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

ARUSH LAL, JUSTIN PARKHURST AND CLARE WENHAM*

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

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

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

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

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

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

4 Florini, 'The evolution of international norms'.

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

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

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

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

International Affairs **100**: 6 (2024) 2599–2622; DOI: 10.1093/ia/iiae238

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conceptualizing norm evolution

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Methods

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

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

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

Analytical approach

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

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

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

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

Examining norm life-cycles in GHS and UHC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Simultaneously, the UHC norm was advancing, yet the material and ideational factors shaping its development did not occur in isolation. Rather, progression

[71] Jeremy Shiffman and Yusra Ribhi Shawar, 'Framing and the formation of global health priorities', *The Lancet* 399: 10339, 2022, pp. 1977–90, https://doi.org/10.1016/S0140-6736(22)00584-0.

[72] 58th World Health Assembly, *Sustainable health financing, universal coverage and social health insurance* (Geneva: WHO, 2005), https://iris.who.int/handle/10665/20383.

[73] Ooms et al., 'Is universal health coverage the practical expression of the right to health care?', p. 201.

[74] World Health Organization, *The world health report 2007: a safer future: global public health security in the 21st century* (Geneva: WHO, 2007), https://iris.who.int/handle/10665/43713.

[75] Daniel Tarantola et al., 'H1N1, public health security, bioethics, and human rights', *The Lancet* 373: 9681, 2009, pp. 2107–8, https://doi.org/10.1016/S0140-6736(09)61143-0.

[76] UN General Assembly, *Global health and foreign policy: resolution adopted by the General Assembly*, 2009, https://digitallibrary.un.org/record/642456.

[77] HM Government, Department of Health, *Health is global: a UK government strategy 2008–13*, 2008, https://webarchive.nationalarchives.gov.uk/ukgwa/20130105191920/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702.

[78] See U.S. Centers for Disease Control and Prevention, 'Global health security', 2023, https://www.cdc.gov/global-health/topics-programs/global-health-security.html.

appears to have occurred in large part *because* of the proliferation of GHS norms. A growing number of actors questioned the efficacy of proliferating infectious disease-specific partnerships (GHS) at the expense of comprehensive health system strengthening (HSS),[79] which many believed could be better addressed through newer conceptualizations of UHC.[80] For example, Vega argued that MDG-related initiatives 'fragmented health systems [and] contributed to inequities in health'.[81]

This context appears to have catalysed a tipping-point for UHC norms, which began with the 2010 *World health report*.[82] By explicitly advising countries to 'raise sufficient funds [and] improve efficiency and equity', the report placed a normative emphasis on financing accessible health services for all, including by obligating international assistance. Language across concurrently adopted regional commitments on UHC (e.g. the Bangkok Statement on UHC and the Mexico International Forum on UHC)[83] suggests that, even domestically, pushback of GHS norms coincided with renewed interest in health promotion and social determinants of health—reflecting a broader (re)commitment to the core principles of the DAA and signalling further adjustments to the content of UHC norms. Finally, a 2012 WHO discussion paper (stating people should have access to '*all* the services' they need)[84] and a 2012 UNGA resolution (stating '*all people*' should have access to nationally determined health services)[85] provide further evidence of a norm cascade. Indeed, Vega contends that UHC became a constant in the world of global health following the 2012 UNGA resolution.[86]

Early signs of convergence Analysis of this crucial period illustrates that GHS and UHC norms were not evolving independently, despite much literature holding them as separate. For example, a human rights frame was not the sole factor carrying UHC over its tipping-point in 2010; instead, new links sparked by 'health-in-all-policies' campaigns[87] alongside increasing calls for aid effectiveness[88] helped (re)construct a formulation of UHC that Granmo argues fell 'more in line with the traditional notion of *hard politics* and the interests of states'[89]—a consequence of securitized policy pathways (albeit, increasingly contested)

[79] Jeremy Shiffman, 'Donor funding priorities for communicable disease control in the developing world', *Health Policy and Planning* 21: 6, 2006, pp. 411–20, https://doi.org/10.1093/heapol/czl028.
[80] Josefien van Olmen et al., 'Health systems frameworks in their political context: framing divergent agendas', *BMC Public Health* 12: 774, 2012, pp. 774–87, https://doi.org/10.1186/1471-2458-12-774.
[81] Jeanette Vega, 'Universal health coverage: the post-2015 development agenda', *The Lancet* 381: 9862, 2013, pp. 179–80, https://doi.org/10.1016/S0140-6736(13)60062-8.
[82] World Health Organization, *The world health report: health systems financing: the path to universal coverage* (Geneva: WHO, 2010), https://apps.who.int/iris/handle/10665/44371.
[83] Granmo, *Health norms in the global governance of development*.
[84] World Health Organization, *Positioning health in the post-2015 development agenda* (Geneva: WHO, 2012), https://www.stoptb.org/2-12-111positioning-health-post-2015-development-agenda-who-discussion-paper-october-2012 (emphasis in original).
[85] UN General Assembly, *Global health and foreign policy: resolution adopted by the General Assembly*, 2012, https://digitallibrary.un.org/record/747119 (emphasis added).
[86] Vega, 'Universal health coverage'.
[87] World Health Organization and Government of Finland, Ministry of Social Affairs and Health, *Health in all policies: Helsinki statement. Framework for country action* (Geneva: WHO, 2014), https://apps.who.int/iris/handle/10665/112636.
[88] Shiffman and Shawar, 'Framing and the formation of global health priorities'.
[89] Granmo, *Health norms in the global governance of development* (emphasis in original).

