The recent outbreak of the COVID-19 pandemic demands imperative discussions in the field of health security and global governance. Traditional studies on health care and global governance have acknowledged the significance of “global” as it rested on the fact that epidemics and pandemics are not restricted within national boundaries. The COVID-19 pandemic has challenged the hierarchical division of norm diffusion. Despite the structural inequalities, the patterns of behavior of various countries, such as China, the USA, Italy, South Korea, and India, in managing the crisis suggest a favorable ground for bringing in the importance of national-level decision-making in the global versus local.
debate. Building upon the arguments from norm theories of diffusion, the article contributes to our understanding that for an effective analysis of the politics of global health governance, the power of local channels in the diffusion of essential health norms cannot be undermined. The article studies the role played by the local-level diffusion processes, in this case, the national state actors in reshaping and integrating essential health norms to make it workable for broader global relevance. As a result, following the norm theories of diffusion, this article analyzes the global–local dynamics with regard to public health in the context of the spread of the COVID-19 health security threat.

Keywords
Covid-19, health security, norm diffusion, global-local dynamics, global governance

Introduction
This article seeks to address the domestic-level diffusion processes of global health norms in the context of the recent outbreak of the COVID-19 pandemic, which came to be known as COVID-19, affecting the lives across several countries. The demographic movement of the virus, intensified by globalization, suggests that a detailed study of global governance in the health security system has to be taken into account. But though a pandemic of such a scale has necessitated the need for global governance, it brings into the argument—how have the domestic diffusion processes affected the conditioning of the global health norms in cases of health security risks? The diverse strategies adopted by various countries at the domestic level in the COVID-19 case suggest that we need to broaden the global–local nexus in the cases of health security threats by analyzing the position of the local in the global and local interface.

In the context of the COVID-19 health security threat, this article highlights the significant role of the national-level diffusion strategies that have influenced the global health security system. This is because while the global governance under the guidelines of the World Health Organization (WHO) has paved the way to deal with the crisis, at the national level, different countries had their own self-regulatory patterns of behavior in dealing with the COVID-19 situation. Despite the
structural gaps when it comes to resource distribution and health care facilities, the COVID-19 scenario has brought back the role of national governments in a new light in their efforts to contain the pandemic, thereby showcasing their influential role in shaping the health security paradigm. The relevance of the study, therefore, lies in the fact that the COVID-19 pandemic showcases the significance of national decision-making in the diffusion of essential health care norms.

It explores the impact of the national policies and how far these local policy channels work in liaison with the international level as active participants in the diffusion process of vital health security norms in case of global health security risks like COVID-19.

According to the exponents of globalization of public health, the transnational spread of epidemic diseases ignores the geopolitical boundaries of the nation-states and made state sovereignty irrelevant under microbial threats (Aginam 2004; Davies et. al 2015). In the past, epidemics such as Ebola, severe acute respiratory syndrome (SARS), and other influenza diseases have brought about the need for global discourse on health security threats (Davies et al. 2015; Novotny 2007). The global institutions like the United Nations (UN) and WHO, along with various other players such as the civil society, governmental, and nongovernmental organizations, have been the heart of the collective action against the global health crises and have achieved remarkable success in containing infectious diseases like HIV/AIDS (Novotny 2007: 23; Sležák et al. 2010). It was claimed that the sovereign state has been considered as frontline actors, but their domestic capabilities were often inadequate and required the support of the global institutions. This discourse on collective collaboration with the WHO and UN along with other nongovernmental and non-state actors in cases of global security threats has downplayed the role of domestic influences in modulating norms to the local settings and the recognition of the local in the global–local operation in health security risks.

It is in this background that we need to situate the recent COVID-19 pandemic and analyze its trends and deviations. The COVID-19 pandemic has reinforced the role of the sovereign and local channels of diffusion in health security threats. The initiatives taken by the respective countries in flattening the rising curve of the virus show that it is vital to expand our analysis at the domestic sphere as norm “integrators” and “facilitators,” thereby exploring their role in the global–local exchanges. The article builds on the wider argument of how norms translate at the national level, which cannot be undermined, and explores the local
attributes of altering and integrating the fundamental health norms. It evaluates how the COVID-19 situation has brought forward the role of “local” as active norm participants in the global health system scenario.

This article does not build on a particular case study, but it takes a cumulative approach of cases through different state responses to the pandemic and links it with the theoretical field of norm dynamics. Our main testing conjecture in the article is to examine the role of local parameters in shaping health care norms in cases of health security threats. It takes into account various government data, statements, and repositories as evidence for developing our arguments. The role of the “local” has got considerable attention in the norms-diffusion literature from scholars like Acharya (2004, 2009), who discusses how the global norm becomes relevant in the regional context through his pathbreaking concept of norm localization.1 Similarly, Cortell and Davis (2000), Checkel (1999), Risse et al. (1999) and Gurowitz (1999, 2006) have analyzed the domestic impact of international norms. Following this line of argument, recent scholars like Hensengerth (2015) and Eimer et al. (2016) have argued for a profound local-level analysis of norm diffusion in recent times.

