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**REGIONAL INTEGRATION AND POVERTY:
HOW DO SOUTHERN REGIONALISMS EMBED NORMS AND PRACTICES
OF SOCIAL DEVELOPMENT THROUGH HEALTH
GOVERNANCE AND DIPLOMACY?¹**

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ABSTRACT

Regional organisations are moving away from traditional market-based goals to embrace issues of welfare and social development, yet little is known what role, if any, regional organisations can play in policy formation that is conducive to embed alternative approaches to development into national and international strategies and normative frameworks. This paper explores how Southern regional organisations and regionalisms as advanced by the Union of South American Nations (UNASUR) and the Southern African Development Community (SADC) are framing and advancing pro-poor norms and goals. While not coherent citizenship-centred projects of regionalism, SADC and UNASUR have manifested new ambitions regarding poverty reduction and the promotion of welfare and are developing modalities conducive to embed these goals in national and global policy-making. The analysis focuses on the specific area of health, a proxy to poverty reduction in both regional organisations, to argue that Southern regional organisations, while neglected partners in global governance of development, are can promote and prescribe standards for social development and poverty reduction; and act as forum for the advocacy of equity and rights. In this context, there are three key messages from this paper: (i) poverty needs to be brought in to the study of regional integration and regional governance; (ii) the efforts of regional organisations to reduce poverty need to be taken more seriously in the literature and in practice; and (iii) regional organisations can be seen as engines of norms, spaces for advocacy and effective normative corridors affecting policy at national and international levels of governance.

KEYWORDS: regional integration, poverty reduction, regional health diplomacy, normative framing, SADC, UNASUR

1. INTRODUCTION

In the vast research field of regionalism that has flourished during the last two decades expectations of what regional governance can deliver have been evaluated primarily in terms of economic and security governance. While much has been written about economic integration, regional institutions and security communities, a discussion of how significant other policy areas have been in the process of region building and governance has lagged behind. Specifically, a rather neglected policy domain in the account of contemporary forms of regionalism has been social policy (see Yeates and Deacon, 2006; Deacon et al 2006; Yeates, 2014a; Deacon et al. 2010). However, since the late 1990s, many regional organisations have widened their mandates to incorporate elements of social policies including mandates on poverty reduction. As a consequence, regional groupings of countries are embracing new agendas and developing plans of action to achieve social goals. Furthermore, regional organisation are framing debates and agendas as to what the purpose of regional integration should be, what kinds of social policies are needed, and what the respective roles of regional, national and international institutions should be in helping to achieve them (Riggirozzi and Yeates, 2015; Riggirozzi, 2014; 2015). This is particularly significant in regions where the extent and intensity of poverty are driving forces behind under-development, inequality and exclusion (UNCTAD, 2015).

Referencing these ideas, this paper takes a closer examination at regional integration and poverty to argue that Southern regional organisations, while neglected partners in global governance of development, could be appropriate platforms to promote and prescribe (alternative) standards for social development and poverty reduction, and a forum for the advocacy of equity and rights at both national and global levels. This also links to a second argument, that regional diplomacy and action is becoming of increasing interest, in terms of its potential to promote progressive and equitable social policies. However evidence of the ways to promote regional engagement vis-à-vis other actors, is insufficiently explored (Riggirozzi and Yeates, 2015).

The paper takes upon this task by comparing the Southern African Development Community (SADC) and the Union of South American Nations (UNASUR) as examples of regional formations increasingly embedding new poverty reduction mandates and pro-poor

commitments in their normative frameworks, regional projects, forms of cooperation, and governance. Based on the collaborative research in the context of the ESRC-DFID-funded Poverty Reduction and Regional Integration (PRARI) project the paper addresses these issues in cross-regional comparative perspective looking at how SADC and UNASUR advance the goals of poverty reduction through health.

The paper focuses on the particular case of health, as this has been a distinctive proxy for poverty reduction in both regions. In recent years, health has become a strategic policy driver redefining the terms of regionalism in South America and South Africa. Both SADC and UNASUR have established institutional mechanisms within the health sector and financial provisions necessary for the professionalisation of the sector and effective implementation of policies increasing access to health care and medicines for impoverished populations and vulnerable communities. The significance of these new modes of health governance lies in the process of regionally-coordinated policies and projects within the regional spaces and in terms of health diplomacy, with enormous implications for poverty alleviation and social development. Yet the way the poverty reduction mandate has been defined, embedded and promoted in each regional institutional framework and practice has differed, and so has the impact of these two Southern regional organisations in redefining trans-border practices and cooperation and interventions.

The driving questions of the paper are: what, if any, is the role of regional organisations developing regional norms and policy frameworks in support of poverty reduction? What are the opportunities and how do regional organisations ensure health policies related to poverty reduction are embedded in national (and international) practices?

Analytically, the study contributes to bridging the continuing gulf between research in social policy and health, which neglects regional governance, and research in regional integration and governance, which pays little attention to the 'low' politics of health and welfare (Riggiriozzi and Yeates, 2015). Investigating what regional formations are saying and doing about access to health (vaccines, medicines and services) enables a new vantage point on the political institutional conditions, constellations and activism giving rise to effective poverty reduction policies (see <http://www.open.ac.uk/socialsciences/prari/>).

As a corollary, the paper seeks to unveil what Acharya and Buzan (2007) recognised as 'hidden' in the thinking and practice of international relations opening up a space in the debate about the role of regions, and regional integration, in developmental strategies and trajectories in the global political economy. The assumption of neglected, hidden South is not surprising as policy makers and social groups from the developed world have often set agendas in global politics; that is what is visible and urgent, what shapes ideas in global governance and beliefs about international behaviour, and ultimately what is a matter of high politics. Claiming, framing and advancing norms in global governance have often been associated by scholarly work with power, influence, and hegemonic dominance of Northern-based states and non-governmental organisations. While this assumption holds on many counts of international policy-making and international relations, it also deserves a closer examination. Developments in global governance during the last fifteen years suggest that the importance of regions and Southern regionalism is increasing in North-South and South-South development agendas, and that regional structures have a transformative capacity in leading new processes of cooperation and sectoral integration which can in turn impact on the way of thinking and practicing social policy and welfare.

