Global Health Diplomacy in East, Central and Southern Africa

REPORT OF A REGIONAL MEETING

April 8-9 2016
Nairobi, Kenya

East, Central And Southern African Health Community (ECSA HC)
with
Regional Network for Equity in Health in East and Southern Africa (EQUINET)

Contents

1. Background and objectives

Since 2010, the East, Central And Southern African Health Community (ECSA HC) has convened several regional meetings on global health diplomacy and from 2011 the organisation has, together with Regional Network for Equity in Health in East and Southern Africa (EQUINET) and the University of Nairobi implemented work to strengthen regional evidence, capacities and policy dialogue in global health negotiations and engagement, under the Strategic Initiative on Global Health Diplomacy (GHD). EQUINET, as a consortium network of organisations based in the region has for several decades built research capacities and evidence at country and regional level on global health issues relevant to health equity in the region and through SEATINI and TARSC leads the research and information component within the ECSA HC strategic initiative. This 2016 regional meeting was convened by ECSA HC with EQUINET in line with HMC Resolution – ECSAHMC50/R2 to prepare and discuss issues on the 69th World Health Assembly (WHA) Agenda and Regional GHD work.

The objectives of the meeting were to
1. Update participants from ECSA-HC member states on Global Health Diplomacy (GHD) and its health impact.
2. Share information and discuss, from a GHD perspective, selected WHA agenda items and related issues from other key global health platforms.
3. Present and discuss research findings, recommendations on effective engagement on GHD and proposals for future work.
4. Discuss proposals for strengthened regional co-ordination and communication on GHD and a framework for monitoring progress

The full programme is shown in *Appendix 1.* Delegates were provided with specific background materials for sessions on a flash drive, and through distributed publications.

The meeting included senior officials delegated or responsible for health diplomacy from ECSA HC member states and South Africa, diplomats from the Africa group from ECSA HC member states, technical personnel from EQUINET and other institutions, including regional organisations and partners. The delegate list is shown in *Appendix 2.*

2. Opening

The opening was chaired by *Dr Samuel Vusi Magagula - Director of Health Services, Ministry of Health, Kingdom of Swaziland.* Swaziland is the current chair of the Regional Health Ministers in the ECSA HC. He welcomed the Director of Medical Services, Ministry of Health Kenya, Dr J. Kioko, IDRC Regional Director, Dr S Carter, all delegates, partners and sister organizations to the meeting. He further welcomed the representatives of the West African Health Organisation (WAHO) and diplomats from the Africa Group in Geneva, noting that their presence was a vital contribution given the discussion of issues for the forthcoming 69th World Health Assembly (WHA). He reiterated the objectives of the meeting (noted above). Dr Magagula observed that GHD has been high on the agenda of political leadership in ECSA HC, with resolutions passed at the Regional Health Ministers Conference (RHMC) in 2010 and 2012 to develop an initiative and capacities for GHD. This is now even more important given the Sustainable Development Goals and demands in the global health agenda to strengthen health systems and reduce the inequalities that exist between countries in health and its determinants. He noted that following the HMC resolutions and the ECSA HC strategic initiative on GHD, there has been a marked improvement in representation and voice at WHA that needs to be sustained, both through prior training of officials and students and through preparatory meetings such as this one. Finally he noted that research and the generation of evidence in partnership with research institutions is a key resource for informing the region's positions and encouraged further research to enable the region to engage more effectively in setting the global health agenda.

Mr Ernest Manyawu, Director of Operations and Institutional Development, ECSA HC, welcomed the delegates on behalf of the ECSA HC and presented the apologies from the ECSA HC Director General, Professor Yoswa Dambisya, who was unable to attend due to unavoidable circumstances. Mr Manyawu referred to the 2010 and 2012 Health Ministers resolutions that proposed the work to create sustainable institutional arrangements, capacities, research and advocacy in the region to participate effectively in international negotiations that affect public health. Mr Manyawu outlined ECSA's achievements to date, in terms of the Ministerial seminars, an Executive course on GHD for senior officials with Africa University (Zimbabwe), University of Nairobi and EQUINET that has exposed about 250 officials, the pre-WHA preparatory meetings, with the agendas drawn from embassies and capitals, a

Meeting delegates at the opening session

proposed MSc. Programme in the University of Nairobi, production of a directory of GHD capacities in the region; a research programme in EQUINET and production and dissemination of policy briefs supporting this work with EQUINET. He appreciated the support the programme has received, while noting that more needs to be done to ensure sustainability of the programme, especially to meet the demand from within the region. An evaluation implemented in 2013 found increased participation by ECSA HC member states at WHA and other global meetings, but this work generated a continued demand to widen capacities and awareness, including within young leaders and students. Mr Manyawu noted the importance for the GHD programme of links across many sectors, between capitals and embassies, and with different institutions and partners in the region. He noted that ECSA HC plans to convene more annual meetings such as this third pre-WHA meeting. He observed that globalisation, climate change, pandemics such as SARs, H1N1 and Ebola, trade agreements and other global processes are impacting on health and health systems in the region, generating a demand for global health engagement. He outlined the definition and role of GHD in this, noting that it calls not only for ministries of health to engage on global health issues, but to also engage within countries with other sectors affecting health, to make health an issue for all policies. Mr Manyawu concluded that advancing health will, in addition to the capacity to provide clinical services and organise public health, depend on success within GHD. Finally, he highlighted the objectives of the meeting (noted earlier).

Ms. Paidamoyo Takaenzana, Counsellor at the Zimbabwe Mission and immediate past Coordinator of the Africa Group in Geneva shared greetings from the Africa Group, currently co-ordinated by Algeria. She welcomed the meeting, ECSA HC's role in capacity building and the sharing of research by EQUINET. She suggested the programme be expanded to include the West Africa/francophone region. She noted the expanding agenda and many issues still being discussed between the Executive Board (EB) meeting chaired by South Africa and the WHA. She outlined the various preparatory meetings being held, including, an expert meeting organized by WHO, a meeting of the

WHO AFRO Regional Director and Ministers of Health on 21st May and a meeting of the AU commission on AU documents, such as the Africa Health Strategy and the Maputo Plan of Action. The 69th WHA agenda was also noted to have an unprecedented numbers of resolutions and global strategies under the theme of: 'Transforming our world, implementation of the 2030 Agenda for sustainable development'. She noted that while the two days for this regional meeting was short, it was a valuable opportunity for African countries and hoped that it would be held in an expanded form in the future.

Dr Simon Carter, Regional director, IDRC-Nairobi welcomed delegates and expressed his pleasure in IDRC participation in the meeting. He noted that IDRC has a vision of healthier lives, cleaner environments, higher incomes, and responsible and accountable governments. IDRC's strategic plan for 2015-2020 focuses on three areas: Ensuring that research has more impact and better returns; building leadership in researchers, and building partnerships towards achieving public interest goals. He appreciated the opportunity for IDRC to understand better the needs and interactions on GHD and recognised its importance for ECSA HC and EQUINET to bring evidence to the table to inform global health negotiations. He noted that IDRC has had a longstanding research relationship with EQUINET and is working with ECSA HC in Canada's effort to support maternal & child health in Africa, including through strengthened human resources for health. In conclusion he wished delegates an engaging and productive meeting.

Dr Jackson Kioko, Director of Medical Services, Ministry of Health Kenya, officially opened the meeting and welcomed all the participants on behalf of the Government of Kenya and the Ministry of Health. He conveyed greetings from the Principal Secretary, and Cabinet Secretary in the Ministry of Health, Dr Kioko acknowledged the importance of the meeting as a preparatory platform for the WHA, the first assembly since the adoption of the SDGs in 2015. This has raised expectations on what will be achieved in Geneva on the global health landscape, both to sustain the momentum generated by the Millennium Development Goals (MDGs) and to address the new agendas in the SDGs, including SDG 3 on health and wellbeing for all. He observed that SDG3 includes commitments to end epidemics of HIV/AIDs, Malaria, TB and other communicable diseases by 2030, to achieve Universal Health Coverage (UHC), and provide safe and effective medicines and vaccines. This calls for research, including on the development of vaccines and access to medicines, and in strengthening integrated approaches. Dr Kioko pointed to other drivers of research, including a decline in external funding leading to inquiry on innovative financing for health, the emerging burden of non- communicable diseases (NCDs) and the responses to public health risks and cross border epidemics such as Ebola. He observed that on 7th April, Kenya, celebrated World Health Day with a focus on diabetes, noting that NCDs are reaching alarming levels in the region and demand policies, plans, capacities and resources for an effective response. In conclusion Dr Kioko, reaffirmed Kenya's commitment to further advance and strengthen regional cooperation in health. He wished the participants fruitful discussions and looked forward to receiving the recommendations. With that he officially opened the meeting.

3.   The World Health Assembly as a forum for GHD

Dr Neema Rusibamayila, Director Preventive services, Ministry of Health Tanzania chaired the session.

Dr. Emmanuel M. Makasa, Counsellor-Health, Permanent Mission of the Republic of Zambia to United Nations, Geneva presented an overview of the 69th WHA and its processes, theme and agenda. In relation to the SDGs, he noted that indicators are being developed but that Africa has resolutions and targets and needs to focus on its priorities. He observed that the WHA is the top level summit for the WHO. It provides a unique opportunity for engagement, although this should start early, well before the summits. The opportunities for engagement are both bilateral, directly between member states and other agencies, and multilateral in the WHA plenaries, committee A & B sessions, side events on specific issues and technical briefings. He further noted that the

Africa group holds morning co-ordination meetings at 8am every morning during the Assembly on African positions on issues tabled that day, and that delegates should also be prepared to engage in drafting sessions that take place at all times of day and evening, where the texts that will appear in the official document is drafted before it comes to the general membership for adoption. He noted that the latter was a key process for African engagement. Dr Makasa observed that the Africa group has two social media platforms supporting these processes (for the diplomats and the Ministers and teams) that enable more rapid internal communication on issues. Dr Makasa outlined the issues being tabled at the 69th WHA. This report captures selected issues and the full set of agenda items he raised is found at http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_1-en.pdf). In Committee A he drew attention, for example, to the WHO reforms;   including on governance, on the Framework of Engagement with Non State Actors (FENSA); to the discussion on NCDs in preparation for the 3rd high-level UNGAS meeting in 2018; the synergies between WHA and COP (the forum for the WHO Framework Convention on Tobacco Control), on the implementation of the International Health Regulations (IHR) and emergency responses and on the public health dimensions of the world drug problem that will be input into an UNGASS high level meeting in Sept 2016. He observed that the WHA will review the achievements of the MDGs and discuss Health in the 2030 agenda for SGD, together with specific areas of attention on maternal, child and adolescent health, healthy ageing, environmental health and strategies and resolutions for specific problems, such as HIV, viral hepatitis, STIs and mycetoma. He noted that some technical issues were now also being discussed in committee B, such as the draft strategy on the health workforce 2030; or the framework on integrated people-centred health services.

Dr Makasa noted the need for an African lens on these issues, such as ensuring that the draft Action Plan 67.15 on violence against women and girls includes issues such as the protection of adolescent girls, or the need to raise attention to capacities and resources for health technology development and access to medicines in discussions on medicines, services and health systems. He noted that administrative matters in Committee B are equally important, as they affect the functioning of the organisation, particularly given the limited number of African personnel at senior level. He particularly noted the need for active engagement by delegates on Action Plans, as these affect implementation of commitments. He observed that some reports may not be reviewed by the Executive Board (EB) and may go straight to WHA, giving countries less opportunity to scrutinize, digest and influence them at an early stage. Finally, Dr Makasa raised that the process for election of a new Director General (DG) has commenced and will continue into 2017. He commented that Africa needs to play a united and effective role in the selection of the future DG, given the large share of public health issues from Africa.