resulting from GHS norm proliferation. By 2009, both were beginning to be viewed as synergistic goals. WHO Director-General Margaret Chan encapsulated this, arguing that disease-specific interventions (GHS) and HSS (UHC) 'are not mutually exclusive but rather mutually reinforcing'.[90] This period marked the nascent 'emergence' of conceptualizing GHS and UHC as an integrated package of norms for states to enact.

Norm internalization and integrated conceptualizations: ideational shifts following GHS and UHC institutionalization (2013–2019)

The west Africa Ebola outbreak and interactions with UHC Observers saw the 2014 west Africa Ebola outbreak as a crucial moment for GHS norm diffusion.[91] The determination of the crisis as a PHEIC requiring support 'on the most urgent basis possible'[92] marked a noteworthy advancement in GHS operationalization. One month later, the UNSC characterized the Ebola outbreak as 'a threat to international peace and security',[93] amplifying security rhetoric beyond the wording of UNSC Resolution 1308. This advancement in GHS discourse reflected not just a deeper internalization of GHS norms, but also a heightened securitization logic. The impact of this progression on GHS norms can be demonstrated by the UN's deployment of its first emergency health mission (the UN Mission for Ebola Emergency Response—UNMEER), which cited 'the unprecedented nature and scope' of the Ebola outbreak[94] as justification for seemingly sidelining WHO to mitigate the crisis—a sign of increasing encroachment by non-health (often securitized) actors into conventional health spaces.

Meanwhile, throughout the Ebola response, WHO reports simultaneously encouraged member states to 'facilitate progress towards UHC'.[95] Notably, post-MDG discourse emerged as a dominant influence on several resolutions at the 67th World Health Assembly, with important implications for states to subtly (re)frame UHC norms. For example, WHA 67/25 urged countries to 'consider the contribution of health promotion in the renewal and reform of [PHC]', while WHA 67/30 encouraged medicines reimbursement lists to 'promote access to essential

[90] Margaret Chan, 'Why the world needs global health initiatives', speech, 22 June 2009, https://www.who.int/director-general/speeches/detail/why-the-world-needs-global-health-initiatives.

[91] David L. Heymann et al., 'Global health security: the wider lessons from the West African Ebola virus disease epidemic', *The Lancet* 385: 9980, 2015, pp. 1884–901, https://doi.org/10.1016/S0140-6736(15)60858-3; Tim K. Mackey, 'The Ebola outbreak: catalyzing a "shift" in global health governance?', *BMC Infectious Diseases* 16: 699, 2016, https://doi.org/10.1186/s12879-016-2016-y.

[92] Maev Kennedy, 'WHO declares Ebola outbreak an international public health emergency', *Guardian*, 8 Aug. 2014, https://www.theguardian.com/society/2014/aug/08/who-ebola-outbreak-international-public-health-emergency.

[93] United Nations, 'With spread of Ebola outpacing response, Security Council adopts Resolution 2177 (2014) urging immediate action, end to isolation of affected states', 18 Sept. 2014, https://press.un.org/en/2014/sc11566.doc.htm.

[94] Gian Luca Burci and Jakob Quirin, 'World Health Organization and United Nations documents on the Ebola outbreak in West Africa', *International Legal Materials* 54: 3, 2015, pp. 532–60, https://doi.org/10.5305/intelegamate.54.3.0532.

[95] World Health Organization, 'Access to essential medicines: report by the secretariat', 14 Jan. 2014, https://apps.who.int/gb/ebwha/pdf_files/EB134/B134_31-en.pdf.

medicines' as part of UHC.[96] Together, these resolutions portray a configuration of UHC norms that attempted to institutionalize rights-based frames from the DAA alongside more contemporary financing approaches (e.g. the 2010 *World health report*).