2. POVERTY OF REGIONAL STUDIES

Multilateral regional organisations are of substantial and growing significance in processes of international integration and international development cooperation (Deacon et al 2010; Riggirozzi and Tussie, 2012; Cavaleri, 2014; Riggirozzi and Yeates, 2015). Their significance is growing because regional formations across the globe are seeking social and political integration to address issues of poverty and inequality and ways to mitigate trans-border social issues and harms. Regional policy cooperation is extending beyond the regionalisation of labour and commercial markets to address opportunities to strengthen actions on poverty reduction and equity (Yeates, 2014a, b). One should not assume that this is new. There is a bulk of literature attesting the distinct question 'is regionalism good or bad for world welfare?' that could be traced back to the early assessments of the European integration (for instance Viner 1950; Baldwin 2008). But it was not until recently when research on the links between regional integration and poverty was explored more systematically. The research agenda was

set up by Schiff and Winters (2003) and te Velde (2006) who focused on the liberalisation of foreign trade, foreign direct investment, and labour migration, and recognised the importance of active regional public policies in ensuring a fair distribution of benefits from economic integration. These scholars indeed opened an interesting debate about economic integration and poverty reduction through economic and market generation and have recognised the importance of active regional public policies in ensuring a fair distribution of benefits from economic integration. But the arguments have not gone any further. Willem te Velde's approach is that regional integration affects the movements of products and factors of production across borders – trade in goods and services and movement of people and capital – and these in turn affect poverty through various routes, although strictly speaking some of this could be seen as economic integration. Within this approach the expectation is that prosperity and wellbeing are achieved as a consequence of economic growth – that is, if the market is free it will deliver to social areas – ignoring the importance of direct interventions on social development and equity. Likewise, Tekere (2012) published a compelling edited volume, *Regional Trade Integration, Economic Growth and Poverty Reduction in Southern Africa*, in which contributors explore the effectiveness of regional organisations in the delivery of poverty-reduction strategies. Much in line with te Velde and Schiff and Winters, the argument suggests that economic growth could be enhanced by regional integration agreements and that competitiveness policies and other free trade agreements could in turn lead to poverty reduction and socioeconomic development (UNCTAD, 2015). Left unexplored in this scholarly endeavour is whether poverty reduction agendas and goals that focus on aspects of welfare and equity are in practice being progressed through regional cooperation, and if so, how regional social policies work in practice addressing social asymmetries across countries and their societies (Yeates, 2014a, b; Riggiozzi, 2014).

In the fields of political sociology and Social Policy, normative arguments have been offered and calls for a stronger social policy focus in the analysis of transnational cooperation in the Global North and South alike are now well established (Yeates and Deacon 2006, Ortiz 2007; Deacon et al 2010; Yeates 2014a,b). These arguments have revolved around effective ways of securing cross-border coordinating and implementing specific projects (for example cross-border employment projects, disaster mitigation funds, vaccination campaigns, food

programmes) within and beyond the EU (*ibid*, also Cavaleri 2014). In the case of the EU some issues related to regulatory frameworks for harmonisation of migration and health policies, services and potentially rights in the social fields have also been explored (*ibid*, also Threlfall 2003; Steffen 2005; Hoffman and Bianculli 2015). Outside the EU, coordinating initiatives in regional spaces has been addressed as means for breaking with traditional models of unilateral transfer of 'ready-made packages' conveyed in global development aid (Almeida et al 2010). Despite these conceptualisations, there is little actual empirical research on regional social policy outside the EU context; specifically on how regional policies address social needs, advance inclusion and promote social development. Not enough is yet known about the significance of regional organisations' ambitions and initiatives for welfare systems, citizenship rights and global governance; and we do not yet know enough about how regional groupings are operating in practice within (and beyond) their territories and fora (see Riggiozzi and Yeates, 2015).

This is not merely academic neglect but the result of how regional integration, particularly in the South, has evolved; namely as economic integration and as security communities (Buzan 2003; Acharya and Johnston 2007; Mansfield and Solinger 2010; Acharya 2011). Regional politics beyond the EU especially was seen to be nested in and modelled by demands for trade and financial deregulation, or the creation of security communities, captured by ideological and political constrictions, securing at the same time regional spheres of influence (Gamble and Payne 1996; Phillips 2004; Nel and Nolte 2010). Regionalism was seen as manifestations of global orders, envisioned as hegemonic politics triggered by the need to engage efficiently in global market activity. Regionalism from this perspective was conceived as a building block to global liberalisation through the interplay between state-led macro-processes of regulation and micro, and often informal, processes of regionalisation led by business and other non-state actors. Scholars embraced the concept of the 'new regionalism' (NR) to reflect the complex linkages among regionalism, globalisation and the neoliberal transformation. New regionalism, in theory and practice, came to explain the contrast with what was identified as 'old regionalism' to refer to previous experiences of regional integration associated with economic protectionism and inward orientation policies of the post-war era (Hettne and Soderbaum 2000; Devlin and Estevadordeal 2001; Gomez Mera 2008). The agenda of 'new' regionalism was also dominated by questions of trade and investment but rather than tariff

protection it was underpinned, politically and ideationally, by the perception of an 'unavoidable reality' of the market-led globalisation and political neoliberalism (Fawcett and Hurrell 1995; Varynen 2003; Serrano 2005). The expectation was that countries with 'open, large, and more developed neighboring economies grow faster than those with closed, smaller, and less developed neighboring economies' (Vamvakidis 1998: 251) and in turn, economic growth would lead to an increase in welfare derived from an improved allocation of domestic resources and labour creation (te Velde et al 2006). These expectations stimulated a large empirical and theoretical literature on the impact of trade on growth, and regional integration as cementing a developmental project (Sunkel 2000: 67; Doidge 2007: 4). The DNA for understanding origins, identity, practices, and what Southern regionalism *is for* became identified with tautological realities of a neoliberal, post-Communist global political economy in the 1990s (Serrano 2005:13) – in most cases seen as outcomes of hegemonic orders (Nel and Nolte 2010). Ultimately, regionalism became a strategy that states adopt in order to bring about a process of neoliberal development, and a tool for reproducing its ideational and institutional frameworks.

But growth based on trade can run in contradictory directions. They can have positive and negative consequences for (social) development: they can, on one hand, distort and diminish trade and growth; on the other hand they can also be used to protect employment and sectors at risk and give them time to adjust. In practice, the desire to overcome the economic disadvantages of fragmentation gave rise to the establishment of a plethora of treaties and regional institutions. As processes of integration through the commercial activities of states and non-state actors developed in Southern Africa, North America, Latin America and East Asia/Asia Pacific since the 1990, the literature recognised that the net benefits of an integration process were ambiguous and distributed in an unbalanced manner among partners (Gamble and Payne 1996; Fawcett and Hurrell 1995; Marchand et al 2005; Hettne 2005). The failure of development policies, particularly of structural adjustment programmes that many developing countries adopted as part of conditional foreign aid packages, failed to reverse the poor economic performance of the previous decade and to deliver well-being for those living within the confines of the region. Furthermore, perceived trade-offs between full employment and price stability; growth and income distribution; or, more generally, between efficiency and equity meant that the economic rationale and even morality of market-led

development strategies at national and regional levels came under scrutiny across the developing world (Grugel and Ruggirozzi 2009; Fioramonti 2012; Ruggirozzi and Tussie 2012).

Recent controversies about the EU in the aftermath of the Eurozone financial crisis, including the unprecedentedly strong showing of EU-sceptic parties in the 2014 European parliamentary elections, however, provide the most current and unequivocal example of how regional organisations are sites of contention (Holden 2012). Predating this crisis, public contestation played a significant role in the unravelling of market-led regionalism in the Americas. Mobilisation to oppose the Free-Trade Agreement of the Americas (FTAA), a US-led continental ambition advanced through official negotiations since the mid-1990s, followed by the formation of national and transnational social movement coalitions demanding ‘another integration is possible’, paved the way to a cycle of contentious politics and the renewal of regional politics that became manifested at the turn of the century (Serbin 2012). Furthermore, while the welfare systems of EU member-states are being challenged by unprecedented levels of public indebtedness, and social backlash against the failure of social democratic models, the resurgence of new forms of nationalisms in Latin America, fuelled by rising global demand for primary commodities which transformed old hierarchies in international political economy, enhanced policy space for the demand for national and regional initiatives on social welfare. Undeniably, regional economic frameworks (Fawcett and Hurrell 1995; Acharya and Johnston 2007), security complexes (Adler and Barnett 1998; Buzan 2003), supranationality and sovereignty (Mattli 1999; Malamud 2003) are fundamental dimensions for the analysis of regional formations. Yet, there is an important agenda of research that finds new relevance given that the international political and economic circumstances that gave substance to new regionalism in the 1980s and 1990s – as a project and an approach – do not hold so firmly any longer, and that we are witnessing new forms of regional cooperation and modes of delivering policies in support of poverty reduction, social protection, and human development embraced by Southern regionalisms.