Therefore, using the theoretical framework of norm dynamics, in light of the COVID-19 health security threat, the study examines the domestic diffusion processes in greater detail and how they work in tandem with the international mechanisms: their role as norm shapers in the global–local nexus by making the global norms applicable in case of health security risks in the local settings. The article is divided into three sections: the first section discusses the evolution of global governance and diffusion of the global health norms. It addresses the present gaps in the literature. The second section gives an overview of the current COVID-19 situation and the national behavior with regard to COVID-19 pandemic. It supports its arguments by analyzing the scopes and obstacles of the local-level variables in containing the disease. Finally, the article concludes by summing up the discussions of the article.

Global Governance and the Diffusion of Global Health Norms: The Gaps in the Existing Literature

In this section, we discuss the existing literature on global governance and public health, thereby addressing the gaps in it. Traditionally, the issues of public health transcended the boundaries of sovereignty and
came under the purview of the “global issues” needing international attention. The past discussions have been limited to the global evolution of the public health norms, focusing on the role of transnational actors and nongovernmental organizations. The twenty-first century saw a course of development in the field of global governance in public health with the UN and WHO as the central organizations at their disposal. There has been a huge flow of global institutions and actors playing a crucial role in the development of global health capacity. Since the 2000s, the UN has come up with a set of its Millennium Development Goals (MDGs) endorsed by 189 states and translated to eight objectives by 2015, which were politically considered as a positive development as it stopped the spread of a number of diseases such as malaria, tuberculosis, HIV, and reduced the child mortality rate (Cockerham 2018). The International Health Regulation (IHR), which was the legal framework for surveillance and containment efforts since the 1950s, was adopted by WHO in 2005 (Davies et al. 2015). The international order consisting of the conglomeration of different sovereign states are in the frontline in dealing with the health threats since the countries alone cannot deal with it and needed collective action in health-associated problems (Novotny 2007: 20–21). Cockerham (2018) argued how in a globalized world order, the transmission of diseases became greatly affected by the effects of contemporary globalization and needed international cooperation and management. Hill (2011), from the perspective of complex theory, argued that the entire network of global health governance, is a complex adaptive system with its multiple and diverse players and their evolving relationships of the global and international interactions. While the states were considered an important part in engaging in cooperation under the ambit of global institutions, there was an attempt to move beyond the state level, owing to the inability of the states to tackle the diseases on their own. The inequalities and lack of capacity of the states, necessitated the need for global governance in the sector of public health, consisting of a range of actors from the transnational to the nongovernmental organization to various private sector firms (Novotny 2007). Scholars like Fidler (2003) and Baker and Fidler (2006) have argued how diseases are not domestic issues but have international considerations and, therefore, discussed why health is important in global agenda. Although this lacuna favored regulations and coordination at the international level, it neglected the importance of the individuality of the state behavior as an important player in the norm diffusion process as it prioritized global over the local. The role of the sovereign has shrunk, and they were
only considered as external players in interceding global norms in controlling the epidemic diseases. Hence, the local was sidelined in the public health sector domain. In the scholarship, a very handful of scholars in the literature have given some attention to the role of the domestic parameters in the context of public health. Scholars like Brown (2014) speak about the national behavior in strengthening the global norms in health system by using the example of the South African system.

The role of the domestic has been given a significant weightage by constructivist scholars in international politics, particularly in the second wave of the literature in social constructivism. Norm literature has strengthened the domestic role of international norms by Gurowitz (1999, 2006), Checkel (1999), Cortell and Davis (2000), Acharya (2004, 2009), and others in the field. Although they had different standpoints, their basic assertion has been the domestic diffusion of international norms. The literature takes a turn with Acharya’s analysis on the congruence-building mechanism at the local level and translation of the global norms to fit the cognitive priors in ASEAN’s context (Acharya 2004: 239). Therefore, local actors modify global norms to make them fit within their cultural settings (Acharya 2004, 2009). Scholars like Hensengerth (2015) have argued that “...hierarchical local-global norm conflicts, has paid insufficient attention to the fact that local actors actively draw on global norms to justify domestic development policies.” Similarly, Cortell and Davis (2000) have emphasized on how domestic-level structures and process affect the compliance with the global norms.

The article borrows from the norms literature to reinforce the role of domestic norms in the case of health security threats and their imperative role as norm integrators in the interplay between global and local. In this global–local nexus, the policymakers collaborate globally at multiple frontiers, but an overemphasis of their dependency on the global institutions, and drive for common interests have led to a hierarchical diffusion of normative analysis. Scholars Stevenson and Cooper (2009) highlight the potential power of the states to modify the diffusion of health norms on the basis of sovereignty. They analyzed that the states play a decisive role in embracing the basic norms of global health governance as they often contest the legitimacy of global governance initiatives if they perceive them to be threats. Such noncompliance by the states suggest that they are not merely at the receiving end of the spectrum.

The utility of state actors and their behavior in norm integrating, building, and shaping in their domestic contexts are not given sufficient
attention: either considered having a contested relation to global or lower in the hierarchy of norm diffusion process in global health. Most of the existing discourse have focused on the limitations of the local or have considered the local as antithetical to the global norm diffusion process. Even if they have been prioritized by some scholars, the tendency has been to highlight the overpowering attributes of the global over the local in the global–local interface.

