

## Chapter 2

# Issue Framing: Making Your Concerns a Global Priority

**Abstract** One of the challenges stakeholders in global public health negotiations face is how to focus media, public and policy-maker attention on a specific public health concern in a way that motivates action. Whether the issue is the threat posed by a new virus (e.g., HIV/AIDS, SARS, H5N1/avian flu, H1N1/swine flu), the impact of the WTO's TRIPS agreement on the access to essential medicines, or the marketing of unhealthy foods to children, defining the issue in a compelling manner is a key first step in any negotiating process.

**Keywords** Issue framing • Stakeholders • Negotiation • Negotiation process • Global Strategy on Public Health Innovation and Intellectual Property • Policy relevant • Winning coalition • Perceptions • Targeting stakeholders • Crafting the message • Timing • Forum choice • Law of the Sea Negotiations • Association of Small Island States (AOSIS) • Brazil • AIDS • United States Trade Representative (USTR) • PhRMA • TRIPS • World Trade Organization (WTO) • Currently Perceived Choice Tool • MDGs • International Health Regulations • SARS • Avian influenza • WHO's Global Influenza Surveillance Network • Convention on Biological Diversity • World Health Assembly • Framework Convention on Tobacco Control (FCTC) • Doha Public Health Declaration

The process of defining a situation, trend, risk or opportunity as something that decision-makers need to and can act upon is part of effective *issue framing*. “*Issue framing*” is a way of conceptualizing the issues in negotiation. It helps negotiators organize and process complex information by focusing on a particular aspect of an issue and providing a field of vision for the problem. In the domain of public health, effective issue framing is only partly a matter of technical analysis and interpretation. Scientific evidence of a health risk is usually necessary but not sufficient to motivate international action. What may be equally or more important is describing the issue in a way that is morally compelling, taps into emotion, arouses a sense of urgency and makes it clear that action can solve the problem. As

Jeremy Shiffman (2009, p. 608) notes, “the rise and fall of a global health issue may have less to do with how ‘important’ it is in any objective sense than with how supporters of the issue come to understand and portray its importance.” For example, one could frame the issue of a product’s risks by arguing that the product is a known carcinogen and should be regulated internationally. One could also argue that the product’s health risks are borne by an under-informed public and the public health systems of developing countries, and that its benefits go primarily to large multinational corporations. The latter framing may be more compelling because it presents the issue as one of protecting the weak and less informed.

It is important to note that the framing of a public health issue is often contested. Proponents of action may state the case for action in stark terms, while those who oppose such action may emphasize uncertainties, the costs of action and the need for further study. In the recently completed negotiations on a Global Strategy on Public Health Innovation and Intellectual Property, for example, competing definitions of the issue were presented by the public health community and the pharmaceutical companies: addressing diseases of the poor vs. protection of intellectual property and drug innovation. The public health community advocated for new mechanisms to promote research and development of drugs for “diseases of the poor,” such as drug-resistant tuberculosis—drugs for which there is neither a lucrative market nor any intellectual property incentive to engage in research and development. The initial position of the public health community was to question the applicability of intellectual property rules for production of drugs for diseases of the poor, arguing that drugs most needed by the poor would not otherwise be discovered, developed and delivered to them. Many pharmaceutical companies countered that any change in intellectual property rules would have drastic effects on drug innovation.

## 2.1 Why Issue Framing is Important

Issue framing is critically important to any negotiation process, for several reasons. First, issue framing is the first and necessary step in making information from biomedical research, epidemiology and related fields “policy relevant.” Through this process, scientists and other technical experts can and must translate scientific evidence and risk and response assessments into problem statements and policy options that are not only intelligible, but relevant and compelling to the politicians, lawyers and social scientists who generally lead global negotiation processes.

Second, the way a problem is framed or defined will influence the entire course of the negotiation and shape the resulting agreement. Indeed, the initial definition or framing of a problem may be the single most crucial factor determining the likelihood and shape of the solution. It will determine what options are developed and put on the table and, to a large extent how well developing countries’ interests can be met. In addition, the way an issue is framed will determine, to a large extent, which stakeholders will support and oppose action, and, consequently,

whether developing countries can attract enough supporters to build a “winning coalition” for action favorable to health. For example, strategically framing a public health issue in a way that connects to the primary concerns of non-health stakeholders may help involve them in a coalition for action.

