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Master's Thesis:

The European Union's Role in Global Health Diplomacy

THREE WORLD HEALTH ORGANIZATION TREATIES IN THE LIGHT OF A CHANGING EU FOREIGN POLICY

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I. Glossary

All agreements and treaties will be provided with the dates of their entering into force instead of the date they were signed.

Abbreviations:

BAT – British American Tobacco
BTA – Bilateral Trade Agreement
CFSP – Common Foreign and Security Policy of the EU
EP – European Parliament
EU – European Union
EURO – European Region within the UN Regional Framework
FCTC – Framework Convention on Tobacco Control
HR/VP - High Representative of the Union for Foreign Affairs and Security Policy/Vice President of the European Commission
FTA – Free Trade Agreement
HIC – High Income Countries
IMPACT - International Medical Products Anti-Counterfeiting Taskforce
IMF – International Monetary Fund
MDG – Millennium Development Goals
NCD – Non Communicable Disease
ITTP – Illicit Trade in Tobacco Products
LMIC – Low and middle income countries
PITT – FCTC Protocol to Eliminate Illicit Tobacco Trade
RILO – Regional Intelligence Liaison Offices of WCO
SACU – Southern African Customs Union
SSFFC – Substandard/Spurious/Falsely-labelled/Falsified/Counterfeit Medical Products
TFEU – Treaty on the Functioning of the European Union
TPP – Trans – Pacific Partnership Agreement
TRIPS – The Agreement on Trade-Related Aspects of Intellectual Property Rights
TTIP - Transatlantic Trade and Investment Partnership
TTC - Transnational Tobacco Company
UN – United Nations
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNDP – United Nations Development Programme
UNICEF – United Nations Children's Fund (until 1953: United Nations International Children's Emergency Fund)
WCO – World Customs Organization
WHA – World Health Assembly
WHO – World Health Organization

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Introduction

> The European Commission and the regional body of the World Health Organization (WHO) are strong actors in the area of global health and cooperation between these two bodies can greatly contribute to a better and more efficient delivery of good health and of health services to millions of people.[1]

This statement from the introduction of the Moscow Declaration (2010)[2] highlights the purpose of this research, namely, to emphasize the growing importance of health issues in world politics and the role the EU plays in the joint effort and cooperation to strengthen global health. As the importance of health related issues is rising due to new international health crises as Ebola, states and intergovernmental organizations such as the European Union (EU) have to increase their efforts in the global health arena as well.[3] In this paper, the role of the EU that it has adopted in a global health context will be examined thereby taking into account its changing goals, emphasis and roles over the past two decades. The EU's behavior as a diplomatic actor within the UN-system will be the center of attention, focusing on three separate, yet connected cases in the setting of the World Health Organization (WHO). The chosen case studies for this thesis are the Framework Convention on Tobacco Control (FCTC), the FCTC Protocol on Eliminating Illicit Trade in Tobacco Products (PITT), and the process of regulating substandard/spurious/falsely-labelled/falsified/counterfeit medical products (SSFFC).

Researching global health from a political science perspective is still a relatively young discipline with only two international treaties focusing exclusively on health, namely, the FCTC and the PITT.[4] Due to the relative youth of the topic, secondary literature is not yet extensive and research is mostly clustered around the Geneva-based, Graduate Institute,[5] as well as some British and Scandinavian Institutes.[6] One of the first comprehensive monographs published on global health is Ilona Kickbusch's, Graham Lister's, Michaela Told's and Nick Drager's *Global Health Diplomacy* (2013) that addresses different concepts, issues, actors and instruments in practice. Other noteworthy

[1] European Commission and WHO Regional Office for Europe Joint Declaration (2010), http://ec.europa.eu/health/eu_world/docs/moscow_declaration.pdf, accessed on 28.04.2015.
[2] 60th Session of the Regional Committee for Europe 13-16.09.2010, Meeting of the member states of the World Health Organization's European Region (WHO EURO).
[3] Director General of the WHO Margaret Chan calls on member states to prioritize Health in her address to the World Health Assembly (WHA) in May 2013, http://www.who.int/dg/speeches/2013/world_health_assembly_20130520/en/, accessed on 28.04.2015.
[4] Along with the treaty establishing the World Health Organization as a UN institution (1946), https://treaties.un.org/Pages/Treaties.aspx?id=9&subid=A&lang=en, accessed on 14.06.2015.
[5] http://graduateinstitute.ch/globalhealth. accessed on 14.06.2015.
[6] *Inter alia*, University of Bath, London School of Hygiene & Tropical Medicine, Karolinska Institute.

works on global health include Kathryn Jacobsen's (2008) *Introduction to global health*, Kent Buse, Wolfgang Hein, and Nick Drager's (2009) *Making sense of global health governance: A policy perspective*, and Neil Arya and Joanna Santa Barbara's (2008) *Peace through health: How health professionals can work for a less violent world*. Jacobsen's book focusses on possible solutions to world health problems and addresses all the key issues of global health at a basic level. It is directed at students of public health. Buse, Hein and Drager's study puts emphasis on the central actors, institutions and mechanisms involved in global health and proposes an agenda for meaningful action in the field. The latter title tries to shed some light on how health professionals can contribute to mitigating and preventing conflicts.

As a result of the recent research history, only a few peer-reviewed articles considered the EU's role within global health diplomacy, including Miriam Faid and David Gleicher's (2011) *Dancing the Tango – The Experience and Roles of the European Union in Relation to the Framework Convention on Tobacco Control* and Thea Emmerling with Julia Heydemann's (2013) *The EU as an Actor in Global Health Diplomacy*. Also, Heydemann has recently completed a doctoral thesis on the EU's behavior in different UN organizations, including the WHO, soon to be published. Other than Emmerling and Heydemann, no one has examined the EU's role in global health diplomacy as a political scientist. Most published articles on related subjects focus either on the policy implications of the respective treaty or on economic and trade effects.[7] This may be due to the perceived lack of importance that is attributed to health as a global issue. Others have focused on the EU's foreign policy without a case study based on negotiation analysis.[8] This thesis will attempt to close this gap in the literature by focusing on the EU and its behavior in international global health negotiations.

The FCTC, PITT and the international regulation of SSFFC medical products are connected by the high economic stakes that countries have vested in them, as well as the aim of attempting to address tensions that may arise between health and trade issues. Negotiating these treaties effectively puts states in the position of having to choose between protecting citizens' health in opposition to respecting regulations of free trade (WTO) and intellectual property (TRIPS). The important factors relevant in these negotiations render them key examples when analyzing EU foreign policy in this area.

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[7] For example, Liberman & Co (2011), ‚Opportunities and risks of the Protocol on Eliminating Illicit Trade' and: Mamudu & Co (2011), ‚International trade versus public health during the FCTC negotiations, 1999-2003'.
[8] Battams, van Schaik & Co (2014), 'The EU as a Global Health Actor: Policy Coherence, Health Diplomacy and WHO Reform'.

Global Health Diplomacy

In the realm of health and health diplomacy there are a number of players involved, including the WHO, representatives of Ministries of Foreign Affairs, other ministries and government bodies, politicians, international agencies and civil society, who may all have different goals for their involvement.[9] Kickbusch, Silberschmidt and Buss (2013) define global health diplomacy therefore as "*… as the multi-level negotiation processes that shape and manage the global policy environment for health*."[10] Parallel to the nexus between negotiations and shaping global health, the EU is in the dynamic process of finding and fulfilling its own role as a regional actor. It is, by its mandate and its trend-setting health legislation, entitled to play a leading role in global health.[11]

International obligations states that "the right to health means that States must generate conditions in which everyone can be as healthy as possible".[12] The WHO holds an important mandate that was agreed upon by its founding members to promote and ensure the highest attainable standard of health for everyone in the world that is possible. Besides their motto of health promotion the WHO is in charge of directing and coordination international health within the UN system, which includes the following areas of work: health systems; promoting health through the life-course; communicable diseases, corporate services, preparedness, surveillance and response; and non-communicable disease.[13] Improving public health by reducing the worldwide consumption of tobacco is a primary goal of the WHO.[14] The WHO Framework Convention on Tobacco Control is an international treaty adopted by the World Health Assembly and its implementation is supported by the Convention Secretariat, which is permanently active throughout the year promoting anti-tobacco measures.[15] The Secretariat of the FCTC is hosted by the WHO and collaborates closely with the WHO to reach its objectives.

As previously stated, global health diplomacy in its current form is a young discipline with increasing importance. The need for the advancement of global health requires the UN system to adapt to new problems and conduct, as well as to accept new players into multilateral diplomacy

9 Kickbusch (2013), 'Global Health Diplomacy – An Introduction', p. 28.
10 Ibid, p. 28.
11 Emmerling & Heydemann (2013), 'The EU as an Actor in Global Health Diplomacy', p. 224.
12 The Right to Health (2013), http://www.who.int/mediacentre/factsheets/fs323/en/, accessed on 27.04.2015.
13 About WHO, http://www.who.int/about/en/, accessed on 28.04.2015.
14 Implementing Tobacco Control, http://www.who.int/tobacco/control/en/control, accessed on 15.06.2015.
15 Implementation and Assistance for Member States, http://www.who.int/fctc/implementation/en/, accessed 28.04.2015.

efforts.[16] One, if not the most important, new player is the EU. The EU has been present but without the possibility to shape policies and spark progress until the post-Lisbon EU foreign policy framework. This is due to the increased opportunities of cooperation between EU member states in the external action framework, which will be explained in the second part of this chapter.

The FCTC Framework is a WHO entity and concerns itself with a wide array of areas that are necessary to impose functioning worldwide tobacco control. It involves measures relating to the reduction of demand for tobacco, protection of the environment, questions related to liability, scientific and technical cooperation, institutional arrangements and financial resources, settlement of disputes and measures relating to the reduction of the supply of tobacco.[17] Limiting access to tobacco products is just as important an issue as the illicit trade in tobacco products to reduce tobacco consumption. This thesis will address the latter issue. The FCTC treaty has shown that more international state cooperation towards a common health goal on a global scale is possible. It remains to be seen if the amending protocol to the FCTC, the Protocol on the Elimination of Illicit Tobacco Trade will be equally successful and if the area of counterfeit and sub-standard medicines (SSFFC) can be regulated with a similar treaty in the future. The latter negotiations remain ongoing (the last high level meeting was in October 2014) and no solution for an agreement or a treaty has been reached, although the states reached a consensus to continue negotiating.[18]

Far too often topics within the WHO, Global Fund and United Nations Aids (UNAIDS) cluster are exclusively considered from a public health perspective. In contrast, political science scholars are concerned with the security aspects of foreign policy when assessing EU Foreign Policy[19]. Applying an international relations and diplomacy perspective to global health negotiations, such as the FCTC and SSFFC, displays these issues as they really are, not only a matter of illicit trade, but also of substantial political interest.

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[16] Kickbusch, I. & Ivanova, M. (2013), 'The History and Evolution of Global Health Diplomacy', p.12.
[17] WHO Framework Convention on Tobacco Control, World Health Organization, WHO Document Production Services, Geneva, Switzerland, 2003.
[18] Report of the third meeting of the Member State mechanism on SSFFC, http://apps.who.int/gb/ssffc/e/a_msm3.html, 27.04.2015.
[19] Edwards, G. (2014), 'The Public Face of a Proto-Something ….: Diplomacy and the European Union', *Diplomacy & Statecraft*, 25:1, pp. 115-116.

EU Evolution of Treaties

The EU started out as the Community for Coal and Steal that did not include any instruments of representation of the then six member states.[20] Every country was in charge of its own policies and only surrendered some sovereign rights in the areas of heavy industrial goods, such as coal and steel. In addition, the High Authority, Assembly, Council of Ministers and Court of Justice were established, which are the forerunners of the institutions as they are known today.[21] In the following decades, more European Treaties were passed[22]. A treaty is defined according to Vienna Convention on Treaties 1969, article 2, as "an international agreement concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation". In 1969 it was common knowledge that international treaties would be concluded between states. The emergence of a political European Union was not entirely foreseeable at this point in time.

While these treaties are important from a historical point of view, the changes that the Lisbon-treaty brought along are so significant that making the attempt of a short summary seems worth the trouble. During the first Gulf War (1990-1991) the European states' shortcoming in regard to collaborating on security issues had been revealed, which resulted in another major change in the EU's structure. There was a strong political appetite to make a strong change towards a more unified foreign policy. The Treaty of Maastricht (1992) abandoned the previous European Political Cooperation in favor of the Common Foreign and Security Policy (CFSP), which despite the name change was not politically binding[23]. During the Balkan Wars in the mid-90's it became evident that not enough had been done to make a stringent and consistent foreign policy possible and that the framework in place needed improvement. Next in the chronological order of treaties was the Treaty of Amsterdam in 1999 that introduced a qualified majority vote "… with the dual safeguards of "constructive abstention" and the possibility of referring a decision to the European Council if a member state resorts to a veto ... ".[24] Joint actions and common positions now became possible and the position of the High Representative was created.

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[20] France, Westerns Germany, Italy, the Netherlands, Luxembourg and Belgium
[21] Treaty establishing the European Coal and Steel Community (1952), http://europa.eu/legislation_summaries/institutional_affairs/treaties/treaties_ecsc_en.htm, accessed on 18.04.2015.
[22] Single European Act 1987, Maastricht Treaty 1992, Treaty of Amsterdam 1997, Treaty of Nice 2001
[23] McCormick, J. (2008), 'Understanding the European Union', p.193.
[24] Common Foreign and Security Policy – History, http://europa.eu/legislation_summaries/institutional_affairs/treaties/amsterdam_treaty/a19000_en.htm, accessed 19.04.2015.

The dynamic change of the EU is evident in the swiftness with which initiatives for new treaties were taken. Making the EU an ever changing and evolving political entity. Given the insufficiencies of the previous agreement (Amsterdam 1999), another big step changing the way the foreign policy is conducted was taken by the Treaty of Nice[25] (2003). Between 2004 and 2007 twelve new states joint the European Union,[26] creating more potential space for disagreement on foreign policy. This is another reason clearer rules were needed to make the Common Foreign and Security Policy (CFSP) more efficient. Some scholars suggested that closer cooperation between European states on foreign policy did not happen because states would be willing to surrender some sovereignty to the EU regarding competition and trade policy; they would not be prepared to do the same in foreign affairs[27]. The Treaty of Lisbon (2009) has endeavored to achieve a higher level in consistency on a foreign policy level, which was meant to clarify the divisions of powers between the EU and member states, including which powers are shared[28]. Thus a (supposedly) better and more consistent foreign policy framework was created to continue to make Europe's voice heard in the world. Explaining the instruments of the post-Lisbon foreign policy framework serves to provide a perspective of comparison between pre-Lisbon and post-Lisbon negotiations in which the EU was involved.

EU Foreign Policy

The foreign policy of the EU is sub-divided into different units, each dealing with a different area of policy, varying in the degree of EU authority to sign contracts or treaties on behalf of the Member States. In the areas of Common Agricultural Policy, the Common Commercial Policy, competition, and common policies on fisheries and air transport the EU has the full competence excluding everything else that is not mentioned,[29] including public health. Mixed agreements is the term for agreements and treaties to which both, the EU and its MS are signatories as it is the case for the agreements dealt with in this paper.

In order to exercise its mandate, the EU needs a number of legal instruments at its disposal.

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[25] Ramopoulos & Odermatt (2013), 'EU Diplomacy: Measuring Success in Light of the Post-Lisbon Institutional Framework', p. 20.
[26] 5th enlargement round 2004: Estonia, Latvia and Lithuania, Poland, the Czech Republic, Hungary and Slovakia, Slovenia, Cyprus and Malta; 2007: Bulgaria and Romania, http://europa.eu/legislation_summaries/enlargement/2004_and_2007_enlargement/e50017_en.htm, accessed on 28.04.2015.
[27] Ramopoulos & Odermatt (2013), 'EU Diplomacy', p. 21.
[28] EU Treaty Overview http://europa.eu/eu-law/decision-making/treaties/index_en.htm, accessed on 22.04.2015.
[29] McCormick, J. (2008), *Understanding the European Union*, p.192.

Historically seen, it has taken the EU quite some time to make its way from a more trade-oriented organization with the mere goal of the single market,[30] towards a more political union. Along with the evolution of the treaties of the EU its role as an international player and negotiator has changed[31]. Its objectives in fighting poverty and helping to contribute to meeting the UN Millennium Development Goals clearly state that, "health is central in people's lives, including as a human right, and a key element for equitable and sustainable growth and development, including poverty reduction".[32] Achieving these objectives will only succeed by the way of decisive and coherent diplomatic action.

In a global arena of international affairs the EU tries to protect and promote the interests of its citizens.[33] As strategy papers by the European Commission and Council indicate health is of an important issue for EU citizens and the world alike and needs to be addressed globally.[34] The obligation to ensure citizens are healthy is also included in the Treaty on the Functioning of the European Union (TFEU) states in article 6(a). From this perspective the EU has not only the right but also the obligation to get involved on the behalf of its Member States by collaborating with them.

The EU's role in health diplomacy is determined by its own objectives, which were laid out for the first time in a 2007 commission strategy paper[35] and later deepened in a Council of the European Union conclusion paper[36] on health strategy. Most importantly for this research it places one of the points of emphasis on non-communicable diseases, which both, the FCTC and the SSFFC areas are part of because they concern themselves with the protection of the population from potentially harmful products. The main question of this thesis is therefore, does the EU speak with one voice and is that a feasible approach?

Structure and Methodology

To provide sufficient answers to the questions raised the thesis will be divided into three main chapters.

[30] Treaty establishing the European Coal and Steel Community (1952), http://europa.eu/legislation_summaries/institutional_affairs/treaties/treaties_ecsc_en.htm, accessed on 27.04.2015.
[31] Edwards, G. (2014) The Public Face of a Proto-Something ….: Diplomacy and the European Union, Diplomacy & Statecraft, 25:1, p. 116.
[32] Council conclusions on the EU role in Global Health (2010), Introduction.
[33] Treaty of Lisbon, Article 2 k).
[34] EC White Paper 2010, Council Conclusions on Health 2008.
[35] The EU in the World – Global Health, http://ec.europa.eu/health/eu_world/global_health/index_en.htm, accessed on 23.04.2015.
[36] Council Conclusion Paper 2010, http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/EN/foraff/114352.pdf, accessed on 24.04.2015.

