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

Key findings and recommendations from a regional research programme 2012-2015

Do global health platforms provide meaningful opportunities to advance equitable health systems and population health in east and southern Africa? What factors have supported effective negotiation of African policy goals on health systems within international and global health diplomacy?

This brief outlines, with hyperlinks to the relevant reports, the findings and proposals for follow up policy review, action and research from a three year EQUINET led policy research programme with government officials, technical institutions, civil society and other stakeholders and in association with the East, Central and Southern Africa Health Community (ECSA –HC). The first two pages provide the broad findings, proposed actions and research agenda. Subsequent text presents the findings and proposals from the specific themes investigated in the programme.

Is there an African 'approach' to global diplomacy on health?

Health has been brought into foreign policy processes for several centuries, as a goal of foreign policy; a tool of foreign policy, to secure economic or security interests of states or as a an intended outcome in the *collective negotiation* of competing interests. While bringing public health into foreign policy dialogue can subject it to wider interests and tensions, international co-operation in health has also played a role in advancing health globally. Health inequities within and across countries are argued to demand action nationally and globally. There is already significant international engagement in African health systems and international interest in African natural resources, including in emerging south-south alliances. Much African foreign policy engagement in global health is undocumented. Our review of what is documented suggested that there have been several foreign policy approaches that have been brought by African countries to negotiations on global health:

i. **African unity, interdependence and reciprocity**, based on the perception that unity and the development of shared positions played a key role in prior achievements in health and in addressing economic and political determinants of health. African countries have, for example, been unified in global negotiations on access to essential medicines, in raising the issue of health worker migration and in cross-border collaboration on control of infectious diseases.

ii. **The liberation ethic and demands of nationhood**, arising from the 20th century anti-colonial struggles and nation building, have raised independence, sovereignty, self-determination and economic and social justice as critical for claiming Africa's position globally and for securing stability nationally. This lens was applied in the 2001 Doha declaration at the WTO and in the use of TRIPS flexibilities to secure equitable access to medicines. Conditionality in global relations have sometimes been perceived as a challenge to such self-determination.

iii. With African countries increasingly dependent on external funding for health sectors, particularly after the Bretton Woods structural adjustment reforms, a tension has emerged in African negotiations of **health as a sphere of development aid or of developmental policy.** Policy positions on comprehensive primary healthcare (PHC) or the framing of the Lagos Plan of Action for the Economic Development of Africa articulated approaches to address structural and social inequalities causing ill health within developmental policies. African countries attempted to protect policy space through regional cooperation. However in practice much international interaction in the health sector has been around the effectiveness and efficiency of development aid, often focused on the management and control of specific diseases.

The findings suggested that these positions resonate with political histories and cultures in the continent and have been productively applied in global health, especially when backed by shared policy positions developed in the regional economic communities (RECs), by policy coherence and institutional co-operation across sectors and by engaging the public, civil society and domestic producers within African countries. However the findings also suggest that African countries often engage late in global health negotiations, in a reactive manner and often within a 'development aid' rather than a 'developmental' paradigm, with approaches that are not always fully defined, framed or coordinated and with gaps in skills and supporting institutions. Contradictions exist, such as when states invoke solidarity at global level, but do not practice it domestically. Global processes may be remote, inaccessible and digitally challenging for many in African countries. The work suggests that African policy positions may fail to have leverage due to problems with process.

As follow up actions, an agenda on global health that positions health equity as a developmental agenda was thus argued to demand strengthening several processes:

- *First* the development of coherent positions *within* countries, across sectors and stakeholders, including civil society and local producers.

- *Secondly*, the forging of and collective consensus on priorities, principles and strategic positions for global engagement across *countries at regional and continental level.* This calls for resources and champions to be identified to take these positions to global level, and for monitoring and review against goals. Institutionalised and sustained co-ordination *within the region* and particularly by the RECs is identified as key, with co-ordination of capacities, roles and issues across the RECs to avoid parallel efforts.

