Analysing Leadership in Global Health Governance

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Sophie Harman and Simon Rushton

Abstract

Rhetoric around the need for more and better leadership is everywhere in contemporary global health governance, yet there has been little articulation of what type of leadership is required, who might play leadership roles, and in what fora leadership might be exercised. Global health governance has widely been seen as a policy space characterised by a multiplicity of (often competing) actors with no overall authority. Yet despite this things do 'get done', and in some cases there are impressive levels of collective action to address particular health problems. We argue that leadership provides an important lens for understanding how things do (or do not) get done in global health governance. Drawing on the existing literatures on global health governance and leadership and agency in international relations, we set out in this paper a framework for analysing leadership in global health governance. Crucially, we argue, such a framework must be specific enough to be operationalisable in terms of a program of research and at the same time broad enough to capture a wide variety of different sources, sites and forms of leadership – including the roles played by 'hidden leaders' who are seldom acknowledged in mainstream analyses of global health politics.

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Introduction

Global health governance continues to be subject to regular calls for reform. Demands for changes in the institutional architecture, greater co-ordination between the myriad agencies involved, and closer partnership between public and private actors are commonplace in contemporary global health discourse. A recurring theme in these discussions has been the apparent need for more (and better) leadership. Leadership rhetoric, indeed, is everywhere: at the international level it is seen as vital to the ongoing project of WHO reform;[1] at the national level as a key factor in developing countries delivering effective health policies and programmes.[2] Yet whilst more and better leadership is commonly seen as the solution to these problems and a host of others, there is little articulation of what type of leadership is required, who might play leadership roles, and in what fora leadership might be exercised. Instead leadership has taken on the status of an unattainable panacea, its absence being both an explanation and an excuse for the overall system's failure to adequately address health needs.

The purpose of this paper is twofold. First, we explore the analytical utility of 'leadership' as a lens through which to examine global health politics, in particular its value in helping to reveal how things 'get done' in global health (or, in too many cases, why they don't). Second, we seek to operationalize leadership as means of analysing global health politics, in doing so arguing that existing work on agency and leadership in International Relations (IR) can provide us with some of the conceptual tools we need to understand leadership in global health. The paper argues that a focus on leadership delivers some revealing insights into the practice of health governance, not least around the setting of global health agendas. However, such an approach also brings dangers – in particular the risk of reifying the roles played by prominent (and often self-proclaimed) 'global health leaders' (the vast majority of whom are white men from the Global North), in so doing obscuring the roles played those who do not fit this image of who a leader is, or how and where he (or, less frequently, she) should act. To guard against this danger we propose a maximalist conceptualisation of both 'leadership' and 'global health governance' which first understands leadership *as a practice* rather than as a position to be held and retained; and which secondly takes

a broad view of *where* leadership in global health is practiced, looking beyond the traditional 'policy hubs' of Geneva, New York, Washington DC and Seattle, and instead viewing global health as a genuinely *global* governance arena.

The paper proceeds in four sections. In the first we explore what existing studies of global health governance tell us about agency. In the second section the paper goes on to consider what we know about leadership as a particular form of agency in global health governance, arguing that whilst there are some insights to be gleaned, leadership has not to date received sufficient analytical attention. In the third section, we suggest that work outside of global health has some important lessons to offer, in particular the literature on agency in IR, and also the existing work on leadership in supra-national negotiation processes. Finally, building upon the literatures examined in the preceding sections, the paper proposes a five-part matrix for analysing leadership in global health governance which is sensitive to the varied forms, sites and sources of leadership which exist in practice.

Agency and global health governance

Scholars in global health have done a good job of mapping and describing the developing and highly complex 'architecture' of global health governance in which agency (in the sense of the ability to create change) is highly diffused. We have good accounts of the variety of actors that play governance roles, of the ways in which new actors have entered this policy sphere over the last couple of decades, and of some of the material and ideational forces that have shaped global health governance. For instance, we know quite a lot about the characteristics, approaches and activities of most of the major global health governance actors, including the WHO,[3] the UN,[4] the World Bank,[5] the IMF,[6] the WTO,[7] NGOs,[8] public-private partnerships,[9] and old and new forms of philanthropy[10] - not to mention the role of states in the contemporary globalisation of health policy.[11] There have also been a number of works that have looked across global health governance as a field and have tried to understand how the pieces of this complicated jigsaw fit together.[12]

It would clearly be impossible to summarize the whole literature within one short paper, but it is possible to draw out three findings about the forms and sources of agency in global health governance which are commonly identified.

