

Transnational Norm-Building in Global Health: The Important Role of Non-State Actors in Post-Westphalian Politics

Paper for the Sixth Pan-European Conference on International Relations, Turin (12-15 September 2007)
Draft, do not cite without permission

Wolfgang Hein / Lars Kohlmorgen

Outline

Introduction

1. Norms and the norm-building cycle
 2. Economic, social and cultural human rights and the right to health
 3. Transformation from a Westphalian international system to a post-Westphalian global system
 4. The case of health: From “health for all” to “access to medicines”
 5. Conclusion
-

Prof. Dr. Wolfgang Hein
German Institute of Global and Area Studies
Neuer Jungfernstieg 21
20354 Hamburg
Germany
Tel.: +49-40-42825-558
hein <at> giga-hamburg.de
staff.giga-hamburg.de/hein
www.giga-hamburg.de/ghg (research project Global Health Governance)

Dr. Lars Kohlmorgen
University of Hamburg
Centre for Globalisation and Governance
Allende-Platz 1
20146 Hamburg
Germany
Tel.: +49-40-42838-7247
lars.kohlmorgen <at> uni-hamburg.de
<http://www.ipgovernance.eu/project/kohlmorgen.html>
www.giga-hamburg.de/ghg

Wolfgang Hein is Head of the Research Programme “Transformation in the Process of Globalization” at GIGA German Institute of Global and Area Studies and Professor at the Institute for Political Science at the University of Hamburg. His main research interests are in the fields of globalization, sustainability and development and global governance with a focus of health.

Lars Kohlmorgen is senior research fellow and lecturer at the Institute of Political Sciences, University of Hamburg and associated research fellow at the GIGA German Institute of Global and Area Studies. His main research interests are in the fields of International Relations, globalization, global governance, global social policy, civil society and politics of intellectual property rights.

Introduction

The International Compact on Economic, Social and Cultural (ESC) Human Rights constitutes codified international law, but many of its provisions are still far from being respected. This paper discusses the hypothesis that global civil society strengthens subsidiary norms (as the right to access to essential medicines) and that the successful fight for the implementation of the norm “universal access to essential medicines” proves the discursive power of civil society organisations (CSOs) to push for the implementation of these norms. Furthermore, we argue that CSOs and other non-state actors are even involved in the implementation of subsidiary norms directly.

We will explain that this important role of CSOs in the norm-building process is related to the transformation of international relations dominated by nation-states to a global system of politics including a variety of non-state actors and hybrid institutions challenging the dominant role of states. Whereas in the Westphalian system the nation-states and their governments were the main institutions respectively actors in setting and implementing norms (the *norm carriers*), this changed with the greater relevance of the global level of politics and of private actors at least in some policy fields. We will analyse the role of CSOs as norm carriers in the norm-building process for the field of access to medicines and use the Finnemore/Sikkink approach of the *norm building cycle* as a starting-point. We suggest that – while international law continues to depend on the acceptance of legal norms by nation states – in Post-Westphalian global politics multiple actor constellations are playing a growing role in substantiating the content of primary norms of international law by subsidiary norms, which are to a large degree implemented through non-state actors in an increasingly global society (section 1). In section 2 we argue that ESC human rights constitute a field of international law, in which this interaction is of particular importance, referring to the field of health. Section 3 explains the dynamics of Post Westphalian politics related to norm-building processes and section 4 analyzes in more detail the norm-building process in the case of access to essential medicines. This is basically an explorative paper using the evidence of a research project on “Global Health Governance and the Fight Against HIV/AIDS” (Hein/Bartsch/Kohlmorgen 2007) to propose some ideas to the discourse on ‘Norm-building in a Global Society’.

1. Norms and the norm building cycle

We understand a *norm* – following Martha Finnemore and Kathryn Sikkink (1998: 891) and in accordance with most of the scholars – as “a standard of appropriate behavior for actors with a given identity”. In contrast, *institutions* describe the way norms and behavioural rules are interrelated, combined and structured in a “common surrounding” or – referring to a definition by March and Olson – “for specific groups of actors in specific situations “ (Finnemore/Sikkink 1998: 891). With *subsidiary norms* we refer to norms that are supplementing primary norms fixed in international law and that are not necessarily legally binding for nation-states (or, at least, do not imply serious sanctions if they are not respected), but which might in fact constitute a necessary component for a substantial implementation of international legal norms. In contrast to primary norms, which are agreed upon – in spite of the transformations of the international system – by nation-states and therefore need the persuasion of

a critical mass of nation states (Finnemore/Sikkink 1998: 895), non-state actors may play a crucial role for implementing subsidiary norms.

To better understand the dynamics of the norm building process and the role of the different involved actors (or: of CSOs in our case) we refer to policy analysis (vgl. Anderson 1975; Windhoff-Heritier 1987; Hill 1997; Sabatier 1999; Sutton 1999; Jann/Wegrich 2006; Pollard/Court 2005) and to the approach to theorise norms by Finnemore/Sikkink (1998). They conceptualise a norm “life cycle”, distinguishing “norm emergence”, “norm cascade” and “internalisation”. We modify their approach and differentiate between following three stages of a norm building cycle:

1. *Norm generation*: Norm entrepreneurs (Finnemore/Sikkink 1998) – we prefer to call them *norm carriers* – such as CSOs, International Governmental Organisations (IGOs) and governments raise a certain issue and try to disseminate and generalise these in the general public and among decision makers by trying to make the underlying ideas and concept hegemonial by making claims and framing the discourse. As the acceptance and implementation of norms depends mainly on governments and nation-states it is most important to convince a critical mass of governments and decision makers to agree to the norm and to support its dissemination. However, in this phase of agenda setting civil society actors play a very important role as it is an open and not formalised process of communication. At this stage, of course, the further diffusion of the norm can fail, if the norm carrier cannot convince a critical mass of the other actors and thus cannot put through and generalise his ideas.
2. *Norm diffusion / norm acceptance*: If a critical mass of states – but also of the general public – is convinced the norm reaches the “tipping point” and is accepted by more and more governments and other actors – Finnemore and Sikkink (1998: 895ff.) call this “norm cascade” – it diffuses and results in a broad acceptance. Whereas the general public – both in the national and global sphere – is important for a norm to gain recognition, the formal acceptance of norms normally occurs in state formal institutions such as governments and IGOs.
3. *Norm implementation*: After the norm is accepted by a majority of actors (including critical actors) it is implemented. We already differentiated between primary and subsidiary norms in the global realm and outlined that the latter can also be implemented by non-state actors, e.g. if they run programmes to provide drugs in developing countries. As subsidiary norms are often accepted by almost all actors including the governments of critical nation-states (such as ‘fighting poverty’ or ‘access to medicines’) but not implemented by all actors (in particular nation-states), in some cases civil society actors are the main implementing force.

In this paper we take up elements of Finnemore/Sikkink’s concept of the norm-building cycle to understand important elements in the process of norm-building. However, there have been some critical comments to this framework in the academic discourse. Besides the claim that its theoretical grounding and justification is rather thin (Hoffmann 2000; Cortrell/Davis 2005: 7f.), some scholars point at the perception of norms as somewhat static. According to these scholars Finnemore/Sikkink’s concept assumes that a norm retains its original meaning

throughout the norm life cycle. This disregards that most norms are modified – sometimes even significantly – in the conflictive process of norm-building (cf. van Kersbergen/Verbeek 2007 218ff.). Bearing in mind these general points of critique and taking into account the post Westphalian world and the importance of subsidiary norms in global governance we propose to supplement Finnemore/Sikkinks approach in at least three aspects:

(a) By distinguishing between primary and supplementary norms on the one hand and between legal and socio-political ‘standards of appropriate behaviour’ on the other, we stress the need to distinguish between different categories of norms. In particular, also in the academic legal discourse, a certain ‘hierarchy of norms’ between primary and subsidiary norms is observed. Within a national legal system, these two levels will mostly be defined by law, backed by the state monopoly of legitimate use of force. In international politics, however, frequently rather general rules are defined, which lack a specification for effective implementation in legal form, as there is no consensus between the many states on that level. With the transformation to a post-Westphalian system, frequently (see section 3.2 for exceptions) implementation depends on the development of socio-political norms by transnational non-state actors which might increasingly be able to use their discursive power to implement norms. While subsidiary (or secondary) norms are developed as a means to guide the implementation of primary norms, they are much more contested if they ‘only’ take the form of legally non-binding socio-political norms. Thus, this type of norms often have to take a long way before they reach the “taken for granted quality” that Finnemore/Sikkink (1998: 904) assume for internalised norms in general. They describe these norms as not being controversial. In contrast, we argue that socio-political subsidiary norms are contested and controversial during and even after their implementation, but that they are still an important substitute for of legally guaranteed secondary norms. This paper explores these mechanisms and conflicts with respect to ESC human rights law in the case of health and access to medicines.