4.   Issues on the World Health Assembly agenda

4.1   International Health Regulations and emergency responses
Dr Isabel Ayagah, Deputy/ International Health Relations Dept, Ministry of Health, Kenya gave a general background introduction on GHD and then focused on the implementation of the IHR and emergency responses. The IHR emerges from over 200 years of history, with new trade patterns in 1830 allowing cholera to spread from South Asia to Europe and North America. In 1851 France convened the first International Sanitary Conference to set agreements to harmonise quarantine regulations for cholera, plague and yellow fever, and in 1892 the first International Sanitary Convention was passed. Several further instruments were passed over time and in 1951, the WHA consolidated them into a single instrument, the International Sanitary Regulations covering plague, cholera, yellow fever, smallpox, typhus and relapsing fever.

This instrument was used in the 2009 Pandemic H1N1 influenza; in the 2012 Middle East Respiratory Syndrome (MERS) epidemic; the 2013 H7N9 influenza outbreak and the 2014 Ebola outbreak in West Africa. In 2014 there was an amendment of IHR on yellow fever. She noted that it is evident that new epidemic challenges are motivating review of the IHR and the capacities to implement them, particularly as public health risks are more rapidly spreading across borders with the increased movement of goods and people associated with globalization.

Dr Ayagah noted that the IHR 2005 IHR 2005 has a comprehensive definition of public health emergencies; an international coordination response to emergencies; state provisions for decision making to assess events; and legally binding language on state duties to develop, strengthen, and maintain the capacities to implement them. After 2007 countries were tasked to assess national structures, resources and capacities to implement the IHR and to put in national plans of action to improve them. In 2014 countries that had not yet achieved the core capacities were given an extension to 2016. However she noted that so far no African country has met the implementation of IHR core capacities.

In a later session *Mr Rangarirai Machemedze SEATINI/EQUINET* presented the scores in African countries in 2015 in relation to their core IHR capacities, shown in the table below

African and global capacity scores, WHO national capacity monitoring framework, 2015

Total Responses Globally = 160 Total Responses for Africa = 31 Capacities in place	Average Capacity score for African Countries (2012)	Average Capacity score for African Countries	% of countries with a score <75%, Africa	Global Average Capacity Score
Legislation	28	60	53%	77
Coordination	46	67	32%	79
Surveillance	64	77	71%	84
Response	52	72	48%	82
Preparedness	35	53	29%	70
Risk Communications	43	61	32%	75
Human Resource	27	56	35%	62
Laboratory	63	73	58%	81
Points of Entry	32	35	13%	61
Zoonotic	60	68	55%	85
Food Safety	42	43	13%	75
Chemical	18	28	10%	56
Radiation	25	36	13%	59

It shows that there has been some progress in African countries in building core capacities to implement the IHR, especially in surveillance of infectious diseases, but less progress in capacities to manage other public health risks.

Source SEATINI, TARSC 2016 EQUINET policy brief

She noted that despite the IHR being legally binding, there are no mechanisms to enforce accountability on weaknesses as the IHR lacks provisions for enforcement, beyond a dispute resolution mechanism for questions concerning its interpretation or application. The WHO role is limited to coordination and it cannot act in the absence of state action. The WHO can only issue recommendations for states to adopt, but cannot enforce these (such as the recommendation not to close borders during the Ebola epidemic that was not followed by many). She suggested that regional blocks have more success in obtaining changes in state practices. With some learning from the experience of Ebola, the DG established a Committee to assess the effectiveness of the IHR 2005, its implementation and to recommend improvements. The review committee proposed recommendations to ensure IHR implementation to: i. implement rather than amend the

IHR; ii. develop a 10-year Global Strategic Plan; iii. finance IHR implementation; iv. raise awareness of the IHR; v. introduce and promote independent assessment of IHR core capacities and vi. improve WHO's risk assessment and risk communication, including through a standing advisory committee and an intermediate level of alert. Section 2 focused on improving delivery of the IHR through IHR national focal points; support to the most vulnerable countries; boosting IHR core capacities within health systems strengthening; improving rapid sharing of public health and scientific information and data, and strengthening WHO capacity to implement the IHR. These recommendations will be discussed at the 2016 WHA, together with a new self-administered assessment tool and a proposal for independent (external) assessment. She noted that in member state feedback to date there were concerns that reporting be simplified and practical for use nationally; that external evaluation raises concerns on national authority / sovereignty, amongst other issues.

The presentation and proposals being tabled at the WHA were discussed by delegates working group 1, and their recommendations are reported in section 6.1.

4.2   Medicine access, R&D and antimicrobial resistance

*Mr Rangarirai Machemedze, Programme co-ordinator, SEATINI/ EQUINET r*eported on research implemented by EQUINET in 2012-5 on local medicine production in ESA countries. He noted that while there is generally a policy commitment for local production of medicines, the research identified numerous barriers, summarised in the figure adjacent. These call for input from many sectors beyond health, including sectors involved in research and development (R & D); intellectual property (IP), trade and commerce, tax and tariff policies; medicine regulations, finance, raw materials procurements and training of skilled personnel.
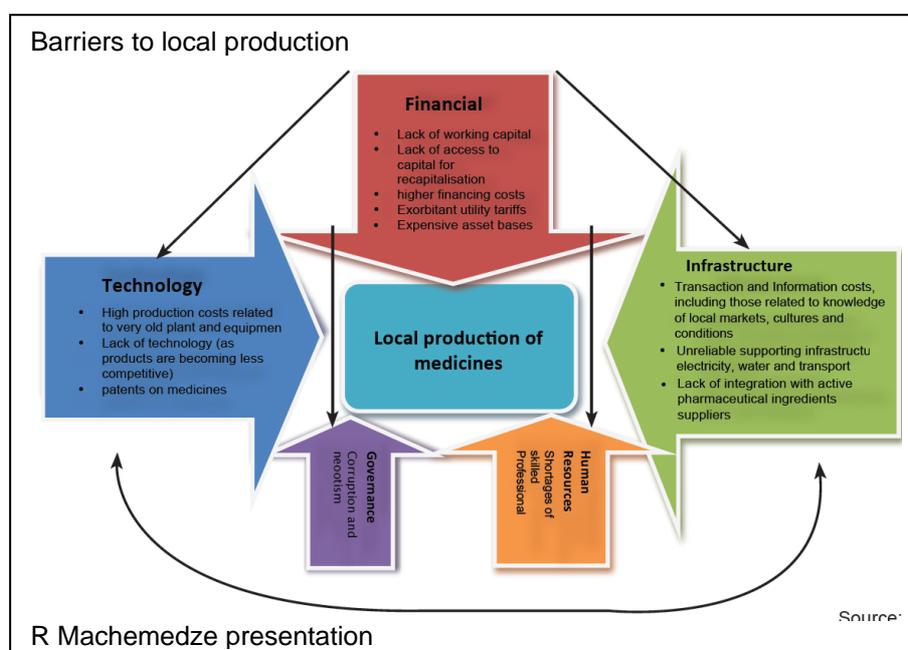
He observed that many of the issues relating to medicines on the WHA agenda are linked, viz of counterfeit and substandard medicines; IP, R & D, and the costs of new medicines. He called for follow up on the recommendations of the WHO Consultative Working Group on R&D Finance and Coordination, including to have a binding treaty on R &D, as a basis for more sustainable funding. He drew attention to the 2012 the framework adopted on pandemic influenza preparedness in relation to the sharing of benefits and indicated that member states need to go back and see if the partnership agreements and other arrangements to ensure this are indeed working.

He observed that antimicrobial resistance (AMR) is on the current WHA agenda, briefly outlining its prevalence, modes of spread, as shown in the figure overleaf, and consequences in terms of increased mortality and costs and longer hospital stays. He noted that over the counter sale of antibiotics and non-compliance with treatment guidelines may be contributing to the spread of AMR, but that its exact scale and determinants are not well known in ESA countries due to inadequate data and

surveillance. What data is available suggests that ESA countries are facing the same increasing resistance to medicines for common conditions found in other countries.

Examples of how antibiotic resistance spreads

From R Machemedze presentation, Source: US CDC 2013
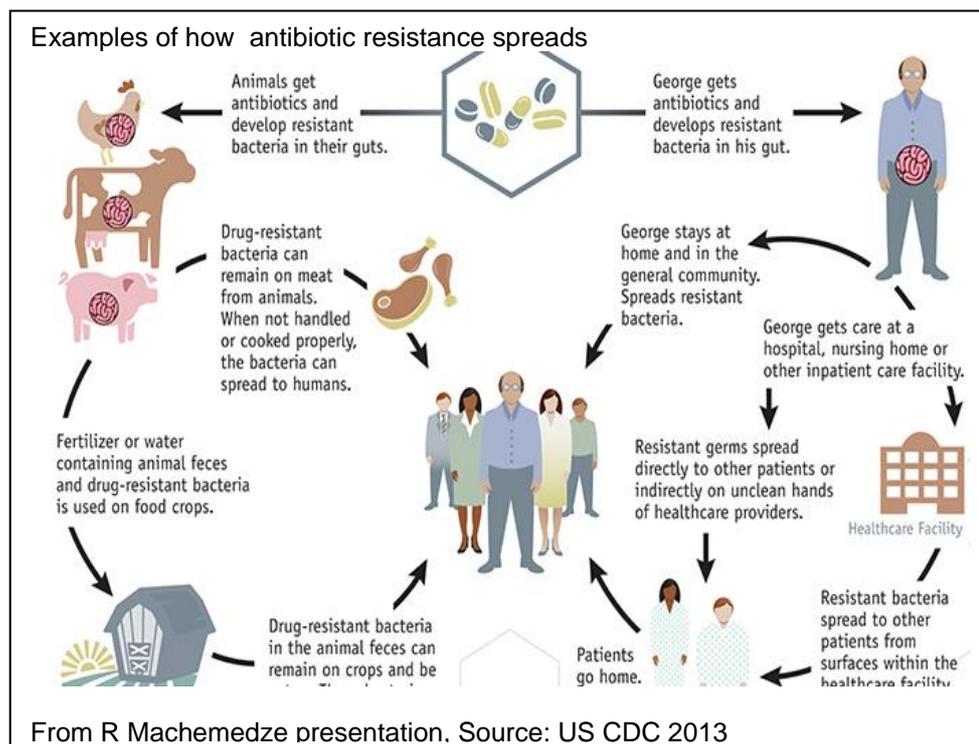
The 68th WHA adopted a global action plan on AMR (resolution WHA68.7) covering improved awareness; surveillance and research; reduced incidence of infection and optimising use of antimicrobial agents; and investment in countering AMR. By 2017 countries should have developed national plans and actions on AMR. Mr Machemedze suggested therefore that ESA countries need to develop a comprehensive policy and plan of action on AMR, linking this to other issues such as access to medicines and control of substandard medicines, integrating it in health systems strengthening, and the implementation of the 8 core capacities of IHR 2005, and noting the implications for R&D and technology transfer. He reminded again that health sectors cannot address this alone. The viability and accessibility of local markets, political and policy stability, regulation, skilled workers, capital markets needed for an integrated approach means that health ministries need to co-ordinate with other sectors on these strategies.

Delegate discussion and recommendations in the working group on AMR and medicines issues are reported in *Section 6.2.*

4.3   Health in the 2030 Agenda for sustainable development
Dr Isabel Ayagah, Deputy/ International Health Relations Dept, Ministry of Health, Kenya chaired the session.

