitchen"* fuels unnecessary competition, already exacerbated by the exclusionary dynamics of global health governance.

Weakened messaging

Overall, GN actors of all types emphasized the dilution of clear, actionable narratives necessary to sustain political and financial support as a primary concern for GHS-UHC coherence.

One GN government official observed:

"I think your message gets diluted. [...] single disease conversations have been so successful, like HIV, Malaria, TB. Because you're really just focusing on one thing. And that seems very solvable. Once you [...] keep expanding out, it becomes overwhelming [...] that's also why GHS as a standalone thing has been very captivating [...] because it seems very tangible."

Meanwhile, GS actors were concerned about possible erosion of specific priorities and principles of each framework, with one civil society representative warning, "*how do we ensure that even as we integrate, we don't lose the unique vulnerabilities [...] around GHS? And UHC?"*

This divergence highlights a tension between GN actors' focus on clarity of individual messages versus GS actors' insistence on maintaining a comprehensive view of both norms.

Strategic considerations: motivations for increasing GHS-UHC coherence

Improving health outcomes

Stakeholders consistently identified the integration of GHS and UHC as essential for improving health outcomes, particularly due to greater coordination and resilient health systems capable of maintaining essential services during crises.

One GN civil society representative asserted, *"if we invest in UHC, if we invest in health security, [...] that will lead to fewer deaths and better economic outcomes, better health outcomes, [...] better societal outcomes."* A GN government official similarly emphasized better outcomes "*if we're more coordinated across the various [GHS and UHC] programs."*

However, GS actors sometimes went further than their GN counterparts to highlight the compounding effects of health crises which may "*driv[e] people into poverty*," with one civil society representative stressing that, *"equity [...] is a fundamental reason why [GHS and UHC]"* must be integrated.

Maximizing efficiencies and resources

The integration of GHS and UHC was frequently highlighted as an opportunity to optimize resources and reduce inefficiencies, particularly by harmonizing health systems components.

One representative of a GN-based donor observed:

"We are duplicating funding infrastructure [...] we don't [...] understand where the overlaps and opportunities are to streamline, to mainstream, to de-fragment [...] it's increasingly [...] about how we can do better with the resources out there."

Meanwhile, a GS donor noted:

"If you address health security as something completely distinct from universal health coverage, then your actions [are] not properly synchronized on the ground, you are just wasting resources [...] synergies help in efficiency, help in bringing the results faster."

GS actors' emphasis on the risk of wasted resources and fragmented attention on the ground indicates a pragmatic focus on avoiding operational inefficiencies that directly affect service delivery – a slight nuance compared to GN counterparts.

Sustaining progress for both agendas

Various stakeholders were motivated by the potential to sustain advancements for both GHS and UHC – largely because they believe initiatives that build coherence can mitigate donor fatigue, prevent the creation of new silos, and amplify the visibility of both agendas through a shared platform for advocacy and funding.

One GN donor cautioned against conventional vertical programs which *"cause fragmentation,"* with a GN government official emphasizing joint/pooled initiatives by noting that *"strength in numbers is the important thing."*

With actors across the board agreeing that *"global financing for health is going down"* a GS donor asserted that without synergizing GHS and UHC, "*you are dispersing attention and you will never reach your goals*" – underscoring the importance of aligning funding streams. This demonstrates a shared interest among GN and GS actors toward sustainability, but a divergence in emphasis on operational versus financial priorities to sustain progress – with a need to balance top-down strategies with bottom-up approaches to ensure effectiveness.

Structural considerations: barriers to GHS-UHC coherence

Conceptual and structural misalignment

Divergent conceptualizations between GHS and UHC frameworks emerge as significant barriers to coherence, reflecting unique priorities and approaches among different actors.

A central reason for the disconnect may be attributed to the conceptual divide in how GHS and UHC are framed, as expressed by a GN government official: *"UHC is about local, country-specific goals, while GHS requires cross-country collaboration."* This dynamic may be compounded by ideological divides, with another GN government official suggesting: *"The GHS agenda is more right-wing, while UHC is more left-wing,"* reflecting competing politics that hinder collaboration.

This conceptual misalignment perpetuates silos between GHS and UHC, with each stream accountable to different mechanisms, as noted by a GS-based civil society advocate: *"Each global health institution and pot of money has its own specific mandates."* One GN-based public-private partnership similarly noted: *"Structures in place for financing global health are disease-specific, technology-specific, and population-specific [...these] define how the money is raised, who pays and where the money goes."*

GS actors have described how this fragmentation also hinders country-level implementation, with one civil society representative pointing out: *"the PPR team and UHC team are often siloed within countries."* Donor-driven systems, they argue, thus create fragmented pathways that are poorly aligned with the integrated vision required for coherence. This bifurcation reveals a deeper issue of divergent operationalization of GHS and UHC initiatives within different actors.

This leads to variation in how both concepts are communicated, with one GN donor highlighting that GHS and UHC *"discourses [...] happen in separate parallel tracks where, in fact, they ought to be combined."* Civil society actors emphasized that GHS's simplicity – *"detect an outbreak, contain it, and prevent global spread"* – makes it more palatable to policymakers than UHC's multidimensional complexity, a sentiment echoed by a GS multilateral official who observed that UHC is often dismissed as *"aspirational"* by practitioners focused on more 'immediate' public health challenges. GN actors therefore focused on aligning overarching narratives and funding streams, while GS voices stressed the importance of tailoring integration efforts to local realities.

Power dynamics and external influences

GS donors described a clear imbalance in power and influence, with one observing, *"The game always is that those who have [more money] take advantage and impose their ideas."* Many informants argue that this leads to an absence of GS voices in shaping the global health agenda, with LMICs often lacking leverage and coming to the table in what one GS multilateral official characterized as a *"pity party dynamic."*

Power asymmetries between GN and GS actors (and across institutional types) therefore hinder GHS-UHC coherence, with GS stakeholders frequently perceiving GN-driven frameworks as

misaligned with local needs, such as another GS multilateral representative noting that: *"global health security is often construed with a very global north lens."*

Of note, some GN actors did acknowledge these tensions, with one government official contending:

"The ways of doing development really need to change [...] if there's a plan towards UHC or there's a plan towards improving health security in a country, we need to be thinking about how our work can fit into what they have proposed."

However, a GS regional health agency representative argued that some of the solutions lie closer to home:

"If regional organizations need funding, it's easy for them to be swayed by what a global player says. [...] we need strong institutions with strong leaders who [...] know what their priorities are, to align global level financing to what they believe is the priority of the country."

Resource allocation and accountability

Fragmented funding mechanisms and insufficient accountability structures exacerbate barriers to GHS and UHC integration, revealing significant disparities between GN and GS actor groups.

Donors often focus on narrow, vertical funding mechanisms, as one GN civil society representative observed a *"lack of long-term vision on the part of funders [...] people fund a report, a project, an event [...] but not building a movement [...] for both agendas that are quite broad and long term."*

GS actors face additional challenges in securing sustainable financing. One GS representative observed *"in many countries [...] sufficient resources is not there. And then they resort to institutions like the Global Fund,"* which they argue inherently prioritize donor-driven priorities over local needs. This imbalance undermines national health systems, with one GS donor describing *"the draining of staff from the public sector to go to the programs which were funded by HIV and AIDS programs because they had money"* and better working conditions.

This piecemeal approach undermines clear accountability mechanisms, with one GN government official cautioning that "*there's no legislation [...] there's got to be coordination across these various departments and agencies."* A GN-based multilateral representative further urged: "*we have to address [GHS and UHC] as an integrated way and in the health system [...] what is lacking here is who is the policeman [...] who secures the accountability."*

Structural considerations: enablers for GHS-UHC coherence

Effective communication

Effective communication emerged as a critical enabler for integrating GHS and UHC, though GN actors seemed to emphasize this more than their GS counterparts. One GN government official highlighted the importance of crisp, tailored messaging:

"A policymaker [...] wants something explained to them in a page or less [...] when you're trying to change hearts and minds [...] how do you focus the conversation in a way that resonates with them?"

This stands in contrast to the perennial challenge of succinctly advocating for cross-cutting initiatives required for HSS or GHS-UHC coherence, with a GN civil society representative explaining: *"we know that complexity leads to confusion, which leads to less buy-in and investment."*

Several informants suggested that more senior, political officials may be better accustomed to viewing issues through integrated 'big-picture' perspectives, rather than distinguishing between GHS and UHC; coherent narratives may therefore resonate better with them than with lower-level technocrats. For example, one GN-based donor observed: *"the Prime Minister is not going to say, 'Oh, you're coming to me on a health security issue today. You're coming to me on a UHC issue [...they] see health as health."*

A senior GS multilateral official echoed this sentiment, and its implication on GHS-UHC operationalization:

"Who is running a health service in some of the most challenging environments? It's the same person. The Director-General of Health Services may be responsible for setting out a PHC strategy, an overall national health policy [...] overseeing the National Action Plan for Health Security. [...] one plan, one budget, one monitoring – that has to be the binding factor."

Part of the solution may therefore be in communicating GHS and UHC in more personal ways, with one GN multilateral representative stating, *"we need to still bring these people, these [GHS and UHC] groups together [...] it's a cultural integration."*

External support

External support through partnerships, collaboration, and funding mechanisms was seen as a critical enabler for GHS-UHC coherence – with relatively converging views across all actor types on streamlining funding channels and fostering synergy among institutions.

One GN multilateral health official remarked, *"the funding flows need to work towards that objective. We now have vertical funds that try to do more horizontal stuff [...] but these funds are certainly in competition with one another. But it's the same health system you're trying to strengthen."* A GS-based civil society advocate further argued:

"Look at the global health institutions that are already supporting countries to strengthen health systems [...] when the pandemic hit, the Global Fund was one of the first partners to put money on the table to respond so rapidly [...] How can all these different organizations synergize? It's about collaboration, coordination."

In response, one GN-based donor emphasized: "*The spirit of the Lusaka agenda and the FGHI process that led it was very focused on what are the priorities at country level and how can we get the global financing system to better align and interface with those."* Many actors believed this might catalyze coherence, given that domestically, *"these things are all incredibly enmeshed. You cannot separate out surveillance for global health security from routine health monitoring and system strengthening."*

Internal implementation

Domestic prioritization and commitment to health – reflected in national budgets and through leadership – were consistently highlighted as critical to GHS-UHC coherence, though the framing differed across GN and GS actors.

One GN government official noted clear value-for-money if efforts for GHS-UHC coherence can secure necessary political leadership:

"If Ministries of Health are [...planning...how...] money for GHS can be used in conjunction with UHC principles, then [...] it's such a self-evidently smart argument [...] there has to be a desire by the national government to actually do this, to appoint [and empower] leadership [...] and then to convene stakeholders, multilateral organizations, funding institutions, bilateral partners."

Meanwhile, GS actors focused more on national capacity-strengthening and resilience which could catalyze GHS-UHC coherence. For example, one GS official of a global health agency observed: *"If you look at national-level planning [...] all of these are particular silos. One easy fix is to bring all these plans into one integrated plan. It's doable, but it's not happening."* A

former GS government official further concluded, "*we need to advocate for a holistic, multisectoral, coherent approach to governance.*"

Discussion

While the shift toward integration of GHS and UHC isn't entirely new(Lal, Parkhurst and Wenham, 2024; Lal, Wenham and Parkhurst, 2024), the COVID-19 pandemic provided a clear policy window(Weber and Driessen, 2010) which increased its visibility and urgency – reinforcing the need for a coherent approach combining emergency response with universal access. Crucially, all respondents (*n=31*) believed enhancing GHS-UHC coherence was an important endeavor, with many emphasizing the need to address fragmentation and identify opportunities for advancing integration, including in their own organizations. This represents an important normative shift, indicating that socialization(Finnemore and Sikkink, 1998) of an emerging 'hybrid norm' linking GHS and UHC is clearly underway.

Analysis of the overarching themes suggests that strengthening coherence between GHS and UHC not only depends on, but can further enhance, three key strategies in health policy and planning: 1) overcoming geopolitical power asymmetries, 2) leveraging strategic collaboration across actor types, and 3) pursuing integrative health diplomacy amid polycrisis. Moving forward, the emerging hybrid norm of GHS-UHC integration can be used to identify best practices and priority actions for how global health governance structures, financing mechanisms, and health systems strengthening initiatives are designed, particularly in a broader diplomatic context characterized by calls for coherence in the face of geopolitical headwinds and resource constraints.

Overcoming geopolitical power asymmetries

The findings reveal entrenched power asymmetries in global health governance, where GN actors dominate agenda-setting, financing decisions, and programmatic priorities, often sidelining GS perspectives in shaping long-term health policies. Ngeuenha and colleagues note that "part of the challenge of coherence across sectors" is that stakeholders perceive the same issues through vastly different lenses.(Nguenha *et al.*, 2024) This divergence is evident in how GN donors prioritize vertical, outcome-driven investments favoring GHS-aligned initiatives such as HIV/AIDS, tuberculosis, and malaria, while GS governments – contending with the dual burden of infectious and chronic diseases and inadequate health services – emphasize UHC-driven capacity-building and primary health care. These asymmetries, reinforced by unequal decision-making power (Kickbusch and Liu, 2022) and misaligned resource allocation, perpetuate conceptual and operational divergences that hinder efforts to sustainably address

complex health challenges. However, the hybrid norm of GHS-UHC provides a strategic pathway to reshape global health agenda in ways that are mutually-beneficial for GN and GS actors. For example, by integrating UHC's emphasis on equitable access within GHS's emphasis on emergency response, it could redefine financing objectives, incentivize pooled investments, and create mechanisms for more inclusive governance. In this way, advancing GHS-UHC coherence can usher a structural realignment in multilateral engagement, positioning GS countries as active architects – rather than passive recipients – of global health reforms that reflect their priorities.