(b) Also in the phases (2) and (3), not only states, but various types of global society actors play a crucial role, as the global polity is increasingly constituted by networks of various types of powerful actors, not only by the interaction of states. The norm of “universal access to essential medicines” is implemented through a complex web of activities by states, CSOs, private corporations, public-private partnerships etc.. The behavioural standard – though being embedded into ESC human rights – is based on a ‘logic of appropriateness’ (March and Olsen 1989) supported by a particular strength of discursive power and persuasion (cf. Payne 2001) in a system of global politics. This argumentation is slightly different to the concept of Finnemore/Sikkink, who include nongovernmental organisations as organisational platforms in the phase of norm emergence, but see no role for them in the other two phases (cf. Finnemore/Sikkink 1998: 899).

(c) Due to this character of post-Westphalian global politics the three phases cannot be as clearly separated as proposed by Finnemore and Sikkink. This makes the question “When does a norm become a norm?” more difficult to answer, but it also points to the fact that the “identity of actors” who act according to a specific norm is increasingly determined in a transnational space. “Access to essential medicines” might be guaranteed by national health systems, but where health systems are not in a position to implement this guarantee, implementation depends on transnational networks like CSOs and Public-Private Partnerships, who

are able to create islands of norm implementation already in early phases of norm development.

2. Economic, social and cultural human rights and the right to health

In particular in the Western world, civil and political rights have been treated for a long time as the core of human rights. In effect, the inclusion of ESC Rights in the Universal Declaration of Human Rights and the negotiation of an international covenant on ESC Rights has been largely pushed by developing and socialist countries. Though the World Conference on Human Rights in Vienna (1995) declares that both are “universal, indivisible and interdependent”, there is a fundamental difference between them: While civil and political rights refer to specific rights of citizens (and also foreigners) against the state and their protection against the illegitimate use of force (which is basically independent on the level of economic development), ESC rights refer to the duty of states to deliver specific goods. Frequently one finds the distinction between “negative rights” and “positive rights”. In the case of ESC rights, a state may simply not dispose of the necessary resources to deliver these goods. Article 2(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes this problem, stating that a state ought to implement these rights “to the maximum of its available resources” and “with a view to achieving (them) progressively”. In addition, article 11 stresses the importance of international cooperation.

This leads to a significant difference with respect to extra-territorial obligations: In general, pushing other states to respect civil and political rights corresponds to classical problems of diplomacy, using various means of power and hegemonic relations to make other states comply with an international agreement. The question of extra-territorial obligations basically refers to the conditions under which military force might be used to force compliance. In the case of ESC rights, however, the situation is much more complex as it implies a transfer of resources without the existence of institutions to make binding decisions on the level and character of resource transfers. Furthermore, as has been argued in the human rights discourse (Windfuhr 2005), it should oblige member states not to take over international obligations which might have adverse effects on the realization of ESC rights. This is a point which is of particular importance concerning e.g. the interdependencies between the TRIPS Agreement and social rights in the field of health.

The ICESCR states that all ‘States Parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (Art. 12.1), which includes ‘The prevention, treatment and control of epidemic, endemic, occupational and other diseases’ as well as ‘the creation of conditions which would assure to all medical service and medical attention in the event of sickness’ (Art. 12.2) (http://www.unhchr.ch/html/menu3/b/a_cescr.htm). These documents, however, are rather inconclusive with respect to the ‘standard of health’ which is supposed to be ‘attainable’. The Committee on Economic, Social and Cultural Rights (CESCR), which was established to carry out the monitoring functions assigned to ECOSOC in the Covenant, also publishes interpretations of its provisions in the form of General Comments. These can be seen as “more or less authoritative statements of interpretation” (Steiner and Alston, 2000: 265), with which

the Committee reacts to political situations, in which the questions concerned have gained a certain level of importance and public attention, though certainly not creating new international law. Nevertheless they can be seen as part of political processes which produce “standards of appropriate behaviour”, which also powerful economic actors like transnational pharmaceutical corporations cannot afford to ignore. Two elements might explain the timing of agreements on such General Comments: (1) There seem to be close links with ongoing processes of a social reconstruction of reality, which puts specific fields on ESC Rights in the center of global attention (including human rights movements) and implies a need for a closer understanding of a specific field of norms. (2) States feel under pressure to define their positions in emerging conflicts and express the need for breaking down general rules into concrete norms where ‘compliance’ or ‘non-compliance’ can be determined rather unequivocally.

In 2000, the CESCR adopted a 20-page document on ‘The right to the highest attainable standard of health’,¹ stating that (§ 47):

“If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.”

Now, § 43 confirms that State parties have an obligation ‘...to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs’ and ‘to ensure equitable distribution of all health facilities, goods and services’. As drugs for an anti-retroviral therapy are on the WHO Essential Drugs List, states are formally obliged to provide this therapy to HIV/AIDS patients, but many sub-Saharan African states (with per capita public annual health expenditures of between US\$ 5 and 20)² are certainly not in a position to fulfil such an obligation. States, however, also have the obligation to assist other states in fully realizing the right to health (§ 39):

“States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of International Organisations take due account of the right to health.”

And, finally, § 64 reads:

“Moreover, coordinated efforts for the realisation of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, the International Labour Organisation, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organisation,

¹ This document is part of a series of comments by the CESCR called “Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights” adopted since 1989, here ‘General Comment No. 14’ (document E/C.12/2000/4), [http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument]

² cf. WHO website at <http://www.who.int/countries/en/>

and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates.”

The “Right to Health” is codified in slightly different formulations in a number of other international agreements.³ As such, it constitutes binding international law, but it is widely seen as a typical example of “soft law”, which corresponds to principles of basic human rights but is certainly also far from being an obligation enforceable by any institutionalized processes. Nevertheless, the last ten or fifteen years have seen various turns in the politics of international organisations which can be interpreted at least as a partial result of a growing influence of global civil society (e.g. poverty reduction and empowerment as strategies of the international finance institutions; the Doha Declaration and WTO/TRIPS). The global governance discourse suggests that we witness some basic changes stressing the growing importance of multi-actor constellations in inter- and transnational politics. As indicated in the introduction, we suggest that taking up and deepening the concept of post-Westphalian global politics can help us to link these changes to the international relation discourse and thus to better understand their basic characteristics than the somewhat diffuse discourse on global governance. Here, we can just outline the basic argument.