The gradual intermixing of GHS and UHC norms became more visible during this period, as parallel gaps in access and affordability between the Ebola and AIDS responses emerged, and multisectoral approaches like HSS were embraced over disease-specific interventions. In December 2014, high-level leaders of the Ebola response agreed to concurrently 'rebuild essential health services [and] build the foundation for universal health coverage'.[97] Meanwhile, then UN Secretary-General Ban Ki-moon noted in his remarks to the UN Economic and Social Council that 'Ebola has brought hard lessons, including the importance of functioning health systems and universal quality health coverage'.[98] This also played out regionally, with African Union Chairperson Nkosazana Dlamini-Zuma claiming the 'Ebola crisis highlighted the weaknesses of our public health systems, and the reasons for our frameworks that call for universal access'.[99]

The 2015 Special Session of the WHO Executive Board was catalytic in conceptualizing GHS and UHC together; the convening itself demonstrated profound internalization of GHS norms by uniting countries against the 'threat' of Ebola, while its report visibly promoted UHC core functions *alongside* emergency response.[100] The session framed the Ebola outbreak as a 'window of opportunity' for HSS 'that lays the groundwork … for universal access to safe, high quality health services'.[101] Complementing this was the promotion of 'resilience', a capacity focused on well-functioning health systems (UHC) during health crises (GHS), which opened a new normative space for states to envision areas of overlap, rather than prioritization of one over the other.

The joint advancement of GHS and UHC norms similarly emerged outside the Ebola response. A 2014 UNGA High-Level Meeting saw states frame non-communicable diseases as a 'great threat to economic and social structures'[102] while simultaneously affirming accessible and affordable chronic health care services through UHC. Similarly, Resolution WHA67.1[103] linked progress for UHC with improved tuberculosis outbreak notifications (GHS). Together, these reflect an evolution in how states viewed vulnerability to both infectious and non-infectious

[96] World Health Organization, 'WHA67', 2014, https://apps.who.int/gb/e/e_wha67.html.

[97] World Health Organization Executive Board, special session on Ebola, *Building resilient health systems in Ebola-affected countries: special session of the Executive Board on the Ebola Emergency* (Geneva: WHO, 2015), https://apps.who.int/iris/handle/10665/251741.

[98] United Nations, 'Secretary-General tells Economic and Social Council Ebola's "hard lessons" show universal quality health coverage critical to post-2015 development agenda', 5 Dec. 2014, https://press.un.org/en/2014/sgsm16398.doc.htm.

[99] African Union, 'Statement of the chairperson of the African Union Commission, HE Dr Nkosazana Dlamini Zuma to the emergency meeting of the African Union Executive Council on Ebola', 8 Sept. 2014, https://au.int/ar/node/25402.

[100] World Health Organization, 'EBSS3: main documents', 2015, https://apps.who.int/gb/e/e_ebss3.html.

[101] World Health Organization Executive Board, *Building resilient health systems in Ebola-affected countries*.

[102] UN General Assembly (68), 'General Assembly high-level meeting on non-communicable diseases urges national targets, global commitments to prevent needless loss of life', 10 July 2014, https://press.un.org/en/2014/ga11530.doc.htm

[103] 67th session of the World Health Assembly, *Global strategy and targets for tuberculosis prevention, care and control after 2015* (Geneva: WHO, 2014), https://apps.who.int/iris/handle/10665/162760.

disease threats, given changes to the content and operationalization of GHS and UHC norms.

Consensus among UN member states to radically move beyond the MDGs arguably had the most significant impact on the integration of GHS and UHC. For example, a resolution titled 'Health in the post-2015 development agenda' urged states to build 'capacities for broad public health measures, health protection and … equitable universal coverage', while identifying the 'synergies between policy objectives in the health sector and other sectors through a whole-of-government, whole-of-society approach'.[104] These efforts culminated in the September 2015 adoption of the Sustainable Development Goals (SDGs), of which SDG3 aimed to 'ensure healthy lives and promote well-being for all'.[105] Achieving UHC was codified as a specific target (3.8), marking a major milestone in legitimizing UHC as a stand-alone obligation for states. Meanwhile, health emergencies and IHR capacity-strengthening were promoted under another target (3.D.1). Granmo argues that the integrative framing of SDG3 was a reflection of states' preferences for 'inclusivity' and 'sustainability', two 'super-norms' that were well positioned to foster international cooperation across health-specific silos, including between GHS and UHC.[106] Kickbusch further asserts that the design of the SDGs to enable cross-cutting linkages suggested a broader shift towards policy coherence and integrative diplomacy, with implications on the content of subsequent global health norms.[107] However, the lack of explicit references to health 'security' is notable (especially given the backdrop of Ebola), suggesting hesitation among some states to further mainstream security discourse in SDG3, with a growing consensus that UHC may be better equipped to address the 'blind spots' of the MDGs.