In the first chapter of the thesis an introduction to diplomacy in the UN context will be given, followed by an explanation of the EU's role in the UN multilateral diplomatic system and a summary of the functioning of the EU's legal instruments in the post-Lisbon foreign policy framework. The second chapter will summarize the histories of the treaties which are discussed leading towards the respective outcome of each of them. After this chapter an analysis will be conducted using the above mentioned parameters, followed by a conclusion that will provide some of the lessons and outlooks that can be reduced from the result of this analysis.

The analytical approach in this paper will focus on the conduct and outcomes of the negotiations to the Framework Convention on Tobacco Control, the amending Protocol on Eliminating Illicit Trade in Tobacco Products, and lastly the Member State Mechanism (MSM) on SSFFC. For the purpose of a close and thorough examination of the negotiations a comparison of the treaty outcomes for their use of diplomatic language will be conducted. This will extend to an assessment on the behavior of EU and its member states on the basis on statements and comments. The treaty texts and the entire official documentation surrounding the negotiations will serve material for research. Hereby, including WHO secretariat reports, notes, decisions, resolutions, and annexes. Also the outcomes of working groups, the Conference of the Parties (COP) documentation, and other official meetings attended on the topics by relevant actors will be examined. This examination will then serve to determine in how far these actions can be categorized as institutionalism or realist school of politics behavior and pass judgement on the EU's implementation of its own reforms in the Treaty of Lisbon.

To serve the context of this thesis the role of the EU in the international public health sector will be introduced in greater detail. This approach is not completely new and has been taken before by Samantha Battams, Louise van Schaik and Remco van de Pas in their article *The EU as a Global Health Actor: Policy Coherence, Health Diplomacy and WHO Reform* with the distinction that they were examining policy coherence rather than diplomatic behavior and used different cases[37]. By examining the EU's role in global health diplomacy, however, this paper will take a new approach on the assessment of the efficiency of the EU as a diplomatic player in a post-Lisbon Treaty context. As an international organization with its members' best interest in mind, the EU possesses its own health legislation, objectives and goals, which determine the way it behaves on the international floor. Before

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[37] Battams, S., van Schaik, L. & van de Pas, R. (2014) 'The EU as a Global Health Actor: Policy Coherence, Health Diplomacy and WHO Reform'. *European Foreign Affairs Review* 19, no. 4, pp. 539–562.

looking at the those objectives and the role the EU plays in the international health context and analyzing the negotiations in the above mentioned treaties the process and development of the EU as an international actor will be summarized.

Subjects of a thorough examination will include statements made by the EU at the different negotiation rounds of the respective treaties, which include the FCTC's COPs and the PITT and SSFFCs working groups and Member State Mechanism (MSM) meetings. The statements will be checked as for their consistency with the EU's pretense to speak with one voice during negotiations. The EU health policy goals[38] and the concurrence of the EU member states with the official position will also be taken into account.

For chapter three, which contains the analysis of the case studies two actor theories of international relations, namely liberal institutionalism and realism will be compared. The aim of this exercise is to better assess the factors that determine the EU's behavior as a diplomatic actor. Moreover, negotiation theories will be looked at and a selection of indicators, which will be examined during the negotiation analysis and identified. In their book, "Getting to yes", Fisher and Ury employ a cluster of qualities that serve to determine how a negotiation strategy is put together with the main distinction of being "soft" or "hard". These indicators will be applied to EU conduct in health negotiations.

Another method used comes from Mary Assunta's and Simon Chapman's article *Health treaty dilution: a case study of Japan's influence on the language of the WHO Framework Convention on Tobacco Control*, where almost the entire FCTC documentation, including reports, text proposals, conference papers, speeches and statements were examined for repeated words, concepts and emerging themes. For this purpose they examine, among other factors the size of the delegation, its goals and final achievements. An exact list of parameters and key indicators will be provided in the introduction to chapter three.

Through the revision of the results of this research the question of whether the or not the EU is an effective diplomatic actor in global health in the post-Lisbon foreign policy framework and whether or not the EU speaks with one voice in international global health negotiations will be answered.

[38] European Commission White Paper on Health (2008-2013) and the Council Conclusions on the EU's Role in Global Health (2010).

I. UN and EU Diplomacy

UN and EU diplomacy should not be regarded as opposites because they have one important thing in common – they are both forms of multilateral diplomacy[39]. Firstly, UN diplomacy is really multilateral diplomacy but carried out in the UN context between member states with one of these goals being to achieve international co-operation in solving international problems[40]. EU diplomacy, on the other hand, refers to any diplomatic activity carried out in a European setting between EU member states. In this case, however, the purpose of the part on EU Diplomacy is rather to show the EU's involvement on behalf of its member states within the UN system and the WHO in particular. Understanding the instruments of recent and past EU diplomacy is important to illustrate the processes of negotiation and decision-making that take place between the EU member states prior to the EU making a statement in the UN on the behalf of all member states.

The first part of this chapter on UN diplomacy will provide a short introduction on UN decision-making in a member state oriented context. Necessary background information on the WHO and other international organizations will be provided in order to establish the framework in which both member states and the European Union operate. When dealing with the WHO a categorization of the organization within the system of international relations will be made placing it in a more theoretical framework. Without such a categorization the assessment of the role that any actor plays within that system is impossible. Understanding the link between the theoretical and pragmatic scope is essential for passing any judgement on an organization's effectiveness which is true for the EU and the WHO alike.

Additionally, information on the purpose and scope of international health diplomacy will be provided because it is the basis for the any diplomatic actor's action within the WHO setting. Since the thesis is trying to shed some light on the role of the EU in the WHO decision-making processes, it is necessary to explain which issues they are occupied with and why the work they are doing in this setting is important.

The European Union part will attempt to give an overview over the history of the EU's foreign

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[39] UN Overview, 'By enabling dialogue between its members, and by hosting negotiations, the Organization has become a mechanism for governments to find areas of agreement and solve problems together.' http://www.un.org/en/sections/about-un/overview/index.html, What is the EU?, 'The EU is unlike anything else—it isn't a government, an association of states, or an international organization. Rather, the 28 Member States have relinquished part of their sovereignty to EU institutions, with many decisions made at the European level.' http://www.euintheus.org/who-we-are/what-is-the-european-union/, accessed on 16.06.2015.

[40] Charter of the United Nations, Article 1.3., http://www.un.org/en/documents/charter/chapter1.shtml.

policy and the treaties it is based on. Precedents that have established the EU as an international actor as well as some legal background and perspective as to why the EU can now be considered a legitimate diplomatic actor within the UN system will be provided as well. Overall this chapter is trying to provide valuable information on EU and UN diplomacy in an international public health setting. Next to that the framework for the further examination of the case studies in the next chapters will be established.

1.1. Multilateral Diplomacy in the UN and the WHO

The regional and global scale of conflicts in the 19th and 20th century made it necessary for States to negotiate together for peace. Similar peace talks were conducted in the mode of conferences.[41] UN diplomacy often takes the form of either conferences or diplomacy within an international or UN organization.[42] It is noteworthy that multilateral diplomacy has its roots in 19th and early 20th century peace diplomacy, in contrast with traditional, bilateral diplomacy, which has been the norm, having taken place for centuries and still taking place today[43].

The conference mode of conducting diplomacy can be seen as beneficial towards achieving a common goal because of the vested interest in its success that the president and board of such a conference have while the members of the delegations may develop a certain *esprit de corps* during the negotiations. Any UN organization is a permanent international conference and has the potential to unite different parties with different views in a social way to achieve a common goal, as for example a treaty. [44] Simultaneously, such conferences with a set goal are being facilitated by the respective UN organization as is the case for the FCTC, PITT and SSFFC conferences that took place in the form of working groups and negotiation rounds.

Since the result at which international organizations often arrive is often some form of agreement or treaty a short definition will be given to point out the differences. Form and content of a 'treaty' or an 'agreement' can differ greatly dependent on the purpose of such a contract and the aim that the negotiating parties have tried to achieve. Ahead of the negotiation process parties may decide to declare the subject of the negotiation subject to the rules of international law or choose to

[41] Berridge (2002), *Diplomacy*, p.146.
[42] Berridge (2002), *Diplomacy*, p. 151.
[43] Berridge (2002), *Diplomacy*, p.105.
[44] Ibid.

not do so. While an agreement does not have to include the obligation to implement its contents into the participating parties' national law, a 'treaty' contains such an obligation.

As for the reason why international organizations are maintained permanently, Berridge offers the example of power preservation in case of France' and the UK's UN Security Council membership as an explanation – meaning that states will try to maintain the status quo of power at the moment the treaty was signed for as long as possible. Another suggestion provided by him is the application of the notion of 'functionalism', which implies a spillover effect of policies in a certain area that will contribute to further integration of the international community[45]. Certainly, there is some merit to this assumption when looking at it from a WHO point of view, since the organization endeavors to promote and enable the best possible health for every human person worldwide. Such an ambitious goal can only be reached by extensive and binding international cooperation. A common problem is that the states involved have to remain engages, which makes a permanent organization necessary[46] and is part of the reason the WHO was established and continues to exist.

But not all UN organizations are alike. They differ in mission, purpose, competence and membership. Although other international organizations outside of the UN system exist, they are not relevant for this research apart, of course, from the EU. Which is why the number of references to organizations outside of the System will only be made when necessary to explain, for example, their involvement within the global health cluster. Categorizing the WHO is important because it shows the rights and obligations member states have, how membership can be obtained and which competencies are attributed to the organization.

The WHO is a specialized agency of the UN and it is an operational, rather than a program, organization[47]. Another criterion is the capacity of implementation, which is important given the aim of examining the impact the organizations treaties have. Despite the WHO being categorized as a loosely binding organization it is strong in implementation. Of course the degree to which international organizations can exercise some degree of legal power and to which its members will feel obligated to concur with its decision is subject to another category, namely the school of thought that it holds in the theoretical framework of international relations. Though arguing this question in-depth is certainly interesting it exceeds the original focus of this thesis to determine the EU's role in diplomatic negotiations.

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[45] Berridge (2002), p. 251.
[46] Ibid.
[47] Rittberger & Zangel (2006), *International Organization – Polity, Politics and Policies*, p. 10-11.

As realism with its state-oriented approach falls short in explaining the EU's position within WHO negotiations, institutionalist theories are better to explain this relationship. Neo-institutionalism has some advantages when trying to categorize the WHO. In alignment with Keohane's theory[48], international organizations are said to facilitate international cooperation by providing a platform to states where they can "… cooperate successfully in the pursuit of a common interest" these interests, however, do not have to be aligned at all times. What is more, states apparently operate on a more equal footing with no need of a hegemon exercising more power than other states[49]. Like the WHO itself, neo-institutionalism promotes a cooperation between states out of common interest, which is exactly what is happening when states cooperate with the goal of improving public health.

The WHO rests on the columns of the treaty that established it on 7 April 1948 and is therefore represents the first United Nations Health Treaty in history[50]. The constitution of the WHO states its purpose as being, "… the attainment by all peoples of the highest possible level of health."[51]
Possibly unjustly, public health as a political issue has not been receiving the political backing within the UN system it is due and that is despite six out of eight Millennium Development Goals being related to health.[52] Throughout the last decades global epidemics have shown time and time again that it is necessary to have a platform to address the issues that come along with health related issues.[53]
In the earlier mentioned bilateral diplomacy as well as in the multilateral context security questions have received a higher level of attention than questions of health or development aid. In the Oslo Ministerial Declaration on Global Health 2007, the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand call for a foreign policy that gives health issues a stronger focus on the international agenda and states that they… believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time.[54]

At the center of the question why public health is an issue of global importance stands the view that the world we are living in is strongly connected and interdependent[55]. Due to worldwide trade and travel no country is truly isolated and subsequently prone to get into contact with diseases

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[48] Keohane, Robert (1989), *International Institutions and State Power: Essays in International Relations Theory.*
[49] Rittberger & Zangl (2006), *International Organization – Polity, Politics and Policies*, p. 18.
[50] History of WHO, http://www.who.int/about/history/en/, accessed on18.04.2015.
[51] Constitution of the World Health Organization (2006), http://www.who.int/governance/eb/who_constitution_en.pdf, accessed on 18.04.2015.
[52] Millennium Development Goals (2000), http://www.who.int/topics/millennium_development_goals/about/en/, accessed on 19.04.2015.
[53] Renganathan, E. (2013), 'The World Health Organization as a Key Venue for Global Health Diplomacy', p. 174.
[54] Oslo Ministerial Declaration—global health: a pressing foreign policy issue of our time (2007), http://www.who.int/trade/events/Oslo_Ministerial_Declaration.pdf?ua=1, p.1., accessed on 19.04.2015.
[55] Faulconbridge, J. R. & Beaverstock, J. V. (2008), 'Globalization: Interconnected Worlds', http://www.sagepub.com/upm-data/24132_19_Hollway_Ch_19.pdf, p. 340, accessed on 22.06.2015.

that have their roots in other countries far removed[56]. The same is true for policy consistency, taxes and the movement of goods – issues that are part of the FCTC (common global policies) and the SSFFC (movement of goods, quality control and intellectual property). Furthermore, the statement's authors suggest using health diplomacy as an enabler to build trust between warring or conflicting parties. Setting up new health facilities and providing aid in the form of medication and healthcare workers could be a way to facilitate conflict resolution and reach the aims of the WHO[57].

The Ebola crisis demonstrates that the WHO has a leading role to play as the global health leader. This role was reaffirmed and further strengthened. Member States became aware that this platform was the only one that could provide the necessary expertise and coordination required to contain the spread of the deadly virus[58]. As within Europe itself it takes a strong and active EU within the WHO as well to carry out and promote a European vision on public health, which will make the WHO stronger and increase the chances of enhancing worldwide public health. The next section will explain how the EU is set up to be a diplomatic actor and what its objectives are in the context of public health.

1.2. The EU in International Organizations & the WHO:

Despite the EU taken over its member states' responsibilities on a many different issues, such as trade or competition policies, the fact remains that it is, by definition, not so different from the UN. It is an international organization (IO) that differs from others by the fact that its member states have delegated some parts of their state sovereignty to the EU and given it the authority to act on their behalf on a number of matters[59]. The EU's participation in IOs has come to be regarded as commonplace, yet, it is also tied to the EU's evolving into a more political union. Today's status quo of acceptance of the EU as a legitimate actor is mostly based on a precedent dating back to 1982, the UN Convention on the Law of the Sea in which the entry conditions to the convention for 'international organizations' were laid out[60]. Besides the law of the sea, there are a number of other precedents that regulate the EU's diplomatic conduct within the UN system.

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[56] WHO communicable diseases cluster.
[57] Kickbusch & Co (2013), *Global Health Diplomacy*, p. 2.
[58] WHO Ebola Special Session, 26.01.2015, Geneva, http://apps.who.int/gb/ebwha/pdf_files/EBSS3/EBSS3_CONF1Rev1-en.pdf, accessed on 19.04.2015.
[59] https://law.duke.edu/ilrt/int_orgs_5.htm, accessed on 16.04.2015.
[60] Kuijper, P.G., Wouters, J., Hoffmeister, F., De Baere, G. & Ramopouls, T. (2013), *The Law of EU External Relations – Cases, Materials, and Commentary on the EU as an International Legal Actor,* p. 202.

The EU's right to represent its member states is based on the Treaty on the Functioning of the European Union (TFEU). Article 218(1) opens by stating that, "… agreements between the Union and third countries or international organizations shall be negotiated and concluded in accordance with the following procedure. 218(2) The Council shall authorize the opening of negotiations, adopt negotiating directives, authorize the signing of agreements and conclude them."

Although not all UN treaties are legally binding in a strict sense for its MS they are of great importance as for providing guidance to the national and, in the case of the EU, the intergovernmental law making process[61]. When speaking of the EU as an international actor it is important to take note of the actions the EU actually takes in facilitating such treaties as the FCTC, the PITT and the role it plays in WTO processes and decision-making. The EU is involved in a broad range of international organizations and treaties and is represented as a political actor in most of these. So when considering the EU's involvement in all these organizations the question arises of how they impact European law and law-making? As this question has been asked before in Wessel and Blockman's article on the IOs influence on EU law, the case study on the FCTC, PITT, and SSFFC in particular is a new approach. Especially the FCTC and the PITT, to both of which the EU is a signatory, call their signatories for action to ensure concrete measures are taken to protect the population from the harmful effects of tobacco consumption[62]. By signing the EU agreed to cooperate and implement those measures within their sphere of influence and has to pass according laws to meet the targets set in the treaties.

The EU's right to act as a political actor on the behalf of its member states is fixed in article 216(1) of the TFEU and states that: "The Union may conclude an agreement with one or more third countries or international organizations where the Treaties so provide or where the conclusion of an agreement is necessary in order to achieve, within the framework of the Union's policies, one of the objectives referred to in the Treaties, or is provided for in a legally binding Union act or is likely to affect common rules or alter their scope.". And Article 217 TFEU adds: "The Union may conclude with one or more third countries or international organizations agreements establishing an association involving reciprocal rights and obligations, common action and special procedure."[63]

In the following it will be explained how the EU as an actor operates in the UN system and at the WHO in particular. The European Commission claims to be supporting the WHO as the most

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[61] Wessel & Blockmans (2014), 'The Legal Status and Influence of Decisions of International Organizations and other Bodies in the European Union' p.13, https://www.coleurope.eu/.../researchpaper_1_2014_wessel_blockmans%20(1).pdf, accessed on 29.03.2015.
[62] WHO FCTC (2005) Article 3.
[63] TFEU 216(1)

important agency in global health[64]. At the same time it is an actor within the WHO system. Decisions are made a unison manner[65] through discussion, meaning that all members have to agree on a common position in order for it to go forward. This happens in so-called EU coordination briefings where representatives from all 28 MS of the EU are invited to discuss and exchange opinions, draft resolutions and trying to set future health agendas[66]. For this purpose the delegates meet once a week during regular weeks; in preparation of conferences of WHO such as the Executive Board meeting or the WHA meetings are convened several times a week or even daily during conferences.

This process is necessary to enable the EU as an actor on the international level to speak on behalf of all of its members and have its voice heard in the global arena. At the same time the EU delegation to the UN serves as a link to the capital of Europe, Brussels.[67] Dealing with international public health issues the EU assumes an active role as a facilitator of law and decision-making in an international context. Since the Lisbon Treaty entered into force in 2009, the role of the EU as an international actor on behalf of its MS has been enhanced. Through these maintained rights the EU can sign contracts, be part of an international convention, such as the FCTC, and in some cases be a member of an IO, for instance the FAO[68].

