Contributions of global health diplomacy to equitable health systems in east and southern Africa

Regional research workshop
REPORT

March 13-14 2015
Johannesburg, South Africa

Regional Network for Equity in Health in East and Southern Africa (EQUINET)

through
Training and Research Support Centre

In co-operation with Centre for Trade Policy and Law Carleton University

and in association with the East Central and Southern African Health Community and Department of Health, South Africa

Contents

1.   Background and objectives

In 2012-2014 the Regional Network for Equity in Health in East and Southern Africa (EQUINET) (www.equinetafrica.org) implemented a policy research programme to examine the role of global health diplomacy (GHD) in addressing selected key challenges to health and strengthening health systems in east and southern Africa with research institutions in the region.

The programme issued an open call and provided grants for investigations in three case study areas that were defined as priorities in GHD by senior officials and Ministers in 2011 for the region. A meeting was held with senior officials, researchers from in and beyond the region and a **review of conceptual frameworks and methods in GHD** (EQUINET Discussion paper 92 and Discussion paper 105) prepared to support the development of the protocols for the research. A policy advisory / review group was set up to review the work. The three case study areas are:

1. ***Implementation of the WHO Code on international Recruitment of health personnel -*** led by University of Limpopo working with ACHEST, ECSA HC and Mustang consultants. The work explored the issues and interests motivating the negotiation of the Code in Africa, how far they were included in the code, and the progress in and use of implementation to raise and advance African interests. Noting that African ministers of health raised the issue of health worker migration on the global policy agenda, the case study explored the shift in interests over the long period of negotiation of the code and factors in the relative lull in efforts on the issue of health worker migration following adoption of the Code. The results are reported in EQUINET Discussion paper 103.

2. ***Collaborating on access to essential medicines through south- south relationships with emergent economies*:** This case study aimed to explore collaboration on medicines production and access between ESA countries and emergent economies. How and with what outcomes have bottlenecks raised in African policy platforms on medicine production and access been negotiated within bilateral agreements with southern partners and in global trade and health forums? The work was implemented by SEATINI and Centre for Human Rights and Development. The team outlined the bottlenecks to local medicines production in Africa raised in policy forums, and explored through experience in Uganda and Kenya how these had, or had not, been addressed in agreements on medicine production with India and China respectively, while also exploring how Zimbabwe had advanced local medicine production without such south-south partnerships. The results are reported in EQUINET Discussion paper 104.

3. ***The participation and influence of African actors on the decision making processes in the World Bank and Global Fund on health financing:*** This case study focused on the participation and influence of African state and non-state actors in the design, implementation and delivery of performance-based funding (PBF). The work was implemented by University of Sheffield and Ministry of Health Zambia. The issue was selected as concepts of participation, accountability and country ownership underpinned much of the thinking surrounding PBF and its introduction in global health policy dialogue. The case study explored this further, including the role of regional organisations and proposed options for strengthening national influence the design and decision-making process for PBF. The results are reported in EQUINET Discussion paper 102.

Prior to the field work all teams implemented stakeholder analysis and obtained the ethical review and clearance for their work. As complementary work, U Sheffield and TARSC carried out a content analysis of policy statements from BRICS and ESA regional and bilateral forums to assess the role of BRICS co-operation in addressing health system priorities in East and Southern Africa (ESA) (Brown et al 2014); and TARSC and Carleton prepared a synthesis of the learning across the case studies (Loewenson and Molenaar). These papers together with papers from the case studies have been

submitted to Journal of Health Diplomacy for a special issue on health diplomacy in Africa in 2015. The reports have been made available on EQUINET website, policy briefs prepared and disseminated on the policy learning and the presentations made at training and policy forums of the ECSA Health Community. An evaluation of the programme is underway.

The reports are all available online and were made available before and at the meeting together with other relevant background documents.

On March 13 and 14 a regional meeting was convened with objectives to
   i.   Present and discuss the findings from the EQUINET research programme and from related research in Africa, and the implications for policy, negotiations and programmes in east and southern Africa;
   ii.   Review methods and challenges for implementing research and analysis on global health diplomacy for policy relevance, from review of research and experience of the work;
   iii. Discuss and propose areas for follow up policy, action and research, within ESA and through south-south collaboration.
The full programme is shown in *Appendix 1*

The meeting was convened by Training and Research Support Centre (TARSC) for EQUINET in dialogue with the Centre for Trade Policy and Law, Carleton University Canada, the East Central and Southern African Health Community (ECSA HC) and with support from Department of Health (DoH) South Africa in the preparations for the meeting and financial support from IDRC (Canada). It included senior officials involved in health from national and regional organisations, health diplomats, researchers from the EQUINET work and others working on health diplomacy and on south-south co-operation in the region and internationally. The delegate list is shown in *Appendix 2.*

2.   Opening

The meeting was opened by *Yoswa Dambisya, Director General of ECSA HC* who welcomed delegates and thanked the South African hosts. He reflected on the development of the work on GHD in both ECSA HC and in EQUINET. He appreciated the long standing relationship he had with EQUINET and between EQUINET and ECSA-HC. For this research programme the work has developed from the meeting held in June 2012 in Johannesburg to design the work now being reported. He asked delegates to keep in mind the challenges facing the region and issues that need to be a focus of strategic attention as the region moves beyond the Millennium Development Goals (MDGs) into a post-2015 agenda, with those arising at global level pertinent to work on health and foreign policy. He observed that in the MDGs targets were set that are still to be met and that we are now again discussing universal health coverage (UHC), an agenda that was already part of the Alma Ata Declaration in 1978. If we still face these shortfalls in meeting long standing goals he observed that we need consider how we need to do things differently in setting and meeting new goals and in moving forward. He expressed his support for the opportunity in this regional meeting to have an in-depth and collective interrogation of some of these questions relating to global health and how the region engages on them.

Delegates were welcomed to the meeting by *Moeketsi Modisenyane, DoH South Africa*, who also chaired the session. Delegates introduced themselves and their organisation and work related to GHD. The apologies (shown in *Appendix 2*) were noted.

Mr Modisenyane added that there is a need to consider the global health challenges and responses to them from an African perspective. He argued that an African narrative will differ from narratives set elsewhere but asked - what then is this narrative? Is it being advanced at global level or are African actors responding to narratives set by others? He observed that the values within African approaches ought to include solidarity and

responsibility, and that goals, agenda's and programmes should incorporate those values, also rooted in African traditions such as Ubuntu. He noted that an increasing number of stakeholders are emerging in global health. While this interest is positive he suggested that there is need to critically analyse how far this is adding new momentum to key goals such as equity and universality in health care.

Rene Loewenson, TARSC/EQUINET, added the welcome from EQUINET and outlined the objectives of the meeting. She noted the work done by EQUINET, as outlined in the background section, arising from priorities set by ministers and policy makers in the region in 2011. She hoped that the meeting would review this work and that done by others to dialogue on what has been learned from this and what should be taken up in future work, in policy, programmes and future research. She raised that GHD is differently understood in different regions and communities, and that heath is brought into foreign policy at global level

- As a *tool* of foreign policy, to secure economic or security interests of states (such as in the management of cross border diseases and global epidemics)
- As an *outcome in the collective negotiation of competing interests* (such as in the negotiation of agreements on recruitment of health workers), and
- As a *goal* of foreign policy (such as in global funding for treatment of people living with HIV).

There is caution on bringing public health into foreign policy, even while there is a reality of growing international co-operation and global engagement on health. She appreciated the wealth and diversity of experience in the room and hoped that the dialogue would critically review the evidence and draw learning from the work done, to support a narrative and engagement on global health that comes from an African perspective and from evidence within the region.

Dr Loewenson read a message from *Qamar Mahmood IDRC Canada* who was not able to attend the meeting but gave support to the work and hoped to engage on the follow up. Finally, she thanked those who had played a role in the work and meeting, including the research teams, Carleton University, ECSA HC, DoH South Africa, IDRC and all delegates for travelling to the meeting.

3. Setting the context for GHD in east and southern Africa

Ernest Manyawu, ECSA HC, presented the activities and learning from the ECSA HC Strategic initiative on GHD. He noted the international negotiations leading to the signing of agreements at the World Trade Organisation (WTO) and particularly the TRIPS agreement that raised awareness of the potential conflicts between trade and public health, particularly given the raised demands to address the disease burden from AIDS in the ESA region. African states participated more actively in international trade negotiations, such as in South Africa, Kenya and Zimbabwe's role in negotiating the protections for public health in the Doha TRIPS agreement, backed by civil society and technical institutions jointly facilitating the institutionalisation of GHD in Africa.

Mr Manyawu outlined that advancing public health in global foreign policy also faces challenges: GHD is a relatively new discipline in Africa, with capacity and institutional gaps to ensure effective participation in the many forums where international negotiations are underway that affect global public health, and to manage the varied and sometimes conflicting interests. Within countries he noted the need to improve dialogue between key ministries on global health issues and to strengthen linkages between academic and civil society capacities and governments. The strategic initiative on GHD in the ECSA HC aimed to address these challenges, to create sustainable institutional arrangements and capacity for the region to participate effectively in the development of international agreements that affect public health. Specifically, it aimed to include research, information and advocacy to inform those involved, to develop capacities in GHD and to facilitate the coordination across government and other stakeholders.
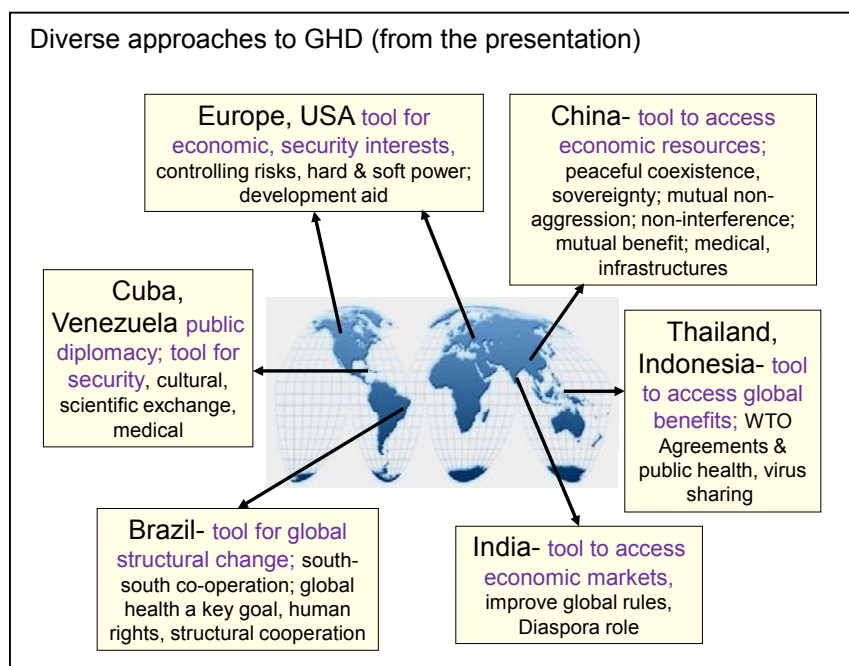
He outlined the work done in the initiative since 2010 by the ECSA-HC as policy lead in partnership with the University of Nairobi and Ministry of Public Health and Sanitation Kenya (on capacity development), and EQUINET (TARSC and SEATINI) (on research). Through this partnership, the initiative has held sessions on GHD with Ministers of Health and senior ministry officials, conducted training on GHD, produced and shared information on the state of GHD in the region, on identified gaps and on evidence and policy information and briefs to support negotiations on negotiations on public health at the WHO, WTO, and WIPO. Meetings have been held on specific issues, such as on the WHO Code on the International Recruitment of Health Workers and as preparatory inputs for the World Health Assembly. A curriculum has been developed for a regional Masters programme on GHD. An evaluation of the programme suggested that the initiative had been associated with strengthened participation by ESA states at the World Health Assembly and increased awareness of GHD. He noted that to date the programme has highlighted the need for a sustainable approach; robust monitoring and review; coordination between governments and technical capacities within the region and with civil society. It is thus planned to sustain and deepen these activities, supported by mobilisation of resources for a sustainable initiative on GHD and by a strengthened network, information sharing and linkage with technical resources in the region.