The Zika outbreak and the introduction of GPW13 Five months after the SDGs were adopted, a new PHEIC was determined for clusters of microcephaly associated with Zika. Scholars have attributed its rapid securitization as a sign that GHS norms were still deeply internalized, particularly among emergency actors.[108] However, the WHO Zika strategic response plan[109] recommended improving access to health services in affected countries (UHC) *alongside* strengthening surveillance and risk assessments (GHS). Several resolutions during the 69th World Health Assembly in 2016 (which coincided with the peak of Zika response and followed a year of SDG3 socialization) affirmed that states were actively

[104] 67th session of the World Health Assembly, *Health in the post-2015 development agenda* (Geneva: WHO, 2014), https://apps.who.int/gb/ebwha/pdf_files/wha67/a67_r14-en.pdf.
[105] World Health Organization, 'Monitoring health for the SDGs', 2024, https://www.who.int/health-topics/sustainable-development-goals.
[106] Granmo, *Health norms in the global governance of development*.
[107] Ilona Kickbusch, Haik Nikogosian, Michel Kazatchkine and Mihály Kökény, *A guide to global health diplomacy: better health—improved global solidarity—more equity* (Geneva: Graduate Institute of International and Development Studies, Global Health Centre, 2021), https://repository.graduateinstitute.ch/record/298891.
[108] Clare Wenham et al., 'Zika, abortion and health emergencies: a review of contemporary debates', *Globalization and Health* 15: 49, 2019, https://doi.org/10.1186/s12992-019-0489-3.
[109] 69th session of the World Health Assembly, *WHO response in severe, large-scale emergencies: report of the Director-General* (Geneva: WHO, 2016), https://apps.who.int/iris/handle/10665/252685.

promoting interrelated GHS–UHC framings. For example, WHA69.1[110] heavily referenced previous agreements central to the advancement of *both* GHS and UHC, noting that 'the integrated, cross-cutting nature of the [SDGs], which call for multisectoral action', compelled states to integrate GHS and UHC capacity-strengthening.

Shortly thereafter, the launch of WHO's Thirteenth General Programme of Work (GPW13) placed health emergencies (GHS) and UHC on equal footing as two overarching goals for 2019–2023. Championed by Ghebreyesus, GPW13 urged global health actors to 'bring health emergencies and UHC closely together', observing the relationship between weak health systems and health crises.[111] It further stated 'WHO will track the impact of its emergency response work … by measuring access to and delivery of … the UHC objective', essentially connecting the monitoring of GHS with UHC implementation. Ghebreyesus, and WHO more broadly, can thus be viewed as norm entrepreneurs of an emerging 'integrated' package of GHS and UHC norms, emblematic of SDG3 and post-Ebola resolutions that endeavoured towards whole-of-society, interlinked health systems.

UHC Political Declaration and WHO Health Emergencies Reports The UN High-Level Meeting on UHC (UHC HLM) in September 2019, the first convening among UNGA member states dedicated to this topic, aimed to 'strongly recommit to achieve universal health coverage by 2030'.[112] However, the simultaneous embrace of GHS discourse by states conveys an alternative, frequently overlooked narrative—that UHC norms had continued to evolve, often in response to concurrent advancements in GHS. For instance, the WHO's preparatory document for the UHC HLM's political declaration in March 2019 urged 'a shift in traditional development thinking' long focused on 'fighting disease', and suggested that UHC 'is both a goal in itself and a means for implementing other goals', including disease prevention and health promotion.[113] This document made no reference to 'health security' or 'health emergencies', and was relatively consistent with preceding UHC-related texts such as WHA 67/25. However, by May 2019, the preliminary draft signalled that states were intentionally introducing GHS-specific language, explicitly mentioning health security and emergencies and alluding to epidemics, pandemics and other threats[114]—a noteworthy shift which was likely catalysed by the simultaneous new PHEIC for Ebola in the Democratic Republic of the

[110] 69th session of the World Health Assembly, *Strengthening essential public health functions in support of the achievement of universal health coverage* (Geneva: WHO, 2016), https://apps.who.int/iris/handle/10665/252781.

[111] World Health Organization, 'Thirteenth general programme of work 2019–2023', https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf.

[112] UHC 2030, 'Political declaration for the UN high-level meeting on UHC', 16 Sept. 2019, https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf.

[113] World Health Organization, *Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage*, 2019, https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_14-en.pdf.

[114] HE Mr Kaha Imnadze and HE Mr Vitavas Srivihok, 'Zero draft of the political declaration of the high-level meeting on universal health coverage', UNGA, 17 May 2019, https://www.un.org/pga/73/2019/05/17/universal-health-coverage-8.