The socioeconomic challenges, the difference in availability of resources, and the cultural challenges at the local level need an analysis of the influence of national government in norm conditioning and integration. Hence, owing to their own specific contexts, the local variables modify and integrate those norms. Och (2018) has highlighted the role of local human rights activist to integrate human rights norm on the local level in the context of convention on the elimination of all forms of discrimination against women (CEDAW). Similarly, though the health security crisis, on the one hand, needs global intervention, the imbalances operating at the different tiers challenge the local diffusion mechanisms, on the other hand. So, the state actors converting the norms to suit the local settings manifest that their role is not confined to being mediators acting as a go-between but rather convert those norms in the local domain for wider workable global relevance, thereby playing a crucial role in global–local exchanges. The literature has scanty evidence in highlighting the significance of the local in the domain of diffusion of global health norms as compared to solely the global.

Moreover, global institutions regulating norms at the international level have also faced criticisms in the past. WHO has faced bitter criticisms in its manner of dealing with the 2014 Ebola health crisis, leading to debates of its dissolution and creation of a new health agency (Kamradt-Scott 2016). Hence, rather than considering the global versus local, we should expand our focus on how the local operates as norm integrators or facilitators in the global–local nexus. As a result, within the discourse of this normative literature, we can assess the trends of the COVID-19 pandemic. An emerging body of literature has focused on the key trends in global governance due to the COVID-19 pandemic. This literature narrates the role of the national-level dynamics in containing the spread of the virus and the challenges faced by the global institutions. Levy (2020) observes that COVID-19 has perturbed the existing structure of global governance, revealing the “fragile nature” of multilateral institutions in the face of the large-scale crisis, thereby shifting toward the rise in economic nationalism with the resurgence of state power.
Along with it, there has been a rise in authoritarian populism, with intrusive government measures and a move toward voluntary governance, driven by private actors (Levy 2020). However, in this global–local interface, Hassan et al. (2021) takes an opposite turn and pushed their arguments favoring the global. According to them, although international bodies like WHO played the coordinating and technical role, its functioning was constrained by “lack of authority” over sovereign states (Hassan et al. 2021). On the other hand, Peters et al. (2020) argues that a world system, which itself became polarized since the outbreak of the virus, caused extreme difficulty for the WHO to carry out its responsibilities, the particular reference point being the divisive politics between China and the Trump administration.

Therefore, these emerging debates regarding the COVID-19 crisis has shown the need to re-evaluate the norm diffusion literature in the context of health security threats by studying the domestic-level processes in a new light in the global–local interface. The competitive arguments in this emerging body of literature regarding the position of the local in tackling the Covid–19 pandemic require the need to probe into the domestic-level practices in further detail. The methods used by the respective states in their territories to handle the crisis suggest the need to assess the role of the domestic government in conditioning the global health norms. The COVID-19 pandemic reflects that the risk of health security threat intertwined together with parameters such as lack of international collaboration on the matter, different socioeconomic infrastructures, and political structures shows the deviant methods adopted by countries in their own local settings. Hence, political systems do matter in health security threats. How the different political systems (unitary or federal) fare in dealing with the pandemic is beyond the scope of this article. The article rather explores how it has given an opportunity to the local-level variable(s) for the further re-establishment of sovereign authority and tests their role as significant “integrators” or “facilitators” of international norms in the global–local dynamics. In other words, apart from the challenges at the global level—how do the state actors at the ground level within their territorial jurisdiction integrate/facilitate the diffusion of essential health norms? What has been the position of the local channels of communication in the global–local norm dynamics in the wake of COVID-19? Walt (2020) argues that although scholars of international politics have come to believe that the states are becoming less relevant, as other actors such as multinational corporations, nongovernmental organizations, and global markets are taking the center
stage, thereby undermining the significance of sovereignty, the new dangers like COVID-19 tell us how humans turn toward the national governments for protection. This paradox, therefore, suggests the need to focus on the domestic policies and how they exert their influence in the norm diffusion dynamics in the global security threats. The discussion on COVID-19 and the positioning of the domestic policies with regard to the pandemic will be discussed in detail in the next section.

The COVID-19 Pandemic and Global Health Norm: The National Behavior in Norm Diffusion

The role of the local as critical anchors of the diffusion process can be analyzed in the recent global health security threat, which is the COVID-19 pandemic. In the global versus local debate, the tandem between the global and local, where the local is an important stakeholder and has the maneuvering capacity in the domestic diffusion context did not receive adequate weightage. The discussions on these interesting dynamics have somewhat remained limited in international politics. This novel COVID-19 pandemic diverged from previous trends as it brought about the discussion of the local-level analysis in a new manner. The health crisis necessitates the study of the anchoring role of the national policies and how they emerge as norm shapers and integrators in the global–local dynamics in the health crisis. It demands a reassessment of the local decisions as significant balancers in the global–local exchanges and facilitators of global health security norms. The COVID-19 disease started in Wuhan, China, in December 2019 and was declared as a pandemic by the WHO. As per WHO’s records, 416,686 people were confirmed with the disease and 18,589 people were killed as of March 26, 2020, as the disease started spreading across 199 countries (UN Report 2020: 3).