As Fidler argues, the transition to a "multipolar" world(Fidler, 2023) necessitates new frameworks that balance the geopolitical interests of middle-income countries with evolving global health governance. The hybrid norm of GHS-UHC helps achieve this balance, promoting cross-cutting principles and ways of working which help shift influence from GN actors to regional bodies and geopolitical blocs with stronger GS representation. As Riggirozzi's notes, regional entities play an "important role in advancing health agendas in member countries" by offering more equitable governance structures(Lencucha *et al.*, 2018), and may therefore be uniquely positioned to operationalize this shift. The African Union's vision for a "new public health order" (Africa CDC, no date) underscores the need to embed GHS and UHC within treaty mechanisms and institutional structures to ensure long-term sustainability, while BRICS – leveraging its growing geopolitical influence (Tediosi *et al.*, 2016) – can drive alternative health financing models that challenge GN's conventionally neoliberal, vertical health reforms. At the same time, shifting global dynamics may open new pathways for GS actors to redefine health priorities through integrative frameworks. For example, with the second Trump presidency significantly gutting global health programs(Burki, 2025), GS actors should increase public financing for domestic health programs, reshaping priorities by positioning UHC as a central pillar and reconceptualizing GHS through a more equity-driven and sustainable approaches(Kickbusch and founder, 2024). Finally, the GHS-UHC coherence can help bridge broader economic and foreign policy agendas – including trade and development finance – enabling collective action on socioeconomic determinants of health through key platforms like the G20 Health-Finance Task Force, and reduced reliance on externally-imposed priorities through improved South-South collaboration. If strategically leveraged, GHS-UHC coherence could mark a turning point in global health governance, ensuring that regional partnerships(Rahman-Shepherd *et al.*, 2025) evolve through integrative frameworks, rather than siloed interventions, shape the next era of multilateral health cooperation.

The Lusaka Agenda's focus on country ownership represents a critical shift in global health governance, aiming to correct longstanding imbalances in decision-making and financial flows that have historically prioritized GN donor-driven agendas over GS national strategies. However, past efforts to reform donor coordination – such as the Paris Declaration on Aid Effectiveness (Buse and Walt, 1996) – have failed due to persistent structural barriers, including fragmented

institutions and a reluctance to relinquish control over resource allocation. Here too, the GHS-UHC hybrid norm provides a conceptual and operational framework that could help Lusaka Agenda as a transformative tool for proponents to bridge the divide between externally-driven priorities and locally-led health system strengthening efforts through a mutually-reinforcing policy paradigm. Furthermore, positioning GHS and UHC as coherent, interdependent objectives, rather than competing priorities, could incentivize harmonized investments that respect country ownership while ensuring that global health priorities remain responsive to both domestic and transnational health challenges.

Finally, GHS-UHC coherence advances efforts to decolonize global health (Abimbola *et al.*, 2024; Baum *et al.*, 2024) by reconfiguring GN-GS engagement, shifting from short-term aid dependency (e.g., official development assistance) to long-term structural investments in health system strengthening(Sridhar, Khagram and Pang, 2008; Sparkes, Shroff and Hanson, 2024). This transition requires more than rhetorical commitments – it necessitates dismantling entrenched financing conditions and decision-making asymmetries that perpetuate GN dominance(Pai, Bandara and Kyobutungi, 2024). Interviewees highlighted that GHS-UHC coherence offered a pragmatic mechanism in the wake of COVID-19 for reconciling GN priorities in surveillance and intelligence-sharing with GS demands for equitable access to countermeasures and sustainable health financing. Beyond pandemic response, this hybrid norm ensures that equity is not merely an aspirational principle but an operational imperative for resilient health systems. By embedding coherence within global governance frameworks, this approach fosters mutual accountability, aligns incentives across geopolitical divides, and promotes an inclusive, sustainable model of global health policy that resonates with both GN and GS actors alike.

Leveraging strategic collaboration among different actor types

Achieving GHS-UHC coherence necessitates leveraging the distinct, yet complementary, roles of governments, multilaterals, donors, and civil society – while dismantling entrenched institutional barriers and path dependencies (March and Olsen, 1998; Raymond *et al.*, 2014; Lal, Wenham and Parkhurst, 2024). As Lencucha argues, "bureaucratic silos"(Lencucha *et al.*, 2018) between these actors continue to obstruct coordination, with respondents underscoring inefficiencies, competing priorities, misaligned funding cycles, and institutional resource guarding as primary obstacles. Historically, governance structures have reinforced these divides, with narrowly defined mandates that have made interests resistant to integration. The GHS-UHC hybrid norm offers a mechanism to navigate these challenges – not merely by harmonizing actor roles, but by establishing clear normative pathways for information-sharing, aligning financial incentives, and fostering multi-sectoral accountability. By addressing the "lack of shared information, delayed and ineffective decision-making as well as the inability to resolve 'wicked problems'"(Quintana *et al.*, 2024), GHS-UHC coherence enables a structural shift toward strategic collaboration.

However, its success depends on sustained political will and institutional buy-in, requiring deliberate efforts to embed coherence into governance frameworks, funding structures, and long-term planning.

Governments are central to national health resilience, tasked with responding to public health threats while ensuring equitable access to care. The GHS-UHC hybrid norm reinforces this dual mandate by fostering a whole-of-government approach that integrates essential public health functions with primary health care(Lal and Schwalbe, 2023), strengthening institutional capacity beyond crisis response. Respondents emphasized that advancing GHS-UHC coherence requires prioritizing cross-cutting health systems interventions, including sustained investments in health workforce development, information systems, and public health infrastructure. The ability of GHS and UHC to bridge "sectoral differences"(Quintana *et al.*, 2024) is particularly critical for overcoming fragmented health policies across ministry agencies and mitigating the effects of electoral cycles (Siirilä and Salonen, 2024), which often hinder long-term strategic planning. Furthermore, interviewees from across actor groups underscored the importance of governments actively championing GHS-UHC integration both domestically and internationally, leveraging diplomatic channels to align global health agendas with national priorities and advocating for greater domestic health budgets.

Multilateral institutions and global health organizations are central to fostering coherence between GHS and UHC, providing normative, technical, and coordination functions that influence global health governance. Their effectiveness in harmonizing health guidance, aligning fragmented health financing flows, and promoting synergies across overlapping agendas, however, remains constrained by competing replenishment cycles, earmarked funding streams, and institutional governance structures that reinforce fragmentation. Many stakeholders underscored the need for a normative shift within these institutions, beginning at the highest levels of leadership – particularly among governing boards of public-private partnerships, where decision-makers remain largely unaccountable (de Bengy Puyvallée, 2024) – and extending to country offices and community leaders. The hybrid norm of GHS-UHC may, in turn, provide a framework for balancing immediate outbreak responses with long-term health system strengthening, equipping policymakers and technical specialists with integrated metrics such as WHO's revised IHR benchmarks and HEPR framework(WHO, no date a) to enhance accountability across global health programs.

Atun et al. argue that "fiduciary requirements imposed on donor agencies by their governing structures which require them to 'ring fence' funding streams or be able to attribute results to their investments" significantly hinder integration.(Atun *et al.*, 2010) Interviewees echoed this concern, emphasizing that GHS-UHC coherence could be advanced through aligned funding mechanisms and pooled, multi-year investments, reinforcing broader literature that underscores the need for more flexible, adaptive financing models.(Atun *et al.*, 2010; Yates, 2021; Lal, Lim, *et al.*, 2022; Holmer *et al.*, 2025) The hybrid norm of GHS-UHC offers a strategic lens through

which donors can reduce duplication, maximize synergies across overlapping priorities(Sachs *et al.*, 2022), and support localization efforts(Charani *et al.*, 2022), ultimately enhancing the cost-effectiveness and sustainability of global health investments. However, respondents warned against new vertical funds or flashy initiatives that exacerbate fragmentation, instead advocating for strengthening existing funding channels and prioritizing horizontal financing. For example, the recently established Pandemic Fund could be strengthened by aligning with GHS-UHC coherence, ensuring that all future investments serve a dual-purpose of strengthening pandemic preparedness alongside universal access to care and equitable health system resilience.

The findings highlight the critical role of civil society organizations in advancing GHS-UHC coherence, as they are uniquely positioned to contextualize global health policies within local realities, ensuring frontline health workers a focus on vulnerable and marginalized groups remain central priorities. Their role in governance accountability is well-documented (Smith, 2019, 2023), with a strong emphasis on inclusivity, community engagement, and coalition-building(Rau, 2006; Olu *et al.*, 2019; AlKhaldi *et al.*, 2021; Ngongo *et al.*, 2024), bridging high-level global health strategies with implementation at national, subnational, and community levels. However, respondents underscored persistent challenges, including resource constraints and pervasive power imbalances, which often hinder the ability of civil society organizations to shape policy. Greater investment in civil society-led initiatives could strengthen the operationalization of the GHS-UHC hybrid norm, which in turn can enable sustained advocacy for both GHS and UHC across shifting investment landscapes – while fostering trust, political will, and multistakeholder collaboration essential for equitable and inclusive health systems.

This study advances scholarship on the politics of integration(Storeng and Béhague, 2016) by demonstrating how normative coherence between GHS and UHC can enhance collaboration across diverse actors. Shifting from fragmentation's empirical drivers to actively fostering hybrid norms offers a pathway to overcoming institutional competition for resources and attention—longstanding barriers to equitable global health partnerships(Puyvallée *et al.*, 2025). Strengthening GHS-UHC coherence transforms competing agendas into synergies, reinforcing a more resilient and responsive global health architecture. While divergent perspectives remain a challenge, aligning these frameworks enables actors to leverage their strengths in governance, financing, health systems, and political mobilization, driving a more unified and sustainable global health approach.

Navigating polycrisis through integrative health diplomacy

The findings emphasize the urgency of systemic, integrated responses to complex global health challenges that transcend siloed approaches. The concept of polycrisis(Wong *et al.*, 2024) characterizes today's era where pandemics, climate change, and armed conflicts intersect with

economic fragility, rising authoritarianism, and the erosion of multilateralism – threatening to stall or reverse public health gains. This fragmented landscape poses formidable challenges for global health cooperation, which "must be viewed through the lens of systemic risk"(Kwamie *et al.*, 2024) requiring multifaceted responses that cross sectors and borders. As the 2030 SDG deadline nears, resilience and the ability to mitigate emerging, overlapping threats must become central to the "everyday business" of health systems.(Rasanathan, 2024) To navigate this landscape, coherent and adaptive health strategies are essential – only to withstand crises but to transform global health governance into a system capable of anticipating and responding to compounding risks.

Kickbusch et al. note that "global health diplomacy seeks to facilitate global coordination and policy coherence for health."(Kickbusch, no date) However, recognizing the "highly interconnected" and "cascaded nature" of polycrisis(Kwamie *et al.*, 2024), Hocking and colleagues advocate for 'integrative diplomacy,' which emphasizes cross-sectoral collaboration, multi-level engagement, and whole-of-government approaches.(Adinoyi, 2018) Applying this concept to global health, integrative health diplomacy may be better suited to coherently address overlapping public health threats by providing a framework to harmonize competing agendas and align fragmented governance mechanisms. In this context, strengthening coherence between GHS and UHC can be a foundational pillar for integrative health diplomacy, unifying diplomatic strategies across the spectrum from disease prevention to emergency response.

Informants highlighted that fragmentation between GHS and UHC has resulted in disjointed global health commitments and funding streams, leaving critical health initiatives vulnerable to backsliding and budget cuts. Increasing isolationism further threatens global health and development assistance – with hard power politics gaining traction in foreign policy circles.(Adinoyi, 2018; Fidler, 2024; Rasanathan, 2024) GHS-UHC coherence offers a necessary counterweight to these trends, providing a strategic pathway to sustain progress amid geopolitical instability and the turbulence of polycrisis. A hybrid norm integrating GHS's security imperatives with UHC's universal access principles ensures that global health agreements retain a balanced focus on resilience to emergencies without compromising equity in care delivery(Lal, Abdalla, *et al.*, 2022). As global governance tilts toward defense-driven priorities, the GHS-UHC hybrid norm can prevent a hypersecuritized global health agenda, ensuring equity remains central to health policy.

Recent negotiations have already reflected this normative shift, with UHC norms like accessible countermeasures embedded in the draft Pandemic Agreement and GHS priorities like outbreak surveillance reinforced in the 2023 UHC Political Declaration.(Lal, Wenham and Parkhurst, 2024) This form of integrative health diplomacy, building on GHS and UHC coherence, will be crucial to both agendas, ensuring that neither is sacrificed to austerity or geopolitical interests. This not only streamlines duplicative health negotiations related to national security and human

rights, but also creates a unified narrative for national and multilateral health obligations, and improves the ability of governments to support pooled global health financing mechanisms.

The GHS-UHC hybrid norm strengthens global health diplomacy by creating a shared framework for negotiation across sectors, governance levels, and geopolitical divides. Integrative diplomacy, as Hocking et al. assert, "can strengthen a country's role as a negotiating partner in the bilateral and global arena."(Adinoyi, 2018) For example, by jointly embedding equity and resilience as core principles, GHS-UHC coherence enables countries to balance global commitments to pandemic preparedness with local commitments to reduce air pollution and improve water sanitation – crucial to addressing the climate-health interface.(Quintana *et al.*, 2024). This alignment enhances both chronic and acute public health responses(Hanefeld *et al.*, 2018; Haldane and Morgan, 2021; Mustafa *et al.*, 2022), equipping states with improved capacity to engage in effective health diplomacy particularly where domestic health issues intersect with international obligations, thus improving crisis coordination and establishing enduring frameworks for joint action on broader health and development challenges. In an era where multilateral solidarity is increasingly fragile, this GHS-UHC hybrid norm offers an alternative to the rise of transactional diplomacy, ensuring that global health remains a pillar of cooperative international engagement rather than a casualty of shifting political tides.