Congo.[115] The adopted UHC HLM political declaration featured the most frequent and robust references to GHS in a UHC-focused document, repeatedly drawing links to communicable disease control, health emergency response, health security and pandemic preparedness.[116]

Meanwhile, the WHO Director-General's health emergency reports similarly reflect incremental integration of UHC discourse into the traditionally GHS-focused series. After years of exclusively detailing progress on IHR core capacities, the 2017 report recognized how infectious diseases stem from 'weak health systems *and* inadequate preparedness and response capacities', and acknowledged a 'greater focus on preventing and managing medical complications caused by Zika virus infection *and* expanding health systems' capacities'.[117] Consequently, WHO committed to supporting countries' health emergencies response through HSS. The 2018 report introduced UHC language for the first time, saying:

> The interrelated issues of safeguarding our health security while promoting our health through universal health coverage are WHO's top priority … Strong health systems are our best defence to prevent disease outbreaks from becoming epidemics … based on principles of universal access, readiness and resilience.[118]

This passage illustrates the harmonization of previously distinct GHS and UHC discourse in a way that transforms the 'content' of both norms, shaped by the concurrent management of the DRC Ebola PHEIC alongside negotiations for the first PHC political declaration since the DAA. These ideational shifts were consolidated in the 2019 WHA report, which explicitly championed 'the integration of universal health coverage and health security', closely reflecting GPW13 framings in a way that obligated state behaviour to address both synergistically.[119]

A new approach: understanding GHS and UHC norms as ongoing processes

Our analysis extends current interpretations of GHS and UHC norms by examining how they have been (re)constructed through contestation and interaction. We therefore propose three major insights: 1) the 'content' of GHS and UHC norms is constantly evolving, even after both have passed through respective norm life-cycles, 2) GHS and UHC norms have significantly influenced each

[115] World Health Organization, 'Statement on the meeting of the International Health Regulations (2005) Emergency Committee for Ebola virus disease in the Democratic Republic of the Congo on 17 July 2019', 17 July 2019, https://www.who.int/news/item/17-07-2019-statement-on-the-meeting-of-the-international-healthregulations-(2005)-emergency-committee-for-ebolavirus-disease-in-the-democratic-republic-of-the-congo-on-17-july-2019.

[116] UHC 2030, 'Political declaration for the UN high-level meeting on UHC'.

[117] 70th session of the World Health Assembly, *Health emergencies: WHO response in severe, large-scale emergencies: report by the Director-General* (Geneva: WHO, 2017), https://apps.who.int/iris/handle/10665/274705 (emphasis added).

[118] 71st session of the World Health Assembly, *Public health preparedness and response: WHO's work in health emergencies: report by the Director-General* (Geneva: WHO, 2018), https://iris.who.int/handle/10665/276289.

[119] 72nd session of the World Health Assembly, *Public health emergencies: preparedness and response: WHO's work in health emergencies: report by the Director-General* (Geneva: WHO, 2019), https://apps.who.int/iris/handle/10665/328553.

other as they developed together, and 3) GHS and UHC norms have been increasingly conceptualized in integrated ways over recent years.

Our analysis demonstrates potential limitations in Finnemore and Sikkink's norm life-cycle model, which sees norms as 'settled' once the tipping-point and cascade have been reached. Krook and True's conceptualization of norms 'as processes' may explain how both norms evolved from distinct policy domains into increasingly synergistic regimes—a phenomenon that is relatively unexplored in International Relations. This is particularly applicable to inherently complex normative situations like GHS and UHC—where multiple norms compete for influence and where, in this case, rather than emerging from the tension as alternative or hierarchical norms, both adapt to each other to maintain relevance.

Continuously evolving norm life-cycles

A re-examination of GHS and UHC norms as ongoing processes suggests that their life-cycles and underlying frameworks have always been—and will likely continue to be—in a state of flux. While this does not negate progressive stages of norm development, it suggests that norm progression is more fluid, marked by periods of reversal, transformation and advancement. Our analysis demonstrates that the content of GHS norms has been continually reconstituted, from the International Sanitary Conferences to the post-Cold War and 9/11 securitization, to HIV/AIDS and the proliferation of vertical disease programmes following the MDGs. Today, a lack of IHR compliance[120] calls for a 'One Health' approach,[121] and rising socio-economic inequities during health emergencies like the COVID–19 pandemic portend future (re)constructions of GHS norms. Meanwhile, early rights-based commitments for UHC characterized as 'health for all' gave way to 'selective coverage' considering economic constraints and globalization, followed by a focus on financial protection and HSS, and ultimately reconfiguration as a cross-cutting target via SDG3.8 based on 'sustainability'. Today, new conceptualizations of UHC norms, reinvigorated by renewed attention on PHC and community-level resilience, have been promoted in the 2023 UHC HLM.[122] As reflected in the texts, these shifts in the content of GHS and UHC norms influenced state behaviour and obligations; evolution is ongoing, as manifested by continued subtle and profound changes.