Third, in a context in which developing countries have limited ability to influence global policy making processes in which powerful developed countries (such as the United States or Western European countries) have an interest (Krasner 1985), issue framing may provide the main opportunity for low-resource stakeholders significantly to influence the negotiation process, especially when the issues are of concern to more powerful stakeholders (e.g., economic policy-makers in developed countries). If limited-resource stakeholders can get involved early to frame the definition of the problem and the terms of the collective debate, they can have enormous influence on the subsequent negotiations and their outcomes. Particularly when more powerful developed countries have not fully formulated or finalized their views on an issue, there may be an opportunity to influence their perspective. Once they have agreed on a definition of the problem and its priority relative to other negotiation issues, however, shifting their views may be very difficult.

## 2.2 Strategic Challenges for Global Health Stakeholders

In the issue-framing process, stakeholders seeking to mobilize others to act need to ask two basic questions:

1. “How can we persuade others that this is a problem that merits international action?” In other words, what kind of problem frame or way of defining and talking about the problem can help motivate parties to come together and negotiate a response?
2. “What kind of problem frame or definition will shape the negotiation process most favorably for *my* health priorities?”

These questions have no easy answers. Because of the nature of global public health challenges today – their cross-sector and cross-border impacts and the need to seek solutions that traverse these same borders—health advocates need to take into account three complicating factors in answering these questions.

First, many solutions will involve a complex package of resources, education, policies and programs that cut across sectoral lines. Thus, advocates will often need to persuade people *outside the health sector*, both nationally and internationally, to act. This requires getting into the “shoes” of counterparts with different values, different world views, different interests, different understandings of the problem and different perspectives and modes of argumentation associated with their professional education. For example, if one is trying to persuade states to adopt lower tariffs on essential drugs, it will likely not be sufficient to present the

health benefits of the policy; one may have to address how such a tariff cut will affect government revenues. In this sense, it is useful to consider cross-sectoral negotiations as cross-cultural ones, with the challenges of communication, mutual understanding and bringing together different values and perspectives that these present.

Second, public health officials will likely need to overcome the common perception that incorporating health concerns entails restrictions and negative impacts on other sectors. In other words, policy-makers in other sectors may see public health regulation as an impediment to development and a limitation on free trade and business flexibility. Incorporating public health concerns is thus often seen as a win-lose proposition.

Third, public health policies may not have immediate, direct and visible benefits for other sectors. The economic benefits of public health are longer term and more indirect, even if very real. Thus, persuading others of the benefits improvements in public health will bring to their sector, whether economy, development, reduction of poverty, trade or governance, is challenging, as they may see themselves as giving up something now in return for an uncertain benefit in the future.

Health policy stakeholders' critical first hurdle is thus to reframe health problems in a way that motivates other sectors to be concerned about them. And, strategies that have been effective *within* the health sector may not be as effective in a cross-sectoral or global context. Presenting evidence of the impact of trade (or other policies) on health will be necessary, but not sufficient. In fact, heightened public concern about an issue may be more important than scientific consensus in determining whether policy-makers take an issue seriously. For health policy officials and other stakeholders who are accustomed to medical or technical responses to public health problems, this represents an enormous shift in thinking and action.

## 2.3 Framing Strategies

Despite the challenges, health stakeholders do have significant opportunities to influence the identification and framing of issues, and they have experienced success in the health field and other fields. Four strategies have proven to be particularly effective:

- (1) Targeting the right stakeholders for action;
- (2) Crafting the message for maximum influence;
- (3) Timing the initiative to build momentum;
- (4) Seeking a favorable forum for negotiation.

### ***2.3.1 Targeting the Right Stakeholders for Action***

The first step in framing an issue for potential international or global negotiation is to determine the target audience. One way to do this is to determine who will need to act, what action they will need to take in order to address the issue, and, if you do not have direct access to or influence on these key decision makers, it is important to determine how to influence them indirectly.

For example, in 2005, a coalition campaigning for aid to Africa determined that the G-8 leadership was their ultimate target for action because these leaders collectively could make a commitment to increase aid to Africa substantially. Having made that assessment, however, the coalition partners recognized that they had no ability to influence G-8 leaders through direct communication at the G-8 Summit. They determined that their best avenue of approach was through the citizens of G-8 countries, who could communicate their views on the need for aid to Africa through letters, e-mails and participation in public events and thereby increase pressure on the G-8 to take action. Their next step was to organize a series of rock concerts in G-8 countries, advocating for aid and giving citizens clear opportunities and instructions for contacting their leaders. Millions of citizens did so, contributing to the G-8 countries' decision to double aid to Africa by 2010.<sup>1</sup>