For normative and political reasons, regional frameworks are restating proposals for growth with equity echoing an energetic movement away from defining poverty as exclusively determined by the lack of income, growth, and standard social needs towards a more holistic understanding of poverty as part of social (in)justice (Grugel and Uhlir 2012; also UNCTAD 2015). Of course normative claims about social development and justice as an overarching

approach to regional governance must not downplay politics. Regional frameworks pushing for such goals in relation to social and economic development have in practice been quite conservative in turning the rhetoric into practice (see St Clair and McNeill 2009). In other words, translating normative principles into politics of compliance and practices for policy implementation remains uneven across world regions.

It is in this context that regional organisations can play a role providing normative frameworks that can structure practices at different levels of governance. There has been some recognition in the field of political sociology that regional organisations can become pivotal actors in cross-border coordination of redistributive projects such as employment projects, social protection, disaster mitigation funds, vaccination campaigns, food programmes; as well as regulatory frameworks for convergence, and harmonisation of policies, services and potentially rights in the social fields (Deacon et al 2007, 2010; Yeates 2014a; also Threlfall 2003; te Velde et al 2006). As Deacon et al. (2010) and Yeates (2014a, b) have argued, there is greater acceptance in global and national policy fora of the distinctive benefits of strengthened regional governance of (social) policy as regional organisations can coordinate cross border policies and responses; provide donors and aid development partners with a hub or point of contact for policy negotiation and resource channelling; become a platform for small countries to enhance their voices through concerted policy positions, enhancing access to and influence over global policy.

From this perspective, it can be proposed that regional governance is about setting normative parameters as much as creating spaces of cooperation for the design and implementation of regional policies. I agree with Acharya (2011) that the study of norm generation and diffusion needs to pay more attention to the agency of regional policy spaces, often considered norm recipients, and their ability to re-enact norms and ideas that may emanate from their member states and societies or from external agents. Recent research shows that developing countries in Latin America, Asia, and Africa played a significant but hitherto unacknowledged or forgotten role in creating post-war norms and institutions related to human rights, sovereignty, and international development (*Global Governance Special Issue 2014*). Likewise, new evidence has been provided on how social relations of welfare are being (re)made over larger scales and how regional actors may initiate new norms to improve health rights in international arenas engaging in new forms of 'regional' diplomacy (see *Global Social Policy*

Special Issue 2015, and prior to that, 2007). The key idea underpinning these debates is that regionalism, particularly as it has been unfolding in the South, provides a space above the state for debate, knowledge-sharing and institutionalisation of new practices and methods of policy formation. It also provides member states' governmental and non-governmental actors with a normative vision in support of expectations in areas such as health (Riggirozzi 2015; Fourie 2013) and social economy (Feinsilver 2008; Saguier and Brent 2015); peace-keeping and security cooperation (Acharya and Seng 2003) revealing at the same time the 'Southern origins' of norms, a nuance that is not fully grasped by the current literature.

In this new register, non-traditional drivers of regionalism, such as poverty and social development – which are still missing links in the academic examination of regionalism – need to be taken more seriously in the theorising of regional governance and practices. Scholars need to engage afresh with questions of how regionalism might be thought to provide [regional] public goods, namely democracy, human rights and the eradication of poverty; and how regional organisations may operate in various policy sectors for which member states and non-state actors entrust with varying degrees of power and decision-making authority to perform specific functions.

To place poverty and social development as part of the regional agenda however is not an easy task. Development has historically been separated from the study and practice of regional legislation or (social) rights-based claims. Addressing social development as a regional goal, and responsibility, could be politically sensitive as it is associated with inequality, discrimination, social vulnerability, people exposed to risk, violence and humiliation often related to social relations and patterns of unfair economic globalisation and exclusionary modalities of production (Grugel and Uhlin 2012: 1706). In a normative sense invoking development as inclusion and equity, the 'right to development' as Grugel and Piper (2009) put it, addresses the most vulnerable based on the recognition of legal obligations, often grounded in state legislation, to create opportunities and capabilities for citizens to enjoy those rights. From this perspective rights not only protect and defend from abuses but also become themselves frameworks for social development and change. In practice, a question that becomes apparent is what role, if any, can regional institutions play in policy formation that is conducive to embed alternative approaches to development into national and international strategies and normative frameworks?

3. EMBEDDING POLICY THROUGH REGIONAL LEADERSHIP AND ADVOCACY

The responsibility of the state delivering social protection, welfare and human development in developing countries is determined by sovereign domestic spending choices albeit constrained by the systematic political economic pressure of mitigating the effects of market reforms or to secure political support of citizens. Often in the absence of state capacity, or willingness, global interventions by private non-governmental organisations and multilateral development agencies have influenced national policy by means of transnational redistribution, supranational regulations, technical advice and co-operation, or through conditional aid (Deacon et al 2007: 8). Increasingly, the presence of regional organisations in public policy-making as they assume new commitments for social development and poverty reduction is emerging as the subject of North-South and South-South development agendas.

Regional institutions can provide normative leadership and direction structuring practices in support of alternative forms of governance, and act as pivotal actors in the creation and advocacy of principles and norms that may in turn enable diplomatic and strategic options for member state and non-state actors (Riggirozzi 2015). In this regard, regional organisations can protect, promote and reshape values for social transformation and change, and help rescale practices in support of socially based approaches to development at different levels of governance, nationally and internationally.

As a policy arena, regions are a privileged space for mobilising and harnessing knowledge, ideas and norms. Regional organisations can help *framing debates* and getting issues on to the political agenda that can in turn draw attention to new issues and affect the awareness, attitudes or perceptions of key stakeholders on issues that are significant to developing countries and their societies, promoting, for example, recognition of specific groups or endorsements of international declarations. Likewise, regional organisations can *expand policy perspectives* and possibilities if they introduce new concepts, ideas on the agenda, consensus, best practices, modalities and ways of thinking a problem and a solution. Finally, regional normative frameworks and regional collective action can assist changes of programmes, policies, institutions, securing *procedural change* at domestic or international level in relation to the process whereby policy decisions are made; for instance by opening new spaces for policy dialogue or affecting policy content and legislative change.