Conclusion

This study addresses chronic fragmentation in global health governance by examining how greater normative coherence between GHS and UHC can strengthen health systems. Positioned along a continuum from prevention to response, GHS and UHC encompass a wide spectrum of global health priorities, making their integration not just a theoretical exercise but a necessary evolution for health policy and planning. While previous research has analyzed the construction and convergence of GHS and UHC norms, this study is among the first to directly assess the perspectives of key stakeholders engaged in efforts improve their coherence.

The interviews reveal that actors' conceptualizations of GHS and UHC have evolved post-pandemic. Equity and community health services are increasingly emphasized within GHS norms, while UHC norms were framed as essential for resilience despite recent political deprioritization. Respondents generally recognize both frameworks as closely interlinked through health systems. Factors influencing coherence include strategic motivations such as improving health outcomes and maximizing efficiencies. However, concerns such as internal resistance and weakened messaging persist. Structural barriers like conceptual misalignment, and power imbalances hinder progress, while enablers like external support and robust internal implementation facilitate better integration. Important variations in actor perspectives across

institutional and geopolitical context highlight both tensions and opportunities for advancing GHS-UHC coherence.

By examining what different actor groups think about GHS-UHC coherence – what it means in practice, how it can be achieved, and what challenges remain – this study offers a crucial window into the politics shaping GHS-UHC integration, and provides actionable insights into how coherent norms can advance these synergies in a post-pandemic context. The findings demonstrate that promoting this emerging hybrid norm provides a concrete pathway to bridging divides between securitized, international cooperation-driven approaches and rights-based, community-centered approaches. This is achieved by leveraging the complementary strengths, underlying principles, and core capacities of both frameworks. Intentional operationalization of coherence is not just about aligning policies and reconciling divergent health strategies among key actors – it is about safeguarding hard-won gains against competing priorities, ensuring neither agenda is sacrificed amid shifting geopolitical dynamics. In an era of rising austerity, eroding multilateralism, and increasing contestation, mainstreaming GHS-UHC coherence counters the pattern of continued fragmented global health efforts by providing a more pragmatic, unified approach to strengthening health systems for future crises.

Having unpacked how different global health stakeholders conceptualize, negotiate, and implement GHS-UHC norms, this research sheds light into the political and institutional processes required to strengthen coherence across global health initiatives. However, future research is needed to better assess the effectiveness of "global health security" and "universal health coverage" framings among different stakeholders(Akhavein, Sheel and Abimbola, 2025), as well as how normative coherence is implemented in national and subnational contexts.

Beyond the immediate policy implications, this study contributes to broader global health scholarship by positioning normative coherence as a critical factor in institutional design, diplomacy, and governance. Previous efforts to improve integration have often failed due to an insufficient focus on the politics of global health, yet as this study illustrates, coherence is not merely a technical or administrative function – it is a strategic and political endeavor. As the global health landscape evolves in an era of polycrisis, recognizing the inevitability of overlapping health agendas is paramount. Addressing fragmentation requires solutions as interconnected as the challenges they seek to resolve. The hybrid norm of GHS-UHC coherence provides a compelling framework for integrating previously siloed principles and core capacities, ultimately helping to address the majority of global health challenges.

While this study centers on the synergies between GHS and UHC, its broader objective is to foster a more equitable and resilient global health architecture by tackling interconnected causes of fragmentation through GHS-UHC coherence. By advancing mutually-reinforcing solutions across governance and diplomacy mechanisms through hybrid normative frameworks, this work

reimagines how global health institutions collaborate, ultimately helping to develop a more adaptive, inclusive, and sustainable approach to global health – one that is better equipped to navigate future political, economic, and social uncertainties.

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Tables (included in separate file)

Table 1. Number of key informants interviewed per actor grouping.

Table 2. Number of key informants interviewed per geopolitical grouping.

Table 3. Findings from thematic analysis of interview transcripts, organized by category, theme, and subtheme.

Table 1. Number of key informants interviewed per actor grouping.

Actor Type	**# of participants**
Multilateral and global health organizations	**9**
Country governments	**10**
Donors, foundations, and international finance institutions	**6**
Civil society organizations	**6**
Total	***31***

Table 2. Number of key informants interviewed per geopolitical grouping.

Geopolitical Group	# of participants
Global South	**13**
Global North	**18**
Total	***31***

Table 3. Findings from thematic analysis of interview transcripts, organized by category, theme, and subtheme.

Categories	Themes	Subthemes
Evolving perceptions of GHS, UHC, and their relationship	*Post-pandemic shifts*	• GHS emphasis on equity and community-level health services • UHC as key to resilience, despite recent deprioritization
	Conceptual relationships	• UHC as foundation for GHS • Interlinked through health system
Factors influencing coherence	*Strategic considerations*	Motivations • Improving health outcomes • Maximizing efficiencies • Sustaining progress for both Concerns • Harder to demonstrate progress • Internal resistance and competition • Weakened messaging
	Structural considerations	Barriers • Conceptual and structural misalignment • Power dynamics & external influences • Resource allocation & accountability Enablers • Clear messaging • External support • Internal implementation

Chapter 9: Synthesis of research and findings

This chapter returns to the central research aim that has animated the thesis: to understand how global health security and universal health coverage have been aligned – and what this suggests about promoting equitable and resilient health systems and a more sustainable global health architecture. At stake in this prompt is more than a technocratic challenge of aligning policy frameworks; it is a fundamentally political inquiry into how different visions of health – anchored in securitization and rights, equity and resilience – are contested, debated, and strategically aligned within an increasingly complex and fractured global order. The chapters preceding this one have each offered a distinctive empirical lens into this process, drawing on archival texts, negotiation documents, and elite interviews to trace the normative and institutional trajectories of GHS and UHC. Taken together, they reveal both how these frameworks interact as well as how global actors interpret, instrumentalize, or resist their alignment depending on context and underlying power dynamics. The rest of this chapter proceeds by first recapping the key research objectives and then summarizing the major findings across the three substantive chapters, mapping how GHS and UHC were historically constructed, how they have converged through diplomatic fora, and how they are now being institutionalized – albeit unevenly – within coherent, hybrid normative arrangements.

9.1 Restating key research aims

This section serves to anchor the discussion of findings in Chapter 10 by reaffirming the core purpose of the thesis and restating the key research objectives and approaches established in Chapters 1 and 5. This thesis originally set out to trace how GHS and UHC – as two historically distinct but increasingly interconnected global health agendas – have been conceptualized, aligned, and evolved through GHD. In responding to this research aim, it drew from constructivist literature to introduce a new conceptual framework on hybrid norms that helps examine how integration between both agendas unfolds through three stages: norm construction, convergence, and coherence. In doing so, the thesis was motivated by a fundamental reconceptualization of GHS-UHC integration as a profoundly strategic, political, and ultimately *normative* endeavor shaped by framing, aligned through negotiation, and embedded through institutionalization.

The central research question was: **How have global health security and universal health coverage been integrated through global health diplomacy – and what are the implications on the broader global health architecture?**

In response to the research question, the overarching objective of this thesis was: **To develop and apply a conceptual framework of 'hybrid norms' to explain how global health security and universal health coverage are constructed, converged, and made coherent through global health diplomacy – and to advance a greater understanding of the 'politics of integration' and how its iterative processes of framing, negotiation, and institutionalization influence the broader global health architecture.**

The thesis was guided by three core research aims, each addressed through the three papers presented in Chapters 6–8 and sequentially tied to a stage in the hybrid norm framework developed in Chapter 4:

1. To analyze how GHS and UHC have been historically constructed as global health norms with distinct discursive foundations and governance priorities – and how repeated interaction and contestation has influenced subsequent alignment and framings.
2. To examine how diplomatic negotiations have contributed to the convergence of these norms – particularly through shared language and overlapping functions, and despite political trade-offs.
3. To investigate how integration between GHS and UHC is conceptualized and operationalized by global health actors, and what institutional strategies and constraints shape efforts toward coherence.

Together, these objectives structured the thesis's empirical investigation and provided a roadmap for understanding how hybrid norms are constructed, converge, and made coherent across the global health architecture – with important insights both for efforts to integrate GHS and UHC, as well as to promote synergies in other areas of global governance and foreign policy.

9.2 Summary of Results

This section synthesizes the findings of the thesis's three empirical chapters, each of which corresponds to a key stage in the hybrid norms framework – construction, convergence, and coherence – and shaped by iterative processes of framing, negotiation, and institutionalization. Together, these chapters offer a granular and temporally sequenced account of how GHS and UHC, two deeply entrenched and historically distinct global health norms, have moved from distinct policy paradigms into increasingly integrated and mutually-reinforcing normative regimes and the emergence of a GHS-UHC hybrid norm. This section revisits the core insights from each chapter while reflecting on their cumulative contribution to the politics of integration: that meaningful integration between complex and overlapping health agendas is not only possible, but observable – though never automatic nor unproblematic.

9.2.1 Summary of Empirical Paper 1 (Chapter 6)

The first empirical paper (Chapter 6), examined the first stage of the hybrid norms framework – construction – by tracing how GHS and UHC evolved as distinct yet increasingly interlinked global health norms. Through a discursive analysis of major global health texts (e.g., international agreements, responses to major health crises), the paper mapped how the securitization of health and the right-to-health emerged as foundational logics for GHS and UHC respectively. It built on Chapter 2's historical and institutional context, and operationalized the theoretical scaffolding laid out in Chapter 3 by foregrounding norms as socially constructed and evolving processes shaped by repeated interaction and contestation.

Anchored in the norm life cycle model and norms 'as processes' approach outlined in Chapter 4, the paper traced the progression of both GHS and UHC from ideational emergence to broader uptake. For GHS, global disease control efforts saw the increasing reliance of securitization language (e.g., "threats," "surveillance," "preparedness") post-Cold War and particularly at the turn of the 21st century following the HIV/AIDS crisis and SARS, with legally-binding agreements like the IHR (2005) helping to operationalize the norm. For UHC, a trajectory from "health for all" to "selective coverage" and eventually to financial protection and HSS was traced, rooted in equity-oriented frames and articulated in global commitments featured in the Alma-Ata Declaration and SDG 3.8. These pathways reflect the distinct 'meta-norms' from which each norm developed – GHS from international security and UHC from human rights – consistent with the genealogy of norm emergence explored in Chapter 3.

However, the paper also emphasized that norm construction in global health is not linear or bounded. Rather than stabilizing after cascade or internalization (as the original norm life cycle suggests), GHS and UHC norms continued to evolve and adapt.

Chapter 6 therefore offered three core insights, with particular relevance for the first 'construction' stage of the hybrid norm framework:

1. **Norm content is continuously (re)constructed.** The "content" of GHS and UHC has shifted over time in response to both internal priorities and external pressures. For example, GHS broadened from a narrow infectious disease focus to include health system resilience; UHC evolved from right-to-health discourses to narrow conceptualizations around financial risk and then to broader community-oriented health systems approaches. This supports Krook and True's view of norms as ongoing processes and complicates conventional assumptions of norm stabilization after cascade (Section 3.1.4).

2. **Norm interaction and contestation shape their evolution.** GHS and UHC norms have significantly influenced each other over time – much more than previous scholarship suggests. In response to critiques of slow progress and definitional ambiguity, UHC actors drew on GHS's political urgency to reframe issues like NCDs as "threats," while GHS actors, particularly in the Ebola response and SDG negotiations, incorporated equity and health systems language typically associated with UHC. These patterns suggest co-evolution, where each norm adapts in response to the other, rather than one displacing the other – a key dynamic elaborated in Chapter 3.

3. **Norm integration is emerging with GHS and UHC as mutually-reinforcing agendas.** Increasingly, GHS and UHC are referenced together in international declarations and technical reports. However, imbalances persist in how GHS and UHC are operationalized, the appropriate governance mechanisms they are shaped through, and different power dynamics given varying policy communities. This anticipates key issues in sustaining normative convergence discussed in Chapter 7.

Together, these findings challenge traditional approaches that view GHS and UHC norms as distinct, stable entities, and instead position GHS and UHC as interactive and evolving normative regimes that increasingly reshape each other in significant ways. This insight affirms the need for the hybrid norms framework to better conceptualize integration not as an outcome but as a process, rooted in contestation and re-alignment. By analyzing the evolution of GHS and UHC through construction, Chapter 6 provides an essential empirical foundation for the broader thesis argument. It demonstrates that the hybridization of these norms is not incidental but historically constructed in ways previous scholarship has largely overlooked, shaped by overlapping crises and shifting institutional mandates. This (re)constructed interdependence – through repeated and strategic framing processes – sets the stage for the convergence and coherence processes that follow, explored in Chapters 7 and 8.

9.2.2 Summary of Empirical Paper 2 (Chapter 7)

The second empirical paper (Chapter 7) examined the second stage of the hybrid norms framework: convergence. Through a comparative analysis of two high-profile international negotiations – the WHO Pandemic Agreement (PA) and the 2023 UNGA Political Declaration on UHC (PD) – the chapter traced how GHS and UHC norms are being aligned conceptually and operationally through GHD processes. It built on Chapter 6 by examining whether and how both norms (and their associated normative regimes), which have been (re)constructed from distinct historical trajectories into increasingly mutually-reinforcing frameworks, were being intentionally aligned through negotiation in practice.