Not always, however, are the conduct and position of the EU quite as clear. Sometimes the EU sees itself unable to admit, as required by European law, an EU position to an international organization when one of their agenda items relate to a matter falling under Union competence. Such a case occurred in 2009, when Greece had admitted its own national position on a matter of the monitoring of ships and port facilities, which disregarded and violated the EU's exclusive competence to confer with the International Maritime Organization (IMO) on this matter. According to Chapter XI-2 of the Annex to the SOLAS Convention and the ISPS Code into Community law, and confirmed by the European Court of Justice later, Greece had ceded that particular competence to the EU. Therefore, their conduct was unlawful and was ruled to have violated European law[69]. This episode shows that national interest and European law do not always go hand in hand in the international diplomatic arena.

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[64] The EU and Multilateral Cooperation on Health Issues, http://ec.europa.eu/health/eu_world/global_health/index_en.htm, accessed on 28.04.2015.
[65] With one voice
[66] The EU in Global Health, http://ec.europa.eu/health/eu_world/docs/20140930_global_health_infograph_en.pdf, accessed on 29.04.2015.
[67] Schübel, D. (2015), Internship Report German Permanent Mission to the UN in Geneva.
[68] The EU and the UN, http://eeas.europa.eu/delegations/un_geneva/eu_un_geneva/index_en.htm, accessed on 30.03.2015.
[69] Judgment of the Court (Second Chamber) of 12 February 2009, Commission of the European Communities v Hellenic Republic, http://curia.europa.eu/juris/liste.jsf?language=en&num=C-45/07, 19.04.2015.

1.3. The EU Foreign Policy after Lisbon

As the EU is a dynamic, ever changing and evolving political entity development to foreign policy was inevitable, particularly due to the insufficiencies of the previous agreement, the Treaty of Nice (2003). Between 2004 and 2007, eight new states joined the EU, plenty of potential space for more disagreement on foreign policy, which is another reason clearer rules were needed to make the Common Foreign and Security Policy (CFSP) more efficient.

Some scholars suggest that closer cooperation between European states on foreign policy did not happen because states would be willing to surrender some of their sovereignty to the EU regarding competition and trade policy, they would not be prepared to do the same in foreign affairs[70]. A better and more consistent effort is therefore needed to continue to make Europe's voice being heard in the world. The Treaty of Lisbon has endeavored to achieve a higher level in consistency on a foreign policy level which was meant to mean a clarification of which powers belong to the EU, which ones belong to the member states, and lastly which ones are shared[71]. Explaining the instruments of the post Lisbon foreign policy framework serves to provide a perspective of comparison between pre-Lisbon and post-Lisbon negotiations in which the EU was involved.

Another new aspect was the possibility of *constructive abstention*, which means that any MS that disagreed with a decision that the EU as a whole had to take, could formally declare its disagreement but would be bound to supporting the EU's position in spirit, thus the process of decision making could not be blocked by a single member state[72].

The President of the European Council

Among the president's most important functions is his fulfillment of the external representation of the EU. This extends to issues related to the EU CFSP. He supports and is supported by the High Representative of the Union for Foreign Affairs and Security Policy. Together they implement the CFSP and try to ensure its unity, consistency and effectiveness. He also represents the Council and

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[70] Ramopoulos & Odermatt (2013), 'EU Diplomacy: Measuring Success in Light of the Post-Lisbon Institutional Framework', p. 20.
[71] EU Treaty Overview, http://europa.eu/eu-law/decision-making/treaties/index_en.htm, accessed on 22.04.2015.
[72] Ibid.

the EU at international summits, usually alongside the President of the European Commission or in his stead[73].

The importance and role of the president remains strong. Since the pre-Lisbon rotating presidency has been abolished, the president is not under the time pressure of a 6-month period anymore as his predecessors were[74].

<u>The European External Action Service (EEAS)</u>

The EEAS was brought into being by the Council Decision 2010/427/EU of 26 July 2010, which established the organisation and functioning of the European External Action Service. What sets the EEAS apart from its predecessors is the fact that it "… assembles staff from the Commission, the Council and the Member States, with both security and development-oriented portfolios, in a single institutional setting"[75]. One thing that remains constant is the separation between CFSP and non-CFSP areas. Thus holding on to a pre-Lisbon procedural duality that in the past has undermined efforts to come to a coherent foreign policy and may continue to do so[76]. The basic problem created by a lack of consistency of both the TFEU and the Treaty of Lisbon is that competences in foreign policy are not always clearly divided between European Council, European Commission and the EEAS.

There is a close cooperation between the EEAS and the other EU institutions with which the EEAS remains in contact and who determine the policies the EEAS implements. So the EU foreign policy is steered by the European Council and defined by the Foreign Affairs Council; the latter bringing together all EU foreign ministers once a month under the chair of the HR/VP to discuss current issues[77]. Actors that determine and co-determine the EU foreign policy on health are the European Commission through the Directorate-General (DG) for Health and Food Safety (DG SANCO), the DG for Development and research as well as the European Parliament and the European Council.[78] Despite transitional struggles within some of the delegations there seems to be a

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[73] The President's Role, http://www.consilium.europa.eu/en/european-council/president/role/, accessed on 23.04.2015.
[74] Ramopoulos & Odermatt (2013), 'EU Diplomacy: Measuring Success in Light of the Post-Lisbon Institutional Framework', p. 22.
[75] Merket, H. (2012), 'The European External Action Service and the Nexus between CFSP/CSDP and Development Cooperation', in: *European ForeignAffairs Review* 17, No.4, pp. 625–652.
[76] Ramopoulos & Odermatt (2013), 'EU Diplomacy: Measuring Success in Light of the Post-Lisbon Institutional Framework', p. 21.
[77] EEAS Relation to other EU Institutions and Bodies, http://www.eeas.europa.eu/background/relations-insitutions/index_en.htm, accessed on 29.04.2015.
[78] Ibid.

functioning *modus vivendi* between the employees deployed by the European Commission and the EEAS. Problems still arise, however, from the fact that the majority of staff in delegations are deployed by the European Commission or the EU member states and these are as Lady Ashton stated, despite their great work '… not my people'.[79] The division of responsibilities and competencies seems to still be a problem as the first HR/VP and EEAS had a rocky start due to the economic and debt crisis, which was primarily solved and dealt with by the traditional actors of foreign policy, the heads of government of the member states and the foreign and finance ministers of these countries.[80] Even in the present global health does not seem to fit in the busy schedule of the current HR/VP who has to deal with a big number of security crises around the globe.[81]

The presence of two Directorate General for Health and Food Safety (DGSANCO) staff members as the leading EU diplomats to the WHO in Geneva clearly indicates the European Commission's (EC) involvement and interest in global health issues in any case.[82]

1.4. Conclusion

The EU is not an official member of the WHO and therefore it has to be stressed that the EU only holds an observer status within the organization. Still that does not have to mean that the EU cannot make their voice heard as it is increasingly invited to participate as a "regional economic integration organization".[83] Instead, it lets its member states speak on its behalf or in some cases the EC will be present as an official negotiator to speak on behalf of the member states.[84] Some authors stated that the Lisbon framework on foreign policy should have strengthened the role of the EU and, even more so, has the coordinating competence for health protection.[85]

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[79] Geoffrey, E. (2014), 'The Public Face of a Proto-Something ….: Diplomacy and the European Union, Diplomacy & Statecraft', p. 123, in: http://www.parliament.uk/documents/lordscommittees/eu-select/transcripts/ ceus20110614ev1.pdf. See also *EEAS Review*, 8(2013).

[80] Ramopoulos & Odermatt (2013), 'EU Diplomacy: Measuring Success in Light of the Post-Lisbon Institutional Framework', p. 29.

[81] E.g. Islamic State in Iraq and Syria, Ukraine Crisis

[82] Staff Members EU Delegation Geneva, http://eeas.europa.eu/delegations/un_geneva/about_us/internal_organisation/index_en.htm, 29.04.2015.

[83] Eggers, B., & Hoffmeister, F. (2006), 'UN–EU cooperation on public health: the evolving participation of the European Community in the World Health Organization', in: J. Wouters et al (Eds.), *The United Nations and the European Union* (pp. 155–168). The Hague. T.M.C Asser Press. In: Emmerling, T. & Heydemann, J. *The EU as an Actor in Global Health Diplomacy.*

[84] As it was the case during the FCTC and the FCTC Protocol negotiations.

[85] Battams, S., van Schaik, L. & van de Pas, R. (2014) 'The EU as a Global Health Actor: Policy Coherence, Health Diplomacy and WHO Reform'. European Foreign Affairs Review 19, no. 4, p. 544.

Article 168 of the TFEU and *The Union's Founding Principles* emphasize that role and give the EU competence to foster cooperation with third countries and international organizations on issues regarding public health.[86] Another factor for the proper functioning of the EU external foreign policy is of course also subject to its member states' consent to the proposed EU position.[87]

Although there is a solid legal basis for cooperation on a wide range of policy issues, EU foreign policy decision making is far from an efficient affair. Due to the lack of best practice regarding the application of the Lisbon Treaty there was a lack of clarity as to which institution and had which competence and how this was going to be applied in real treaty making situations.[88] The weakness that a system of shared competences represents becomes visible in the crises the EU is dealing with at the moment – internally as well as externally. On the EU's eastern border Russia has reasserted itself as a military power, annexing Crimea and actively supporting a secession movement of ethnical Russians in Eastern Ukraine.[89] Inside the EU the ongoing debt crisis surrounding Greece cannot be solved and is threatening European unity.[90] There is no mechanism in the Lisbon system that could force the EU member states to adopt a common position. Unity in decision making therefore has to be voluntary. This leads to a slow, sometimes inconsequent reaction by the EU, its member states, and its institutions.

In spite of each country's different interests regarding Russia, EU governments were able to reach an accord on prolonging the sanctions regime against Russia.[91] If the EU wants to be able to react quicker and more determined in the face of international crises, using the "Passerelle Clause" for speeding up the reaching of consensus on important decisions may be an option.[92]

Evidently, the competences and opportunities for successful cooperation on foreign policy issues are in place. The following chapters will show, if and how they have been put into practice in a global health negotiation setting.

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[86] The Union's Founding Principles: Classification and Exercise of Competences, http://europa.eu/scadplus/constitution/competences_en.htm, in: Battams, Schaik & Pas (2014), p. 544.

[87] Battams, S., van Schaik, L. & van de Pas, R. (2014) 'The EU as a Global Health Actor: Policy Coherence, Health Diplomacy and WHO Reform'. European Foreign Affairs Review 19, no. 4, p. 545.

[88] Ramopoulos & Odermatt (2013), 'EU Diplomacy: Measuring Success in Light of the Post-Lisbon Institutional Framework', p. 25.

[89] Reuters, 'Special Report: Where Ukraine's separatists get their weapons' (2014), http://www.reuters.com/article/2014/07/29/us-ukraine-crisis-arms-specialreport-idUSKBN0FY0UA20140729, Reuters, accessed on 22.06.2015.

[90] 'Griechenland – Das Drama nimmt kein Ende' (2015), http://www.zeit.de/wirtschaft/2015-06/griechenland-eurogruppe-schuldenkrise, Zeit Online, accessed on 22.06.2015. and 'Grexit und die Gefahr politischer Instabilität', http://www.sz-online.de/nachrichten/grexit-und-die-gefahr-politischer-instabilitaet-3131597.html, accessed on 22.06.2015.

[91] 'EU verlängert Sanktionen gegen Russland', http://www.zeit.de/politik/ausland/2015-06/eu-russland-ukraine-sanktionen-verlaengert, Zeit Online, accessed on 22.06.2015.

[92] 'EU-Außenpolitik: Ukraine-Krise könnte Katalysator für mehr Integration sein Stiftung Wissenschaft und Politik', http://www.swp-berlin.org/publikationen/kurz-gesagt/eu-aussenpolitik-ukraine-krise-koennte-katalysator-fuer-mehr-integration-sein.html, accessed on 22.06.2015.

II. A WHO Case Study

This chapter is going to deal with three treaties and international agreements negotiated under the auspices of the WHO by mapping out the EU's role in global health diplomacy and by having a close look at its foreign policy framework. Generally speaking it would serve the purpose of evaluating the EU's foreign policy well to compare the EU's conduct as a diplomatic actor over various fields of UN-policies. However, due to the scope on health related issues in this thesis it is more appropriate to exclusively compare health related treaties. Broadening the scope of analysis further demonstrates another relationship between the three examined case studies. All of them touch upon the aspect of trade and thus created some degree of controversy between the WHO member states negotiating them as well as the industry who felt their interests were threatened.[93]

Where the FCTC and its official Protocol focus explicitly on trade, the SSFFC movement does not even adequately address the problem of illicit trade to begin with. Although the WHO recognizes an increase in trade in medical products and ingredients fit to produce medical products,[94] trade and intellectual property (IP) issues are excluded from the negotiations. Some countries, such as Brazil, oppose the inclusion of IP issues under the pretext that such provisions would only be used to enforce trade laws rather than protecting public health.[95] The exclusion was seen as necessary when the WHO embarked on the negotiations and adopted resolution 65.19 that defined the mandate of the Member State Mechanism for SSFFC.[96]

By examining the treaties and the corresponding documentation in detail, an attempt will be made to shed some light on the political difficulties that lie behind the veil of what is visible on the surface. Officially, all countries have their citizens' best interests at heart and want them to be healthy, however, the lengths to which states will go to achieve that goal varies. Sometimes countries will ferociously protect economic interests in negotiations to the detriment of the health of their citizens. How the EU and its member states deal with opposition will demonstrate how effective it is carrying out its foreign policy in WHO negotiations.

The structure of this chapter will be as follows, firstly, a definition and brief history of each of the

[93] FCTC Article 15, FCTC Protocol Article 6-13.
[94] Counterfeit Medicines, http://www.who.int/mediacentre/factsheets/fs275/en/, accessed on 27.05.2015.
[95] Saez, C. (2015), 'IP Rights Must Remain Distinct From Fake Medicines Policy at WHO, Members Warn', http://www.ip-watch.org/2015/01/30/ip-rights-must-remain-distinct-from-fake-medicines-policy-at-who-members-warn/, accessed on 27.05.2015.
[96] WHA 65 Resolutions, http://apps.who.int/gb/ebwha/pdf_files/WHA65-REC1/A65_REC1-en.pdf, accessed on 27.05.2015.

agreements will be provided and the functioning, purpose and scientific debate surrounding the according treaty will be summarized. Secondly, there will be a negotiation summary followed by stating the outcome of the process to date.

2.1. The WHO Framework Convention on Tobacco Control

> The objective of this Convention and its protocols is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented the Parties at the national, regional and international levels …[97]

On 27 February of 2015 the Health Community celebrated the 10 year anniversary of the WHO Framework Convention on Tobacco Control (FCTC) entering into force. The treaty marked a mile-stone when it was signed in 2003 because it was the first international treaty focusing primarily on health-related issues. FCTC stands for Framework Convention on Tobacco Control and is the first international treaty that focuses on public health and was negotiated under the auspices of the WHO. The purpose of FCTC is to tackle the so-called "world-wide tobacco epidemic", in other words it provides a legal body and platform for its members to devise strategies to respond to the globalization of tobacco trade and consumption.[98]

Adopted by the World Health Assembly (WHA) on 21 May 2003, it finally entered into force two years later on 27 February 2005[99] with this year marking the celebration of its 10th anniversary. With a total of 180 signatories[100], the WHO FCTC "has become one of the most widely embraced treaties in the history of the United Nations …"[101]. The treaty consists of 38 articles, which are divided into 11 different parts. Included in those sections are, most importantly for the purposes of this paper, the measures relating to the reduction of the supply of tobacco, scientific and technical cooperation and communication of information, the settlement of disputes and in the beginning of the treaty text but very importantly the

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[97] FCTC, Article 3.
[98] WHO FCTC celebrates its 10th anniversary, www.who.int/fctc, accessed on 28.03.2015.
[99] Ibid.
[100] Zimbabwe became the latest member on 04.03.2015
[101] FCTC Signatories, http://www.who.int/fctc/signatories_parties/en/, accessed on 28.03.2015

relationships between this treaty and other agreements[102].

Brief history of the FCTC

As early as 1995 during the 48th WHA the member states of the WHO put the idea of a tobacco control treaty into motion by requesting the Director General (DG) of the WHO to devise a feasible instrument in order to regulate tobacco production, trade, advertisement and consumption world-wide. Steady progress continued and at the 52nd WHA the MS decided to establish two bodies to draft the framework convention whilst calling upon each other to continue the negotiation[103]. The process is said to have been carried out in a transparent fashion, according to the WHO, as the first session of the Intergovernmental Negotiating Body in Geneva in 2001 was preceded by a public hearing in which tobacco industry shareholders could voice their concerns[104]. Subsequently, the first draft was worked out and released for further discussion in January 2001. The negotiations continued until February 2003 when the final session of the negotiation body was held. After a diplomatic efforts, the chair of the committee received instructions to draft resolution text that should be submitted to the 5th COP pursuant to WHA52.18.[105] The WHA adopted the resolution unanimously and it was opened for signature[106]. 180 states have signed the Framework Convention on Tobacco Control to date which makes it one of the most widely accepted treaties in the history of the UN. The next section will concern itself with the structure and the way the FCTC operates.

Structure and Governing Body of the treaty

The governance and functioning of the FCTC is determined in the framework convention text itself. Part VIII – XI and articles 23-38 are dealing exclusively with issues regarding the governance and policy making functions of the treaty. At the center of the organization stands the Conference of the Parties (COP), which is the governing body of the FCTC. It consists of the member states that are signatories to the FCTC and functions as an instrument to review the implementation process of the FCTC. Furthermore, it takes decisions on the implementation of the convention, can adopt protocols, annexes

[102] Table of Contents, WHO Framework Convention on Tobacco Control, updated reprint 2005, Geneva, Switzerland.
[103] FCTC, p. 33.
[104] FCTC, p.34.
[105] WHO resolutions are always labeled by providing firstly the edition of the current WHA and secondly the number of the agenda item.
[106] FCTC, p. 35.

and amendments to the convention. The exact conduct of the COP is determined through the rules of procedure which were specified between COP1 – COP3, starting from COP3, the regular sessions of COP are held with two-year intervals[107].