That regional organisations can affect the framing of normative frameworks, and promote change through capacity building in support of alternative social values and practices adds nuance to conventional analysis, particularly within comparative regionalism, that has centred almost exclusively on scrutinising ‘tangibles’ when assessing the role and relevance of regionalism in policy or regime change as measure of *meaningful and effective* regionalism (de Lombaerde et al 2010; Börzel 2011). Less attention has been paid at how regionalism is part and parcel of what Acharya identifies as the creation of ‘normative congruence’ (2004: 241; 2011) to highlight the capacity of regional organisations to amalgamate and compromise international and the already rooted system of beliefs and prevailing norms in the region and in domestic arenas. Of course, different institutional frameworks support different kinds of collective action and allow different normative claims to be made, framed, and advanced (Keck and Sikkink 1990). Yet, the study of regionalism, within the IPE and IR, as well as political sociology fields, should pay greater attention to the ‘protagonist’ role regions as space of policy making and as actors themselves, that despite important inequalities of many sorts between members, are providing alternative opportunities to rework policy frameworks, ethos, and regimes, affecting national and global/international systems of norms and governance.

In line with these arguments, the subsequent study of Southern regionalism as advanced by UNASUR and SADC sheds new light on the opportunities and limitations of Southern regionalisms in the active construction through discourse, framing, and embedding of specific norms and practices conducive to embedded policies of poverty alleviation in national and international systems.

4. RECASTING POVERTY REDUCTION IN SOUTHERN REGIONALISMS: THE CASES OF SADC AND UNASUR

Mandates, approaches, and institutionalisation of poverty reduction in SADC

Fostering development through regional integration has been a major objective of African governments since most countries on the continent became independent in the 1960s. In the first two decades of the post-independence era, the focus of regional integration in Africa was,

understandably, more on political cooperation rather than economic integration, as African leaders strived to rid the continent of the vestiges of colonialism. Since the 1980s efforts have been made to shift the focus of regional integration from political cooperation to economic integration. In light of this, the establishment of SADC in Southern Africa in 1992, although undoubtedly economically motivated, it developed institutional mechanisms that aligned more broadly economic development, equality and rights (Pallotti 2004).

SADC's origins as a regional organisation were certainly shaped by conflict and political instability, in many cases associated with the legacies of apartheid and colonialism, and by the dominant neo-liberal agenda that had gained ascendancy in Africa following the end of the Cold War (Schoeman 2002). Domestic political factors, particularly as some countries in the region were transiting to democracy and the end of the apartheid era, meant that regional agreements could help to lock-in political stability and much needed economic development. But the region was also faced with a distinctive health crisis related to HIV/AIDS in the 1980s and 1990s. In this context, it is not surprising that although SADC clearly declared its objectives around the goals of promoting economic development and growth, there was also, yet allegedly less visible, a rhetorical reference to human rights associated to the achievement of economic development and regional integration (see SADC 2002: art. 4). Of significance in this context was the approval of the Regional Indicative Strategic Development Plan (RISDP), the framework in which the SADC pursues socio-economic objectives, including the fight against the HIV/AIDS, a central policy under SADC's remit (Mankazana 2015).² HIV/AIDS has effectively become a proxy to regional health policy and to poverty reduction strategies, acting as vector for vertical programmes tackling specific vulnerable populations such as women, miners, and children (*ibid*).

Tackling pro-poor, equity and social rights in the development agenda of SADC has been a difficult task. SADC's member states differ widely in their political, cultural and socio-economic background. Ethnic differences and legacy of intra- and inter-state conflict also affects not only politics and welfare in the national space, but also the construction of a sense of 'common' at the regional scale and the capacity to work together toward common goals (Jones and Hellvick 2012). There are a number of other challenges that undermine Southern

² http://www.sadc.int/files/5713/5292/8372/Regional_Indicative_Strategic_Development_Plan.pdf

Africa's potential for deeper integration, not least its financial dependency on foreign aid. Nonetheless, the severity of the HIV/AIDS epidemic, with critical economic and social consequences, in the 1990s acted as driver for a group of civil society organisations in South Africa and Zimbabwe to mobilise and demand the development of a regional code on HIV/AIDS (der Vleuten and Hulse 2013: 26). The role of the NGOS and trade unions in this campaign was particularly significant as they found in the SADC tripartite Employment and Labour Sector Committee an institutional structure of opportunity to address at a regional scale the socio-economic consequences of HIV and its impact on economic development and employment (Armstrong et al 2011: 159). The initiative was taken up by. In 1997, the SADC Code on HIV/AIDS and Employment was adopted as a non-binding document yet as a reference point in national codes and business codes. The Code frames HIV/AIDS as a major health problem with employment, economic, and human rights implications (der Vleuten and Hulse 2013: 26). The sense of risk, and its economic consequences, of HIV/AIDS, intensified by the burden of co-infection with Malaria and Tuberculosis, was catalyser for a regional organisation that still focuses on economic integration to uptake health as a key issue of the regional agenda and practice. According to the Code, SADC member states should collect, share, and disseminate data on HIV/AIDS and coordinate their policies to combat HIV/AIDS.

The Code was the first document in a series of policy initiatives at the regional level. The SADC Protocol on Health (approved by the Summit in 1999, although into force in 2004) made policy recommendations based in the Code that are binding for all member states. The Protocol, adopted at the peak of the HIV/AIDS epidemic, and in the context of the "moral cosmopolitanism" set by the MGDs (Acharya 2004: 242), reaffirms the notion that a healthy population is a prerequisite for (sustainable) economic development. In 2003 SADC established a separate HIV/AIDS unit, under the Social and Human Development Directorate, to ensure the coordination of regional activities and adopted the Maseru Declaration which includes reducing the stigma and discrimination associated with HIV/AIDS within legal and policy frameworks for cooperation.³

³ Maseru Declaration, available at http://www.sadc.int/files/6613/5333/0731/Maseru_Declaration_on_the_fight_against_HIVand_AIDS2003.pdf (accessed 15 December 2015)

What this means is that SADC has effectively provided normative frameworks that structure practices of national and international policy makers and practitioners, as well as to review, harmonise and/or develop bilateral and regional policies and strategies in order to assist member states. But its main limitation is its dependency on donors. To a large extent this has been even more the case as these programmes are often skewed by the priorities of Western donors, who are driven by evidence-based outputs, rather than politically sensitive programmes of reform, and who need to justify to their national constituencies the rationale of intervention and foreign aid. More than half of SADC's US\$79 million annual budget in 2014 came from donors (ENCA 2015). Dependency may also mean engaging in power constellations, institutional processes, interests of national and global actors affecting the way health and social welfare approaches are defined and resources distributed. Facing the pressures of HIV/AIDS and other communicable diseases SADC and SADC countries are particularly susceptible to advance national programmes that are supported financially by donors, and that come with specific approaches, if not conditions, attached to them. According to Harman (2015: 468), despite the positive rhetoric about poverty reduction of many donors and multilateral aid agencies, and despite having the best intentions, programmes from international non-governmental and philanthropic organisations, and private charities have been often guided by their specific views, agendas and objectives. Effectively, the last fifteen years have been marked by a rise in vertical health spending where development assistance has been allocated to specific diseases, whereas HIV received more international assistance than any other health issue in Southern Africa, but where very little has been done to strengthen weak healthcare systems, which are in many cases unreachable or distrusted by the people they are designed to help, or to tackle deeper culture issues related to stigma and discrimination. The risk is that what is visible and urgent for external agencies takes priority over what is deemed marginal in developing countries. Actions targeted on people living in poverty that ignore social determinants of poverty and social exclusion risk discriminating against the very people they are ostensibly designed to benefit. Likewise, significant parts of the health sector, from health ministries to residential officers and practitioners, may organise around fulfilling international criteria attached to aid programmes undermining other opportunities to address concerns that may be important to a specific country (*ibid*: 8). As a result, approaches to inclusion and rights turned attention to health promotion through individualistic focus on lifestyle and behaviour change strategies,

which while important brushes aside a more effective integrated and comprehensive health care solution in the long term. For instance, PEPFAR, launched in 2003 by the US President, George W. Bush, had at its core the so-called ABC guidance; that is, 'Abstinence, Be faithful and consistent Condom use'; while the UN programme in HIV/AIDS (UNAIDS) and the WHO articulated a framework for 'voluntary medical circumcision for HIV prevention' with the financial support of Gates Foundation, PEPFAR, the World Bank and the WHO (UNAIDS 2011).

