

# Practitioner Interview with Preciuos Matsoso



## Preciuos Matsoso

Former Director-General of Health, South Africa and Co-Chair of the Intergovernmental Negotiating Body on the WHO Pandemic Agreement.

### Biography

Over the past two decades, Precious Matsoso has helped shape some of the most consequential negotiations in global health governance, moving between national policy leadership and multilateral diplomacy with uncommon authority. Her work has unfolded in politically sensitive and institutionally complex settings, where technical questions are inseparable from matters of power, trust, and public responsibility.

As Director-General of Health of South Africa, she led the historic expansion of the country's public-sector antiretroviral treatment programme at a critical stage of the HIV/AIDS crisis. Through regulatory reform and sustained engagement with key constituencies, she helped build one of the largest HIV treatment programmes in the world, widening access to life-saving medicines on a national scale. At the multilateral level, Ms. Matsoso has chaired and co-chaired major negotiations in global health governance, most recently playing a central role in guiding discussions toward the WHO Pandemic Agreement. In the fraught aftermath of COVID-19, she worked in a climate marked by geopolitical tension and deep institutional mistrust, helping to keep negotiations credible, focused, and politically workable. In recognition of her leadership in this field, UNITAR named her the 2025 Doha Best Negotiator of the Year.

In this interview, Ms. Matsoso reflects on what it means to lead negotiations under pressure and on the demands of building consensus in an increasingly polarized global health landscape.

*Interview conducted on 4 February 2026 by **Filippo Martini**, IGN Fellow and JGN Growth & Production Team Lead, with **Mehdi Aissaoui**, IGN Fellow and JGN Growth & Production Associate.*

**Filippo Martini:** You were recognized as the 2025 Doha Best Negotiator of the Year by UNITAR for your instrumental role in leading negotiations on the pandemic agreement. What were the main challenges you faced in coming to an agreement?

**Precious Matsoso:** We started negotiations in an already polarized and divided world. During COVID-19, some countries did not have access while others hoarded supplies, and there was misinformation in the public domain. All of that meant we had to start by building trust. That was clear from the outset, because the World Health Assembly Special Session resolution required that, before negotiations, we identify the elements that must be incorporated in the legal instrument. We couldn't simply decide what we thought was important; we had to go back to member states and hear what they believed would help them confront the next pandemic, if and when it happens.

So we had to be systematic because we couldn't just make a list and present it to member states. We reviewed the reports generated during COVID-19, including evaluations and reviews, and consolidated them. There were about 300 recommendations. The question became: how do you select from 300 recommendations? We created a digital platform and grouped themes together. We identified four key themes, which we described as strategic pillars: equity (because equity was a key concern), governance, finance, and health systems and tools. We organized the recommendations into those four themes.

Then we also needed an open-ended process where countries could submit written inputs. We received about 3,200 written submissions, which we had to synthesize. After that, there was disagreement among member states. One group liked the four strategic pillars; another group said the instrument is about pandemic prevention, prepared-

ness, and response, and it should be presented that way. So you had two schools of thought, and bringing them together was extremely difficult.

It was an absolute nightmare, because we had to produce the first working draft. We did a crosswalk between "pandemic prevention, preparedness, and response" and the four strategic pillars. The document was repetitive and duplicative, but we decided to present it that way. When we presented that first working draft, there was an uproar: "This document is a disaster." We said, precisely: it will look like a disaster because you all have different views. We wanted you to see on paper what those views look like before we put together a legal draft.

**Mehdi Aissaoui:** In that context, what was more decisive: technical expertise or political instinct?

**PM:** It was a combination. WHO has six regions, so the bureau included representation from each region. I represented the Africa region. But once we became the bureau, we served the whole world, not our regions. We were elected by our regions, but our responsibility was global. Also, in many multilateral negotiations you have the chair and maybe the vice-chair. In our case, we had a chair from developed countries and one from developing countries. That shows how polarized things were. The responsibility of these two chairs was to bring the two worlds closer, to bring the two worlds together. So it wasn't only technical expertise; it was also understanding politics with a capital "P" and politics with a small "p."