3. Transformation from a Westphalian international system to a post-Westphalian global system

We have argued that some weaker and poorer States in particular in Sub-Sahara Africa are not able to fulfil the obligations deriving from international ESC human rights law. Additionally, due to internal power relations and the interests of national elites, some of these states are not even willing to direct available resources to fight infectious diseases and to guarantee a right to health for their citizens. Furthermore, with the transformations of the international political system we can observe a shift of political authority away from nation-states. Capacities to regulate and conduct policies are transferred upwards and downwards from the nation state to international actors on the one hand (internationalisation) and local actors on the other hand (regionalisation, localisation), as well as sideways from state actors in general to a wide range of non-state actors (privatisation, transnationalisation) (Rosenau 1997; Jessop 1999, 2004). The following figures gives a schematic representation of this spatial shift of authority

³ In addition to the International Covenant on Economic, Social and Cultural Rights, see the Convention on the Elimination of All Forms of Discrimination Against Women (Articles 10, 12 and 14), the Convention on the Elimination of All Forms of Racial Discrimination (Art. 5) and the Convention on the Rights of the Child (Art. 24). In addition, Art. 35 of the Charter of Fundamental Rights of the European Union refers to the rights established by ‘national laws and practices’ and adds that: ‘A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities’. Furthermore, we find commitments by governments to improve human health in a number of declarations and Programmes of Action (Agenda 21, chapter 6, §§ 1 and 12; Cairo Programme of Action, Principle 8 and § 8.6; Copenhagen Declaration, Commitment 6, Beijing Declaration, §§ 17 and 30, Habitat Agenda §§ 36 and 128) and, of course, in the Millennium Declaration.

and of the transformation of a *Westphalian*⁴ international system of politics to a *post-Westphalian* global system of politics.⁵

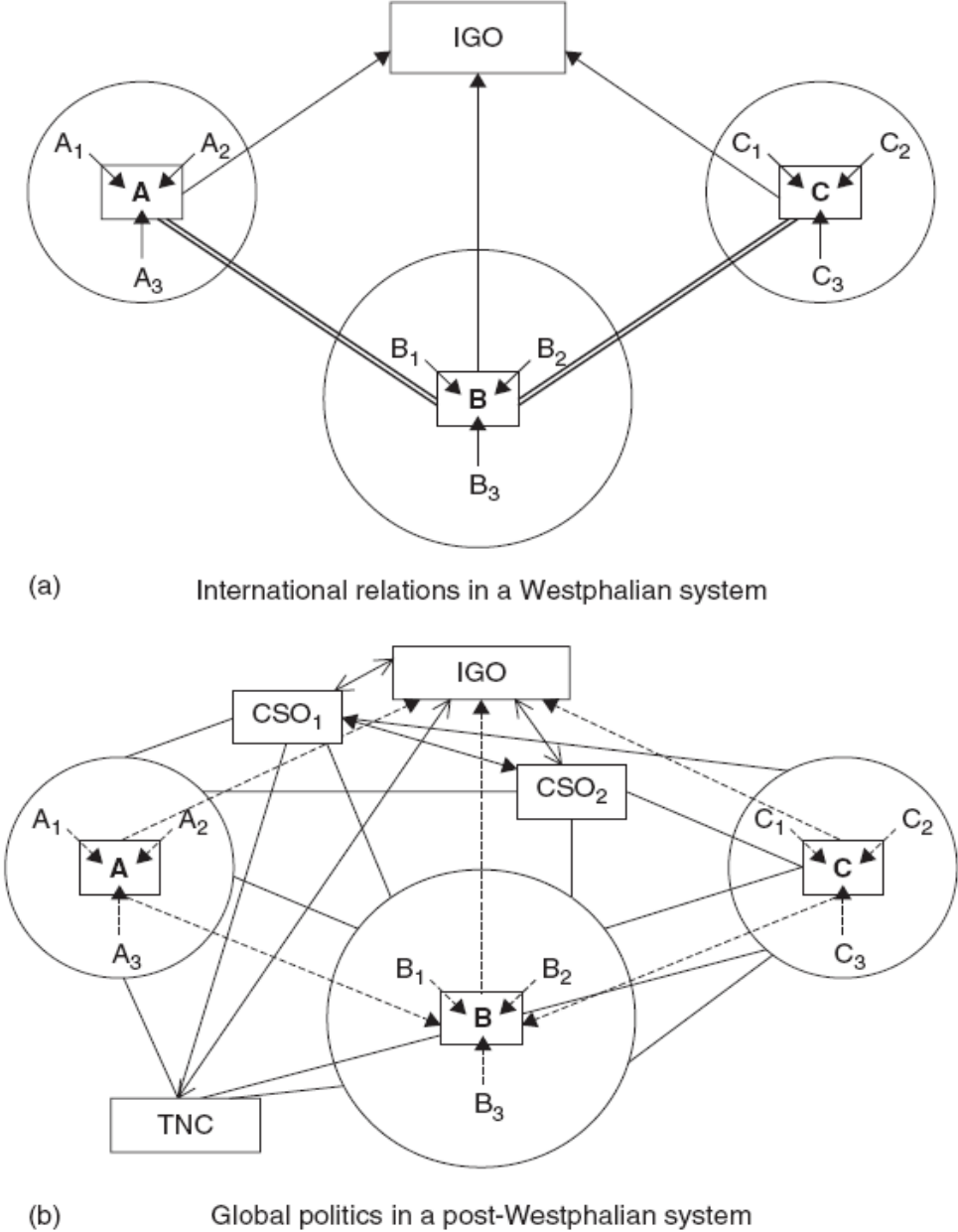


Figure 1.1 Transformation of international relations into a system of global politics
 Source: Own figure.

⁴ Referring to the role of the Westphalian Peace in 1648 in the development of a system of international relations between sovereign nation states.
⁵ David Fidler (2004, 2005) has thoroughly analyzed ‘Post-Westphalian Public Health’ with respect to the global reaction to SARS and the revision of the International Health Regulations (IHR); he concludes that the new IHR constitute a shift towards ‘an expanded governance strategy that integrates multiple threats, actors and objectives in a flexible, forward-looking and universal manner’ (2005: 68).

The traditional system of international relations was based on *an aggregation of interests at the national level*. Thus, negotiations at the international level were led by governments on the basis of these nationally aggregated positions, which, in the first instance, reflected power relations within nation states. The outcome of these negotiations was a result of power relations between nation states, either mediated by decision-making procedures within International Governmental Organisations (IGOs) or various characteristics of specific countries (or group of countries) within the international system. Meanwhile, the intensification of international economic and social relations has produced a situation in which the Westphalian system was transformed by international negotiations that increasingly limit the power of national societies towards a sovereign formation of their internal political and economic order and of their external relations (in particular the GATT-WTO process). Globalisation, the liberalization of markets, and the increasing need to deal with transnational/global problems created the opportunity for the direct interaction of non-state actors, thus establishing new transnational spaces of interests and power that prevent a full aggregation of interests on the national level but produce dynamics and opportunities through a transnational cooperation of non-state actors, which increasingly limit the political options of nation states.

We have arrived at quite a complex structure of interaction and relations between the different actors. Whereas in the ideal Westphalian system there are basically the two alternatives between cooperation in an IGO or a bilateral cooperation between states, in the post-Westphalian structure there are many possibilities for cooperation and conflicts among nation states, IGOs, CSOs, and transnational corporations. The ‘old’ actors of the Westphalian systems are included, but their roles are transformed by challenging their political monopoly through the emergence of new, genuinely transnational actors. As in the Westphalian System the nation-state was the main institution for norm-setting we can now observe new modes, spatial levels and institution that are additionally important for norm-setting.

3.1 International law: Mechanisms of norm-building and compliance when a unified state authority is missing

- (a) Compliance with respect to the adaptation of internal politics and national law to international rules⁶:

In a system of nation states, hegemonic power structures play a central role to define the rules of cooperation in an international society. Non-governmental organisation might have played an important role in pushing the rise of certain norms (like abolition of slavery, status of medical personnel in warfare), but state actors have been taken care of pushing other states to integrate international law into national legal systems. Today the growing density of transnational social relations and of systems of international law and transnational rules in many different policy fields have created a much higher complexity of relations beyond the nation

⁶ See the concept of an *international society* as developed by the English school of international relations, see e.g. Buzan 2004).

state: Powerful non state actors (in particular: transnational corporation) challenge the hegemonic position of powerful nation states and norms set in one policy field challenge norms in other fields (like: WTO and human rights).