2.1.1. Negotiations of the FCTC

Some scholars consider the text of the FCTC as strong and stress that this perceived strength is due to the involvement of developing countries.[108] From the early beginning different issues with different views of the participants emerged. Between 1999 and 2001 the Council of the European Union assigned two non-public negotiating mandates to the European Commission for the FCTC negotiations.[109] In the format that remains in principle the same today, the member-states of the EU (only 15 in 1999) would meet for an EU coordination before every negotiation round with their mission representatives and the representatives of the EU Presidency and European Commission. A common position would be found for the Presidency or the European Commission to read out. If this was impossible to agree on, the issue would have to be referred on to the next highest level, the Committee of Permanent Representatives or the EU Council.[110]

As mentioned earlier, the six Intergovernmental Negotiation Body (INB) sessions were preceded by two open-ended working group sessions that took place in 1999 (25-29 October) and earlier in the year of 2000 (27-29 March) prior to the first session of the INB. These working-groups established the key points and drew up an overview of issues that would need to be included in a future tobacco control document.[111] While the open-ended working groups focused on the outline of the treaty, the intergovernmental working groups served as a means of addressing issues that had not been sufficiently discussed yet and let up to the first conference of the parties (COP).[112]

The INB1 negotiations, or rather, pre-negotiations were exemplary for the other three INBs to come. Formalities were discussed and the agenda of what was to be included in the treaty text were debated. Also, great progress had been made substantial in identifying relevant proposals from among

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[107] Conference of the Parties to the WHO Framework Convention on Tobacco Control, http://www.who.int/fctc/cop/en/, accessed on 31.03.2015.
[108] Liberman (2011), 'Opportunities and Risks of the new proposed FCTC Protocol on Illicit Trade', p. 218.
[109] Guigner, S. (2009), 'The EU and the health dimension of globalization Playing the World Health Organization card', p. 138.
[110] Ibid, p. 139.
[111] Provisional Agenda of the Second Meeting of the Working Group on the FCTC (2000), http://apps.who.int/gb/fctc/PDF/wg2/ef21.pdf, accessed on 08.05.2015.
[112] Report of the second session of the intergovernmental working group on FCTC (2005), http://apps.who.int/gb/fctc/PDF/igwg2/FCTC_IGWG2_7-en.pdf, accessed on 08.05.2015.

the almost 4000 submitted, although little actual negotiation had taken place.[113] Only the fifth session brought along a breakthrough with a new Chair's text having been presented (document A/FCTC/INB5/2) that allowed the Negotiating Body to embark on the actual process of negotiation.[114] In the following a short summary of the position of the EU throughout the six INB sessions will be given.

EU position

When the first Intergovernmental Negotiation Body (INB) convened in 2000 the EU was still represented by the current EU presidency holder France.[115] From the beginning the EU believed in keeping the negotiations as wide and open as possible in order to allow for all involved parties a maximum amount of flexibility and involvement.[116] France was represented, alongside other EU member states, on the highest local level[117] through their ambassador Mr. Petit and a delegation of 13 delegates. Some of these are EU officials.[118] In the participation list for the INB, the EU is further represented under the category of "Representatives of Intergovernmental Organizations", which consists of seven delegates, including the Ambassador and the then Chief of the Directorate General for Health and Consumer Protection, M.J.F. Ryan. The latter was representing the European Commission.

The EU called (through Mr. Petit from France) for the establishment of open-ended working groups.[119] France continued to speak on the behalf of EU throughout the first INB, other states, such as the UK, supported statements previously made by the EU.[120] Furthermore, the EU supported a health-over-economy position in regard to potential economic problems in some tobacco-industry dependent countries in sub-Saharan Africa[121], which Mr. Ryan made clear on behalf of the European Commission.

It seems that the position of the EU was a strong one from the very beginning, given that the EU was able to speak with multiple voices at the negotiations. At the negotiation table the European Commission, France as presidency, and the other member states could make statements to get the EU's point across, which should have given it an advantage over other states without the backing of a similar

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113 FCTC INB 6 Summary Records (2003), p.6.
114 Ibid.
115 FCTC INB1 Summary Records (2000), http://apps.who.int/gb/fctc/PDF/inb1/FINAL_FCTC_INB1_SR_COMPILATION.pdf, accessed on 07.05.2015.
116 INB1 (2000), p. 8.
117 Hierarchy of Diplomats, U.S. State Department Protocol for the Modern Diplomat, http://www.state.gov/documents/organization/176174.pdf, 09.05.2015, p. 9.
118 INB1 List of Participants, p.9.
119 INB1, p. 8.
120 Ibid, p. 26.
121 INB1, p. 22.

alliance.[122] Another advantage was that the EU already had a comparatively strong tobacco control framework in force within their own jurisdiction, which was due to the single market policy that meant a sharing of responsibilities between the EU and its member states.[123] All in all the EU level of commitment was strong due to the leadership of EU Commissioner for Health, David Byrne (who held the post from 1999 to 2004), who even encouraged his successors to carry on the fight against tobacco.[124]

Drawing from that strong level of competency the EU emerged as part of a coalition consisting of government delegations, intergovernmental organizations, and civil society groups that wanted an FCTC with strong language.[125] Among these countries were next to the EU Australia, Canada, New Zealand, Norway, the English-speaking Caribbean and some Latin America countries, Pacific Island States and WHO African, Eastern Mediterranean and Southeast Asia regions, the Tobacco Free Initiative (TFI), World Bank, and the Framework Convention Alliance (FCA).[126] Their common position was mainly based on an agreement on questions of trade. For example, there was an agreement to delete Article 2.3.[127] and Article 4.8.[128], both articles stated that existing international trade provisions would have to be honored over public health. Thus, they were meant as anti-interference clauses.

Later the "health over trade" versus "trade over health" positions would become an object of debate again when debating the Protocol on Eliminating Illicit Tobacco Trade (PITT) 129. Trade provisions went on to play a role in the SSFFC process as well as there are some intersections that are tackled in cooperation with a variety of actors. One example of this cooperation is the WTO that deals with "counterfeit" pharmaceuticals in relation to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement.

During the FCTC negotiations it already became clear that the conduct on the trade issues was by no means a point the parties could agree on. Three positions emerged; firstly, the "pro-health" position,

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[122] Ibid.
[123] Faid, M. & Gleicher, D. (2011), 'Dancing the Tango: The Experience and Roles of the European Union in Relation to the Framework Convention on Tobacco Control', p. 6.
[124] Ibid, p. 8.
[125] Mamudu, H.M., Hammond, R. & Glantz, S.A. (2011), 'International Trade vs. Public Health during the FCTC Negotiations, 1999-2003', p. 5.
[126] Ibid.
[127] FCTC INB6 Draft §2.3. 'Priority should be given to measures taken to protect public health when tobacco control measures contained in this Convention and its protocols are examined more compatibility with other international agreements.'
[128] Ibid. §4.8. 'While recognizing that tobacco control and trade-related measures can be implemented in a mutually supportive manner (to protect public health), Parties agree that tobacco control measures shall be transparent, implemented in accordance with their existing international obligations, and shall not constitute a means of arbitrary or unjustifiable discrimination in international trade, or Tobacco control measures taken to promote public health in accordance with the provisions of this Convention shall not be deemed as constituting a means of arbitrary or unjustifiable discrimination in international trade.'
[129] Faid, M. & Gleicher, D. (2011), 'Dancing the Tango: The Experience and Roles of the European Union in Relation to the Framework Convention on Tobacco Control', p. 4.

which was held by civil society representatives; the "no-interference" position, which was held by WHO, TFI and WTO and to some extent also the EU; and finally the silence position that sought a compromise by excluding an explicit trade-provision.

Thus, at the center of the negotiations stood the question of how to define the relationship of FCTC to other international treaties with a primary focus on trade. The 'Health over Trade' position was strong because it combined the support of the entire South East Asia Regional Office (SEARO), African Regional Office (AFRO) and Western Pacific Regional Office (WPRO) regions and their member states, as well as support from countries, such as China.[130] Here the aim was to protect health by minimizing the possibility of losing already established tobacco control measures that would be subjected to trade challenges by countries where the multinational tobacco companies are headquartered.[131] On the other hand the opposition to health over trade argued that the provisions provided through by the GATT/WTO Treaties were sufficient to ensure tobacco control measures within the FCTC could be implemented successfully.[132]

Remaining silent provided countries and organizations who wanted to see the treaty move forward with an option that would leave the controversial trade provision out of the picture.[133] From this position the question of the hierarchy of treaties could be left untouched for the time being which freed up the space to reach a consensus in other areas. Delegates favoring the silence position wanted to exclude Articles 2.3. and 4.8. from the discussion because they felt changes in that area would have subordinated the FCTC to existing international agreements and the GATT in particular.[134]

In the end, the trade provision was dropped and only reference retained in the preamble that focused on the governments' right to protect public health.[135] In this discussion the European Commission positioned itself on the side of those seeking an additional trade provision because it was seen as a priority to ensure the countries' rights to design their own tobacco control measures while honoring other international agreements.[136]

While the EU was not really able to leave their mark on this part of the negotiations, they succeeded in another way. Article 11 deals with the tobacco packaging and labeling provided an

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[130] Bloom, J. & Shapiro, I. (2003*) International Trade and Health: We can do better than Silence*, 6th Meeting of the Intergovernmental Negotiating Body, FCA Bulletin 40, http://www.fctc.org/publications/bulletins/doc_download/39-fca-bulletin-40-inb6, 09.05.2015.
[131] Ibid. Refers especially to the United States of America where lobbying from the Tobacco producing industry was strong.
[132] Mamudu, H.M., Hammond, R. & Glantz, S.A. (2011), 'International Trade vs. Public Health during the FCTC Negotiations, 1999-2003', p. 6.
[133] Ibid, p. 7.
[134] Ibid.
[135] FCTC (2003) Preamble, p.1.
[136] Callard, C. (2009), Personal Communication, in: Mamudo, M & Co (2011).

opportunity for the EU to play a pivotal role. It was the pre-existing European law in this area and the political leadership assumed by the EU that made a last minute adaption of this point possible.[137] The corresponding EU document was the European Commission Tobacco Directive from 2001 in which paragraph 7[138] on product descriptions provides a template for the FCTC's Article 11. Because of the EU's proven track-record on enforcing public health, it gained credibility. In some respects the EU had shown to the conference participants that successful implementation of tobacco control measures in an international setting was possible.[139] Articles 9, 10, 11 and 13 were further articles the EU took leadership in.[140]

2.1.2. Outcome

When the negotiations to the FCTC started in 1999 many third parties outside the EU feared that the EU would have an extra advantage because of the perceived double-representation (EU and member states) the European countries would have.[141] Every EU country retains the right to raise its flag during official meetings, independent from the right of representation transferred to the EU. In practice this will usually mean that the member states will speak in support of the statement made by the EU. Indeed, according to some, the EU is an influential and strong actor in the UN-System and has shown this in the course of the FCTC negotiations.[142] There is a certain appeal to the idea of many different countries joining their voices to speak as one. This statement by a French Ministry of Health official sums up why a common EU position is so influential:

> It is the system of the United Nations. One State, one voice. Vote is possible but in fact everything is decided by consensus after having been negotiated. We have more weight at 15 or 25 and more ….It creates an impression of mass, of an obstacle uneasy to break. More than if 25 countries agree together but do promote their opinion in an isolated way ….There is a logic of attraction, like in the laws of gravity.
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> Interview, French Ministry of Health official, Paris (April 2006)

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137 Guigner, S. (2009), 'The EU and the health dimension of globalization Playing the World Health Organization card', p. 140.
138 EC Tobacco Directive 2001 (2003 revision), http://ec.europa.eu/health/tobacco/docs/dir200137ec_tobaccoproducts_en.pdf, 10.05.2015.
139 Guigner, S. (2009), 'The EU and the health dimension of globalization Playing the World Health Organization card', p. 141.
140 Ibid.
141 Ibid, p. 7.
142 Guigner, S. (2009), 'The EU and the Health Dimension of Globalization: Playing the World Health', in: Orbie, J. & Tortell, L., *The European Union and the Social Dimension of Globalization How the EU Influences the World,* p. 138.

After the last INB and the subsequent adoption of the Convention at the WHA point the FCTC process, was and is by no means complete. Rather much remains to be done on the implementation side of things. Besides that, the involvement of the developing countries and even better international cooperation have to be points of interest moving forward.[143]

2.2. The FCTC Protocol to Eliminate Illicit Trade in Tobacco Products (PITT)

From the perspective of the EU the PITT negotiations had a different point of departure. During the FCTC negotiation process the role of negotiating on behalf of the EU and its member states was filled by the country holding the EU presidency and the European Commission through the Directorate General for Health and Consumer Protection (DG SANCO). Now at the PITT the European Anti-Fraud Office (OLAF) was leading the negotiations and was supported throughout by DG SANCO (the service in charge of the FCTC co-ordination). The Council mandated the Commission to negotiate the Protocol in its Council Decision of 20 December 2007.[144]

There is a certain disparity of logic when it comes to the PITT. Why is a Public Health oriented organization like the WHO getting involved in trade issues? Perhaps simply because they felt like they had to. Illicit Trade in Tobacco Products (ITTP) is a threat to public health because they are said to undermine taxation and price policies related to national and international tobacco control. Since international cooperation is supposedly the most efficient way to deal with the problem of ITTP, the FCTC embarked on the mission to pass a Protocol on ITTP.

Jonathan Liberman and his co-authors argue in their 2011 article on the advantages and disadvantages of the PITT that expertise, experience and capacity were needed to combat illicit trade were not to be found in public health agencies, such as the WHO[145]. According to them the trade and crime fighting agencies such as WCO and UNDAC are better suited for this task. Still, the MS of WHO and the FCTC showed their capability as well as political will, pushing the negotiations through that resulted in the eventual protocol. As mentioned in the section on the FCTC treaty, hierarchy and interference has been regarded as an issue and most certainly did not pass unnoticed during the PITT negotiations.

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[143] Liberman, J. (2011), 'Four COPs and Counting, in: Tobacco Control', p. 215.
[144] EC Press Release, Commission welcomes positive outcome of WHO conference with signature of a protocol to stop illicit trade on tobacco, Brussels 16.11.2012, http://europa.eu/rapid/press-release_IP-12-1223_en.htm, 03.06.2015.
[145] Liberman J. & Co. (2011), 'Opportunities and risks of the Protocol on Illicit Trade in Tobacco Products', p.1.

History and Purpose

Before signing the convention protocol the parties of the treaty underwent a lengthy negotiation process from 2008-2012 to determine the exact measures to be included in the protocol. The FCTC has an overlap with another international treaty, the General Agreement on Tariffs and Taxes (GATT), which is also legally binding and sometimes contradicts measures introduced in the context of tobacco control. Article XX of the WTO/GATT treaty includes some exceptions to the trade in certain products. It states that in order to prevent trade discrimination: "nothing in this Agreement shall be construed to prevent the adoption or enforcement by any contracting party of measures: […] (b) necessary to protect human, animal or plant life or health". Next to the WTO and FCTC treaties, the United Nations Convention against Transnational Organized Crime (UNTOC) and the United Nation Convention against Corruption (UNCAC) are vital instruments in tackling international ITTP (Interpol 3). Despite their value for the greater understanding of the ITTP issue, examining these other organizations does not serve to assess the EU's role in global health.

2.2.1. Negotiations

Everything began with the mandate to carry out negotiation on a trade protocol was given to a newly formed INB by the delegates of the second FCTC COP. The INB was therefore mandated to draft and negotiate a Protocol on Illicit Trade in Tobacco Products that would build upon and complement the provisions of Article 15 of the FCTC. As a basis for starting negotiations, COP2 recognized the template for a protocol on illicit trade, prepared by an expert group established by the first session of the COP.[146] After four years of negotiation the fifth and final session of the INB was held from Thursday 29 March to Wednesday 4 April 2012 at the Geneva International Conference Centre (CICG).[147] At the 5th INB the delegates agreed to a final draft for the PITT that would go on to be submitted to the 5th COP of the FCTC in Seoul, South Korea in the fall of the same year.[148]

In some opinions expressed about the PITT negotiations, some states were under the impression that the role of the Presidency in comparison to its work in the development of the FCTC had changed.[149]

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[146] Framework Convention Alliance Executive Summary Report of the 5th FCTC Protocol INB (2012), http://www.fctc.org/images/stories/FCA%20INB5%20Report.pdf, accessed on 12.05.2015.
[147] Fifth session of the Intergovernmental Negotiating Body, http://www.who.int/fctc/protocol/about/inb5/en/, accessed on 12.05.2015.
[148] Ibid.
[149] Faid, M. & Gleicher, D. (2011), 'Dancing the Tango: The Experience and Roles of the European Union in Relation to the Framework Convention on Tobacco Control', p. 11.

During the FCTC, the Presidency had acted as a mediator between the member states, collecting and reconciling opinions before the actual INB negotiations started which was not the case at the PITT anymore, where the European Commission started to play a bigger role in this function.[150] For the EU it was important to take an even more active role in the PITT negotiations for several reasons. Not only did they take a stance for the introduction of clearer rules to tackle the Illicit Trade in Tobacco Products (ITTP) during the FCTC negotiations – it is also part of the EU's responsibilities towards its citizens to enforce stricter rules. Among the guidelines the European Commssion sets for itself on global health is the integration of health concerns in multilateral and bilateral agreements without compromising safety. This goal is not restricted to the health and livelihood of its own citizens but expands to the target of globally promoting health.[151]

For the Negotiations of the PITT the same method was applied as for the FCTC; open-ended working groups were established that helped outline and prepare the INB sessions in which the text of the protocol would be discussed.[152] "Although negotiations have not yet successfully produced a draft protocol, the INB on illicit trade, which was chaired by the European Commission, provides a positive example of the capacity and capability of the EU."[153]

EU Position

As mentioned in the introduction of this paper, the EU was committed to tackle ITTP even before the negotiations in Geneva started. Early initiatives against cigarette smuggling by strengthening border controls were taken by the European Parliament (EP) as early as 2007.[154] This resolution of the EP was based on the recommendations made in the EP "Green Paper[155] on launching a public debate on environmental tobacco smoke". It took another EP resolution that was partly directed towards the European Commission, calling on them to cooperate more closely with member states and to implement more binding rules in tobacco control to get the European Commission more active in the process of

[150] Ibid.
[151] EC Strategy paper on Global Health (2010).
[152] Faid, M. & Gleicher, D. (2011), 'Dancing the Tango: The Experience and Roles of the European Union in Relation to the Framework Convention on Tobacco Control', p. 5.
[153] Ibid, p. 7.
[154] European Parliament resolution of 24 October 2007 on the Green Paper 'Towards a Europe free from tobacco smoke: policy options at EU level', http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P6-TA-2007-0471&language=EN, 19.05.2015.
[155] Green Papers are documents published by the European Commission to stimulate discussion on given topics at European level. They invite the relevant parties (bodies or individuals) to participate in a consultation process and debate on the basis of the proposals they put forward. Green Papers may give rise to legislative developments that are then outlined in White Papers. Definition from: http://europa.eu/legislation_summaries/glossary/green_paper_en.htm, accessed on 19.05.2015.

fighting ITTP.[156]

The EU carried responsibility, with Mr. I. George-Walton chairing all sessions of the INB, including the 5th session of the Protocol negotiations with the 5th one being the last session that would eventually finalize the Draft Protocol for submission to the WHA. As seen in the FCTC negotiations, the fact that the EU is speaking with one voice does not always contribute to the success of reaching the goal they set out to accomplish. During one of the INB sessions of the PITT the EU Presidency expressed a point of view that went contrary to the view of 6 non-EU states. Later, the chairperson summarized that "six parties wanted to go left" and "one party wants to go right".[157] Obviously, the EU would have liked to be perceived as the sum of 27 different and equally important member states rather than being considered as "only" one voice.