Initially, during the first wave, the WHO and UN were formally unperturbed by the outbreak of the virus as they believed “these chains of transmission can be interrupted” through “proper management of hygiene, proper management of case identification, isolation and social distancing...” (WHO Conference Report at UN 2020). Similarly, the UN in its report, Shared Responsibility, Global Solidarity: Responding to the Socio-economic impacts of COVID-19, discusses in length the necessary steps required to globally contain the pandemic (UN Report 2020). The UN, speaking of the complexity of the virus, asks for a large-scale
multilateral response and acts decisively to quickly prevent the transmission of the virus (UN Report 2020). As the virus devastatingly spread across countries, the prospect of the organizations at the international level seems to be dwindling in effectively handling the pandemic. Moreover, despite guiding the countries at the basic level, both UN and WHO have faced major criticisms in their dealings with the pandemic: first, though the discussions of the UN spoke of call for action, the organization could not come to a resolution in providing a comprehensive plan to tackle the pandemic. The United Nations Security Council (UNSC) only met after 100 days of the pandemic and then failed to come up with any meaningful resolution (Muggah et al. 2020). Despite the UNSC General António Guterres launched the Global Humanitarian Response Plan in March 2020, there seemed to be fluctuations in inking an extensive collaborative resolution to deal with the crisis (United Nations 2020). The UN found itself caught amidst the conflict between its member states, particularly the major powers—USA and China—which prevented it from taking any collective real-time measures in the health crisis. In a statement as issued by Reuters, Richard Gowan, UN Director for the International Crisis Group think tank, had opined “After weeks of China and the US bickering about the origins of the virus, a simple statement from the Council about the need for cooperation would be a reassuring signal” (Nichols 2020). Second, it has also revealed the shortcomings of WHO, which was caught in controversies because of its delay in acknowledging the human-to-human transmission. However, although WHO’s self-reported time line claimed that there was a limited human-to-human transmission chain on January 14, 2020, it did not deny the possibility of a wider spread (WHO Timeline 2020). Furthermore, WHO’s fluctuating statements in the social media was deeply criticized for echoing China’s voice, as it discarded the preliminary evidence for the human-to-human transmission, relying solely on Chinese public health data and, Indeed, praising China for its methods of outbreak control (Givas 2020; National Review 2020; Wolfowitz and Frost 2020). On the one hand, WHO’s dependency on China fueled other countries to immediately take action against the new virus; on the other hand, it garnered considerable criticism. WHO, at the preliminary stage, believed that it was very difficult to gather data about the dynamics of the epidemic in China, while supporting that the country had responded to the clusters in an extremely timely fashion (WHO Press Report 2020a). WHO’s praising for China and its shifting statements about the risk calculations from stating “incorrectly” about the risk to being “moderate,” to claiming it as an error and “potential pandemic” have made its member states
divisive, thereby making WHO vulnerable to misinformation and power politics of the countries (Hoonhout 2020; Thuburn 2020). In the context of the supranational and international organizations, the pandemic has invoked serious questions of efficacy as it revealed “schism between North and South European states” after the financial and migrant crises (Klaus et al. 2020).

The global cooperation and transparency on health norms seemed to be lacking as both WHO and UN have oscillated midair with the members tossing the ball at one another’s courts for bringing out clear policies. While the first wave exposed the problems faced by the institutions in disease surveillance and response coordination, the second wave further manifested the challenges faced by the global bodies for building a collective strategy for vaccination. The COVAX program, co-led by the WHO, Gavi, and the Coalition for Epidemic Preparedness Innovations (CEPI) alongside the delivery partner the UNICEF was meant for equitable distribution of vaccines but faced immense struggle to meet the needs of the countries, particularly the developing countries. The COVAX facility was supposed to manage at least two million doses of COVID-19 vaccines for distribution in the low- and middle-income countries (De 2020). Despite the request from WHO officials to use the COVAX facility for the procurement of vaccines, most of the major wealthy nations have prioritized their own domestic markets, sourcing vaccines directly from the manufacturers, through advance-purchase agreements. Due to this stockpiling—popularly called as “vaccine nationalism”—by a small group of wealthy nations such as Australia, Canada, Japan, the UK, and the USA, the COVAX program has fallen short of delivering the planned supplies for the year 2021 (Chatterjee et al. 2021; Guarascio 2021). This “me-first” attitude by the developed countries, “wrecked COVAX’s ambition to take overall charge of the global fight against pandemic” (Guarascio 2021). The COVAX, which was based on the self-financing aid from the high-income countries, found itself crippled as it failed to engage the wealthy nations in the global vaccination drive. As these countries favored their own commercial interests by signing bilateral deals with individual vaccine manufacturers, their interest in COVAX faded (Usher 2021).

In light of the lack of effective mechanism delivered by the two biggest international platforms, the state actors have adapted their own self-regulatory mechanism, modulating the global health norms, and emerged as dominant norm facilitators in the global–local norm dynamics in both the first and second phases of the pandemic. Though the states have faced hurdles in their own territorial sphere of operation, we find
them to be active role-players in this global health security threat, integrating the necessary health norms to contain the virus in their population. This pattern shows the relevance of the local-level analysis in the COVID-19 case. While, on the one hand, it has given them the opportunity to reclaim sovereignty, it has also shown them to be important stakeholders as norm facilitators in the global health security system. The COVID-19 case also challenges the dichotomy between global and local by emphasizing on the role that the local played in shaping the norm dynamics at the global–local interface. Therefore, at the national level, the various policies/models adopted and the constraints faced by the countries at the ground level during the spreading of COVID-19 point to the need for local-level understanding as important norm balancers in the global–local relationship without giving an upper hand to the global.