### ***2.3.2 Crafting the Message for Maximum Influence***

Once you have identified the actors you want to influence, and the “pathway” to reach them, the next step is to frame the message in a way that has the best chance of influencing them. Certain kinds of problem framing are more persuasive than others. Research on communicating global health messages to publics and policy-makers in developed countries indicates that the most effective message platform tends to:

1. Describe the problem using credible facts the audience can relate to, and, to the extent possible, describe how the problem affects the target actors, their constituencies or issues they care about.
2. Describe a viable solution to the problem with hopeful, positive, simple language and tangible examples of how the solution might work (or has worked).
3. Advocate action steps to help solve the problem, i.e. calls on target actors to do something specific.
4. Make a moral appeal for action. Messages need to connect emotionally with the target audience to inspire them to take action.
5. Make a concrete call to action (Global Health Council 2005).

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<sup>1</sup> G8 Hokkaido Toyako Summit Leaders Declaration, 8 July 2008, available at [http://www.mofa.go.jp/policy/economy/summit/2008/doc/doc080714\\_\\_en.html](http://www.mofa.go.jp/policy/economy/summit/2008/doc/doc080714__en.html).

**Box 2.1** “[G]lobal polio eradication has been positioned as a humanitarian crusade to rid the world of a scourge that has afflicted children for millennia. Many older advocates from industrialized nations may view this positioning as both credible, accepting the idea that polio is truly a problem the world can be rid of, and salient, remembering a time when polio caused havoc each year in their own countries” (Shiffman 2009, p. 609).

The importance of effective message crafting is illustrated by two contrasting examples: the failure of developing countries’ to achieve equitable sharing of ocean resources (in the Law of the Sea negotiations) and the success of small island states in negotiating the climate change-related Kyoto Protocol. In the Law of the Sea negotiations, developing countries insisted that seabed resources such as manganese nodules be shared according to the principles of the New International Economic Order (NIEO). The moral claim on which the NIEO was based—that developed countries owed developing countries a large debt to compensate for their exploitation during the era of colonialism – was not compelling to developed countries. In fact, this argument strengthened U.S. and other Western countries’ opposition to developing countries’ interests and agenda. Industry representatives with an interest in seabed mining argued that the declaration that the seabed was the “common heritage of mankind” was “collectivist,” and that seabed production controls were “OPEC-like cartelization,” and that mandatory technology transfer damaged intellectual property rights. They argued persuasively to the U.S. government that what was at stake in the negotiation was not only rights to seabed mining and their financial interests, but a precedent with respect to global governance (Sebenius 1991, p. 128).

In the negotiations on the Kyoto Protocol, by contrast, the Association of Small Island States (AOSIS) became an influential driver of action. AOSIS framed the problem of climate change in a way that connected inaction to very concrete, disastrous consequences (such as the complete disappearance of small island states) and created a moral dilemma for the large industrial countries. They also presented the threat of global climate change not merely as a threat to Pacific and Caribbean islands, but to the physical (and economic) integrity of the East Coast of the United States, highlighting a potential loss of immediate concern to the U.S. This framed the problem in terms of U.S. interests, not just those of small island states, and helped to bring the U.S. to the table (see [Chap. 8](#)).

Message crafting is important not only for creating a compelling argument, but also for generating persuasive options for negotiation and building alliances to achieve public health outcomes. Brazil’s success in achieving lower prices for pharmaceuticals for AIDS sufferers was due in part to the Government’s ability to understand the concerns of key decision makers in the United States and frame the decision in a way that made it difficult to refuse to take action. At issue was a provision in Brazil’s patent law requiring local production as a

condition for foreign patent holders to receive protection in the country. The United States—led by the Pharmaceutical Manufacturer’s Association (PhRMA) and the U.S. Trade Representative (USTR)—viewed this as inimical to free trade and a violation of the TRIPS agreement. USTR had on previous occasions exerted significant pressure on Brazil (through the threat of trade sanctions) to change its patent laws to favor stronger protection—with success. In this instance, however, that pressure did not work. Rather than accept the US characterization of the issue at stake as the legality of its patent law and the protection of intellectual property rights, Brazil chose to frame the issue for negotiation as one of “access to essential medicines.” This approach enabled Brazil to overcome the opposition of the United States to reducing prices of AIDS drugs. The President of Brazil was able to attract diverse allies within the country (including ministries, NGOs and industry groups), in the United States (including NGOs and media), and internationally (within multilateral forums and other countries). NGOs in both Brazil and the US took up Brazil’s causes and worked hard to disseminate information to key decision makers and the public.<sup>2</sup> Articles appeared in newspapers or on the internet characterizing the US position as unethical. Gradually, public opinion began to shift towards the Brazilian side (See [Chap. 7](#), p. 209).