2.2.2. Outcome

The Protocol was finally signed on 12 November 2012 when it was presented to the 5th COP in Seoul, South Korea. With this signing the first protocol amendment to the FCTC came into being and was opened for ratification, acceptance, approval or accession of all FCTC parties the protocol has been signed by 54 states and 8 states are parties to the treaty to date.[158] Considering that out of 180 parties to the Framework Convention, only 54 have signed the treaty, the rate of acceptance is not particularly high. For the Protocol to enter into force Article 45(1) of the Protocol must be fulfilled. It states that: 'This Protocol shall enter into force on the ninetieth day following the date of deposit of the fortieth instrument of ratification, acceptance, approval, formal confirmation or accession with the Depositary.'[159]

Here it is important to point out the difference between being a signatory versus being a party to the protocol. According to Article 10 and 18 of the Vienna Convention on the Law of Treaties, a signing only entails an expression of good will and an approval of the contents of the treaty, whereas the signature qualifies the signatory state to proceed to ratification, acceptance or approval. It also creates an obligation to refrain, in good faith, from acts that would defeat the object and the purpose of the treaty". In any case, the signatory is not legally bound. A ratification of any kind, however, is when a state indicates its consent

[156] European Parliament research service, briefing 16.01.2014 on EU action to reduce illicit trade in tobacco products, accessed on 15.04.2015, p. 5.
[157] Faid, M. & Gleicher, D. (2011), 'Dancing the Tango: The Experience and Roles of the European Union in Relation to the Framework Convention on Tobacco Control', pp. 13-14.
[158] FCTC Protocol on Illicit Trade Ratification, http://www.who.int/fctc/protocol/ratification/en/, accessed on 19.05.2015.
[159] FCTC Protocol on Illicit Trade in UN Treaty Collection Chapter IX Health, https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4-a&chapter=9&lang=en, accessed on 19.05.2015.

to be bound to a treaty, if the parties intended to show their consent by such an act, which the EU did in the case of the PITT.[160] With this current status it looks as though the PITT, despite agreement by the international community during the INB sessions, still has some way to go before it can enter into force with 32 more states having to ratify it.[161]

2.3. The WHO SSFFC Member State Mechanism

There is a connection between the before mentioned treaties on tobacco control and the regulation of medical products. Both types of products related to it are being traded internationally and therefore are also subject to illicit trade. What is more both categories of products are of essential importance to the EU and its citizens and are already regulated under European law.[162] On a WHO level, the European Commission is a member of the International Medical Products Anti-Counterfeiting Taskforce (IMPACT) whose establishment by the WHO dates back to the year of 2006. IMPACT is a platform to inform the public on issues regarding SSFFC medical products. Besides that they aim to build coordinated networks across and between countries in order to halt the production, trading and selling of fake medicines around the globe.[163]

What the WHO defines substandard/spurious/falsely-labelled/falsified/counterfeit medical products as products that are designed to appear identical to the genuine product. Although they will not always cause an adverse reaction, they may fail to treat the disease or condition for which they were intended.[164] Facts and concrete data on the market of such medical products are, according to WHO, not fully known.[165] Neither is the scale of the problem fully known, nor can states, companies and other stakeholders agree on an exact definition.[166] Identifying problems caused by medical products under this definition, on the other hand, is easy. In 2012 more than 125 people died in Pakistan due to substandard heart medicine. A manufacturing error that allegedly was detected in time but ignored by the

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[160] Arts.2 (1) (b), 14 (1) and 16, Vienna Convention on the Law of Treaties 1969 via http://ask.un.org/faq/14594, accessed on 19.05.2015.
[161] 'It ought to be law - 32 more ratifications needed to make the illicit trade Protocol an international law', http://www.who.int/fctc/mediacentre/news/2015/wtnd2015/en/, accessed on 28.05.2015.
[162] EudraLex Volume 1 - Pharmaceutical Legislation Medicinal Products for Human Use, http://ec.europa.eu/health/documents/eudralex/vol-1/index_en.htm, 28.05.2015: In fact, there is already some cooperation in the field of medicines control between the EU and the US, http://ec.europa.eu/health/international-activities/key-documents_en.htm, accessed on 28.05.2015.
[163] http://www.who.int/impact/about/en/, accessed on 28.05.2015.
[164] 'SSFFS – How big is the problem?', http://www.who.int/medicines/services/counterfeit/faqs/magnitude/en/, accessed on 18.05.2015.
[165] Ibid.
[166] Attan, A., Barry, D., Basheer, S., Bate, R., Benton, D., Chauvin, J., Garret, L., Kickbusch, I., Kohler, J., Midha, K., Newton, P., Nishtar, S. Orhii, P. & McKee, M. (2012), 'How to achieve international action on falsified and substandard medicines', in: *BMJ* November 2012.

manufacturing company, resulted in a deadly bone marrow suppression in the patients.[167] In other cases, falsified antiretroviral (intended to treat HIV/AIDS) and falsified cancer medicine have been accidentally distributed to patients with yet unknown results.[168]

Unlike the FCTC, the SSFFC has not been made subject to an international treaty or agreement yet. However, within the confines of the WHO exists the so-called Member State Mechanism (MSM) that serves as an international platform on which health diplomats from all the WHO MS can exchange views, opinions and move toward an international agreement that could establish some ground rules for the trade and production of medical products. Recently, there has been some progress towards achieving such an agreement, although there is still a long way to go. Like FCTC, the SSFFC is an issue that, as stated by some authors[169], has to be tackled in an international approach involving both international organizations and states.

Countering the spread of Substandard/spurious/falsely-labelled/falsified/counterfeit medical products is an important endeavor vital to global public health, yet the title of the negotiation as well as the avoidance of a categorization of the matter within international law indicates how sensitive and difficult the issue is politically[170]. This is exactly where strategies of "properly packaging the deal" are coming into play. Finding the right name to define a problem or the process to solve it into words, so that different diplomatic stakeholders can "keep their faces"[171] is a challenge in the early stages of diplomatic negotiations that the SSFFC is still struggling with.[172]

The European Commission also recognizes the seriousness of the problem of illegal and unregistered medicines, reflected in their Global Health Strategy paper, which states, 'with regard to access to medicines, the EU is committed to preserving access and affordability to essential medicines in line with the principles of the Doha Declaration. 'So while the EU seems to be at least officially committed to progress on the issue, the reasons for there being so little movement must lie elsewhere.

[167] 'Choudary A. Police body recommends action against 17 people', Dawn, Pakistan (2012), http://www.dawn.com/news/695377/police-body-recommends-action-against-17-people, accessed on 20.05.2015.
[168] HIV/AIDS in Kenya: majority of patients with suspect Zidolam-N receive follow-up consultations. 2011. www.msf.ca/themes/news-reader/2011/11/hivaids-in-kenya-majorityof-patients-with-suspect-zidolam-n-receive-follow-up-consultations, accessed on 18.05.2015; WHO. Falsified lamivudine, zidovudine and nevirapine tablets (Zidolam-N) in Kenya. 2011. http://apps.who.int/prequal/info_press/documents/Falsified_ZidolamN_23September2011.pdf, accessed on 18.05.2015
[169] Mackey, T. K., & Liang, B. A. (2013), 'Improving global health governance to combat counterfeit medicines: a proposal for a UNODC-WHO-Interpol trilateral mechanism', *BMC Medicine*, 11:233, http://www.biomedcentral.com/1741-7015/11/233, accessed on 10.04.2015.
[170] Ibid.
[171] Preserve their dignity.
[172] Berridge (2002), *Diplomacy – Theory and Practice*.

2.3.1. Negotiations

Between the different stakeholders involved in medicines there seems to be a lack of essential consent on what the common goal is they want to achieve. While there is certainly consensus on the goal of providing reliable access to safe and effective medicines, overarching problems of intellectual property or pharmaceutical pricing enter the negotiations thus making it difficult to find common ground.[173] Similar to the tobacco trade the medicine trade suffers from a struggle of protecting citizens‘ health versus abiding to trade law that will often protect intellectual property and trade privileges.

Through the most recent Decision EB136 (1) at the WHO's Executive Board Meeting, SSFFC was confirmed as an agenda point for the upcoming WHA (May 2015). The decision paper is part of the current WHA 68 under agenda point 17.3 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products Documents A68/33 and EB136/2015/REC/1, decision EB136(1). It is a sign of the involved states‘ willingness to keep negotiating in the MSM in order to reach some kind of consensus and move forward towards a clearer definition of the issue.

EU Position

The EU clearly positioned itself in a statement made at the 130th EB in January 2012, stating that they supported a strong leader of the WHO in ensuring the safety, quality and efficacy of medical products and in promoting access to affordable, quality, safe and efficacious medicines". Access to drugs for everyone and a strategy to control and prevent the spread of SSFFC medical products has to be a priority of all states.[174]

2.3.2. Outcome

So far no consensus on a treaty or more binding rules has been reached. In the final report of the last meeting of the MSM in October 2014 nothing more was agreed but to postpone the review of the Member State mechanism by one year to 2017.[175] All communication channels between member states stay open

[173] Attan, A., Barry, D., Basheer, S., Bate, R., Benton, D., Chauvin, J., Garret, L., Kickbusch, I., Kohler, J., Midha, K., Newton, P., Nishtar, S. Orhii, P. & McKee, M. (2012) *How to achieve international action on falsified and substandard medicines*, in: BMJ November 2012, p. 2.
[174] WHO EB 130, SSFFC EU Statement.
[175] Report by the Director General to the WHA, provisional agenda item 17.3. SSFFC, 20.03.2015.

and more time is given to the entire process on finding a way to address substandard medical products. Every chain is only as strong as it weakest link and it is evident in the field of national legislation on falsified medicines. While legislation is some countries is strict, it is rather lax in others which makes it easy for criminal networks to store illegal medical products in countries where prosecution is weak or nonexistent.[176]

2.4. Conclusion

The EU is becoming more and more active in the field of Global Health Diplomacy as has been demonstrated. That being said it is not certain, if the chosen strategies are yielding the desired results. When trying to display unity and a common purpose the EU might be operating in accordance with the Common Security and Foreign Policy Framework, it is however unclear, if this unity is always in the EU's best interest and a good strategy to achieve diplomatic results. At times, the quantity of more single parties supporting an issue may be perceived as more convincing than only one strong voice speaking on its own. During the FCTC the three pillar system of the EU foreign policy was still intact and led to the country holding the EU Presidency, the European Commission, and the EU member states all making statements. There should be at least some debate as to whether this approach was stronger as far as negotiation impact goes. While there may have been a greater struggle to achieve coherence in a common position, there were ultimately more different voices, expressing the same opinion at the negotiation table.

Interests in trade and health do not always go hand in hand. While the EU has been a supporter of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and is a member of the WTO and the World's Intellectual Property Organization (WIPO), it is also striving to protect its citizens' health.[177] In any case the EU acknowledges a problem that frequently enters SSFFC negotiations that "Patent protection can lead to higher prices by delaying the supply of cheaper generic alternatives."[178] Expanding this argument often leads to the conclusion that patents on medicines restrict access to treatment for citizens in LMICs. According to the European Commission, however, patents on self-developed medical products are increasingly filed in those developing countries themselves,

[176] Attaran, A., Barry, D., Basheer, S., Bate, R., Benton, D., Chauvin, J. & McKee, M. (2012), 'How to achieve international action on falsified and substandard medicines', p. 3.
[177] http://ec.europa.eu/trade/policy/accessing-markets/intellectual-property/, accessed on 28.05.2015.
[178] http://ec.europa.eu/trade/policy/accessing-markets/intellectual-property/access-to-medicines/, accessed on 29.05.2015.

which they claim makes these countries more competitive on global markets.[179] It appears that the EU is caught in the middle between protecting its own Intellectual Property interests, while still ensuring equal treatment of poorer countries elsewhere. The next chapter will address in greater detail how the EU managed these contradicting goals to find a compromise during SSFFC negotiations.

A different layer of conflicting interests is present in the EU's dealing with tobacco control and the tobacco companies. Although not the wider topic of this thesis the alleged influence of "Big Tobacco" on EU policies is inseparable from the issue of tobacco control in Europe. Industry influence through lobbying is hard to trace and its real impact on the FCTC negotiations not always easy to reconstruct. Still, the following prominent example from the recent past should at least make the European Public suspicious of the European Commission's real motives on tobacco control. Philip Morris International, signed a 12-year anti-contraband and anti-counterfeit agreement with the EU and 10 member states in 2012 in which it agreed to pay around €1 billion to help finance a crackdown on illicit trade in tobacco products and counterfeit cigarettes.[180] While a big share of this money is used to purchase items that aid tobacco control, such as airport scanners and sniffer dogs, it is uncertain if all that money is put to its proper use. Philip Morris naturally received something in return. The European Commission dropped a US court case against PMI, involving accusations against Philip Morris that the company had been a complicit in cigarette smuggling by intentionally oversupplying some European countries.[181] This example shows that the EU is not always as unbiased as it may seem on the surface of the negotiations.

Finally, when trying to place global health diplomacy and the EU's role in it in a wider context one has to consider that a lot of the strategies applied to health related negotiations are based on lessons learned from environmental treaties.[182] Health and Environment are similar in several ways, including the political perspective, which can be seen in the fact that both areas use and accept international organizations. Policy in both domains has been shaped by scientific findings that would appear to be common sense on which basis treaties are drawn up. Furthermore, both areas are global in their reach, although the impacts at local and regional levels may be varying.[183] During negotiations the stages of negotiations and what they entail are similar. A pre-negotiation phase with fact finding, public opinion polls, and lobbying is followed by the actual negotiations in which taking positions, bargaining and

[179] Ibid.
[180] Nielsen, N. (2014), Investigation Part V: *Dalli's big tobacco theory*, https://euobserver.com/smoke-and-mirrors/126125, accessed on 29.05.2015.
[181] Ibid.
[182] Taylor, A. (1996), 'An international regulatory strategy for global tobacco control'. *Yale Journal of International Law,* 21 (2), pp. 257–304. in: Kirton, J.J. & Guebert, J.M. (2013), 'Global Environmental Diplomacy: Comparing and Sharing', in: Kickbusch (2013), p. 142.
[183] Kirton & Guebert (2013), 'Global Environmental Diplomacy: Comparing and Sharing', p. 142.

reaching an agreement occur, accompanied by more lobbying.[184] The following chapter will concern itself with the strategies and language used during the treaty negotiations and will try to shed some light on how one is to interpret the EU's diplomatic behavior in an International Relations theory context.

[184] Berridge (2002), *Diplomacy – Theory and Practice*, p. 150.

III. Analysis of the EU foreign policy within the UN

3.1. International Relations Theory

This chapter is going to deal with the EU's role in Global Health negotiations from a more analytical point of view. In order to explain EU diplomatic behavior there are a number of theories that could be employed for that purpose. Therefore, this analytical approach will be twofold: first the corresponding international relations theories will be introduced. In the following an analysis of the negotiation strategy of the EU will be conducted. At the end of the chapter the results of the strategy analysis will be interpreted and aligned with international relations theory thus providing a broader basis for discussion of an EU foreign policy. Through this approach it will be possible to draw conclusions and point out some of the implications for the EU in the global health context.

The reason why the three case studies FCTC, FCTC Protocol and SSFFC have been chosen is their interconnectedness. All three of them are issues debated in the context of global health and are convened at the WHO Headquarters in Geneva and all three of these are issues that the EU and its member states have a high interest in that needs to be protected.[185] Because of the active role the EU has played and continues to play, these three treaty making processes present a great example for the EU's role in Global Health Diplomacy. Medicine control has another asset that sets it apart from other health related issues in the WHO context. It is, in comparison to other ongoing processes such as the International Health Regulation and the Pandemic Influenza Preparedness Framework, very controversial as the analysis below demonstrates.[186]

Before embarking on the analysis of the negotiation strategy some short definitions will be provided on how some of the contemporary International Relations (IR) theories are adapted to fit the context of the EU. Firstly, there will be a brief discussion of institutionalist versus realist theory. Both of these concepts will be used at the end of the chapter to define the nature of the EU's diplomatic behavior in multilateral negotiations. Through this categorization an assessment can be made on how applicable a theoretical approach to a treaty is and in which category the behavior of the actors involved falls.[187] From recognizing the right category conclusions can be drawn as to how the EU has been acting and how their foreign policy approach could be changing in the future due to the lessons learned.

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[185] See: European Commission White Paper (2008-2013).

[186] Governing Body Documentation on Pandemic Influenza Preparedness, http://apps.who.int/gb/pip/, accessed on 12.06.2015.

[187] Assunta, M. & Chapman, S. (2006), ‚Health and Treaty Dilution', in: *Journal of Epidemiology and Community Health* (1979-),Vol. 60, No. 9, pp. 751-756.

For this case study the count will be limited to the EU representatives and the EU member states. Only where necessary other actors will be examined. Each of these examinations of negotiation strategies and actions will be considered within the confines of particular treaty article. To provide a justification for the method used for the examination of the negotiations a short discussion of other theories in the field of negotiations will be provided. Finally, the question on the consistency of the EU's foreign policy strategy will be answered.

