

Chapter 6

The Process and Practice of Negotiation

Graham Lister and Kelley Lee

Reader's Guide

Global health diplomacy has been defined as the art and practice of negotiation in relation to global health issues. This chapter draws on generic concepts of **negotiation** as a process of diagnosis, formula development, exchange and implementation, reflecting the shared and sometimes contested values, power relationships and interests of the many different actors involved. It sets out a framework for understanding the main phases of **global health negotiation** process as they arise in many different contexts. The negotiation of global health issues is shown to be a driver of the regimes of global health governance institutions that are shaped by the new trends in global governance described in the previous chapter. The leadership and development of diplomatic **negotiations** at every level with an increasing range of actors is therefore key to global governance for health.

G. Lister (✉)

London South Bank University, London, UK

Global Health Programme, Graduate Institute of International and Development Studies,

PO Box 136, 1211 Geneva 21, Switzerland

e-mail: g_c-lister@msn.com

K. Lee

Simon Fraser University, Blusson Hall, Room 11300,

8888 University Drive, Burnaby, BC, Canada V5A 1S6

London School of Hygiene and Tropical Medicine, London, UK

e-mail: kelley_lee@sfu.ca; Kelley.Lee@lshtm.ac.uk

Learning Points

- Understanding the negotiating process from diagnosis of issues and interests, the establishment of a formula to provide a framework for resolution of conflicting interests to the detailed process of negotiating exchanges to resolve the issues.
- The need to define and frame the issue in a way that can be accepted and addressed by all parties to negotiations.
- The importance of engaging relevant stakeholders and aligning their interests.
- The key role of information and knowledge in preparing a negotiating position.
- The design of the process and formula for the process of detailed negotiation.
- Insights for the conduct of detailed negotiation and exchange and in particular the importance of timing.
- The importance of continuing negotiation in the implementation of international treaties or agreements.
- The exercise of **meta leadership** in **global health negotiations**.

Introduction: The Negotiation Process

Negotiation can be defined as a process of exchange between two or more interested parties for the purpose of reaching agreement on issues of mutual concern. Zartman and Berman (1982) distinguish three main phases leading to agreement: the diagnostic phase, during which the issues are identified, stakeholders engaged and information is prepared, the formula phase, establishing a shared framework for agreement including the process of exchange and the detailed phase of negotiation and exchange. Negotiation is also crucial to the effective implementation of any international agreement, requiring ongoing monitoring and possibly arbitration of disputes by an international body.

Negotiation can be characterized in terms of the expression of values and power. **Global health negotiations** often invoke shared values and goals, though interpretation and interests may differ. As Fisher et al. (1997) note, negotiations based on common principles are fundamentally different to negotiations based on positional power. Where values are shared, stakeholders are more likely to seek, as a minimum, to accommodate the specific interpretations and interests of each party. More constructively they may collaborate to find new solutions to mutually recognized problems. Where values are not shared, stakeholders are more likely, either to avoid the issues or to seek to develop a position of advantage to advance one interest over another. While in the former case there are great advantages in sharing information and working for a “win-win” integrative solution, in the latter case the sides may

wish to apply game-theory based strategies that emphasize their position or the extent of the power of one side in relation to the other, it is assumed that one side wins at the expense of the other.

The ethical values of health as human rights are generally recognized by all the parties as defined in the constitution of the WHO and this can provide a basis for the negotiation of outcomes that can be considered “fair” in these terms. But even values such as fairness and rights to health may be interpreted in different ways. Moreover, it is also clear that the other interests of the parties, as examples: their trade, economic, and security concerns shape their interpretation of health values. Thus while **global health negotiations** tend to be couched in terms of the expression of shared values and concerns for health, it is also possible to discern the interplay between the specific interests and powers of the parties.

Global health negotiations can arise in many different ways in relation to threats posed by different diseases and determinants of health or as a consequence of other foreign policy issues such as security and trade. They often involve multiple stakeholders and interests, both because they deal with trans-border issues and because health and its determinants, including globalization, have impacts across all social and economic spheres. The health issues negotiated are often uncertain in their long-term impact and capable of different interpretation, thus an agreed evidence base and effective presentation of information are essential during the negotiation of international agreements and in their implementation.