Brazil’s framing of the issue in terms of public health also effectively linked its situation to that of Africa, where concern about the spread of AIDS had increased substantially—so much so that in May, 2000, President Clinton issued an Executive Order declaring that the US government would not impose trade sanctions against African governments that violated American patent law in order to provide AIDS drugs at lower prices (Lewis 2000).<sup>3</sup> Brazil made this link explicit by underlining its negotiation with the U.S. as a precedent-setting model for Africa. “Brazil has raised this banner because it is a cause that has to do with the very survival of some countries, especially the poor ones of Africa,” President Cardoso of Brazil had said in an interview with the *New York Times* (Petersen and Rohter 2001). This effectively made it more difficult for USTR and PhRMA to exert pressure on Brazil without significant public and international outcry.

Finally, by expanding the issue beyond a pure “price negotiation,” Brazil and its allies enhanced their negotiation power by creating possibilities for new options that allowed the United States to back down from its initial position. The reframing enabled the United States to find a way to take the decision Brazil wanted without being seen as compromising on its biggest concerns: protection of intellectual property and avoidance of a bad precedent for future

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<sup>2</sup> See, e.g., Oxfam 2001 and Medecins Sans Frontieres 2001.

<sup>3</sup> The Order prohibited the US from taking action pursuant to US trade laws against any sub-Saharan African country that promoted access to HIV/AIDS drugs in a way that provided adequate protection of intellectual property in accordance with TRIPS provisions. Executive Order 13155 of May 10, 2000, “Access to HIV/AIDS Pharmaceuticals and Medical Technologies.” *Federal Register*. Vol. 65, No. 93 (May 12, 2000).

negotiations. “[T]he [May 2000 executive] order strikes a proper balance between the need to enable sub-Saharan governments to increase access to HIV/AIDS pharmaceuticals and medical technologies and the need to ensure that intellectual property is protected,” President Clinton commented at the time (Clinton 2000). It still required countries to provide “adequate and effective intellectual property protection”, but accepted the WTO’s standard on patents, rather than applying the US’s more stringent rules and included some important caveats preserving the US’s rights to take action (Executive Order 13155, Sect. 1(a)). The Executive Order applied only to African countries at the time, but its effects spilled over immediately to the US-Brazil dispute. Two days later, five major pharmaceutical companies agreed to negotiate voluntary price cuts in Brazil, and in June, 2001, the United States withdrew its complaint with the WTO concerning the Brazilian law.<sup>4</sup>

The *Currently Perceived Choice* tool (see Appendix 2) can assist in the process of framing issues and messages in ways that facilitate action on public health priorities—particularly in situations in which counterparts (whether other Ministries in the country or other countries in the context of an international negotiation) are refusing to take action favorable to public health. Consider the example of a situation in which the Ministry of Health of Country X, in cooperation with the WHO, would like action to be taken in neighboring Country Y to restart a vaccination campaign that was halted by Country Y. Country Y has refused access to WHO and NGOs to perform the vaccinations. Country X is concerned that without the vaccinations, the spread of disease across its border will be rapid and devastating. After some analysis, the Minister of Health of Country X and WHO determined that local authorities (and not the national Ministry of Health) should be targeted, as they initiated the prohibition of vaccines. There is overwhelming evidence of the effectiveness and safety of the vaccines—enough, they believe, to convince even the strongest skeptic. But it has not been sufficient to motivate effective action by the local authorities, even under pressure from the national Ministry of Health. The following illustrates one way in which the local official might be thinking about his choice:

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<sup>4</sup> Brazil restricted the possibility of compulsory licensing to cases of a national health emergency and agreed to notify the US government in advance if it found it necessary to issue a compulsory license (Wogart et al. 2008).