Institutionalism vs. Realism in EU Foreign Policy

The theory of international relations is easily adaptable to current issues of international politics which is also true for the field of global health. One thing that is peculiar is how old the current theories are. Most of them date back to the 1980's and 1990's. Since then the international organizations that were singled out as a central theme in theories such as liberal institutionalism and institutionalism have not sufficiently been examined under the same theoretical framework. Are the results still the same as they have been when looking at states' behavior in the UN-system in the 90's? Common sense suggests that when taken into account how much the EU has changed in the early years of the 2000's and the WHO that changed along with it (WHO reform movement), liberal institutionalist attitudes should have been strengthened. Realist theories often claim that the UN "has assuredly not given grounds for confidence it can save the world."[188] This assumption is not fair because it fails to take into account that many UN organizations are member state driven, meaning that initiatives that an organization takes are initiated by its member states.[189] As this kind of thinking is strongly inspired by action or non-action taken in the UN Security Council, an instrument in which blocking strategies for geopolitical reasons are common and render the council unable to act.[190]

Global Health Diplomacy is a great example for liberal institutionalism because the word "global" already indicates that health is a cross-border, international issue and any progress in this area will have to be accomplished through international cooperation. Institutionalism has been adequately described by John Baylis and Steve Smith by stating: 'imagine a world in which actors other than states participate directly in world politics, in which a clear hierarchy of issues does not exist, and in which force is an ineffective instrument of policy.'[191]

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[188] Milner, H. (1997), ‚Interests, Institutions and Information', in: Devitt, R. (2011) ‚Liberal Institutionalism', p. 4.
[189] E.g. the WHO, UPR (Universal Periodic Review)
[190] Hassler, S. (2013), *Reforming the UN Security Council Membership: The Illusion of Representativeness*, p. 27.
[191] Baylis, J. & Smith, S. (e.d.) (2005), 'The Globalization of World Politics: An introduction to International Relations', in: Devitt, R. (2011), 'Liberal Institutionalism: An Alternative IR Theory or Just Maintaining the Status Quo?', p. 1.

Thus it differentiates itself from realist assumption that international politics is a struggle for power in which military security issues will always be prevalent.[192] In a setting where all parties can hope to gain a higher standard of health, there should be less space for a realist type of behavior, especially not from the delegates of the EU. Where other regions of the world are less integrated and only entertain loose, non-binding partnerships, the EU is integrated in many areas including a common health legislation.[193] According to Graham Allison, the rise of global scale problems has shown "that states can no longer react unilaterally to these threats and that it is only through regional and global regimes that policy responses can be coordinated to deal with new security threats."[194]

Analysis of Treaty Negotiation Strategy

> "Who's winning?" is as inappropriate as to ask who's winning a marriage. If you ask that question about your marriage, you have already lost the more important negotiation — the one about what kind of game to play, about the way you deal with each other and your shared and differing interests.[195]

Before the use of strategy the EU in WHO negotiations can be analyzed a brief introduction is needed of how the different stakeholders communicate with each other during the negotiations. When operating in a diplomatic, multilateral setting delegates have to communicate with each other in a language everyone understands. In a WHO this will usually mean that delegates speak in one of the official UN languages,[196] while real time translation through trained and licensed interpreters will be provided.[197] When, however, the alleged time frame of the interpreters' presence has run out (usually around 5:30pm) the plenum has to continue the negotiations without interpretation, which most of the time means to continue in English.[198]

One of the key challenges in diplomacy is to find formulations during negotiations, which are acceptable to all parties. Thereby the diplomats strive to find words which combine precision with

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[192] Ibid.
[193] EU Health Legislation expands to areas such as Illicit Drugs & Medicines, Tobacco Control and Food Safety, http://ec.europa.eu/health/legislation/policy/other_legislation/index_en.htm, accessed on 14.06.2015.
[194] Allison, G. (2000), 'The Impact of Globalization on National and International Security' in: Donahue, J. & Nye, J. (ed.) *Governance in a Globalizing World*, p. 84.
[195] Fisher, R., Ury, W., Patton, B. (2005) *Excellent onderhandelen – een praktische gids voor het best mogelijke resultaat in iedere onderhandeling*, Amsterdam:Uitgeverij Business Contact, p. 71.
[196] English, French, Arabic, Chinese, Spanish and Russian.
[197] http://www.who.int/substance_abuse/research_tools/translation/en/, accessed on 03.06.2015.
[198] The chairperson has to get all of the delegates' consent in order to proceed with the negotiations in that manner. If any country objects, the meeting has to be adjourned on the following day or at another date, in.

ambiguity.[199] As controversial as this concept sounds, it allows both parties to preserve their face and ensure there is enough room for a different interpretation. After all, treaties sometimes express rather principled willingness of moving in a certain, agreed direction rather than guaranteeing a swift implementation of an agreement. Diplomats will go to great lengths in order not to express any opinion while speaking out and even proposing texts. This can sometimes be "achieved by using a more complicated style, complex sentences, digressions, interrupting one's own flow of thought and introducing new topics."[200] When looking at the EU statements and the contributions of the EU member states one has to take into account that the member states are sometimes not just speaking on behalf of the EU but at times include the entire WHO European Region and its 53 member states.[201]

Negotiations can run smoothly or rather slowly depending on the stance the parties involved are taking. The choice of which indicators to use is tough, considering there are many different ways to approach such an analysis. First of all, there are the "classic negotiation theories". Part of this category are the authors Richard Walton and Robert McKersie[202] who designed a theory of labor negotiations in the 1960's differentiating between distributive bargaining, integrative bargaining, attitudinal structuring, and intra-organizational bargaining. Howard Raiffa was the first to present a framework taking into the complexity of multilateral negotiations. He used thirteen negotiation characteristics, which includes one of the factors of this analysis, the number of participants.[203] Later David Lax and James Sebenius developed a model of analysis that incorporated prescriptive analysis of how parties in a negotiation should act. Among other factors they included internal and external characteristics that often occur when multiple parties on a single side, such as the EU, are involved.[204]

Larry Crump suggests a method that comprises a number of elements that is going to be used in this inquiry as well. He employs a five level approach for his negotiations analysis which entail: identification of the negotiation architecture, analysis of context, analysis of structure and relationships, analysis of process and analysis of decision-making.[205] Especially the first three steps have been discussed in length, examining the EU and WHO structures, in the previous chapters of this thesis in order to set the scene for an in depth analysis of the actual negotiation process.

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[199] Scott, N. (2001), 'Ambiguity versus Precision – the changing role of terminology in conference diplomacy', in: Jovan Kurbalija, J. & Slavik, H., *Language and Diplomacy,* p. 153.
[200] Stanko, N. (2001) Use of Language in Diplomacy, in: Jovan Kurbalija, J. & Slavik, H., *Language and Diplomacy,* p. 45.
[201] For instance the UK at INB5 through Mr. Kingham.
[202] Walton, R.E. & McKersie, R.B. (1965) *A behavioral theory of labor negotiations: An analysis of a social interaction system*, in: Crump, L. (2015), ‚Analyzing Complex Negotiations', *Negotiation Journal*, Volume 31/Issue 2, pp. 85-170.
[203] Raiffa, H. (1982), *The Art and Science of Negotiation.*
[204] Sebenius (1992), ‚Negotiation analysis: A characterization and review', *Management Science* 38(1), p. 18.
[205] Crump, L. (2015), 'Analyzing Complex Negotiations', *Negotiation Journal*, Volume 31/Issue 2, p. 138.

In the following a method of evaluation will be employed that is based on assessing the quality of the strategic approach a party is taking towards the negotiations. These indicators are partly based on "The Harvard Negotiation Project" series book "Get to Yes" by Roger Fisher, William Ury and Bruce Patton. Goals and priorities, as well as the number of participants are two indicators taken from Mary Assunta's article, while the indicators relating to strategy are taken from Fisher, Ury and Patton. The negotiation strategy of the EU will be analyzed using a combination of the following indicators:

i. Goals and Priorities:

Under this point the objectives or goals of the EU will be named.

ii. Number of participants:

European Commission, EEAS, Country holding the current EU Presidency, EU member states total. It is has to be mentioned that due to space constraints in the Executive Board Room in the WHO main building sometimes a limit on participants per party has to be imposed. This means that when a delegation registers a certain number of participants not all of them will be present at the same time on most occasions. Because of this constraint the size of the delegation is not necessarily an indicator for the effectiveness and strength of a parties negotiation abilities.

The reason for the choice of the negotiation round for the FCTC and the FCTC PITT is based on the assumption that in the beginning of the negotiations goals and priorities are revealed. By choosing the last but one negotiation round the perspective is marked by the fact that much has been discussed between the negotiation parties while some of the most pressing issues are still on the table.

iii. Negotiation strategy:

What seems to be the strategy of the EU and which means do they employ in order to get their way? Ideally a teaching, condescending style of negotiating needs to be avoided especially by the EU that is sometimes seen as imposing its viewpoints on others.[206] An "argumentative style sticking strictly to one position endangers negotiation process – this behavior is even more counterproductive when there are multiple parties involved negotiation styles"[207] The table

[206] Battams, S., van Schaik, L. & van de Pas, R. (2014) 'The EU as a Global Health Actor: Policy Coherence, Health Diplomacy and WHO Reform', p. 555.

[207] Fisher, R., Ury, W., Patton, B. (2005), *Excellent onderhandelen – een praktische gids voor het best mogelijke resultaat in iedere*

provided in appendix II illustrates some of the typical behaviors parties show in a negotiation, indicating which options a participant has at its disposal.[208]

Following the identification of negotiation behavior the shown behavior of the EU will be analyzed comparing the principles of negotiations with the above mentioned IR theories. Proceeding in this way presents a simplification of Fisher's form of analysis since there many more criterions in goals and in outcomes that could be discussed. However, this analysis is focusing more on getting to grips with which role the EU has fulfilled and what is has done during the negotiations rather than discussing what it should have done.

Not having complete access to the so-called verbatim records of the INB sessions is not ideal – still, it is possible to draw conclusions from an examination of the summary records of the meetings. These records consist of a series of summaries of every statement made by every party present at the negotiations, which allows for the application of some of the above mentioned indicators from the table and for a comprehensive analysis of the negotiation proceedings.

iv. <u>Outcome – accomplishments</u>

With regard to the outcome analysis William Zartman suggests to use the structure, in this case the made up of all the analytical indicators, to explain the outcome through a structural analysis. This approach yields three types of solutions: coalition analysis – who worked together with whom, leadership analysis – who was in charge, and procedural analysis – How have the results been achieved. By identifying these factors one can identify the power relations between the parties involved.[209]

These methods for negotiation analysis still serve the overarching purpose on determining, if the EU is speaking with one voice and whether this voice has weight with the other parties and contributes to effective negotiations in the Global Health context.

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onderhandeling, Amsterdam:Uitgeverij Business Contact, p. 27.

[208] See: Appendix II.

[209] Zartman, W. (1991), 'The structure of negotiation. In International negotiation: Analysis, approaches, issues', in: Crump, L. (2015), 'Analyzing Complex Negotiations', Negotiation Journal, Volume 31/Issue 2.

3.2. FCTC

I. Goals and priorities

The EU's initial areas of priorities for the negotiations of the FCTC included the phasing out of tobacco subsidies, product regulation on issues such as misleading descriptors (the use of terms like "mild" and "light"), traceability of tobacco products (to combat illicit trade) and global restrictions on all forms of advertising and promotion of tobacco products.[210] Besides that the EU called for stricter non-smoker protection rules.[211]

II. Number of participants - EU and member states and selected number of other states to serve as a comparison[212]

To all negotiation rounds the EU brought a sizable delegation that showed its determination and poise to leave its mark on the negotiations. Other parties with sizable delegations included China, Russia, Japan and Malawi. The latter took special interest in the negotiations due to its economic dependency on the production of raw tobacco.[213]

III. Negotiations

Intergovernmental Negotiation Body 1st Session (INB1):

Upon the opening of the first INB the delegation of the EU displayed unity right away by asking the chairperson to sit the French delegation next to the European Commission which was granted. At the first statement made by France on the behalf of the EU the French ambassador expressed an open and constructive attitude in regard to the method of work.[214] The scope of the convention was supposed to be as wide as possible to make a final agreement of all parties involved more likely. Norway aligned itself with that statement already indicating that it would collaborate with the EU during these negotiations.[215]

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[210] EC press release, Brussels, 28 November 2001 http://europa.eu/rapid/press-release_IP-01-1688_en.htm, 03.06.2015.
[211] INB1 Summary Records, p. 22.
[212] For overview on participants of INB 1 & 5 See: Appendix 1
[213] Tobacco, the largest cash crop, generated about K 12 billion of export revenue in 1999 and accounted for more than one third of total revenue from agriculture and about 15 percent of GDP in the same year, http://www.fao.org/docrep/006/y4997e/y4997e0i.htm, accessed on 15.06.2015.
[214] INB 1 Summary Reords, p. 7.
[215] Ibid, p. 10.

The UK went on to speak on the same note supporting an open dialogue and doing so not only on its own behalf but on the behalf of the entire European Region (WHO EURO). Furthermore, the UK supported the Canadian statement that had previously called for a transparent treaty making process.[216] Only a few statements later France took the floor again, outlining the correlation between tobacco use and cancer. In this statement France called for strict rules and clear targets to be part of the convention. Also, the proposed WHO deadline of concluding the negotiations in 2002 found the EU's approval. Mr. Ryan of the EC added that the FCTC should not just set rules but also include implementation guidelines and called for the development of protocols amending the FCTC.[217]

Overall there was visible support for the positions brought forward by either France in the role as the EU Presidency of the Council of the European Union or the European Commission. Creating smoking free environments, for instance, was one position introduced by France that gained support from EU countries Finland, Sweden as well as countries from the European Region Turkey, the Czech Republic and Guinea.[218] During this first round of negotiations the France as representative of the EU Presidency took turns with the European Commission to issue statements on behalf of the EU. Support came from other EU countries and the countries that sought to become part of the EU. The first INB did not stir up much controversy which was mainly due to the early stage of negotiations.

Intergovernmental Negotiation Body 5th Session (INB5):

On the first day of INB5, the European Commission pointed out that much had been achieved at this point and that one was happy about the progress that had already been made. However, despite a high focus on outcomes in the negotiations "compromises involving less ambitious and explicit alternatives should not become a rule which would lead to the lowest common denominator".[219] In saying this the European Commission called for a clear use of language, rather than a vague text that other parties favored, such as Japan.[220] Denmark had its turn representing the EU in the role of the holder of the EU Presidency and supported the Commission's statement saying that they wanted the convention to be as meaningful as possible in relation to its content.[221]

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216 Ibid, p. 17.
217 Ibid, p. 22.
218 INB1 Summary Records, pp. 63-81.
219 INB5, p. 8.
220 Assunta, M. (2006), p. 751.
221 INB5, pp. 7-8.

Uzbekistan praised the successful collaboration between the countries of the European Region and the chair of the INBs, whose drafting skills contributed to a smooth and constructive negotiation process.[222] Later the European Commission spoke on Article 6 of the FCTC calling for the deletion of a reference to vulnerable groups. What was special in this regard was that Bulgaria, Czech Republic, Hungary, Malta, Poland, Romania, Slovakia and Slovenia aligned themselves with the EU by being featured in the European Commission's statement.[223] This was a strong signal for a united European front in these multilateral negotiations and a sign of how well the above mentioned countries worked on their endeavor to become full members of the EU, with eventually all of them succeeding.

Denmark raised its flag again at a later point again, speaking out in favor of a strong illicit trade Article 15.[224] Again support for the EU came from Romania, who went so far as to urge the EU to commit to a strong stand against tobacco advertising in the context of Article 13.[225] As in the first INB, the EU again assumed a very active role during this 5th INB. The EU spoke often and made many suggestions on how to resolve issues, such as referring to content (Article 13 (tobacco advertising) and Article 15 (Illicit Trade in Tobacco Produts) and also regarding the rules of procedure (Articles 23, 24, and 26).

IV. Outcome and Analysis

The Intergovernmental negotiation body is a great example of EU and member state collaboration in a Global Health Context. Apart from France, which held the EU presidency only the European Commission and the UK spoke on the EU's behalf complimenting each other and working together. Likewise was the behavior of states that sought accession or membership to the EU like Poland and Romania who emphasized their commitment to implement a higher standard of health legislation in order to align themselves with already existing EU policy.[226]

While the EU established itself as a constructive and reliable actor that spoke with one voice it was not able to push for a use of treaty language that was as strong as they had initially hoped. Japan, as one of the countries closely involved with "Big Tobacco" through the part ownership in Japan Tobacco, succeeded to some extend in "watering down the language of certain articles.[227] Optional language

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[222] INB5, p. 9.
[223] INB5, p. 17.
[224] INB5, p. 30.
[225] INB5, p. 35.
[226] Ibid, p. 28, 42.
[227] Assunta, M. & Chapman, S. (2006), 'Evidence Based Public Health Policy and Practice: Health Treaty Dilution: A Case of Japan's

prevailed in four key issues, that the Japanese delegation had identified as important, namely packaging and labelling; advertising and promotions; liability and financial resources.[228]

3.3. The WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products

This negotiation round, although related in topic, started under a different pretext for the EU. The success of FCTC, with a very strong EU role manifested trust, which led to the assignment of more responsibility and a bigger role during the Protocol on Illicit Trade in Tobacco Products (PITT) negotiations. At the beginning of the first negotiation round (INB1) Ian Walton-George of the European Community was elected chairperson of the meeting and would remain in that position for all of the following INBs.[229] Furthermore, the EU had just recently expanded to a total number of 27 member states[230] meaning the EU had to coordinate the opinion of all 27 member states instead of the previous 15 member states.

I. Goals and priorities

The EU endeavored the establishment of a global tracking and tracing regime, supply chain of tobacco, tobacco products and manufacturing equipment for making tobacco products to conduct due diligence on their customers in order to prevent money laundering.[231] In addition the European Commission White Paper "Together for Health" from 2007 reaffirmed the EU's intention that a "high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities".[232] This included a close implementation of international agreements, such as the FCTC.[233]

II. Number of participants[234]

An interesting side-effect of the treaty rules was that at the Protocol negotiations only such parties could

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Influence on the Language of the WHO Framework Convention on Tobacco Control', p. 754.

[228] World Health Organization. Provisional Summary Record of the First Plenary Meeting (A/FCTC/INBó/PL/SR/l Corr 1).

[229] Protocol on Illicit Trade INB1 Summary Records (2008), p. 1.