Regardless of the criticisms faced by WHO, it had issued an initial framework of guidelines, giving a starting direction to state actors. It called for a “comprehensive” approach to “break infection and prevent the chains of transmission” through testing and isolation (WHO Press Report 2020b). The UN also suggested tailored response to countries, depending on the countries having no cases, sporadic ones, clusters, or community transmission, ensuring effective physical distancing, quarantines, isolation, lockdowns, and contact tracing (UN Report 2020). However, in the absence of a global plan, the onus of responsibility seemed to be pushed on the state actors who have, in turn, played a larger role in integrating the global health norms, following own self-regulatory adaptive practices at the ground level. In the WHO’s directives to control the disease by adopting a “whole-of-government” and “whole-of-societies” approach (MoHFW India 2020a), we find that the state actors had their unique internal policies to prepare themselves for the pandemic and contain the spread of the virus, thereby shifting the focus of our understanding from global- to local-level methods. The article expands the views in these specific themes/areas to study and analyze the national behavior in facilitating the global health norms: creating awareness, risk preparedness, and controlling the infection.

**National Behavior: Awareness, Risk Preparedness, and Control of COVID-19**

Different countries had a vital role to play at the national level in spreading awareness, preparing for the risks and mechanisms of control
regarding the COVID-19 disease to their respective population, which was extremely important for such a highly transmissible disease. We find that the states had modulated crucial awareness policy among their own population, thereby facilitating an environment of alertness on the ground level about the health security risks of COVID-19. The domestic state actors were the motivating forces who used the support of powerful technology for creating awareness and surveillance mechanisms to ensure accurate contact tracing and keeping people in mass quarantines for preventing the spread of COVID-19 among communities. China, for example, used the help of new technologies like the use of big data and artificial intelligence to strengthen contact tracing and managing priority population to provide early clinical treatment (WHO-China Joint Mission 2020). The Indian government also used technological support for preventing misinformation of COVID-19 and the spreading of the required information about the pandemic, particularly among the rural population, through radio campaigns like “M-I-L Kar Ladengey” (The CSR Journal 2020). The Indian government also launched its individual programs such as the Arogya Setu mobile application through a public–private partnership to enable people to assess the health risks of the COVID-19 pandemic (WHO India Report 2020b). South Korea too used advanced technology and innovation in its local settings for disseminating area-specific information about the health threat via mobile emergency alerts, applications, and websites (UNDP Seoul Policy 2020). Keeping the public informed through transparent disclosure of real-time information and daily briefings through media channels by Korea Center for Disease Control and Prevention (KCDC) was the central feature of the government’s response to the COVID-19 crisis (UNDP Seoul Policy 2020).

Since January 2020, almost more than 140 countries have responded to the COVID-19 outbreak by implementing policies aimed at containing the virus by restricting movement and social distancing and even adding stimulus packages to boost up the economic impact (Financial Times 2020). At the individual level, the countries with varying political structures and socioeconomic resources have adopted their own distinct strategic policies in the context of health security to contain the transmission of the virus. As the diverse state actors realized that self-isolation along with personal hygiene was necessary to flatten the curve for the spread of the disease, they opted for different lockdown plans for prevention. The Chinese government used strict and thorough measures such as complete lockdown of the epidemic center at Wuhan and
surrounding Hubei province, as well as major cities of Beijing and Shanghai (WHO-China Joint Mission 2020). In an interview, the WHO representative to China, Dr. Gauden Galea, has claimed that

...the extraordinary efforts made by the Chinese population to limit transmission of Covid-19—through social distancing, quarantine, and careful hand and respiratory hygiene—has made a difference. (Interview WHO Europe 2020).