- *Thirdly* it calls for effective communicators, for good communication between capitals, RECs and diplomats, individually and collectively, to ensure coherence between country and continental engagement at global level and negotiation for the RECs to be formally included in key global processes (as is currently the case for the European Union at the World Health Assembly). At the same time, actors driving global processes, including from expert committees, should be invited to dialogue in the regional and continental forums.

A follow up research programme could, in real time and *working with those directly involved,* support the actions above, while generating knowledge to inform and assess prioritised policy agendas. This implies giving attention to both content and process, linking health equity to procedural justice. A number of issues under global negotiation could provide a focus for this. Those raised at in the programme and at regional level include:

(i) health worker training and deployment, including engagement with the current WHO expert committee review of the Code on International Recruitment of Health workers;

(ii) global health governance in the response to health emergencies, learning lessons from the African and international response Ebola;

(iii) identifying and advancing African priorities, principles and policy support for primary health care in the 'health system strengthening' and universal health coverage agendas; and

(iv) clarifying and delivering on operational goals for medicine production and trade and for health technology development and innovation in the region and in south-south co-operation.

On any one of these four issues, a research programme could explore and bring to regional review the strengths and deficits in current processes for shaping and taking forward ESA positions and discourse within and across the three key process dimensions raised for follow up action above: in the multi-sector and multi-actor processes *within* countries, in the institutionalising of processes in the RECs *across* countries, and in the communication and engagement with diplomats, with expert committees and in bringing global actors into regional platforms. It can also review how these processes are being managed in other regions, for lessons learned and to explore entry points for alliances on common concerns and interests.

Advancing African agendas in global health

A case study led by the University of Limpopo on **the WHO Global Code of Practice on the International Recruitment of Health Personnel** (the "Code") explored how an inequitable 'brain drain' of health workers from ESA countries to high income countries was raised and pursued globally on by African ministers of health, through to negotiation and implementation.

In the late 1990 and early 2000s most ESA countries wanted to arrest the loss of skilled health professionals, termed 'looting' of health workers in one regional forum, and to obtain some form of compensation for the significant losses of public funds in investments in training and for the costs to health systems. A long diplomatic process ensued, across a range of regional and international institutions, including with the WHO and at the World Health Assembly (WHA), with the World Bank and UNESCO, the negotiation of a Commonwealth Code of Practice for the International Recruitment of Health Workers in 2003 and bilateral and regional agreements on the issue.

A Code was unanimously adopted by the World Health Assembly in May 2010. Many of the proposals made by African countries were included in its final wording. As the negotiations progressed, however, African countries

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yielded ground on the issue of "compensation" and "mutuality of benefits", that is on getting a return on the investments they had made on training health workers from the countries they migrated to. The case study found that the exclusion of these concepts was interpreted by African policy actors as a watering down of the Code, as was its voluntary nature.

Strong, high level African political champions communicating clear collective positions enabled the issue to rise in the global agenda, reinforced by a range of bilateral and multilateral agreements that demonstrated the possible. Through WHO-AFRO, through the African group of countries in the Commonwealth, and through the Africa Group at the WHA, African countries were able to develop combined negotiating positions that strengthened their voice and influence. However in the long process to reach a global agreement, the debates were not always well communicated to stakeholders within countries, weakening their support and their later implementation of the Code. Some key champions from the early stages were no longer at the table in later stages. Bringing differing country-specific interests into a unified platform yielded compromises that could become weak points in negotiation and implementation.

While African countries spearheaded the Code, the 2013 report to the WHA by the WHO Secretariat on the implementation of the Code found limited implementation and reporting from African countries. External migration was found to have been overtaken by concerns on internal migration as a policy concern, with limited routine monitoring of or evidence on migration and its costs. The case study also found lack of preparedness for implementation; overburdened human resource (HR) departments; lack of champions to drive the process; lack of regional coordination, including from the WHO; perceptions of inadequacy of the Code; poor mobilisation of national level stakeholders and little publicity on progress of Code implementation. During the negotiations, there was little discussion of implementation, underestimating the resources and capacities required and suggesting that future negotiations on global accords factor in the mechanisms, capacities and resources for implementation as a shared global responsibility. Civil society actors played a key role in raising awareness on and explaining the contents of the Code in simpler terms and in support of fair benefit. However weak integration of civil society into the measures for implementation of the Code weakened their role in implementation and in holding governments domestically and internationally to account on implementing the commitments in the Code.