The first – certainly not unique to the health sphere – is that money talks. The ability to finance global health projects and institutions is a key source of agency, not least through the ability to dictate how that finance is used. Perhaps the best example of financial resources being a source of agency in global health is that of the Bill and Melinda Gates Foundation. Famed in global health circles for having a larger budget than the WHO, the Foundation's Global Health Program has exhibited tremendous influence with regard to its ability to finance activities and institutions directly, influence agendas, and secure a presence in high-level global health summits and the World Health Assembly. It is true that attributing this agency solely to finance is a simplification - the personal profile and gravitas of Bill Gates himself (as well as Melinda) also plays a part, as does the reputation of the experts who work with and for the Foundation - but it is the Foundation's ability to put its financial muscle behind those issues that it prioritises (inextricably linked to those issues in which Bill and Melinda have a personal interest) that has made it one of the most powerful and influential non-state actors in global health governance.[13] More traditional international financing organizations such as the World Bank are also able to exercise agency as a consequence of their ability to mobilise funds, in the case of the Bank through core International Development Agency (IDA) or International Bank for Reconstruction and Development (IBRD) project funds as well as multi-donor trust funds for specific health priorities. Again, the World Bank's agency cannot be attributed solely to its ability to financially support specific health projects. The fact that it has a long-standing country presence and well-developed relationships with both governments and United Nations agencies in-country also gives it tremendous influence.[14] Thus though the Bank may not always bring the most money to the health table, its combination of finance, in-country longevity and proximity to government provide a unique source of agency in global health.

Conversely, a reliance on external finance can seriously inhibit an actor's ability to exercise agency. The cuts to the WHO's core budget, for example, have been widely seen as having reduced

its scope to exercise agency in global health.[15] The institution continues to be able to articulate health needs, concerns and priorities but often lacks the necessary finance to support work in specific areas or to carry out the initiatives that it might wish to pursue (unless it can persuade governments to support them through Extra-Budgetary Funds). Even the organization's 'softer' normative role seems to be under threat as the lack of funds impacts on its knowledge production capacity, and the range and scope of its activities comes under increasing scrutiny from its funders, some of whom desire a narrower, more technically-focussed and less politicized WHO.

A second agency-related finding to be drawn from studies on global health governance is a tendency for new institutions to be created when existing ones are thought to be failing, for whatever reason. From the turn of the millennium, global health has seen a rapid and sprawling growth of new multilateral institutions, non-governmental organisations, public-private partnerships and product development partnerships. Some of these, such as the Global Fund - which was intended to fulfil a gap in rapid financing to combat 'the three scourges' of HIV/AIDS, malaria, and tuberculosis - were created specifically because of a belief that existing institutions such as the WHO, UNDP, or the World Bank were not capable of delivering effectively.[16] Elsewhere new organizations have grown up in response to the availability of funding in particular areas, a phenomenon seen most clearly around HIV/AIDS. This was certainly the case with the growth of the NGO industry in countries where the disease had high prevalence and was targeted for international financial assistance.[17]

Again, such emphasis on "the new" can restrict the space in which the incumbent institutions of global health, such as the WHO, can exercise agency. Some see this as a good thing, as the WHO is forced to compete with other agencies and address some of the problems that people see with the institution. On the other hand, it plays into the idea that the WHO is a failing institution, reducing the space the organization has to act on its mandate and its potential to exhibit the agency it is often accused of lacking, creating a vicious circle of underachievement and under-valuation.

The increasing number of institutions has also divided the overall 'global health pot' between a greater number of actors. During the early years of global health's institutional boom this was less of a problem as it coincided with a dramatic increase in overall funding for global health. Partnerships such as the Global Fund and GAVI were created and given large budgets with which to work. Now, however, budgets are tightening, and there seems to be a reduction in the rate of institutional creation. Those that have already been created, however, are presumably here to stay. As a result, global health actors are increasingly being forced to compete with each other to maintain (let alone increase) their funding levels.

The third finding we distil from the global health governance literature is that the bewilderingly complex, ad hoc and non-hierarchical institutional architecture has created problems. In terms of setting a consistent and deliverable global health agenda the problem, arguably, is a surfeit rather than a lack of agency. This is particularly evident with regard to overlapping mandates, competing aims and objectives, and double-dipping in the pot of project financing. Multiple initiatives have been established over the last 10-15 years in an attempt to co-ordinate the work of different global health actors. These include donor partnership groups or meetings; principles such as the 'three ones' articulated by UNAIDS to co-ordinate the global AIDS response in-country; technical working groups; the designation of lead agencies in specific sectors; and major global agreements such as the Paris Declaration. However despite the range and number of initiatives – which in themselves demonstrate how multiple mechanisms of co-ordination can also complicate the problem further – problems of overlap and 'mandate creep' abound. The multiplicity of actors also imposes significant transaction costs, not least on recipient countries. Such countries have to manage the different interests, objectives and demands of their numerous 'partners', a task that can stretch already under-resourced government capacity and can lead to a shifting of priorities towards those health issues seen as popular or appealing to external donors. Whilst it could be argued that the existence of multiple donors can actually enhance the agency of developing countries as they have an opportunity to play different donors and different tranches of aid financing off against each other, in practice such complexity frequently generates

a management headache for governments and can contribute to a distortion of priorities of an individual state's health objectives.