[230] 6th enlargement round in 2007 with Romania and Bulgaria joining the EU, http://ec.europa.eu/enlargement/policy/from-6-to-28-members/index_en.htm, accessed on 10.06.2015.

[231] FCTC Protocol INB1 Summary Records (2008), p. 10; European Commission Press Release 2012, http://europa.eu/rapid/press-release_IP-12-1223_en.htm, accessed on 10.06.2015..

[232] EC White Paper: Together for Health – A Strategic Approach for the EU 2008-2013.

[233] Ibid, p. 8.

[234] For IBN1 and INB4 participants see: Appendix I.

participate who had previously signed the FCTC. All other countries who had not done so were assigned observer status. Countries who had only observer status prominently featured the United States of America, Switzerland, Italy and the Russian Federation. Interestingly, countries that have borders with major transit countries for illicit cigarettes, such as Slovenia, Romania[235] or South Africa[236] had relatively large delegations, as opposed to countries where the problem of illicit trade in tobacco products is less of a problem, such as in the UK or Finland. At the 4th Protocol INB the EU was the first featured under this name and in contrast to the FCTC several years earlier it was listed in the column of a full party, rather than an intergovernmental organization.[237]

III. Negotiations

Intergovernmental Negotiation Body 1st Session (INB1):

The meeting was chaired by the European Community through Chairperson Ian Walton-George who had been elected chairperson at the very beginning of the meeting.[238] Austria expressed the hope early on that in a spirit of compromise the participants would find a way to create, "meaningful, well-balanced, and practical instruments", which would allow for many countries to join the protocol. The Austrian delegate also called for a high amount of flexibility and a "strong sense of compromise" from all delegates.[239] Later Slovenia illustrated the high financial costs of the illicit trade in tobacco products and called for a global and multilateral response to the issue.[240] The European Commission stressed that the goal of having a protocol by 2010 was ambitious, as it would turn out too ambitious, but that there was a common understanding of the problem that all parties had to solve together.[241]

Slovenia was again taking the floor on behalf of the EU and its member states at the second meeting. Here the EU put forward the goal of negotiating strong provisions on tracking and tracing, rules for ensuring the legitimacy of customers and for due diligence. Moreover, the EU "wished to reserve its position on licensing, enhanced law enforcement, offences, sanctions and penalties; and jurisdiction until

[235] http://www.dw.de/teil-1-rum%C3%A4nien-im-dunst-der-schmuggler/a-17620530, 11.06.2015. and http://bnr.bg/de/post/100122935/kampf-gegen-zigarettenschmuggel-auf-dem-balkan, 11.06.2015.
[236] http://www.fctc.org/images/stories/INB-3/INB3_report_illicit_trade_in_South_Africa.pdf, 11.06.2015.
[237] PITT INB4 List of participants, http://apps.who.int/gb/fctc/PDF/it4/INB4_DIV_1_Rev2.pdf, 12.06.2015.
[238] PITT INB1, p. 1.
[239] PITT INB1, p. 4.
[240] PITT INB1, p. 5.
[241] Ibid, p. 6.

specific proposals were available for consideration."[242]

In the third meeting the European Community drew attention to the fact that many EU member states already had licensing regimes for tobacco in place. Anyhow, the EU would still be open for suggestions on how to improve such legislation.[243] Later Mr. Rowan (EU) repeated the EU's appeal for a strong tracking and tracing regime and gained support from the delegate of Djibouti in the next statement.[244] On the question of putting a provision in the protocol that takes into account that law enforcement authorities had different structures and therefore different needs the EU received strong general support from all participating parties.[245] Upon Djibouti and Burkina Faso pointing out that international cooperation in information sharing was important yet hard to accomplish due to a lack in capacities the EU responded by offering to put a clearer provision on that issue in chair's text.[246]

Intergovernmental Negotiation Body 4th Session (INB4):

At the 4th INB the issue that the EU had declared as being vital to their interests was being discussed, namely the supply chain control which entailed the tracking and tracing regime (Article 7) and the "License or equivalent approval system" (Article 5). Oman, supported by Kenya, India, and Bhutan suggested to include the phrase "all tobacco products" into the paragraph, explaining that while in Europe cigarettes may be the only relevant product, this certainly was not true for the rest of the world including their respective regions.[247] Next the Chairperson pointed out that various parties had already spoken in favor of the inclusion of "all tobacco products" over "cigarettes". He therefore asked the only two parties who had spoken against that provision Japan and the EU to consider showing some flexibility.[248] Japan decided to yield to the pressure of the majority while the EU did not further comment on the issue at this point in time.[249] Rather the EU brought up the idea that the phrase "a government-controlled tracking and tracing system" should be replaced by "a tracking and tracing system controlled by the Party"[250] which Brazil found acceptable. The EU had thus succeeded in diverting some attention away from an issue they needed more time to discuss in their party by making a new suggestion in the same article. An

242 Ibid, pp. 9-10.
243 Ibid, p. 17.
244 Ibid, p. 20.
245 Ibid, p. 31.
246 Ibid, p. 49
247 PITT INB4 Summary Records (2010), p. 28-29.
248 Ibid, p. 30.
249 Ibid, p. 31.
250 Ibid, p. 32.

agreement on tracking and tracing could not be agreed on during that session.

In the following session the EU remained insistent on its discomfort in regard to paragraph 2 and wanted to have the Chair put on record that the EU preferred "cigarettes" rather than "all tobacco products".[251] Eventually, however, the majority's opinion prevailed on paragraph 2.[252] Some difficulty arose on the information sharing, where Brazil and the EU did not see eye to eye. The chair suggested that the two parties solve the issue in informal discussions.[253] There was more controversy when the EU made a remark on the "competent authorities" discussion placing on record their "displeasure at the criticism that the 27 Parties in the European Union had been subjected to the previous day".[254] Indeed, on the previous day Brazil had impliedly suggested that the EU – although they did not explicitly name them – had adopted "a trust-based approach to the tobacco industry".[255] The EU declared that it was not its intention to attribute any rights to the tobacco industry whatsoever.

IV. Outcome and Analysis

In the Protocol negotiations one could again witness the EU employing a very subtle use of soft power negotiating through plentiful use of good energy, input, ideas, suggestions, good will and living out the ideal they asked others to respect the approach of a culture of compromise.
Arguments were usually built by providing an example, followed up by a suggestion on how to proceed on a certain paragraph or how to rephrase it in a way to make it acceptable for all parties. When pressed by other parties, the EU displayed the ability to stand its ground and reject false accusations.[256]
Remarkably, the EU fully led the negotiations themselves with the representatives of the 27 member states serving more as a supportive audience, rather than real actors. This was to become a role model for the EU negotiating in a WHO context as the SSFFC negotiations will show in the following.

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[251] Ibid, p. 37.
[252] FCTC Protocol on Eliminating Illicit Trade in Tobacco Products (2013), Article 8, para 2, p. 15.
[253] PITT INB4 Summary Records (2010), p. 46.
[254] Ibid, p. 59-60.
[255] Ibid, p. 45.
[256] As in Article 7 discussion, INB4 Summary Records, p. 59.

3.4. Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit (SSFFC) Medical Products[257]

I. Goals and Priorities

Among the most important priorities for the EU in the SSFFC process are giving the WHO a fundamental role in ensuring the safety, quality and efficacy of medical products and in promoting access to affordable, high quality, safe and efficacious medicines.[258]

II. Number of participants

While the FCTC and FCTC Protocol negotiations had a large number of participants the SSFFC process has not yet reached the conference level. Rather, the Member State Mechanism (MSM) and Working Groups are much smaller in scale. At the first MSM the number of participants which are particularly high for Nigeria, Brazil and Argentina are foreshadowing the high interest these countries have in access to medicines and the distribution, counterfeiting and intellectual property issues. Especially Brazil, Argentina and India would be countries to contribute excessively during the negotiations.[259]

III. Negotiations

Though the SSFFC process is being dealt with in the form of meetings, working groups and the MSM it is not yet clear, if the final outcome of this process is going to entail a treaty. Therefore, in the beginning very practical matters were discussed, which included the scope of the MSM, structure of governance and the funding of the MSM.[260] The most important outcome of this first round of negotiations was the agreement of the member states on the exclusion of intellectual property considerations regarding "“substandard/spurious/falsely labelled/falsified/counterfeit medical products”.[261]

Due to its character of agenda setting, the first MSM meeting, which was chaired by Ambassador Umunna Humphrey Orjiako of Nigeria[262], was not very controversial. Moreover, an in-depth analysis of

257 For MSM1 and MSM3 participants see: Apendix 1.
258 EU Statement, 65th WHA, http://eeas.europa.eu/delegations/un_geneva/documents/eu_statments/who/20120525_ssffc_en.pdf
259 Particularly at MSM3.
260 MSM1 Summary, http://www.who.int/medicines/areas/policy/IPC_dec2012_Kopp_SSFFC.pdf, 13.06.2015.
261 Ibid.
262 Update on WHO discussions on SSFFC, http://www.who.int/medicines/areas/policy/IPC_dec2012_Kopp_SSFFC.pdf, 12.06.2015.

this first MSM session is not possible because no summary or verbatim records have been released by the WHO.

MSM session number 3 took a very confrontational turn, mainly as a result of issues relating to intellectual property, which were essential to the participation of developing nations, such as India and Brazil, who could not be kept out of the discussion. Previously, the WHO had been confronted with accusations of being overly influenced by the intellectual property interests of the pharmaceutical industry. States like Brazil and India who themselves produce a fair amount of medical products felt their economic interests being threatened by the turn the debate was taking.[263] With that being said the negotiations of MSM3 had two major texts as its basis. India had prepared a text on the "Identification of Actions, Activities and behaviors that fall outside the mandate of the MSM using the WHO e-Working Group online platform where all WHO member states could post their input.[264] The Argentinian paper dealt with Recommendations to detect and deal with actions, activities and behaviors that result in SSFFC medical products.[265]

While these very technical papers were partly discussed during the working group meeting 27-28 October, their contents were opened for discussion again during the main MSM session held from 29-31 October. On the Argentine recommendations the EU quickly came into conflict with Brazil. After the EU proposed the replacement of the phrase "active pharmaceutical ingredient" by "starting materials" a discussion broke loose on whether this was acceptable with the United States, Brazil and Bolivia arguing against it.[266] Re-emphasizing that this was a vital point, the EU managed to achieve some extra deliberation time from the other parties through bilateral negotiations during breaks whilst keeping the according passage in brackets. Eventually, the EU proposal was kept in the final text,[267] which can be interpreted as a success of EU negotiation.

The negotiations were about to get heated, even emotional during the second negotiation round of the same day. Upon discussing the "Indian Paper" on exclusions of the scope of the MSM the EU proposed a minor wording change on Article 3 adding "unintentional" to the middle of the phrase "minor

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[263] WHO working group drafts resolution on SSFFC medicines, http://www.securingindustry.com/pharmaceuticals/who-working-group-drafts-resolution-on-ssffc-medicines/s40/a1098/, accessed on 13.06.2015.
[264] SSFFC Indian Paper on the *Identification of Actions, Activities and behaviors that fall outside of the mandate of the Member State Mechanism*, WHO e-Working Group, Version 17.10.2014.
[265] SSFFC Argentine Paper on *Recommendations to detect and deal with actions, activities and behaviors that result in SSFFC medical products*, Version 16.10.2014.
[266] SSFFC MSM3 Meeting Report, Permanent Mission of Germany to the UN in Geneva, 29.10.2014.
[267] Report on the Third meeting of the MSM on SSFFC, Annex 1, Article 2.1.8. a), http://apps.who.int/gb/ssffc/pdf_files/MSM3/A_MSM3_3-en.pdf, accessed on 14.06.2015.

[unintentional] deviations".[268] Argentina, India and Tanzania rejected that proposal, which led the EU to ask for a short consultation break. No consensus could be reached in the end. A real deadlock in the negotiations due to a principle disagreement between developing and developed countries emerged when Australia suggested the adding an extra sentence on Article 7 which is a border/customs provision. The addition went "[and except if there are grounds for suspecting the existence of SSFFC medical products]" and, if passed, would have enabled an importing country to seize medical products they deemed dangerous to their populations. Brazil left the factual level of argument by asking, 'which national legislation is better than another?' and went on to call for no restrictions on trade.[269] It did not end there and Brazil went on by implying that they felt as though "outside of EU countries were being discriminated against". Trade should be left out of the discussion. In turn Monaco and Ireland spoke in defense of the right to protect public health and were countered by Brazil again, which asserted that "getting any medications into another country was more important than ensuring the quality of the products".[270] The meeting was thereafter closed. During the next two days the issue could not be solved either and the deadlock remained despite the EU's attempts to bilaterally sort out the issue.

IV. Outcome and Analysis

In the end the Argentine Paper containing recommendations to tackle and deal with SSFFC medical products was adopted while the Indian paper on which issues should remain outside of the focus of the MSM could not be agreed on. When looking at the negotiation of the Indian Paper the "trade vs. health" perspective from the FCTC negotiations reemerged. Some parties as the EU or Australia favored the possibility of being able to stop suspicious medical products at the border if they did not meet the importing countries standard. Brazil insisted on the principle of neutrality and free trade.[271] At the end of the MSM meeting the Steering Committee[272] requested that the MSM review that was meant to take place at the 69th WHA in 2016 was to be postponed by one year because additional time was needed for discussion.[273] This proposal was granted by the MSM and reaffirmed during this year's 68th WHA. A clear definition of what exactly SSFFC entails was not agreed and the issue was left pending.

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268 Report on the Third meeting of the MSM on SSFFC, Annex 2, Article 3, http://apps.who.int/gb/ssffc/pdf_files/MSM3/A_MSM3_3-en.pdf, accessed on 14.06.2015.
269 SSFFC MSM3 Meeting Report, Permanent Mission of Germany to the UN in Geneva, 29.10.2014.
270 Ibid.
271 SSFFC MSM3 Meeting Report, Permanent Mission of Germany to the UN in Geneva, 29.10.2014.
272 Consists of the President and two Vice-presidents elected for a three year period.
273 Report on the Third meeting of the MSM on SSFFC, Article 11.

During the third MSM a number of indicators that show the EU's efficiency as a diplomatic actor in global health became evident. Defending health as highest principle, speaking with one voice, using soft power and flexible tactics, whilst not responding to threats and provocations, were all factors that made the EU a strong negotiator in this negotiation round. In its final report the EU evaluated the ongoing process as slow but full of merit because it kept all important parties, especially India and Brazil at the negotiation table.[274]

3.5. Conclusion

Negotiating Global Health treaties during official meetings was and is just one small and visible part of what is happening at the scene. Behind closed doors in bilateral and multilateral discussions compromises are made that would otherwise be impossible due to time constraints.[275]

The EU's use and preference of strong and direct language during all of the negotiations dealt with the selected case studies leads to the conclusion that the EU's announced intentions of putting health first are genuine. If direct language breeds strong and binding treaty texts, the EU has certainly done its best to shape the FCTC and the FCTC Protocol in that way. In a field such as Global Health that still does not receive as much attention as security policy the EU is already well represented. In numbers, as well as in resolve with the member states, supporting the commission at every turn. The case studies have shown that in the area of Global Health the member states of the EU align themselves with the EU's position, assuming an almost ideal liberal institutionalist position. Countries in the EU have recognized that:

> "Joint leadership of foreign affairs governance will persist and establish a complex web of national, supranational and intergovernmental governance structures, which together establish Europe's compound executive order. The inherent coordination requirement may be tiring and sometimes compromise the EU's effectiveness on the international stage, but it remains an indispensable side effect of joint political leadership. In case of fruitful coordination it allows all actors to jointly benefit from ‚the strength inherent in united action."[276]

What the international community is dealing with in the case of Global Health goes beyond the scope

[274] Chamorro, L., Matthews, M. & Mendelin, O. (2014) *WHO – Creating global momentum against falsified medicines – 3rd Meeting of the Member State Mechanism on SSFFC medical products*, Delegation of the EU to the UN Office in Geneva.
[275] PITT INB4 Summary Records (2010), p. 218.
[276] Weiler, J.H.H. (1999), in: Thym, D. (2011), p. 460.

of mere security policy and beyond the sphere of influence of "blocking" institutions, such as the UN Security Council. This is the reason why there is visible progress in the global health arena. Member States of the WHO can agree on a common interest and a common goal, to attain the highest possible standard of health for their citizens.

In that endeavor they are united with governments not getting involved, as much as they are in other policy areas. Thanks to this absence of the highest level of leadership technocrats within the ministries of Health and Development take the driver's seat in drafting new laws and binding resolutions. Despite the differences in opinions that still occur there is a sense of camaraderie and a positive spirit of moving towards a common goal. The main opponent in the examined fields of access to medicines and tobacco control is the industry that it places profits over public health and the well-being of people.

Possibly, what we can observe here is some form of a political spill-over effect. One already integrated region, the EU, combines all its influence and joint power to push for a common goal that is assumed to be shared with the rest of the world. Because the other states see that this international cooperation is working in their favor they may decide to cooperate on other issues as well. If that were true, there could be hope for the UN as a platform for global joint action after all. As in the 1950's the European Community for Steel and Coal because of its success "spilled over" to create more integration between European countries and caused the development of new institutions the same may be happening if WHO member states continue to successfully collaborate in the field of global health.[277]

While this is probably true for questions of trade, development, environment and health, which are always mutually beneficial, the success of global health diplomacy may not be transferable to other areas of global politics - especially not to the bigger geo-strategic questions of war and peace. These issues touch upon further reaching problems such as access to natural resources and securing spheres of influence. Some of the issues addressed in these health negotiations reach further.

Next to the cooperation between countries within the EU they have an even further outreach, redefining the foreign policy and the EU's relationship with the BRICS countries. As the SSFFC negotiations have shown India and Brazil are forces that have to be reckoned with, both, in trade and in international politics. A partnership with Brazil is vital to the EU since it relies on Brazilian support in the WTO setting where the EU needs support defending its agricultural subsidy scheme in place.

[277] Haas, E.B. (1958), ‚The Challenge of Regionalism‘, in: *International Organization*, Vol. 12 / Issue 04, pp. 440 – 458.