Dr Catherine Sanga, Counsellor, United Republic of Tanzania Mission to the UN examined the introduction and elements of the health related SDGs, and the issues of concern and the way forward on the proposals for the WHA on Health in the 2030 Agenda. She gave a background to the 17 goals and 169 targets in the SDGs adopted in 2015, aiming to cover economic, social and environmental dimensions of sustainable development in an integrated manner, with attention to equity and to completing the unfinished MDG agenda. She observed that all the SDGs relate to or contribute to health, although there is one Health goal, SDG3, with 13 targets. Most of these build on the MDGs with new areas of NCDs and achievement of universal health coverage (UHC).
In the ESA region, UHC has been on the agenda for some time through the primary health care (PHC) approach. There is, however, some concern on how the terms are

being understood, with different interpretations of UHC, raising a need for these terms used in global agendas, and others such as health systems strengthening, to be clearly defined from the regional perspective. Not having this can lead to agreements being reinterpreted beyond their original intention. She noted that such debates call for a WHO that is independent of private interests and a secretariat that is guided by technical evidence and not interests of particular member states. She further noted the difficulty that is likely to arise in measuring progress on targets, due to countries having diverse priorities, definitions, was of measuring progress and differing information systems and capacities, especially if issues such as equity are to be properly assessed. This was already an issue with the MDGs and is likely to be even more of an issue with the SDGs.

Dr Sanga drew delegates' attention to the report of the WHO Secretariat on the role of health sector and WHO in implementing the SDGs. WHO will take a leading role in supporting countries to set their own national targets and strategies, to define research priorities, to monitor progress in achieving the health-related SDGs, and will also advise on best-buy interventions. She informed the meeting that two resolutions were proposed for adoption under this agenda item – on Strengthening essential public health functions in support of the achievement of universal health coverage and on Health in the 2030 Agenda for Sustainable Development, still under negotiation. She urged delegates to read the SDG 2030 document (in the background materials provided) and to discuss the draft resolutions and be prepared to participate in the working sessions during 2016 WHA to finalize them. She recommended that the working group review the draft to make recommendations (as reported in the working group reports, see *Section 6.3*).

4.4   Integrated people centred health services
Dr Rene Loewenson, Director, Training and Research Support Centre/ EQUINET reviewed WHA Committee B Agenda Item 16.1 on Integrated People Centered Health Services (IPCHS) for the implications for health system strengthening in ESA countries.
She noted the WHO EB report and the resolution in this area, provided to delegates, and also the related policy documents from the region, particularly the Regional Committee for Africa resolution AFR/RC62/R3 and resolution CD49.R22 on integrated health service delivery based on primary health care, the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems by Member states of the WHO African Region; the Framework on Primary Health Care and Health Systems in Africa adopted by member states at the WHO African Region 59th Regional Committee meeting in 2009; and the AU agenda 2063. She noted that these provide a point of reference against which to assess the WHO global proposals from an African lens. She indicated that this is important as the high share of the global disease burden disease burden in Africa indicates that for a document to pass the global test it has to pass the Africa test!

The WHO report on IPCHS refers to numerous drivers for the approach, including an ageing population; innovation in health technology; climate change; globalization; rising costs of healthcare; NCDs; social literacy; and urbanization. In the Africa region there are slightly different contexts, such as of still highly youthful populations; of a need to protect biodiversity and ensure access to health technology; and of natural disasters, water and food security and trade in harmful goods raising health burdens. A double disease burden calls for integration of responses to both communicable diseases and NCDs, learning lessons from HIV. At the same time she indicated there are poor communities in high income countries that may experience some of these conditions. She outlined the vision of the IPCHS ("a future in which all people have access to health services that is provided in such a way that responds to their preferences, are coordinated around their life course needs and are safe, effective, timely, efficient and of acceptable quality") and the key features of the framework for IPCHS, noting its intersecting domains and its five strategic directions of empowering & engaging people; strengthening governance and accountability; reorienting the model of health care; co-ordinating services, within an enabling environment. This appears to be a more narrow vision than that of PHC that addresses the determinants of health equity, including the political action and power

relations. She observed that the African documents cited include health as a social right, demanding stewardship of the resources and ecosystems that make us healthy.

Analyzing these differences she concluded that the PHC agenda, as developed in the African documents, is a broader agenda, so that the IPCHS can only be viewed as a subset of PHC from this lens.

This is reflected also in the strategies. The Framework on Primary Health Care and Health Systems in Africa (which is not referred to at all in the IPCHS document) raises key areas shown adjacent. The language is somewhat different, referring specifically to public health leadership, to community ownership rather than simply community participation, and raising health technologies as a key strategic area (such as pharmaceutical, diagnostic, IT and procurement capacities, indigenous resources, biodiversity, IP), rather than the much lower

Key areas of the African Framework on PHC and Health Systems in Africa

WHO Afro Regional Committee 2009 in R Loewenson presentation

profile given to it in the IPCHS. She noted that the IPCHS places attention on process aspects of systems, while the African documents also give focus to the deficits in basic infrastructure, and on integrating responses to communicable diseases and NCDs.

In conclusion Dr Loewenson summarized that IPCHS contributes to but is not a substitute for comprehensive PHC. She noted that the African framework is a rather concrete, systematic document that provides a basis for further discussion on what we mean by health system strengthening, including to update it for new system challenges relating to NCDs, drawing from the IPCHS, but also from learning within the region. She urged for follow up to these African frameworks, to update, review their implementation and use them, given that there is still space for Africa to be more assertive about what it means by health system strengthening.

Delegate discussion and recommendations in the working group on health in the 2030 agenda and the IPCHS are reported in *Section 6.3.*

4.5   WHO Reform and Framework of Engagement with Non State Actors (FENSA)

Dr. Emmanuel M. Makasa, Counsellor-Health, Permanent Mission of the Republic of Zambia to United Nation and *Ms. Paidamoyo S Takaenzana, Counsellor, Zimbabwe Mission in Geneva* reported on the developments on the WHO reforms and the FENSA.

Dr Makasa pointed out that the reform process was wide and had started a long time back, referring to a video that explains the reforms in an accessible manner at https://www.youtube.com/watch?v=2MCi1tArm-s#action=share.   He noted that the challenges experienced during the Ebola outbreak have exposed WHOs weaknesses in its effectiveness on the ground and at country level. The reform process is categorised within four areas:
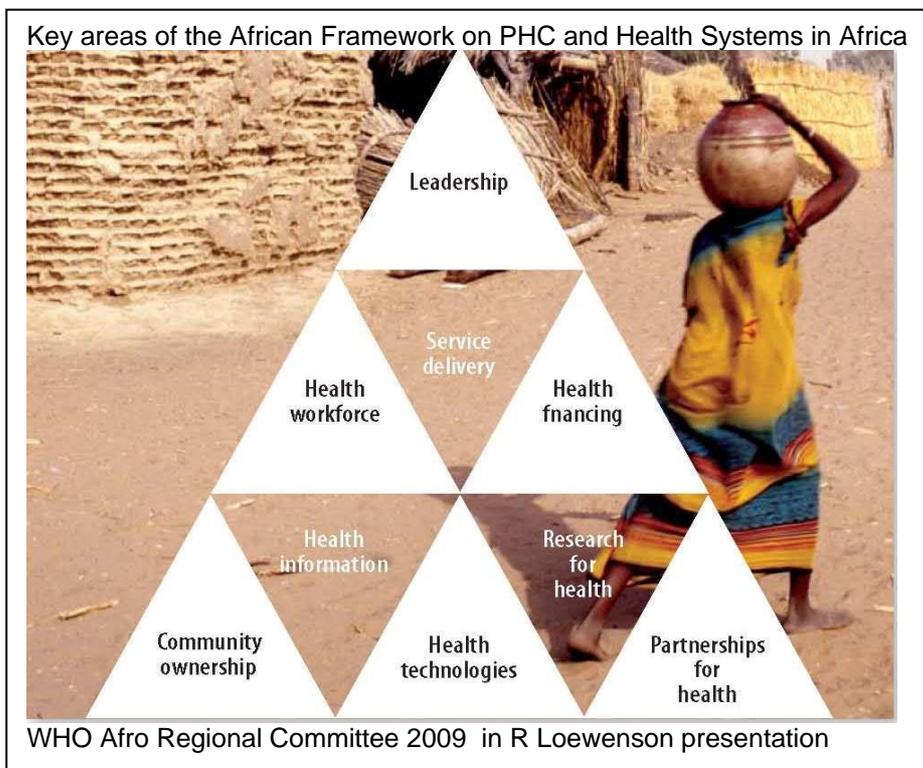
- Programmatic reform, covering alignment of resources to leadership priorities (UHC; MDGs and SDGs; IHR; NCDs and mental health; access to medicines; reducing inequities and action on social determinants.
- managerial reform, covering communication; information management; evaluation, accountability & transparency; and human resources;
- Governance reform; covering strategic decision-making and effective engagement with stakeholders (FENSA). The Working group negotiations on the latter are now open to all states, and
- Emergency reform, covering preparation for and respond to outbreaks and emergencies with health consequences, aligned to the other three areas and covering programme, fund and human resource issues.
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Dr Makasa noted some disconnect between priorities being defined at headquarters level and a desire for a bottom up approach that responds to country and regional priorities. This is compounded by capacity weaknesses in country offices that he observed need to be addressed. Information management needs to be driven first by what can be analysed and used for improvements at country level and not simply for global reporting. He noted the need for countries to have information policies, with regional guidance. Dr Makasa noted that WHO has developed a framework for emergency responses, and is developing categories to classify emergencies to determine responses, including recruitment of emergency personnel from state and non-state sources.

The Figure below gives an overview of these different areas and the process of reform
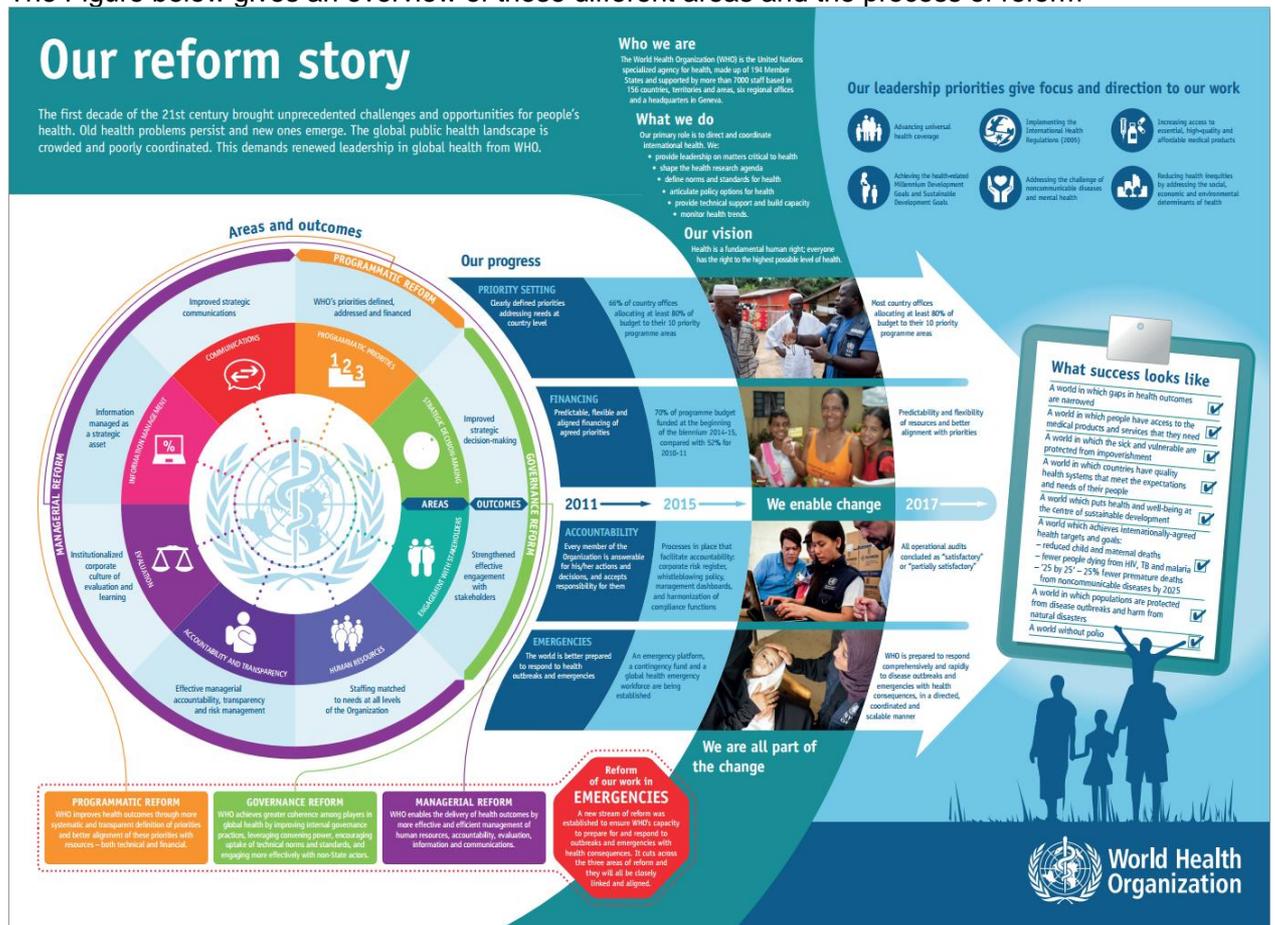
Source: WHO 2016 from the presentation by Dr Makasa