China followed a phased approach to contain the virus: prevention of exportation of cases from Wuhan to other provinces, reduction of the intensity of virus, and reduction of the cluster of cases (WHO-China Joint Mission 2020). China’s initial national approach was accompanied by a science- and risk-centric approach with tailored implementation at various provinces in the country (WHO-China Joint Mission 2020). In India, the Modi government at the center used a constitutional–legal framework and imbibed an early stringent complete lockdown model. The Modi government “in exercise of the powers under section 6(2)(i) of the Disaster Management Act, 2005, issued an order for State/UTs prescribing lockdown for containment of Covid-19 epidemic in the country for a period of 21 days with effect from 25 March 2020” (WHO India Report 2020a). The government also imposed heavy passenger restrictions, banning international flights and interstate travels, only allowing the flow of essential commodities (WHO India Report 2020a). Along with this, the government also ensured strengthening of surveillance and health capacity, together with mandatory physical distancing (geographic quarantines practices) through Integrated Disease Surveillance Programme (IDSP) (MoHFW India 2020a; WHO India Report 2020a). The government established a “scenario-based approach” to deal with scenarios such as travel-related case reports, local transmission, large outbreaks that are amenable to containment, widespread community transmission, and India became endemic for COVID-19 (MoHFW India 2020a). For this purpose, an interministerial coordination group and center–state coordination channels were created (MoHFW India 2020a). At the micro-level, the Indian government came up with a micro-plan to tackle the local outbreak of COVID-19 based in defined geographic areas by mapping the infected regions and allocating various human resource functionaries like health care workers consisting of accredited social health activist (ASHA)/Anganwadi workers/auxillary nurse midwife (ANM) along with a supervisory medical officer for recognizing infected clusters, active surveillance, and contact
tracing (MoHFW Micro-Plan India 2020b). The lockdown strategies of all the countries have been very different from one another and so have been their mechanisms to chart out the paths to ease down lockdown measures (Financial Times 2020). East Asian countries, including Vietnam and Korea, were the first movers like China to implement containment measures, while Europe, North America, and Africa took a longer time frame to implement measures (Financial Times 2020). Apart from time frame, the lockdown dynamics at the ground level had been very diverse, across the countries, suiting to the local settings. While India, France, Italy, and the UK implemented mandatory and most restrictive quarantine norms, some other European countries such as Spain, Germany, Italy, and Denmark started with strict measures, which gradually eased down (Kaplan et al. 2020). In fact, governments across the various European countries, which imposed strict measures such as restricting borders and banning public gatherings had planned to lift sanctions at different speed levels (Parson 2020). The USA went for a lockdown much later, and, here, the individual states have been more proactive in imposing a “patchwork” of lockdown policies (Financial Times 2020). In comparison to other countries, it was the state authorities in the USA that were the real first movers as compared to the federal government that declared a state of emergency independent of the national emergency, thereby giving an upper hand over the federal government to halt the spread of the virus in the communities (Vinjamuri 2020). Hence, Vinjamuri (2020) claims that in countries such as China, Singapore, South Korea, the USA, the UK, and the rest of Europe, the divergent policies have been the product of state capacity and legal authority, which simultaneously highlight the optimum role played by centralized state authority, federalism, and private sector. Among the Nordic countries, Sweden’s political structure adopted its model of relaxed lockdown to contain the virus, where the citizens took self-responsibility of social distancing but allowed the businesses and primary schools to remain open, as the government let the society to function without restrictions. (Anderson 2020).

Information and communications technology (ICT) used for contact tracing and surveillance to detect infected people became a significant part of many of the countries, but the democratic government of Southeast Asia, like South Korea, seemed to be the flagbearer as it effectively used aggressive surveillance, contact tracing, and rapid testing methods to contain the virus instead of a widespread lockdown model followed by China. South Korea’s measures to tackle the health
security threat was based on a fast-paced 3T strategy of “trace, test, and treat” instead of lockdown or ban on arrival from abroad except a few countries (Yilmaz & Aydin 2020; Syaifani 2020). South Korea went through a drive of virus testing program with approximately 85 such stations across the country in conjunction with nearby municipal hospitals or public health centers (UNDP Seoul Policy 2020). Quite similar to South Korea, Hong Kong, Taiwan, and Singapore too have used targeted strategies: “relied on tools such as robust testing, contact tracing to identify people who came in contact with infected people and may have been exposed to the virus, mass surveillance, isolation of the ill, and stringent travel restrictions” (Kirby 2020). The Singapore government also went for a “Circuit Breaker” model by amplifying the “safe-distancing measures to reduce movement” and thereby “minimise the further spread of COVID-19” (Government of Singapore 2020).

With reference to this diverse behavioral pattern of the different countries, it can be said that although WHO initiated the preliminary guidelines, at the micro-level, the specific state actors, depending on their political structure, nature, and other local conditions, were the determinants of the norm integration of the essential health norms for tackling COVID-19. This does not mean that the political structures of these countries have not faced criticism. “Austerity measures, sclerotic leadership and civic repression have all been cited as likely causes of political inadequacy” (Klaus et al. 2020). But the role played by the national leadership in tackling the pandemic has definitely brought about a focal shift in which health care norm diffusion was not previously visualized.

At the individual level, there have been isolated pockets and active participants in shaping the various quarantine measures, thereby modifying them according to their local settings. The local channels are significant stakeholders in the norm diffusion process at the global–local nexus stressing the power of the local agencies in shaping the way the norms translate into various societies, making them globally relevant in the domestic spaces.

Additionally, we find that while the countries behaved as isolated pockets with some explicit decision-making elements in their sphere of operation, they have often been influenced by the features of other countries, thus adopting and modifying those practices according to their distinctive local situation. This suggests overlapping patterns of behavior of cross-diffusion facilitated by the state actors themselves, with varying intensity, according to their local conditions. The overlapping attributes showcase how the local behavior and norm
conditioning have wider implications and are not just confined to their own domestic spaces. Therefore, instead of any central organization facilitating cooperation among countries, we find that a unique strategy adopted in the context of a specific country has inspired other countries to test in their own territorial sphere to restrict the spread of the virus. Regardless of having different backgrounds of political and health infrastructures, many countries have borrowed the norms suitable for their own local conditions, reflecting how local channels, thus, can have international implications in facilitating the reduction of COVID-19. This challenges the top-down model of diffusion and reiterates the significance of the local as crucial norm balancers in this global–local cycle of norm diffusion. It also indicates the importance of the local in the global–local exchanges. Despite the criticisms, we cannot overlook or bypass the fact that it was China’s lockdown strategy at the local level, which influenced the WHO and other countries at the international platform, for early detection and prevention of the disease. China’s model has been very effective as it implemented a “differentiated, location-specific response to limit transmission so that public health measures are tailored to the differing realities on the ground” (Interview WHO Europe 2020). China’s differentiated and customized response within its country led to the suggestion by WHO representatives that “responses must be tailored to the local context” (Interview WHO Europe 2020). “China’s national approach of rigorous and uncompromising use of non-pharmaceutical methods, to contain transmission of Covid-19 in multiple settings provide vital lessons for global response” (WHO-China Joint Mission 2020).