These three agency-related issues – the link between finance and agency; the creation of new institutions; and the potential for too much (and too often uncoordinated) agency - have intersected with underlying structural factors to present a number of challenges to contemporary global health politics. Global inequalities (both economic and heath inequalities, the two of which are closely linked) have not been tackled. The need to address the social determinants of health has been the subject of much rhetoric, but far less concrete action. The global financial crisis is also having an impact on global health. ODA for health is starting to drop as other areas such as infrastructure begin to grow, some donors have withdrawn from partnerships such as the Global Fund, and a perception of 'aid fatigue' amongst the wider public is growing, particularly with regard to diseases such as HIV/AIDS, challenging the assumption that global health financing will always feature highly in the public conscience. This is all occurring at a time when the position of health in international development financing is being discussed in the context of the 2015 Millennium Development Goal (MDG) deadline. Three of the eight original MDGs were health-related, and much of the investment in global health over the first decade of the new millennium was driven by that commitment. Questions remain, however, over the extent and scope of health's representation on the post-2015 development agenda. The fact that global health is susceptible to being portrayed as bloated, with multiple (and at times competing) actors increases the danger that it may find itself slipping down the list of priorities.

Whilst these three insights are commonly found across the existing literature on global health governance, another thing that characterises the vast majority of these works is a tendency to take institutions (or partnerships between institutions) as the principle agents of global health governance. As a result, the agency of individuals working both within and outside of these institutions is often overlooked. This corporatist approach to institutional agency has the merit of simplifying the analysis of what is, even in simplified form, an overwhelmingly complex policy space. At the same time, however, it brackets off much of what we know about the practice of

institutional politics – for example that bureaucrats can wield power and authority,[18] that personalities (and inter-personal group dynamics) contribute to determining political outcomes,[19] and that institutions do not always behave in a coherent fashion – nor do they necessarily behave in the ways their creators intended.[20] A focus which privileges institutions and their 'outputs', therefore, risks undervaluing the processes through which those outputs are produced – as a consequence missing some important determinants of how things 'get done' in global health governance. A focus on individuals and their exercise of leadership, we argue, has much to contribute here.

Leadership in global health

Where scholars have examined individual agency, they have exhibited a strong tendency to focus on particular types of individual - predominantly white, Western and male - who have, according to mainstream accounts, shaped and led the current discourses and practices of global health. There have, for example, been a number of studies of individuals who head (or hold other senior positions in) global health institutions, including individuals such John D Rockefeller,[21] Gro Harlem Brundtland, Lee Jong-Wook,[22] Bill Gates,[23] Jonathan Mann,[24] and Peter Piot.[25] We also know about the ways in which high-profile celebrities such as Bono have aligned themselves to global health issues. Senior politicians have also attracted attention as individual agents capable of shaping global health. George W. Bush, for example, played a widely-noted leadership role in the scale-up of anti-retroviral treatment for people living with HIV/AIDS (as well as supporting prevention strategies) through his President's Emergency Plan for AIDS Relief (PEPFAR).

In some cases these leaders have been widely praised for their influence on global health as a policy field. Jonathan Mann, for example, has been credited with a crucial role in the development of global responses to AIDS, and in particular with promoting a human rights-based approach to AIDS and other health issues. Elsewhere, judgements on the leadership of particular individuals have been more mixed. Bill Gates has been the subject of criticism in some quarters despite his foundation's huge investment in global health. Perhaps more predictably, George W.

Bush has divided opinion. Whilst PEPFAR is seen by many as a key part of the effort to achieve universal access to ARVs, the leadership Bush demonstrated was not without controversy. Prevention programmes were originally funded on the condition that the 'C' of ABC – Abstain, Be faithful, use a Condom – was not used. PEPFAR programmes were also subject to the 'global gag rule' (repealed by Obama in 2009) that prevented US aid from going to any organisation that provided or offered services related to termination of pregnancy, and only organisations and groups that explicitly opposed prostitution would be eligible for funds.[26] These conditions led to considerable consternation among parts of the global health community, particularly among those working on reproductive health and women's health.

Similar controversies have arisen around political leaders who have deliberately attempted to challenge the status quo. The ex-Minister of Health for Indonesia, Siti Fadilha Supari is a prime example. In seeking to challenge the global virus sharing system that is a fundamental part of influenza vaccine production, Supari was seen by some as playing a leadership role on behalf of the developing world in contesting a system which resulted in many of the countries supplying virus samples (including Indonesia) in effect being priced out of purchasing the vaccines that those samples were used to produce. Others, however, saw Supari's tactic of withholding virus samples as highly problematic. Even some of those who supported her point in principle were uneasy about the tactic of effectively 'holding the world to ransom' through the refusal to share samples.[27]

Leadership, these examples show, is often controversial and – despite the rhetoric which presents leadership as a solution to global health ills – it is not necessarily an unproblematic good. But whilst scrutiny of the roles of such high-profile figures as Supari, Bush, Gates and Mann is an important part of analysing global health politics, it is far from the whole story. Indeed, we argue here that the focus on these high-profile figures draws attention away from the less obvious 'hidden leaders' who also play instrumental roles in creating and implementing global health programmes, subverting or reinforcing global agendas, and shaping the outcomes of policy discussions in a range of different countries and contexts.