**MA:** Canadian Prime Minister Mark Carney remarked, "If we're not at the table, we're on the menu." Given your work representing African and Global South interests in global health negotiations, what more can be done to ensure global health governance is more inclusive and equitable, and when should negotiators hold firm?

**PM:** Given how things unfolded, most developing countries came with one objective in mind: ensuring that the instrument addressed equity. If a proposal did not capture inequities experienced during COVID-19, it did not receive support. To the extent that a group of countries formed what they called “like-minded countries,” and they said they were the group for equity, essentially to protect the text and ensure that it addresses equity.

**FM:** Thank you. It sounds like a structured, capacity-building process, with technology as a tool but not the driver. And it also seems you took stakeholder views seriously. Is that a fair reading?

**PM:** Yes, of course we had to. What was complex about these negotiations is that in the room you had lawyers, public health specialists, scientists, trade experts, and diplomats. When someone speaks, it depends on who is listening, and sometimes they talk past each other. It was our duty, as the bureau, to bring them back into alignment.

Another unique difficulty was that every time we had discussions, the bureau produced a revised text. That changed the dynamics, because member states ended up negotiating with the bureau. We told them, “We’re here to facilitate.” But they replied, “You produce the text, so you have to defend it and explain why.” We would respond, “We incorporated your comments, and we hoped that would make you happy.” But in some instances, I had to remind them, “You are not here to negotiate with us as the bureau; you must negotiate among yourselves.”

The most intriguing thing is what happened after the zero draft. Countries made on-screen textual amendments with attribution. We started with a 42-page document and it grew to a 208-page document because we had to incorporate all comments. They did not want those attributed amendments to be made pub-

lic, and they did not want them shared. We had to say, “We cannot work on the basis of hundreds of attributed amendments across multiple versions. It’s not sustainable.” So we produced revised drafts. But with each draft, one group would be satisfied, and another would not. I used to tell them, “The only time I’ll know we’re on the right track is when you’re either all unhappy, or all happy.”

**MA:** In recent years, major powers have adopted more nationalist stances, and some even withdrew from WHO. From your perspective, how has this rise in nationalism affected global health diplomacy and international cooperation, and where do we go from here?

**PM:** For me, it feels like *déjà vu*. When we worked on access to medicines, particularly HIV medicines and antiretrovirals, they were unaffordable. There were debates about the TRIPS Agreement and the Doha Declaration, and there were bilateral free trade agreements. So, I’m saying this isn’t new. The difference now is that it’s happening at a time when there are also tariffs and broader trade issues. Back then, it was more narrowly about TRIPS.

Countries debated whether to include “TRIPS-plus” provisions in free trade agreements, meaning provisions that went beyond TRIPS. Many countries could not afford the high prices of antiretrovirals, so we had to find ways to support them. South Africa has a very high burden of HIV, and we had to find a way forward. We went to court and negotiated a settlement. That’s where some of my negotiation skills came from. It helped us scale treatment, and today close to 7 million people are on treatment. There are benefits to staying at the table and finding solutions.

With today’s developments, I hope there is still an opportunity for countries to sit around the table, because administrations change and new administrations bring new priorities. However, this pan-

demic agreement will go beyond multiple administrations. Countries under pressure now don't have to block the process of negotiating the annex, but ratification will depend on their parliaments and political environments. Treaty-making takes time. We hope that by the time countries begin ratifying, and as the agreement moves toward entry into force, the current geopolitical turbulence will have eased.

**FM:** You've already touched on what drew you into negotiation. How did you first become involved in multilateral governance and negotiation?