Ms Takaenzana added that governance reform also refers to alignment across the three levels of the organisation. She noted the difference between the Pan American Health Organization, (and AMRO) and other regions, given that the former is a stand-alone organization with its own Executive council. WHA decisions thus still need to be debated

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and adopted in PAHO before they apply in that region. These differences may also affect discussions on how to improve management coordination with the Regional Directors and their accountability vis a vis the WHO DG and member states. She noted further that while there has been attention on the performance management and assessment for Regional Directors, there have also been issues with Assistant Director General positions not currently being advertised and being made by appointment of the DG, with a call for more openness and accountability on such top positions in WHO. The management review also covers making the WHA more effective, given the increasing number of agenda items. This has led to a review of the rules of procedure that is likely to be discussed at the 2018 WHA, including recommendations on improving the use of ICTs.

Dr Makasa noted that FENSA aims to enable WHO to play its leadership role as the UN agency responsible for global public health by enabling responsible engagement with non-state actors while preserving its integrity and protecting it from undue influence. In the discussion of the FENSA, key issues have been raised of WHO's underfunding by member states, making it vulnerable to influence through earmarked funding, opening the organisation to influence by non-state actors. While many aspects of FENSA are agreed, there are issues to resolve, including implementation of FENSA at all three levels of WHO; waiver of FENSA during outbreaks and emergencies; contention over secondment of non-state actor staff to the WHO; accreditation of NGOs and technical collaborations WHO; financial contributions and conflict of Interest. A document has also been prepared on the impact of implementation of FENSA but it is under debate. Dr Makasa noted a view that FENSA should be given first priority and that an implication document be a subsequent issue and not a condition for adoption of the FENSA. He noted that there have been many compromises to get to the current FENSA draft, but that it would benefit the Africa region in protecting the public interest nature of the WHO.

There was some discussion on the WHA agenda. While it was noted that there should not be barriers to countries raising issues, there needs to be a way of managing the process, especially for smaller over-stretched delegations. The African group has played an enabling role in building unified positions to enable a division of roles to help address the constraint of numbers, but it was also felt that the agenda needs to be more manageable. If too long then matters cannot be resolved, including at the EB, and are referred to follow up meetings (with cost implications). It was noted that the election of a new DG in 2017 may have raised additional pressure for agendas to go through prior to the change. It was noted that African countries would need to be even more organised around processes, including around side events.

Delegate discussion and recommendations in the working group on the WHO reforms and FENSA are reported in *Section 6.4.*

4.6   WHO Code on International Recruitment of Health Workers and the Health worker agenda 2030

Dr. Gibson Mhlanga, Principal Director, Ministry of Health Child Care, Zimbabwe chaired the session.

Mr Edward Kataika, Director of Programmes, ECSA HC, Tanzania examined the implementation of the WHO Code of International Recruitment of Health Workers, based on research implemented in 2013-4. He noted the history of the Code, from calls made within the region due to outmigration of skilled health workers, leading over many years of negotiation to the adoption of WHO Code in 2010. He noted the strong role played by African countries in the negotiation of the Code, but that after its adoption that voice appeared to have fallen, including in reporting on implementation. The research found that the negotiation process was long, with changing actors and perceptions of a declining concern with external migration, and more attention to inadequate production or employment. There was also a perception that African interests in compensation or mutuality of benefits were diluted in the Code, and that as a voluntary document it lacked force. He noted however that a binding obligation on monitoring and reporting could be

used to strengthen its application. After adoption the research found that there were limited steps taken to disseminate it widely to stakeholders at country level and ministries, especially overburdened HR departments, were poorly prepared for implementation.

Mr Kataika observed therefore that within the region there is limited evidence of the Code being used. He raised a general issue in negotiations of preparing for implementation as during the development processes in future negotiations, in terms of designated authorities for implementation and reporting and information systems and in engaging civil society advocacy. He also noted the need for more active participation of regional organisations in coordination of follow up. He suggested that research on HRH migration would need to shed light on whether indeed external migration losses are no longer significant. In the meantime he urged ESA countries to report and to engage at WHA and in the WHO expert group review on their barriers to Code implementation or concerns on its relevance to their priorities.

Mr Kataika noted that the draft strategy on HR for Health: Workforce 2030 was mandated in the 67th WHA and is to be presented at the 69th WHA. It raises that accelerating progress towards UHC and the SDGs calls for universal access to health workers. The strategy has four strategic objectives, namely:
a. to optimize performance, quality and impact of the health workforce through evidence-informed policies on human resources for health;
b. to align investment in human resources for health on the current and future needs of the population, taking account of labour market dynamics;
c. to build the capacity of institutions at subnational, national and international levels for effective leadership and governance of actions on human resources for health, and
d. to strengthen data on human resources for health, for monitoring of and ensuring accountability for successful implementation of both national and global strategies.

Dr Suwit shared his experiences in negotiating the Code, acknowledging the shortfalls found in the study, but observing that this is a gradual movement. He noted that the problem found with implementation of the Code is not unique. Many WHA resolutions face this problem, due to lack of follow up at country level.

Delegate discussion and recommendations in the working group on the WHO Code and the health worker agenda are reported in *Section 6.5.*

5.   Global health financing initiatives
Professor Garrett Wallace Brown, University of Sheffield, Department of Politics, presented the four new global funding mechanisms launched in 2016, linking to the SDGs 2030 Agenda. There have been six consistent trends in financing, viz:
a. Evidence-based country coordinated financing mechanisms;
b. Multi-sectoral governance at country level;
c. Enhancing accountability, monitoring and evaluation and surveillance;
d. Results-based / performance based financing;
e. Sustainable financing for health, and
f. The International Health Partnership agenda (IHP)
The four new health funding mechanisms are:
a.   The Global Financing Facility (GFF)
b.   The WHO R & D Fund
c.   The WHO Contingency Fund for Emergencies (CFE)
d.   The World Bank Pandemic Emergency Facility (PEF)

He presented information on each of these initiatives, with the issues for African countries. The **Global Financing Facility** is linked to WHO's Global Strategy for Women's, Children's and Adolescents' Health and its Five Year Operational Framework being discussed at the 2016 WHA. At country level the GFF expects within the first year a national review and plan to achieve targets; functional health data collection and

annual health sector reviews and after 4 years a National health financing strategy with increasing domestic resources; demonstrable progress, and civil registration and vital statistics (CRVS) for birth and death registration to support population targets and monitoring. A total of 62 high-burden, low- and lower-middle income countries are eligible to receive funds from the GFF of between US$10 mn and US$60 mn. There are Four 'Frontrunner' countries: DRC, Ethiopia, Kenya and Tanzania; Four 'Second Wave' countries: Cameroon, Liberia, Mozambique, Nigeria, Senegal and Uganda, and 5-10 countries from (ECSA countries): Zambia, Zimbabwe, Swaziland, Mauritius, Malawi and Lesotho. Notably the GFF is regarded as a bridge fund that leads into to a loan increasing the demand to show investment from government and take over by budgetary financing. He noted that the documents include the language of health system strengthening, linked to the six WHO 'Building Blocks. It raises demands on ESA countries to align the targets to national strategies, but with opportunities to learn from the experience of those countries that are already involved in the first wave and to engage through the two ECSA countries sitting on the board (Kenya and Tanzania). He noted that there is a potential for regional exchange and support given the number of ESA countries involved and potential for regional support for CRVS (noting also that IDRC is managing the GFF 'Centre of Excellence' for CRVS.

The **WHO Research and Development Fund** financial modelling tools and mechanisms are still being discussed at a special meeting prior to WHA. Out of 133 stakeholders consulted, only 19 were African. He noted that the fund appears to subsidize the normal groups doing R&D, despite language on sustainability which provides an opportunity to bring in research and development capacities, and to advocate for representation/participation within the groups deciding on funding, especially for type 2 and 3 diseases.

The **Emergency Contingency Fund** aims to fill the critical gap from the beginning of an emergency until resources from other financing mechanisms begin to flow. It enables WHO to deploy experts and begin operations immediately, within 24hours. He noted that the details are still to be finalised, as is the amount of funding. He indicated that disbursements will depend on a budgeted plan being developed in 24-48hours, prepared on standard custom templates current being designed. The performance indicators are on the WHO and not on the states that receive the funds. Prof Brown indicated that this fund is on the 2016 agenda, and there are opportunities to shape the standards on what is expected from the fund and to make connections with health system strengthening.

The **World Bank Pandemic Emergency Facility** is an insurance mechanism that could tap resources from both insurance and the bond markets, disbursing funds based on pre-agreed triggers. It is very new as a form of insurance scheme, underwritten and fronted by the World Bank trough bonds and premium payments by countries. He noted that it is supposed to be ready by 2016 but the details are not yet developed. The funds to underwrite it will be decided in the G7 and G20.

Professor Brown reflected on the available opportunities of how this will support health system strengthening and the UHC agenda. He noted that the two latter funds speak directly to a security agenda. This may raise concerns on implications of other processes. For example, if an intermediary alert is raised under the IHR for a country paying premiums the PEF as an insurance scheme, what happens to the premiums? Who will compensate for higher risk, if it's meant to help those most in need? What provisions will be made for prevention? What provision will there be for regional flexibility in application of these funds?

Delegate discussion and recommendations in the working group on the health financing arrangements are reported in *Section 6.6.*

6.   Reports and recommendations of the working groups

Following the presentations, member states, Africa group diplomats, regional organization delegates and resource persons discussed the issues and documents being tabled in 6 groups during the two days:

Group1:   International Health Regulations, Emergency responses and Ebola
Group 2:   Medicines access, R&D and Antimicrobial resistance
Group 3:   Health in the 2030 agenda for Sustainable Development, Health system strengthening and the Framework for Integrated people centred health systems
Group 4:   WHO Reform and FENSA
Group5:   Health worker issues: The WHO Code, the Health Worker agenda 2030
Group 6:   Global health system financing and performance based financing

Each group discussed for their specific agenda item a. the issues and positions recommended, with supporting evidence; b. responses to counter-positions /arguments and c. questions and information gaps still to be addressed. This report summarises the discussions and the recommendations made by the meeting after review of the group work reports. *Dr Maximillian Bweupe, Deputy Director, Ministry of Health and Mr Moeketsi Modisenyane, Department of Health South Africa* chaired the report back sessions.