Partly this shortcoming is a result of the spaces and fora in which we generally think of global heath as being governed. High profile conferences and summits generate attention around particular types of leaders, but not around those who do not attend such events (may not even have not heard of such events), or attend but do not have a prominent role in plenary sessions and press conferences. Likewise, the clustering of global health institutions in Geneva (and New York, Washington DC, London and Seattle), reinforces a particular view of who is governing global health and where that governance is happening. These spaces and the agents who operate within them are of course important and should not be ignored. Yet one of the key insights of the first generation of scholars of 'global governance' was that governance happens everywhere. James Rosenau, for example, wrote in the first issue of the journal *Global Governance* that

> The United Nations system and national governments are surely central to the conduct of global governance, but they are only part of the full picture. Or at least in this analysis global governance is conceived to include systems of rule at all levels of human activity - from the family to the international organization - in which the pursuit of goals through the exercise of control has transnational repercussions. The reason for this broad formulation is simple: in an ever more interdependent world where what happens in one corner or at one level may have consequences for what occurs at every other corner and level, it seems a mistake to adhere to a narrow definition in which only formal institutions at the national and international levels are considered relevant.[28]

But whilst the global health governance literature has clearly (and often explicitly[29]) built upon the thinking of Rosenau and others on global governance, it has too rarely taken up the challenge to see what is happening in the more obscure corners and at the less high-profile levels.

There are, however, some notable exceptions. Sanjoy Bhattacharya's detailed historical work on Smallpox eradication in India, for example, highlights how Indian health workers and research partners were pivotal to the disease's global eradication. As Bhattacharya argues, "it would

be simplistic to reduce the worldwide smallpox eradication programme to the ideas and actions of a handful of individuals or, indeed, the institutions to which they were associated."[30] Yet, as he also highlights, this is what has often happened, with the contributions of those operating at the national and sub-national levels (especially within the developing world) often being neglected in accounts of the history of smallpox that have tended to reify individuals working with Western institutions such as CDC.[31] As Bhattacharya notes,

> it is no surprise to witness organised efforts on the part of government and nongovernment agencies to highlight their contributions to this memorable triumph. The danger, of course, is that these exercises will chronicle relatively few voices and then present them as being representative of the "reality" of the eradication programme as a whole; such an approach is to be avoided, although these individual voices are, of course, valuable. The global project to limit the spread of variola, as it evolved in the 1960s and 1970s, involved countless participants. It was simultaneously an international and local entity, and each avatar had several constituents.[32]

The lesson we take from the work of Bhattacharya (and others who have sought to reveal the activities of what we here term 'hidden leaders') is that understanding how things 'get done' in global health (or, to use the language of leadership studies, how the agency of multiple actors can be harnessed in pursuit of common goals) requires us to take into account *both* high-profile 'visible' leaders *and* often-ignored 'hidden' leaders. Failing to take both into account risks providing a skewed picture of how global health governance works, and also brings the other problems we noted above in relation to the reification of a particular type of (usually white, Western, male) leader. This, it seems to us, runs counter to the whole idea of health (and health governance) as 'global'. A key requirement for the analytical matrix that we present in the final section of the paper, therefore, is that it must provide a means of examining the influence of both visible and hidden leaders in global health politics.

Agency and leadership in International Relations

First, however, we look beyond the global health governance literature to examine what insights from other fields might provide conceptual tools that can contribute to the building of a framework for the analysis of global health leadership. This involves, in particular, understanding agency in at the international level and then understanding leadership as a particular form of individual agency.

Agency

Any understanding of leadership in the international sphere has to be based on an underlying conception of agency. Questions of agency are one of the central pillars of IR scholarship. Historically, discussions of agency in mainstream IR tended to focus on states as actors. The discipline's primary interest in the inter-state level of analysis made this in many ways a natural choice: states go to war, states sign treaties; states create international organizations; and states adopt foreign policy positions. Of course, as David Williams argues,[33] such 'black-boxing' of the state – the US gives money to HIV/AIDS; the UK prioritises maternal child health – is generally recognised even by those who perpetuate it as a form of intellectual 'shorthand'. Yet the use of such a shorthand is nevertheless seen by many IR theorists as defensible, even desirable. For Kenneth Waltz, for example, states were the fundamental units within the international system. The properties, characteristics and make-up of those units did not matter much in his system-level approach to theorising international politics; only the position of units within the system mattered.[34] Individual human agency was less important to Waltz's system-level theorising because personalities and behaviours can change whereas structures of the state and the system in which states operates endure: 'abstracting from attributes of units means leaving aside questions about the kinds of political leaders, social, and economic institutions and ideological commitments states may have.'[35] Alexander Wendt, coming from a very different theoretical position, argues that agency can ultimately only be attributed to individual persons, although he goes on to make the

case that states acting within the social environment of international society can be treated as analogous to individuals and understood as persons with moral roles and responsibilities as well as legal and judicial claims to sovereignty.[36]