These development are closely linked to the question of extra-territorial obligations of international human rights laws, already referred to above. In a Westphalian system of sovereign states it might have been a moral issue (or an issue of “national interest” to do so), but there was a lack of power to support these obligations in an *international* human rights system, while at the same time contravening interests prevented compliance with human rights norms in national political systems. With the increasing power of a global civil society and a growing interest to solve problems which historically were treated as internal matters of foreign countries, the issue has changed its character: To accept extra-territorial obligations might become a matter of legitimacy in a global society.

(b) International Organisations and non state actors in the development of transnational norms

Due to the hegemony of neoliberal concepts in economic globalisation during the 1980s and early 1990s, progress in the realisation of social rights was slow in most developing countries as priority was given to economic liberalization and political freedom. Since the mid-1990s, insights have gained ground that poverty reduction and improvements in health do not automatically result from liberalisation and economic growth, and that parts of the global economy are marginalised or even excluded from trade and foreign investments (especially parts of Africa). Today, poverty reduction and greater efforts to fight infectious diseases like HIV/AIDS are among the top issues of the global political agenda to mitigate the biggest social problems resulting from economic liberalisation. At the same time, the globalisation process – as already outlined above – has intensified the density of social and political interactions on a global scale. We face an increasing global awareness of conflicts and social problems. Richer countries realise that problems in marginalised regions are also to some extent their problems, as for example in the case of infectious diseases or HIV/AIDS threatening the economic and political stability in some countries and regions which might in turn have international consequences. Thus, the increasing global awareness of problems and the global activities to tackle these issues are related to the self-interest of well-to-do people in the North (Hein/Kohlmorgen 2007).

Due to a lack of adequate reactions of nation states and IGOs to these global problems, civil society and private sector actors play a prominent role in the evolving global governance – particularly in social and health policy affairs. Protests against unequal social development are less and less mediatized through national borders, just as social and political risks are more and more globalised. The *rise of a global polity* (Ougaard 1999; Ougaard/Higgott 2002) relates to this dialectics of inequality and the reactions of wealthier actors to the risks as well as to problems of global equity inherent in problems of global health. Structures of conflict and compromise, that is the aggregation of political interests, are also increasingly globalised, which implies the additional importance given to the reaction to global risks. These developments, of course, also have their impacts back on the national level of health politics. Though

on the one hand, nation states, in organizing their health systems, have become more and more dependent on conditions they cannot control, global markets and global political cooperation, on the other hand, have a huge potential for improving health care.

In this setting, we have to ask for the role of the formally legitimised UN organisation in the norm building process, the WHO. One of the objectives and ascribed functions of the WHO is to set internationally accepted norms and standards and to give technical guidance and advice for member countries in promoting health. But it is not only involved in building subsidiary norms: The WHO offers an institutional basis on which to propose and negotiate rules, conventions, and thus forms of international law (for example WHO Framework Convention on Tobacco Control, International Health Regulations). Thus, the WHO is (or should be) in the center of the norm building process in global health governance.

Although this described functions generally have not changed in the transformations of the international system, WHO plays a different role as a norm carrier. In the Westphalian System, WHO was both the “organisational platform” (Finnemore/Sikkink 1998) for nation-states as norm carriers and an important norm carrier as actor itself. However, in spite of some relevance of the international level, the nation state constituted the main area of politics. In the Post-Westphalian System, first of all IGOs such as the WHO are supposed to become more important due to the increased inter- and transnational interconnectedness. At the same time, nation-states (and IGOs) have to compete with CSOs and other non-state actors in the process of generating and disseminating claims and norms. The WHO is still an important organisational platform to build norms, however, also within the WHO non-state actors have – informally – more influence: First, as the WHO is influenced by the activities and discourses of global health governance and thus internalises trends and claims from ‘outside’. Second, as the WHO has opened itself at least to some extent for more participation of non-state actors, e.g. of CSOs but also of private for-profit actors or by attending and creating global public-private partnerships. As actor in the more important global realm of health politics, the WHO has to face competition in establishing norms by non-state actors, and at the same time is criticized very often e.g. for being ineffective or for being not consequent enough in striving for human rights by CSOs.

3.2 Multi-actor constellations and the development of subsidiary norms

If there is a strong interest among hegemonic powers for a specific international regime they will do everything to create a high level of compliance with international norms. Institutions and explicit or implicit forms of sanctions will be developed to implement them. Supplementary norms will be agreed upon which develop clear criteria of compliance. This is the case for the international monetary and trade systems (IMF, GATT and WTO), but also for more specific regimes like the Organisation for Security and Cooperation in Europe or the Treaty on the Non-Proliferation of Nuclear Weapons. In this case national governments are the main actors which have to comply .

In the case of ESC Rights, however, compliance frequently is beyond the scope of government action (lack of resources) or is simply not given priority due to conflicting interests. Hegemonic powers do not want to be held responsible for a level of resource transfer and for

changes in the international economic and political order deemed necessary to favour ESC human rights in poor countries. In addition to that, the various lines of the development discourse proves, if anything, that it is extremely difficult to predict cause-effect relationships in global development.

In a Post-Westphalian system there is a different arena for the aggregation of interests: CSOs, but also TNCs and foundations increasingly operate at a global scale and are able to interact beyond the level of national politics and also to develop alliances with specific national governments or international governmental organisations (like global public-private partnerships) to counteract strategies of traditional hegemonic actors. There are also new forms of a deployment of a significant amount of resources which can be mobilized by CSOs, large foundations and in the framework of corporate social responsibility by TNCs. Global expert commissions on an ever increasing range of topics have developed as a new form to create political consensus on a global level and to push states to accept positions and norms which have consolidated themselves in the realm of global civil society. Though in traditional terms of power (armed forces, economic resources, decision-making power in political institutions) non state actors cannot match powerful states, discursive power has become an element in political conflicts difficult to calculate – at least in the context of democratic states. In some cases this has resulted in political realignments, strengthening forces in powerful states which stress the importance of global social or environmental policies.

It is generally accepted in the literature that this huge web of interactions plays an important role in global norm-setting processes, in particular in the phase of norm-emergence. In a post-Westphalian world, however, it makes sense to assume that multi-actor constellations increasingly develop a consensus about what is important in a specific political field (beyond all conflicts in other fields) and begin to agree on some relatively simple norms – like guaranteeing universal access to essential medicines – which supplement primary norms and allow their implementation and control by more or less ‘guaranteeing’ public reactions whenever the standard is broken. These are basically hypothetical reflections, but as we intend to show the conflict on access to medicines provide some evidence for the emergence of this form of norm-building.

4. The case of health: From “health for all” to “access to medicines”

The WHO was founded by the members of the international community ‘for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples’ (WHO Constitution). Therefore, it is the organisation of nation states to promote global health, and the delegates of member states decide on the organisation’s strategies and policies in the World Health Assembly. The WHO constitution declares that ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being’. ‘Health for All’ is not only the aim of WHO as an organisation but it is also established as the central objective of international and national health activities by the nation states throughout the world. The International Conference on Primary Health Care in Alma Ata in 1978 proposed and the World Health Assembly in 1979 endorsed Primary Health Care as a strategy to

achieve the objective of ‘Health for All by the Year 2000’, not just by giving the poor a minimum of health services (in a more liberal sense), but by providing health services for all as the foundation of a comprehensive health system (in a more universalistic sense). During the 1980s the concept of Selective Primary Health Care became dominant in discourses and in health activities. This strategy focused on specific diseases in developing countries and on the lack of immunization and defined so-called attainable goals. Some donors, international organisations and scholars favoured this concept, and its influences reach to the current focus on fighting specific (mainly infectious) diseases.