The findings demonstrate that securitization served as an enabling condition for the emergence of GHS norms,[123] while the right to health served as an enabling condition for the emergence of UHC norms.[124] Both norms have further

[120] Sadia Mariam Malik, Amy Barlow and Benjamin Johnson, 'Reconceptualising health security in post-COVID–19 world', *BMJ Global Health* 6: 7, 2021, https://doi.org/10.1136/BMJGH-2021-006520.

[121] Yibeltal Assefa et al., 'Global health security and universal health coverage: understanding convergences and divergences for a synergistic response', *PLoS ONE* 15: 12, 2020, https://doi.org/10.1371/journal.pone.0244555.

[122] UN General Assembly, 'Political declaration of the high-level meeting on universal health coverage', 25 Sept. 2023, https://documents.un.org/doc/undoc/ltd/n23/272/29/pdf/n2327229.pdf.

[123] Preslava Stoeva, 'Dimensions of health security—a conceptual analysis', *Global Challenges* 4: 10, 2020, https://doi.org/10.1002/gch2.201700003.

[124] Gorik Ooms et al., 'Universal health coverage anchored in the right to health', *Bulletin of the World Health*

evolved since their respective ideational origins, but it is precisely *because* of (not in spite of) their dynamic and iterative histories that they persist today. Understanding GHS and UHC norms as continuously evolving processes thus helps to: 1) upend the view that normative development in GHS and UHC follows a linear path, 2) characterize GHS and UHC both as norms themselves *and* as a means for shaping other (re)constructed norms (and corresponding regimes), and 3) suggest that recurring patterns observed after significant international agreements and health crises are likely to persist in shaping future shifts in GHS and UHC.

Interlinkages through interaction and contestation

GHS norms have traditionally maintained a narrow focus on infectious disease control and health emergency response, further reinforced by IHR core capacities; increased support for UHC norms is routinely preceded by the elevation of underlying principles like equity and inclusivity. However, our analysis also suggests that the resurgence of rights-based discourse from UHC often fuels critiques of GHS (e.g. as being overly accommodating of national security interests at the expense of vulnerable populations), which has sometimes resulted in a deprioritization of GHS (e.g. within SDG3) or a transformation in the content of GHS (e.g. within the 2014 Ebola response). This discursive view of norm change also helps explain ideational shifts in UHC. For example, UHC norm entrepreneurs responded to critiques over ambiguous 'context-specific' definitions and the glacial pace of 'progressive realization' by increasingly drawing on 'high politics' framings conventionally associated with GHS[125] (e.g. 'front-line' health workers, characterizing non-communicable diseases as a 'threat' to national and economic security, mainstreaming UHC in emergency preparedness).[126]

Interestingly, repeated contestation and interaction between GHS and UHC has not led to the obsolescence of either norm, as is often expected in fraught normative landscapes, but has in fact helped both norms adapt to maintain relevance—with different framings emphasized at different times. This was the case with the SDGs agenda, which pushed GHS norm entrepreneurs to promote HSS following decades of siloed disease-specific programming, while also enabling UHC norm entrepreneurs to move beyond the confines of selective health insurance to re-emphasize UHC's roots in social determinants of health. Moving forward, GHS and UHC advocates could capitalize on each other's unique strengths. Our analysis suggests that GHS norms have generally enjoyed significant inertia due to perceived 'high politics' and conventional top-down governance structures, thereby catalysing global investments in ways that UHC norms have struggled to mobilize. Meanwhile, UHC norms traditionally enjoy broader support among global South and civil society actors given rights-based foundations, a blind spot of the GHS

Organization 91: 1, 2013, pp. 2–2A, https://doi.org/10.2471/BLT.12.115808.

[125] Jeremy Youde, 'High politics, low politics, and global health', *Journal of Global Security Studies* 1: 2, 2016, pp. 157–70, https://doi.org/10.1093/jogss/ogw001.

[126] World Health Organization, 'Communicable and noncommunicable diseases, and mental health', n.d., https://www.who.int/our-work/communicable-and-noncommunicable-diseases-and-mental-health.

regime. Building off their complementary (re)constructions may help both GHS and UHC norm entrepreneurs advance their goals in the face of new challenges.