Undoubtedly, the Global Fund and the Global Alliance for Vaccines and Immunisation (GAVI), the Vaccine Alliance, as well as other funders and philanthropies, have had success in slowing the rate of HIV infection, tuberculosis, and malaria and providing vaccines and immunisation against diseases such as pneumococcal disease and meningitis worldwide. Yet further discussions about integration of disease led interventions into primary health care systems, and a shift in discourse from disease leading public health emergency to a conception that intersects with rights will also need exploring ways to moving from country-specific funding models engage and utilise regional instruments and agreements for the implementation of policies. This is a critical step for SADC, considering the number of poverty-stricken citizens who are susceptible to the disease and are unable to access health services to combat the disease.

To be clear HIV, malaria and Tuberculosis, that is specific disease and specific populations, do need to be addressed, and SADC and donors have supported a good deal of work in the field, SADC by creating a platform seeking congruence between international norms and national needs; donors by advancing health campaigns, setting up dedicated clinics, treatment centres, vaccinations and other work on the ground, but the risk of exacerbating vertical humanitarian approach to assistance is that it provides a problem solving approach and responses focusing on risk management disregarding socio-economic determination of health and health-policy burden and thus real opportunities for anti-poverty efforts ensuring systematic attention to social disadvantage, vulnerability and discrimination.

This is a key challenge as there is limited funding and resources for programme implementation which affects anti-poverty efforts in Southern Africa. Vertical approaches are what donors offer and governments are happy to be compliant with, as compliance may be basis for further assistance. This is why SADC could be seen as *a hub*, an organisation that

offers effective institutional 'spaces' for regional policy debate engaging member states to commit to poverty reductions through health, with a particular focus on disease-led policy interventions.

Embedding pro-poor policy in the SADC region: harmonising and domestication of norms

Like all regional organisations, particularly inter-governmental, there is a question of national implementation and how regional normative frameworks travel to national settings and translate into commitments that are important to consider. Legal and institutional provisions for the incorporation of the policies embedded in the SADC Protocols into the national legal orders of member states are weak. The importance of health as a regional problem and the notion that it needs to be addressed regionally, although embedded in the key SADC policy documents, is still far from being the foundation of a regional practice. SADC is not articulating regional policies to be implemented at the national level. It is not an implementation agency. SADCs added value as a regional organisation rests in its capacity to frame issues leading to a regional agenda setting. Acting as a hub or forum is key to identify and discuss rising problems brought up by member states, and coordinate with development partners around goals. Rather than concentrating on technical cooperation and acting as a bloc in global diplomacy, SADC represents a forum organisation that concentrates on agenda-setting, in coordination with member states, non-state actors and donors addressing health challenges in the region.

For donors and aid partners, it may provide a single point of contact for discussions relating to member countries, while acting as a channel through which to disburse development aid (Yeates 2014b). For social and advocacy actors, this type of forum organisation can provide a distinctive platform for consensus building and for civil society organisations to engage in common initiatives (Godsater 2014).

SADC has a mandate to harmonise national health policies (Jones and Hellvick 2012), a process that translates proposals into normative, protocols, and plans of action. As such SADC develops, often based on proposals from nation states to the Secretariat, regional templates, setting standards through regional guidelines and protocols for approaches to disease treatment, surveillance, laws, and health targets across the region. This process allows a form of, what Acharya (2011: 97) defined as, 'norm subsidiarity' creating minimum standards to be set vis-à-vis regional and international goals. Unlike Acharya's expectations, however, this

process whereby local or regional actors create rules is less a move to 'preserve their autonomy from dominance, neglect, violation, or abuse by more powerful central actors' but rather one that allows for harmonised platforms and policy frameworks for member states, and potentially donors, to follow guidelines. This has been important for instance in the implementation of cross-border projects such as the setting up of mobile clinics at the borders, or for the agreement of SADC Best Practices Criteria on HIV and AIDS. Harmonisation is also important as it allows for inter-country comparisons and tracking of impact, identifying the ways countries may respond to the guidelines and implement practices, which in turn may enable revision of common approaches across the region.

While SADC's 'normative framing' role may support legislation and budgetary commitments to deliver programmes in accordance to international law and regional protocols, embedding regional social development policies in the SADC region is limited by financial conditions and the regions dependency on, and vulnerable to shifts in, donor priorities and their discrete areas of intervention (Mooketsane and Phirinyane 2015: 346), on the one hand; and institutional conditions that place SADC as a platform for regional harmonisation of norms but remain weak for policy engagement, particularly with donors. Donors' regional perspectives remain significantly influenced by country, and their specific, priorities and circumstances. In other words while SADC Secretariat and normative frameworks may be referential to countries, donors tend to engage bilaterally, and it is less clear how, if at all, SADC encourages donors to work 'regionally' (see Albertyn and Tjønneland 2011: 18-19).

Similar dilemmas, different regional responses in the case of UNASUR

Unlike SADC in Southern Africa, UNASUR is a new experience for South America: a regional governance project based not on economic integration but on social policies and political cooperation; that functions with new ambitions and tangible plans for embedding new norms on equity across levels of governance through regional policies and international diplomacy as a bloc (Riggirozzi 2015; Herrero and Tussie 2015).

UNASUR is the most recent attempt at regional governance in South America and it follows on from two quite intense decades of, sometimes controversial, region-building based chiefly on principles of increasing inter-regional trade and market opening, alongside increase poverty and inequality as a consequence of economic crisis and austerity during the 1980s

and 1990s. In both regions, the imperative of mobilising resources to reduce poverty became central but SADC and UNASUR responded differently to this challenge advancing distinctive approaches and institutional forms.

The idea of political and social cooperation in UNASUR came up to fit the changing face of democracy in the region. As Acharya (2003) notes, changes to the form of national democracy profoundly affects the nature of regional governance. In the case of South America, after two decades of neoliberal democracy and market-based governance, the new Left governments took office across the region – in Venezuela (1998), Brazil (2002), Argentina (2003), Uruguay (2004), Bolivia (2005), Ecuador (2006), Paraguay (2008) and Peru (2011) – promising mixed economies and a generally pragmatic combination of welfare and populist policies. This uncoupling of democracy from the market dramatically transformed what ‘supporting’ democracy and development at the regional level would mean. The era of ‘post-neoliberalism’ as it has been called (Sanahuja 2012), is characterised not only by a rejection of unmediated markets but also by a resurgence of nationalism through new Left governments that reasserted equity and sovereignty as distinctive national and regional identities in South America.