In 1977 WHO produced for the first time a list of essential medicines to be seen as the basis for medical interventions in developing countries. To prevent unnecessary expenses on medicines (due to a prevailing orientation at brand names) the list provided an overview on the availability of cheaper generics which could substitute branded drugs. “Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage form, with assured quality, and at a price the individual and the community can afford” (Quick et.al. 2002: 913). In fact, “during the first half of the 1980s, world market prices for drugs on the WHO model list fell by 40% through increased demand and competition” (ibid.). Pharmaceutical companies protested against this interference with their chances to exploit patents, but in fact very few of the listed drugs were patent-protected. This means that there were no legal problems in copying them anywhere in the world, but it also means that there were rather few newly developed medicines on the market which were particularly geared to diseases prevailing in developing countries. This list of essential medicines provides a link to the actual access discussion by claiming the need to provide these medicines at an affordable price.

As we know, by 2000, the objective of ‘Health for All’ was not attained, and the likelihood of attaining it in the near future remains rather slim. Nevertheless, in 1998, WHO (to be precise: the World Health Assembly) renewed this objective under the label of ‘Health for All in the 21st century’. This statement also proclaims that the availability of essentials of Primary Health Care should be ensured (Cueto, 2004; Thomas and Weber, 2004: 192 et seq.). Still, WHO had been severely hampered by a lack of internal flexibility to react to the new challenges of globalisation and neo-liberalism and a freeze of contributions to its budgets (Yamey, 2002; Brown et al., 2006; Lee, 2004; Kohlmorgen, 2007). However, we can state that ‘Health for all’ is established as a norm since the 1980s, even if it is contested and not implemented in all countries.

4.1 Norm generation and diffusion: Campaign for Access to Essential Medicines

Since the 1990s, the norm ‘Health for all’ has been in a sense substantiated by focussing on the fight against poverty related diseases, other specific fields (e.g. vaccination campaigns) and the claim ‘access to medicines’. Initially, the discussion focused on neglected diseases, but then the process gained momentum around access to antiretrovirals (ARVs) in the fight against HIV/AIDS. The new focus on infectious diseases and the attempts to establish the access norm are a differentiation of the general norm “health for all”. While “health for all” seems to be an overambitious target, “universal access to essential medicines” appears as

much more manageable and realistic – in particular, since it is widely known that the generic production of medicines can be comparatively cheap. Thus, it seems obvious that the denial of access to life-saving medicine constitutes a global scandal. Picking up this scandal for campaigns together with the a rapidly growing global civil society with corresponding means of communication developed a high level of discursive power of CSOs. On the contrary, the construction of effective health systems in the poorest countries, which is a precondition for an reaching access to medicines, still is widely defined as a development “problem” and imposes great efforts both for the developing countries and the international community. Nevertheless, the access issue turned out to be a very prominent claim in the international debates on trade and development since the late 1990s.

The high prominence of the fight against infectious diseases, however, can only be partly explained by the influence of CSOs and perspectives on poverty reduction. Its significance was also a result of the perception that ill health in developing countries and the global spread of infectious diseases like HIV/AIDS, SARS, or Tuberculosis could pose a dual threat to global security: one that results from the global spread of these diseases and that affects the local population directly, and one that is linked to political and economic instability resulting from ill health, poverty, and underdevelopment and that has an indirect effect on national and international security (Peterson 2002, Youde 2005, Fidler 2004). This new perception of health risks is related to a broadening of the security concept since the end of the Cold War. While security was traditionally perceived as military protection against external threats to one’s own territory and population, the concept has been expanded since the 1990s to include non-military threats, emanating from economic risks (oil dependency, financial volatility), illegal activities (drug trafficking, organized crime), environmental changes (global warming, conflicts on water), and social problems (migration, infectious diseases). In July 2000, the UN Security Council convened its first-ever session on health and acknowledged ‘that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security’ (SC Resolution 1308: 2). The report of the UN ‘High Level Panel on Threats, Challenges and Change’ stresses that ‘any event or process that leads to large-scale death or lessening of life chances and undermines States as the basic unit of the international system is a threat to international security’, listing infectious diseases and other social threats like poverty as one of six clusters of threats (UN 2004: 23).

Thus, we argue, the social and human rights interests of CSOs coincide with self-interests of industrialised countries like containing the risks of a global spread of infectious diseases and of political instability. This political constellation of interests provided an environment that made it possible to run an at least partially successful campaign for access to medicines. The claim “access to essential medicines” was first and foremost raised and postulated by CSOs so that we can identify them as main norm carriers in the norm building phase of *norm generation*. Besides CSOs also some Southern government such as in particular the Brazilian government argued for increased treatment, for a strengthened involvement of treatment in the HIV/AIDS programmes of International Governmental Organisations (such as WHO and UNAIDS) and for greater commitments of G8 to enhance access to medicines.

At this stage of the norm building process, in particular the negotiations concerning the TRIPS agreement within the World Trade Organisation (WTO) became the center of the CSO

campaigns. From 1996 onwards, Health Action International successfully developed a campaign against the effect of TRIPS on limiting the access of poor people to patented medicines, scandalizing the disaccord between high prices and profits for pharmaceutical companies on the one hand and the suffering and dying of millions of AIDS victims on the other. They argued that intellectual property rights were not only a trade but also a public health issue and thus managed to link these two aspects. Since the late 1990s, a large network of CSOs, led by Médecins Sans Frontières (MSF)⁷ have been advocating and campaigning for access of poor AIDS victims to ARVs in the ‘Campaign for Access to Essential Medicines’, which included advocacy and lobbying against efforts of industrialized countries within the WTO to establish international patent protection for drugs that are needed in developing countries (Sell 2002; ‘t Hoen 2002; Schultz/Walker 2005). The campaign for low-cost medicine was not only carried out at the global level – by means of activities and lobbying within the WTO and other IGOs – but also in particular countries.⁸

After the claim “access to medicines” was generated and established in the global health and development discourses and many hesitant actors (such as some G8 countries, IGOs) were convinced and/or morally compelled not to reject these demand, the *diffusion of the norm* proceeded and led finally to a broad *acceptance* at least on the level of agreements, statements commitments, and programmes. The Doha Declaration (that supplemented the TRIPS agreement) and the agreement on § 6 of that declaration on 30 August 2003, can be interpreted as a result of the activities of the main norm carriers, the CSOs, in cooperation with some governments of developing countries. CSOs not only lobbied representatives of IGOs and Northern governments, but also became increasingly important as advisors to developing country members of WTO and helped them coordinate their positions in the subsequent re-negotiations of the TRIPS agreement. Governments of developing countries cooperated with CSOs during the negotiations and CSOs brought in their political, legal, and technical knowledge and their contacts to governments of industrialized countries (UNDP 2002: 104ff.). Hence, during this process, CSOs were changing their character from basically mobilizing and advocacy actors towards cooperating experts and actors with a negotiating role in the global political process. CSO networks were highly efficient in four domains: creating media attention and public interest, mobilizing support both from the public and the private sector, lobbying representatives of IGOs and governments of industrialized countries, and empowering poor Southern countries to take a strong position in the negotiations.

Meanwhile, the prices for AIDS treatments in developing countries dropped noticeably, on the one hand because of generic competition. On the other hand CSO activities – which, aside from TRIPS-focused activities, include campaigns against transnational pharmaceutical corporations (TNPCs) with the objective to reach low prices – and the increased global consciousness concerning the need for AIDS treatment have led to a price reduction.⁹ This

⁷ MSF invested the money they received for winning the Nobel Prize in 1999 for greater parts in this campaign.

⁸ Prominent examples are the conflicts concerning patents and drug prices in South Africa and Brazil (cf. von Soest/Weinel 2007; Calcagnotto 2007)

⁹ The availability of generic ARVs offered mainly by Indian producers, negotiations of the Clinton Foundation, the World Bank, UNICEF and the Global Fund with these generic producers in India for special prices in bulk purchases, the improved negotiating position of developing countries due to the Doha Declaration and the TRIPS Amendments and, finally, concessions by TNPCs themselves have led to a dramatic fall of ARV prices in developing countries. Since the late 1990s they fell from well over US\$ 10,000 to about US\$ 140 (for generics, per

influence of CSOs also becomes apparent if we look at the initiative for a ‘Global Framework on Essential Health Research’, which is currently under discussion in WHO, which links up the question of prices of medicines with the problem of investments in R&D and the organisation of incentives for research (which patents are expected to provide). This initiative was influenced and kicked off by a proposal for a ‘Medical Research and Development Treaty’ made by the US-NGO Cp-Tech and supported by many CSOs in 2005¹⁰. It was brought into the Executive Board in January 2006 by Kenya and Brazil and thereafter debated in the World Health Assembly in May 2006, which then decided to establish the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (IGWG) that should make recommendations for an improvement of health research for neglected diseases and for the conflict between IPRs and public health.