Follow up research could inform and support these actions, to explore perceptions and evidence on emerging regional concerns on health workers and how they are being taken up at national, regional and global level. Evidence suggests that costs and losses from out-migration continue to be a problem, albeit poorly measured, so that the perception of external migration as a less critical concern needs to be further explored, from the lens of health and other sectors. A follow up research programme could also inform the engagement on the review of the Code, providing evidence on areas of and barriers to implementation. It could explore and provide learning from experience of other codes, such as the WHO International Code of Marketing of Breast-milk Substitutes, to inform proposals for the review.

Negotiating global policies that align to national goals

Millions of dollars are channelled each year to African governments to support health systems from external funders, and from global institutions such as the World Bank and the Global Fund. Much of the money is provided in the form of "Performance Based Financing" (PBF) schemes. The second case study led by U Sheffield reviewed African agency in **decision making on and design of these PBF schemes.**

PBF transfers resources on condition that particular actions are taken or predefined performance targets achieved. It is promoted by leading global funders to improve the efficiency and effectiveness of health financing. For local ownership, the targets should be developed through the active participation of local actors from the bottom-up; rather than being set by global institutions from the top-down.

The case study found documented evidence that PBF has incentivised targeted health outputs and increased accountability mechanisms in some settings. These effects need substantive investment in health information systems and are more successful for targeted health interventions, like payment per patient seen, and not on whole-of-system targets. Vertical PBF schemes can thus incentivize 'health silos' that are not always fully integrated into comprehensive PHC. With these mixed effects, surveyed government officials and health service stakeholders in ESA countries gave both positive and negative views of PBF. The schemes were reported to: fulfil the need for health funding, curb corruption in management of funds, increase effectiveness and accountability in the delivery of aid funds, increase value for money in health financing, and facilitate the monitoring of global institution interventions in health.

Bottom up formulation of system priorities. Kaisipul, Kenya.
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However stakeholders did not see PBF schemes as being built on local learning, but rather as 'buying' behaviour through cash incentives, in 'one-size fits all' approaches that do not adequately reflect the complexity of systems. They were perceived to bring unintended consequences such as: distortion of national health priorities; 'gaming' and 'cherry-picking' of conditions for treatment; creating 'perverse incentives' and hidden costs in health services. PBF schemes were seen as driven top-down, with limited space for participation at all levels. Some termed them as a new form of 'structural adjustment'. 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 RECs were underutilised. At the national level, there was some evidence of multisectoral participation in target setting and of an integrated systems approach with PBF, although multi-sectoral participation was often limited and priority targeting sometimes ad hoc. Regional stakeholders observe that some recipient countries do not perceive that they can input to the design of PBF and may officials face pressure to adopt targets due to the significant resources that accompany them.

As follow up actions, review of the case study findings suggest that there is space for greater African agency in the design and implementation of global financing arrangements. Before discussions open, countries can share information on priorities and approaches that will address health system gaps, including with embassies, and engage on these at political level, so that technocrats are not disempowered in taking up areas of genuine disagreement at the time of negotiation, or in turning down proposals that contradict national policies and system goals. It is recommended that negotiators thoroughly examine what has and has not worked elsewhere and what conditions and capacities have affected practice and outcomes in other settings, to assess the relevance for the local context and strategic plan, including for equity. Multi-sectoral bodies were found to support more positive outcomes from PBF. They provide an opportunity to bring in academics, researchers and health personnel of various disciplines and levels in the design, implementation and evaluation of PBF. It was recommended that several issues be raised upfront, including what investments will be made in information, monitoring and evaluation systems; what measures involving local practitioners will be supported for reporting and addressing problems, for feedback and review, and what will happen when external funding is phased out.