<b>Box 2.2</b>	
<b>Currently perceived choice</b>	
Decision Maker: Local Authority in Country Y	
Decision he/she believes she is being asked to take <sup>5</sup> : “Shall I now bow to pressure from the West and the Central Govt. to re-start a potentially dangerous vaccination campaign?”	
If I say “YES” (Consequences of saying “yes”)	If I say “NO” (Consequences of saying “no”)
<ul style="list-style-type: none"> <li>- Would be seen as capitulating to the West and the Central Government</li> <li>- Will be accused by religious leaders (and my supporters) of participating in a Western plot to make our children infertile</li> <li>- Would confirm that children were paralyzed due to ignorance and unfounded rumors, as stated in the press</li> <li>- Would be seen as incompetent: would accept that our initial test was erroneous</li> <li>- Would admit mistake and would discredit our doctor who conducted the tests</li> <li>- Would be seen as not protecting the people; Central Government would get the credit from the people, other countries in the region and the global community</li> </ul>	<ul style="list-style-type: none"> <li>+ Would be seen as standing up to the West and the Central Government</li> <li>+ Will be hailed by religious leaders as protecting the lives of our children and of future generations</li> <li>+ Will be seen as standing up for fairness and promoting further transparency by the Central Government</li> <li>+ Will be seen as supporting my personnel in our State, and not admitting a mistake</li> <li>+ I may be able to play a bigger role in next elections with support that my stand will garner</li> <li>+ I can always agree later</li> </ul>
<sup>5</sup> Reminder: The question that is being asked <i>may not</i> be the question that is being <i>heard</i> by the decision-maker. See Appendix 2 for further explanation of the Tool	

In reviewing the Currently Perceived Choice, the Ministry of Health officials from Country Y and the WHO may gain insight into why the evidence they presented regarding the spread of disease and the safety of the vaccines failed to convince the local authorities. Other relevant factors affecting the local authorities’ decision regarding vaccination include:

- (1) The influence of religious leaders in the province. The Ministry and WHO might ask whether the religious leaders might be useful stakeholders to target, given their influence over the decision.
- (2) The importance to local officials and stakeholders of participation in the process of devising and implementing solutions and of receiving credit for successes. It is important that the process not be seen as a Central Government process, but that it reinforce local credibility, authority and visibility.
- (3) The importance to local leaders of being perceived as competent (or at least not incompetent), especially vis-à-vis the Central Government and the West.

With a better understanding of the factors affecting target stakeholders’ perceptions of the problem, it becomes clear that having medical evidence to support the action the WHO and Ministry of Health favor will likely not be enough to

generate decision makers' support, and, in this case, might even trigger negative reactions. The question might need to be reframed to target the local officials (and not the Ministry of Health), and to take account of the other factors influencing the target stakeholders' decision.

### ***2.3.3 Timing the Initiative to Build Momentum***

In addition to the knowledge of *whom* to target and *how* to craft the message, a third aspect of framing is critical: timing. Is the time right to move forward with a campaign or proposal for action? To make this assessment, health stakeholders need to answer three questions:

- Is there an opportunity to link the issue to existing global priorities and resources?
- Is there a dramatic event or situation that provides a focus for public attention and a rallying point for action?
- Is there an appropriate forum available, with a mandate that could be interpreted or stretched to include the issue?

Often, a core group of stakeholders will recognize the need to address a specific public health concern, while policy-makers and the wider public do not yet believe the issue has achieved sufficient salience to motivate action. In these situations, convergence with existing global priorities and resources may allow for linkages that lead to a tipping point. For example, climate change was initially viewed by some as predominantly an environmental problem rather than a development problem. Yet the impacts of climate change can directly affect the efficient investment of resources and the achievement of development objectives. At the same time, how development occurs has an impact on climate change and the vulnerability of societies (OECD 2005). Developing countries succeeded in reframing the issue from one of protection of the environment to "sustainable development." As the framing of the climate change problem shifts to include linkages between environment and development, the specific concerns of developing countries are gaining prominence on the climate change agenda (Chigas et al. 2007).

Similar opportunities for linkage that increase the salience of public health have arisen with regard to the UN's Millennium Development Goals. The MDGs, which were adopted as a UN General Assembly Resolution by the heads of state at the 2000 Millennium Summit, include commitments directly related to public health issues: to reduce child mortality, to improve maternal health and to halt and begin to reverse the spread of HIV/AIDS, malaria and other diseases by 2015.<sup>5</sup> The high global visibility of the MDGs and their prominent entrance into the development

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<sup>5</sup> See [www.un.org/millenniumgoals/](http://www.un.org/millenniumgoals/).

debate have provided an opportunity for advocates of these public health causes to frame their concerns in ways that directly connect to the global agenda of development and poverty eradication. By linking their priorities to concrete action pledges from the MDGs public health advocates and officials can raise their prominence and argue more persuasively for action on public health.