4.2 Norm implementation: Many commitments but slow progress

Taking into account the complexity of international rules and global social and economic inequality impinging on the problem of access to medicines, it is obvious that this norm cannot be implemented as a simple legal norm (e.g. based on the General Comment of the CESCR quoted above). As shown in Table 1 (see section 5), compliance with this norm is based on its acceptance and creative adaptation by multiple actors in the post-Westphalian global polity which has led to its implementation at least with respect to a basic precondition of access to ARVs, making it basically affordable to the international community to pursue a strategy of universal access. However, even it is to some extent an accepted global norm, its *implementation* lacks progress. Implementation depends on lower prices, but still most poor countries are in addition dependent on financial transfers to pay for medicines and treatment institutions.

Indeed, the G8 countries and Kofi Annan/the UN established the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria in 2001. The Global Fund is a new form of hybrid regulation that seems characteristic for current structures of global health governance (Bartsch and Hein, 2003; Bartsch, 2007). It can be characterised as a multilateral funding mechanism that works like a global public private partnership (GPPP). It has a new and – compared with IGOs – unconventional governance structure as it includes nation-states (eight from the North, seven from the South), CSOs (3), foundations (1) and companies (1) as voting members in its Executive Board. WHO, World Bank and UNAIDS are only non-voting members. Recipient countries have to create a Country Coordinating Mechanism with the participation of all stakeholders (including civil society and private sector) that is authorised to apply for funds to conduct programmes. The Global Fund has attracted pledges of US\$ 10.9 billion until 2008 and received US\$ 7,3 billion to support programs in 132 countries thus far (June 2007).¹¹ Although 94.4% of the money donated is provided by OECD members, 1.1% by non-OECD countries, the Global Fund can be interpreted as governance mechanism that gives non-state

person/year, in some countries) in 2005 (MSF, 2005: 10). Hence we now have a situation in which the transfer of international resources in many poor countries could at least open a window for starting treatment programmes on a larger scale.

¹⁰ The e-mail list of ip-health (ip means “intellectual property) produced by Cp-Tech played an essential role for a broad distribution of information on IP-issues to the international community in all matters related to IP and access to medicines.

¹¹ 56% of these funds are provided for HIV/AIDS measures like prevention and treatment.

actors a greater influence in the implementation of the global norm ‘access to medicines’. Furthermore, the important role of private foundations shows that non-state actors have an important function for the implementation of the norm. In particular the Bill and Melinda Gates Foundation is a very influential actor. After Warren Buffet’s gift of more than US\$ 30 billion and with an estimated annual spending of US\$ 3 billion per year it is one of the greatest funders of global health promotion and the fight against infectious diseases. And also the activities and negotiations of the Clinton Foundation play an important role in global health and in the diffusion and implementation of the ‘access to medicines’ norm. For example, it initiated negotiation – with participation of the World Bank, UNICEF and the Global Fund – with Indian generic producers to reduce the prices of ARV for developing countries.

Besides the Global Fund, state (or IGO) run programmes such as the Multi Country HIV/AIDS Program (MAP)¹² and the President’s Emergency Plan for AIDS Relief (PEPFAR)¹³ contribute to an expansion of treatment in the field of HIV/AIDS. Although there are significant improvements – the number of people receiving antiretrovirals increased from 300,000 in 2002 to 2 Million in 2006 (UNAIDS 2006) – it is obvious that there are great challenges for the international community. In 2006, 7.1 Million people still were in need of ARV treatment (UNAIDS 2006). To some extent the commitments of the powerful Northern governments seem to be lip service. For example, there are manifold conflicts between developing countries and industrialised countries within the World Health Organisation and the World Health Assembly on the Global Framework on Essential Health Research, as the governments of industrialized countries still are not ready to lower the protection of intellectual property rights. There are a number of issues which need further analysis before the question whether “universal access to essential medicines” can be considered to constitute a firm norm in global politics:

- The pharmaceutical industry successively accepted the need to improve access of the poor to medicines and, in effect, provided some mechanisms to support this goal (differential pricing, participation in global public-private partnerships to ease access). Nevertheless, they pursued their agenda of trying to secure strong international IPRs, now shifting the forum of their activities towards bi- and multilateral trade agreements. Taking into account the possibility of a limited impact of the newly introduced patent right in India with the possible use of compulsory licenses for producing second-line ARVs and for example Tamiflu, TNPCs did everything to secure TRIPS+ clauses in bi- and multilateral trade agreements, particularly those of the US. In all the FTAs negotiated since the late 1990s they pushed the US government to include clauses which forced the trade partners to exclude the possibility of using flexibilities included in TRIPS. Most partners agreed to these demands, as their priorities were oriented towards gaining access to the US markets for their export industries. These problems had been discussed at length in relation to different US trade agreements

¹² Since 2000, the World Bank runs the Multi Country HIV/AIDS Program (MAP). Together, 26 African countries have received more than US\$ 1 billion so far.

¹³ The bilateral programme PEPFAR will provide US\$ 15 billion to fight HIV/AIDS until 2009 (US\$ 9 billion for new bilateral programmes in 14 African and Caribbean countries, US\$ 5 billion for existing programmes in 75 countries and US\$ 1 billion for the Global Fund). At the G8 Summit 2008 in Heiligendamm President Bush announced that another US\$ 15 billion will be provided until 2012.

with Latin American countries and with Thailand.¹⁴ If “universal access” has been established as a true global norm one should assume that these clauses in bi-lateral trade agreements could not become effective without mobilizing large resistance. This is an important question to pursue.

- This leads to the next point: The acceptance of a political norm might be limited to rather specific issues in a specific political constellation. If a subsidiary norm in the global realm can be effective without being implemented in the form of international law, its implementation depends on the continuity of pressure exerted by specific actors (i.e. CSOs). Thus, after it has been broadly accepted many CSOs might reduce their efforts in campaigning and creating political pressure. The development of recent conflicts around compulsory licences in the cases of Thailand and Brazil provides some evidence that the ongoing salience of the health (and in particular) access problematique in developing countries will lead to a continuous attention of civil society and to an increasing attention of policy makers in these countries in this field.
- *Universal access to essential medicines* has developed as a norm due to the conflicts around access to ARVs. Of course, there are many other essential medicines than just ARVs; the norm must be applicable to all medicines to treat all kinds of diseases. The question of the so-called neglected diseases have been the focus of the second great debate in this field; it refers, however, to another aspect of the global medical R&D system, i.e. that it creates only incentives for research on medicines which promise to have a large monetary demand¹⁵. Another field similar to the situation of ARVs is developing with the increasing importance of the so called “diseases of the rich” in poor and middle income countries: heart diseases, cancer etc., where also patent-protected medicines play a significant role. More recent conflicts in the access field have to be scrutinised in order to exclude the possibility that access to ARVs only constitutes a special case due to the strong international attention paid to HIV/AIDS. In fact, recent conflicts on compulsory licenses suggest that the issue will in fact increasingly spread to medicines against other diseases. One of the two compulsory licenses Thailand issued in early 2007 concerns Clopidogrel, a medicine against heart diseases (see ip-health, February 20th, 2007).
- Still the problem of financing R&D of medicines cannot be solved by simply providing (or: assuring) flexibilities in the use of intellectual property rights. The issue of the neglected diseases point to the fact that differential pricing (to provide cheaper medicines to poor countries) cannot be successful way to “save” the property rights system. In addition there also is a growing access problem in industrialized countries due to the scientific and technical potential to develop ever new medicines and forms of medical treatment which put health systems in rich countries under pressure as well.