For these reasons the negotiation of global health issues can be protracted and though agreements to joint action on health emergencies are often reached within days, this may reflect years of preparation and exchange. Where issues arise within other policy spheres the process can sometimes be very protracted but can be hastened by international events as shown by the negotiation of Trade Related Aspects of Intellectual Property (TRIPS) and access to medicines.

Box 1 The Negotiation of TRIPS and Access to Medicines

World Trade Organisation negotiations on TRIPS were first concluded as part of the Uruguay Round of the General Agreement on Tariffs and Trade (GATT) in 1994. This reinforced the protection of intellectual property rights including those applying to pharmaceuticals, for all countries joining the WTO. The agreement was negotiated purely as a trade concern without regard to public health consequences. As HIV/AIDS and other global health issues gained increasing prominence many resource poor countries and international civil society groups found that TRIPS presented a further obstacle to access to affordable medicines.

This issue came to the fore when the Government of South Africa passed the Medicines Act in 1997. This was intended to enable the SA government to license the production of drugs to treat some of the complications of HIV/

(continued)

Box 1 (continued)

AIDS, thus avoiding patent restrictions. An international group of 39 pharmaceutical companies challenged the legality of the act in the Pretoria High Court. This challenge might have succeeded, but for the intervention of a local civil society group called the Treatment Action Campaign (TAC) who alerted the international network of civil society groups in this field and won the right to present their case in court. Protests grew around the world and in the face of this the pharmaceutical firms withdrew their challenge. As a result the legislation was applied more widely than had originally been intended, particularly in relation to HIV/AIDS medicines and other countries followed South Africa's lead in passing similar measures.

The public awareness raised by this case was one of the factors that led to the partial resolution of this issue in the WTO resolutions of 2001 and 2003 (see Box 3).

Diagnosis***Identifying and Framing the Issue***

In **global health negotiations** the first step is the identification of issues that are ready or “ripe” for resolution and to frame them in a way that all parties can recognize. This must invoke a common recognition of a problem and the moral and practical case for action. The time when an issue is “ripe” for resolution may depend on

Box 2 Negotiation of the International Health Regulations and Severe Acute Respiratory Syndrome

An illustration of how events can raise awareness of issues and thus facilitate negotiations is provided by Lee (forthcoming 2013) who describes negotiations to revise the International Health Regulations, initiated by a resolution of the World Health Assembly (WHA) in 1995 amid concerns about emerging and re-emerging diseases. While a revision process commenced, progress proved glacial due to the lack of interest and support by key member states. It was not until the outbreak of severe acute respiratory syndrome (SARS) in 2003–2004 that sufficient political priority was forthcoming. This led to concerted efforts, under the auspices of an Intergovernmental Working Group on the Revision of the International Health Regulations, which reached agreement on the revised IHR (2005) which countries have adopted.

factors such as the emergence of research evidence, the response to a crisis or simply as a result of ongoing international discussions.

Issues for global health negotiations are identified in many different ways: as a result of the policy leadership role of WHO, as an outcome of a specific review, or a concern of national governments or groups such as G8 or the EU. Issues may also be raised by civil society groups or as a result of negotiations in spheres not previously associated with health such as the World Trade Organisation. But it is not a simple matter to introduce a new issue to the crowded agenda of global health diplomacy. Moreover the way in which an issue is framed, how it is identified and the policy context in which it is viewed is crucial to subsequent global health negotiations. As Labonté and Gagnon (2010) note, global health issues arise in many different **policy frames**: security, development, global public goods, human rights, trade and ethical/moral reasoning.

Box 3 Framing HIV/AIDS Issues

Issues raised by the spread of HIV/AIDS have been raised in many international fora and policy contexts, framed in different ways, as examples:

- UN Security Council Declaration 1308 of 2000 addressed HIV/AIDS as a security issue and specifically a threat to UN peacekeeping operations.
- The United Nations Millennium Declaration which led to the agreement of 189 countries to the MDGs framed HIV/AIDS as a development challenge.
- The Declaration of the UN General Assembly Special Session of 2001 can be seen as framing the HIV/AIDS crisis in terms of global public goods and the need for joint action and funding.
- In 2006 Member States of the UN adopted a Political Declaration on moves towards ensuring universal access to HIV/AIDS prevention and treatment that frames this issue in terms of human rights.
- The WTO Ministerial Conference in 2001 proposed the Doha Declaration on the TRIPS and Public Health, which balanced trade considerations with ethical/moral reasoning with respect to HIV/AIDS and other global health issues.
- This question has still not been fully resolved as the declaration was only implemented in 2003 by the WTO General Council as a temporary waiver of TRIPS rules. As a consequence negotiations on the application of paragraphs 4–6 of the Doha Declaration that permit the compulsory licensing of drugs (circumventing patent rights) in response to threats to public health considered to be a national emergency or other circumstance of extreme urgency must be negotiated on a case-by-case basis in the light of local conditions (see Box 5).

However the issues are identified, it is important to raise the policy questions in a way that will be recognized by all relevant stakeholders. This does not mean pandering to the lowest common denominator but it does require the legitimate interests of all parties necessary for eventual agreement to be acknowledged. The policy lens or frame applied to the issue may also determine the fora at which the issue will be raised and the way it will be resolved.

One difficulty faced by many of the government and interstate institutions traditionally engaged in global health diplomacy is that their commitment to existing **policy frames** and ongoing international regimes may make it difficult for them to identify and raise new issues. For this reason civil society organizations including **advocacy** groups and foundations that are less bound by formal roles and positions can sometimes play an important role as in stimulating new thinking to identify and frame issues.

Engaging Stakeholders and Aligning Interests

A second step during diagnosis can be described as engagement of stakeholders or the **alignment of interests**. This involves exploring the perspectives and points of agreement and disagreement between all relevant parties. The parties establish their respective negotiating stances build relationships and common understanding between aligned groups and, if they are wise, explore the positions of other parties.

In the context of **global health negotiations** the **alignment of interests** may include developing a shared position amongst regional or other international groups of states such as the EU, G8/G20 and South–South cooperation. It may also include the alignment of actors at national level to develop national global health strategies. But it is not just states that come together in this way, civil society groups and other actors may also seek to establish shared positions to strengthen their **advocacy** for action on global health issues.

Box 4 Negotiation of the Framework Convention on Tobacco Control

Proposals for an international convention on tobacco control were first raised at the Ninth World Congress on Tobacco or Health in 1994, which resulted in a proposal to the WHA meeting of 1995. Following this the WHO considered various formulae for such a convention, and it was decided to try to produce a Framework Convention to promote international and national action. This was accepted at the WHA meeting of 2000. An International Negotiating Board (INB) was formed which negotiated the wording of the convention over two years. In 2003 the Framework Convention on Tobacco Control (FCTC) was adopted by the WHA, the convention came into effect in 2005 after 40-member states had signed, often following internal dialogue. By 2010, 168 countries had signed, 15 of these including the USA have yet to bring the FCTC into national laws by formal ratification.

(continued)

Box 4 (continued)

While this may seem a long drawn-out process, agreement on the FCTC was relatively swift compared to other international agreements and laws. And while the issues were intensively negotiated from 2000 to 2003 the preparation of the grounds for such an agreement by building national awareness and action was a much longer process. Brazil was the second country to introduce graphic warnings on cigarette packs, it has a history of awareness raising and controls on tobacco stretching back to 1990. Its programme of public engagement and working with civil society organizations to reduce smoking rates is regarded as exemplary and perhaps for this reason and because of the growing importance of emerging countries such as Brazil, Russia, India, China and South Africa in international fora—and as target markets for tobacco companies, Brazil is invited to chair the INB. This is described by Lee et al. (2010) as an example of the way Brazil has deployed “soft power” in global health.

It is a tribute to the diplomatic skills of those who negotiated the FCTC that so many countries and organizations from the European Union to national patient groups feel that they have played an important role in its formulation. Consultations within and between countries ensured a coalition of interests was created capable of withstanding the tobacco companies, who were clearly intent on defending their position. Instead of ignoring them WHO initiated public hearings both at international and regional levels to make the consultation process open to them but also transparent to public opinion.

The interests of stakeholders and consortia defined at this stage should clarify the shared goals that provide the basis for aligning interests. Depending upon circumstances it may be that the negotiating strength of a group or consortium is best served by acting together as a negotiating bloc or acting as separate agents with common interests. For example, in certain fora the interests of civil society groups may be most effectively expressed as a single voice, but in other circumstances they may be more effective when supporting a common view from different perspectives.