A single dramatic new development may also create a window of opportunity to draw public attention to a public health issue and move toward action. The outbreak of the Severe Acute Respiratory Syndrome (SARS) epidemic, a human respiratory disease, in southern China in late 2002 and its subsequent rapid spread throughout the world illustrated the wide-ranging impact of a new disease in a closely interconnected and highly mobile world. The outbreak of SARS highlighted the importance of a worldwide surveillance and response capacity to address emerging microbial threats through timely reporting, rapid communication and evidence-based action. Shortly after SARS was recognized as a threat to human health, the WHO took swift and sweeping measures. These measures included issuing global alerts that were amplified by the media and brought greater vigilance and more rapid detection and isolation of cases; direct technical support to assist in epidemiological investigations and containment operations; and the establishment of research networks to enhance knowledge about the disease (WHO 2003). This new and emerging communicable disease threat was also a catalyst for renewing interest in completing longstanding negotiations on the revision of International Health Regulations (WHO 2003b)<sup>6</sup> and changing the scope of these regulations from just three diseases – smallpox, plague and yellow fever—to include all “public health emergencies of international concern” (WHO 2005).

Similarly, the outbreak of avian flu in 2006 and a crisis that emerged from efforts to develop an international response to it drove global health stakeholders to reframe a previously deadlocked issue—whether viruses should be treated as sovereign resources or as shared international concerns—in terms of access to vaccines. During previous negotiations on the Convention on Biological Diversity, disagreements about sovereignty and ownership of biological materials had

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<sup>6</sup> The International Health Regulations aim to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade (IHR 2005, Article 2). They are an international legal instrument that governs the roles of WHO and its member countries in identifying and responding to and sharing information about public health emergencies of international concern. The IHR build on and expand a series of regulations, the International Sanitary Regulations, adopted in 1951. In 1969, they were revised and adopted as the International Health Regulations, regulating three diseases: cholera, plague and yellow fever. The 2005 regulations include smallpox, polio, SARS and new strains of human influenza that member states must immediately report to the WHO and provide specific procedures and timelines for announcing and responding to public health events of international concern.

prevented agreement on virus sharing.<sup>7</sup> Indonesia, the country most affected by the H5N1 (avian flu) virus, had announced in 2006 that it would no longer share samples of the virus with WHO's Global Influenza Surveillance Network. The loss of access to H5N1 virus samples posed serious risks to global health security, because samples of the virus are essential for development of flu vaccines. In response, national governments renewed international negotiations through an *ad hoc* meeting in Jakarta.

In the negotiation process, government negotiators reframed the issue of virus sharing, shifting from a focus on sovereignty and ownership (a framing which had led to deadlock) to one of the "responsible practices for sharing avian influenza viruses and resulting benefits" (WHO 2007a).<sup>8</sup> This reframing allowed for recognition of a country's sovereignty over the viruses while creating an obligation to share them. That obligation was formally affirmed in a resolution of the World Health Assembly (World Health Assembly 2007).

### 2.3.4 Seeking a Favorable Forum for Negotiation

As the avian flu virus sharing example shows, effective negotiators may seek not only to reframe an issue, but also to shift the forum in which the issue is discussed. Making the choice of a forum part of negotiation strategy is especially useful when one forum seems more likely than another to resolve the issue in a way that meets the negotiator's interests.

In the case of the avian flu virus, the Convention on Biological Diversity had deadlocked on the question of sovereignty over biological resources. Faced with a crisis in 2006, international health negotiators pushed for the issue to be reopened in an *ad hoc* forum focused specifically on sharing the avian flu virus, and then sought ratification of their proposals not in the Convention on Biological Diversity, but rather in the World Health Assembly. For these negotiators, safeguarding public health was much more important than protecting national property rights. Therefore, they convened a forum far more focused on public health concerns than on biological property rights, and sought formal government ratification through

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<sup>7</sup> The Convention on Biological Diversity (5 June 1992) defines biological resources to include "genetic resources, organisms or parts thereof, populations, or any other biotic component of ecosystems with actual or potential use or value for humanity" (article 2) and states that "the authority to determine access to genetic resources rests with the national governments and is subject to national legislation" (article 15.1). Genetic resources are defined to include "any material of plant, animal, microbial or other origin containing functional units of heredity" (article 2). See Fidler 2008 for an analysis of the international legal dimensions of virus sharing.

<sup>8</sup> In announcing Indonesia's resumption of virus sharing, Dr David Heymann, WHO's Assistant Director-General for Communicable Diseases, commented: "We have struck a balance between the need to continue the sharing of influenza viruses for risk assessment and for vaccine development, and the need to help ensure that developing countries benefit from sharing without compromising global public health security." (WHO 2007b).

the World Health Assembly, where they could be confident that public health concerns would outweigh sovereignty concerns.