It would be wrong, however, to portray IR's engagement with agency as lacking in nuance: even amongst those who see states as the primary agents, it is certainly true that there have been important and influential debates and a growing interest in the question of 'who governs'.[37] Two examples are the agency-structure problem/debate/problematique and work that has examined the question of *which* states are able to exercise agency on the international level. The former debate, which essentially arose from the perceived failure of structure-driven (often structural realist) accounts of international politics to deal with major changes such as the end of the Cold War, resulted in new theorising about the relationship between agency and structure, and to disagreements over the relative weight that should be given to each in explaining political outcomes. The latter stream of work has used the concept of agency as a normative framing for investigation bringing 'peripheral' states often seen as subject to, not agents in, international relations to the fore. This has particularly been the case with regard to African agency.[38] African states have often been seen as something exceptional - not really states in the western conception of the term. Despite the fact that they are a politically and socially diverse set of polities, the history of colonialism has tended to lump African states into one (problematic) category. Emphasising agency as a lens through which to investigate African states' roles in international relations, such work seeks to overcome the idea of Africa being 'acted upon' by the international system rather than African people, states, and collective endeavours acting in their own right.[39]

As we go on to discuss further below, leadership is something that is practiced by individuals – an idea which makes it problematic to apply these traditional ideas about agency in IR. Elsewhere, however, IR scholars *have* looked at individual agency. For example, Colin Wight, contra-Wendt, argues that a personification of the state which treats states as "individuals writ large" obscures individual human agency within the state. As Wight says, 'this seems to be little different from previous forms of structuralism that essentially write out individuals and treat them

as ciphers for structural forces' leaving little room for individual agency and an assumption on the sources of collective agency that gives states the space to act.[40] Whilst this is a fair critique of some of the system-level theorising of Wendt (and indeed of Waltz and others) there is, of course, also a long history of 'looking inside the state' to understand 'what makes them tick', from Graham Allison's classic *Essence of Decision*[41] to today's work on foreign policy analysis.

There has also been a good deal of work that has examined individual human agency outside the context of the state. Indeed there is a widespread acknowledgement amongst most IR theorists that states are not the only significant actors in contemporary international politics, even if some continue to prioritise states in their analysis. One example of such work is the literature that has examined individual agency within international institutional structures, perhaps most notably within international organizations. Robert Cox's essay on the 'executive head'[42] was a classic statement of this kind, and it has been followed by a literature that has examined the bureaucracies of international organisations and how those bureaucracies can exercise agency both corporately and through the actions of individuals within them[43] – including literatures examining the holders of specific positions such as the UN Secretary-General as actors in world politics capable of exercising significant degrees of agency.[44] Work on civil society's role in international relations has also paid attention to the role of individuals, including celebrities and other high-profile actors.[45]

Notwithstanding the discussions over who or what has agency, there has been relatively little conceptual examination of what 'agency' in the international sphere actually means – especially when compared to the emphasis that the discipline has placed on understanding 'structure.'[46] As Supreme Court Justice Potter Stewart famously said of hard-core pornography, there is a sense that we all know agency when we see it, even if it is rarely actually defined. Colin Wight, however, proposes a conceptualisation of agency that is 'multi-layered' and that "explicates the fragmented nature of this problematic concept."[47] In doing so he attempts to avoid falling into what he sees as the trap of personifying the state by taking into account three 'levels' of agency:

agency as the capacity to (intentionally) do something (which Wight calls agency$_1$); agency in the sense that those with the capacity to do something are acting as 'agents' of something other principal (agency$_2$, which locates agents within a particular socio-cultural context); the third level (agency$_3$) describing "'position-practice-places' which agents$_1$ inhabit on behalf of agents$_2$."[48] Wight's attempt to clarify this through an example runs as follows:

> An example of the way in which these three levels of agency are complexly related to each other can be drawn from an examination of the nature of a diplomat. X, our putative diplomat, is at once an agent$_1$, he has a unique personality which is itself a consequence of his unique personal make-up and the many forms of agency$_2$ and agency$_3$ which have shaped and formed X throughout his life. Nonetheless, at a given point in time X assumes a specific 'positioned-place-practice' within *one* of the realms of agency$_2$ (the diplomatic service) which X inhabits. This 'positioned-place-practice' delineates the function that X now plays in this particular form of agency$_2$. Yet X, due to his potential as an agent$_1$ – and his participation in differing forms of agency$_2$ – is never an automaton simply practising in accordance with his place in the positioning.[49]

Leadership

Getting to grips with understanding different levels of agency, the role of individuals in the international sphere, and the relationship between individual agents and the states or other bodies on whose behalf they act is crucial for our purposes because, as Oran Young agued, leadership is inherently an activity carried out by individual human beings. He noted (with some clear echoes of the quote from Wight above) that

> the recent emphasis on hegemony and, more generally, structural determinants of collective outcomes in international society has had the effect of diverting attention from the roles that individuals play as leaders who are able to exercise significant influence over

> processes of institutional bargaining. To avoid the resultant pitfalls of reification, it is important to bear in mind the relationship between individuals and collective entities, such as states and international organizations. Those who become leaders in institutional bargaining frequently act in the name of or as agents of states or international organizations. But in the final analysis, leaders are individuals, and it is the behavior of these individuals which we must explore to evaluate the role of leadership in the formation of international institutions.[50]