Using a multimethod qualitative approach, the chapter mapped how discourse and core functions of each norm appeared in iterative draft negotiation texts of the other regime. Specifically, it traced:

- In the PA (GHS context): three UHC-linked discursive frames (equity, human rights, and social determinants of health) and three core functions (affordability of medical products, prioritization of vulnerable populations, and PHC) were promoted;
- In the PD (UHC context): three GHS-linked discursive frames (resilience, existential threats, and infectious diseases) and three core functions (outbreak preparedness, emergency response, and One Health) were promoted.

These findings reflected signs of an emerging shared normative framework in which GHS and UHC were being articulated beyond their own diplomatic silos through increased complementarity and interdependency between their underlying features. As theorized in Chapter 4's view of the politics of integration, such moments of discursive and functional pairing through negotiation constitute key indicators of convergence – evidence that stakeholders are not merely referencing each other's agendas, but embedding their respective logics into joint instruments for governance and implementation.

Chapter 7 offered three major takeaways corresponding to the second 'convergence stage of the hybrid norm framework:

1. **The COVID-19 pandemic acted as a catalyst for normative convergence.** By exposing the structural limitations of both siloed GHS and under-resourced UHC systems, the pandemic served as a "critical juncture,"[522] creating a window of opportunity (discussed in Chapter 3) uniquely positioned to promote normative alignment. Both the PA and PD identified COVID-19 as a trigger for reevaluating status quo approaches and called for greater synergy between GHS and UHC agendas. Equity and resilience – emerging as overlapping discursive frames – provided normative anchors for this shift. These shared frames helped actors integrate each norm's functions into the other's negotiations (e.g., PHC in the PA, pandemic preparedness in the PD), building on Chapter 2's identification of associated interventions capable of shaping institutional alignment.

2. **Second, convergence occurred through incremental advancements in complementarity and interdependency – not necessarily explicit unification.** Negotiators increasingly relied on a shared normative framework that positioned key discourse and core functions of each norm together (e.g., affordable and accessible pandemic countermeasures in the PA, One Health strengthening in the PD) to signal alignment. These linkages, which were often implicit and incremental rather than visibly explicit (e.g., referencing PHC as a foundation for GHS and UHC), affirmed the hybrid norm model's claim (Section 4.3) that norm convergence unfolds through strategic layering, where normative elements are combined in ways that maintain each regime's autonomy while advancing shared aims. Importantly, this process was rarely translated to consistent incorporation, as inclusion of specific principles in preambular sections didn't necessarily mean that corresponding actions would be agreed in operative paragraphs – advancing insights on norm institutionalization and in GHD contexts (Chapter 2).

3. **Third, convergence was constrained by political and operational trade-offs.** As negotiations progressed, both texts exhibited some level of retreat from their apex integration (i.e., the Zero Draft of both agreements displayed the highest level of normative convergence). UHC references in the PA and GHS references in the PD were diluted, delayed, or replaced with softer language and proxies (e.g., resilience standing in for GHS; equity for UHC). Techniques like caveats, trade-offs, and forum shifting were also used to broker consensus – often at the expense of normative clarity. These tactics echo the diplomatic dynamics described in Chapters 2 and 3, with path dependencies and geopolitical divides limiting ambitious commitments. The case studies showed that while convergence was widely accepted in principle, its operationalization remained uneven, contingent on

[522] Wiyeh and others, 'A Critical Juncture in Global Health'.

institutional constraints and shifting political will (further unpacked in the following study in Chapter 8).

Together, these findings advance the 'convergence' stage of the hybrid norms framework by illustrating how GHS and UHC – previously framed as competing paradigms – are increasingly expressed through shared language and interlinked functions within GHD. They affirm a central insight of this thesis: that integration is not simply about coordination between policy areas, but a normative process shaped by discursive choices and political dynamics. These findings also set the stage for the final empirical chapter, which moves beyond negotiated texts to explore whether these signs of convergence are being institutionalized into sustainable governance practices, and what this means for the long-term coherence of the global health architecture.

9.2.3 Summary of Empirical Paper 3 (Chapter 8)

This chapter constitutes the final empirical contribution of the thesis, and directly engages the third stage of the hybrid norm framework: coherence. Having traced how GHS and UHC were conceptualized and came to be aligned across discourse and policy frameworks (construction), and then how both agendas were negotiated together in key diplomatic forums (convergence), this chapter shifts focus to the everyday practices through which their coherence is understood, pursued, and operationalized by key actors. In doing so, it addresses a central research aim of tracing how hybrid norms are institutionalized across the global health architecture, and sheds light on the political and institutional dynamics that shape the integration of contested global health agendas.

Drawing on a thematic analysis of 31 key informant interviews with officials from governments, multilateral institutions, donors, and civil society organizations, Chapter 8 captures a moment of significant normative flux (post-pandemic, mid-SDG timeline) when actors are actively navigating tensions between overlapping agendas, operational mandates, and divergent geopolitical priorities. This empirical analysis underscores that coherence is not a technocratic endpoint, but rather a normative process mediated by power asymmetries, institutional interests, and strategic incentives. As such, it advances this thesis's core argument: that hybrid norms emerge not only through discursive alignment, but also through deliberate institutional practice shaped by the politics of integration.

The results from this empirical study can be broken into four groups of findings:

- **Evolving perceptions of GHS and UHC**: Interviewees described shifting post-pandemic understandings of both GHS and UHC that reflect a broader reconfiguration of normative priorities. GHS was increasingly reframed in terms of equity and continuity of services, while UHC was reaffirmed as foundational to system resilience, even amid its political deprioritization. These shifts demonstrate vital role of framing processes (Chapter 3), and the potential for an emerging hybrid norm rooted in shared logics across both regimes.

- **Conceptual relationships between GHS and UHC**: Respondents expressed growing consensus that GHS and UHC are interdependent and mutually reinforcing. Many actors also situated GHS within the broader umbrella of UHC, framing the latter as the systemic infrastructure that enables the former. This mirrors the hybrid norm framework's emphasis on conceptual layering and complements earlier findings from Chapters 6 and 7. However, the chapter also highlights persistent variation in how these relationships in principle can be operationalized in practice – a key point of divergence that reflects the limits of normative convergence in the absence of institutional coherence.

- **Strategic considerations for GHS-UHC coherence**: The motivations and concerns described by interviewees reflect the political and organizational dimensions of integration that lie at the heart of this thesis's constructivist and political science lens. Actors were drawn to GHS-UHC coherence for its potential to improve outcomes, optimize resources, and sustain visibility across agendas – but were simultaneously wary of diluted messaging, internal resistance, and accountability gaps.

- **Structural considerations for GHS-UHC coherence**: Interviewees suggested that GHS-UHC coherence was either constrained or enabled by structural forces like funding models and decision-making authority – revealing the embedded institutional path dependencies and geopolitical asymmetries that the thesis identifies as central barriers to integration (Chapter 3). At the same time, informants pointed to enablers such as strategic communication, synergistic financing, and country-led implementation, which serve as potential vehicles for the institutionalization of hybrid norms.

Chapter 8 thus offered three key takeaways which help delineate important lessons for the third 'coherence' stage of the hybrid norm framework:

1. **Advancing GHS-UHC coherence helps redress entrenched geopolitical power asymmetries.** As shown throughout the thesis – particularly in the analysis of actor dynamics in Chapter 2 – the politics of normative integration are inseparable from broader geopolitical hierarchies. This chapter builds on that foundation, revealing how GN actors continue to dominate global health agenda-setting, while GS actors advocate for more equitable, systems-based approaches centered on UHC. The GHS-UHC hybrid norm offers joint approaches to help rebalance these asymmetries: it enables GS governments and regional institutions to assert leadership over priority-setting, financing models, and governance arrangements. In doing so, it advances the thesis's claim that hybrid norms can catalyze structural shifts in the distribution of power within GHD.

2. **Strategic collaboration across actor types is essential to operationalize coherence.** This finding reinforces a core thread running through the empirical chapters: hybrid norms depend on multi-actor alignment, but this alignment is only achievable through normative

coherence supported through political coordination and shared institutional investment. Chapter 8 reveals how coherence is shaped by how actors interpret their roles, negotiate incentives, and coordinate across governance levels. These dynamics connect directly to the thesis's broader conceptualization of norms as socially (re)structuring tools for global health through deliberate, actor-led efforts. It further adds nuance by showing how actor roles are mediated by resourcing patterns and historical silos – underscoring the importance of actor type and institutional identity in shaping the operationalizing coherence.

3. **GHS-UHC coherence can anchor integrative diplomacy in an era of polycrisis.** This final takeaway situates the hybrid norm within the broader geopolitical moment addressed in Chapters 2 and 10: one of compounding risks, weakened multilateralism, and urgent demands for more adaptive global governance. The findings highlight how GHS-UHC coherence can serve as a scaffold for integrative health diplomacy – an approach that aligns with the thesis's constructivist framing of diplomacy as a site of norm translation and political negotiation. By embedding equity and resilience across both acute and chronic health challenges, this hybrid norm positions GHS-UHC as a unifying agenda that transcends fragmented policy silos and short-term donor cycles. As such, it reflects the thesis's argument that hybrid norms are not only products of institutional compromise, but also tools for navigating complexity and fostering more responsive forms of international cooperation.

Chapter 10: Discussion and conclusion

After the preceding chapter summarized the major findings and lessons from the three related empirical papers, this final chapter outlines the key contributions of this thesis. It also aims to ground the thesis's implications along the three main intersecting bodies of scholarship relevant for this work: global health governance and diplomacy, constructivist international relations theory, and political sciences literature.

While each chapter has made incremental contributions in their own right – particularly through greater understanding of why and how the agendas of global health security and universal health coverage have been aligned through health diplomacy processes – their collective impact is best appreciated alongside the hybrid norms framework developed across this thesis. This framework extends, critiques, and reorients how we conceptualize norm interaction, contestation, and integration in global governance. In doing so, the thesis seeks not only to fill gaps but to challenge assumptions – by moving beyond the treatment of norms as isolated entities and instead illuminating how entrenched normative regimes co-evolve and strategically reshape one another through political framing, diplomatic negotiation, and institutional design. This marks a departure from the dominant approaches in health system integration, policy coherence, and norm change theory and its applications. Additionally, the thesis adopts a unique blend of discursive and content analysis

research methods, which provides a possible prototype for future qualitative research on examining incremental norm development and alignment in contested, cross-sectoral policy environments.

Based on such an understanding, the chapter proposes implications for the policy and practice of global health – and for creating a more equitable, resilient, and sustainable global health architecture. This reorientation is especially urgent in an era where pandemics, climate shocks, and structural inequities demand coordinated global responses. By tracing a more nuanced politics of integration between GHS and UHC, the thesis contributes to more grounded and politically informed understandings of how other normative agendas evolve – and how global policy and governance can more effectively respond.

10.1 Substantive contributions (empirical and interpretive)

10.1.1 Revealing the emergence of a GHS-UHC hybrid norm through global health diplomacy

A first substantive contribution of this thesis is to empirically document and conceptually frame the emergence of a hybrid norm linking GHS and UHC – not as a policy goal, but as an evolving normative project that is being actively negotiated and institutionalized through processes of health diplomacy. Existing scholarship has largely characterized GHS and UHC as parallel but isolated agendas[523], linked only superficially through high-level commitments or aspirational policy language. This thesis challenges that framing by showing that GHS and UHC are best understood as clustered norms that have evolved into supernorms with overlapping normative regimes – indeed, each with distinct discourses and core functions – but which are increasingly co-constructed through diplomatic and institutional engagements.

This reframing offers a more accurate and nuanced understanding of how GHS and UHC have evolved through sustained interaction and contestation. Drawing on the hybrid norms framework introduced in Chapter 4 and applied across Chapters 6-8, the thesis shows that GHS and UHC have influenced one another in more significant ways than previous literature has acknowledged. Chapter 6 demonstrates how moments of crisis – particularly HIV/AIDS, SARS, Ebola, and Zika – have generated discursive interaction between the two agendas, with actors drawing on overlapping language and principles related to protection, access, equity, and systems strengthening. Rather than viewing fragmentation as fixed, this thesis highlights how GHS and UHC have continually shaped and responded to one another over time, producing an evolving relationship that is best understood in normative terms. This insight responds to gaps in global health and IR literature that tend to treat norms and regimes as separate or sequential, rather than engaged in long-term processes of strategic alignment.

[523] Fidler, 'From International Sanitary Conventions to Global Health Security'; Hoffman, 'The Evolution, Etiology and Eventualities of the Global Health Security Regime'; Allen, 'The Philosophical Foundations of "Health for All" and Universal Health Coverage'; Bump, 'The Long Road to Universal Health Coverage: Historical Analysis of Early Decisions in Germany, the United Kingdom, and the United States'.

This interaction has become more visible and sustained in recent years, especially following the COVID-19 pandemic. Chapter 7 shows how recent global negotiations – including the WHO Pandemic Agreement and the 2023 UN Political Declaration on UHC – reflect growing alignment between the two agendas. For example, references to UHC through equity and accessible health services appear repeatedly in drafts of the Pandemic Agreement, while the UHC declaration emphasizes preparedness, surveillance, and system-level resilience in ways that clearly draw on GHS discourse. These developments suggest that a shared normative framework is taking shape, characterized by increasing complementarity across both the discourses and core functions of GHS and UHC. Rather than a merger or formal integration, this reflects GHS-UHC convergence as an incremental process, constrained by political trade-offs in order to achieve consensus.

This alignment is now increasingly visible in practice. Chapter 8 illustrates how actors across different sectors are more proactively applying hybrid GHS-UHC approaches to address overlapping policy priorities and operational needs. Interviewees referenced information systems, community-level response, and workforce development as areas where integration is already underway. PHC, in particular, was described as a foundation for both agendas, a framing now embedded in the WHO's 14th General Programme of Work (GPW14) which prominently positions PHC as the foundation for health security and UHC. [524] These developments show that the hybrid norm linking GHS and UHC is not only being articulated in global discourse, but is also guiding institutional planning and implementation in mutually-reinforcing ways.