6.1: Preparedness, surveillance and response
Specifically on
- *Committee A: 14.1 Implementation of the International Health Regulations (2005)*
- *Draft Recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, 18 March 2016*

The meeting reviewed the draft recommendations of the review committee on the Role of the International Health Regulations (IHR) (2005) of 18 March 2016. The meeting input is shown against each of the 12 review committee recommendations below:
1. *Recommendation 1:* The proposal to implement rather than amend the IHR was supported by the meeting.
2. *Recommendation 2:* On the committee proposal to develop a 10-year global strategic plan the meeting noted that:
   a. a ten year period is a long time frame and operational goals and reviews are needed for one year, five year and ten year periods, to see if targets are being met and to address deficits;
   b. WHO needs to widely consult member states before finalizing the plan;
   c. The plan should include an implementation framework;
   d. The team responsible for implementing the strategic plan should be clarified.
3. *Recommendation 3:* On financing IHR implementation, it was noted that:
   a. Evidence on progress in IHR 2005 core capacities indicates that progress has mainly been made in Africa on issues related to cross border disease surveillance and response. Other core capacities (on food safety, chemicals, radiation, that may be more trade related, with less pandemic risk), have made far less progress. These areas should not be neglected and specific attention is needed to them so that implementation of IHR is comprehensive;
   b. The IHR is the primary umbrella in the global health security agenda, so that funding should be directed towards the implementation of capacities for and implementation of the IHR, and the global health security agenda should be complementary and linked to the IHR implementation;
   c. There is need to clarify to member states where the funds referred to by the review committee are going: to who, for what, and the amounts? The meeting observed that prior IHR implementation review suggested that most funding went into commodities to deal with emergencies, but the meeting observed that this is

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not strengthening health systems and prevention of emergencies as a long-term investment. The meeting thus recommended more emphasis on sustainable funding for longer term health systems strengthening to prevent and manage emergencies on a more sustained basis.

    d. There is need to clarify how the assessment will be used to allocate resources, viz not just to decide on the funding levels but to ensure funding for member states to address identified gaps.

4. *Recommendation 4:* On raising awareness of the IHR, it was noted that:
   a. The priority should be on raising IHR awareness at national level and within countries, focused on mapping and building local institutional capacities.
   b. The WHO role in supporting national awareness needs to be strengthened and more effective use made of available funds for this;
   c. Regional awareness approaches can help to pool and make more effective use of resources and roles to support national IHR awareness.

5. *Recommendation 5*: On the introduction and promotion of independent assessment of IHR core capacities, the meeting noted that:
   a. Introduction of an independent assessment tool requires amendment of IHR, contradicting recommendation 1. Encouraging a regional approach to peer review of country reporting (as below), complemented where requested by voluntary independent assessment avoids this problem.
   b. It would be preferable to have a regional approach to assessment, where countries report and the WHO regional committee is used as a forum for countries to hold each other accountable at a regional level. Having a process for country reporting and regional review provides a means for greater focus on measures to strengthen capacities at regional level. The tool (see later) can be designed to be relevant to and comparable across regions to allow for peer review and support within regions and comparison across regions. It was noted that this regional approach has been used in other existing assessment programmes within the African region, such as the malaria score card, and that there is need to review these programmes for how they have used assessments to build / strengthen country capacities;
   c. The assessment tool should be reviewed at regional level by member states, to ensure relevance to the region;
   d. A roster of experts *within* the region able to carry out reviews/assessments should be established and maintained, with capacity building for expertise in this area, to ensure regional support for the country implementation of assessments;
   e. Independent assessment can then be focused on areas of core capacities where there are greater deficits, to identify measures to address these and to focus investments in these areas;
   f. The establishment of global alliance for IHR assessment housed in WHO HQ Geneva raised concerns. Apart from the fact that it is expensive there was concern that population health would be better protected by directing available resources to strengthen information gathering, analysis and response capacities *within* countries, with regional peer review and support as above. African countries need to obtain information on and engage with the proposal for the global alliance, as the globally driven external assessment, and use of external experts appears to draw resources away from the more country and regional driven approach above.
   g. It was also noted that advocacy for a regional approach to assessment should also be taken to the G7 meeting in Japan (that will be happening at the same time as the WHA). This means finding out which African delegates will be attending and providing them with information to take an African position on this issue.

6. *Recommendation 6:* On improving WHO's risk assessment and risk communication through a standing advisory committee and an intermediate level of alert, it was noted that:

a. An intermediate level alert can raise alarm and stigma, especially when countries receive negative information and are not provided support to deal with those issues. The modalities for this thus need to be better explained, including in terms of how it will be used for supporting response and how 'harm' will be avoided. It was further noted that there is need for clearer information on the implications of raising the intermediate level of alert for financing, including insurance contributions to the new World Bank scheme, and for resourcing responses.

b. There is need for clearer information on the role of the committee before its approval: What is its link to existing systems? It was supported that it be at WHO and not in the World Bank or other institution so its decisions are accountable to member states, but what is its role in relation to the World Bank emergency insurance proposals?

7. *Recommendation 7:* to enhance compliance with requirements for additional measures and temporary recommendations was supported by the meeting;

8. *Recommendation 8*: to strengthen IHR national focal points was supported by the meeting;

9. *Recommendation 9:* to prioritize support to the most vulnerable countries was supported by the meeting;

10. *Recommendation 10*: to boost IHR core capacities within health systems strengthening was supported by the meeting;

11. *Recommendation 11:* to improve rapid sharing of public health and scientific information and data was supported with the note that this must include benefit sharing, viz by including the improvement of rapid sharing of public health and scientific information and data;

12. *Recommendation 12:* to strengthen WHO's capacity to implement the IHR was supported by the meeting.

Overall it was noted that the IHR has strength in not limiting to addressing emergencies after they have happened but in building public health capacities and actions to detect, prevent and control them. The IHR should be understood as the umbrella, and that other 'global health security' measures should be aligned to it. The arguments for strengthening bottom up, and for advancing greater country control and regional roles in the IHR should be clearly linked to population health and public health interests and to the effectiveness of building / strengthening local / national health systems to detect, prevent, manage and respond to public health risks and emergencies.

6.2: Research and development and Antimicrobial resistance
Specifically on
- *Committee A: 14.4 Global action plan on antimicrobial resistance*
- *Committee B: 16.2 Follow-up to the report of the Consultative Expert Working Group on Research and Development*

The meeting reviewed the Global action plan on antimicrobial resistance and noted that:

1. There is need to *first* for a focus on access in African countries to overcome the gap in access to *existing* antimicrobials and vaccines;

2. R & D should not only focus on antibiotics but on other antimicrobials, including antifungals; diagnostics and vaccines in line with the major disease burdens. Higher income countries may see this as a distraction from their concerns on AMR, but the unmanaged public health burden (and risks) that deficits in access lead to, need to be shown;

3. African countries should continue to engage private pharmaceutical manufacturers to ensure that medicines and vaccines relevant to Africa are produced and to promote the transfer / development of technology to and within African R&D and related institutions. While investors may argue that only investments that provide good market returns are justified, the cross border public health risk of unmanaged diseases needs to be shown;

4. The Africa group and country officials should encourage African countries that have not yet ratified the WTO TRIPs flexibilities for public health[1] to do so.
5. The meeting called for further audit of / information on:
   a. The magnitude and extent of AMR in Africa, especially to ensure plans are based on accurate local data and not just modelling;
   b. Current experience and institutional measures in Africa on the protection and use of traditional medicines and the investigation of their beneficial ingredients.

6.3: Health in the 2030 Agenda for Sustainable Development and the Framework for integrated people centred health systems

Specifically on
- *Committee A: 13.2 Health in the 2030 Agenda for Sustainable Development*
- *Committee B: 16.1 Framework on integrated people-centred health services*

The meeting reviewed the draft resolution on Health in the 2030 Agenda for Sustainable Development and proposed that:

1. The resolution (e.g. PP10 and in (OP) 1(2) of the draft) makes reference to comprehensive primary healthcare and publicly led health systems and in PP9 make reference to stewardship of resources for health and to healthy ecosystems, as for example raised in the AU African Agenda 2063;
2. In (PP8) strengthen reference to International Health Regulations as the umbrella for building and reporting on public health capacities to prevent and manage international public health risk and emergencies;
3. Member States be vigilant to attempts to change SDG agreed language to accommodate sexual rights and sexuality preferences.
4. The resolution in OP(4) on mobilization of domestic resources for health add text to include reference to equitable health financing to address also how resources are allocated, spent, used and accessed for health;
5. The resolution in OP(3) include text on international co-operation in Research and Development guided by goals to reduce health inequities, and in OP95) including reference to benefit sharing;
6. In the section on the 'Requests the DG'
   a. Address the repetition of information in (5) and (8)
   b. Clarify the scope of 'relevant actors' named in (5) and (8) and avoid language that diminishes WHO role in these areas;
7. The resolution should include reference to the strengthening of systems and capacities in relation to national health information systems; population level local / household data and vital registration systems to support the planning and review needed for the health and SDG agenda in-country. There is also need for information systems to be harmonized for sharing across countries, especially at regional level;
8. Information and reporting on the health SDGs be delinked from narrow target driven performance based funding and related more closely to financing support for sustained improvements in institutional, systems and population health outcomes.

The meeting reviewed the Framework for integrated people centred health systems (IPCHS) and noted that:
1. The current Framework on IPCHS falls short of comprehensive primary health care (PHC) and excludes some key areas of the 2008 Ougadougou Declaration and 2009 Framework for PHC and Health systems in Africa adopted by African countries at the WHO Afro regional committee in 2009. It is therefore essential for African Member States to continue to engage on advancing comprehensive PHC and Health systems (HS) strengthening at WHO and WHA in follow up to WHO

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[1] As of 2016 the nine countries that had ratified the TRIPS flexibilities for public health in the ECSA region were Botswana, Kenya, Lesotho, Mauritius, Rwanda, South Africa, Tanzania, Uganda and Zambia.

RC resolution AFR/RC62/R3, and to make clear that IPCHS should be seen as subset of PHC and not a substitute for it.

2. The African Framework on PHC and HS and the AU Agenda 2063 raise a number of areas more prominently than the IPCHS, including health technology (including research and development, audit and equity in access to / benefit sharing in health technology; neglected diseases and protection of indigenous resources); complementarity between system responses to communicable and NCDs (including in relation to women and youth as key demographic groups); public health authority and healthy ecosystems (including links to emergency responses and to audit and regulation of private sector); and on fair equitable financing of health systems (including alignment of international partners to national systems financing).

3. The Alma Ata definition of PHC remains more comprehensive and guiding as a vision for health systems and the IPCHS vision should make explicit reference to it. In the subsidiary IPCHS vision, the reference to 'people's preferences' should be reviewed as it may be read to include individual preferences that are antagonistic to public health (such as harmful environmental practices, refusal of child vaccination, FGM etc.).

4. The (adaptation and) adoption of the Framework for IPCHS should be under the member state roles in the EB resolution 138/R2 and not under the WHA.

5. As an immediate follow up the EB resolution 138/R2 be reviewed and revisions proposed to make reference in the preamble to the 2008 Ougadougou Declaration and 2009 Framework for PHC and Health systems in Africa, and in the text to integrate recognition of comprehensive PHC as a wider framework, so that the DG is urged to follow up further on WHA62.12 on improvements in PHC and HS strengthening including through integrating frameworks developed within the regions.

6. The WHO Afro RC be approached in the Programme Subcommittee meeting to include on the agenda follow up on the 2009 Framework for PHC and Health systems in Africa to
   a. Report on and review its implementation
   b. Examine areas for integration taking note of new challenges (NCDs, health emergencies, IHR) and the Framework on IPCHS
   c. Raise implications for global level follow up to WHA62.12 on PHC and HS strengthening and for the Framework on IPCHS.

7. A policy brief be prepared comparing the Framework for IPCHS against the 2008 Ougadougou Declaration, 2009 Framework for PHC and Health systems in Africa and AU Agenda 2063, to inform discussions at the WHA and WHO Afro RC.