But even if we accept the basic premise that leadership is practiced by individuals, there are still plenty of conceptual difficulties in applying leadership as a concept. Leadership Studies has struggled for decades to define and agree on the use of the term. Fleischman et al[51] identified 65 different classification systems that had been developed at that point, and there remain divides at the most fundamental levels, including over whether leadership is about the shaping of a group process; whether it is a trait that individuals either do or do not possess; or whether it is a particular form of behaviour.[52]

Each of these understandings has been evident in the long history of works on political leadership, which long pre-date the recognition of any formal discipline of 'leadership studies'. For a long time 'big man' theories of the charismatic political leader dominated. Over time, however, there has developed a literature of more direct relevance to the study of global health governance which has sought to understand the broader and more nuanced role of leadership (and associated phenomena, such as policy entrepreneurship) in policy processes,[53] including in supra-national settings. This literature has often foregrounded the roles played by individuals (at least, as we shall see, by particular types of individual).

Oran Young made a helpful distinction between 'structural leaders' (who are "experts in translating the possession of material resources into bargaining leverage"); 'entrepreneurial leaders' (who rely on "negotiating skill" to make agreement possible); and 'intellectual leaders' (who rely on "the power of ideas to shape the thinking of the principles"). All of these forms of leadership,

Young argues, play a role in the reaching of international agreements.[54] As to the identities of those leaders, Young argues that structural leaders "are almost always representatives of major actors involved in bargaining processes", but that those who exercise the other forms of leadership can be far more diverse: he cites, for example, scientists who helped shape global action on ozone depletion,[55] whilst other have examined those who hold formal leadership positions, such as chairs of negotiations.[56]

Here, in the context of international negotiations, leadership is essentially being understood as a social process in which leaders (using whichever form of leadership) attempt to influence those (usually states) who have the power to either agree or not with a particular negotiated outcome. The aim of leadership, therefore, is to bring multiple actors together around a common goal. The means by which the different kinds of leaders Young identifies seek to create that convergence of opinion vary – using resources as leverage (structural leadership); using persuasion and bargaining tactics (entrepreneurial leadership); and using ideas to shape the way in which participants understand the issue and their own interests (intellectual leadership). In each case, however, the overall aim is to bring the various parties involved in a negotiation to agreement.

For our purposes – attempting to better understand how things 'get done' in global health governance– a similar understanding of leadership as a process of harnessing the agency of multiple actors best provides us with the tools that we require. Indeed the definition of leadership that we adopt here is simple (although in some ways deceptively simple): following Northouse[57] we define leadership as "a process whereby an individual influences a group of individuals to achieve a common goal". We also stress (and discuss further below) that it is important to take into account the fact that such influence takes place in a specific context, place or setting. Others who have grappled with the issue of leadership in international politics have often settled upon similar definitions - Joseph Nye for example, describes leadership as "mobilizing people for a purpose."[58]

There are, however, two remaining (linked) hurdles to operationalising the idea of leadership in relation to global health. The first is that there is more to global health governance

than formal negotiations. To be sure there are formal international negotiations over health issues, but governance processes are much more diverse than this: individual organizations have their own policies; non-state actors play important governance roles; national governments (and sub-national entities) make decisions and undertake actions that have international consequences; and a conglomeration of individuals shape or subvert practices of global health in the implementation and interpretation of policy directives and ideas. Understanding how things 'get done' also requires us to look at policy implementation, not just policy making. So Young's work – and that of a number of others who have also focussed on formal negotiation processes[59] - gives us some useful tools, but addresses only part of the picture.

Second, and following on from this, even Young's diverse group of intellectual leaders (including renowned scientists and others who might be able to influence international negotiations) does not cover the breadth of those that we include in our category of 'hidden leaders', many of whom would have no access to international negotiations but who nevertheless play a role in the governance of global health. As we noted above, accounts of agency and leadership in global health have tended to focus on organisations – international institutions or community based organisations for example – or prominent leaders that fit a particular mould. However we argue that 'hidden leaders' play a fundamental role in getting things done in global health that whilst not prominent in mainstream accounts of global health policy show clear leadership in engaging followers and mobilising around global health issues – just as with the Indian health workers and others in Bhattacharya's history of smallpox eradication.

An analytical model for investigating leadership in Global Health Governance

In outlining an analytical model for investigating leadership in global health governance we build on the insights to be derived from the works of Young, Wight and others, but use them in a way which is at once specific enough to be operationalisable in terms of a program of research and at the same time broad enough to capture a wide variety of different sources, sites and forms of leadership. Our starting point is that that we can best understand 'leadership' in the international

sphere as a specific form of agency. But whilst it is individual human beings who actually exercise leadership, they will be doing so within the particular context of their role ('positioned-practice-place' in Wight's terminology) and often on behalf of a principal (for example they will be acting as a representative of a particular state, international organization, NGO or affected community). As Wight reminds us, however, their individual characteristics as an agent$_1$ with particular life experiences and histories will also matter.