Together, these findings contribute to a greater understanding of the extent to which GHS and UHC have been and continue to be aligned through GHD. They highlight the emergence of a shared normative framework – one that reflects increased interconnectedness and complementarity between security and rights-based priorities – and demonstrates how this hybrid norm is being actively pursued across discursive, institutional, and operational domains. Recognizing this history provides important context – and greater support – for future attempts at alignment and integration.

10.1.2 Unpacking 'hidden' advancements in aligning GHS and UHC

Another substantive contribution of this thesis is to demonstrate that convergence between GHS and UHC can often appear implicit and incremental, rather than made explicit in the final text of international agreements. While policy documents are frequently assessed based on the formal commitments they articulate, this thesis takes a different approach – examining earlier drafts, discursive framing, and thematic references to uncover the underlying integration dynamics that often remain invisible in final outcomes. Chapters 7 and 8 provide evidence that integration is not only occurring through overt commitments, but through more subtle forms of alignment – including the selective inclusion of shared discursive themes and overlapping core functions in texts that are otherwise framed around one regime or the other.

[524] WHO, 'WHO Fourteenth General Programme of Work, 2025-2028'.

This dynamic is particularly evident in the negotiation processes leading up to the WHO Pandemic Agreement and the 2023 UN Political Declaration on UHC. While both documents ultimately included some explicit references to the other agenda (e.g., references to UHC in the PA zero draft, and pandemic preparedness and response in the PD), it is the implicit references that provide perhaps the most compelling evidence of convergence. These include the direct integration of core themes such as equity, access, and PHC from the UHC domain into GHS-focused texts, and the inclusion of One Health, disease surveillance, and emergency response from GHS into UHC commitments. In both cases, this embedded complementarity reflects not only rhetorical alignment but growing awareness of the agendas' interdependence towards a shared normative framework – even when not labeled as such. These forms of implicit alignment offer valuable insights into how normative priorities are being co-constructed and gradually integrated, particularly through global health diplomacy.

These convergence patterns are analytically significant for what they include and for how they evolve. The presence of caveated language, thematic dilution, or forum shifting – especially in later drafts – signals the trade-offs negotiators are willing to make to secure consensus.[525] Notably, the most explicit and pervasive references to convergence appeared in the zero drafts of both the PA and PD – but many of these were traded away in later rounds of negotiation to facilitate broader agreement. Indeed, Phelan et al. tracked similar regression in the way linkages between environmental health, gender equality, and Indigenous populations were "water[ed] down" in later drafts of the PA.[526] However, implicit references may sometimes carry more weight than final language suggests, as they reflect deeper socialization of each agenda's core principles and underlying features. At the same time, these implicit markers can also obscure broader power dynamics or allow for rhetorical flexibility that weakens implementation.

A more skeptical view might therefore ask whether such indicators of convergence truly signal normative integration or simply co-option for strategic or political purposes.[527] But the evidence presented across all three empirical chapters suggests something more enduring. While actors may have initially used UHC language to bolster the legitimacy of GHS initiatives, the repeated invocation of equity and access has slowly transformed GHS's own discursive core. Likewise, the incorporation of risk and emergency preparedness into UHC-related instruments has altered the architecture of UHC itself. Normative integration, then, is not a one-time act, but a dynamic and recursive process. Both GHS and UHC have been shaped not only by their own norm entrepreneurs but by their entanglements with each other.

[525] Camille La Brooy, Bridget Pratt, and Margaret Kelaher, 'What Is the Role of Consensus Statements in a Risk Society?', *Journal of Risk Research*, 23.5 (2020), pp. 664–77, doi:10.1080/13669877.2019.1628094.
[526] Phelan, Negri, and Hesselman, 'Environmental Health'.
[527] Wenham and others, 'Global Health Security and Universal Health Coverage: From a Marriage of Convenience to a Strategic, Effective Partnership'.

Recognizing convergence at this level reveals how diplomacy is not only advancing normative integration, but also managing the boundaries of what actors are willing to formalize in different contexts. As shown in Chapters 7 and 8, incremental progress may be both a calculated necessity as well as a sign of genuine alignment in highly contested settings where such efforts were previously deemed unfeasible. This aligns with what some scholars have described as a 'strategic ambiguity.'[528] Still, the broader goal should remain pushing for explicit recognition of normative integration – firmly anchored in shared principles and mutual reinforcement – so as to avoid future undermining or weakening of either parent norm.

10.1.3 Contending with divergent meanings and experiences of GHS-UHC integration

A third substantive contribution of this thesis is to demonstrate that the pursuit of normative coherence between GHS and UHC – understood as the institutional embedding of shared norms – is experienced unevenly across actor types and geopolitical contexts. Drawing on thirty-one elite interviews, Chapter 8 explores how national governments, multilateral agencies, donors, and civil society conceptualize and operationalize coherence differently – often shaped by geopolitical position, institutional mandate, and political context. At the same time, the study affirms that support for the greater integration was nearly universal among interviewees – across Global North and Global South respondents alike. In fact, regardless of institutional background, respondents broadly agreed that greater alignment between GHS and UHC was needed, particularly in light of fragmentation and overlapping crises. This reifies the emergence of a hybrid norm that has begun to be socialized among global health stakeholders.

However, the meaning of coherence and the conditions under which integration was considered legitimate varied significantly across actors. These variations often reflected both actor type and broader GN/GS divides. Government actors in the Global South, for instance, consistently alluded to GHS-UHC coherence as essential to making health systems work under constrained conditions – a practical necessity linked to navigating fragmented financing, donor-driven agendas, and overlapping mandates.[529] For these actors, normative integration was seen as valuable primarily when it reinforced UHC's core principles, such as equity, access, and people-centered care. Donor representatives and technical partners, especially those based in the Global North, were more likely to describe coherence in relation to efficiency, sustainability, or measurable outcomes. Civil society organizations, including those from both North and South, emphasized the importance of rights-

[528] Linsenmaier, Schmidt, and Spandler, 'On the Meaning(s) of Norms'; Frederick J. Boehmke, 'Policy Emulation or Policy Convergence? Potential Ambiguities in the Dyadic Event History Approach to State Policy Emulation', *The Journal of Politics*, 71.3 (2009), pp. 1125–40, doi:10.1017/S0022381609090926; Van Kersbergen and Verbeek, 'The Politics of International Norms'.

[529] Meisterhans, 'Health for All'; Pai, Bandara, and Kyobutungi, 'Shifting Power in Global Health Will Require Leadership by the Global South and Allyship by the Global North'; Alison T Mhazo and Charles C Maponga, '"We Thought Supporting Was Strengthening": Re-Examining the Role of External Assistance for Health Systems Strengthening in Zimbabwe Post-COVID-19', *Health Policy and Planning*, 2024, p. czae052, doi:10.1093/heapol/czae052.

based approaches, accountability, and meaningful participation, often expressing concern that security framings might overshadow long-term health systems efforts. Multilateral actors occupied a mediating position – acknowledging the legitimacy of both agendas and often seeking to balance functional integration with political feasibility. These differences extended beyond conceptual to reflect concrete tensions in how coherence was pursued, negotiated, and resisted.

These insights are only made possible by approaching GHS and UHC as normative regimes rather than as technical sectors or policy goals. Viewing them in this way enabled the thesis to examine coherence not just in terms of institutional coordination, but as a form of negotiated alignment between different sets of values, power structures, and governance logics. The hybrid norms framework introduced in Chapter 4, and the attention to actor-specific discursive strategies in Chapters 6 and 8, made it possible to surface the constraints and competing expectations that shape GHS-UHC integration in practice. This approach also helps reveal how power operates in subtle but significant ways – through agenda-setting, financing conditions, and normative framing, as previously explored by various scholars[530] – thereby offering a richer understanding of what coherence looks like and what it demands. This means grappling with how GHS and UHC norms are operationalized through competing visions and mandates: centralization versus decentralization, top-down versus bottom-up approaches, divergent narratives, and opposing underlying interests. Ultimately, this contribution shows that while normative alignment is widely supported in principle, its meaning and uptake are shaped by deeper institutional and geopolitical asymmetries that must be acknowledged and addressed if integration is to be both effective and legitimate.[531]

10.2 Foundational contributions (conceptual, theoretical, and methodological)

10.2.1 Development of hybrid norms framework

The first foundational contribution is to constructivist international relations theory, particularly to the literature on norm evolution. While earlier work – most notably by Finnemore and Sikkink – has provided powerful conceptual tools to trace how new norms emerge, cascade, and become internalized, this model has generally focused on single-norm trajectories. Its primary unit of analysis is one of a solitary norm advancing through clearly identifiable stages in a broader normative context. Yet the international system rarely operates with such conceptual clarity. Norms do not evolve in a vacuum.[532] They exist in dense, overlapping fields of competing and coexisting

[530] Marten, 'How States Exerted Power to Create the Millennium Development Goals and How This Shaped the Global Health Agenda'; Ilona Kickbusch and Austin Liu, 'Global Health Diplomacy—Reconstructing Power and Governance', *Lancet (London, England)*, 399.10341 (2022), pp. 2156–66, doi:10.1016/S0140-6736(22)00583-9; Rushton and Williams, 'Frames, Paradigms and Power'.
[531] Ilona Kickbusch and Anna Holzscheiter, 'Can Geopolitics Derail the Pandemic Treaty?', *BMJ*, 375 (2021), p. e069129, doi:10.1136/bmj-2021-069129; Albert Persaud and others, 'Understanding Geopolitical Determinants of Health', *Bulletin of the World Health Organization*, 99.2 (2021), p. 166, doi:10.2471/BLT.20.254904; Labonté, Martin, and Storeng, 'Editorial'.
[532] Finnemore and Sikkink, 'International Norm Dynamics and Political Change'.

normative claims.[533] This is especially true in global health governance, where agendas like GHS and UHC are not only deeply institutionalized but politically and operationally intertwined.

This thesis therefore proposes a necessary refinement for cases like this one: a shift from linear norm cycles to interactive normative regimes. By developing a hybrid norms framework built around three iterative stages – construction, convergence, and coherence – it captures how two norms (with well-established associated regimes) can evolve not only in tandem, but *because of* each other. In this way, the framework draws on and extends existing analytical approaches in this space: it complements Finnemore and Sikkink's model by accounting for multi-norm dynamics, builds on Fidler's account of global health diplomacy as a site of norm negotiation between established regimes, and draws from Krook and True's framing of norms as dynamic processes shaped through contestation and social interaction. This synthesis allows for a more sophisticated mapping of what happens when distinct normative architectures collide and how new forms of normative alignment may be established.

What distinguishes this framework is its explicit attention to normative interaction (not just institutional or policy alignment) as the central object of analysis. By focusing on GHS and UHC as evolving normative regimes, this thesis departs from earlier approaches that treated integration primarily as a technical, administrative, or sectoral exercise. It reframes integration as a normative process, where alignment is not just about functions or financing, but about evolving ideas, values, and expectations. Importantly, this shift to norms can help enhance the legitimacy of integration efforts by more meaningfully identifying and contending with deep-seated ideological divergences or path dependencies. This framing is essential for capturing how actors negotiate institutional mandates as well as shared meaning and political commitment across historically-distinct regimes.

The three-stage hybrid norm framework of construction, convergence, and coherence contributes distinct analytical advantages at each stage of integration. The construction phase surfaces how each agenda's normative identity is historically framed and reshaped through actor discourse and institutional codification (Chapter 6). Convergence highlights the subtle yet strategic ways in which actors begin to negotiate and align discursive themes and core functions – even without explicit agreement (Chapter 7). Coherence focuses on how this alignment is experienced and institutionalized in context, revealing asymmetries in uptake and implementation across organizational and geopolitical settings (Chapter 8). Together, these stages allow for a more precise and layered understanding of how integration unfolds – not as a single event or output, but as a process of norm interaction over time. The last stage of the hybrid norm framework is important, as this marks a reconfiguring of actors' identities and values in ways that bridge both norms as well as codifies inherently synergistic approaches moving forward. In this way, the hybrid norm can advance an accompanying norm of integration for future efforts, in a sort of self-perpetuating cycle.

[533] Phil Orchard Wiener Antje, 'Norms and Norm Contestation', in *Routledge Handbook of Foreign Policy Analysis Methods* (Routledge, 2022); Mende, 'Norm Convergence and Collision in Regime Overlaps. Business and Human Rights in the UN and the EU'.

The hybrid norms framework contribution to norm theory and offers a transferable set of conceptual tools for analyzing norm development and interaction in other domains. Hybrid norms provide a powerful lens for analyzing how global actors navigate competing agendas, enabling a form of pragmatic alignment that better balances institutional legacies with emerging priorities and cross-cutting crises. The framework can therefore be used to examine how overlapping agendas are aligned (or fail to align) in other areas of global governance, including to address 'wicked' problems like economic inequality, forced labor, and humanitarian crises.[534] By foregrounding normative dynamics, this framework brings into focus the often-overlooked discursive and ideational dimensions of integration, which are essential to understanding both progress and contestation in complex global systems.

10.2.2 Theoretical advancements on the politics of integration

Another foundational contribution lies in the thesis's articulation of the 'politics of integration' as a distinct analytical lens. While many integration efforts are viewed as preordained or as technical adjustments to shared goals,[535] this thesis shows that integration is neither automatic nor apolitical. Rather, it must be understood as a strategic and normative process, shaped by power asymmetries, institutional incentives, and geopolitical positioning. Furthermore, the thesis argues that integration efforts must have clear endpoints to work towards, which norms can provide through shared discourse and core functions. Through this lens, the thesis provides a methodological pathway to examine integration as it unfolds – not only as a discursive or operational alignment, but as a carefully debated, often contested, project of legitimacy with strategic normative destinations.