4.   Findings of the regional research

This section presents findings of the EQUINET regional research through presentation of the findings by a member of the team, discussant comment and delegate discussion, chaired by *Magda Awases WHO* and Rene Loewenson and in the afternoon by *Flavia Senkubuge University of Pretoria*. This was followed up by round-table discussions on the four areas presented in 4.1-4.4 below to discuss the learning on GHD from the research; the implications of the findings for policy and programme level and the knowledge gaps that still need to be addressed. The three case study areas in 4.2-4.4 were, as noted earlier, identified as priority areas in the regional health policy interactions on GHD in 2010.

4.1   Is there an African approach to health diplomacy?
Moeketsi Modisenyane, DoH South Africa, presented findings from a review paper on

African perspectives in global health diplomacy prepared in the EQUINET research programme.[1] The paper highlighted the historical developments in health as a foreign policy issue and the diverse perspectives brought to GHD from different regions. He observed that much African diplomacy in global health was undocumented, but that the literature reviewed suggested that there were three

Diverse approaches to GHD (from the presentation)

Europe, USA tool for economic, security interests, controlling risks, hard & soft power; development aid

China- tool to access economic resources; peaceful coexistence, sovereignty; mutual non-aggression; non-interference; mutual benefit; medical, infrastructures

Cuba, Venezuela public diplomacy; tool for security, cultural, scientific exchange, medical

Thailand, Indonesia- tool to access global benefits; WTO Agreements & public health, virus sharing

Brazil- tool for global structural change; south-south co-operation; global health a key goal, human rights, structural cooperation

India- tool to access economic markets, improve global rules, Diaspora role

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[1] Loewenson, R., Modisenyane, M., Pearcey, M. (2014). African perspectives in global health diplomacy. Journal of Health Diplomacy Vol 1:2: 1-19

main African foreign policy approaches to negotiations on global health:

i. **African unity, interdependence and reciprocity** (termed Ubuntu in South Africa), envisioning unit as a key factor in African freedom and using 'pan-Africanism' and 'continentalism' as lenses to engage new forms of economic or political exploitation and develop shared positions. This has been applied in GHD in negotiations on access to essential medicines, and in regional policy harmonization processes, such as in the SADC HIV Trust Fund and cross-border collaboration on malaria, TB and HIV and AIDS control.

ii. **Advancing the liberation ethic and demands of nationhood,** arising from the 20th Century anti-colonial struggles and nation building projects. They posit independence, sovereignty and self-determination and economic and social justice as critical for reclaiming Africa's place in international society. Specific lessons from this approach can be drawn from the 2001 Doha declaration at the WTO, the experience of South Africa's confrontation with big pharmaceutical companies, and Rwanda's full use of TRIPS flexibilities. He noted that there have been tensions between this approach and the use of human rights and other global frameworks that impose conditionality in global relations where they are perceived to challenge self-determination.

iii. **A tension between health as a sphere of development aid or an element of developmental policy** arose in the 1950s through the use of primary healthcare to re-organise health systems in developmental states. This was challenged by the Bretton Woods institution structural adjustment programmes cutting social spending, while the growth of extractive industries and the export of primary commodities widened inequality. He noted that Africa became increasingly dependent on external funding. Although a developmental alternative was framed in the Lagos Plan of Action for the Economic Development of Africa it was constrained by global trade and other policy influences, with aid approaches in the health sector not addressing the structural inequalities causing ill health framed in developmental policies. African countries attempted to protect policy space through regional cooperation. He observed the need to transition from dependence on external funders to address long term economic, socio-political exclusion and injustices.

He outlined how these perspectives were used in active diplomatic engagement, including in the negotiation of the TRIPS Agreement and Public Health and in alliances with South and civil society networks in pushing African agendas. He noted that the liberation ethic, solidarity and unity in African diplomacy can be seen as an assertion of interests and a defensive strategy, but that where policy positions are not shared across countries, sovereignty outweighs unity, as foreign policy plays a role in domestic power and nation building. He argued that there are new possibilities and demands for foreign policy in the interest around African natural resources, in the ongoing transformation of global power arrangements and in emerging south-south alliances, but also observed that while a disease based approach is not sustainable, addressing structural determinants of health confronts dominant global economic models and calls for greater policy coherence and networking across stakeholders nationally. Addressing health inequities within and between countries calls for action nationally and globally and a global political solution

As a discussant on the paper, *Emmanuel Makasa, Zambia High Commission, Geneva,* raised queries and comments on the issue of African approaches to health diplomacy. He noted that that African countries often engage late in global health negotiations, with approaches that are not always fully defined, framed or coordinated and with gaps in skills and institutions. At country level there is interaction between countries and international institutions and funders, but often with a reactive approach that responds to an agenda set elsewhere. He noted that engagement calls for African agenda setting, and equity in health should be part of that agenda. At the country level, other sectors that have an impact on health need to be brought into the discussion and countries need to forge common positions at regional level. He cited the recent Ebola outbreak as demanding a coherent position from African regional bodies and from the African Union,

as a basis for putting issues on the agenda at global level. He made several recommendations for future work, e.g. to adopt a strategic and proactive approach, that is sustainable and long term, or agenda changes too quickly for changes to take root. He too recommended involving sectors beyond ministries of health, and improved information exchange and communication across actors at all levels. For example, he noted that if AU positions are not passed on to diplomats to engage at the global level, representatives end up speaking as individual countries, rather than as regional or continental voices.

In the discussion that followed delegates noted that the contexts for diplomacy are changing and the process dynamic. It was raised that engaging in this context means thinking about the links and interactions both *within* Africa and those internationally, North and South. It is necessary to confront contradictions, such as when states invoke solidarity at global level, but do not practice it within countries. The reactive nature of African engagement was noted in the process for the Sustainable Development Goals (SDGs). Some delegates noted barriers to African participation in the processes for their development, and others noted the need for African forums to initiate the invitation for global committees driving such processes to meet with them. In the discussion it was also noted that that there are competing discourses on global health *within* Africa, and different interests of other forces beyond health (economic, military, security, nation-building etc.) that influence global level negotiations. These need to be better understood to assess the impact of throwing health 'into this mix'.

4.2   African engagement in GHD on health worker migration
Yoswa Dambisya ECSA HC presented the findings of the case study on GHD on health worker migration and the implementation of the WHO Code on international recruitment of health personnel as presented in the case study report.[2] The study sought to identify the extent to which the policy interests of African countries were incorporated into the Code, the factors affecting this, and how the Code is being used by ESA countries, including in ongoing diplomacy on HR issues.

The Code was developed in the context of a significant decline in health systems in part due to out-migration of health workers (HR) with global engagement emerging from Africa to provide more just returns for African investment in the health workforce. The demands from the continent and discourse on migration led to policy shifts, with the United Kingdom and the Commonwealth negotiating bilateral and multilateral agreements. The Code was eventually adopted at the WHA in 2010. It aims to facilitate and promote international co-operation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems. He raised that although African voice was eloquent in the development and lobbying for the adoption of the WHO Code, it has been much more mute in Code implementation and monitoring. The perception found of the Code in the region was that African interests were watered down in its final version, with compensation and mutuality of benefits excluded, and the voluntary nature seen to weaken effectiveness. There was burn out of those involved in the negotiations for the Code and high turnover among key role players in the negotiations over a protracted period. However external migration was also no longer found to be perceived as a high priority, overtaken by concerns on internal migration. Limited implementation of the Code was found, with limited effort to disseminate it, and a general lack of knowledge on it. The study found lack of preparedness for implementation; overburdened HR departments; lack of champions to drive the process; lack of regional coordination; lack of strong leadership on the Code from the WHO; perceptions of inadequacy of the Code; poor mobilisation of national level stakeholders and little publicity on progress of Code implementation. The study made various

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[2] Dambisya YM, N Malema N, C Dulo C, S Matinhure S, P Kadama P (2013) 'The engagement of east and southern African countries on the WHO Code of Practice on the International Recruitment of Health Personnel and its implementation', EQUINET Discussion paper 103, EQUINET, Harare

recommendations for increasing Code implementation, including through appointment of designated authorities, strengthened HR departments and information systems, and more active reporting with support from WHO and regional organisations. Prof Dambisya also observed that the lack of involvement of civil society and research institutions in the processes weakened African voice and implementation and recommended stronger collaboration in future work.

Mr Ibadat Dhillon as discussant noted that despite the inadequate implementation of the Code thus far, it was a victory for African countries and has a number of potentials to be realised. He saw it as a sign of increasing maturity of African GHD that procedural provisions like binding reporting were fought for and included, despite opposition from high income countries. However, he noted that all those countries that opposed the inclusion of binding reporting in the Code have fulfilled their reporting obligations, whereas of the countries that wanted it, only one (Rwanda) has, and only a fraction of African states have established dedicated reporting responsibilities. Even so, he suggested that this is a start. The fact that there is reporting from high income countries shifts the discussion from a paradigm of aid to one of responsibility. He noted that WHO has set a committee to review and report on the relevance and effectiveness of the code. He attributed weak WHO leadership on implementation to the lack of funding for this work and suggested that the WHA is an important forum where African actors were able to set the agenda. As a result it should be invested in. However, GHD efforts should not just be focused at the WHA, given that other global institutions control resources. Further he suggested that evidence shows that out-migration continues to be a problem but is not adequately measured, in part as health is subjugated to other considerations at country level.