6.4: WHO Reforms and FENSA

Specifically on
- *Committee A: 11.1 Overview of reform implementation*
- *Committee A: 11.2 Member State consultative process on governance reform*
- *Committee A: 11.3 Framework of engagement with non-State actors*

The meeting reviewed the reform proposals and noted that:

1. **On the programmatic reforms**
   a. Data / evidence at WHO should be guided by information from the ground and the approach should in general be more 'bottom up' than 'top down'. Measures should aimed at strengthening countries and regions should be driven by and support capacities, processes and evidence from countries;
   b. The programmatic priorities should emerge from countries and regions, with a dialogue between global and more bottom up processes;
   c. The assessed membership contribution to WHO should be increased, to ensure this is increased as a share of the organisation's budget and attention is given to how funds are used. African member states need to indicate their readiness to increase their contributions to WHO to have member states control the programmes and agenda of the organization.

2. **On the managerial reforms**
   a. The lack of capacity at WHO country offices is a priority concern that needs to be addressed if other areas of programmatic and governance strengthening are to be achieved. This is identified in part to arise from a mismatch of skills and people within the organization. This calls for support for sub regional centres and intercountry support teams, and for a better alignment of skills and personnel to countries and regions to ensure equitable and effective distribution. Country offices should be strengthened in terms of staff and skills, with greater support from regional to country offices. This should aim to strengthen capacity of the staff in place and personnel from within the region.
   b. The ADGs as senior management should be technically competent in their area of work. All jobs should be matched with skilled persons.
3. **On the governance reforms**
   a. The Regional director should remain answerable to ministers of health in the region
   b. The relative autonomy of the WHO AFRO region needs to be further reviewed (given for example the differences with PAHO and AMRO), including the extent to which this demands funding to the regional office from member states and the options of tying / earmarking member African state contributions to the regional office. This may be an area for follow up policy analysis.
   c. The mismatch between agenda items and time in the WHA needs to be addressed (too many items, too little time). The measures for inclusion of agenda items, the amount of time given to presentation of positions should be reviewed to achieve an improved balance (such as by cutting intervention from 3 to 2 minutes), without adding barriers to submission by countries of resolutions.
4. **On the emergency related reforms**
   a. There needs to be clearer information provided on how new emergency personnel, funds and programmes are aligned to / fit with wider programmes and processes in the WHO, and their link with other programmes and funds being set up at regional level and with those being set up outside the WHO and the lines of information sharing, responsibility and accountability between them.
   b. New measures and resources for emergencies should meet principles of transparency, accountability, regional inclusion, gender equity and should link to wider system strengthening.
5. **On the FENSA**
   a. It would be desirable to conclude the FENSA at the current WHA
   b. It should apply to all levels of the organisation, and in all regions
   c. Specific guidance should be developed for emergencies. While the need for speed is acknowledged it should not lead to FENSA principles being undermined during emergencies and guidance for emergencies should be developed that is consistent with it.
   d. Conflict of interest issues between the many interested parties need to be managed: a policy on conflict of interest should be developed and applied.
   e. The document on the implications of FENSA should be discussed when the FENSA negotiation is completed. It was noted to have numerous areas that raise questions or need further discussion and should not detract attention or time from the FENSA.

As general contributions on this area
1. The financial and bureaucratic reforms are key to making the organization more effective but these are not being addressed.
2. The FENSA is a product of lack of trust among different stakeholders in WHO, more than the weakness of the current guidelines for dealing with non-state actors.

3. For African countries, there is a problem in countries spending a lot of time firefighting agendas that don't belong to the region. There is a need to redirect our focus to agenda items that emanate from priorities and perspectives within the region, such as our agenda on comprehensive PHC. These issues that belong to us we can drive at country level, AFRO, WHA and other platforms.
4. We should also resist a situation where agenda items brought from the region, such as Sudan's resolution on mycetoma is pushed back to be discussed at regional level and not WHA. The issues raised in Africa have global relevance. Taking them forward globally is possible and necessary, and takes determination, support from country alliances, and links to key issues that have wider relevance, such as the link between mycetoma and neglected diseases.

6.5: The WHO Code and the Health Worker Agenda 2030
Specifically on
- *Committee B: 16.1 Health workforce and services: Draft global strategy on human resources for health: workforce 2030*

The meeting reviewed the reporting on the WHO Code and the Health Worker Agenda 2030 and noted that:
1. More efforts be made to raise regional and within country awareness on the Code and to set up and report on country implementation plans that is embedded within and not separate to national HR strategies;
2. Further research be implemented by ECSA and EQUINET on current levels and directions of flow of HR external migration, in terms of implications for PHC and HS strengthening and losses in skills and experience and in training and HR investments.
3. Countries take forward implementation and reporting in the Code through
    a. Making an investment case for its implementation;
    b. Deliver on the Abuja commitment of 15% government domestic budget allocation to health;
    c. Reporting in measures taken and barriers in its implementation, including through bilateral agreements;
    d. Identifying champions within line ministries with roles in HR to champion issues raised at national level;
4. WHO Afro support Member States on implementation by
        Providing technical assistance and capacity building to implement the Code;
    a. Preparing a brief on the current status of reporting and identify and report on the gaps and barriers in implementation of the Code for regional and Africa group review.
5. In relation to WHA16.1 the draft Global strategy on HRH Health worker agenda 2030
    a. Include reference in the text to meeting HRH needs for comprehensive PHC
    b. Include text on health worker own health care needs and measures to ensure financing for and access by health workers to the health care services they need;
    c. Include text on the rights of health workers, their role in and protection and support in relation to emergencies and IHR; their protection against occupational health risks (including infection control measures) and awareness and management of ethical issues, including differential treatment of external and national health workers in emergencies.

6.6: Global Health System Financing
Specifically addressing the four new global financing initiatives in health:
- *The Global Financing Facility (GFF)*
- *The WHO R & D Fund*
- *The WHO Contingency Fund for Emergencies (CFE)*
- *The World Bank Pandemic Emergency Facility (PEF)*

The four new global financing initiatives were discussed, noting that information on them is very recent and rapidly changing. The meeting recommended that :

1. More information be provided on these funds and the implications for health system strengthening and their alignment to national policy to support policy engagement;
2. There be greater dissemination of information to regional, country and national institutions, including civil society, to build country and regional voice on country needs and positions for these funds to align with national policies and measures;
3. On the GFF:
   a. The SADC, EAC and the ECSA Regional senior officials/BPF forum be used to share learning from front runner countries (Kenya, Tanzania) and second wave countries (Uganda) to be able to provide input to other countries in their decision making and negotiations around GFF and to provide input to GFF board members (Kenya x 2, Tanzania) from the region;
   b. Any funding arrangement clearly state the measures / indicators that one has to meet in order to satisfy results and the accounting conditions upfront, to avoid generic language as is presently found (e.g. 'complying with various results based standards') and to judge how they align/integrate with nation and regional strategic plans.
4. On the CFE and PEF:
   a. The role of these funds be harmonized within measures to fund the strengthening of core capacities for implementation of the international health regulations (noting the issues raised above on strengthening the regional role and supporting country authorities in the implementation of the IHR);
   b. The links between and relationship of the two funds (CFE and PEF) be clarified, and their links be clarified with the AU Commission level funds for emergencies;
   c. Further information be provided on the scope for regional and country roles in relation to how resources will be raised, managed, disbursed, inputs procured and country and regional capacities built, and how evidence will be generated and used in decisions on and review of funding streams;
   d. Further evidence based information be provided by the WHO and World Bank at global and regional level on the implications of using an insurance type funding arrangement for the PEF, especially for the Africa region, (with questions such as what the implications will be on premiums and responses of countries getting an intermediary level alert; and how funding will proactively address capacities for prevention);
   e. The meeting noted the need for global funds to strengthen and not weaken AU, regional and country level measures and capacities to resource and respond to emergencies and to prevent them under the IHR;
   f. The meeting noted that the development of parallel funds outside the WHO can raise the financial vulnerability of the WHO, and that while there must be strengthened monitoring of impact and results, more attention be given to financing mechanisms that are not earmarked or at minimum that work in synergy with core funding and systems support at all levels;
   g. An information brief be prepared (before the WHA?) on how far the CFE, PEF and other global funding arrangements for emergencies are consistent with the implementation strategies for the IHR, are harmonized and address in their design support for effective capacities, responses, health system strengthening and funding mechanisms at AU, regional and country level and the implications of these funds for countries and regions (addressing issues such as those raised in 4d above);
5. Generally, in relation to the WHO, it was noted that as long as the funding is voluntary, it may be earmarked, so the issue of focus is that of increasing contribution to WHO, including to get a common position on the assessed country contributions in the region, and in the Africa group.

6.7: General / crosscutting issues
As general contributions crosscutting all areas
1. For African countries, there is a problem in countries spending a lot of time firefighting agendas that don't belong to or emanate from the region. There is a need to redirect our focus to agenda items that emanate from priorities and perspectives

within the region, such as our agenda on comprehensive PHC. These issues that belong to us we can drive at country level, AFRO, WHA and other platforms.

2. There is a deficit in the follow up and domestication of treaties, commitments, and resolutions that are championed from Africa. This is exemplified by the limited follow up and reporting on the WHO Code, the still limited ratification of the public health related flexibilities in the WTO TRIPS agreement (where only 9 ECSA countries have ratified). The meeting proposed that:
    a. countries establish an international health desk in Ministries of Health to widen information sharing on and follow through on resolutions and other internationally agreed documents;
    b. table resolutions and commitments with the legislature for discussion;
    c. raise them with related ministries in multi-sectoral meetings;
    d. share them with civil society for wider awareness raising;
    e. generate evidence at national level with support from WHO and technical partners to feed into national policy dialogue and regional and global engagement on the follow up.

3. There is a need to strengthen involvement of regional and national technical resources in national and regional processes for the WHO RC, the WHA and in other health related global processes, such as those emanating from World Bank, Gates and other Foundations, Global alliances etc. The meeting noted options for this to:
    a. Engage national and regional technical 'think tanks' in providing information briefs, data/ evidence from research, analyses to support specific global negotiations (as for example EQUINET has done with ECSA, other RECs and Africa group or as has been the case in the Africa inputs at the COP);
    b. Use the WHA as a capacity building opportunity, including students and young professionals and African national and regional technical agencies in prior preparatory work and in country delegations, both for them to prepare inputs on issues and for their mentoring by senior personnel (as for example is being implemented in Thailand). This may be done without adding a financial burden to countries by African institutions and universities self-funding their participation;
    c. Strengthen south-south interaction between think tanks in Africa and other regions of the south (such as by ensuring that African technical / civil society institutions are involved in the South Centre briefings).

7. Development of GHD work in the region

Mrs Tulipoka Soko, Ag. Director, Nursing & Midwifery Services, Ministry of Health, Malawi chaired the final session, which involved presentations and plenary discussions.

7.1 Proposals for research and monitoring of progress on GHD

Dr Rene Loewenson, Director, Training and Research Support Centre presented a summary of the lessons from the research done by EQUINET in 2013/4 that had fed into information briefs, forums and policy dialogue:
- The research work on negotiating performance based financing showed the need for clear positions on health system strengthening outcomes aimed for; strong monitoring and evaluation systems aimed for; and involvement of multi-sectoral bodies in setting positions (e.g. CCMs). However it was also apparent that to influence design in global funding you had to go upstream, to influence processes before the designs were set.
- The research work on the WHO Code pointed to the need to prepare for implementation in future negotiations, and for more active involvement of the regional community, technical actors and civil society in processes both for negotiation and follow up.
- The research work on Medicines pointed to the need for government multi-stakeholder leadership and co-ordination for issues that involved many sectors, and for clear operational goals when engaging in negotiations, including for

factors that may be upstream of but influence the final outcomes, such as for training, prequalification to support local production.