Follow up research could inform efforts at regional level and in the Africa group to evaluate the system and equity impacts of PBF and other financing options, to assess the full spectrum of factors impacting on poor health system performance, and to develop and negotiate options that draw from good practice within the region, that address performance factors and that better align to the needs of African health systems. New approaches will be demanded to give effect to the Sustainable Development Goals and to ensure sustainable and equitable domestic and global financing of and delivery on health system strengthening and universal health coverage. There is thus scope for research that builds dialogue on this within Africa and with other regions, including on the levers and processes for taking options to global level.

## African engagement in south-south co-operation on health

New perspectives on international co-operation in health are gaining profile, building on lessons learned from south-south co-operation. As an issue of both political and strategic positioning, international co-operation is seen to imply a 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, and taking the different organisational cultures into account. It calls for sustained commitment and interaction to construct strategic and political consensuses, close partnering between health and foreign affairs sectors to draw on the strengths of each, appropriate institutional arrangements to respond to foreign policy decisions and to avoid responsibilities being obscured, and regional arrangements that build political strength and widen "strategic room" to a greater extent than that afforded by bilateral relations.

Research in the EQUINET (Brown et al 2015) explored how far the resolutions, commitments, agreements and strategies from BRICS (Brazil, Russia, India, China and South Africa forum) and Brazil, India and China (BIC) as forums for south-south co-operation reflect the stated commitment to equitable co-operation and address policy concerns articulated in the African Union and in ESA regional organisations. It focused on policy statements on medicines, health financing and

health workers. The content analyses of ESA and BRICS policy documents revealed that all three areas were commonly raised, with synergies in the broadly stated priorities between ESA and BRICS/BIC policy documents. However, there was less common statement of specific operational commitments or goals for these areas, and some evidence of differences in focus between countries in BRICS and Africa. For example there was a shared concern on medicines. However the BICs documents focused more on market access, while the ESA policies focused more on overcoming skills, capital, legal and technology barriers to local production, and on measures for bulk procurement. The analysis suggested that African countries need to ensure that stated aims of mutual benefit are realised through operational commitments and specific goals.

A third case study led by SEATINI *on the bottlenecks to essential medicines production in ESA countries* and how they are addressed in selected collaborations between ESA countries and emergent economies explored this more deeply. While 37 Sub-Saharan African countries currently produce pharmaceuticals, South Africa is responsible for over 70% of this production, and only South Africa has a limited degree of Active Pharmaceutical Ingredient (API) production. The research highlighted a number of interacting barriers to local production identified in AU and regional plans and by key informants in ESA countries, including: limited governmental support in the initial stages to encourage domestic investment, capital and technology shortfalls, small national markets, high tariffs on imported inputs, unreliable and costly infrastructure, skills shortfalls, a prohibitive intellectual property regime and regulatory and enforcement gaps, summarized in the figure below.