At the First Summit of South American Presidents in 2000, which was to give rise to UNASUR a few years later, discussions turned on how to support regional democracies and encourage development by deepening contacts and flows of ideas, as well as material goods, across the region (Riggirozzi and Tussie 2012). The South American Union of Nations, UNASUR, was established in 2004 Cuzco, Peru, and set out three principal goals. Two were fairly standard: the promise to reinvigorate inter-regional relations and the commitment to the creation of physical infrastructure (roads, energy and communications) to support better regional development. But alongside these was a promise of greater political cooperation in poverty eradication, particularly in health (*ibid*). UNASUR’s Constitutive Treaty explicitly declared the need to foster integration in ways that would support social inclusion and poverty eradication in ways that were based on the realisation of rights.⁴ The duty to support rights-based social policy, delivered through member states, came to be framed as a ‘regional’ responsibility.

⁴ UNASUR Constitutive Treaty. Available at <http://www.unasur.org/uploads/0c/c7/0cc721468628d65c3c510a577e54519d/Tratado-constitutivo-english-version.pdf> (28 March 2014)

Moreover, a democratic clause was added to the Constitutive Treaty in 2010, allowing for measures to be taken against a member state if the democratic process is put in danger. Marking a profound departure from the early experience of regionalism, UNASUR became indeed a 'space for political action' as well as space for reformulation of norms in support of the delivery of rights-based social provision in and through member states, in ways that would link the delivery of more inclusive social policy to the embedding and strengthening of social democracy.

UNASUR has committed itself to supporting effective social policy in member states since its formation. Unlike SADC, and in marked contrast to the emphasis on trade and investment in earlier phases of region-building, UNASUR official documents placed a strong rhetorical emphasis on 'rights'. Within the regional social agenda, health became indeed UNASUR's primary drive and so commitments to poverty reduction crystallised through rights-based health policies. That health was a defining feature in both regional agendas, albeit differences, is not fortuitously. In SADC the factor 'crisis', and crisis-solving, mostly associated with the big three diseases, has been key driver in how and why SADC turned to health. The driver in UNASUR was also related to the scale of poverty in South America, although less reflective of the health/poverty profile as determinant of policy approach. In South America, poverty rates were falling by more than 14 per cent between 2000 and 2013 (CEPAL, 2013) but the region's poor have still been at risk from the (re)emergence of infectious diseases such as dengue, chagas, and parasitic diseases. In parts of the region, such as Bolivia, Paraguay and Peru, communicable diseases still determine the quality of life and life expectancy, while only limited access to basic medicines is still common (Holveck et al 2007). This bleak situation is worsened by reduced technical expertise and inefficient national health regulatory structures affecting as a consequence accessibility, quality, and equity in health services delivery. Not surprisingly, government failures to deliver decent health care figured as part of the anti-neoliberal protest across the region through the 1990s and first years of the new millennium, as spending on public health plummeted as a consequence of neoliberal reforms and budgetary cutbacks as the privatisation of health insurance directly reduced access to healthcare and rights (Szekely and Birdsall 2003). But, unlike SADC, health in South America is also a policy area where expert knowledge is valued and one where the region has some experience of successful and longstanding regional cooperation built through PAHO. Despite

their economist focus, MERCOSUR and the Andean Community also worked together to put in place trans-border epidemiological control and surveillance in response to, and support of, increased traffic of trade and people (SELA 2008: 56), meaning that UNASUR can build on an existing legacy of cooperation. Moreover, adopting health as the key policy area for UNASUR reflects the demands of activist health professionals in the region that since the 1950s have been campaigning for decent health care as part of a social justice agenda in South America embraced by social actors and welfare states (Birn and Nervi 2014). In Brazil, indeed, demands for the right to health were embedded within the agenda of democratisation. The *movimiento sanitarista* (health movement) was part of the social movements that organised to demand redemocratisation in the 1970s and early 1980s. It also played a role in the Constitutional reform in 1988 that led to the introduction of a universal public health system in Brazil (De Mendonça et al 2010). Grassroots social movements campaigned in Brazil and elsewhere around the slogan '*salud es democracia*' ('health is democracy') promoting the idea that health provision is a central element of meaningful citizenship.

The shift to the Left at the level of member states has opened up an opportunity to promote equity in health policies more broadly. In some countries, such as Bolivia and Ecuador, rights based ideas about health were framed as part of the concept of '*buen vivir*' (well-being) and embedded in new constitutions, amid discussions about what 'universal' health care might look like in South America.

Framing rights based social development goals as a central element of meaningful and inclusive citizenship at the regional level also draw from Brazil's pioneering forms of health diplomacy leading international demands for access to medicines in response to the escalation of HIV and for price reductions in the procurement of pharmaceuticals for national health programmes in the 1990s (Nunn 2009). Of course, health has more 'market traces' than other welfare sectors and that may also explain why it is important in both regions and for regional organisations. Dependency on international pharma creates vulnerabilities amongst developing countries. Scholars have been paying considerable attention to how transnational alliances and advocacy efforts of NGOs can make a difference in terms of campaigning for more equitable, pro-poor development (Conca 2005; Hochstetler 2003; Yashar 2002). This is something that unlike SADC, and unlike previous experiences of regional integration in the Americas, UNASUR developed quite strikingly intervening with pre-

discussed and agreed bloc positions at the World Health Organisation and vis-a-vis international pharmaceuticals for common procurement of medicines (Riggirozzi 2015; Herrero and Tussie 2015). As such, both regional organisations aligned and shaped collective set of priorities in health but while in SADC the total burden of the disease, and the need for time-sensitive responses facing pandemics, have been important factors in the approach to regional health governance, in UNASUR health became an issue-area carefully linked to the idea of socially and democratically responsive regionalism, as a vehicle for inclusion and citizenship and as a vehicle for advocacy contesting the *status quo* in global health governance (UNASUR 2009: 14; UNASUR 2011; Riggirozzi 2015).

In order to advance the agenda of UNASUR in this area, and a policy approach based on equity and rights, the South American Health Council, created in 2009 as an inter-governmental body, approved a Five Year Plan (*Plan Quinquenal*) which outlines actions on five priority areas: (1) surveillance, prevention and control of diseases; (2) development of Universal Health Systems for South American countries; (3) information for implementation and monitoring health policies; (4) strategies to increase access to medicines and foster production and commercialisation of generic drugs; and (5) capacity building directed at health practitioners and policy makers for the formulation, management and negotiation of health policies at domestic and international levels (UNASUR 2009b).