In the delegate discussion the gap was raised between the content of the Code and the concerns of African countries, such as on the *within* country migration of health workers to well-funded programmes to the detriment of other services. Noting that the code was being reviewed in WHO, delegates observed the need to address the root causes of migration and retain health workers and questioned how far the bilateral agreements included in the Code have incorporated innovative clauses on this. It was suggested that it would be useful to review the lessons learned from other voluntary codes, such as that on breastfeeding. There was a view that the issue at this stage is to focus on implementation and reporting, including by investing in other sectors that play a role, such as labour ministries.

4.3   Engagement in south-south cooperation on medicines production
Mr Rangarirai Machemedze, SEATINI, presented the findings of the case study research on medicines production and procurement in the ESA region and the role of south-south co-operation[3]. The research aimed to identify the bottlenecks to local medicine production in ESA, and how far south-south co-operation in local medicine production with BRICS country partners in Uganda and Kenya (and without in Zimbabwe) have addressed these bottlenecks, as an input to policy and negotiations.

With the high disease burden and lack of access to safe, effective and affordable medicines, encouraging local production of medicines is seen as one response, given that it also contributes to economic and industrial development, and to technological capacity. Currently, 37 Sub-Saharan African countries are pharmaceutical producers, with South Africa responsible for over 70% of annual production, and Nigeria, Kenya, and Ghana together contributing 20%. Only South Africa has a limited degree of Active Pharmaceutical Ingredient (API) production. The research highlighted infrastructure, capacity, financial, technology and governance barriers to local production, but also positive examples of south-south practice, including the CIPLA/QCIL partnership in

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[3] SEATINI, CEHURD (2014) Medicines production and procurement in east and southern Africa and the role of south-south co-operation, EQUINET Discussion paper 104, EQUINET: Harare.

Uganda, the Kenyan government support for the Kenya Medical Research Institute, and Zimbabwe's research councils, Scientific Industrial Research and Development Centre, National Institute of Health Research and Human Capital in Science and Technology.

He noted that technology transfer would stimulate local production, if it is encouraged by factors such as viable local markets, political stability and good economic governance and effective regulation and skills inputs. He outlined how the Ugandan CIPLA/QCIL partnership had used south-south cooperation to address some of these factors, such as for staff training and exchanges, and for capital investment. However he also noted that the same south-south inputs were not found in Kenya where the planned investment did not take off, and that despite government policy support in Zimbabwe, there were still contradictory trade measures such as high tariffs on imported raw materials for local production.
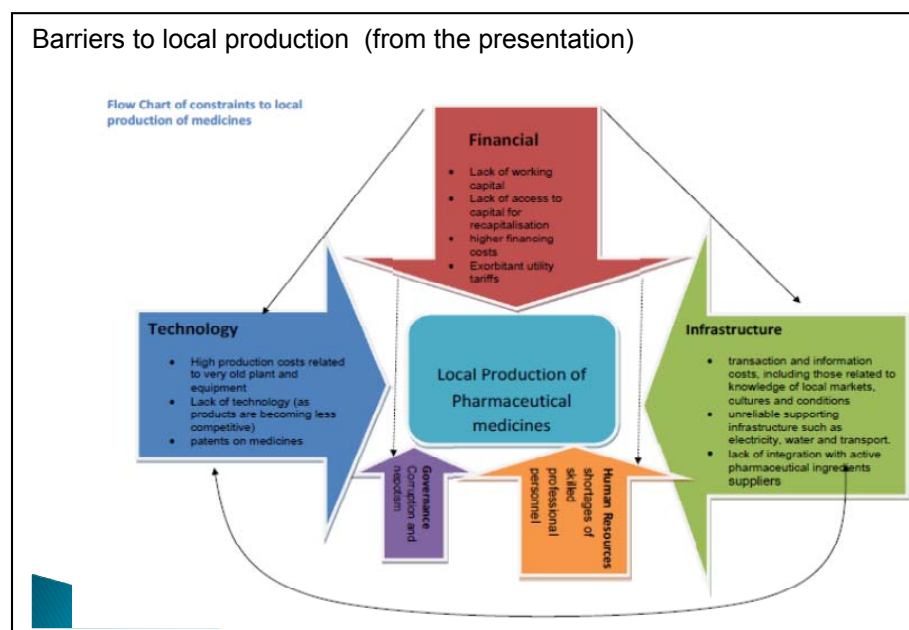
Barriers to local production (from the presentation)

He noted that the rationale for local production outweighs the fears, and that examples such as the QCIL – CIPLA co-operation on technology transfer and HR development show the potential for local production of APIs leading to cheaper products, but that achieving this would need policy to move to implementation in domestic laws, policies and co-operation agreements on pharmaceutical production, including to ensure transparency and quality of practice; to strengthen dialogue among governments, pharmaceutical companies and training institutions to train, attract and retain skilled personnel; and to enable the industry with infrastructure support and fiscal incentives. He also indicated that ESA countries would need to negotiate for a share of external funds to be used for local procurement from companies prequalified by WHO. He noted that while south-south co-operation may be one route to overcoming these obstacles, with most of the medicine in the region imported coming from India and China there may be less interest in localising production in Africa from these countries given their role as exporters to the region.

Ropafadzai Hove, Ministry of Health and Child Care, Zimbabwe, as discussant on the paper commented that ministries of trade, finance and justice must be incorporated in these discussions on medicine production and that the issues need to be debated and understood at both policy, senior official and implementation levels, with capacitation for local level workers to implement policies. She suggested that civil society and other non government organisations can assist to support this, if they have a constructive and meaningful engagement. She observed that local production needs good manufacturing standards, which may vary from one place to another and that the process of local production needs to be multi-disciplinary.

In the delegate discussion, delegates raised the role of external funders in medicine production, and the possibilities of aggregating markets. Delegates suggested learning from prior efforts in the East African Community (EAC) to implement medicines production, and from other examples of regional production and co-operation, given the importance of regional level action for addressing capital and market factors. It was noted

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for example that SADC is undertaking reviews of laws and agreements to make sure that production in the region is TRIPS compliant. It was also raised that there is need to assess how far ESA countries are exploiting the flexibilities and provisions in current agreements. It was commented that the results of the study be more widely disseminated in the region to encourage policy dialogue on the findings.

4.4 African engagement in global governance on health financing

Patrick Banda, Ministry of Health of Zambia, presented the findings from the case study on how African actors participate in global health governance processes on performance-based funding (PBF).[4] PBF is the transfer of money or material goods conditional upon taking a measurable action or achieving a predetermined performance target. The research identified two types of PBF. Type 1 exhibits narrow targets based on payment for service or outcome, and is preferred by most external funders, as it makes it easier to set targets and track performance. Type 2 has targets based on broader health system indicators and outcomes and arose through local pressure to integrate PBF into system strengthening. Reliable targets for Type 2 funding are hard to set due to monitoring and evaluation shortcomings, and it is difficult to track performance.

The study reviewed existing research into PBF, which has exhibited evidence of some Type 1 success, but also problems. There is a lack of evidence supporting causal relationship between PBF and Type 2 system strengthening, due to: difficulty isolating variables; poor sampling or evidence 'cherry-picking'; and issues with generalizability. He noted that the view that PBF 'works' is often unsupported by evidence, and there is lack of clarity on who is driving the PBF agenda. The study highlighted that, at the global level, participation was generally by invitation, special request or by national proposal in-line with funder initiatives; with pressure from funders to adopt PBF and well organized funder agenda and target setting. There was little scope found for regional influence in PBF schemes and regional bodies were found to be underutilised. At the national level, there was evidence of multisectoral participation in target setting; of an integrated systems approach with PBF; of improved national targets that are 'owned'; but also of limited multisectoral participation and of ad hoc / distorted priority targeting in PBF.

Local models for PBF/RBF (from the presentation)

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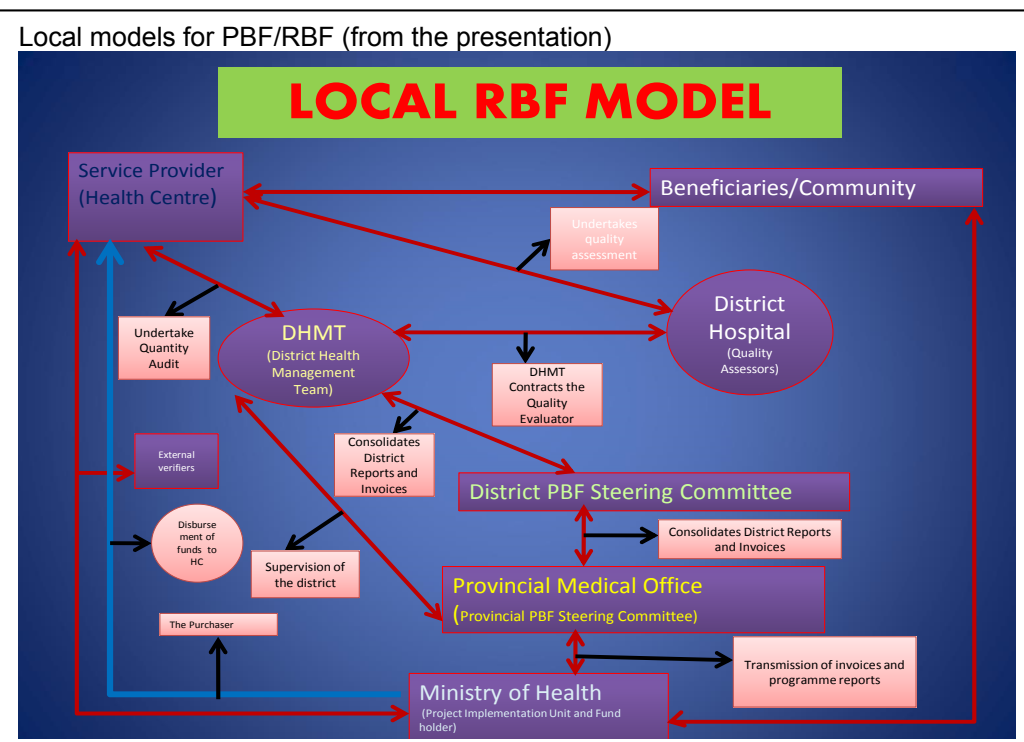
[4] Barnes A, Brown G, Harman S, Papamichail A, Banda P, Hayes R, Muliamba C (2014) 'African participation and partnership in performance-based financing: A case study in global health policy', EQUINET Discussion Paper 102, EQUINET: Harare.