Dialogue on the findings within the region pointed to an overarching platform of follow up work to develop a regional position on Health system strengthening. The meeting pointed to a strong support for strengthening an African position on HSS that is based on comprehensive PHC, and that takes forward the frameworks developed in the region to date. This raises opportunities to do more participatory research, linking evidence directly to dialogue and negotiation processes, to review the implications of this position on health system strengthening for the IHR and emergency responses, for the SDGs, for the funding mechanisms under discussion and other areas of global agreement. .

The HMC and states have also asked are we making progress in GHD? From the research and learning on what has supported effective engagement we identified some areas of progress that can be used to assess this question that was the basis of the short Likert scale survey distributed in the meeting. It is intended to point to areas for discussion and review rather than as a statistical exercise. There was a 100% response rate at the meeting from the 11 delegates asked to complete the form, from the seven ECSA member countries, from one regional organisation and one diplomat.

While a more detailed analysis of the responses will be prepared in a separate report, she presented preliminary findings. They indicated that within countries and at regional level there was political support and health issues were championed globally by political leaders. The sustained co-ordination of the Africa group was also noted as a key strength in the region. However there was weaker performance on having a GHD focal point/ desk and multi-stakeholder committee in countries, and in engaging with local technical actors and civil society. Indeed having a focal point was identified as a key challenge to be addressed at country level. At regional level the survey indicated that there were weaknesses in setting shared targets for health policies discussed in south –south platforms and in monitoring and supporting implementation of global agreements. Lack of funding for and consistency in engagement on GHD was identified as challenges to address.

The results suggest that having a country focal point may be an important step to support co-ordination of other actors, to draw in other capacities for GHD work and for the consistency of the work. Delegates agreed in discussion on the need to set up a national desk. They noted that support for International Health Relations/ GHD as a desk was not consistent, in part due to a lack of understanding of its role in ministries. It was suggested that this may need good communication on the value of focal points. They also noted the need to start with what was available and try to embed GHD work within existing departments. It was further raised that it could be useful to identify, map and finding ways to effectively engage with technical actors and other non-state actors in country to support GHD work.

Delegates suggested that the follow up analysis remove the '3 don't know' from the averages and have a wider range of scoring for the future rounds of use of the survey. This was noted and Dr Loewenson asked delegates to raise any other feedback on the tool so it can be strengthened as a regular means of assessing progress and opening discussion on key issues to address to strengthen GHD capacities within the region.

7.2   Experiences of organizing GHD in Thailand

Dr. Suwit Wibulpolprasert, Vice Chair, International Health Policy Program Foundation (IHPF), Health Intervention and Technology Assessment Foundation, Ministry of Public Health, Thailand presented experiences of GHD capacity building in Thailand. From his earliest experiences of the WHA in the late 1990s, Dr Suwit learned the lesson to 'never to leave the table or you'll be on the table', that is if you are not present you cannot defend your interests. That is when they realised that they needed capacity. This has become even more important with the growth of global actors, agencies and agendas. He noted that there are several positions one can take: passively waiting to react, actively

going out to get something for one's own interests, or getting something for the whole world. The latter is a 'good global citizen'.

He noted that this changing global environment was evident in the changing WHO budget, shown adjacent. In 1998, about half of WHOs funding was from assessed (country) contributions, and half from voluntary contributions. By 2012/3 the WHOs own budget contribution fell to 24%, with the larger share coming from voluntary contributions, such as from the Gates Foundation.

WHO budget: assessed and voluntary contribution

From presentation by Dr Suwit Wibulpolprasert
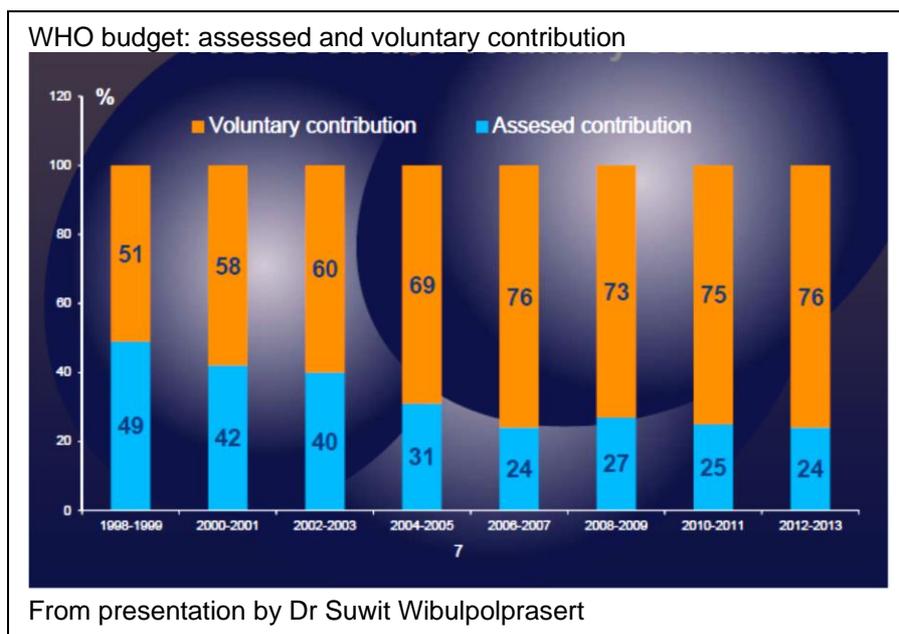
Out of numerous challenging experiences, in Thailand there was an understanding that they needed to build their capacity. They used the WHA as a 'school', to learn from each of its many agendas, to build capacity, including for other global health negotiations.
In 1999 they started the International Health Scholars program (IHP). Applicants needed a good command of English, to be in their early to middle career and to be interested. They got more than 300 applications, and selected 30 to join the activities, with the best 4-6 brought to the WHA. After a few years they learned that they had to institutionalize to be sustainable. Thus IHP evolved into the International Health Policy Programme (IHPP) which is under the Bureau of Health Strategy. They also established a Mahidol University Global Health (MUGH), a technical arm based in an academic institute to provide external technical support. Every year they have:
- Regular national GHD capacity building activities - Workshops, conferences and preparation meetings for the WHO Regional committee (RC), EB and WHA;
- Regional activities- regional GHD workshops, RC preparation meetings, to build one voice;
- GHD capacity building in other member states, including Bangladesh, China, Indonesia, Japan, Maldives, Nepal, Sri Lanka, Vietnam.
They have created a GHD Workshop manual for Training of Trainers (TOT).

In preparation for the WHA in March to May each year the provisional WHA agenda is used to identify delegates for each agenda from line departments, with representatives from universities, professional bodies, civil society, private sector and partners. All those not in government are assigned an agenda based on their interests and expertise and must make an intervention that has to be approved. A novice is assigned to lead on 1-3 agenda items, two to three novices are responsible for one agenda, and each agenda has one coach and one mentor who have the final say. Whenever a novice reads the intervention, at least one coach or mentor provides support. Novices gather evidence, review literature, and provide information for domestic consultation and to input to the country position. Once the country position has been agreed they draft the first draft of the intervention. Those agenda items that are political or need a policy decision are submitted for approval by the Health Minister.

At the WHA, every morning there is a briefing from 8 to 9am. Thailand brings about 50-60 delegates, divided into 3 groups, each led by a coach and a mentor. Each group reviews what has been done and achieved the previous day, and the new issues and who is responsible. The group stay in an apartment, cook and eat lunch together and build an economy of scale to make the numbers brought affordable.

Over 20 years they have built capacities to deliver constructive, evidence based short interventions, to negotiate amendments to texts of resolutions, for themselves and for wider interests of developing countries, to set the agenda and propose resolutions. From 2008, they proposed and it was accepted to build one voice on common items of interest from the South-East Asia region, and they have also invested in processes to sensitise new policy makers and build political understanding on the programme. Countries tabled a resolution at the RC in 2011 to make sure the WHO regional office helped and every year there are several regional meetings in preparation for EB, WHA and the Global Fund constituency.

Dr Suwit shared many areas of learning from the experience. The programme has benefited from long term and continuous leadership and sustainable capacity building that is policy linked, involving not only the Ministry of Public Health, but other Ministries like Foreign Affairs, as well as other public and private agencies. Institutionalising the programme and focusing on practical learning by doing instead of a lecturing model was also identified as key to developing technical capacity and negotiation skills. Connecting with other states and organisations helped to build the social capital that plays a key role in GHD, to form strategic alliances with like-minded countries.

The presentation raised much interest and discussion. Dr Suwit commented that they managed conflict of interest between the different stakeholder groups involved in GHD within the country by bringing them together, noting that they learned to work together over time. He noted that they don't have indicators to monitor their success but learn by doing, from the involvement and participation in relevant process and from the ability to table agendas and raise resolutions, from their connections. He noted that it has been has been a gradual learning process. Many novices are lost along the way and not all rise to be junior coaches. He observed that there were many similarities between the African experiences and Thailand and that they would like to work with African countries, to maintain the links and support the capacities, because Africa has many strong leaders.

7.3 Enhancing communication and co-ordination on GHD
Mr Ernest T. Manyawu, Director of Operations and Institutional Development, and Mr Edward Kataika, Director of Programmes, ECSA HC opened a follow up discussion with delegates on enhancing communication and co-ordination within countries, in the region and between capitals and embassies. They indicated that they were eager to hear recommendations to sustain and strengthen the initiative and opened the floor to feedback.

Delegates raised numerous comments and recommendations, suggesting:
a. Using the regional process to motivate high level leadership to formalise GHD focal points to improve coordination, communication and building capacity.
b. Borrowing from the Thai experience, setting a timeline for activities in preparation for various meetings, including the AFRO regional committee meetings, EB, and WHA.
c. Creating of an online platform that would allow communication between those involved in GHD without having to wait for face to face meetings, which could be used to prepare and share information, policy briefs and resources before such meetings.
d. Broadening the participants. They noted that while the training began as an initiative for senior government officials and policy makers, but there was need to find a way to involve other stakeholders, students, civil society and build GHD capacity early.
e. Preparing specific policy briefs, such as on the IHR and emergency funding.

f. Ensuring that the meetings are annual and official, so delegates and Ministers know that a position would be developed through the process co-ordinated by ECSA HC;
g. Continuing to invite WAHO and formalising links with them to have joint meetings and involve more member states and representation from West Africa in the annual GHD meeting.
h. Reviewing the format of the meetings to build capacity, such as by having more time for working groups to develop positions, involving stakeholders, diplomats in the groups, and bringing in students to the process to build capacity;

Mr Manyawu appreciated the input and promised to follow up on the issues raised. He indicated that they would as ECSA secretariat come up with a position and possibly a paper on the institutionalization of GHD, to take the discussion further with the policy makers. He indicated that they would look at the issue of timelines and synchronising the meetings to give sufficient time to input to resolutions and that they would continue with resource mobilisation and awareness creation to try and meet the demand. He introduced the delegate from University of Nairobi, Dr Joseph Wangombe, who has taken forward a Master's programme which is now with the University senate. He indicated that ECSA HC would work with the University also on certificate, short courses, to widen access to training. He appreciated, however, learning from the Thai experience, that capacity building and institutionalisation take time and has to be sustainable.

In terms of existing regional resources, WAHO noted that they were very happy to be represented at the meeting and would continue to work closely with ECSA on GHD for this WHA and beyond. They noted also links that they had made with EQUINET. EQUINET noted its online database and newsletter as a source of information from the region.

Finally Mr Manyawu presented a brief database tool to map the focal points in Ministries, and institutions and experts working on GHD in countries, to compile available resources. He noted that ECSA is emailing this form to all member states and those at the meeting to complete for ECSA to compile to keep the database up to date.

Concluding the session, Dr Suwit remarked, that in half a day he was very impressed and inspired by the activities in the ESA region. He promised to share their workshop training resources. He suggested 'starting small and thinking big', and that long-term committed champions would be key to help to gradually build up momentum and trust in GHD. With this he suggested, eventually sustainable financing would be secured.