Secondly, Brazil is a key market in South America. China, the United States, and the EU compete for a maximum access to this growing market.[278]

With India relations are growing in importance as well. While the importance and mutual benefit of maintaining good relations with one another is clear to both parties, much more can be done to nurture that relationship. Consultations at the multilateral level (such as in global health) and in bilateral consultations should be deepened as well in order to establish a more meaningful partnership that goes beyond mutual trade benefits.[279]

Despite the free trade policies the EU is trying to establish with Brazil and India, health negotiations indicate that there the EU is not only perceived as partner but also as a competitor. This is why the EU has to maintain its benevolent negotiation style, showing the will to compromise but being firm in the defense of its opinion. The successful cooperation on health issues might, in turn, prompt a stronger cooperation in the field of trade and foreign policy as well. Here the EU has an opportunity to use soft power in its favor to get ahead of China and Russia who are also competing for more cooperation and market access in these countries.

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[278] Whitman, RG. & Rodt, A.P. (2012), 'EU-Brazil Relations: A Strategic Partnership?'. European Foreign Affairs Review 17, no. 1, p. 36
[279] Khandekar, G. (2013), 'The EU: India Strategic Partnership: From Blind Acknowledgement Towards Recognition', *European Foreign Affairs Review*, Issue 4/1, pp. 508–509

Conclusions

In this paper it was possible to show that there is a consistent development in the EU's dealing with topics related to public health. Through this thesis a research gap in the field of Global Health has been filled that previously existed in the examination of global health negotiations from an EU point of view. Moreover, the fields of tobacco control and access to safe medicines could be aligned with trade related aspects. This was done employing an analytical approach aimed at the negotiations rather than previously determined policies.

Prior to the FCTC process the EU's external action had been limited primarily to environment (Kyoto) and trade (GATT/WTO/TRIPS). This external action has not always been successful as the Copenhagen climate change summit in 2009 and the loss of seats for the EU at the International Monetary Fund in 2010 showed.[280] In spite of this we are witnessing a spillover of cooperation within the EU to other important areas such as emergency response (refugee crisis), security policy (Ukraine/Russia), and health (Ebola). Today's issues in international politics seem just too great to be tackled unilaterally, rather a strong, unified European foreign policy approach is needed to solve the current crises.[281]

In terms of the development that the EU would have to take, it seems inevitable to undertake another comprehensive reform of the European foreign policy framework. The Treaty of Lisbon can only be a first step in the right direction.[282] Yet this seems to be the case most notably in the field of security policy. As far as multilateral diplomacy in the field of trade is concerned, the EU already is a strong actor and advocate of its member states' interests.[283] At its current states it is a vivid participator in the WHO as well and is a champion of the WHO's ideals. As the WHO itself is concerned it is also subject to change. Change that is necessary in order to adapt to current developments in global health. The manner in which that happens appears to be a mix of a 'spillaround' and 'buildup'. Applying Philippe Schmitter's definitions the WHO is widening its current operational scope to include a stronger operational branch in emergency response as well.[284] However, as scope and tasks of the organization widens the budget is only slightly increased.[285] An element of 'buildup' on the other hand, is the establishment of the WHO

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[280] Emerson, M. (2011), 'Upgrading the EU's Role as a Global Actor', p. 2.
[281] Interview with Filip Radunović, Project Manager at ERSTE Foundation, 'Ukraine Crisis: Status Quo, Challenges and Possible Solutions', http://www.erstestiftung.org/blog/ukraine-crisis-status-quo-challenges-and-possible-solutions/, accessed on 24.06.2015.
[282] Lohmar, R. (2014), 'The Treaty of Lisbon: Closing the Democratic Deficit of the EU?', http://www.academia.edu/6762388/The_Treaty_of_Lisbon_Closing_the_Democratic_Deficit_of_the_EU, accessed on 24.06.2015.
[283] Boening, A., Kremer, J., and van Loon, A. (eds.) (2013), *Global Power Europe - Vol. 2: Policies, Actions and Influence of the EU's External Relations*, (New York: Springer), p. 277.
[284] Schmitter, P. (1971), 'A revised Theory of Regional Integration', McCormick, J. (2008), *Understanding the European Union*, p. 10.
[285] Programme Budget 2014/2015 = US$ 3977 million, in: Draft Resolution Programme Budget 2014/2015,

contingency fund for health emergencies. Regardless of definition, the influence and power of the WHO is rising and the EU is part of that development.

The FCTC has shown the way in terms of how to negotiate a health treaty with so many different stakeholders involved and conflicting interests of the corresponding industry whose lobbying efforts had to be repelled.[286] The FCTC was ratified with relative ease while the PITT still awaits ratification by at least 40 FCTC signatory member states.[287] Without ratification the latter document remains a significant brainchild without the opportunity of implementation. Finally, the SSFFC medical products process is caught up in stalemate with the next review of the MSM being due in 2017.[288] This important process, started in order to ensure access to safe medicines for everyone, is still a far cry from a possible treaty with binding rules. If one wants to judge the EU foreign policy in global health by results, one has to conclude that these results are mixed. As shown in this paper the EU has a strong position and is influential during negotiation, yet that does not mean it can speed up processes that sometimes take decades to reach significant progress.[289]

For the member states of the EU it has become natural to surrender the rights to negotiate in global health to the EU. Most importantly the role of the European Commission from a mere institution or multilateral instrument has changed. It has become more of a supranational actor which is evident in its ability to modify policies within the EU.[290] Applying historical institutionalism Paul Pierson claimed that the European Commission had developed into a multitiered system of governance that limited its member states' power.[291] In EU foreign health policy framework this is true and at the same time necessary to reach results. Decisions are made in the EU coordination meetings as explained earlier. Member states obviously still can make their voice heard in this setting but reaching a compromise is an almost compulsive requirement. At this point it seems questionable at best that the EU member states should decide to enhance the Lisbon foreign policy framework. While this appears to be a necessary step in security politics the ongoing approach seems to working for global health.

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http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7Add1-en.pdf; Programme Budget 2016/2017 = US$ 4385 million, in: Draft Resolution Programme Budget 2016/2017, http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7Add1-en.pdf, accessed on 24.06.2015.

[286] Assunta, M. & Chapman, S. (2006), 'Evidence Based Public Health Policy and Practice: Health Treaty Dilution: A Case of Japan's Influence on the Language of the WHO Framework Convention on Tobacco Control', p. 755.

[287] WHO calls for action against illicit tobacco trade on World No Tobacco Day, http://www.who.int/mediacentre/news/releases/2015/world-no-tobacco-day/en/, accessed on 24.06.2015.

[288] Report by the Director General to the WHA68, provisional agenda item 17.3. SSFFC (2015), http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_33-en.pdf, accessed on 24.06.2015.

[289] Hence the FCTC took 12 years from the first initiative towards implementation, *History of the WHO Framework Convention on Tobacco Control* (2009), p. 3.

[290] Pierson, P. (1996), 'The Path to European Integration A Historical Institutionalist Analysis', *Comparative political studies*, 29(2), p. 158.

[291] Ibid.

Despite the accomplishments pointed out in this paper the WHO and EU alike still have a long way to go in order to achieve better health on a global scale. For too long, health has been neglected by politics. It is therefore important to shed some light on how political processes are being carried out in the arena of global health. Repeatedly, the media has criticized the WHO for not acting properly to combat SARS, H1N7 and recently the Ebola crisis.[292] What is not being said is that the WHO is a member state driven organization; its member states have the mandate and the financial means to steer the WHO's policies in the right direction.[293] So when the Organization fails at something, as it has been perceived with Ebola, the WHO does not fail on its own. The member states have a vital role to play in enabling WHO to prevent and to react to health crises and with 28 member states of the EU being a member of WHO, so does the EU.

Especially in the field of tobacco control the impact of the EU is visible including both, the WHO policies which the EU helped underway in conferences and negotiations and in implementing those guidelines itself.[294] The proactive role the EU has assumed when negotiating the FCTC and the FCTC Protocol has resulted in the creation of some level of acceptance among other states in the WHO.[295] A great opportunity thus presents itself to capitalize on this development and take on a leading role in making medicines safer while combating illicit trade in medicines.

This year's 68th WHA should be seen as a step ahead with several important actions being taken towards international cooperation in different fields including Antimicrobial Resistance (AMR), World Nutrition and future Emergency Preparedness.[296] Also a contingency fund to react to future outbreaks has been put into place and will be replenished soon to amount to $100 million.[297] Political progress on this issue may be an indicator that states are willing to cooperate on other pressing issues such as AMR[298], Vaccination or Nutrition. A spillover effect from one area of global health to another is not predictable nor by any means guaranteed yet very desirable.

[292] World Health Organization's Ebola Response Draws Criticism, http://www.voanews.com/content/world-health-organization-ebola-response-criticized/2528251.html, accessed on 14.06.2015.
[293] Keeping Compromises – Accountability of Dr. Margaret Chan during her first term as WHO Director General, http://www.who.int/dg/Report_card_cover_28_06.pdf, p. 18, accessed on 14.06.2015.
[294] Battams, S., Van Schaik, L. & van de Pas, R. (2014) *The EU as a Global Health Actor: Policy Coherence, Health Diplomacy and WHO Reform*, European Foreign Affairs Review 19, no. 4, p. 541-542.
[295] Ibid, p. 555.
[296] WHA 68 Agenda (2015), http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_1Rev1-en.pdf, accessed on 15.06.2015.
[297] $100 million contingency fund launched by World Health Organization, http://www.humanosphere.org/global-health/2015/05/100-million-contingency-fund-launched-by-world-health-organization/, accessed on 15.06.2015.
[298] Tackling AMR is part of Germany's G7 Presidency priorities, *Merkel: G7 müssen Kampf gegen Antibiotika-Resistenzen unterstützen,* http://www.bundeskanzlerin.de/Content/DE/Pressemitteilungen/BPA/2015/05/2015-05-23-podcast.html;jsessionid=A8FCC6D9B9C32349542BA8C4F97EA6E3.s4t2, accessed on 15.06.2015.

While Ebola on its own has been a terrible humanitarian tragedy, it represents an opportunity[299] for the world to move in the right direction by acting on issues of global health and making health a priority in domestic and international politics. Ebola has to be a wake-up call to all states in the world to collaborate more closely in health politics. Despite the mentioned progress the lack of media coverage on this year's WHA speaks volumes over the attention global health issues are receiving from the world's television and newspaper audiences. Too often initiatives to make populations healthier are not sufficiently in the spotlight. Therefore, it is even harder to put pressure on governments or intergovernmental organizations such as the EU to push negotiations on a certain subject in a certain way. People are simply unaware of what is happening or why it is important. In some countries and on WHO level initiatives to promote public health are already underway though more needs to be done.[300]

More than ever, the EU has to emancipate itself and become a stronger leader in Global Health. Not only for the sake of its member states and their protection but out of a heightened sense of responsibility for the world. Europe is only a small continent, and while it is still relatively rich, its military capacities are ever shrinking. Diplomacy can be a strong weapon to retain and exercise influence. With the right emphasis on the right topics the EU can continue to play a leading role in global politics. Global health should receive more public attention but also should be seen as a role model for other policy areas, a role model from which the EU member states can learn and adopt strategies from. If the EU should implement the lessons learned from the global health arena to other areas such as international security policy, it could become a much stronger and more influential international player. The currently existing Lisbon foreign policy framework provides the basis to act in unison and effectively, but only if the EU member states are willing to surrender some more sovereignty to the EU.

The three case studies discussed above have shown that, in principle, a common goal of all states exists to ensure safe products, access to medications and stricter tobacco control roles. Still, a general problem of global health diplomacy emerged time and time again; economic interests quickly start to blur the discussion between states whenever trade or intellectual property issues arise. In fact, these economic interests prevailing over the protection of health of citizens might be a huge factor in why poverty reduction aims, as they have been agreed to in the MDGs, are unsuccessful. Theoretically speaking, free trade should create jobs, economic development and thus eradicate poverty in the LMICs.

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[299] Dr. Frieden USA, Statement delivered at the Ebola Special Session at the EB in January in Geneva, „the Organization must seize the opportunity afforded by the Ebola crisis to make the necessary significant changes“, Ebola Resolution EBSS3, http://apps.who.int/gb/ebwha/pdf_files/EBSS3-REC1/EBSS3_REC1.pdf#page=1, accessed on 15.06.2015.

[300] Präventionsgesetz im Bundestag, http://www.bmg.bund.de/themen/praevention/praeventionsgesetz.html, accessed on 16.06.2015.

However, in practice the costs of poor health and weak health systems are much higher and outweigh the benefits that free trade in e.g. tobacco products or counterfeit medical products might provide.[301] If one may regard the EU's role in Global Health as successful, it seems logical to agree with one of the doctrines of liberal institutionalism. A "… greater emphasis on soft power and cooperation through the forms and procedures of international law […] the machinery of diplomacy" can evidentially be part of a successful foreign policy.[302]

A lot has been accomplished in recent years and agreements have been reached on quite a wide array of global health areas. This success of global health initiatives can in part be thanked to the EU's and its member states initiatives. "The EU remains proof that nation states can and in fact have shared sovereignty, not only for the collective benefit of its own exclusive club, but with benefits for global governance."[303] On a critical point, having a single voice does not always mean having an effective voice but may in some cases mean finding and expressing the "lowest common denominator".[304] Still, with the amount of leadership shown in recent years, this can lead us to conclude that in negotiations in a WHO setting the EU does indeed speak with one, sometimes powerful, voice.

[301] The True Cost of Poor Health, http://www.tcyh.org/employers/downloads/Extra_MayoCostOfHealth.pdf, accessed on 15.06.2015.
[302] Nye, J. S., & Donahue, J. D. (Eds.).(2000), *Governance in a globalizing world*, in: Devitt, R. (2011) *Liberal Instituitonalism*, p. 2.
[303] Faid, M. & Gleicher, D. (2011), 'Dancing the Tango: The Experience and Roles of the European Union in Relation to the Framework Convention on Tobacco Control', p. 2.
[304] Battams, S., van Schaik, L., & van de Pas, R. (2014), 'The EU as a Global Health Actor: Policy Coherence, Health Diplomacy and WHO Reform', p. 561.

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Appendix 1:

Number of Participants:

	FCTC			**Protocol to Eliminate Illicit Trade in Tobacco Products**			**SSFFC**	
	EU	Other Delegations		EU	Other Delegations		EU	Other Delegations
INB I.	France 13 (9 French officials, 4 Council of the EU officials), Spain 13, UK 11, European Commission 9, Finland 9, Ireland 7, Germany 6, Sweden 6, Denmark 6, Greece 6, Netherlands 6, Austria 5, Belgium 4, Italy 4, Portugal 3, Luxembourg 2	Canada 13, China 13, Turkey 12, Russia 10, Brazil: 9 delegates including the ambassador and chairperson of the meeting, United States of America 9, Malawi 8, Japan 7	INB I.	Slovenia 11, European Community 11, France 10, Romania 9, Spain 9, The Netherlands 8, Austria 7, Belgium 7, Ireland 6, Greece 6, Poland 5, Germany 4, Lithuania 4, Slovakia 4, UK 4, Malta 3, Sweden 3, Hungary 3, Denmark 3, Bulgaria 2, Finland 1, Portugal 1	China 24, Canada 10, Thailand 10, South Africa 9, India 8, Chile 7, Timor Leste 6, Brazil 6, Saudi-Arabia 6, Japan 5	MSM I.	France 2, Finland 2, The Netherlands 2, UK 2, Belgium 1, Greece 1, Ireland 1, Italy 1, Spain 1, Sweden 1, EU 1	Nigeria 11, Brazil 9, Argentina 6, United States of America 5, India 4, Indonesia 3, Russia 3
INB V.	European Commission 16, UK 15, Finland 14, Spain 13, Denmark 12 (7 Danish officials, 5 EU officials), Germany 11, France 11, Ireland 10, Netherlands 8, Sweden 8, Greece 7, Belgium 6, Austria 4, Italy 4, Portugal 3	Russia 21, China 18, Japan 18, United States of America 16, Canada 16, Mexico 10, Thailand 10, Turkey 10, Brazil 9, Indonesia9, India:8, Cuba 7	INB IV.	Spain 17, European Union 14, Romania 11, France 10, Germany 9, UK 7, Hungary 7, Greece 6, The Netherlands 6, Austria 6, Italy 5, Belgium 5, Sweden 4 (EU Presidency), Portugal 4, Slovenia 4, Finland 3, Ireland 3, Malta 3, Poland 2, Bulgaria 2, Denmark 2, Slovakia 2, Estonia 1	China 18, Nigeria 16, Thailand 15, Russia 14, Ghana 13, Brazil 11, Mexico 11, Turkey 11, Canada 10, Serbia 9, United Arab Emirates 8, Japan 7, South Africa 7, Tanzania 7, Venezuela 7, Malaysia 6, Montenegro 2, Ukraine 2, Albania 1	MSM I.	EU 4, Spain 4, Italy 3, Czech Republic 3, The Netherlands 3, Finland 2, Greece 2, Sweden, 2, Poland 2, France 1, Germany 1, Ireland 1, Austria 1, UK 1	Brazil 6, Argentina 5, India 5, USA 5, Switzerland 4, Indonesia 3, Nigeria 3, Republic of Korea 3, Monaco 2

Appendix II:

Possible negotiation strategies and mind sets according to Roger Fisher and William Ury:[305]

Soft	**Hard**	**Principle**
Parties are friends	Parties are opponents	Parties are finding solutions
Aim is to reach consensus	Aim is to win	Aim is a reasonable result achieved in an efficient and friendly manner
Make concessions in order to preserve friendship	Demand concessions as condition for a good relationship	Separate the people involved from the problem
Be soft towards people and the problem	Be hard towards people and the problem	Be soft towards the people and hard towards the problem
Trust	Distrust	Operate independently from your trust
Be flexible in changing positions	Stick to your position	Concentrate on interests not on positions
Make offers	Threaten	Explore interests
Honestly say how far you are willing to go	Mislead the other party about how far you are willing to go	Avoid having a bottom line
Accept one sided losses to reach consensus	Demand one sided advantages as a condition	Invent options for mutual gain

[305] Fisher, R., Ury, W., Patton, B. (2005), *Excellent onderhandelen – een praktische gids voor het best mogelijke resultaat in iedere onderhandeling.*

	for consensus	
Looking for the one answer – that the other is going to accept	Looking for the one answer – that you are going to accept	Develop multiple options to choose from, decide later
Look for agreement	Insist on your position	Insist on using objective criteria
Try to avoid ending up in a battle for the power of will	Seek to win that very battle	Try to reach a result based on standards independent of will.
Yield to pressure	Exercise pressure	Reason and be open to reasons; yield to principle, not pressure