From the study recommendations were made to ensure that the design of schemes reflect national priorities, by taking 'national ownership' of the agenda; knowing the possibilities and limits of PBF; using a multi-sectoral approach in managing PBF and building an evaluation capacity, especially of national system outcomes. He also noted that it's also ok to say no. Given that there is little room for equitable diplomacy in the current system as funding comes with procedural conditions, the study team raised the importance of influencing global initiatives at the macro (global) level, in advance of their being raised within the region.

Potentials and Problems in PBF schemes (from the presentation)	
CURRENT POTENTIAL OF PBF SCHEMES	**WHY PBF SCHEMES CAN BE PROBLEMATIC**
More regional cooperation	Not enough evidence that PBF strengthens overall health systems in the long run
More inclusive governance mechanisms	PBF can compromise the quality of care to meet targets
Better integration of PBF schemes into National Plans and Health Systems	PBF cannot always integrate into a country's health financing systems and governance systems
Functional Monitoring and Evaluation Systems	Monitoring and Evaluation Systems are often not robust enough
	PBF can often overburden health sector with extra reporting formats
	PBF can cause long term reliance on external financing

In the delegate discussion the question was raised, 'How would PBF differ if ESA countries had had more agency in the funding process?' To this it was noted that the question is perhaps not how *PBF* would differ, but rather how this input would align funding to where it is needed to improve overall health system performance in the different contexts of different countries and how this expenditure can be better monitored.

5.   Round table discussions on the regional research

Delegates divided into four round-table groups, one group for each of the four areas presented in 4.1-4.4, to discuss the learning on GHD from the research; the implications of the findings for policy and programme level and the knowledge gaps that still need to be addressed.

5.1   On African perspectives in global health diplomacy

On the *learning on GHD from the research,* delegates noted that while the perspectives raised were valid, there are weaknesses in African engagement on GHD. There is poor coordination in the region in building the positions for GHD, weakening the unified front and leading to global targets and policies being set *for* rather than *by* the region. It was suggested that development aid has been influential, but is not sustainable. ESA countries need to build more self-determined strategies and sustainable ways to handle health problems. An African approach to GHD was seen to require a multi-sectoral understanding and approach. It was also observed that a coherent African approach to GHD requires links between the national, the regional, and the global levels. Discussions need to happen within ESA countries, with a national agenda being developed to ascertain the priorities in each country. These then need to be reflected, co-ordinated and supported at the regional level and taken for negotiation to the global level.

On the *implications of the findings for policies and programmes* delegates suggested that agendas that are important for the African continent, such as technology transfer, need sustained and longer term processes to be achieved. It was observed that to achieve this global health and foreign policy need to be institutionalised and mainstreamed into discourse and policy nationally, in regional organisations (the AU commission, EAC and SADC), with shared analysis and clear and disseminated goals and targets to focus and sustain the attention of government and other national actors.

On the *knowledge gaps for future research*, delegates raised:

- How does the ESA region / Africa develop evidence-based agendas for global health negotiations? What learning is there from other regions?
- What are the priority sustained issues for global health as perceived from different multisectoral actors and stakeholders within the ESA region?
- What measures are needed to enhance the co-ordination and communication across the necessary actors at national and regional level and between embassies and capitals? What learning is there from where this is working well?

5.2 On the WHO Code on recruitment of health workers

On the *learning on GHD from the research,* delegates noted that African countries need to have clearer positions on issues under global negotiation continentally or within the sub-region, to avoid being overwhelmed by the multiple global and other actors and interests that are influencing the direction of discussions. It was noted that regional organisations positions will be more legitimate and powerful when emanating from well discussed country positions within the region. The Code work highlighted the gap that exists between ideas and their implementation in the region. It pointed to the need to identify and allocate resources to implement strategies raised at policy level, whilst noting that health commitments articulated globally are not always at the top of government funding agendas nationally. The work also pointed to the need for stronger in-built, institutionalised feedback mechanisms at all levels, including to local populations who need to be empowered and educated to ensure that accountability. Specifically on the issue of health worker migration, there has been a near absence of civil society advocacy and involvement, especially in rural areas often most affected by within and external health worker migration.

Delegates identified that solidarity/unity is possible to build during negotiations but may easily fall apart when it becomes time for implementation. It was noted that when an agenda is being advanced, there must be a simultaneous process of preparation for implementation, taking cognisance of capacities and work burdens, including within the WHO al office.

On the *implications of the findings for policies and programmes* delegates suggested that from the findings it appeared that consistent feedback, dissemination and institutional review mechanisms need to be established or strengthened at national and regional level and with embassies, that are inclusive of all relevant actors including affected communities. Being iterative and sometimes long, the processes for policy making need to have sustained attention and institutional continuity, with links made to those producing evidence and to regional bodies and the AU. Investment needs to be made in capacities and resources to implement

Meeting delegates in the round table discussions

agreements, particularly those that are advanced from within the region, and again links to AU and regional body review processes will facilitate / spur implementation and dialogue on overcoming constraints.

It was noted that the WHO review process on relevance and effectiveness of the Code through the Advisory Expert Group provides an opportunity to provide a more proactive

and organised input from the region. What position is the region taking to this process and how will it be used to address perceived shortfalls in the Code? It was mentioned that the WHO International Code of Marketing of Breast-milk Substitutes was strengthened by review and reporting processes. How can the binding areas of the Code be used to strengthen the non-binding areas? It was noted that Cameroon and South Africa are representing Africa in the review process, so how can these African delegates be supported in the Advisory Expert Group?

On the *knowledge gaps for future research*, delegates raised:
- What is the ESA/African position and strategy for the review process on relevance and effectiveness of the code through the Advisory Expert Group and how can this be informed by experience of other codes?
- A need to track in a more systematic way the dissemination and implementation of the Code, to assess the resources used to support implementation and the constraints to it. (This could also be compared with how this is being done in other regions).
- Evidence supporting policy dialogue on the continued and sustained development of HR in the region.

5.3 On south-south/ global negotiations on local production of medicines

On the *learning on GHD from the research,* delegates noted that many of the constraints to local production driving non-competitive prices lie in the operating environment (eg costs of electricity, transport, tariffs on raw materials). These need co-ordinated action from a number of sectors, making strong political leadership and executive/ state intervention crucial for success, to compensate for shortfalls. Examples of this intervention included providing time-bound and specific subsidies to encourage local production; improving appropriate regulation and trade regimes; and ensuring provision of the infrastructure for production. The research also suggested that companies may need to form consortiums, with different product lines, to share risk and capacities, widen markets and respond to purchasing of combined medicine needs from external funders. This may call for regional Integration and specialization, to support special economic zones at country and regional level. There is potential to learn from China on this area.

A distinction was made between technology transfer and innovation to make clear the role and presence of African innovation and to raise policy attention to the levers needed to support local innovation, including in terms of funding and local research institutes. At the same time it was noted that LDCs have been on the defensive on issues of technology transfer, and it was suggested that LDCs be more proactive and hold partners responsible for their commitments. The TRIPS agreements have provisions obliging developed countries to undertake technology transfer, but this is not being done. It is not about hand-outs, but about responsibility and duty to meet agreements, and it was suggested that there is scope for a more proactive African position that changes the discourse on this, including in south-south discussions.

On the *implications of the findings for policies and programmes* delegates suggested that GHD matters be integrated within professional and management training for all sectors engaging in medicines production, such as on global agreements and TRIPS flexibilities. External funders come from countries with market interests, so while they may support pooled procurement and donate medicines, there is little scope for them to support local production, unless as joint ventures. Delegates supported a recommendation made from the research for countries and the region to negotiate for a share of external funds for medicines to be used for local procurement from companies prequalified by WHO. Information on agreements signed is a challenge and there needs to be greater transparency with key stakeholders on these to support their implementation. Dialogue needs to be initiated on the skills needs of industry to support local production with educational and training institutions to ensure they produce the graduates suitable for the industry.

On the *knowledge gaps for future research*, delegates raised:
- What agreements have been signed in the region on medicines production?
- How can LDCs and the region take advantage of the transition period for implementing TRIPS agreement on pharmaceuticals to support local medicines production, particularly by operationalising the extension currently under review?
- What are the most critical (quantified) cost drivers to address to improve competitive pricing? How have these been negotiated and addressed in other regions?
- How many companies within the ESA region are WHO prequalified? Of those that are prequalified how many products are they producing? What measures are needed to widen the range and what options for consortia of producers? (How has this been achieved in other regions?)
- What spaces and provisions should be used to reframe the issue of technology transfer from 'charity' to obligation and to include support for innovation within the region?

5.4   On participation in the design of global financing and PBF

On the *learning on GHD from the research,* delegates observed that recipient countries are not setting the agenda, some do not perceive that they can input to the design of PBF and the interests and contexts that are involved from both funder and recipient need to be better understood to engage the funders from their own interests. This needs to be done before discussions open on funding in a more proactive manner, by identifying, defining and sharing information on priorities and approaches that will address health system gaps, including with embassies, and by engaging at political level on these so that technocrats are not disempowered at the time of negotiation.

As *implications of the findings for policies and programmes* delegates thus suggested that the assumption that payments drive performance be challenged by assessing and highlighting the full spectrum of factors impacting on poor performance and engaging on how these will be addressed. In relation to PBF it was noted that the implications from evidence need to be shared with policy leads, with the critical factors affecting outcomes such as the need for of a well-functioning health information system and governance and accountability structures, so that the costs of these are built into negotiations. It was also noted that there is need to make clearer at both policy, implementation level and with the public the long-term implications of financing strategies on the health system and the implications of changed external funder priorities and the exit strategies for external funders. Delegates observed that African culture respects and honours gifts, so there is need to manage aid support in a manner that protects this tradition but allows for negotiation of interests and outcomes.

On the *knowledge gaps for future research*, delegates raised:
- Are there differences between the types of funding modalities - results based financing; performance based financing; performance for results- and how do the reforms differ in their application and outcomes?
- Evaluation of different designs of intervention: supply side and demand side. Where are the decisions on PBF interventions made?
- How do different countries compare, both successful and unsuccessful? This should include countries beyond the pilot phase, to evaluate whether there are pre-requisites for success.
- What is the impact of PBF on health systems? Need impact evaluations (after five years perhaps) to assess the sustainability of these initiatives;
- What are the levers for all levels of actors for agenda setting and sustaining discourse at within and across countries in the region on the financing options for equitable and resilient systems and for taking this to global level?