The COVID-19 scenario also establishes the fact that apart from the translation of health norms in specific contexts, the local channels have also played a crucial role in global and local exchanges of norms, leading to shared diffusion and integration chains, thereby challenging the global–local dichotomy. As we find, China’s policy of containing the health threat, which not only helped other countries in their capacity to contain the threat but also international organizations like WHO, while working consistently with the Chinese authorities learned about the virus, spectrum of clinical disease, and effective ways to stop the transmission (WHO Plan 2020).

Hence, individual local responses, with the domestic policies at the forefront, had global manifestation, showcasing the significance of the local channels in the global–local tandem of norm diffusion. The countries at an individual scale adopted diverse strategies to prevent the
transmission of the disease among its population, and, at the same time, their respective experiences led to shared/cross-diffusion of techniques, which the countries have altered and modified according to the need of its own “locale.” This led to complex local channels of transfer and integration of health security norms, where the domestic processes played a pivotal role by adopting, maneuvering and amalgamating the health security norms in multidimensional ways. At the national level, the result of the policies adopted by the state actors have not only shown their capacity as significant norm integrators within their sovereign reach but transcended to other countries as well. In the norm diffusion ladder, the domestic is not necessarily at the lower level of the echelon for mediating global health norms. They are essential norm shapers who besides influencing the norm diffusion process at the level of the domestic, exhibit their norm moderating power, which has wider international implication in the global–local nexus.

Moreover, the global health crisis, which needed multilateral responses, took a back seat, and commitments of such cooperation for vaccines, medicines and personal protective equipment (PPE) did not bear much fruit. Alternatively, to illustrate the processes of local agencies, we find that the state actors, through bilateral channels, facilitated the advancement of new levels of cooperation for accessibility to essential health care items in the COVID-19 crisis. Taiwan and the USA went for bilateral cooperation to supply PPEs to each other, and the mutual assistance arrangement was recognized in a joint statement, which was signed by both the countries (Lim 2020). In the joint statements, the two countries have claimed to strengthen US–Taiwan consultation and cooperation, that they will cooperate on a range of activities under a partnership such as research and development of rapid tests, vaccines, medicines, exchange of equipment, and better contact tracing techniques (US–Taiwan Joint statement 2020). Taiwan made a strong impact at the global scale through its humanitarian assistance measures of sending millions of medical provisions to its other diplomatic allies and the European Union (EU) member states in Northern, Central and Eastern Europe (MOFA Taiwan 2020). This also opened new zones of cooperation between Taiwan and other countries like Taiwan’s first cooperation with the Czech Republic led to the setting of a partnership to develop and manufacture rapid tests and vaccines (Asia News.it 2020). Even new scope of cooperation through this health diplomacy could be seen in the South Korea–Africa relationships as South Korea sent test kits to Madagascar. Government-to-government approach or G2G to assist
Indonesia’s COVID-19 emergency shows Korea’s collaborative approach toward Asian neighbors, including Indonesia (Syaifani 2020). These new avenues of cooperation among the countries in the case of the COVID-19 crisis have reshaped the world order as it reflected how the state actors or local channels of communications have been in the driving seat to tackle the pandemic.

Further, these new avenues of cooperation could be seen in the second phase of the pandemic in the form of vaccine diplomacy. Due to the burgeoning gap between the rich and the poor countries in procuring adequate vaccines through the COVAX program, there has been a rise in the global diplomatic efforts for fair distribution of vaccines through what is known as vaccine diplomacy. The inequity of global vaccine access also converted the vaccines into “diplomatic bargaining chips” as it provided the ground to build up the soft power diplomacy as an important foreign policy tool (Pannu and Barry 2021). On the one hand, while WHO officials criticized vaccine diplomacy as a “geopolitical maneuvering” (The Times of India 2021), the outcome of this practice brings into the limelight the new bilateral channels regulated by national governments to support the low-income countries to obtain essential COVID-19 vaccines. In this context, Tran (2021) mentions, “many observers believe that countries like Russia, China and India are engaging in the vaccine diplomacy to exert their influence, the recipients of the vaccine probably view the vaccines as better than no vaccines.”