¹⁴ There are a large number of critical texts on Free Trade Agreements with TRIPS+ provisions. The UNCTAD-ICTSD Project on IPRs and Sustainable Development has presented a number of interesting studies on these negotiations (see www.iprsonline.org/resources/FTAs-htm); Oxfam produced various briefing notes and briefing papers on this subject (Oxfam 2002); see also Vivas-Eugui 2003 and Abbott 2006.

¹⁵ For a concise report on the links between intellectual property rights and access to medicines see the final report of the WHO Commission on Intellectual Property Rights, Innovation and Public Health (CIPRH/WHO 2006).

We already referred to the WHO discourse on a Global Framework on Essential Health Research which has led to the establishment of an Intergovernmental Working Group on Public Health, Innovation and Intellectual Property Rights. However, it seems quite improbable that this will result in the incorporation of the “right of universal access to essential medicines” as an effective supplementary norm into international law.

5. Conclusion: The important role of non-state actors in the development of subsidiary ESC norms .

In this paper, we have described the transformation of a Westphalian international system of politics to a post-Westphalian global system of politics, which implies a spatial shift of authority from the national to the inter- and transnational level of governance and politics. Additionally to the ‘old’ actors, the nation states and IGOs, which retain power, civil society and private for profit actors are important players in the global realm. This creates a complex governance structure with manifold interactions and relations between different actors and institutions spanning over different levels of action. Thus, whereas in the Westphalian system the nation-states and their governments were the main norm carriers setting and implementing norms this changed at least in some policy fields. Notwithstanding the greater relevance of IGOs, we can identify a lack of governance at global level. It is obvious that there is no global state and that the global statehood shows some deficiencies. Social policy oriented IGOs are sometimes overstrained as they do not have enough resources and formal power to conduct sustainable social and health policies. At the same time, nation states keep their formal power and cannot be forced by existing law to guarantee social rights and implement norm health for all. Thus, there is a kind of vacuum in the global realm, which is filled partially by civil society organisations and foundations. They take over functions to establish and also implement norms: transnational subsidiary norms and therefore are important norm carriers in the current system of global governance.

In global health, the norm “health for all” is widely accepted since the establishment of the WHO in 1948. However, its implementation lacks of progress and many countries do not have even the ability to guarantee a minimum of health care. Since the mid of the 1990s, the global health community focused more and more specific facets of this general norm, such as neglected diseases, infectious diseases and the very issue of access to medicines. The claim “access to essential medicines” was raised by CSOs, which started a successful campaign focussing on affordable prices and IPR and trade policy inside the WTO/TRIPS against the background of the HIV/AIDS epidemic. Thus, CSOs are the main norm carriers in the phase of *norm generation*. They framed this conflict by making the scandal of the disaccord between high prices of drugs and the suffering and dying of millions of AIDS victims subject of the discussion. Furthermore, this campaign fell on fertile ground as the governments of industrialised countries were more and more anxious about the transborder spread of infectious diseases and the consequences for international security. Without the interests of the governments of rich countries in reducing the threats through infectious diseases and poverty the

conditions for the CSOs to be successful in framing the conflict and in exerting some considerable influence would not have been thus good.

Table 1: Access to Medicines: Norm building process and main norm carriers

stage of carrier norm building \ main type of norm	<i>civil society</i>	<i>private for profit</i>	<i>hybrid</i>	<i>state</i>
<i>norm generation</i>	Campaign for Access to Essential Medicines			Brazilian government conducts HIV/AIDS programme and argues for increased access
<i>norm diffusion / norm acceptance</i>	Campaign for Access to Essential Medicines		<p>conflicts on TRIPS and IPRs: inside/around WTO; lawsuit in South Africa (TNCs vs. government)</p> <p>Commission on Intellectual Property Rights, Innovation and Public Health (hosted by WHO)</p>	<p>governments of Southern countries arguing for increased access</p> <p>WHO, UNAIDS, World Bank and UNICEF arguing for increased access</p> <p>conflicts on TRIPS and IPRs: e.g. USA vs. Brazil inside WTO; debates within WTO, WIPO and WHO</p> <p>WTO: TRIPS/Doha Declaration</p> <p>WHO: IGWG</p>
<i>norm implementation</i>	<p>codices + guidelines for CSOs</p> <p>distribution programmes</p>	<p>codices + guidelines for companies</p> <p>Accelerating Access Initiative</p> <p>donation programmes</p> <p>activities of Gates Foundation</p>	<p>Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria</p> <p>GPPPs (R&D, funding)</p> <p>3 by 5 (initiated by WHO)</p> <p>codices + guidelines for nation-states, companies and CSOs</p> <p>Clinton Foundation negotiates lower prices for ARVs</p>	<p>Southern governments</p> <p>Northern governments (funding + treatment programmes, bilateral ODA)</p> <p>PEPFAR</p> <p>commitments of G8</p> <p>activities of IGOs: World Bank (MAP), UNICEF, WHO, UNAIDS</p> <p>Global Framework on Health Research (WHO)</p>

The norm “access to essential medicines” diffused through many organisations and institutions and has been widely accepted in the course of time: There is both formal *acceptance* of the norm in state institutions (e.g. WHO, UNAIDS, World Bank, WTO/TRIPS) but also acceptance amongst non-state actors such as foundations and other civil society organisations.

These non-state actors play an important role in the *implementation* of the access norm. Although also state actors (G8 countries, US government (PEPFAR), some Southern countries) increased their efforts and spending to fight HIV/AIDS, foundations such as the Gates Foundation and the Clinton Foundation and many bigger and smaller CSOs are involved in the endeavours to provide access to medicines in poor countries.

We have demonstrated, that non-state actors are crucial at all stages in the process of building subsidiary norms. However, finally we have to query if we can generalise this case to other fields of social policy. Certainly, the case of the HIV/AIDS epidemic and access to ARVs has a specific character, as the disaccord between the availability of drugs, high prices for them and the suffering of millions of AIDS victims in poor countries is so obvious. However this could be also said for the fight against hunger as globally there are enough resources to end all starvation. We have to ask why scandalizing other dimensions of poverty like the lack of access to clean water and sanitation, chronic hunger and starvation etc. does not lead to such a great global awareness as in the case of access to medicines. One reason may be that the fight against one single diseases such as HIV/AIDS and furthermore the focus on the medicines issue is much more concrete and tangible than fighting against poverty in general or against hunger in all poor countries. Another cause can be seen in the self-interests of the industrialised countries, which perceive infectious diseases as threat to themselves. However, these are just preliminary explanations. A comparative study of civil society activities and the constellations of interests in different fields of global social policy could be helpful to answer the question of different conditions and outcomes of ESCR norm-building. For the case of health, we can conclude that the densification of global social relations and the strengthening of global civil society linked to a situation where instability in poor regions is perceived as an increasing threat to the security of “the rich” have led to the establishment of a norm helping the poor. This norm is still contested in its implementation, but it is widely accepted and cannot be denied.