These issues were carried forward into the final round table discussions on next steps, reported later.

6.   African engagement in international cooperation

The next session, co-chaired by *Luvuyo Ndimeni Dir Human Rights, South Africa and Yousuf Vawda, School of Law, University of KwaZulu-Natal* heard from EQUINET and wider research on the region diverse dimensions of African engagement with Brazil, India, China and new international actors such as the BRICS.

6.1   Perspectives from Brazil on south-south cooperation with Africa

Celia Almeida, ALAMES/Fiocruz, presented the Brazilian perspectives on south-south cooperation in health between Latin America and Africa. She highlighted that since 2000, Brazil has expanded south-south co-operation, with an emphasis on social concerns, particularly health and without conditionalities, with a priority given to countries in Africa and in Latin America. Technical cooperation is thus a strategic area of collaboration between the Foreign Ministry and the Ministry of Health in Brazil. She outlined the features of Brazilian international cooperation, as:

- Respect for national conditions and specific challenges of countries cooperated with, not merely reproducing successful Brazilian practices on foreign soil.
- Co-operation arising out of expressions of interest from the applicant country.
- Projects conceived and executed jointly with active participation by specialists from both Brazil and the interested country.
- Permanent concern given to strengthening national capabilities and sustainably developing the local society.
- Cooperation as a two-way street, benefiting countries (good practices, technology and expertise) with learning from experience for constant improvement of programmes, measures and institutions.

Brazil's structural cooperation in health (from the presentation)

Almeida C., May 2010
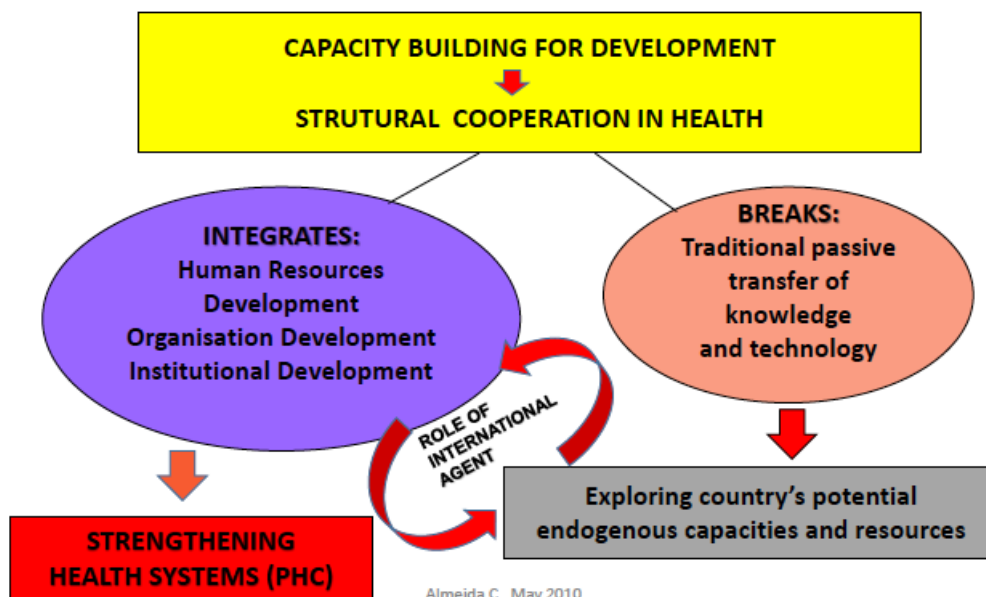
The main co-operation projects with African countries aim at training health personnel in research, teaching or services, and strengthening or setting up health system (core) institutions, such as National Institutes of Health, National Schools of Public Health, institutes for technological development and production, factories, faculties for graduate and professional training, and polytechnic health colleges. Structural cooperation instruments include:

- Co-ordination and related visits to Brazil and to African and Latin American countries.
- Establishment (or support) of national and regional networks.
- Technical-scientific and research joint development and exchange programmes.

- Support to personnel development.
- Advice and technical support to health system development (services, organisations and health programs).
- Donations and sales of products and medical supplies produced by Fiocruz and in-country public laboratories.

She reflected on the lessons learned through these co-operation programmes:
- **Applying horizontality:** as a political and strategic position, implies continuous exchange of experience, joint learning and sharing of results and responsibilities with national and international partners, with decisions taken at several levels and different loci of power, taking the different organisational cultures into account.
- **Focusing on health capacity building raises a major challenge,** with more work needed on how to implement it with a view to strengthening health systems and partnering crucial to identify issues and tackle problems. She noted that high expectations for effective results go hand-in-hand with limited administrative mechanisms on both sides, demanding appropriate institutional arrangements to respond to foreign policy decisions and avoid responsibilities being obscured.
- **Locating initiatives in a regional context** based on the understanding that for greater effectiveness in international cooperation, it is important to construct regional arrangements that build political strength and widen "strategic room" to a greater extent than that afforded by bilateral relations.
- **Involving Health Ministers in constructing strategic and political consensuses,** through frequent meetings among the countries at a variety of locations and levels, in partnership with other international organisations and prominent actors committed to promoting South-South cooperation in health.
- **Close partnering between health and foreign ministries nationally,** to associate health expertise with the strengths of the foreign affairs sector to improve health diplomacy.

She concluded with recommendations for the meeting for how to formulate a better notion of international health cooperation, through:
- Supporting comprehensive health system development (universality and equity) to overcome fragmentation and lack of coordination in health sector reform processes and to build interchange of experiences.
- Emphasising long-term needs by strengthening key institutions to acquire true leadership, promoting a future-oriented agenda and balancing specific actions with knowledge generation.
- Moving from single programme-based interactions driven by a global orientation to strategic planning centred on "recipient" country realities, broadly incorporating the social determinants of health.
- Prioritising population-based (health needs-oriented) programmes over activities focused strictly on individual care, and
- Promoting community participation and society engagement.

6.2 Integrating global health into foreign policy on antiretroviral medicine in South Africa

Moeketsi Modisenyane, speaking as a doctoral student at the University of Pretoria, presented a working paper exploring the integration of global health into South African foreign policy in relation to access to antiretroviral medicines (ARVs), through how the 'problem', 'policy', 'politics' streams and 'policy entrepreneurs' interrelate. He elaborated on the content of these streams around the focus issue, and observed that from the initial evidence GHD provides a rationale for integration of these streams. It has helped to prioritise health in South Africa's foreign policy and to drive coordination and collaboration across sectors. It potentially can promote regionalism for African development and south-south cooperation and facilitate engagement and collaboration with transnational networks. He noted that this was work still in progress but that the evidence suggests that international relations are complex and nuanced, and that the

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diplomacy process can be unpredictable. It is not only influenced by interests, but also by factors such as political leadership, bureaucratic capacity and the maturity and reputation of negotiators. He reflected on the emerging lessons for strengthening South Africa's engagements on GHD, namely:

- Conditions for engagements, such as in the Constitution, (in a rights based approach) and the National Health Act of 2003 that provide for access to health services for all, as well as a vibrant democracy, institutions of governance to ensure accountability and transparency, effective local citizen/community engagements in health delivery and regional and global leadership.
- Coordination and collaboration, through fostering better coordination across government departments, especially among staff responsible for health, foreign policy, and international development.
- Engaging key domestic and transnational actors, such as civil society organizations, academia, professional associations, and individual opinion leaders, hosting of World Health Organization Collaborating Centres and various experts who participates in WHO technical committees;
- Regionalism for Africa development: through strengthening SADC as a regional institution to address and mitigate trans-border social harms, with innovative regulatory frameworks and harmonization agendas that can impact on national policy making and management in health of the region such as SADC HIV Trust Fund, four country initiative on TB in Mines, and the E8 malaria elimination.
- South-South cooperation and aid effectiveness, through bilateral technical assistance to improve the quality of technical support to low-income countries, directing resources to where they are most needed, such as in the Trilateral collaboration with Cuba on health workers in Mali, Rwanda and Sierra Leone.

He concluded with recommendations for the meeting for how to formulate a better notion of global health diplomacy, from SA perspective, that none of the four streams alone could explain all of a country's behavior, and the success of diplomacy depends on the artful use of different combinations and interfaces of these streams and the actors that shape them.

6.3   BRICS cooperation in addressing ESA health system priorities

Dr Rene Loewenson, TARSC presented findings from a review paper implemented in the EQUINET research co-authored with Garrett Brown, Mokhetsi Modisenyane and Andreas Papamichail.[5] Seeking to determine how far the resolutions, commitments, agreements and strategies from BRICS and Brazil, India and China (BIC) as south-south co-operation address regionally articulated policy concerns in AU, SADC, EAC and ECSA HC policy and ministerial resolutions on health systems in East and Southern Africa (ESA). The study undertook a literature review and content analyses of ESA and BRICS/BIC policy documents post 2008 within the three focus areas of EQUINET research on GHD, that is of resource mobilization/ health financing; research and development and local production of medicines; and training and retention of health workers. From the review of literature, several features became apparent. An increase in the amount of publication on BRICS (Brazil, India, China, Russia and South Africa) and Africa reflected increasing interest in the area, although with limited publication from an African lens. She observed that BRICS is not a unified block in global health, with diverse approaches, and there is more concrete health co-operation of individual BRICS and African countries at bilateral level than multilateral cooperation. The content analyses of ESA and BRICS policy documents revealed that all three all three areas had high relative coverage, with medicines the most commonly stated area in both, and synergies between the policy documents in all three areas, albeit with very broad statements in the BRICS statements. She summarized the findings (to be published in the full Journal of Health Diplomacy paper) and the common and different features of how the areas are

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[5] Brown GB, Loewenson R, Modisenyane M, Papamichail A (2015 in press) Business as usual? The role of BRICS co-operation in addressing health system priorities in East and Southern Africa, submitted to Journal of Health Diplomacy

covered in the African and BRICS policy documents. The findings suggested numerous features of equitable cooperation, including joint declarations and commitments and synergies in broad priorities and the values underlying them, that also suggested the possibility of joint positions in global negotiations. At the same time there was less common statement of operational commitments or goals for these areas, and some evidence of differences in focus between BRICS and Africa countries. For example there was a shared concern on medicines, but more focus in BICs documents on market access, while ESA policies gave more focus to overcoming barriers to local production: skills training, capital investment, harmonising laws, technology transfer and bulk procurement. She suggested that African countries still need to ensure that partnerships between BRICS and the ESA region are true to stated aims of mutual benefit, such as through operational commitments and specific goals, through tapping the BRICS Development Bank role as development facility and in knowledge exchange; and through tapping the opportunity of South Africa, China and India being allocated 'access to medicines, vaccines and diagnostics' at the 2013 BRICS Ministerial meeting.