The framework identifies three interrelated processes at the heart of this: framing, negotiation, and institutionalization. These were drawn from empirical analyses across Chapters 6-8 and build on existing constructivist, political science, and health policy literature. Framing reflects how actors with divergent priorities use discourse to push integration forward (or resist it), mobilizing terms such as "equity" or "resilience" to encode deeper normative meanings. Negotiation encompasses both formal arenas (e.g. WHO or UN negotiations) and informal diplomatic spaces, where actors weigh trade-offs, signal alignment, or assert strategic interests. Institutionalization then reflects how norms are embedded into governance structures, often unevenly, by navigating path-dependent policies, financing mechanisms, programmatic mandates, and varying interests and priorities. Together, these three processes offer a fresh perspective on the politics underpinning integration efforts – highlighting that integration may not always be about moving from one space *into* another (as

[534] Jale Tosun and Julia Leininger, 'Governing the Interlinkages between the Sustainable Development Goals: Approaches to Attain Policy Integration', *Global Challenges*, 1.9 (2017), p. 1700036, doi:10.1002/gch2.201700036; Miriam Weber and Peter P J Driessen, 'Environmental Policy Integration: The Role of Policy Windows in the Integration of Noise and Spatial Planning', *Environment and Planning C: Government and Policy*, 28.6 (2010), pp. 1120–34, doi:10.1068/c0997.

[535] Mohammad Shahzad and others, 'A Population-Based Approach to Integrated Healthcare Delivery: A Scoping Review of Clinical Care and Public Health Collaboration', *BMC Public Health*, 19.1 (2019), p. 708, doi:10.1186/s12889-019-7002-z.

existing health system integration literature often emphasizes), but can also enable movement *toward* a new normative endpoint, as well as facilitate alignment *across* sectors and *between* existing regimes.

This framing draws on and extends the work of Storeng and Béhague, who have cautioned that efforts to merge global health agendas often "mask deep-seated ideological tensions,"[536] such as equity-oriented framings "uncomfortably" coexisting with instrumental health security logics. By making contestation visible – not just as a barrier, but as a productive space for alignment – this approach provides tools to assess how integration efforts reflect broader struggles over legitimacy and authority. As Chapter 7 and 8 demonstrated, resistance to integration may not stem from opposition to shared goals, but from concern over how alignment unfolds – who defines it, whose values are privileged, and what gets sacrificed. By drawing on these findings, key stakeholders like WHO and the World Bank may be able to add needed nuance to their technical guidance on how to more effectively link up GHS and UHC through more effective integration strategies between essential public health functions and primary health care interventions.[537]

These insights are not limited to GHS and UHC. The analytical scaffolding of framing, negotiation, and institutionalization can support future research across fragmented global regimes from climate-health intersections to migration-development policy.[538] When paired with the hybrid norms framework, it offers a more complete methodology for tracing integration processes: how norms evolve, how actors navigate their alignment, how policymakers contest framings across institutional and diplomatic settings. In doing so, this thesis contributes theoretical and conceptual tools to more accurately and critically assess normative integration within and beyond global health governance.

10.2.3 Novel multi-method qualitative approach for analysing normative integration

This thesis was also methodologically novel in the field in its use of real-time discursive analysis to examine norm integration as it unfolded across successive stages of global negotiations. While most norm scholarship relies on finalized documents or retrospective evaluations[539], this thesis draws from draft iterations of two major international instruments – the WHO Pandemic Agreement and

[536] Storeng and Béhague, '"Lives in the Balance"'.
[537] World Health Organization, 'Building Health Systems Resilience for Universal Health Coverage and Health Security during the COVID-19 Pandemic and beyond: WHO Position Paper' 2021, 2021 <https://iris.who.int/handle/10665/346515>; Organization, *Health Systems for Health Security*; 'Strategic Investment for Health System Resilience: A Three-Layer Framework' 2024, 2024, doi:10.1596/978-1-4648-2116-5; WHO and Unicef, 'Operational Framework for Primary Health Care: Trasforming Vision into Action'.
[538] Abbasi, 'Climate, Pandemic, and War'; Kristie L. Ebi and others, 'Interactions between Two Existential Threats: COVID-19 and Climate Change', *Climate Risk Management*, 34 (2021), p. 100363, doi:10.1016/j.crm.2021.100363; Bellizzi and Severoni, 'Refugees and Migrants at the Heart of the Synergies between Universal Health Coverage, Health Security and Health Promotion'.
[539] Didier Wernli and others, 'Emergent Patterns in Global Health Diplomacy: A Network Analysis of the Resolutions Adopted by the World Health Assembly from 1948 to 2022', *BMJ Global Health*, 8.4 (2023), p. e011211, doi:10.1136/bmjgh-2022-011211; Hisbaron, 'Shades of Green: A Comparative Study of Climate Discourse in the Kyoto Protocol and the Paris Agreement'.

the 2023 UN Political Declaration on UHC – to analyze how convergence between GHS and UHC was shaped, contested, and ultimately embedded (or diluted) in language.

Doing this involved building on and adapting the work of Alejandro and Zhao to apply a structured, multi-method approach by combining content analysis to identify discourse themes and core functions, followed by detailed discourse analysis of how these evolved across successive drafts. Second, it introduced a chronological, draft-by-draft tracing method that allowed for systematic observation of changes in language and framing across time. Third, the analysis was conducted as a comparative case study across two distinct but overlapping normative regimes (GHS and UHC), each with its own institutional histories, discursive anchors, and actor coalitions. This presented a high degree of analytical complexity, and yet enabled the thesis to model how norm integration between entrenched regimes can be empirically studied with rigor, granularity, and comparative depth.

More broadly, this real-time discursive analysis offers a methodological approach well-suited to uncovering the subtle and often hidden dynamics of normative alignment. It allows researchers to detect minor textual shifts, strategic reversals, and the influence of political decisions on the visibility and placement of key ideas – such as whether principles appear in preambular versus operative paragraphs, or are framed as aspirational versus binding. These discursive signals can indicate deeper shifts in power, legitimacy, and actor positioning as they are happening. By focusing beyond what is included in final texts to how that inclusion unfolds over time and along sequential drafts, this method provides a powerful approach to analyzing norm evolution both within global health governance and in other policy domains, and could even be used to influence negotiations and diplomatic efforts as they are unfolding.

10.3 Implications for policy and practice

This section translates the central insights and contributions of the thesis – from theoretical provocations to empirical observations – into practical implications for policy and practice. While the earlier chapters explored *what* integration looks like when understood as a political and normative phenomenon, this section asks: *so what*? The aim is not to provide a checklist for implementation, but to offer three major reflections that can guide actors as they navigate the complex (and often contradictory) terrain of aligning global health security and universal health coverage. These implications matter because they force us to grapple with the politics of integration – not merely as an operational challenge, but as a normative and diplomatic imperative with real-world consequences for equity, legitimacy, and sustainability in an increasingly fractured global health landscape.

10.3.1 Pursuing GHS and UHC synergies through normative integration

This thesis argues that integration between GHS and UHC must be reframed as a normative imperative rather than a technical or administrative solution to long-standing fragmentation. As demonstrated in Chapters 2-4, the dominant literature tends to emphasize coordination through institutional restructuring, budget alignment, or service delivery models. But integration built solely on those terms lacks the legitimacy and durability that come from shared normative foundations. When integration efforts foreground collective and cross-cutting principles values such as equity, solidarity, and accountability, they not only improve policy coherence between both agendas, but help rebalance power and restore trust by aligning actors around common purpose. [540]

The findings across Chapters 6-8 demonstrate that integration was most meaningful when norms and their underlying features began to be integrated. For example, references to equity and primary health care within the Pandemic Agreement, or the incorporation of resilience and outbreak preparedness into the UHC Political Declaration, reflected a gradual but strategic alignment of discursive priorities and core functions. These shifts helped establish common ground between agendas without requiring full institutional mergers, which likely would have been unfeasible. Crucially, they also signaled a reorientation of GHS toward system-wide protection, and of UHC toward crisis responsiveness – marking early signs of coherence and a new hybrid norm. By aligning around normative endpoints, integration becomes a strategy for building legitimacy and shared accountability, as well as technical efficiency (which several key informants in Chapter 8 called for).

This approach is especially important given the structural asymmetries between GHS and UHC. GHS norms appeal to authority, and continue to attract high-level political attention and securitized funding; UHC norms may appeal better to empathy, and are often framed as aspirational and domestically-driven. Additionally, while both agendas have their critics and blindspots, they ultimately provide complementary solutions to complex health challenges. Normative integration offers a way to mitigate these distinctions by creating a shared discursive space where both agendas can be advanced through mutually-reinforcing dimensions. Rather than relying on vague alignment or ad hoc coordination, harmonization grounded in *normative* integration allows actors to identify synergistic goals and pursue coherence through negotiated, context-specific pathways. In doing so, it creates the conditions for a more principled and politically inclusive form of global health governance, financing, and health systems. Support for the normative principles underpinning both GHS and UHC may signal resurging support for 'human security,' defined by the Commission for Human Security as the imperative "to protect the vital core of all human lives in ways that enhance human freedoms and human fulfilment;"[541] the concept has been viewed by some[542] as a bridge

[540] Agyepong and others, 'Lancet Commission on Synergies between Universal Health Coverage, Health Security, and Health Promotion'.
[541] Commission on Human Security, *Human Security Now: Protecting and Empowering People* (UN) <https://digitallibrary.un.org/record/503749?ln=en>.
[542] Fumio Kishida, 'Human Security and Universal Health Coverage: Japan's Vision for the G7 Hiroshima Summit', *The Lancet*, 401.10373 (2023), pp. 246–47, doi:10.1016/S0140-6736(23)00014-4.

between individual health protections and broader "collective health security."[543] Indeed, scholars like Anand assert that "the concept of human security has wide reach and includes multiple concerns," ranging from health insurance to prevent ill health (more in line with traditional conceptualizations of UHC) to expansive issues like natural disasters and major disease outbreaks (more in line with traditional conceptualizations of GHS).[544]

As Tollefson et al. note, "integration of vertical programmes must be done carefully, so that the disease programmes also achieve intended goals, including elimination goals. A partial solution might be for global health financing agencies to consider how disease-specific infrastructure can be optimised to support health emergency preparedness and response when making future investments [...] and to establish flexible fund disbursement mechanisms that can be activated in an emergency."[545] Drawing on this approach, key stakeholders engaged in GHS-UHC integration should prioritize cross-cutting policies and actions that advance both agendas, framed around common narratives and shared priorities. This thesis has laid out a few examples, which should serve as a starting point: equitable and resilient PHC, including trained health workers and interoperable data systems; pooled financing and long-term investment cycles in domestic public resources; community engagement and diverse decision-making for more accountable and sustainable health systems and initiatives, among others. This will be important if policymakers and practitioners are serious about building equitable and resilient health systems by addressing longstanding fragmentation across the global health architecture.

10.3.2 Reforming the global health architecture

Efforts to strengthen synergies between GHS and UHC will remain out of reach as long as global health financing and governance structures reinforce fragmentation. As this thesis and previous studies have shown, donor incentives, budgeting practices, and planning cycles remain largely siloed – reflecting institutional mandates rather than integrated health system priorities.[546] Despite rhetorical support for aligning GHS and UHC, efforts remain constrained by vertical funding flows, disconnected governance forums, disease-specific monitoring frameworks, divergent narratives, and siloed thinking.[547] Furthermore, funding timelines and replenishment cycles remain deeply fragmented between organizations working on GHS and UHC initiatives. These misalignments not only obstruct coordination, but weaken implementation and accountability.[548]

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[543] Heymann and others, 'Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic'.
[544] Sudhir Anand, 'Human Security and Universal Health Insurance', *The Lancet*, 379.9810 (2012), pp. 9–10, doi:10.1016/S0140-6736(11)61148-3.
[545] Tollefson and others, 'Lessons Learned from the COVID-19 Pandemic'.
[546] Spicer and others, '"It's Far Too Complicated": Why Fragmentation Persists in Global Health'.
[547] Mansour and others, 'The Shock Effect'.
[548] 'Health Leaders Discuss Mechanisms and Coordination of Global Health Governance and Finance', 7 December 2022 <https://www.unsdsn.org/global-health-governance-and-finance-webinar-summary>.