The themes make sense both epidemiologically in that some are areas where cooperation would be of direct benefit to the region's population (disease control, for example, or the prospect of greater availability of generic drugs) whilst others correspond to the political demands of post-neoliberal governments and their grassroots supporters, such as the development of a universal health system, and capacity building for implementation of reforms and negotiations. By taking up health, and institutionalising the right to health, UNASUR directly connects itself with and gives answer to the social struggles for access to health and 'health sovereignty' that differentiates itself from notions of pro-poor and vulnerable populations, widely considered as the 'language of donors' and a tool for exacerbating vertical humanitarian approach to assistance brushing aside real opportunities for social change.⁵

⁵ Interviews with ISAGS Chief of Cabinet, 10 November 2014

One issue that quickly became apparent is that, in order to tackle health inequalities and embed the notion of rights and universality in health within the region, more than cross border cooperation and surveillance would be required from governments; the region would also have to develop some shared mechanisms to address policy capacity for embedding rights-based notions of health in practice, nationally and globally. Put differently, for UNASUR to champion the right to health it needed knowledge-sharing about how this might be delivered through policy and normative reform at national and international levels of governance. This led in turn to the creation of a regional health think tank, the South American Institute of Health Governance (Instituto Sudamericano de Gobierno en Salud, (ISAGS), under the auspices of the Health Council and reporting directly to it. ISAGS tasks are to provide policy-oriented and informative research, training and capacity building for member states.⁶ Its main functions are to:

- 1) identify needs, develop programmes and capacity building for human resources and leadership in health;
- 2) organise existing knowledge and carry out research on health policies and health governance as per request of the South American Health Council or member states;
- 3) systematise, organise and disseminate technical-scientific information on regional and global health, with the intention of supporting decision-making process and advocacy;
- 4) support the formulation of UNASUR's common external policies to back up negotiations in global and international agendas;
- 5) provide technical support to national health institutions.⁷

ISAGS has emerged as the most active level of health governance within UNASUR and the key tier of regional health governance, the Health Council – or the Ministries of Health –benefits in a number of ways, from being more effectively briefed at international meetings to having regional expertise to call on to support national health targets. Located in Rio de Janeiro, Brazil, ISAGS is able to capitalise on the leadership of Brazilian diplomats and health experts

⁶ For information about UNASUR Thematic Groups, networks and ISAGS, <http://isags-unasul.org/site/sobre/?lang=es>, accessed 2 April 2014

⁷ Resolución CSS 05/2009 Sede y creación ISAGS abril 2009

in international negotiations on the provision of medicines and the right to health and on the historic *movimiento sanitarista*, and other the Brazilian health research institutions such as the Oswaldo Cruz Foundation (Buss and Do Carmo Leal 2009).⁸ ISAGS is, almost inevitably, more radical than the Health Council itself. Its core philosophy is that health provision cannot be left to the market and its position within the governance structure in UNASUR means that it has been able to infuse policy making with a rhetoric about rights and universalism. It gives UNASUR an aura not just of technical know-how and expertise, much in the way of PAHO, but conveys the message, through new normative frameworks and practice, that health is a matter of politics and rights as well as part of a more comprehensive approach to social determinants of health and democratic standards. In many ways being a new institution, tied to the new regional political economic coordinates in South America and being genuinely South American means that ISAGS/UNASUR is in a better position to deliver effective health governance than PAHO, a Washington-based institution with more than one hundred years of history and with a mandate that focuses on ‘health coverage’ rather than ‘universal access to health’ as supported by ISAGS/UNASUR. These are different ways of addressing how health care reaches societies, and ultimately speak of different conceptions of entitlement and equality.⁹

Embedding the right to health in regional and global governance

ISAGS became active in strengthening health governance capacity, acting in the advocacy of the right to health and in support of policy-making and policy reforms towards universalisation of health across the region (UNASUR 2009; Riggirozzi 2015). Working as a ‘knowledge broker’ ISAGS has been active in capacity building and training activities in situ, working together with policy makers and practitioners towards the goals of setting up UNASUR-sponsored Public Health Schools in Peru, Uruguay, Bolivia and Guyana and the UNASUR Network of Public Health Schools supports training across the region. Reforming institutions and practices is a key way of embedding principles of equity and rights in the provision of health care. In line with this, ISAGS has also provided support directly to

⁸ Interviews with ISAGS Chief of Cabinet, 10 November 2014; and with former Officer at the Pan-American Health Organisations, 12 June 2012

⁹ Author’s interviews with ISAGS Chief of Cabinet, 10 November 2014; and with former Officer at the Pan-American Health Organisations, 12 June 2012. Also UNASUR *Plan Quinquenal*.

Ministries of Health in Paraguay and Guyana on primary care and the preparation of clinical protocols and supported reforms aimed to move towards universalisation of health sector provision in Colombia, Peru and Bolivia (ISAGS 2013).

ISAGS office is an active knowledge producer, gathering, assessing and disseminating data on health policies of member states; benchmarking health policy and targets for members; and establishing effective mechanisms of discussion and diffusion of policy based knowledge and best practices through regular seminars, workshops and special meetings, in support of policy reform and by demand of member states (Agencia Focruz de Noticias 2012).¹⁰ The diffusion of information is not only based on disease risks, for instance combatting HIV/AIDS, influenza and dengue fever across the region, but also about policies and (best) practice where ministers and government officers shared views and experiences in the provision of health care and challenges of universalisation and regulation (PAHO 2010; UNASUR 2011; ISAGS 2013). These initiatives, developed in a relatively short time framework since the creation of UNASUR, are at odds with previous projects of South American regionalism and they stand as evidence of UNASUR's grounded approach.

UNASUR has also been instrumental, as *'industrial broker'*, in the establishment of two projects to promote harmonisation of data for public health decision-making across the region: a 'Map of Regional Capacities in Medicine Production' approved by the Health Council in 2012, where ISAGS, is identifying existing industrial capacities in the region to coordinate common policies for production of medicines; and a 'Bank of Medicine Prices', a computerised data set revealing prices paid by UNASUR countries for drug purchases, and thus providing policy-makers and health authorities a common background and information to strengthen the position of member states in purchases of medicines vis-à-vis pharmaceuticals. Based on this, joint negotiation strategies, as a purchase cartel, are also in place to enhance the leverage vis-à-vis pharmaceutical companies. UNASUR Health Council is also seeking new ways of coordinating industrial capacity for the production of generic medicines, potentially in coordination with the Defence Council. This was confirmed in a seminar organised by UNASUR and the Ministry of Defence in Argentina, in April 2013, where a proposal for the creation of a South American Program of Medicine Production in the field

¹⁰ Author's interview with ISAGS Chief of Staff, 29th August 2012.

of Defence, was discussed (UNASUR CEED 2013).

These practices are not only oriented to generate conditions for embedding right-based and universal approaches to policy making and implementation but are also reaching outside the region through active regional health diplomacy. UNASUR is effectively enabling representation and claims-making as a unified regional actor, and advancing rights-based development approaches in global governance. In effect, interventions as a bloc at the WHO and World Health Assembly (WHA), took the view that ‘germs, norms and power’, as put by Fidler (2004), define an international structure where risks, regulatory frameworks and resources disproportionately favour the developed world and international pharmaceuticals. Likewise lack of attention or interest on certain diseases as well as uneven representation of developing countries in international fora means that there are neglected dynamics of finance and less visibility of certain issues in the global agenda that particularly affect many developing countries and their populations. For UNASUR therefore health diplomacy is a mechanism for questioning traditional spheres of power and the normative foundations of it in global health governance. As such, since 2010 UNASUR took up a role acting as a corrective to the side-lining of rights on account of risk/security concerns in international health politics. One of the first positions taken by UNASUR at the WHO concerned the impact of intellectual property rights on access to medicines and the monopolist position of pharmaceutical companies on price setting and generics (Riggirozzi 2015).