References

- Abbott, Frederick M. 2006: TRIPS II, Asia and the Mercantile Pharmaceutical War: Implications for Innovation and Access; Draft Paper for the Conference on Economic Challenges in Asia, Stanford Center for International Development, May 31-June 3, 2006.
- Anderson, James E. 1975: Public Policy-making: An Introduction. New York
- Bartsch, Sonja/Hein, Wolfgang 2003: ‚TRIPS und globale Partnerschaften. Konflikte um den Zugang zu Medikamenten im Rahmen von Global Health Governance’, in: *Peripherie*, 23 (90/91): 202-231.
- Bartsch, Sonja 2007: ‚The Global Fund to Fight AIDS, Tuberculosis and Malaria’, in: Hein et.al. 2007: 146-171.
- Bartsch, Sonja/ Kohlmorgen Lars 2007: ‘The Role of Civil Society Organizations in Global Health Governance’, in: Hein, W., Bartsch, S. and Kohlmorgen, L. (eds), *Global Health Governance and the Fight Against HIV/AIDS*. Basingstoke: Palgrave Macmillan: 92-118

- Brown, Theodore M./Cueto, Marcos/Fee, Elizabeth 2006: 'The World Health Organization and the Transition from 'International' to 'Global Health''; in: *American Journal of Public Health*, 2006, 96: 62-72.
- Buzan, Barry 2004: *From international to world society? English school theory and the social structure of globalisation*. Cambridge University Press.
- Calcagnotto, Gilberto 2007: 'Consensus Building on Brazilian HIV/AIDS Policy: National and Global Interfaces in Health Governance', in: Hein et al. (2007) : 172-201.
- CIPIH/ WHO 2006: *Public health. Innovation and Intellectual Property Rights. Report of the Commission on Intellectual Property Rights, Innovation and Public Health*, Geneva: WHO.
- Cortrell, Andrew P./Davis, James W. 2005: *When norms clash: international norms, domestic practices, and Japan's internalisation of the GATT/WTO*; in: *Review of International Studies* (2005), 31: 3-25
- Cueto, Marcos 2004: 'The Origins of Primary Health Care and Selective Primary Health Care'; in: *American Journal of Public Health*, November 2004, 94(11): 1864–1874.
- Fidler, David 2004: *SARS, Governance and the Globalization of Disease*, Basingstoke: Palgrave.
- Fidler, David 2005: 'From International Sanitary Conventions to Global Health Security: The New International Health Regulations'; in: *Chinese Journal of International Law*, Volume 4, Number 2 (2005): 1-68.
- Finnemore, Martha/Sikkink, Kathryn 1998: *International Norm Dynamics and Political Change*, in: *International Organization*, 52: 4, 887-917.
- Hein, Wolfgang 2007: 'Global Health Governance and WTO/TRIPS: Conflicts Between 'Global Market-Creation' and 'Global Social Rights'', in: Hein et al. 2007: 38-66
- Hein, Wolfgang/Bartsch, Sonja/Kohlmorgen, Lars (ed.) 2007: *Global Health Governance and the Fight Against HIV/AIDS*. Basingstoke: Palgrave Macmillan
- Hill, Malcom 1997: *The Policy Process: a Reader*. London
- Hoffmann, Matthew J. 2000: *Exploring Norm Emergence and Evolution: An Investigation with Agent-Based Models*. Working Paper [http://www.psych.upenn.edu/sacsec/abir/_private/Pamla/Hoffmann_norms.doc]
- Jann, Werner/Wegrich, Kai 2006: *Theories of the Policy Cycle*; in: Fischer, Frank/Miller, Gerald/Sidney, Mara (eds.) 2006: *Handbook of Public Policy Analysis: Theory, Politics, and Methods*. London (forthcoming)
- Jessop, Bob 1999: *Reflections on Globalization and Its (Il)logic(s)*; Working Paper, Lancaster University; URL: www.lancs.ac.uk/fss/sociology/papers/jessop-reflections-on-globalization.pdf.
- Jessop, Bob 2004: *Multi-Level Governance and Multi-Level Meta-Governance*; in: Bache, Ian/Flinders, Matthew: *Multi-level Governance*. Oxford 2004: 49-74
- Kersbergen, Kees van/Verbeek, Bertjan 2007: *The Politics of International Norms: Subsidiary and the Imperfect Competence Regime of the European Union*; in: *European Journal of International Relations*, Vol. 13 (2): 217-238
- Kohlmorgen, Lars 2007: *International Governmental Organizations and Global Health Governance: the Role of the World Health Organization, World Bank and UNAIDS*;

- in: Hein/Bartsch/Kohlmorgen 2007: 119-145.
- Lee, Kelley 2004: The Pit and the Pendulum. Can Globalization Take Health Governance Forward? In: *Development*, Vol. 47, No.2 2004: 11-17.
- March, James / Olsen, Johan P. 1989: *Rediscovering Institutions. The Organizational Basis of Politics*, New York: The Free Press.
- Médecins Sans Frontières (MSF) 2005: *Untangling the web of price reductions. A pricing guide for the purchase of ARVs for developing countries*, 8th edition, June 2005; URL: www.accessmed-msf.org.
- Ougaard, Morten 1999: *Approaching the Global Polity*. CSGR Working Paper No. 42/99. University of Warwick, Coventry.
- Ougaard, Morten/Higgott, Richard (Hg.) 2002: *Towards a Global Polity*. London: Routledge Chapman & Hall.
- Payne, Rodger A. 2001: *Persuasion, Frames and Norm Construction*; in: *European Journal of International Relations*, Vol. 7 (1): 37-61
- Peterson, Susan. 2002: 'Epidemic Disease and National Security'; *Security Studies* 12 (2): 43-81.
- Pollard, Amy/Court, Julius 2005: *How Civil Society Organisations Use Evidence to Influence Policy Processes: A literature review*. London
- Oxfam 2002: *US Bullying on Drug Patents: One Year after Doha*. Washington, DC (Oxfam Briefing Paper No. 24).
- Quick, Jonathan/Hogerzeil, Hans V./Velásquez, Germán/Rägo, Lembit 2002: *Twenty-five years of essential medicines*, in: *Bulletin of the World Health Organization*, vol 80 (11): 913-914.
- Rosenau, James N. 1997: *Along the domestic-foreign Frontier. Exploring governance in a turbulent world*, Cambridge
- Sabatier, Paul (ed.) 1999: *Theories of the Policy Process*. Boulder
- Schultz, Mark/Walker David, 2005. 'How Intellectual Property Became Controversial: NGOs and the New International IP Agenda' *Engage*, Vol. 6:1: 82-98.
- Sell, Susan K. 2002: 'TRIPS and the Access to Medicines Campaign'; in: *Wisconsin International Law Journal* 20, No. 3: 481-522.
- Soest, Christian v./ Weinel, Martin 2007: 'The Treatment Controversy: Global Health Governance and South Africa's Fight Against HIV/AIDS', in Hein et.al. 2007: 202-225.
- Steiner, Henry/Alston, Philip 2000: *International Human Rights in Context. Law, Politics, Morals*, 2nd ed., Oxford: Oxford University Press.
- Sutton, Rebecca 1999: *The Policy Process: An Overview*, ODI Working Paper 118, London
- 't Hoen, Ellen 2002. 'TRIPS, Pharmaceutical Patents and Access to Essential Medicines: A Long Way from Seattle to Doha'; in: *Chicago Journal of International Law* 3: 27.
- Thomas, Caroline/Weber, Martin 2004: 'The Politics of Global Health Governance: Whatever Happened to 'Health for All by the Year 2000''?'; in: *Global Governance* 10 (2004): 187-205.

- UN 2004: A More Secure World: Our Shared Responsibility. Report of the High-level Panel on Threats, Challenges and Change. New York: United Nations.
- UNDP 2002: Human Development Report 2002. Deepening Democracy in a Fragmented World, New York, Oxford: Oxford University Press.
- Vivas-Eugui, David 2003: Regional and bilateral agreements and a TRIPS-plus world: the Free Trade Area of the Americas (FTAA), Geneva: QUNO, QIAP, ICTSD.
- Windfuhr, Michael (ed.) 2005: Beyond the Nation State. Human Rights in Times of Globalization, Uppsala: Global Publications Foundation
- Windhoff-Heritier, Adrienne 1987: Policy-Analyse. Eine Einführung. Frankfurt a. M./New York
- Yamey, G. 2002: 'WHO in 2002. Why does the world still need WHO?', BMJ, Vol. 325, No. 7375, 1294-1298.
- Youde, Jeremy 2005: 'Enter the fourth horseman: health security and International relations theory'; in: The Whitehead Journal of Diplomacy and International relations; Winter 2005