These issues have been further complicated by significant cuts to global health assistance among major donors (e.g., recently terminated USAID programs affect US$75.9 billion in funding[549]). Wiyeh et al. warn that, without corrective action, this may lead to continued reliance on inefficient institutional pathways – often reinforced by philanthropic funders and private sector influences – which undermines the effectiveness and sustainability of health initiatives in many LMICs, particularly in Africa.[550] In response, they argue this context represents a critical juncture, "offering an opportunity for recipient countries to strengthen health sovereignty and take greater ownership of their health responses."[551]

This has implications even beyond the thesis's focus on GHS and UHC alignment. What is needed for a more coherent global health architecture is not simply harmonized language, but a shift in how donor priorities are designed and operationalized. Budget structures must support dual-purpose investments that strengthen both emergency preparedness and routine health services. Geopolitical realignments could be a necessary catalyst towards greater support for regional mechanisms and bodies, improved progress on UHC, greater representation of Global South leadership in pandemic preparedness and emerging threats like climate change – in ways that are potentially more equitable and ultimately more sustainable. Countries like Brazil and Thailand offer examples: their emphasis on domestic health system strengthening – through sustained investment in primary health care, health workforce, and local accountability – has improved pandemic response capacity while advancing universal coverage.[552] Donor governance platforms such as the G7, G20 Health-Finance Taskforce, and Global Financing Facility must move beyond high-level alignment to resource integration directly, embedding it into financing frameworks, joint planning mechanisms, and evaluation metrics.[553]

This thesis calls for strategic realignment as an intentional practice across the global health architecture: integration should not be left to technical harmonization at the country level, but supported through upstream reforms that create enabling conditions at the global level. That includes donor incentives tied to cross-functional outcomes, pooled or flexible funding mechanisms, and metrics that reward systems strengthening rather than vertical performance. Perhaps most importantly, geopolitical asymmetries (particularly between GN and GS actors) must be rectified if meaningful cooperation is expected; efforts like the Lusaka Agenda can help address this.[554] Rasanathan et al. affirm this, noting that "overhauling the global health financing architecture requires grappling with the power asymmetries and misaligned incentive structures that have led to the current financial cliffs." Building on this, recent scholarship further highlights how declining

[549] Mansour and others, 'The Shock Effect'.
[550] Wiyeh and others, 'A Critical Juncture in Global Health'.
[551] Wiyeh and others, 'A Critical Juncture in Global Health'.
[552] Marten and others, 'An Assessment of Progress towards Universal Health Coverage in Brazil, Russia, India, China, and South Africa (BRICS)'; Tangcharoensathien and others, 'Health Systems Development in Thailand'.
[553] 'Five Ideas for the Future of Global Health Financing'; Røttingen and others, 'Shared Responsibilities for Health'.
[554] FHGI, 'The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process – FGHI'.

donor support may also create space for LMICs to assert greater ownership over their health agendas (particularly in GHS and UHC), pursue legal and policy reforms, and develop more locally driven, regionally coordinated solutions. Strengthening regional institutions like the Africa CDC and ASEAN health networks, improving financial data systems, and aligning procurement and budgeting processes can help embed coherence and accountability – enabling more self-sufficient, decolonized, and sustainable health systems over the long term.[555]

Normative integration between both agendas – grounded in shared principles of equity, resilience, and accountability – must be treated as a core objective of financing and governance reform. Without it, the ambition of GHS-UHC integration will remain aspirational, and fragmentation will persist despite earnest efforts. This is vital to building equitable and resilient health systems and addressing longstanding fragmentation across the global health architecture.

10.3.3 Fostering integrative diplomacy and governance through hybrid norms

Hybrid norms, as conceptualized in this thesis, offer a strategic model for bridging competing imperatives across the global health architecture. By holding national security *and* individual human rights[556], or resilience *and* equity, in constructive tension, a GHS-UHC hybrid norm helps navigate the deep-seated divisions that often forestall integration efforts. As demonstrated in the empirical chapters, they are uniquely positioned to enable discursive and functional convergence that is both politically viable and responsive to institutional realities – allowing diplomatic actors to reference shared values while preserving space for political discretion and contextual adaptation, such as through 'strategic ambiguity'. Hybrid norms can thus offer both a conceptual and pragmatic approach for advancing integration in complex and contested governance environments.

The hybrid norm framework thus calls for a fundamental rethinking of global health diplomacy. This thesis has shown how norm integration is best sustained when diplomacy is structured to accommodate negotiations across shared values, recognize institutional diversity, reconcile detrimental power imbalances between its actors, and is committed towards shaping collective agendas. In recognizing this, it is not only important to understand how hybrid norms can be fostered to promote synergies, but also to appreciate its role in promoting a norm of integration, which can end up becoming a socialized practice like any other norm and encourages actors to draw

[555] Rasanathan and others, 'Navigating Health Financing Cliffs'; Mansour and others, 'The Shock Effect'; Michael Kunnuji and others, 'Why "Elevating Country Voice" Is Not Decolonizing Global Health: A Frame Analysis of in-Depth Interviews', *PLOS Global Public Health*, 3.2 (2023), p. e0001365, doi:10.1371/journal.pgph.0001365; Catherine Kyobutungi, Ebere Okereke, and Seye Abimbola, 'After USAID: What Now for Aid and Africa?', *BMJ*, 388 (2025), p. r479, doi:10.1136/bmj.r479.

[556] Benjamin Mason Meier, Judith Bueno de Mesquita, and Sharifah Sekalala, 'The Pandemic Treaty as a Framework for Global Solidarity: Extraterritorial Human Rights Obligations in Global Health Governance | Bill of Health', *Bill of Health*, 13 October 2021 <https://blog.petrieflom.law.harvard.edu/2021/10/13/pandemic-treaty-extraterritorial-obligations/>.

on systems thinking and collaborate across silos in new and productive ways.[557] While developed through the GHS-UHC case, this framework can be applied to other areas where cross-sectoral cooperation has proven difficult, including One Health and planetary health[558], or between digital health and human rights.

A diplomacy anchored in hybrid norms helps shift the pursuit of integration from a top-down mandate to a negotiated, adaptable, and inclusive practice. This reframing embeds integration into the way problems are defined, agendas are constructed, and solutions are implemented. It cultivates a habit of working across regimes and sectors – grounded not in uniformity, but in negotiated synergies. Building on this, "alternative institutional frames – like human rights-based normative orders, and global egalitarian and emancipatory social norms – may open up pathways for reducing health inequities," as suggested by Kentikelenis and Rochford.[559]

This model of integrative diplomacy is especially urgent in an era of overlapping crises, constrained resources, and growing fragmentation.[560] As Menon and colleagues posit, "several crises threaten population health across the world, including the aftermath of COVID-19, climate change, forced migrations, and more. How governments and health systems respond to these crises will be telling, with implications for not only the public's health but also its engagement in participatory democracy."[561] From pandemic risks and natural disasters to shifting geopolitical alliances and armed conflicts[562], actors are being asked to coordinate across mandates without coherent frameworks to jointly support them. Additionally, as noted above, in this moment of a drastically reduced fiscal space, the efficiency of our investments is going to matter immensely. Scholars have already emphasized the importance of navigating these "health financing cliffs" through increasing efficiencies, reducing duplication of efforts, and reallocating funds to support synergistic goals. [563] Promoting hybrid norms through as a core approach of diplomacy and governance reforms might offer a flexible but principled method for mitigating these challenges. Indeed, Phelan et al. argue that "such multidimensional health threats need to be addressed in an integrated and collaborative manner based on multisectoral, interdisciplinary, and inter-institutional cooperation."[564] These settings require diplomatic strategies that can bridge institutional divides while maintaining coherence around shared priorities.

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[557] Aku Kwamie and others, 'Prepared for the Polycrisis? The Need for Complexity Science and Systems Thinking to Address Global and National Evidence Gaps', *BMJ Global Health*, 9.9 (2024), doi:10.1136/bmjgh-2023-014887.
[558] Phelan, Negri, and Hesselman, 'Environmental Health'.
[559] Kentikelenis and Rochford, 'Power Asymmetries in Global Governance for Health'.
[560] Adinoyi, 'Futures for Diplomacy'.
[561] Anil Menon and others, 'The Role of Health and Health Systems in Shaping Political Engagement and Rebuilding Trust in Democratic Institutions', *The Lancet Regional Health – Europe*, 53 (2025), doi:10.1016/j.lanepe.2025.101326.
[562] Kumanan Rasanathan, 'How Can Health Systems under Stress Achieve Universal Health Coverage and Health Equity?', *International Journal for Equity in Health*, 23.1 (2024), p. 244, doi:10.1186/s12939-024-02293-2.
[563] Rasanathan and others, 'Navigating Health Financing Cliffs'.
[564] Phelan, Negri, and Hesselman, 'Environmental Health'.

As fragmentation deepens and global health systems face converging pressures, this integrative mindset rooted in normative rethinking will be essential to building governance arrangements that are resilient, equitable, and capable of responding to the complex challenges ahead.

10.4 Limitations

This section reflects on the limitations of the study while situating them within the broader aims of the research. Like any qualitative inquiry into complex, evolving institutional processes, this study carries certain boundaries shaped by its scope, time restraints, and research design. While justifiable given the constraints and strategic decision-making to complete this project, it is important to acknowledge these limitations to better ground the findings and lay the foundation for future research efforts.

The thesis primarily concentrates on global-level institutions, negotiations, and actors, particularly those operating within multilateral settings such as the WHO, UN, and international financing institutions. While national and regional dynamics – such as domestic health policy reforms or the roles of regional bodies like ASEAN and Africa CDC – play crucial roles in shaping GHS-UHC integration, these are not a core focus of this analysis. This emphasis on global forums reflects the thesis's core aim to foreground the role of GHD and multilateral governance in shaping norm convergence. At the same time, it inevitably misses how hybrid norms manifest and evolve across national contexts, especially in LMICs where the tensions between vertical and integrated programming are often most visible. Future research should more systematically explore these settings and examine how global signals are translated or contested within national systems.

A second limitation stems from the temporal scope of the research. This thesis captures a specific post-COVID moment in global health diplomacy, one in which integration and alignment became unusually prominent on the international agenda. Yet the final stage in the hybrid norm framework (normative coherence), as developed throughout the thesis, requires sustained institutional uptake and alignment – processes that unfold over years. Instruments like the Pandemic Agreement have not yet been adopted, and their long-term effects cannot be assessed within the study's timeframe. What appears as an emerging hybrid norm today may not endure. Budget cycles shift, priorities change, and political support may falter. This already happening with dizzying intensity, given major cuts to global health funding.[565] While discursive signals and institutional commitments suggest important normative movement, the coherence they point toward remains, in many respects, aspirational. Longer-term, longitudinal studies will be necessary to evaluate whether the trajectories observed here translate into structural reform and sustained integration.

A third limitation concerns the inherently interpretive methodology. Thematic analysis and elite interviews offer rich insights into meaning-making, norm articulation, and discursive negotiation, but

[565] Kickbusch and founder, 'Trump, the Rise of the Global South, and a New World Order for Health'; Burki, 'WHO, USAID, PEPFAR'.

they do not provide causal explanation. The research design, for the sake of feasibility and scope, privileges the normative and discursive dimensions of global health diplomacy over the measurement of inputs or the attribution of specific outcomes. As such, it surfaces how actors conceptualize integration and frame normative alignment, but it does not test hypotheses about why certain outcomes occur or attempt to quantify them. Future studies could build on this blind spot by incorporating more comparative case studies and mixed-methods approaches to better assess causality and deepen explanatory scope.

Finally, the empirical base, while indeed diverse in terms of actor and geographic representation, is shaped by practical constraints. The interview sample was limited to 31 participants, and the source materials relied primarily on English-language texts. This introduces potential gaps in representation, particularly from non-English-speaking contexts. Moreover, as in all qualitative research, the interpretive lens of the researcher necessarily shaped the coding, analysis, and synthesis. While a variety of data was achieved and findings were triangulated across sources, the boundaries of the corpus must be acknowledged.

Taken together, these limitations reflect the necessary trade-offs of qualitative inquiry – particularly in normative analyses like this one. They do not diminish the value of the findings, but they clarify the space in which the results should be situated.[566]

10.5 Future research directions

This thesis contributes to an emerging body of work on global health norm integration, and it offers a conceptual and substantive foundation for further research in this area. Building on the findings and limitations outlined above, this section identifies five avenues for future research that extend the theoretical, empirical, and methodological contributions of this thesis. These directions reflect the need to deepen, broaden, and translate the hybrid norms framework across different settings and sectors, while refining the tools for analysing the politics of integration.

1. **Deepening analysis of hybrid norm uptake at multiple levels**: This thesis has traced the construction, convergence, and emerging coherence of hybrid norms through global diplomacy, but further research is needed to explore how these processes unfold across different levels of governance. National health policy environments, in particular, offer important insights into whether discursive alignment at the global level translates into operational synergies in practice at the community level. Future work could use case studies to investigate how hybrid norms are adapted – or resisted – through domestic financing frameworks, health security legislation, or UHC implementation pathways. These contexts may reveal alternative configurations of integration not captured in multilateral processes.

[566] Parkhurst, *The Politics of Evidence*.

2. **Linking normative integration to policy and system outcomes**: The empirical analysis of GHS-UHC alignment developed here emphasizes the political and discursive dimensions of integration. A key next step is to examine whether convergence around values such as equity, resilience, or solidarity actually contributes to improved health outcomes or system performance. Future studies could assess whether countries or institutions that reflect normative integration in their policies also exhibit greater effectiveness in crisis response, broader public trust, or stronger institutional coordination. Combining discourse analysis with implementation research or outcome evaluation could generate much-needed evidence on whether hybrid norms actually lead to more sustainable and shock-proof systems. Furthermore, more research is needed to identify the extent to which GHS-UHC integration is becoming a political priority in global health, and using well-established frameworks (e.g., Shiffman and Smith[567]).

3. **Investigating how non-state actors shape the politics of integration**: As demonstrated throughout this study, norm alignment is deeply shaped by political negotiation via states. However, other actors involved in priority-setting and global agenda-setting – especially philanthropies, private foundations, and multilateral financing initiatives – remain analytically underexamined. Their role in reinforcing, diluting, or redirecting the content of hybrid norms warrants closer study. Future research could examine how these actors strategically deploy the language of integration and coherence, and whether their funding models and institutional mandates continue to reify vertical silos despite rhetorical convergence.

4. **Applying the hybrid norms framework across fragmented global agendas**: This thesis introduced a novel framework for analysing integration between two institutionalized and partially overlapping normative regimes. The same framework could be extended to other domains where norm contestation and policy fragmentation have created similar tensions. Emerging cross-sectoral issues such as planetary health, artificial intelligence (AI) and human rights, or humanitarian crises offer fertile ground for applying the construction–convergence–coherence model. Each of these areas faces the challenge of negotiating shared norms across epistemic communities, institutional boundaries, and divergent political priorities, and could benefit from the methodological approaches to inform future research.