**PM:** It began with access to antiretrovirals in South Africa. Beyond that, I had opportunities to chair multiple negotiations and high-level meetings. One was in Botswana, during the Bush era, when there were debates about why the U.S. was establishing a parallel process when we had the Global Fund, around the creation of PEPFAR. I was chairing, and civil society and the U.S. government were fighting in the room. I said, "I'm going to kick all of you out of this room, because this meeting is about HIV/AIDS. The highest burden is in Southern Africa. Anyone who wants to help us deal with this burden should sit down and look for solutions. If you want politics, go and join those who are politicking, we want to solve the problem because people are dying. If you want to join hands with us, by all means. If not, out." I was very firm, but we reached a positive outcome. After that, I chaired negotiations to establish the WHO Health Emergencies Programme, post-Ebola. It was difficult. We negotiated through the night for two days. On the first day we finished at about 9 p.m.; on the second day at about 6 a.m. I said, "Go and freshen up." When they left at 6 a.m., we were down to one sentence; everything else had been agreed. That's part of my journey. I've had opportunities to chair multiple negotiations and high-level meetings from that background.

**FM:** Do these multilateral negotiations differ from negotiations at the national level?

**PM:** At national level, I was Director-General of Health in South Africa, and we went to parliament almost weekly. The administrative offices are in Pretoria, but parliament is in Cape Town, a two-hour flight, so I flew twice a week to confront parliament. In legislative drafting, political parties rarely agree. Because you introduce the law, you have to defend it, "sell" it, and get them to support the legislation. It's a different set of skills. Sometimes you face people with limited technical understanding who speak politically. You have to maintain your cool, be patient, and help them understand. In both multilateral and national settings, there is one key ingredient: patience. You must be patient.

**MA:** A former UN Special Rapporteur on the right to education, Katarina Tomasevski, said that human rights should be budgeted, not just advocated. What's your view?

**PM:** I couldn't agree more. When budgets are presented in parliament, civil society should have an opportunity to engage, because they are on the ground. They see the problems, and they must be able to say, "With this budget, you'll never solve what you want to solve." You need to hear voices that are closest to the problem. In South Africa, our constitution includes the right to health and other socioeconomic rights. But it's not enough to have words in the constitution; it has to be translated into action. At provincial level there must be hearings so people can ask, "With this budget, over what period are you going to implement this?" That's how bureaucrats and politicians are held to account.

**FM:** During your time at the National Department of Health, you led the rollout of HIV treatment in South Africa. What were the critical moments that enabled the expansion of treatment?

**PM:** We started from an era of denialism. One administration did not believe we should have antiretrovirals. The next administration was willing to introduce them in the public health system. But we had to do it in partnership. We involved different stakeholders and established a council, now called the South African National AIDS Council, chaired at high political level, by the Deputy President. We sat together and asked, “What do research institutions tell us? How can the private sector help make medicines affordable? How do we use infrastructure so people don’t have to travel long distances to get their medicines? What do health professionals need?”

Doctors prescribe. We told them, “For us to deal with this, we have to train nurses to prescribe”. We negotiated with doctors asking that they could supervise, but to let nurses do the work. It was well received. We trained nurses, rolled it out, and we brought in labor unions to address workplace needs. It was a very inclusive process, and that’s one reason it became one of the successful programs in the country.

**FM:** How do pharmaceutical and health-tech companies shape the regulatory landscape in Africa?

**PM:** When I said “private sector,” it was broader than pharmaceutical companies. It included mining and logistics, because there is cross-border movement, and HIV is linked to mobility. We brought employers in and said: your employees need to be tested and treated, including in transport and trucking. Pharmaceutical companies were part of it too. We told them they needed to keep prices low so we could treat as many people as possible.

**FM:** What strategy worked best in engaging these actors?

**PM:** Dialogue. We had regular meetings. For example, if civil society marched because cancer medicines weren’t affordable, I would call industry and say, “Let’s

meet, can we find a solution?” You have to build trust; it doesn’t happen on its own. Civil society includes activists and patient groups. Patient groups may work closely with industry, but activists may not. When elephants fight, the grass suffers. Here, patients suffer. So, we find a way toward a lasting solution. Managing diverse groups helps, because you learn different dynamics as you engage different stakeholders.

**FM:** You’ve emphasized dialogue, and listening. They are simple concepts, but not easy to practice.

**PM:** You have to listen, and you don’t have to be defensive. When you’re Director-General, not everything works. You may hear that somewhere in a clinic people are unhappy. You have to listen. People appreciate when they feel heard. You don’t go there with ready-made solutions; you listen, and based on that, you find a way to meet them halfway. You may not have all the answers but demonstrate that you are listening and trying to solve problems.