Stakeholders may also indicate certain sticking points, for example it may be that some governments would be unable to countenance certain forms of prohibition of tobacco use, or would not accept the political and economic impact of limiting alcohol marketing. This will indicate the points at which these parties would walk away from negotiations, it is therefore important either to find a way round such sticking points or to develop new creative solutions to overcome such barriers. It is important to understand the walk away points for all parties to a negotiation as these define the **negotiating space**.

Gathering and Using Information

Effective information gathering and use is essential for **global health negotiations**. Information will be of greatest value once the concerns of all relevant stakeholders are identified as it is then possible to gather information and moral and policy arguments to address the issues of greatest contention in subsequent exchanges.

The way in which information is used and publicized is also vitally important to **global health negotiations**, which are usually conducted in public, or at least in an open transparent process. Scientific papers may be appropriate sources for data but will seldom present information in a way that is most amenable to policy makers or public discussion. Civil society organizations often have more freedom to advocate for a policy case than other parties and can be important in raising public awareness and support for policy change. They may appeal to the public through traditional and new media and, for example, by utilizing celebrity power.

In the period leading up to formal exchange the parties to a negotiation often produce initial position papers setting out their aims and objectives and the relevant evidence on which they draw. They may seek to form a wider coalition for their position by conducting consultations with other parties and groups. This brings a danger that they may trap themselves into commitments that provide no room for negotiation. Thus it is important for global health diplomacy to ensure that the interests of all parties are recognized and that positions statements focus on values and goals rather than specific solutions to the exclusion of other options.

The exchange of views during the diagnosis phase helps to ensure there is a shared understanding of the issue to resolve differences of interpretation and to focus negotiations on points of contention. It should also help each of the parties to understand the perspectives of the others which may be constrained by national economic, cultural, and political circumstances.

Technical knowledge may also be required as global health issues often require some understanding of public health impacts or options for cost-effective intervention. Where a health issue involves other policy sectors, such as trade, agriculture or the environment, cross-sector knowledge is essential.

Box 5 Technical Knowledge in Interpreting the Doha Declaration

The 2007 dispute between the Ministry of Health in Thailand and the pharmaceutical company Abbott Laboratories over the compulsory licensing of the HIV/AIDS drug Kaletra (a combination of Ritonavir and Lopinavir) described by Lee ([in press](#)) illustrates the need to bring together different types of technical knowledge. Negotiations between the ministry and private company required specialist knowledge of the drugs themselves and their effectiveness, knowledge of public health conditions and specifically the prevalence of HIV/AIDS and access to relevant medicines in Thailand as well

(continued)

Box 5 (continued)

as detailed understanding of the legal flexibilities available under the TRIPS agreement, and its interpretation in the subsequent decisions on the implementation of paragraphs 4–6 of the Doha Declaration on the TRIPS Agreement and Public Health.

Negotiating the Formula

Designing the Process

Once the issues have been clarified and information and interests shared, it may be realized that the parties can proceed directly to agreement. However, as many global health issues are complex and multi-faceted it may be necessary to design a specific **formula for agreement** for the resolution of outstanding issues. The formula defines the **negotiating space** (the limits within which agreement can be reached) and the terms in which agreement will be reached. It is important for the formula to be kept relatively simple but with sufficient scope to allow all parties to benefit from the eventual agreement. The formula identifies the points of disagreement and the terms in which these will be negotiated. Thus for example in relation to tobacco control a study was carried out to determine the form of agreement that would be most appropriate and most likely to gain support from member states of the WHO.

The design of the detailed negotiating process requires agreement upon:

- The objectives of discussion, the issues to be resolved and the broad principles on which agreement might be based.
- The participants including representatives of groups of states and possibly civil society organizations that might be invited as participants or observers.
- The forum for discussion, which might be an existing international agency such as the WHA or United Nations General Assembly or a special meeting or discussion process at some neutral location.
- The chair and secretariat to mediate the meeting, agreeable to all parties.
- The process of the meeting including the timescale, stages of negotiation, arrangements for media coverage and the issue of communiqués.
- Details of meeting arrangements such as the layout, provision for break out discussions and other factors that affect the atmosphere of the exchange.
- The method of agreement whether by consensus, voting or informal agreement subject to later **ratification**.
- The language(s) of the agreement can be important since languages impart cultural assumptions and some allow greater ambiguity of expression than others.