5. **Expanding the methodological repertoire for studying integration**: The thesis adopted an interpretive, discursive approach grounded in elite interviews and textual analysis. While effective in tracing meaning-making and strategic framing, this approach could be complemented by other methodologies that illuminate integration from different angles. Social network analysis, for instance, could map institutional relationships and actor coalitions involved in norm diffusion. Computational methods could identify patterns in how normative language travels across policy spaces. Process-tracing might also help uncover how specific framings influence policy preferences or institutional choices through

[567] Shiffman and Smith, 'Generation of Political Priority for Global Health Initiatives'.

more causal pathways. Finally, Delphi analyses might offer a more granular and accurate set of cross-cutting interventions that diverse stakeholders believe should be prioritized to foster GHS-UHC integration. These tools offer promising pathways for better understanding how integration is facilitated or constrained through structure as well as discourse.

Taken together, these directions reflect the evolving relevance of hybrid norms beyond the case of GHS and UHC. If global governance is increasingly shaped by overlapping mandates, fragmented institutions, and divergent normative frameworks, then studying the politics of integration – and the mechanisms through which shared norms emerge – will remain central to understanding and shaping future health and policy architectures.

10.6 Final reflections

This thesis began with a question: Are universal health coverage and global health security really "two sides of the same coin"?[568] That question quickly gave rise to more: Why do well-established agendas like global health security and universal health coverage – each backed by overlapping institutions, mandates, and funding streams – continue to operate in parallel rather than in partnership? Why, despite their shared goals, do our global health systems remain so deeply fragmented? For those seeking to ensure the survival of UHC in the face of budget cuts and existential threats, or to make GHS more equitable and better attuned to the needs of LMICs, then promoting synergies between the two is not optional. It is critical.

Throughout this research, I have drawn attention to the ways in which GHS and UHC have historically diverged, both in their normative underpinnings and their institutional designs. But I have also highlighted their increasing interaction, particularly during moments of crisis. Through this work, I argue that what we are witnessing is not just the alignment of two frameworks, but the emergence of something altogether new: a hybrid paradigm that seeks to integrate security and rights, equity and resilience, prevention and care. This is a delicate balancing act. It must be done without obscuring distinct principles or erasing hard-won progress associated with either norm. But if managed carefully, it offers the chance to address some of the most urgent challenges of our time: the slow-burning crises of under-resourced health systems, neglected populations, failing trust in multilateral institutions, and the climate-health emergency.

At its heart, this research aimed to offer both a diagnosis of this fragmentation, as well as a roadmap for what a more sustainable global health architecture might look like. The solution, I have argued, lies in reckoning with the normative foundations that influence how global health agendas are conceptualized, aligned, and operationalized – rather than through bureaucratic reorganization or technical guidance alone – thus charting a clearer path for cross-sector coordination and collaboration.

[568] WHO, 'Exchange of Views on the Importance of Health in Development'.

Mitigating fragmentation, as this thesis has shown, is never simply technocratic – it is *always* political. A fragmented architecture reflects how institutions are arranged, whose priorities are elevated, which values are encoded, and which trade-offs are normalized. To treat fragmentation as a neutral outcome is to misunderstand its stakes. During a period marked by rising nationalism, geopolitical competition, skepticism in global solidarity, and significant economic constraints, these stakes are even more pressing. In moments like these, when threats feel existential, there can be a reflex to focus inwards and focus on one's own priorities and interests. But this is shortsighted, and will fail in a world that requires collective action on public health challenges.

While this thesis did not aim to justify or advocate for either GHS or UHC, it does posit that normative integration between both can help address many of the criticisms associated with each agenda – by balancing their respective strengths and limitations. This dynamic may also hold relevance for other complex health agendas that warrant reform but remain constrained by path dependency and institutional inertia. The move to reorient global health around integrated norms is therefore essential. Indeed, because the causes of fragmentation are interconnected, so too must be the solutions. This is the central premise of the hybrid norm framework developed in this thesis. In the context of GHS and UHC, it enables a vision of integration that is strategic, not superficial; responsive, not reactive; and inclusive, not imposed.

As such, integration should be viewed as a layered process of interaction and evolution, rather than as a fixed endpoint. It involves choices that are contested, often fiercely. Yet these choices (and their resulting policy prescriptions) are also malleable, framed by discourse, negotiated through diplomacy, and embedded in institutions. By advancing our understanding of the politics of integration, moving beyond conventional scholarship that focuses on the evolution of a singular norm, this thesis illuminates how the broader normative regimes of GHS and UHC have (and will likely continue to) evolve together – not by collapsing into one another, but by aligning strategically across shared discourse and complementary core functions. This approach offers a new lens through which to view integration as a creative act of synergy rather than a series of concessions.

It is also important to acknowledge that integration can have its drawbacks, and fragmentation can indeed have its advantages. However, instead of relying on efficiency metrics or institutional restructuring alone, this thesis argues for a rethinking of the politics of integration as an evolving process, which (if pursued effectively) can strengthen normative legitimacy, enhance collaboration, and sustain shared priorities across multiple sectors. Integration done well must balance the goals of both parent norms, and do so with a clear understanding of power, context, and consequence.

As Rasanathan and colleagues urge, "the new era of global health must be rapidly constructed without seeking merely to restore what was."[569] This endeavor requires us to be much more comfortable recognizing that our priorities and solutions will bleed into one another. Global health cannot be cleanly divided into vertical silos or sealed policy domains. Instead, we must acknowledge

[569] Rasanathan and others, 'Navigating Health Financing Cliffs'.

and even embrace the messiness of real-world *inter*dependence. The ways in which we attempt to advance global health goals is going to look – and indeed *must* look – different. It will require us not only to use large parts of the interagency, but to also develop richer understandings of how different pieces of our systems interact, and where progress can be made *despite* chronic fragmentation. In this context, hybrid norms become a tool not of compromise, but of synthesis – bringing together principles and core capacities from across different paradigms in order to build institutions that are stronger, more legitimate, and more responsive to shifting global realities.

The empirical and conceptual insights presented here are rooted in the specific case of aligning GHS and UHC, but their implications extend much further. The fragmentation this thesis describes is not unique to health. It reflects broader structural and normative dynamics that affect many areas of global governance and foreign policy. Consequently, my framework aims to help explain how established regimes – each with their own complex constellation of actors and interests – might be better harmonized through iterative construction, convergence, and coherence of their underlying norms. And in doing so, it opens up new ways of thinking about integration as a site of strategic transformation for many of humanity's 'wicked problems'.

In this sense, my thesis has attempted to offer something more ambitious than a solitary case of norm integration in global health. It has presented fresh ways of thinking about how progress can be made amid fragmented and contested politics. It has highlighted how alignment of underlying values and obligations – through strategic framing, thoughtful negotiation, and iterative institutional design – can help navigate impasses that frequently stall international cooperation. And it has shown how these efforts can be successful in striking a balance between collective security and individual needs, between Global North and Global South, and between short-term response and long-term system strengthening. This is not a finished project, but a provocation – a call to continue rethinking how global health is governed, and more importantly, why.

Ultimately, this thesis invites both scholars and practitioners to reimagine integration as a transformative political and normative endeavor – one that must be grounded in shared ideals, sustained through mutual reinforcement, and built to withstand the complex threats of the 21st century. While the integration of GHS and UHC has provided a compelling example of this, it has also revealed something much larger and enduring: The power of synergistic norms to reshape institutions. The potential of shared discourse and core functions to align actors. And the potential of integrative diplomacy to forge new paradigms out of old contradictions.

Integration, therefore, is not the end. It is just the beginning of asking better questions about what kind of systems we want, for whom, and on whose terms.

And in a world of overlapping crises, these questions have never been more essential.

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As the empirical chapters each have their own individual numbered references in footnotes, this presents the collected list of all works cited throughout this thesis.

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Annex

1. Information sheet and informed consent form (Chapter 8)

LSE Department of Health Policy

Pathways to coherence:
perspectives on integrating global health security and universal health coverage

OVERVIEW

I would like to interview you as part of a doctoral research project at the London School of Economics and Political Science (LSE), studying the links between global health security (GHS) and universal health coverage (UHC). This interview is to consult with you to help improve our understanding of how diverse global health stakeholders understand and use these concepts in the broader global health architecture. This research will contribute to my doctoral thesis and associated research outputs, such as academic journal publications.

INTERVIEW PROCESS

Your participation in this interview is wholly voluntary. You may choose to answer or not answer any of the questions posed during the interview process. You may end the interview at any time.

What participants will do

The interview will be conducted over Zoom or in-person (if feasible), and will last approximately 30 minutes to 45 minutes. You will be asked questions about your knowledge and experience working in either/both global health security and universal health coverage, particularly in recent years.

With your permission, interviews will be sound recorded using Zoom and/or a digital recorder, and I may also take notes. The results of this research will be available via open access publication in due course.

Security of Confidential Data

All sound files and related notes will be electronically stored in a secure password-protected data repository held by LSE, and will only be accessible by me and my PhD supervisors. The sound files will be transcribed by me, and with the assistance of a digital transcription software that will maintain the confidentiality of the data. The transcripts will be stored securely in accordance with university policies.

Withdrawal from the study

You may withdraw from participation in this study during the interview and up to July 1, 2024 (when analysis and writing of outputs will commence). Please contact me directly if you wish to do so.

Follow up
If you have any further questions about this project, please feel free to contact me:

- Arush Lal
- Email: arush.lal@gmail.com
- WhatsApp: +16787041301 / Phone: +44 7749 752844

If you have any concerns about the research or researcher, please contact Lyn Grove (Research Governance Manager) at l.grove@lse.ac.uk.

Ethics number: 58402

LSE Department of Health Policy

CONSENT FORM

This interview is to consult with you about recent efforts to integrate global health security and universal health coverage. Please note that:

- Your participation in this interview is wholly voluntary. You may choose to answer or not answer any of the questions posed during the interview process. You may end the interview at any time.

- You may choose to withdraw your consent at any time. In such a case, I will destroy all data related to the interview.

- Your participation in this interview is confidential and anonymous. Data related to this interview will not include your name, but a code only I know. It will be stored securely according to university policies. We will not publish your name or any identifying information.

- The research will help contribute to my doctoral thesis and lead to academic publications like journal articles, which I will make available to you if you wish. You will not be identified in any of these documents.

- We do not anticipate any risk to you from participating in this research. If you feel there is any risk please let us know so we may address it or end the interview.

- We hope you will find participating in our research beneficial in terms of contributing to knowledge around global health security, universal health coverage, and health policy.

After reading the above, please either fill out the section below or provide verbal consent, depending on your preference:

Your first and last name: **Please read the below statements, and place an "X" in the box (or verbally consent) if you agree:**	
Do you consent to participate in the interview?	
May I take notes during the interview?	
May I sound record the interview?	
Do I have your permission to contact you if there is anything I would like to clarify from the interview or follow up on?	

Thank you again for your assistance in this project.

Ethics number: 58402

2. Interview guide (Chapter 8)

Interview Guide (Semi-Structured)

Confidentiality and consent protocol

At the start of each interview, reiterate the following commitments:

- Participation is entirely voluntary, and participants may pause or stop the interview at any time.
- Responses are confidential and will be anonymized in any outputs.
- If any identifiable references emerge during analysis, you will be contacted to confirm whether you are comfortable with inclusion and, if so, how you would prefer your organization or affiliation to be represented.
- You may choose to speak off the record for any part of the interview.

Section 1: Framing and definitions

Objective: Understand the participant's interpretation of GHS and UHC and how these have evolved over time, particularly in response to COVID-19.

- How do you define global health security in your work or organization?
    - What core principles or capacities does it include?
- How do you define universal health coverage?
    - What elements are most important in your framing?
- Has your understanding of these terms changed since the onset of the COVID-19 pandemic?
    - In what ways?
    - Has COVID-19 affected how you or your organization prioritize these agendas?
- Do you see any limitations or issues with how these terms are currently used?
- How would you describe the relationship between GHS and UHC?
    - Do you see them as complementary, in tension, overlapping?

Section 2: Institutional engagement and strategic approaches

Objective: Explore the extent and nature of the participant's engagement with efforts to align GHS and UHC, and perceived motivations, challenges, and approaches.

- Are you or your organization engaged in efforts to enhance coherence between GHS and UHC?
    - How would you characterize these efforts?

- Do you believe integration between GHS and UHC is a useful or important endeavour?
    - Why or why not?
- What are the main motivations (personal or institutional) behind efforts to promote GHS-UHC integration?
- Do you have any concerns or risks you associate with these integration efforts?
- Have you been involved in any initiatives, programs, or strategies that aim to integrate GHS and UHC?
    - What has been your approach?
    - Have you encountered any barriers?

Section 3: Operationalization and impacts in the global health landscape

Objective: Identify perceptions of how GHS-UHC integration could or should be embedded within broader governance, financing, and policy structures.

- How do you think GHS-UHC integration could be best operationalized?
    - What activities, frameworks, or governance mechanisms should be prioritized?
- How might efforts to integrate GHS and UHC affect:
    - Different types of actors?
    - Global health governance structures?
    - Financing and resource flows?
    - Other global health agendas or programs?
- What are the most promising tools, mechanisms, or strategies available to support integration in the current global health architecture?

Section 4: Future pathways and priorities

Objective: Understand forward-looking reflections on how GHS-UHC integration efforts can be strengthened, and what practical steps are needed.

- What are the most important challenges that need to be addressed to enable effective GHS-UHC alignment?
- What opportunities do you see for advancing this agenda in the near term?
- From your perspective, what would be the most helpful outcomes of this research?