In the discussion that followed, delegates noted the need to continue and deepen work on the interactions with BRICS countries, to track and build measures for accountability on resource flows and implementation and to address the power imbalances that influence negotiations, even within south-south co-operation. It was also suggested to widen the lens to document and bring information on the wide range of emerging blocks, bilateral, multilateral and plurilateral interactions involved in co-operation on health, and to not only focus on health platforms but more widely assess what is taking place that has health impact in other UN and sectoral forums. At the same time a caution was expressed that this brings health into complex terrains, calling for sustained work that builds a depth of analysis and understanding and for strategic interactions, such as between health and foreign policy actors in the region. For example terminology matters and that the language of exchange needs to consider both the health and the foreign policy use (with the example given on the different use of the term 'non-state actors'). Bringing health to diplomacy at global level was noted to bring health into an environment fraught with politics, that while it can yield profile for health, can also yield outcomes that compromise or defeat intended health goals.

7. African engagement in epidemic and humanitarian responses

This session, chaired by *Isabella Ayagah, Ministry of Health, Kenya,* raised through two presentations how co-operation and diplomacy have been applied in epidemic and humanitarian responses. While these contexts present compressed or unusual conditions for health and foreign policy, they are also not uncommon, as witnessed by the recent response to the Ebola epidemic, and as an entry point for longer term interests merit attention.

7.1 Fighting Ebola as a field of civil-military cooperation
Dr Adam Kamradt-Scott, University of Sydney, presented findings on the response to the Ebola outbreak in West Africa in 2014, and particularly on health sector responses to increased military involvement in humanitarian responses and global health. While civil-military cooperation in health is not a new phenomenon, the military contribution to public health has traditionally been to enforce protections and controls and, more recently, as a strategic (and controversial) tool to 'win hearts and minds'. He noted that militaries often have access to a great deal of funding and to areas of countries that may not be accessible to civilians , are efficient at logistics and can build technical cooperation that support health innovation, such as happened with the smallpox vaccination program. Military activities in health however bring time limited interventions that can have long-term impact, with interests and objectives that are not those of the health community, with a culture, scale and approach that does not align well to traditional health approaches and lack of formal agreements on cooperation. He indicated that his

institution is supporting work to build an evaluation framework to understand and evaluate civil-military cooperation in complex health emergencies to inform more active civil engagement in this area. Dr Kamradt-Scott also detailed the launch of a new Masters in Health Security that the University of Sydney is launching in February 2016.

7.2   Global health diplomacy in humanitarian action

Valerie Percival, Carleton University, presented an overview of the role of global health diplomacy in humanitarian action. She noted that diplomacy in humanitarian contexts operates in a compressed time frame, in complex operations, where chaos and confusion may reign, with little time to engage and to ensure access to vulnerable populations. Diplomacy tools can be critical to success, but within multiple forums and with a focus on 'neutrality' of actors to overcome obstacles. This makes non-involvement in conflict a key task for humanitarian actors, raising barriers to how they integrate with longer term institutions and processes, including within the United Nations. She compared the approaches used in humanitarian situations in Libya, Haiti, Pakistan and Burma, in terms of conditions of access, respect for humanitarian neutrality and the role of other institutions, including regional institutions. The work raised possible lessons for African countries: It highlighted the importance of norms and institutions such as the Alma Ata declaration, that if not profiled need to be reinvigorated and reiterated. It also raised the importance of paying attention to relationships and to testing norms and institutions as processes unfold and it raised the key role of networks, whether local or regional.

These presentations were only able to give a brief view of a large area. In the discussion, delegates observed that research into how health is tackled as a security issue and on the military response to health issues is necessary, to make this field more transparent to scrutiny and to build strategies for how to manage and engage with military responses in health. This was raised as necessary given the involvement of militaries in relief and other activities affecting health within and beyond the region. There was also caution raised on how this is done, noting that locating health as a security issue can distort the public health and social values that underlie health policies and strategies in the region. It is a complex area that merits more discussion. Delegates noted the issue of testing norms and institutions, and raised the need to explore further the 'neutrality' of humanitarian actors, noting the distrust in some states and governments of humanitarian work being an entry point for external actors and interests.

8.   Synthesising learning from the research

This session, chaired by *Rangarirai Machemedze, SEATINI, EQUINET,* explored learning from across the research programme and work at regional level.

8.1   Development of a tool in the SADC region for policy monitoring

Ana Amaya, UNU-CRIS, presented the work of UNU-CRIS and partner institutions on the Poverty Reduction and Regional Integration (PRARI) project studying what regional institutional practices and methods of regional policy formation are conducive to the emergence of embedded pro-poor health strategies, and what national, regional, and international actors can do to promote such practices and methods. She outlined work to develop indicators for participatory review of this in the SADC region, to generate policies and actions to address problems faced by neglected populations; strengthen partnerships and local capacity building; and enable actors can monitor policies.

A workshop for the SADC region in December 2014 on areas for policy monitoring highlighted the need for a multi-sectoral approach to health and related issues; to provide evidence to demonstrate the cost-effectiveness of investing in health; to address issues of governance; and to ensure buy-in from leadership levels. She noted the importance of regional processes for this, but also the need for this to be based on active participation of national actors.
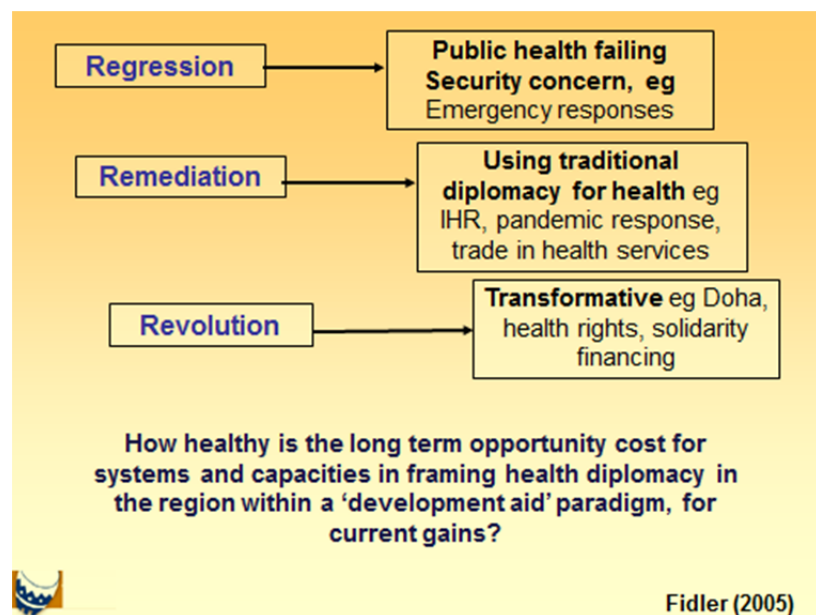
8.2 Learning from across the EQUINET research

Rene Loewenson, TARSC/EQUINET, presented the learning from across the different desk reviews and case studies in the EQUINET programme, within the areas of agenda setting, policy development and selection and policy implementation. This is based on a paper from the programme to be published in the Journal of Health Diplomacy.

She noted (citing examples) that:

- Influence in **agenda setting** was influenced by linkages to recognised global issues, such as the MDGs; by high level political leadership and clear and consistent articulation of issues; with backing from civil society and from south-south alliances. However, African voice in agenda setting was also noted to be weakened by issues as being externally driven and by exclusion from the formal and informal dialogues at global level.
- In **policy development**, the positive experiences drew on the presence of regional and national policies, high level executive support, a clear understanding of proposals, backed by bilateral or multilateral agreements and strong capital-embassy links and African group unity. However the studies showed that policy development is a politically complex and long process; where limited access to evidence; reluctance to challenge external funders and consultant influence can lead to losses in desired content.
- In **policy selection**, positive outcomes emerged where countries were more self-reliant in own funding, could draw on role models, domestic private sector support, and where there was unity within and strong champion countries in the ESA community. However the politically competitive, sometimes conflictual nature of the process posed challenges, particularly where there was weak domestic policy and civil society support and weak information flows.
- Finally **policy implementation** was more likely where policy negotiations were widely disseminated, where the areas negotiated already had synergies with existing policy, laws and practice, with support from the domestic private sector and civil society and exchange between countries regionally. Conversely, the studies highlighted that a loss of institutional memory, perception of negotiation as the 'end point', poor resourcing of and preparation for implementation and weak involvement of civil society weakened policy implementation in the areas studied.

These experiences suggest strengths to build on in future negotiations, and gaps to address. However, in observing Fidler's three forms of diplomacy,[6] she questioned whether the common framing of health diplomacy in a development aid paradigm is suppressing more transformative options, and the development or use of the areas of strength find in the case studies that support such approaches.

Regression → **Public health failing Security concern, eg** Emergency responses

Remediation → **Using traditional diplomacy for health** eg IHR, pandemic response, trade in health services

Revolution → **Transformative** eg Doha, health rights, solidarity financing

How healthy is the long term opportunity cost for systems and capacities in framing health diplomacy in the region within a 'development aid' paradigm, for current gains?

Fidler (2005)

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[6] Fidler, D. (2005). Health and foreign policy: A conceptual overview. London: Nuffield Trust.

Lebogang Lebese, Department of Health South Africa, as discussant to the papers, identified as challenges to effective African involvement in GHD the gap in expertise, and in links between technical, negotiation and or political expertise. She noted that regional economic communities (RECs) were expected to play a stronger role in global health, but are not always doing so and may even be bypassed in the global to national interaction. She indicated that this called for wider understanding of the mandates of the different organisations, their role and areas of focus and for political and technical leadership. She also posed that there are opportunities for ESA countries: GHD is a new phenomenon that African states can still claim a space within. The conclusion of the 'MDG period' opens space for new negotiations and GHD is within the function of RECs with possibilities for coordination, negotiation with stakeholders, and political and technical linkages. This means that the RECs should have clear roles, mandates, goals and strategies for GHD, coupled with effective accountability structures supported by data from member states and platforms for experience sharing. The RECs are well-placed to build capacity for producing evidence and to disseminate and exchange learning across countries.