Participants in such exchanges will also need to establish their own rules of engagement, for example who will lead the delegation, what are their negotiating

objectives and walk away points and what freedom do they have to negotiate compromises, to what extent can they represent other members of a group and how will they report back to the governments or groups that they represent.

The processes of framing the issue, the **alignment of interests**, gathering and using information and design of the **formula for agreement** can be seen as steps in preparation for detailed negotiations, which as Drager et al. (2000) note is of fundamental importance to the success of health negotiations.

Detailed Negotiation and Exchange

In conventional negotiation theory bargaining is often characterized by strategic offers and counter offers, with trades proceeding from larger scale claims and concessions to smaller adjustments as differences between parties are resolved. There may be elements of game theory applied with opening moves design to probe the position of others rather as in a chess game. While elements of this sort of bargaining can be seen in **global health negotiation** it is more likely that issues will be resolved through a managed process of exchange in accordance with a process designed as described in the previous section.

Before commencing the detailed exchange process the secretariat may produce an outline draft as a basis for negotiation. This may establish principles for the resolution of issues with areas of disagreement couched in broad terms acceptable to most participants for more detailed discussion. The initial draft may be itself a product of prior discussion and negotiation since, as in any negotiation, an opening proposition can anchor expectations as to the outcome and may define what would be considered success or failure in the talks. Setting expectations too high can be a mistake as it can lead to a perception of failure if they are not met, expectations set too low may result in outcomes that do not challenge participants to seek creative solutions.

Typically the parties reviewing the draft will identify areas which they would wish to see amended and various changes in wording will be proposed to the secretariat and discussed in detailed sessions before agreeing upon a communiqué signifying general agreement.

Headline discussions may be accompanied by other forms of diplomacy and exchange to resolve misunderstanding and barriers to agreement. For example, where a policy may have a financial impact on one or more countries, there may be side room discussions of mechanisms to offset or reduce the economic impact by aid or trade mechanisms. Civil society organizations may exert moral pressure on negotiators from the perspectives they bring of people affected by the policy and by astute use of the media.

The search for agreement can be described as a process in which a range of reciprocal exchanges builds mutual obligation and understanding on which broader agreements can be based. The participants in most global health negotiations seek an outcome from which all parties can claim success. This is essential since although agreements may be ratified and set in international law, compliance depends largely upon the willing acceptance of the agreement by the signatories.

Confirmation and Implementation

Theoretical models of negotiation stress the importance of confirming the agreement, it is often said that nothing is agreed until everything is agreed. The point at which a negotiation culminates in an agreement is therefore of great importance. This can also be true of agreements on global health, many of which are negotiated “down to the wire”.

While agreement to a communiqué may be seen as a successful outcome to detailed negotiation, in many cases there will be a further stage in which the agreement is formally agreed by a UN body with the legal status required to establish international law. This will require careful wording of agreements to be signed, together with clear proposals for monitoring its observance. Terms included in the document and the legal obligations assumed by signatories to the agreement should be as clear as possible, though some parties may intentionally leave “wiggle room” for subsequent interpretation.

In many cases states sign an agreement but reserve the right to confirm their legal assent to the law in national legislation. This may be because internal political mechanisms require the agreement of legislative bodies, particularly in federal states such as the USA. Thus in the case of the FCTC outlined in Box 3, while President Bush signed the convention he did not submit it for Senate approval.

It may seem that there should be no further negotiation of the terms of an international treaty between the acceptance of a communiqué and **ratification**. But in practice there are often further negotiations at the time of **ratification** and subsequent adoption and implementation by states. Discussions at this stage will focus on the definition of terms and their specific application, how agreements are monitored and on the conjuncture of different international obligations. These are often the most difficult and crucial issues.