Typical international forums for health authorities to negotiate rules and regulations on health issues include the WHO's World Health Assembly (WHA) and its related processes of intergovernmental meetings,<sup>9</sup> the governing boards of the Joint UN Programme on HIV/AIDS, the Global Fund and Global Alliance on Vaccines and Immunization, and increasingly the UN General Assembly.<sup>10</sup>

*Ad hoc* forums are gaining in importance, especially in public health. They provide an opportunity to focus attention, resources and policy-making *directly* on public health issues, rather than on public health priorities in forums in which they are a secondary concern. The 2003 Framework Convention on Tobacco Control (FCTC) is an example of an *ad hoc* negotiation process that produced the first framework treaty adopted under the auspices of the WHO. The FCTC is designed to strengthen international and national cooperation to reduce the growth and spread of the global tobacco epidemic, which disproportionately affects developing countries. It was negotiated under WHO authority and is modeled on the framework convention-protocol approach successfully utilized in international environmental law.<sup>11</sup> In preparation for the negotiations, the World Health Assembly established an Ad Hoc Inter-Agency Task Force on Tobacco Control under WHO leadership. Though part of WHO's mandate was to improve coordination and cooperation across UN agencies, the choice of WHO as the convener of the negotiation process also served a strategic purpose: to replace the UN Conference on Trade and Development as the UN convener. In the existing UNCTAD forum,

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<sup>9</sup> See, for example, the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, <http://apps.who.int/gb/phi/>; the Pandemic Influenza Preparedness (PIP) process, <http://apps.who.int/gb/pip/>; the Conference of the Parties to the WHO Framework Convention on Tobacco Control (FCTC) and the Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products, <http://apps.who.int/gb/fctc/>; and the WHO Global Code of Practice on the International Recruitment of Health Personnel, [http://apps.who.int/gb/ebwha/pdf\\_files/WHA63/A63\\_R16-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf).

<sup>10</sup> See, e.g., UN General Assembly Resolution 64/265 (13 May 2010) on the prevention and control of non-communicable diseases; UN General Assembly Resolution 63/33 (26 November 2008) (requesting the UN Secretary General to prepare "in close collaboration with the Director-General of the World Health Organization, and in consultation with Member States, to submit to the General Assembly at its sixty-fourth session, in 2009, a comprehensive report, with recommendations, on challenges, activities and initiatives related to foreign policy and global health, taking into account the outcome of the annual ministerial review to be held by the Economic and Social Council in 2009"); UN General Assembly Resolutions 63/234 (22 December 2008), 61/228 (22 December 2006), and 55/284 (7 September 2001) on "2001–2010: Decade to Roll Back Malaria in Developing Countries, especially in Africa"; Declaration of Commitment on HIV/AIDS, UN General Assembly Resolution A/RES/S-26/2 (27 June 2001).

<sup>11</sup> The "framework convention" approach has been used widely in climate change negotiations. It involves negotiating a general agreement that acknowledges the existence of the problem with principles for a solution, including perhaps targets for action, followed by negotiation of specific protocols with details of how the principles will be put into practice. This step-by-step approach was in part a reaction to the years of negotiation of a detailed and comprehensive Law of the Sea treaty that was ultimately rejected by the United States (Sebenius 1991, p. 14).

the tobacco industry had substantial influence on agenda setting and decision making, and had blocked meaningful action to limit trade in tobacco (Collin et al. 2002).<sup>12</sup> Once underway, the FCTC process gained significant political momentum and turned into a worldwide public health movement (Roemer et al. 2005).

Health issues are also increasingly negotiated in non-health *ad hoc* forums. The negotiation of the 2000 Cartagena Protocol to the Convention on Biological Diversity illustrates the increasing significance of such nontraditional forums. In order to adequately address the potential risks posed by cross-border trade and accidental releases of “living modified organisms,” negotiators had to consider environmental issues as well as matters of health, food safety, trade, property rights and socioeconomic development. Even though the core issue of biosafety made environment ministers the driving force behind the negotiations, subsequent ratification and implementation demanded coordination with ministries of health, science and technology, agriculture, and trade. Those players could thus move their specific concerns onto the agenda (Martinez 2001).