Constraints and bottlenecks to local production
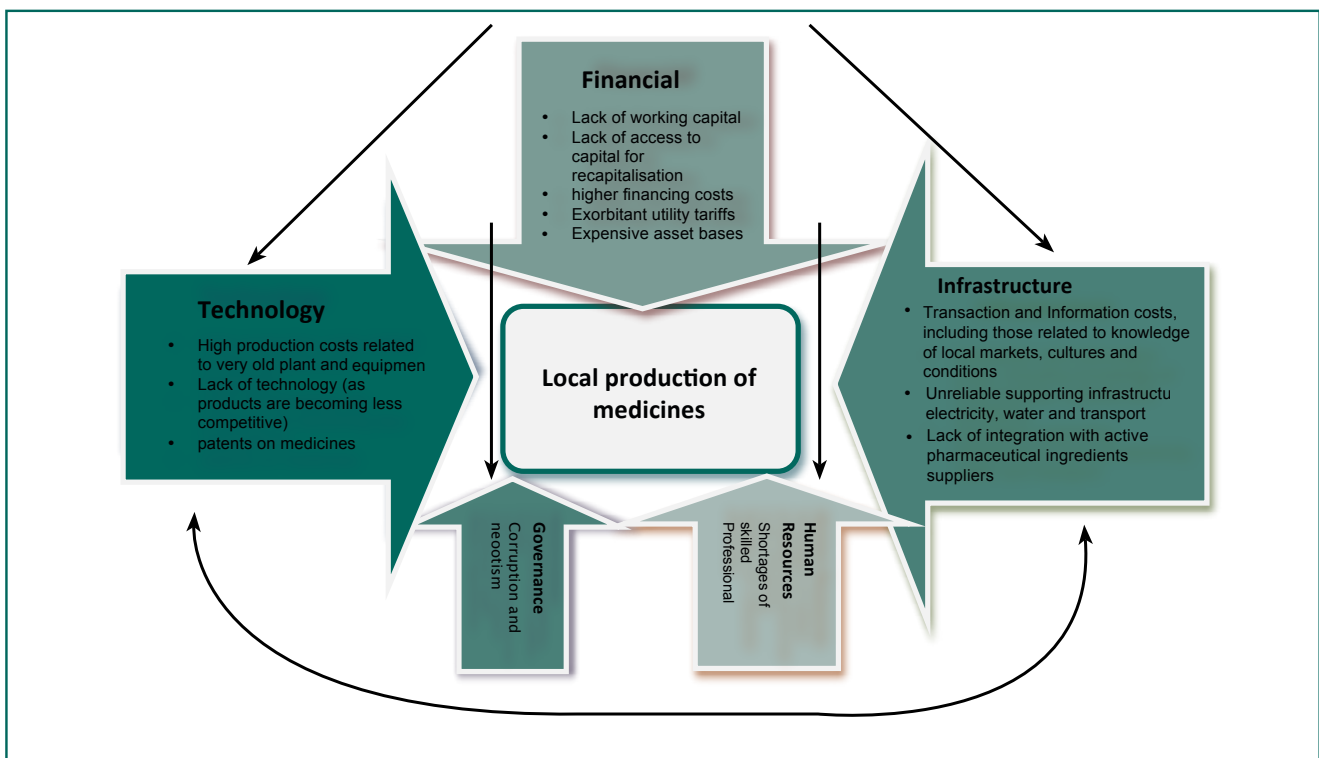
Source: SEATINI and CEHURD 2014

There is evidence of new interest in medicines markets and production in ESA countries from emergent economies. In Uganda, for example, on request by that government, Cipla Ltd, a leading Indian pharmaceutical manufacturer entered a joint venture with local partner Quality Chemicals Ltd (QCL). This enabled local production of antiretroviral medicines and anti-malarials under licence from Cipla Ltd. Cipla invested in training and exchange programmes and in technology transfer to support the plant, while the Uganda government provided infrastructure, local market, fiscal and regulatory support. Such examples show the potential for south-south co-operation in local production. However, the case study also highlighted the need for ESA countries to actively negotiate for prioritized inputs from partners. ESA governments would also need to dialogue across ministries of trade, finance and justice and with African pharmaceutical companies and training institutions to implement policies and to set enabling laws and capacities for their enforcement; including to support prequalification; to develop, attract and retain relevant capacities and skills; to provide supportive incentives, tariffs and infrastructure and negotiate regional trade agreements to widen the market size to improve the returns to producers, and to access skills, technology and investment capital.