I saw this in the pandemic agreement negotiations: even if member states repeat themselves, you sit there and listen. Once, an EU member spoke and then another raised the flag to repeat the same point. I said, “You’re not going to repeat what your colleague said. We’ve listened. We need to give others a chance.” They were very angry. Many came at me. I said, “This is bullying. I’m chairing, and I will give each one a chance, but I won’t allow one group to dominate.”

**MA:** How do you hold that line under pressure, where ethics, economy, and politics collide? What’s your philosophy?

**PM:** Sometimes I just have to pray and say, “Oh my God, please help me, there’s trouble.” But staying calm helps. Being calm and patient helps a lot. One time Egypt was out of line and I said, “I’m going to use my prerogative as chair and

I'll kick you out of this meeting." They were not used to that. Another day there was a fight. Countries were arguing, others joined in, and I hit the table and said, "I'm not going to allow my meeting to deteriorate and stoop to this level, not when I'm chairing." It went silent. I said, "Let's take a break. Go and get some fresh air. When you come back, maybe you'll be much better." And sometimes I sing. Sometimes I read a poem and say, "I wrote a poem for you, just as a reminder." I use different skills. I use everything to try and get people to move together.

**MA:** Would you say it all boils down to misunderstanding?

**PM:** Some issues are ideological; others are entrenched views; some are mistrust. There was a trust deficit from the beginning. What I found interesting is that when we had informal sessions, when countries met by themselves, they were relaxed and spoke to each other nicely. At one stage we had disagreement about language in an article. I asked the U.S. and Russia to go out and propose a text. They came back with a proposal they both agreed on. I said, "Let's give them a standing ovation." One would not have thought the U.S. and Russia could do that, but I pushed them.

**MA:** Looking ahead, are you optimistic about the future of international cooperation in health, with initiatives like the pandemic agreement now in place? What gives you hope for global health diplomacy, and what challenges will the next generation need to address?

**PM:** On hope for cooperation: South Africa recently presided over the G20, and I chaired negotiations in the health working group on a declaration. Initially there was one country, Argentina, that did not want SDGs, WHO, the pandemic agreement, climate change, and other items in the text. They wanted a lot removed. Other countries did not agree. The U.S.

did not attend the meetings; they came right at the end, when we had almost finished. I managed to move the text through the stages, through what we call "yellowed" and then "greened."

When the U.S. came, they wanted the declaration to focus on one topic only, NCDs - Noncommunicable diseases - and delete everything else. What was interesting is that the other G20 members objected. That gave me hope: even if the U.S. is not in the room or does not agree, the other members can still cooperate. Saudi Arabia was not happy with climate change; we found language to accommodate them, using "climate change" and "adverse weather conditions" interchangeably. Italy also had concerns; we found a way to accommodate them. In the end, the U.S. did not want the whole document, and Argentina did not want certain items. We said: "Fine. The agreement is 18 minus 2." That's how we presented it, and we released the green text. When I look at how countries conducted themselves, it gave me hope that cooperation is possible despite geopolitical shifts.

For the next generation, I recently returned from Thailand for the Prince Mahidol Award Conference, where we discussed aging and the global burden of disease. In Africa, there is a youth bulge, while life expectancy is increasing, so you will have both dynamics at once. In other regions, fertility rates are dropping and populations are declining. We must take advantage of the demographic dividend by investing in youth and making our countries work. Health systems matter, but unemployment and poverty are larger socioeconomic problems that health alone cannot solve. Health can contribute and serve as a safety net where other sectors fail, but it cannot solve everything through a health lens.

The policies we make today are for future generations. It's better if they are at the table and part of policy-making. I still

maintain that people like us should step back a little, provide guidance and advice, and let the younger generation take leadership. And we should allow them to make mistakes and then catch them and support them.

**FM:** With your long-term perspective on how to engage the next generation, we come to the end of our dialogue. Thank you for your time and the generous contribution in this interview.