Moreover as Spector and Zartman (2003) note, effective implementation of any international agreement requires ongoing monitoring over many years. Whether issues can be resolved by conciliation between the states, by arbitration by an international agency or by reference to the International Court of Justice will often depend upon circumstances. The WHO may be required to examine the performance of states and raise questions about the extent of their observance of global treaties. International agreements thus help to define the roles and regimes of agencies like WHO in global governance. And as the role and functions of international agencies evolves this will in turn influence the way international agreements are applied. Thus **global health negotiation** can be seen as a mechanism that drives the ongoing evolution of global governance for health as an open system responding to its geopolitical context.

Box 6 Virus Sharing Indonesia and the International Health Regulations

In 2007, Indonesia halted the sharing samples of strains of the Avian Flu virus H5N1 as required by the International Health Regulations. Indonesia was at

(continued)

Box 6 (continued)

the epicenter of this outbreak with more confirmed human cases and deaths from the disease than any other country. Stopping virus sharing was therefore seen as a serious threat to measures to counter a potential global pandemic. The Indonesian government claimed that samples were being used by pharmaceutical companies to produce patented vaccines for high-income countries which would be unaffordable to Indonesia. Moreover they pointed out that the Convention on Biological Diversity of 1992 requires that countries from which genetic material is drawn should share the benefits of its use.

What followed from this dispute was a protracted negotiation of the interpretation of the International Health Regulation and other international agreements which affect the conditions applied to the sharing of virus samples. These negotiations described by Irwin (2010) are still ongoing, they invoke wider issues concerning capacity for vaccine production, the rights of states to share the benefits of virus sharing, the role of WHO and funding of global public goods for health.

Since global health treaties and agreements often also imply a moral obligation, there is a further “court” at which disputes can be raised, which is the court of public opinion. Civil society organizations often play a valuable role in holding governments or international companies to account in this way, pointing out infringements of human rights or failures to meet their obligation under international agreements and laws.

Leading Global Health Negotiation

Chapter 12 discusses the leadership role of WHO in **global health negotiations**. But organizational leadership is also essential for the negotiation of global health issues at regional, national and local levels. This is not achieved by command and control, planning and budgeting or by evidence and analysis alone, but by working with others to share ownership of and responsibility for global health and build mutual respect and trust.

Discussion of the negotiation process would be incomplete without recognition of the importance of the skills required to lead such negotiations. The examples given in later chapters provide many instances of the ways in which personal leadership has brought people from different countries and organizations together to achieve common goals. The qualities required are described by Marcus et al. (2011), as “meta leadership”, which requires:

- An encompassing vision of the values of global health, the political context and the situation as seen from all perspectives, in order to frame the issue in a way that can be accepted by all participants.

- The emotional intelligence required to understand and empathize with different perspectives and influence thinking and action across national, cultural and institutional boundaries by engendering shared understanding and common purpose.
- The ability to encourage and draw on shared leadership from other individuals, institutions and organizations with different skills and perspectives to empower them to act together to achieve common goals.
- The personal integrity, self-awareness and self-control required to lead negotiations unbiased by any prejudice, to “speak truth to power” where necessary and thereby earn the trust of people from different countries and organizations.

Meta leadership is demonstrated by many of the practical examples as shown in all chapters of this book, it is best learnt by reflecting on experience of leading global health negotiations, perhaps first across local organizations and then with increasingly challenging international contexts. Complex international interdisciplinary negotiation often requires distributed leadership at many different levels as shown in the South African Access to Medicines case introduced in Box 1.

Box 7 Leadership in the South African Access to Medicine Case

The South African Medicines Act of 1997 was signed into law by President Nelson Mandela, but by 2001, when the issue came to the Pretoria High Court, the new president Thabo Mbeki was denying the existence of HIV/AIDS and his health ministers were falling into line. Despite the strong institutional and personal support for South Africa’s position by Dr Gro Harlem Brundtland of the WHO, it was felt that the pharmaceutical companies would win their appeal against the Act and fearing this implementation of the act was suspended. The Pharmaceutical Manufacturers Association seemed certain to win, they even appeared to have the backing of Kofi Annan, the EU and the USA.