As follow up actions, regional stakeholders recommended that ESA countries in the RECs:

- Dialogue with local industry and training institutions on the skills gaps for local production;

- Within the RECs, set goals and operational targets to achieve in south-south cooperation, including in overcoming bottlenecks for local production of medicines;

- Advance these goals through platforms such as the 'access to medicines, vaccines and diagnostics' process in BRICS, where South Africa, China and India were allocated leadership at the 2013 BRICS Ministerial meeting;

- Within the RECs, set policy principles to be followed in south-south cooperation, moving from single programme interventions to strategic planning based on population health and comprehensive health system development;

- Identify appropriate personnel for and engage in 'talk' platforms – multilateral, regional and south –south - to advance African positions; and in 'action' platforms to operationalise and monitor implementation of goals on health workforce training, local production, capacity building for centres for regional excellence and laboratories and other priorities;

- Within the RECs, identify and engage on priorities for the BRICS Development Bank, as development facility and in knowledge exchange.

Follow up research support these actions by:

- Sharing and discussing the findings from the research in the RECs;

- Identifying the global and bilateral agreements that have been signed in the ESA region relevant to medicines production and the policy space to be used, including how ESA countries can take advantage of the transition period for implementing the TRIPS agreement on pharmaceuticals to support local medicines production, particularly by operationalising the extension currently under review.

- Identifying the factors affecting WHO prequalification in the ESA region and the measures needed to widen the range of medicines produced by prequalified factories as an agenda for south-south knowledge exchange and dialogue;

- Identifying the most critical (quantified) cost drivers to address to improve competitive pricing and how these have been negotiated and addressed in other regions;

- Exploring existing legal provisions and policy spaces and commitments to reframe the issue of technology transfer from 'charity' to obligation, including to support innovation.

African engagement on health

Analysing the results across the case studies showed some common issues (Loewenson and Molenaar Neufield 2015). ESA influence in agenda setting was strengthened by high level political leadership and clear and consistent articulation of issues; with backing from civil society and from south-south alliances. Influence on global policy development was supported by having clear regional and national policies, role models and domestic support, with strong capital-embassy links and unity in the African group. Policy implementation was more likely where policy negotiations were widely disseminated, and where the areas negotiated had synergies with existing practice, and support from domestic actors and regional exchange.

Health diplomacy in Africa was commonly found to be framed in a 'development aid' paradigm. Yet this paradigm may be suppressing more transformative forms of international co-operation needed to address global inequalities, skewed power and procedural injustice in global processes, to address structural determinants of health, promote health rights and build comprehensive, universal health systems. Regional stakeholders identified future challenges facing African health systems, including: a demographic transition, climate change, urbanization, resource extraction, water stress and food shortages. These pressures will raise demand for health services and health workers and rising levels of social inequality can raise pressure for two tier services and increase social insecurity and fragmentation. ESA countries will need to address such challenges within a liberalized globalization, to fund and deliver universal comprehensive PHC based systems, to lever health promoting action from other sectors, to invest in information systems that inform decision making and to engage a more informed population. These projected challenges generate even greater demand for a transformative, *developmental* paradigm in international co-operation in health in support of African driven agendas, as is articulated in the AU's Agenda 2063.

> **A number of research areas** were raised to explore further such future challenges:
> - To assess and project the distributional/equity consequences of specific global policies, processes and co-operation activities, including those related to the SDGs and UHC.
> - To generate evidence in the region and draw learning from other regions to inform regional standards and codes of practice in the extractive industries for protection of public health and fair contribution to health systems and social determinants of health;
> - To systematically review prioritized trade policies and practices for their consequences for health, and for the use of local resources in health, eg traditional medicines.
> - To explore the role and impact of social media and social mobilisation of civil society in Africa in generating narratives and positions to address global health challenges;
> - To provide evidence to support responses to new demands, such as for non communicable diseases or surgery within integrated primary care and wider health systems.

The range of actions and research approaches highlighted in the regional programme and review point to the need for a stronger, more co-ordinated political and technical role for the RECs in global health, coupled with effective structures for participation and accountability, information and evidence and platforms for strategic review and exchange of experience and learning. They also call for participatory research practice that informs the definition and understanding of the problem but that also analyses what drives change, in processes that involve the key actors, norms, institutions and forums for diplomacy and co-operation in health.

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