Led by Ecuador and Argentina, UNASUR also successfully advanced discussions on the role of the WHO in combating counterfeit medical products in partnership with the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), an agency led by Big Pharma and the International Criminal Police Organisation (Interpol) and funded by developed countries engaged in intellectual property rights enforcement. Controversies focused on the legitimacy of IMPACT and its actions seen as led by technical rather than sanitary interests, unfairly restricting the marketing of generic products in the developing world. At the 63rd World Health Assembly in 2010, UNASUR successfully proposed that an intergovernmental group replaced IMPACT to act on, and prevent, counterfeiting of medical products. This resolution was approved at the 65th World Health Assembly in May 2012. In the course of this meeting, UNASUR also lobbied for financial support and research to meet the needs of developing countries.

More recently, UNASUR led discussions at the WHO to improve the health and wellbeing of people with disabilities. This action plan was successfully taken up at the 67th session of the World Health Assembly in Geneva, in May 2014, when the WHO's 2014-2021 Disability Action Plan was approved. This plan focuses on assisting regional WHO member countries with less-advanced disability and rehabilitation programs and will be carried out by the WHO in conjunction with regional organisations such as the Caribbean Community (CARICOM), Central American Integration System (SICA), Southern Common Market (MERCOSUR) and UNASUR.

The presence of UNASUR in this type of health diplomacy, and its coordinated efforts to redefine rules of participation and representation in the governing of global and regional health, and production and access to medicine vis-à-vis international negotiations, are indicative of a new rationale in regional integration in Latin America based on international leadership and policy-making. These actions create new spaces for policy coordination and collective action where regional institutions become an opportunity for practitioners, academic and policy makers to collaborate and network in support of alternative right-based principles of health governance. At the same time they are indicative of new processes in the creation and development of rules in which southern regional organisations take a stand as 'protagonists'.

5. CONCLUSION

The regional experiences of SADC and UNASUR open an unprecedented opportunity to evaluate and compare how and why regional organisations define concerns affecting ordinary people. It is also an opportunity to assess whether and how these concerns are embedded in national and international practices. It would be an overstatement to claim that new ambitions related to poverty and health, as manifested in agendas, policies and institutional capacities in both UNASUR and SADC, mean that these organisations are actually playing a new, and effective, role. There is certainly a credibility problem related to the current gap between rhetoric and reality. The fact is that in the absence of binding mechanisms of enforcement and compliance Southern regionalisms play a much smaller role than they could do. Reforming national legislation, in health but not only, is still a challenge for both SADC and UNASUR as currently there no institutional conditions to embed regional norms and policy in

domestic legislation. Regionalism is not a governing mechanism and changing policies or regimes remains within the boundaries of sovereign decision making.

However, it would be a mistake to think that the absence of the supranational structure rules out other ways of advancing practices in support of more inclusive societies and regional governance. There are indeed opportunities for SADC and UNASUR to close the gap between what they *can* do and what they actually *do*, in at least in some fields. Since the late 1990s regional organisations have started to tackle questions of the relationship between trade, labour and social standards, and of how to maintain standards of market competition with a new social ethos (Yeates 2014b: 2; Yeates and Deacon 2006, 2010; Riggirozzi 2014). Furthermore, a lesson in the fight against HIV is precisely that mobilisation of solidarity, led in many cases by civil society helped to embed new issues related to marginalisation, stigma, rights and health, and perhaps a sense of shared responsibility, in SADC and UNASUR.

This is a clear distinction from previous regional integration experiences in Latin America and Southern Africa and suggests that the potential of regional action for addressing issues such as social development, rights and inclusion relies on the opportunities and institutional setting they provide. Of course, the context in which goals, agendas and institutions are set up is important as policies and institutions manifest in different forms. SADC is a product of neoliberal, open regionalism. UNASUR was formed to contest that and to rework norms of regional governance. Likewise, dependency on donors and the prevalence of specific diseases such as HIV/AIDS are conditioning factors not only for what regional organisations such as SADC can do but also the scope of regional health policy. With this in mind we can understand why the approach to social determinants of health has not entered – was not embedded- with such strength in SADC compared to UNASUR. Likewise, the concept of vulnerable populations (ie workers, women, children) do not feature in the language of and the way UNASUR address poverty through health policy.

Both SADC and UNASUR however are about setting parameters, creating normative frameworks structuring new practices in support of alternative models of governance as much as creating spaces for cooperation and implementation of programmes. SADC has a credible and respected role in the harmonisation of health policies. Although in practice the boundaries can be blurred, SADC portrays a secretariat-based work, framing and harmonising policies for stakeholders and programme-oriented agencies. By framing debates SADC depicts

approaches to policy processes and opportunities for affect policy thinking and acting upon issues. While not an implementing agency, its value relies on getting issues on to the political agenda drawing attention and the awareness of members in relation to the recognition of endorsement of international declarations, and of specific groups such as donors of priorities in member states.

Because of the context in which was created, the beliefs and ideologies it was supported and the political ethos it supports, UNASUR has embedded in its mandates and institutional forms the notion of social development and welfare. It has emerged as a more assertive regional organisation compared to SADC because in addition to farming it has acted as a collective actor making its voice heard within the region and in the global community. Like SADC, UNASUR seeks to also embed new normative goals and standard in its member states. Unlike SADC it created mechanisms to facilitate, through thematic networks and a regional think tank, the re-allocation of material and knowledge resources in support of public policy formulation and policy reform on the ground. Furthermore, UNASUR emerged as an important actor in the regional/global corridor of norm diffusion and policy change. Of course, UNASUR is mainly formed by middle-income countries where financial resources are not reduced to the multilateral donors and where there is a vibrant and politically influential local/regional network of experts informing policy-making in the area of health. In fact epistemic communities and networks found in UNASUR a platform enabling representation and claims-making (Riggirozzi 2014: 251; 2015).

Unlike the EU where normative provisions for market regulation, market compatibility, and coordination and standardisation of policies, UNASUR and SADC do not rule as legal umbrella for law-cases, and national policy regulation. This is a limitation in terms of how far inter-governmental organisation can push for and oversee change in national policies. Yet they can align and shape collective set of priorities framing and providing normative leadership and direction in support of alternative forms of governance. In this regard, while regional originations may encounter critical limitations in terms of embedding policy change in domestic arenas, the credibility gap may be reconsider in light of new opportunities for promoting and reshaping values for social transformation and change, and socially based approaches to development that regional organisations promote.

In this respect, the argument advanced here establishes at least the value of devoting more attention to the linkages between regionalism and poverty reduction not only through policy interventions but also through framing and expanding policy horizons, playing such normative role in regional and global politics. Scholars interested in agenda setting in global politics, who often place attention to the dominance of powerful Northern-based actors, should hence address new corridors of diffusion of norms, that emanate from the region, as well as the agency of Southern regional arrangements as entrepreneurs advancing and reworking norms at different levels of governance.

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