8. Closing

The closing session was chaired by *Dr Maximillian Bweupe, Ministry of Health Zambia.*

Mr Rangarirai Machemedze, SEATINI/ EQUINET gave closing remarks for EQUINET. He gave his thanks to the delegates, diplomats and partners. He noted EQUINET's longstanding involvement in GHD work in the region, including in meetings, in Nairobi, Lilongwe, Harare, Arusha and Mombasa. He explained that EQUINET is a network of technical, state, parliament and civil society institutions from the region promoting equity. EQUINET has provided evidence and information to support policy dialogue with ECSA HC and other regional organisations and countries, and has collaborated with the ECSA HC for over a decade through a regularly reviewed memorandum of agreement. He informed how EQUINET had met with various African missions in ECSA region early in the work to hear their concerns and issues and that the research agenda drew on this and the feedback from policy makers in the region. EQUINET and ECSA HC has similarly met with the Africa group in 2016 and values meetings such as these to ensure that its research and the evidence generated has relevance to negotiations on health.
He appreciated the partnership EQUINET has had with IDRC since 1998 and the support from IDRC to involve in the network the expertise needed to implement work that is

useful for such processes. He noted that the meeting agreed that the primary health care approach is one we should take into GHD engagement, drawing on Alma Ata and more recently the African Ouagadougou declaration on PHC. He thanked all for their contribution and urged delegates on returning to share the issues, positions, recommendations discussed with their colleagues in the health sector and in other relevant sectors.

Mr Edward Kataika, Director of Programmes, ECSA HC also thanked delegates for their participation, despite the pressures of much other work, noting this as a sign of their commitment to strengthening GHD. He said that ECSA HC's role is to facilitate member state interactions. He appreciated the need for a longer time for adequate preparations for WHA, and indicated that ECSA HC would keep this in mind for future meetings, but indicated that there were resource constraints for this meeting. He thanked the diplomats from Geneva and the valuable insights they brought, the excellent contribution from Dr Suwit, the collaboration with WAHO and the technical partners: EQUINET, University of Nairobi, and IDRC Canada. He expressed ECSA HC's commitment to strengthening these partnerships and expressed ECSA HCs own commitment to facilitate the strengthening of GHD.

Dr Isaac Kadowa, Principal Medical Officer, Ministry of Health expressed thanks to delegates and presenters for their active participation during the two days that generated a lot of very important suggestions and recommendations. He appreciated ECSA's and EQUINET's consistency in implementing the GHD work and the hosting from the Republic of Kenya in Nairobi, 'the city in the sun'. At a personal level he noted that this was now his fourth meeting, and that all were useful, with vibrant discussion and relevant recommendations. He observed that the onus was now on the delegates to communicate the recommendations and debrief their colleagues and partners. Noting that global health was now being discussed at forums beyond the WHA, he called for a widening of the focus and capacity building, including on the proposed Masters programme in Global Health developed by University of Nairobi. He wished all safe journeys home and to the WHA in Geneva and declared the meeting closed.

Meeting delegates at the closing session

Regional GHD meeting April 2016

Appendix 1: Programme

TIME	SESSION	RESPONSIBLE
DAY ONE FRIDAY 8TH APRIL 2016		
0830-0900	Registration	ECSA HC
	Opening : Chair: Dr S Magagula, Ministry of Health Swaziland	
0900-0945	Welcome Overview of the GHD work in the region and meeting objectives Africa group opening remarks IDRC opening remarks Official Opening	Dr S Magagula, MoH Swaziland Mr E Manyawu, ECSA HC Ms P Takaenzana, Zimbabwe Mission in Geneva Mr S Carter, Regional Director, IDRC Dr J. Kioko, Ministry of Health Kenya
0945-1000	The WHA as a key forum for Global Health Diplomacy	Dr E. Makasa, Health attaché, Zambia high commission
1000-1030	Tea Break	All
	Issues on the WHA agenda I Chair: Dr N Rusibamayila, Ministry of Health Tanzania	
1030-1050	International Health Regulations (IHR), Emergency responses and Ebola	Dr I. Ayagah Min of Health, Kenya
1050-1110	Medicine access, Research &Development (R&D) and Antimicrobial resistance	Mr R. Machemedze, SEATINI /EQUINET
1130-1300	Working group on negotiating position, debates strategies and evidence Group1: IHR, Emergency responses and Ebola Group 2: Medicine , R&D and Antimicrobial resistance	Delegates
1300-1400	Lunch	All
	Issues on the WHA agenda : II Chair: Dr I Ayagah, Ministry of Health Kenya	
1400-1415	Health in the 2030 Agenda for Sustainable development	Dr C. Sanga, Health Attaché, Tanzania High commission
1415-1430	HSS in Integrated People Centred Services (IPCHS)	Dr R. Loewenson, TARSC/EQUINET
1430-1450	WHO Reform and Framework of Engagement with Non State Actors (FENSA)	Dr E. Makasa, Health attaché, Zambia high commission, Ms P Takaenzana, Counsellor, Zimbabwe Mission in Geneva
1515-1545	Tea Break	All
1545 -1715	Working group on negotiating positions, debates, strategies and evidence Group 3: Health in the 2030 agenda for Sustainable Development, HSS and IPCHS Group 4: WHO Reform FENSA	Delegates

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TIME	SESSION	RESPONSIBLE
Closing of the day		

DAY TWO - SATURDAY 9TH APRIL 2016		
	Working group feedback Chair: Dr M Bweupe, Ministry of Health Zambia	
0900-1000	Plenary feedback of working group discussions For groups 1-4	Group rapporteurs
1000-1030	Tea Break	All
	Issues on the WHA and global health agenda Chair: Dr G Mhlanga, Ministry of Health Zimbabwe	
1030-1050	The WHO Code on International Recruitment of Health Workers and the Health worker agenda 2030	Mr E Kataika, ECSA HC
1050-1110	Global health system financing and Performance based financing	Prof G. Brown Sheffield University
1110-1130	Discussions	
1130-1230	Working groups on negotiating positions, future work Group5: Health worker issues: The WHO Code, the Health Worker agenda 2030 Group 6: Global health system financing and performance based financing	Delegates
	Working group feedback Chair: Mr M Modisenyane**,** Department of Health South Africa	
1230-1330	Plenary feedback and discussion of working groups For groups 5-6	Group Rapporteurs
1330-1430	Lunch	
	Development of GHD work in the ECSA region Chair: Mrs T Soko, Ministry of Health Malawi	
1430-1500	Regional proposals for follow up research on GHD and Findings on the indicators for monitoring and review of progress on GHD Discussion	Dr R. Loewenson, (TARSC/EQUINET)
1500-1545	Experiences of organizing GHD in Asia Discussion	Dr S Wibulpolprasert, Int Health Policy Program Foundation, Thailand
1545-1645	Enhancing communication and co-ordination within countries, within the region and between capital-regions-embassies; Updating the database of GHD focal points and resources Discussion	Mr E Kataika, Mr E Manyawu, ECSA HC Delegates
	Closing Chair: Dr M Bweupe, Ministry of Health Zambia	
1645-1700	Official Closing	Mr E Kataika, ECSA HC Mr R Machemedze, EQUINET Dr I Kadowa, MoH

Appendix 2: Delegate list

No.	Country/Institution	Nominee & Designation
1. ECSA HC Member States		
1	**Kenya**	**Dr Isabel Ayagah** Deputy/ International Health Relations Dept, Ministry of Health, P.O. Box 30016-00100, Afya House, Nairobi. Kenya
2		**Dr Eric Osors** Epidemiologist, Ministry of Health, P.O. Box 30016-00100, Afya House, Nairobi, Kenya
3		**Ms Peace Masinde** International Health Officer, Ministry of Health P.O. Box 30016-00100, Nairobi, Kenya
4		**Mr Blevin Ian** Ministry Health P.O. Box 30016-00100, Nairobi, Kenya
5	**Malawi**	**Mrs Tulipoka Nellie Soko** Ag. Director, Nursing & Midwifery Services, Ministry of Health P.O. Box 30377, Lilongwe 3, Malawi
6	**Swaziland**	**Dr Samuel Vusi Magagula** Director of Health Services, Ministry of Health P.O. Box 5, Mbabane, Swaziland
7	**Tanzania**	**Dr Neema Rusibamayila** Director, Preventive Services, Ministry of Health, Community Development, Gender, Elderly and Children P.O Box 9083, Dar es salaam, United Republic of Tanzania
8		**Dr Catherine Sanga** Counsellor, United Republic of Tanzania Mission to the UN Geneva, Switzerland
9	**Uganda**	**Dr Isaac Kadowa** Principal Medical Officer, Ministry of Health P.O. Box 7272, Kampala, Uganda
10	**Zambia**	**Dr Maximillian Bweupe** Deputy Director, Ministry of Health Lusaka, Zambia
11		**Dr. Emmanuel M. Makasa** MD,MPH Counsellor-Health, Permanent Mission of the Republic of Zambia to United Nation 17-19 Chemin du Champ-d'Annier 1209, Geneva-Switzerland
12	**Zimbabwe**	**Dr. Gibson Mhlanga** Principal Director, Ministry of Health Child Care P.O Box CY1122, Causeway, Harare, Zimbabwe
13		**Ms. Paidamoyo S Takaenzana** Counsellor, Zimbabwe Mission in Geneva 27 Chemin William Barbey,1292 Chambesy, Geneva, Switzerland

No.	Country/Institution	Nominee & Designation
**2. Partners and invited delegates**		
14.	**South Africa**	**Mr. Moeketsi Modisenyane** Director, Department of Health P/Bag X 828, Pretoria,001, South Africa
15	**West African Health Organisation (WAHO)**	**Dr Assogba Laurent** Deputy Director General, WAHO, Bobo- Divulasso, BP153, Burkina Fasso
16		**Dr Keita Namoudou** Primary Health CARE/ HSS, WAHO Bobo- Divulasso, BP153, Burkina Fasso
17	**Thailand**	Dr. Suwit Wibulpolprasert Vice Chair, International Health Policy Program Foundation (IHPF), Health Intervention and Technology Assessment Foundation, Ministry of Public Health Tiwanond Road, Nonthaburi 11000, Thailand
18	**International Development Research Centre (IDRC-CRDI) Canada**	**Dr Simon Carter** Regional director, IDRC-Nairobi P.O. Box 42082, Nairobi, Kenya
19		**Mr. Qamar Mahmood** Senior Programme Officer, IDRC P.O Box 150, Kent Street, Ottawa, Canada
20	**University of Nairobi**	**Prof. Joseph Wang'ombe** University of Nairobi, CHS/KNH School of Public Health P.O. Box 19676 0202, Nairobi,Kenya
**3. Convenors**		
21	**East Central and Southern Africa - Health Community (ECSA HC)**	**Mr Ernest T. Manyawu** Director of Operations and Institutional Development, ECSA HC P.O. Box 1009, Njiro Road, Arusha, Tanzania
22	www.ecsahc.org	**Mr Edward Kataika** Director of Programmes, ECSA HC P.O. Box 1009, Njiro Road, Arusha, Tanzania
23	**Regional Network for Equity in Health in East and Southern Africa**	**Dr Rene Loewenson** Director, Training and Research Support Centre 47 Van Praagh Ave, Harare, Zimbabwe
24	**(EQUINET)** www.equinetafrica.org	**Mr Rangarirai Machemedze** Programme Coordinator, SEATINI 20 Victoria Drive, Newlands, Harare-Zimbabwe
25		**Professor Garrett Wallace Brown** University of Sheffield, Department of Politics, 510 2TV, United Kingdom
26		**Ms Connie Walyaro** Consultant, Meeting rapporteur P.O. Box 65092-00618, Nairobi/ Kenya