One man called Zackie Achmat, a gay HIV-positive South African of mixed race, made a difference. Leading the TAC he vowed not to take anti-retroviral treatment until it was available to all South Africans. TAC won the right to present their case in court. And they made their voices heard beyond South Africa. Working with international gay and lesbian groups and the support of NGOs led by Ellen’t Hoen of Médecins sans Frontières they built a worldwide campaign for access to medicines that ensured that Clinton and Annan shifted their rhetoric and European Countries began to back down. Facing mounting public disapproval the pharmaceutical companies withdrew their case in a meeting with Nelson Mandela.

Zackie continued to campaign against Thabo Mbeki’s refusal to fully fund HIV/AIDS treatment and eventually became seriously ill until persuaded by a personal appeal from Nelson Mandela to abandon his pledge to refuse treatment.

Conclusions

Experience of **global health negotiations** shows the importance of sound diagnosis including the way issues are framed, the **alignment of interests** and the development and presentation of information. This can help to prepare for the time when the issue is ripe for resolution, perhaps as a result of unfolding events or as a shared understanding of common interests and concerns for global public goods emerges. The formula for the resolution of issues including consideration of the form and nature of any international agreement and the terms in which it can be resolved is crucial to successful negotiation of an agreement. But even when formal agreement is reached diplomatic negotiations centred on the international agency responsible for monitoring the agreement are likely to continue. Such negotiations shape the roles and regimes of the international agencies and are the essential basis for global governance for health. While this calls for shared organization leadership at every level it also depends upon on the personal leadership qualities of key individuals.

Questions

1. Does everyone interpret human rights to health in the same way? If not why not?
2. Describe a negotiation process for a health issue with which you are familiar, can you discern key phases and stages within the process?
3. Give examples of global health issues arising in other policy contexts—security, trade or development?
4. What are the advantages and disadvantages of forming a group of nations or a coalition of civil society organizations to press for global health policy change?
5. If you are to take part in a consultation on a global health issue what information would you seek?
6. What do you think are the most important points to consider in setting up a global health negotiating process?
7. What can ensure that an international agreement on a global health issue is implemented effectively, what can go wrong?
8. What competence do you feel you have to **lead global health negotiations**, how can you build your capability in this field?
9. Who showed leadership in the South Africa Access to Medicines Case and who did not?

References

- Drager, N., McClintock, E., & Moffitt, M. (2000). *Negotiating health development: A guide for practitioners*. Geneva: WHO Conflict Management Group.
- Fisher, R., Ury, W., & Patton, B. (1997). *Getting to Yes: Negotiating an agreement without giving in*. London: Random House Business books. ISBN 9781844131464.
- Irwin, R. (2010). Indonesia, H5N1, and global health diplomacy. *Global Health Governance*, III(2). (Spring 2010) <http://www.ghgj.org>.
- Labonté, R., & Gagnon, M. L. (2010). Framing health and foreign policy: Lessons for global health diplomacy. *Globalization and Health*, 6, 14. doi:10.1186/1744-8603-6-14. London.
- Lee, K. (forthcoming 2013). Key factors in negotiations for health. In T. Novotny, I. Kickbusch & Told M (Eds.), *Twenty-first century global health diplomacy*. London: World Scientific Publishing.
- Lee, K., Chagas, L. C., & Novotny, T. E. (2010). Brazil and the framework convention on tobacco control: Global health diplomacy as soft power. *PLoS Medicine*, 7(4), e1000232. doi:10.1371/journal.pmed.1000232.
- Marcus, L. J., Dorn, B. C., Kritek, P. B., Miller, V. G., & Wyatt, J. B. (2011). *Renegotiating health care: Resolving conflict to build collaboration* (2nd ed.). Boston: Jossey Bass.
- Spector, B. I., & Zartman, I. W. (Eds.). (2003). *Getting it done: Post agreement negotiation and international regimes*. Washington DC: United States Institute of Peace Press. An analysis of the link between diplomatic negotiations of the implementation of international agreements and the regimes of global governance institutions.
- Zartman, I. W., & Berman, M. (1982). *The practical negotiator*. New Haven, CT: Yale University Press.

Further Reading

- Barston, R. P. (2006). Negotiation, chapter 4. In R.P. Barston, *Modern diplomacy* (3rd edn.) (pp. 48-69). Harlow: Pearson Education Limited.
- Walker, R. (2011). *Manual for UN delegates, conference process, procedure and negotiation*. Geneva: United Nations Institute for Training and Research.