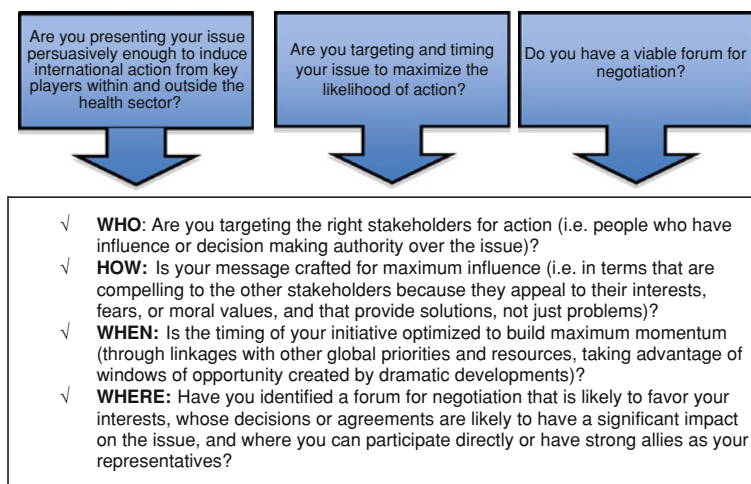
Public health concerns have also featured prominently in trade negotiations. In the Doha Development Agenda, the WTO-led trade negotiations that began in November 2001, for example, many developing countries viewed an agreement on Trade-related aspects of intellectual property (TRIPS) and public health as an essential element of the trade agenda. The resulting Public Health Declaration reflected the success of developing countries in ensuring that TRIPS would be interpreted in a way that supported their public health goals.

When health negotiators are considering how best to frame an issue for action, they should also consider what forums are available for international negotiations and decisions on the issue. As the avian flu and tobacco control examples illustrate, the choice of forum may support or undermine the potential for agreements that advance the negotiator’s interests. Negotiators should keep at least three criteria in mind as they consider where to “bring” an issue for international action:

1. *Likelihood that the forum will produce an agreement or decision that meets our interests.* Is this a forum where representatives are likely to share our view of the issue and to agree with our preferred course of action? If the negotiator’s goal is to advance a public health interest over an economic interest, then the WHA is likely to be a more favorable forum than the WTO. However, the likelihood of support alone is not enough to drive the negotiator’s decision.

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<sup>12</sup> The FCTC was negotiated in six sessions of the Intergovernmental Negotiating Body, with “intersessional” consultations and individual and group consultations by the chair with various delegations, and was approved by the 56th World Health Assembly on 21 May 2003. A Conference of the Parties to follow up on the FCTC held its first meeting in 2006. It has since established working groups on different articles, as well as an Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products.



**Fig. 2.1** Issue framing

2. *Likelihood that agreements/decisions in this forum will have real impact.* How directly and how strongly will agreements and decisions reached in this forum affect the outcome we are seeking? Are agreements reached here binding on actors whose behavior we are seeking to change? Are commitments made here likely to result in resources being mobilized to support action on the issue? Though a negotiator may believe that the WHA is more likely to favor his/her interests than the WTO, the issue may be one on which the WHA actually has little or no power to bind key actors, and the WTO, by contrast, does have such power. Public health advocates decided to advocate for access to pharmaceuticals through the Doha TRIPS negotiations in large part because the WTO has far more authority and resources to enforce an agreement on access to pharmaceuticals than the WHA.
3. *Our ability to participate in negotiations under the auspices of this forum:* Is this a forum where our agency/coalition can be directly represented, or will we need to work through others? If we cannot be present ourselves, do we have allies among the representatives who can effectively negotiate on our behalf? If not, do we have a way to build those alliances in a timely fashion? Particularly in the case of non-health forums, such as the WTO or the Convention on Biological Diversity, health negotiators must determine whether they can “get to the table” themselves, or whether they will need to work through government delegations that are led by trade, environment or development agencies whose primary concerns are different. Building relationships and alliances with counterparts in non-health agencies is especially important when health advocates must count on those counterparts to represent their interests, and can have only indirect participation in the negotiation process.

## 2.4 Conclusion

Issue framing, which is summarized in Fig. 2.1, is the crucial first step in making public health concerns a global priority and motivating action, especially because the mere existence of scientific evidence of a public health concern is usually not enough to drive policy-makers to act. By framing the problem and the terms of the broader debate, less-influential stakeholders can have a major impact on the terms of the ensuing negotiations and resulting agreement. As they seek to craft a compelling framing of the issue, negotiators also need to target stakeholders who are empowered to act, link to other high priority issues on the international agenda, and move their issue to a forum that is favorable to their interests and to action.



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