Delegates discussed the issues raised. It was noted that things might become more positive if/when African states have their own sources of funding, but that this was not automatic and that higher levels of funding do not alone guarantee positive outcomes. The issue of roles, capacities and leadership was also raised as key, implying the need for a culture of what it means to be a person with public responsibility, including in terms of life-long learning, The role of the RECs was further discussed. It was noted that there is *within* region variation and questioned whether the notion of common but differentiated responsibilities could be applied to global negotiations. It was also noted that the African RECs need to formally have a seat at the global table. For example the European Union EU has an opportunity to be effective in GHD because they are formally given a seat at the negotiating table. The question was asked: Why has the AU not positioned itself similarly? RECs attend some forums but under the accreditation of member countries rather than under their own accreditation. It was viewed that African RECs need formal recognition in their own right as is given to the EU.

8.3   Learning on the processes and priorities for future GHD research

Valerie Percival, Carleton University noted some consistent messages emerging throughout the meeting that effective involvement by African actors in GHD demanded leadership; voice; driving not following the process; predicting problems and opportunities; and taking action to make change. African actors have the ability to shape the GHD process, but this needs appropriate information and knowledge to define the agenda, and understand the levers to drive that agenda, including through regional convening. African actors must develop clear, specific, and implementable policy prescriptions that are able to shape change within particular contexts, and then **sell** these policies. This implies projecting the distributional and other consequences of GHD and health co-operation (or its failure), analysed from different perspectives, including gender and inequality perspectives. This means that research is not only a tool for informing the definition and understanding of the problem, but that it is also a process in which key actors, norms, institutions and forums for diplomacy need to be engaged.

In terms of the methods for future research she noted that the programme has so far identified the nature of current conditions and processes. She recognised that triangulation of methods and evidence to verify information, involving multiple types of actors and larger, more diverse stakeholders in interviews are crucial to implement research on GHD, while understanding the challenges this implies. Future work could now go further to develop more explanatory, analytic research on what drives change. While the heuristic steps have been useful, she noted that deeper explanatory work

could use Kingdons' streams[7] to understand the change processes and to this end, a common framework looking at agenda setting, policy development, policy selection and negotiation theory to bring this to the context of diplomacy. She identified that researchers need to think about actors, positions, range of possible outcomes and distributional consequences.

Felix Maonera, African, Caribbean and Pacific (ACP) Group secretariat shared some initial feedback from the evaluation of EQUINET programme underway, noting suggestions made for future research work in this area to build on the work done to date to focus on areas relevant to strengthening health systems; to build institutional knowledge and communication across national institutions; and to explore emerging global alliances with Asian and Latin-American countries. He noted for example as one issue understanding   what the MDGs did for African health, and the level of African voice in the SDGs.

Delegates raised the need to focus on the policies affecting health systems *within* the region, with a research agenda shaped from shared priorities across the countries of the region and their implications for the global level, and exploring the alignment and policy convergence with these priorities at regional and global level. For example, how is the policy dialogue on domestic resource mobilisation being driven and addressed? It was, for example, observed that the focus on universal health coverage (UHC) can lead to a dominant focus on financing, to the cost of the many other material and social dimensions of effective primary health care and health systems.

9.   Moving forward: future work in the ESA region

After the rich inputs of the meeting, delegates reviewed in round table discussions the priorities for future research, analysis and institutional action on health and foreign policy: at global level, in regional and south-south interactions and in longer term horizons. These working group discussions in the three areas were presented to and further contributed to by the plenary. The main points are summarised in this section.

9.1   On ESA region intervention in co-operation on global health

The meeting recommended:
- A more co-ordinated process in the region, institutionalised within the RECs, to define and reach a consensus on priorities and strategic positions and principles within the region before collectively promoting these at the global level, with resources and champions identified to support global engagement.
- A distribution of roles and responsibilities between RECs to avoid parallel efforts and promote a more coordinated approach, while identifying the strengths of each regional organisation and building capacities and strategies for engaging on and negating a common agenda.
- Ensuring sustained institutionalised processes, methods, goals/ targets and review and feedback mechanisms on areas prioritised for GHD.
- Strengthened communication across sectors and key stakeholders *within* countries at all policy levels, including local private productive sectors and civil society.
- Ensuring that the RECs are formally included in global processes (as for the EU).
- Preparing in the RECs input to review processes on key global agreements, for example for the current WHO expert committee review of the Code, such as to use the binding procedures to address gaps in non binding areas.

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[7] Kingdon, J.W. (1995). Agendas, Alternatives and Publics Policies, 2nd edn. New York: Harper Collins.

It was also noted that bringing health into foreign policy brings it to a political/diplomacy space. The language and messages need to be packaged in a way relevant to all the sectors involved. Engaging in that space requires understanding the processes involved, and the diverse audiences with different procedures for interpretation of results. Engaging in global health demands strong communicators and communication.

Further research areas were suggested that address these concerns or that help to build these processes that could inform future GHD research in the region:
- How is unity and reciprocity being cultivated, organised and applied in GHD?
- How are the expert committees working at global level, including in relation to effectiveness of participation of African actors? What lessons from regions that are most effectively using these committees?
- What mechanisms and processes are there for civil society participation at the national and regional level in global health negotiations? How have other regions addressed this?
- How are the issues that are prioritised for GHD by the health sector in the region viewed by other actors within and beyond the region?
- What technology development and innovation opportunities are there within the region/ continent and within current global agreements? How have other regions addressed this?
- How were African stakeholders and countries involved in shaping the SDGs? Did any other regions take different approaches? What does this learning raise for future proactive engagement in global processes?
- What impact is the military role in humanitarian and/or health emergencies having on the health agenda in Africa?
- What tool and measures can be used to assess progress in GHD at national and regional level?

Meeting delegates in the round table discussions

9.2   On ESA intervention in regional/ south-south /BRICS processes

The meeting recommended that ESA countries set an agenda within the RECs of:
- Setting the goals and operational targets that the region seeks to achieve in the engagement with BRICS and in south-south cooperation, such as in overcoming gaps in capacity for local production of medicines.
- Identifying the principles to be followed in the engagement in the BRICS and in south-south cooperation, making reference to existing policy documents.

- Engaging in the platforms that exist for collaboration. Two separate areas were identified: 'talk' platforms and 'action' platforms. The 'talk' platforms include multilateral forums, regional forums etc. in which Africa can engage with BRICS so that African positions are advanced. The 'action' platforms require that the capacities for implementation of goals be identified – health workforce training, local production, centres for regional excellence and laboratories –to determine how BRICS and south-south collaboration can aid capacity building in these areas.

Further research was suggested to deepen the analysis of the role south – south collaboration can play in the existing areas worked on in the EQUINET research to date, viz on health system financing, on health worker adequacy, distribution, retention and skills and on medicines production, both within the region and at global level, for this to inform the BRICS and other forums. For example as raised earlier:
- How many companies within the ESA region are WHO prequalified? What measures are needed to widen the range of medicines produced such as through consortia of producers? How has this been achieved in other regions?
- What spaces and provisions should be used to reframe the issue of technology transfer from 'charity' to obligation and to include support for innovation?

9.3   Emerging/future concerns for ESA/African engagement in GHD

The meeting recommended:
- Systematic review of evidence, raising awareness, dialogue and development of regional positions on responses to the challenges projected for African health systems, including: the demographic transition and increased demand for health services and health workers; increasing urbanisation; rising levels of social inequality and the consequent pressure for a two tier health system within countries; and the impact of climate change, water stress and food shortages on health.
- Reviewing and identifying appropriate sustainable longer term options for ESA countries on health system financing, and the longer term system impact of current financing models to inform global and country negotiations on future financing.
- Developing and advocating health system and comprehensive PHC responses to non communicable diseases in global agendas.
- Review of the developments in continental organisations (AU, an African CDC, new development banks) and learning from other regions.
- Investment in inter-operable health information systems that can capture, store, generate, analyse and provide health data to inform decision making on health systems within and across countries in the region to inform planning, policy development, negotiation and implementation and, together with social media, that can be used to educate populations.
- Building a bottom up approach that involves and engages on health issues with other sectors beyond health, with civil society and private actors to build multisectoral dialogue, collaboration on and tools for proactive responses to projected trends.

Meeting delegates discussing issues in the future horizon

These areas were all identified as relevant for *further research,* together with:

- A review of evidence and learning from other regions on the health impact of the extractive industries in the region, to support work on minimum standards/ expectations on health and contribution to health systems for corporations to address (eg as a code of conduct/practice).
- A systematic review of current trade policies and practices for their consequences for health, and for the use of local resources in health, eg traditional medicines.
- The role and impact of social media and social mobilisation of civil society in generating narratives and positions to addressing global health challenges and improving health outcomes of populations?
- The skills set and system needs for trauma injuries (given that surgery is already an agenda item for the WHA).

9.4   Widening cross sectoral and stakeholder involvement in GHD

In an interactive activity, delegates raised the actors that need to be brought into future GHD work, as presented in Table 1 below. Some actors were raised multiple times, as indicated. The list shown in Table 1 was indicative and those already in the regional meeting (embassies, ECSA-HC, EQUINET teams, specific technical institutions) were not raised as they were already involved and should remain so.

The exercise highlighted the view raised several times in the meeting that the national and regional levels were primary for future research, whatever the theme, and should play an important role, and that the work should involve sectors outside health, particularly trade, finance, and foreign affairs. A number of civil society actors were raised, including health worker associations. The meeting also identified the need to involve media in future work.

Actors in different constituencies to engage in future work on GHD from participatory review

Table 1: Actors to bring into GHD process

Global	Regional	National/State	Civil Society	Private	Academic	Other
International, domestic and private funders Foundations; USAID, Gates	SADC (x2)	MPs and Ministers	Citizens	Private sector x4	Academics	'Champions' for GHD- - former presidents and first ladies
World Bank (x2) IMF	EAC	Other sectors: Trade & Commerce x6; Finance x5 Foreign Affairs x3; Labour x2; Water; Environment Social welfare Justice; Defence	Civil Society Organisations x4	Employer associations	Policy, economic, social research institutes	Celebrities
Research Funders: IDRC	ECOWAS/ West Africa Health Org (WAHO) (x2)	Kenya Institute of Diplomacy	Health professional associations	Banks	Scientific community	Reps from health professional societies
ILO	African Union Social Commission	Agricultural organisations	Trade unions	Private individuals	Africa University (Intellectual Property)	Media x3 Health journalists
UNIDO	Regional Develop-ment Banks	Health workers	SDH net	Industries Mining Manufacturing	Graduate Institute	
International Commission on Climate Change	RECs	Country reps at WTO	TAC	Faith based organisations X2	South Centre	
WIPO	Health Africa	Scandinavian politicians	Public Health Association			
Specific countries eg Norway	AMREF	Health profession regulators	WLSA (Women in Law in SA)			
ASEAN, Latin American regions	AMHR-NEPAD	Policy implementation units	Patient advocacy organisations			
	Codesria	Regulatory bodies				

In conclusion, it was noted that these proposals and the recommendations on the areas of future work would be summarised in a brief and reviewed with ECSA HC, EQUINET SC, IDRC, SADC and others at the meeting.