Mutually reinforcing integration

A 'norms as processes' approach helps unpack the ways in which GHS and UHC norms continue to be constructed through integrated discourse and core functions. Our analysis traces the diffusion of UHC norms within GHS documents (e.g. WHO health emergency reports) alongside concurrent diffusion of GHS norms within UHC documents (e.g. iterative drafts of the 2019 UHC HLM political declaration)—both examples of meaningful incorporation in spaces where they were once excluded. The positioning of GHS and UHC as mutually reinforcing norms intensified as a result of the post-MDG agenda. This may suggest further integration and potentially new (re)constructions as the SDGs approach their own deadline in 2030, which has been further shaped by negotiations for a new pandemic agreement, IHR amendments, and subsequent UN HLMs related to GHS and UHC.[127]

Moving forward, challenges remain in reconciling fundamental differences between GHS and UHC norm regimes due to their diverse constituencies and conceptualizations. Our analysis shows that GHS norms, rooted in securitized approaches often favoured among foreign policy circles, are better primed to be operationalized through international legislation. Meanwhile UHC norms, rooted in human rights, are primarily framed as domestic issues warranting local, context-specific interventions. This creates divergences in how epistemic and ontological communities conceptualize GHS and UHC, and how both are implemented (e.g. GHS actors may approach antimicrobial resistance through global surveillance, while UHC actors may respond through local health worker training). Furthermore, the legally binding mechanisms through which GHS norms are codified tend to more explicitly obligate specific steps for capacity-strengthening (e.g. IHR). In comparison, UHC norms often have broader human rights implications, and therefore may be more challenging to pass through targeted international law; this sometimes leads to relatively ambiguous commitments that lack rigorous technical guidance (e.g. the UN Convention on the Rights of Persons with Disabilities promotes principles of access and non-discrimination, but makes no explicit mention of UHC, nor of strategies for financial protection).[128] This poses challenges for the holistic pursuit of both norms: global commitments towards the 'right to health' cannot be well protected because states ultimately decide their own levels of UHC, while GHS is undermined internationally by inequitable access to health services domestically.

[127] Arush Lal et al., 'Pandemic preparedness and response: exploring the role of universal health coverage within the global health security architecture', *The Lancet Global Health* 10: 11, 2022, pp. e1675–83, https://doi.org/10.1016/S2214-109X(22)00341-2.

[128] UN Division for Inclusive Social Development, 'Convention on the Rights of Persons with Disabilities (CRPD)', https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd.

GHS norms may initially appear to hold greater normative weight in international forums, given relatively clearer obligations through legally binding instruments. However, while the securitization narratives associated with GHS can be effective catalysts for tangible policy actions, this framing often proves reactionary and short-termist; meanwhile, rights-based frames can be powerful motivators for longer-term, sustainable action.[129] For the moment, however, UHC advocates appear to be more accommodating of GHS norms than vice versa. Similarly, the relatively anaemic embrace of UHC discourse into the GHS regime (as opposed to GHS discourse into UHC initiatives) may suggest that GHS has undergone more rigorous normative grounding than UHC (possibly due to perceived urgency of GHS discourse during crises and/or the 'robustness' of GHS core functions institutionalized by security actors). The GHS regime may therefore be more resistant to integrate UHC norms than the other way around.

The variation in normative weight among different actors also means there may be occasions where integration appears (e.g. evoking UHC discourse during recent health emergencies) but is not meaningfully operationalized for political or operational reasons, implying the need to distinguish between 'lip service' and sustained uptake (i.e. their co-presence in a document may not be enough to substantiate convergence). Solely relying on the norm life-cycle would suggest that GHS and UHC norms (and their emerging intersections) are only influential *after* they have 'emerged' and been internalized. However, our view of GHS and UHC norms as ongoing processes posits that interaction and contestation matter more to normative development—and indeed to subsequent integration—than conventional literature suggests. This means that even if a major negotiation fails to ensure norm compliance with GHS, or a crisis struggles to immediately advance UHC reforms, the very process of norm (re)construction can inevitably 'connect [policy-makers] with deeper normative paradigms that subtly shape policy solutions' in ways that warrant deeper study.[130]

Implications for broader International Relations theory

These findings have broader implications for International Relations, and for the strategic development of co-evolving norms in other spheres of governance. This article demonstrates that norms are dynamic—not only in the temporal sense, but also in the sense that normative development occurs in response to both internal and external factors. Indeed, norms evolve through contestation and interaction with each other and, importantly, as a consequence of strategic determination by norm entrepreneurs who seek to interlink and integrate normative positions within broader norm regimes.[131] This might be for agenda-raising reasons for a

[129] Fourie, 'AIDS as a security threat'.

[130] Martha Finnemore and Kathryn Sikkink, 'Taking stock: the constructivist research program in international relations and comparative politics', *Annual Review of Political Science*, 4: 1, 2001, pp. 391–416, cited in Lisa Forman, Gorik Ooms and Claire E. Brolan, 'Rights language in the Sustainable Development agenda: has right to health discourse and norms shaped health goals*?* *International Journal of Health Policy and Management* 4: 12, 2015, pp. 799–804, https://doi.org/10.15171/ijhpm.2015.171. _

[131] Clare Wenham, 'Forum shifting in global health security', *Bulletin of the World Health Organization*, vol. 102,

norm which has less saliency—to 'hitch' it to a more politically dominant norm so that both policy areas are developed in tandem—or to ensure that norm evolution does not lead to a 'siloization' of policy pathways.