Given the number of institutions that play global health governance roles at all levels, and the huge number of people involved in them, individual agency is obviously a hugely widespread phenomenon involving many thousands of individuals across the world. Leadership (at least successful leadership) is, however, a more limited phenomenon. Leadership requires the individual agent to be pursuing a particular purpose (related to global health), and it also requires intent – a conscious effort on the part of an agent to turn other agents into followers. Who these leaders are in practice is an empirical question – but one which is, we argue, 'researchable' through applying the matrix we set out below to particular areas of global health governance (for example, to examine leadership around a particular disease or policy).

The identity of leaders' (intended) followers is another empirical question, but there are some general things that we can say. And here things become even more complex because there are multiple forms of individual and collective agents that leaders may wish to influence: governments; publics; philanthropists; private corporations; international organizations – and the list could go on. What unites these putative followers is that they must also possess agency (either individual or collective). Thus the goal of a leader in the context of global governance is to *harness the efforts of multiple agents in pursuit of a common goal*. Why some leaders succeed and some fail in harnessing the efforts of multiple agents – what determines their success or failure - is yet again an empirical question. There are, however, indications in the literature about some of the factors that may contribute to successful leadership including power, charisma, the existence of a conducive external environment[60] and the ability of leaders to successfully adapt their message to the social context.

The logic underpinning our belief in the utility of leadership as an analytical concept is, briefly stated, this: global health governance has widely been seen as a policy space characterised by a multiplicity of (often competing) actors with no overall authority capable of setting, still less enforcing, a coherent agenda. Yet despite this things do 'get done' in global health governance, and in some cases there are impressive levels of collective action designed to address particular health problems. Such things do not emerge by chance. Leadership, we argue, is one of the key factors in the harnessing of multiple agents to produce such collective action outcomes.

Of course, it is also the case that structure and not just agency matters. Leaders are agents acting within (and constituted by, as well as constituting) a particular structure. The study of leadership must therefore incorporate this broader context and recognise that "individual leadership approaches in conjunction with contextual and situational approaches are indispensable for understanding causality in international relations and comparative politics today."[61] To understand leadership, therefore we propose an analytical model that proceeds from the insights of Wight, Young and others but which takes into consideration the need to recognise hidden leaders, which is sensitive to structure and which connects leadership to specific outcomes – desired or otherwise. As such we propose five analytical points on which leadership can be analysed with global health: i) position-presence; ii) intent; iii) context; iv); form and v) outcome.

A Five-Point Matrix for Analysis

1. *Identity and positionality.* The first question concerns who is exercising leadership around a particular health issue, policy etc. and (where relevant) on whose behalf they are exercising that agency (e.g. is it as a representative of a state, an NGO or something else). The ability of particular individuals to exercise effective leadership is of course shaped by this positionality, but also by a wide variety of other factors including geography, personal wealth, expertise, cultural relations and chance. As Bill Gates Sr (father of Bill Gates) has pointed out, Bill Gates would not have become Bill Gates if he had been born in a

developing country.[62] However that is not to say that if Bill Gates had been born in Tanzania he could not have exhibited leadership; he may not have established Microsoft or his Foundation, but he could still have mobilised the people around him in pursuit of a specific outcome. Such an outcome may not have had comparable world-wide coverage or impact but it would remain a position and context specific outcome that may have impact given his position and presence. Hence even though identity and positionality are crucial in understanding the constraints on leadership, they should be used to reveal rather than obscure different forms, sources and sites of leadership.

Methodologically speaking, there is clearly a challenge to be addressed in identifying those who are exercising 'hidden leadership'. If they are hidden, how can we find them? Whilst it is important not to underestimate this difficulty, our contention is that it is one that can be addressed, and that designing research in a way that is sensitive to the existence of hidden leaders can enable their governance contributions to be brought out into the open (subject to the caveats we address below about the necessity of leaders remaining hidden in some political contexts). Careful empirical tracing of particular policy making and implementation processes is, we would argue, the key to identifying hidden leaders and tracing their contribution. Bhattacharya, whose work on Smallpox eradication we discussed earlier, serves as a model here: beginning with an awareness that events in Geneva and Atlanta cannot explain everything about the ultimate success of the global Smallpox eradication campaign leads to a project design that combines what is happening at the global level to a careful empirical analysis of what is happening at the national and sub-national level, in the process revealing a whole new set of agents who are playing important (leadership) roles. The challenge for those working in global health governance, therefore, is to expand their horizons beyond the traditional 'policy hubs' and to better engage empirically with global health governance on a more genuinely global basis.

2. *Intent*. Once leaders have been identified, the issue of their intent can be investigated. Questions here include why they took on a leadership role around a particular issue, what their motives were, how these activities fitted with their professional commitments and roles, and how they strategized about the ways to forward a particular agenda and to create followership. Institutions and actors are often keen to take the credit for various successes in global health and distance themselves from perceived failures. To match leadership between individuals or institutions and outcomes it is therefore crucial to map original intent: this requires not just an analysis of an actor's retrospective intent, but a historiographical tracing of their key positions and actions, partnerships and alliances with regard to a specific health outcome.