Apart from bolstering the geopolitical bilateral ties between countries, it also showcased how the national governments of the countries have tried to promote a network of equitable distribution of essential health services to meet the global vaccination goals. China’s vaccination drive was a state-led engagement, where the homegrown national vaccines were produced, marketed, and provided to countries left behind vaccine inequity (Lee, 2021). Whereas the Western countries have been criticized for hoarding vaccines, in vaccine diplomacy, the rising powers like China and India seemed to play a significant role in sending vital COVID-19 vaccines to the neighboring countries. China categorized the vaccines as global “public good” and provided vaccine aid to a number of developing countries, particularly promising priority access to the ASEAN and African countries (Yang 2021). India, on the other hand, under its diplomatic mission named “Vaccine Maitri” emerged as one of the major suppliers of COVID-19 vaccines to its neighbors in South Asia such as Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka, and other developing countries such as Myanmar, Mauritius, and
Seychelles to name a few (Dhar 2021; Khan and Dhama 2021). Russia too entered early in the vaccination diplomatic drive, offering the African Union 300 million doses of the Sputnik V vaccine in February along with financing packages to distribute the vaccines (British Foreign Policy Group 2021).

Hence, the COVID-19 vaccination drive highlights the debate between vaccine nationalism versus vaccine diplomacy, which necessitates to strike a balance between securing vaccines for its own population and supplying vaccines to the needy low-income countries. It is observed that in this debate, the national governments emerged as key players in deciding essential health security norms, relegating the WHO to the background.

Therefore, three trends that can be observed from the analysis about the role of the local regarding containing the COVID-19 pandemic are as follows: First, the nature of the pandemic that has kept the global governance at the edge of its seat suggests that while the national policies to contain the virus have been varying in the different states, the balancing wheel seemed to be largely in the hands of the local channels of communication. Second, they have been important norm integrators within their sovereign threshold, who adopt, create, and modify global norms according to their own specific context. Third, the local channel of actions has a transnational impact through their shared/cross-diffusion of the local strategies. However, it is a bottom-up approach as compared to the traditional top-down international pressure (Och 2018: 5) by any of the international organizations. Finally, the COVID-19 vaccination drive brought into the frontier the debate between vaccine nationalism versus vaccine diplomacy, where the national governments shaped the contours of the distribution of essential health security assets.

**Concluding Remarks**

The article unpacks the role of the local-level dynamics in the diffusion of essential health norms in case of global health threats like the COVID-19 pandemic. Although the local-level discussions have been acknowledged in scholarly literature, particularly in the norm literature, there has been a limited approach to understand the applicability of the local parameters in shaping the global–local tandem in norm dynamics. Despite advancements in the literature in the global–local debates by norm scholars, there has been an overarching emphasis on the global
over the local. We see this gap between the global and local, particularly in the context of global health governance discourse, and owing to the trends of the epidemic, the national contributions were confidently sidelined or considered to be dependent on the international organizations for tackling the diseases in previous analyses. The unique aspects of the local parameters were either scantily discussed, completely dismissed, or taken for granted in the global–local exchanges. However, the COVID-19 pandemic shifts this focus of the study from global methods to tackle the pandemic to the local channels as the national policies emerged as significant stakeholders in the global–local interactions. Hence, distinctive and dynamic aspects of local diffusion mechanism need to be evaluated through a wider lens.

COVID-19 highlights that the local dynamics were at the forefront in containing the virus, with the national policies being the significant norm balancers in the global and local interplay. It negates the international organizations to be the lead actors in channelizing essential global health norms. While international organizations like WHO initiated the guidelines, essential health norms were integrated by the local state actors according to the specific environment of their local contexts. The national actors have adopted, modified, and established the various lockdown measures to contain the health risk, according to their own political structures and local socioeconomic conditions. While they have integrated the norms in their own specific contexts, their local experiences have inspired other countries and also global organizations, challenging the traditional transnational top-down diffusion and highlighting how the local gives back to the global in the down-top process. On the one hand, they have adopted and integrated the norms in their local context; On the other hand, their experiences have led to shared/cross-diffusion of techniques, urging the need to look at the national governments beyond norm conciliators. Hence, the role of local is not only confined to mediate global norms to the local, but they alter/modify and give back to the global in a myriad global–local norm dynamics.

To conclude, the article, applying the theoretical tool of global–local norm diffusion, analyzed the lacunae of global health governance discourse and challenged the hierarchy of the global over local in containing epidemic/pandemic at the international level. The COVID-19 challenged the previous methods of containing the virus from a top-down approach. The strategies adopted by the countries to tackle the norm reiterates how in the global–local context, the local played a larger role in restricting the pandemic. In contrast to the multilateral
collaborations, which took a back seat in the pandemic, the local-level leadership along with their diverse approaches and challenges were the driving force to stop the spread of the pandemic. Theoretically, it further strengthens the role of the local as to having equal weightage in the global–local norm balancing and not simply external entities in interceding the global norms. Rather, the pandemics enlarge the spectrum of research of the local–local influence and local–global influences by exposing the power of local channels in modifying/integrating and shaping the norms in their local context in cases of health security threats. Therefore, local processes shaped the road map of the global health norm dynamics in the light of the pandemic in the global–local structure.

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1. The national domestic level and the local level have been used interchangeably in the article, following Acharya’s discourse on norm localization. While he used it mainly at the regional context of ASEAN, the theoretical tool has been used to analyze specific domestic-level diffusion process by scholars like Hensengerth (2015) to explain local/domestic contestation of global norms in Cambodia’s hydropower. Eimer et al. (2016) also used it to explain the localization of international norms in the context of commodification of knowledge in India and Brazil. For a further detailed analysis of the domestic diffusion, check the second wave of constructivist scholars like Checkel (1999) and Cortell and Davis (2000).

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