This work therefore demonstrates the agency of diverse actors to push for normative alignment seen to be of value (albeit not necessarily for the same reasons) in recognition of the strategic purpose of norm integration where two powerful norms each co-produce greater stability when co-evolution occurs. It also points to the importance of interactive norm regimes, and proposes that once a tipping-point for normative integration has been reached, expectations for such interlinked approaches may become self-fulfilling. As such, it may not be that newly emergent norms simply supersede or replace 'older' norms. Rather, a dynamic process of norm (re)construction is likely to enable more nuanced positions.

The findings of this article also have implications for other sectors, which see an opportunity to integrate different normative positions collectively, rather than considering diverging framings to be a zero-sum contest. Multiple forums in global governance could benefit from understanding the political and practical feasibility of this—particularly areas facing interlinked challenges, including climate change, conflict resolution, human rights, economic inequality, humanitarian crises and nuclear non-proliferation. Policy-makers and advocates in each area might benefit by pushing for greater interaction between their normative positions and those that offer new strategic advantages, to ensure mutual reinforcement amid growing resource constraints and fluctuating policy priorities.

Conclusion

In tracing their origins from securitization and right-to-health frames through subsequent development following major international agreements and crises, we ultimately characterize GHS and UHC norms as continuously evolving, closely interlinked and increasingly integrated. We argue that both norms have been iteratively (re)constructed after significantly shaping each other, and have subsequently constituted new sets of obligations for states and non-state actors to jointly pursue public health efforts. In doing so, we provide a wider conceptual contribution to both global health and International Relations, conducting a careful genealogy of these two norms covering not just where and when they were invoked, but also the ways in which this represented a shifting of their content.

Our analysis demonstrates that examining the intersections between GHS and UHC reveals more about their nature (which is inherently interconnected) than studying their distinct pathways (which appear initially dichotomous). Thus, we find that the norm life-cycles of GHS and UHC do not follow a linear course from emergence to internalization: rather, the trajectory of their underlying components, including discourse and core functions, are fraught with points of interaction and contestation, as domestic and global stakeholders attempt to redefine, reshape and reposition them in light of internal and external dynamics. This contributes

2024, pp. 123–9, https://doi.org/10.2471/BLT.23.290480.

to the wider norms literature, arguing that the 'content' of GHS and UHC norms is constantly evolving (including after both have passed through respective norm life-cycles), allowing practitioners to account for nuanced changes in normative development.

By analysing the development of GHS and UHC norms together—rather than separately, as is usually done—this study offers a more comprehensive understanding of their respective life-cycles and increasingly synergistic (re)constructions. We therefore argue that GHS and UHC norms should not be viewed as stand-alone or independent concepts, but rather as interrelated and mutually reinforcing normative regimes. Furthermore, their co-evolution does not reflect a straightforward accumulation of insights. Instead, GHS and UHC norms appear to develop in reaction to one another, partly in line with prevailing paradigms and partly as a response to the very different needs of their stakeholders. Most importantly, both norms appear to thrive on each other as they have co-evolved, with different weightings and narratives being leveraged at different points in time. So, while GHS and UHC may still be considered separate norms with respective regimes (indeed, in practice they often require individual policies and budget lines), both are ultimately delivered through the same health system, and it may be strategically salient to approach them together.

Noting the challenges of identifying precise characteristics for each stage of norm development, further research is needed to examine how non-health norms affect GHS and UHC emergence; how legal instrumentalization or regime politics influence subsequent internalization; and how the COVID–19 pandemic affects the convergence and coherence of GHS and UHC norms. Additionally, while this study was intentionally focused on examining discursive shifts in GHS and UHC largely codified by states through high-profile international agreements (which arguably may be relatively susceptible to normative integration from other policy areas), further research could focus on the more 'mundane' day-to-day shifts in normative development, as well as the crucial role of non-state actors (e.g. civil society and donors) in constructing GHS and UHC norms.

This account of how multiple norms compete in a dynamic interplay to continually influence and reshape each other offers crucial insights to forecast normative development in the face of novel, interlinked challenges. By advancing our understanding of how two powerful norms (each embedded within distinct, yet overlapping, regimes) inevitably engage in intricate processes of norm contestation and interaction resulting from proximity and politics, this study allows us to envision a more constructive pathway for norm change—one that does not result in the ultimate obsolescence of either norm, but rather one that enables harmonization and resilience of (re)constructed norms through strategic integration. The lessons derived from this work not only contribute to the scholarly discourse on international norms theory, but also offer pragmatic implications for practitioners navigating the complexities of global health governance and other areas of foreign policy in an ever-shifting normative landscape.