3. *Context*: Leadership is subject to the context in which it takes place. The political, social, economic and temporal context defines how leadership operates and how (and whether) it produces specific outcomes. Take two examples. First a leader that mobilises resources for health concern X in a time of economic boom may be seen as an effective leader in resource mobilisation, whereas a leader that fails to generate income or protect jobs in a specific sector during a time of economic austerity may be seen to fail. Second a leader wants to roll out vaccination against disease Y. However, the community in which they work distrust the vaccine and the vaccinators, a thought echoed by the opposition government of the time. A leader who is successful in implementing the programme and mobilising support for it may be seen as effective in generating a beneficial output for global health. A leader who decides that this is not what the community wants and uses the resources for other health endeavours may also be seen as effective for responding to the community's wants and the political context of the country even though the public health objective has not been met. In both examples the leaders can be labelled 'effective' depending on the context in which they work and who does the labelling. Therefore in

each scenario of analysing leadership, context determines what is seen as effective/successful and by whom and crucially as well, who is deemed ineffective and why.

Context also shapes explanations as to why a leader may be hidden. A leader may be hidden because they operate at a level that means they go unnoticed. However, they may be deliberately hidden because of the context in which they are working. To be a leader, of course, means being visible – at least to the audience one is trying to persuade. Yet some leaders may deliberately hide from certain parts of society (such as their government) so as to maintain the work that they do or protect the interests of the community they serve.For example, a leader in Polio vaccination in Karachi, Pakistan may deliberately be hidden from groups that distrust and target vaccination workers but may still display a leadership role in mobilising workers and support among other key populations within the area. Hence context is not only about outcomes but is also about why a specific leader is hidden and whether their desire is to remain hidden. This is important to both how we understand leadership in global health but also how we design methodologies (and how we publish findings) that are sensitive to the contextual constraints and opportunities to such leadership.

4. *Form.* Form is perhaps the area in which most studies of leadership cluster, often with regard to how to be a better leader. For our purposes, form should not reveal how to do or improve leadership but necessitates a focus on the different types, skills and mechanisms of leadership used at multiple levels. As noted above, Young identified a number of different forms of leadership (structural, entrepreneurial and intellectual). Better understanding of which form of leadership particular leaders use, and which are influential in particular governance processes, could shed significant light on the way in which things 'get done' in global health governance, and on which sources and techniques are particularly influential within this governance arena. A focus on the form of leadership

exhibited by hidden leaders is once again of crucial importance here; leadership means different things to different people and is context specific, thus the form leadership takes should be shaped to these contexts and positions. It is hidden forms of leadership and the context in which such leadership takes place that is often overlooked or ignored yet hold the most revealing insight into how global health policies work or fail.

5. *Outcome.* The final part of the matrix for analysing leadership is to trace the contribution of the leader to a particular political outcome. Outcomes can be a failed, partial or full realisation of intent. Although we present outcomes last (as it would be in the chronological exercise of leadership) in practice this may be the starting point for research into a particular case study, with an outcome representing a point from which to trace back the identity/positionality, intent, context and form of leadership involved in producing that outcome.

Conclusion

Global health governance is marked by an abundance of agents. However, what is frequently lacking in the current understanding of governance processes in global health is how individual agency impacts upon (and translates into) governance outcomes – raising such questions as who is exercising leadership; why; how; where; and with what effects. This paper has argued for a more holistic examination of the role of leadership in influencing a group of agents to come together in pursuit of common global health goals. This, it seems to us, is crucial to understanding how things 'get done' (and why they don't) in a governance context as diverse and uncoordinated as that which we see in global health. Important in this is the investigation of the leadership that happening beyond the (western) hubs of global health activity.

A focus on leadership at multiple levels and different contexts matters for three reasons. First locating leadership beyond the global health hubs of presumed decision-making we can begin to fully globalise global health by expanding our critical lens to account for the individual agents

mobilising political will and support for a number of different global health outcomes that are unseen when taking a global – i.e. institutional - perspective. Second, a focus on hidden leaders enhances understanding of the challenges, limits and opportunities to the delivery and local formation of a number of global health priorities and how such agency can undermine, reshape, or heighten specific health outcomes. In other words, we can begin to unravel how things get done both within and beyond the elite in global health. Finally, consideration of hidden leaders will help identify any mismatch between context and intent in global health policy. In this regard context is the most challenging and central component of the five point matrix for leadership outlined in this paper.

We propose that any account of leadership has to be drawn from a full understanding of agency that transcends the idea that states and institutions (predominantly western based states and institutions) are the agents of global governance, to account for individual intent and action that is position- and context- specific. In doing so, studies on global health can begin to take fuller account of the hidden leaders that in practice exhibit considerable leverage and leadership in global health. Frequently it is these hidden leaders that get things done, subvert or enact wider forms of leadership and that reinforce or challenge ideas of what the global health agenda should look like. But whilst such a broad view of agency in global health governance seems normatively desirable, it does pose challenges for researchers. This paper has proposed an analytical framework for understanding leadership based on five points of analysis: i) identity/positionality; ii) intent; iii) form; iv); context and v) outcome.

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