10   Closing

Rene Loewenson thanked all delegates and presenters for their time, invaluable input, papers and research. She indicated that EQUINET would produce this meeting report and will disseminate the research that has already been published through various channels, including in academic journals and with partner institutions. The meeting report and research will be used as the basis for dialogue with senior officials and with delegates to identify opportunities for exchange across work already underway in the region and to identify new areas for collaborative work, including with other regions

Yoswa Dambisya, on behalf of ECSA HC, Patrick Kadama, on behalf of delegates, and Lebogang Lebese on behalf of DoH South Africa gave closing remarks. Prof Dambisya expressed ECSA HCs excitement at being part of the meeting and the entire process. He looked forward to the report and noted that a next step is to incorporate these issues into ECSA HC agenda and forums, including in collaborative relations across regional organisations. Dr Kadama expressed gratitude to the organisers of the meeting on behalf of delegates and to the delegates. He noted that he had been involved since the GHD research programme started in 2012 and was happy with the efforts to involve delegates in setting the agenda for the process throughout. He urged delegates to take the learning back to their countries and disseminate it from minister level to community level to show how issues that arose years ago **are** being responded to and that things **are** being achieved.

Finally Dr Lebese expressed the DoH's pleasure at being able to host a meeting with delegates and discussions of a high calibre. She noted that South Africa welcomed being host to such meetings and that institutions like EQUINET trust SA to be there when support is needed. She thanked all partners and reiterated the point raised in the meeting that health is a collective responsibility, and not that of government alone and that all need to take the work forward. She wished all delegates safe travel home.

Appendix 1: Programme

Friday 13 March 2015

TIME	SESSION	SESSION PROCESS	ROLE
OPENING– Chair Mr M Modisenyane, South Africa Dept of Health			
08.30-09.30	Opening, Introductions Overview of the programme	Opening remarks	Prof Y Dambisya Director General ECSA HC
		Welcome Delegate introductions	Mr M Modisenyane, Dept Health SA
		Overview of the EQUINET Regional research programme; Meeting objectives and adoption of the agenda	Dr R Loewenson, TARSC /EQUINET
09.30-10.00	Setting the context on GHD in ESA	Issues and learning from the ECSA strategic initiative on GHD: GHD challenges and responses in the region Discussion	Mr E Manyawu ECSA-HC
10.00	**TEA**		
AFRICAN ENGAGEMENT IN GHD: FINDINGS OF THE REGIONAL RESEARCH Co-chairs Dr M Awases WHO Afro, Dr R Loewenson TARSC			
10.30-11.15	Is there an African approach to health diplomacy?	Findings from the review paper on African perspectives in global health diplomacy	Mr M Modisenyane, Dept Health SA
		Discussant	Mr E Makasa, Zambia High Commission, Geneva
		Discussion	
11.00-11.45	Experiences of African engagement in GHD on health worker migration	Presentation of the findings on GHD on health worker migration and the implementation of the WHO Code on international recruitment of health personnel	Prof Y Dambisya, ECSA HC, Prof N Malema U Limpopo
		Discussant Discussion	Mr I Dhillon, USA
11.45-12.30	African engagement in south-south cooperation on medicines production	Presentation on the findings on overcoming barriers to medicines production through south-south cooperation	Mr R Machemedze, SEATINI Mr M Mulumba CEHURD
		Discussant Discussion	Ms R Hove, MoHCC Zimbabwe
12.30	**LUNCH**		
AFRICAN ENGAGEMENT IN GHD: FINDINGS OF THE REGIONAL RESEARCH Chair Prof F Senkubuge University of Pretoria			
13.45-14.30	Experiences of African engagement in GHD on health financing	Presentation of the findings on African actors, global health governance and performance-based funding Discussion	Dr Patrick Banda, Ministry of Health, Zambia
14.30-15.15	Round tables on the four research areas	Round table discussions, one table each on one of the four research areas above 1. What learning on GHD? 2. What implications from the findings for policy and programme level? 3. What knowledge gaps that need to be addressed through follow up work?	Delegates
15.15	**TEA**		
AFRICAN ENGAGEMENT IN INTERNATIONAL CO-OPERATION – Co-chairs Mr L Ndimeni Dir Human Rights, South Africa, Prof Y Vawda, School of Law, University of KwaZulu-Natal			
15.30-17.00	African engagement in BRICS	Perspectives from Fiocruz and ALAMES on south-south co-operation between Latin America and Africa	Dr C DeAlmeida, ALAMES/Fiocruz

TIME	SESSION	SESSION PROCESS	ROLE
		South Africa's experiences in foreign policy on access to antiretroviral medicines- 15 min	Mr M Modisenyane, Dept Health SA
		Findings of the content review of policies on the role of BRICS co-operation in addressing health system priorities in East and Southern Africa Discussion	Dr R Loewenson, TARSC
17.00	**END OF DAY**		

Saturday 14 March 2015

TIME	SESSION	SESSION PROCESS	ROLE
REVIEW OF DAY ONE - Chair Ms M Mamdani, Ifakara Health Institute			
08.30-09.30	Review of round table reports	Feedback from the four round tables Discussion	Round table rapporteurs
AFRICAN ENGAGEMENT IN INTERNATIONAL CO-OPERATION Chair Dr I Ayagah, Ministry of Health, Kenya			
09.30-10.15	African engagement on epidemic and humanitarian responses	Fighting Ebola: opening a new field of civil-military cooperation Health diplomacy in humanitarian action Discussion	Dr A Kamradt Scott, University of Sydney Ms V Percival, Carleton University
10.15	**TEA**		
SYNTHESISING LEARNING FROM RESEARCH ON AFRICAN ENGAGEMENT IN GHD Chair Mr R Machemedze, SEATINI, EQUINET			
10.45-11.45	Opportunities and challenges for ESA regional bodies	Developing a tool in the SADC region for policy monitoring Learning from the research on African intervention in in agenda-setting, policy development, policy selection and implementation in GHD Discussant: Regional roles in global engagement Discussion	Ms A Amaya, UNU-CRIS Dr R Loewenson, TARSC/EQUINET Dr L Lebese, DoH South Africa
11.45-12.45	Working groups	Working groups on recommendations for priority areas of research, capacity building and action: Group 1: ESA region intervention in agenda-setting, policy development, selection and implementation in GHD Group 2: ESA region engagement with BRICS and in south-south platforms Group 3: Horizon setting- emerging/ future concerns for ESA/African engagement in global health	Delegates
12.45	**LUNCH**		
MOVING FORWARD: FUTURE WORK IN THE ESA REGION– Chair Dr P Kadama, ACHEST			
14.00-15.50	Report back on working groups	Feedback from the three working groups Discussant: Doing research on GHD: learning on the methods from the EQUINET programme Discussant: Preliminary findings from evaluation of GHD work and research Participatory activity on actors in future work	Working group rapporteurs Ms V Percival, Carleton University Mr F Maonera, ACP Group Dr R Loewenson
CLOSING SESSION– Chair Dr R Loewenson, EQUINET			
15.50-16.15	Next steps and closing remarks	Summary of next steps and closing remarks	EQUINET, DoH, ECSA HC, EQUINET and delegates

Appendix 2: Delegate list

LAST NAME	FIRST NAME	COUNTRY	ORGANISATION
Amaya	Ana	Belgium	Research Fellow UNU-CRIS
Ayagah	Isabella	Kenya	International Health Relations Unit, Ministry of Health, Kenya
Awases	Magdalena	Zimbabwe	Adviser, Human Resources for Health Development Inter-country Support Team for East and Southern Africa (IST/ESA) WHO Regional Office for Africa
Banda	Patrick	Zambia	Directorate of Policy and Planning, Chief Planner - Planning and Budgeting Ministry of Health Zambia
Dambisya	Yoswa	Tanzania	Director General, East, Central and Southern Africa Health Community
DeAlmeida	Celia Maria	Brazil	Senior Researcher ENSP/Fiocruz, Representative ALAMES
Dhillon	Ibadat	USA	Independent researcher
Hove	Ropafadzai	Zimbabwe	Director Pharmacy Services, Ministry of Health & Child Care
Kadama	Patrick	Uganda	Director of Policy and Strategy, African Centre for Global Health and Social Transformation (ACHEST)
Kadowa	Isaac	Uganda	Principal Medical Officer, Ministry of Health, Uganda
Kamradt Scott	Adam	Australia	Senior Lecturer, Centre for International Security Studies, University Of Sydney
Lebese	Lebogang	South Africa	National Department of Health South Africa
Loewenson	Rene	Zimbabwe	Director, Training and Research Support Centre Cluster lead, EQUINET
Machemedze	Rangarirai	Zimbabwe/ Botswana	Southern and Eastern African Trade, Information and Negotiations Institute (SEATINI) and SADC Council of NGOs, Cluster lead, EQUINET
Makasa	Emmanuel	Zambia	Counsellor-Health: Permanent Mission of Zambia, Geneva
Malema	Nancy	South Africa	Professor, University of Limpopo
Mamdani	Masuma	Tanzania	Ifakara Health Institute
Maonera	Felix	Switzerland	Deputy Head, Geneva Office, Secretariat of the African, Caribbean and Pacific (ACP) Group
Manyawu	Ernest	Tanzania	Director of Operations and Institutional Development East, Central and Southern Africa Health Community
Modisenyane	Moeketsi	South Africa	International Relations, National Department of Health, South Africa
Mulumba	Moses	Uganda	Director, Center for Health, Human Rights and Development (CEHURD), Cluster lead, EQUINET
Ncube	Caroline	South Africa	Head, Department of Commercial Law, Faculty of Law, University of Cape Town
Ndimeni	Luvuyo	South Africa	Directorate of Human Rights, Department of International Relations and Cooperation
Papamichail	Andreas	Scotland	University of St Andrews Consultant, TARSC
Percival	Valerie	Canada	Assistant Professor, Norman Paterson School of International Affairs, Carleton University
Senkubuge	Flavia	South Africa	Health Policy and Management School of Health Systems and Public Health University of Pretoria
Vawda	Yousuf	South Africa	Professor, Academic Leader: Public Law School of Law, University of KwaZulu-Natal

Apologies:

Durham	Saranne	South Africa	Western Cape Department of Health
Molenaar	Bente	Canada	Carleton University
Mahmood	Qamar	Canada	International Development Research Centre (IDRC)
Matsau	M	South Africa	National Department of Health South Africa
Sematiko	Gordon	Uganda	